One Path Mental Health

Client Library

The models we use in treatment, written for an intelligent adult.
Begin anywhere. Each page teaches one idea, says why it works, and ends with a practice.

This library belongs to: _____

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Start here

Welcome. Begin Anywhere.

You are holding the models we use in treatment, written for an intelligent adult — not a workbook you have to finish, and not a test. Every page teaches one idea, says why it works, and ends with something small to try and bring to session. Pick the section that matches the week you are having. That is the whole method.

Where do you want to begin?

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Three agreements

You are not a diagnosis; these pages describe patterns, not people.
Nothing here replaces a conversation — if a page stirs something, that is material for session, not a problem to manage alone.
Take what fits and leave the rest. Disagreeing with a page is a legitimate outcome.

If today is hard, skip all of this and go to page 6. Your safety plan is on page 7.

Start here

A Path Through, If You Want One

Most people reach for pages as they need them. If you would rather be walked through, here is the route clinicians use most — one section a week, with the single page to start from in each. If your clinician gives you a different route, theirs wins.

1. **The nervous system — the Ladder**
   The three states your body moves through and how to tell which one you are in. Everything is easier once you can name the state.

2. **The nervous system — the Stress Cycle**
   Why a stress response has to be completed, not just survived, and how to complete it.

3. **Mind — Three Layers of Thought**
   Where thoughts come from, which layer you can actually work with, and the thought record that does it.

4. **Relationships — Attachment**
   The pattern you learned early and still run with the people closest to you. Most conflict in the house makes sense from here.

5. **Conditions — your page**
   The one page that explains your own diagnosis: what is happening, and what treatment does about it.

6. **Medication and sleep**
   How medication works, how to talk to your prescriber, and how to get sleep back.

7. **Mindfulness and the body — Attention**
   The three-minute breathing space, then breath and body. Short daily reps.

8. **Recovery — the plan**
   The relapse-prevention plan, the first 90 days, a letter to your future self.

How a page works

Page one teaches the model and a sidebar says why it works and where it came from. Page two is the practice — lines to write on, a checklist, or a scale to score. Write in the book. It is yours.

Safety · Read this first on a hard day

If Today Is Hard

Some days the feeling outruns every skill in this library. That is a nervous-system event, not a verdict on you or on treatment. This page is short on purpose.

1. **Tell a staff member, in person, now**
   You do not need the right words. "I'm not okay" is a complete sentence. Someone is awake at every hour, and this is precisely what they are here for.

2. **Change the body before you change the mind**
   Cold water on the face. A fast walk. Breathe out longer than in. Give the wave ninety seconds before you decide anything about anything.

3. **Do not be alone with it**
   Sit in the common area. You do not have to talk. Overwhelmed and alone is the one combination we are built to avoid here.

4. **Use the plan you already made**
   Your safety plan lists your warning signs, your reasons, and your people. It is on page 7 of this library. Staff have a copy if you cannot find yours.

If you are thinking about ending your life or hurting yourself

Tell staff immediately. Outside the house, call or text 988 (Suicide & Crisis Lifeline, 24/7). If there is immediate danger, call 911. Having the thought is not the same as acting on it; thoughts pass, and they pass faster with someone next to you.

Afterward — not now — the Nervous-System Ladder and the Window of Tolerance explain what just happened in your body. Understanding it is for later. Right now: people, body, plan.

When the wave has passed

Come back to Start Here on page 4 and choose a section. Or let a staff member choose one with you. The hard day is not the whole story; it is one page of it.

Safety · Keep this where you will find it

Your Safety Plan

A safety plan is a short, personal list you build when you are steady, to use when you are not. It is not a contract and not a promise to be fine. It is six parts, in order, written in your own words, so that on the worst hour of a bad day you do not have to think — you only have to read.

The six parts

1. **My warning signs**
   The thoughts, feelings, body states and behaviors that tell you a crisis may be building. Yours, specifically.

2. **Things I can do on my own**
   Two or three things that have ever taken the edge off, without another person: a walk, cold water, music, a shower.

3. **People and places that take my mind off it**
   Not for talking it through — for company and distraction. The common area counts.

4. **People I can ask for help**
   The ones you would actually tell. Names and how to reach them.

5. **Professionals and the numbers**
   Staff at the house, day or night. The 988 Suicide & Crisis Lifeline: call or text 988. If there is immediate danger, 911.

6. **Making my space safer**
   Means matter. What you have agreed staff will hold for you, and why: distance between an urge and an act is what saves lives.

Why this works

The Safety Planning Intervention (Stanley & Brown, 2012) is a brief, collaborative plan written with a clinician. Its logic is neurological: in an acute crisis the prefrontal cortex — the part that plans, keeps perspective and remembers what has helped before — goes partly offline while the alarm system runs. A plan written when you are steady does that thinking in advance. In a multi-site emergency department study (Stanley et al., 2018), people who left with a plan and follow-up calls showed 45 percent less suicidal behavior over six months and were about twice as likely to attend outpatient care. It is recommended in VA/DoD and Joint Commission guidance.

At this house

Every client makes one at intake, whatever kind of week they are having, because things change fast and staff want a page to open with you rather than start from nothing. Your clinician reviews it with you after any hard day. If you have never had a thought of harming yourself, the plan still stands; it is a plan for distress, and distress visits everyone.

Fill It In With Your Clinician

Write it in your own words, with your clinician in the room. Names, not categories; actions, not intentions. If a part is empty today, leave it and come back.

1 · My warning signs

Thoughts, feelings, body, behavior — the first things I would notice: _____

2 · Things I can do on my own

3 · People and places that take my mind off it

4 · People I can ask for help

Name and how to reach them: _____

5 · Professionals and the numbers

Staff at the house, day or night. 988 Suicide & Crisis Lifeline: call or text 988. Immediate danger: 911. _____

My clinician: _____

My prescriber: _____

6 · Making my space safer

What staff hold for me, and why: _____

In session: bring this.

Your clinician signs the copy in your chart; this one is yours. Keep it where you will find it on a bad day — not where it looks tidy.

Section

The nervous system

Most of what gets called a symptom is a body state before it is a story. These pages teach the states, how to tell which one you are in, and how to move between them on purpose.

In this section

The Window of Tolerance 10

The Stress Cycle Is a Loop. Close It. 12

Your Body Knows Before You Do 14

When You Leave: Dissociation Explained 16

What Do You Want Your Life to Be About? 18

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If you read only one page here

The Nervous-System Ladder — page 28.

The Window of Tolerance

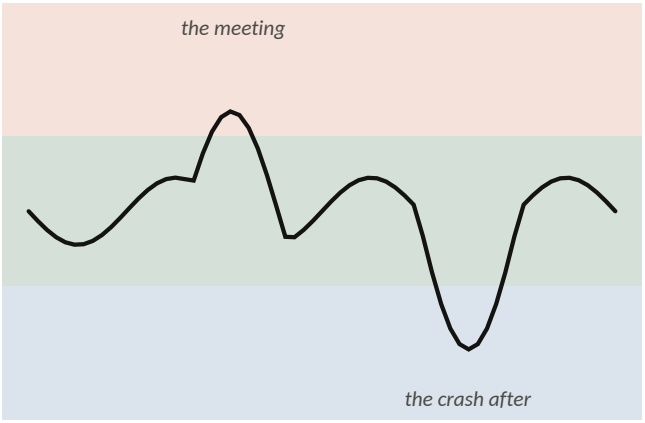
There is a band of arousal inside which you can think and feel at the same time. Above it you are flooded; below it you are gone. Most of what gets called a symptom is simply what life looks like from outside the band. The band is not fixed. It narrows under chronic stress and trauma, and it widens with practice.

One band, two exits

Hyper-arousal
flooded, racing, braced, furious, panicked

The window
can think and feel at once; can choose

Hypo-arousal
numb, foggy, heavy, far away, blank



High performers often live near the ceiling for years and call it drive. The cost shows up as the crash: a drop through the floor that looks like depression but is the body's recovery after too long on alert. Both exits are physiology, not character.

Why this works

The window of tolerance is Siegel's term (The Developing Mind, 1999) for the range of arousal in which the prefrontal cortex stays online and can regulate the limbic alarm underneath it. Push arousal past the ceiling and the prefrontal circuits go quiet: attention narrows, memory degrades, judgment collapses into threat logic. Drop below the floor and the system conserves: numbing, fog, immobility.

Trauma and sustained stress narrow the band, which is why small triggers can produce large reactions. The window widens through many regulated returns: feeling activation rise with support and coming back, rather than avoiding it or white-knuckling through it. Trauma-informed treatments (Ogden, Fisher) are organized around this principle.

Coming back in

From above the ceiling

Exhale longer than you inhale. Cold water on the face or wrists. Push against a wall for thirty seconds. Orient: look slowly around the room and name five things that are actually here. Then words.

From below the floor

Stand up. Move with rhythm: walk, rock, shake out the hands. Light, warmth, a sour or strong taste. Someone regulated nearby, not asking you to talk. Then words.

Skills learned inside the window are the only ones available outside it. Practice when you do not need them.

Map a Day In and Out of the Window

Map a day

Pick yesterday, or run this tomorrow in real time. At each point, write one word for where you were (inside · above · below) and what was happening. Honest, not tidy. After a week the pattern shows: what pushes you over, what drops you under, and what reliably brings you back.

Where I was

Waking: _____

Mid-morning: _____

Midday: _____

Late afternoon: _____

Evening: _____

Bedtime: _____

What I noticed

What pushed me above the ceiling: _____

What dropped me below the floor: _____

What brought me back, and how long it took: _____

Widening the window

The band does not widen by staying calm. It widens each time arousal rises, you stay with it a little longer than feels comfortable, and you come back on purpose. Choose one daily moment this week to practice a return instead of an escape. Bring the map to session.

Next · The Stress Cycle Is a Loop. Close It.

The Stress Cycle Is a Loop. Close It.

The stressor and the stress are two different things. The stressor is the email, the board, the diagnosis, the lawsuit. The stress is what your body did in response: a full physiological loop built to end in action and then safety. Dealing with the stressor does not close the loop. Only the body can.

Seven ways the body closes the loop

COMPLETION	WHY IT WORKS	MINIMUM DOSE
Movement	Does what the stress prepared you for; burns the chemistry	20 to 60 minutes, hard enough to breathe
Slow breathing	Vagal brake; long exhale signals safety	Five minutes, exhale longer than inhale
Real contact	A friendly exchange tells the brain the world is safe	One warm, non-transactional conversation
Laughter	The involuntary kind, shared	Until you lose your breath
Affection	Sustained touch with someone trusted	A twenty-second hug, both leaning in
A good cry	Lets the wave finish instead of stopping it	Until it ends on its own
Making something	Emotion routed through craft, music, cooking	Thirty minutes, no audience

Why this works

Emily and Amelia Nagoski (Burnout, 2019) drew the distinction between stressors and the stress response cycle. When the brain reads threat, the hypothalamic-pituitary-adrenal axis and the sympathetic branch mobilize: adrenaline, cortisol, blood to muscle, digestion and repair paused. The loop evolved to end in running, fighting, and then the all-clear of safety among others.

Modern stressors are resolved by thinking, waiting, or sitting through a meeting, so the body never receives the signal that the threat has passed. Stress accumulates and becomes the backdrop. The completions below are not relaxation tips; each one delivers a physiological end-of-threat signal. Exercise has the strongest evidence; the others are well supported.

Notice what is not on the list: solving the problem, being told it is fine, a drink, scrolling. Those manage the stressor or mute the signal. The loop stays open underneath, and open loops stack.

Seven Days of Closing the Loop

The log

For seven days, name the biggest stressor of the day and what you did, if anything, that let the body finish. One line each. The point is not to close every loop. It is to see how many days you close none.

Day 1 — stressor / what closed it: _____

Day 2 — stressor / what closed it: _____

Day 3 — stressor / what closed it: _____

Day 4 — stressor / what closed it: _____

Day 5 — stressor / what closed it: _____

Day 6 — stressor / what closed it: _____

Day 7 — stressor / what closed it: _____

Which completions I actually used this week

- ◯ Moved hard enough to breathe
- ◯ Slow breathing, five minutes
- ◯ A warm conversation
- ◯ Laughed until out of breath
- ◯ Twenty-second hug
- ◯ Let myself cry
- ◯ Made something
- ◯ None of these

The one you can keep

Pick the completion you are most likely to repeat after discharge, and tie it to something that already happens daily: after the last meeting, before the drive home, after the kids are down. Write it on the line of the day you first try it. Bring the log to session.

Next · Your Body Knows Before You Do

The body · Interoception

Your Body Knows Before You Do

Interoception is the sense of the inside of your body: heartbeat, breath, gut, muscle tone, temperature. It is the raw material of every emotion. Many capable people have spent decades overriding it, and then cannot say what they feel until it has become a migraine, a panic attack, or a decision made in anger.

Signals that arrive before symptoms

SIGNAL	OFTEN CARRYING	EARLY MOVE
Jaw, shoulders	Braced effort; anger held	Unclench, drop the shoulders, exhale
Chest tight, breath high	Anxiety, anticipation	Lengthen the exhale; widen the gaze
Gut knot or drop	Dread, a decision you dislike	Name what the gut is objecting to
Heavy limbs, slow	Sadness, depletion, shutdown	Stand, light, warmth, small movement
Restless, buzzing	Unspent activation	Move it: walk, stairs, push a wall
Numb or blank	Overwhelm; the system has muted itself	Cold, texture, orient to the room

Why this works

The insula integrates signals from the viscera into a felt sense of the body's state (Craig, 2002); that felt sense is what the brain labels as an emotion. Damasio's somatic marker work and Garfinkel's research on interoceptive accuracy point the same way: people who read their bodies well regulate emotion better and decide better. Chronic override, trauma, and depression blunt the signal; anxiety amplifies it without accuracy.

The body scan from Kabat-Zinn's Mindfulness-Based Stress Reduction is the standard training tool, with moderate RCT support for anxiety and depression. The skill is attention without correction: noticing the signal before you fix it, judge it, or explain it.

The body scan, done properly

Not this

Trying to relax each area. Scanning for problems. Deciding what a sensation means. Quitting when the mind wanders, which it will.

This

Ten minutes, lying or seated. Move attention slowly from feet to head. At each area: is there sensation, and what is its quality: warm, tight, pulsing, nothing. Nothing is a valid answer. When the mind leaves, return without comment.

Three Days of Body Mapping

Body map, three days

Once a day, at a consistent time, scan four regions and write what is there in a few words. Sensation only: tight, warm, hollow, pulsing, blank. No interpretation until day three.

Day 1

Head, face, jaw: _____

Chest, breath: _____

Gut: _____

Limbs, posture: _____

Day 2

Head, face, jaw: _____

Chest, breath: _____

Gut: _____

Limbs, posture: _____

Day 3

Head, face, jaw: _____

Chest, breath: _____

Gut: _____

Limbs, posture: _____

What the body seemed to be saying: _____

In session

Bring the map. Look for the region that reports first and the one that reports loudest. The first one is your early-warning system; learning to hear it is the whole project.

Next · When You Leave: Dissociation Explained

Trauma · Dissociation & dual awareness

When You Leave: Dissociation Explained

Dissociation is not madness and not weakness. It is the mind's oldest emergency exit: when escape is impossible, the system leaves by going distant, numb, or blank. It saved you once. The problem is that it still fires in rooms where you are safe, and it takes your judgment with it.

The continuum

POINT	FEELS LIKE	WHAT IT IS DOING
Absorption	Lost in a book, highway miles you don't recall	Ordinary; attention narrowed
Numbing	Flat, muted, 'I should feel something'	Volume turned down on emotion
Depersonalization	Watching yourself from outside; body not yours	Self split from experience
Derealization	Room looks fake, far, dreamlike	World held at a distance
Shutdown	Blank, time lost, can't move or speak	Full immobilization; the last exit

Why this works

Dissociation sits on a continuum that everyone uses; trauma pushes it from a tool into a reflex. Under inescapable threat the dorsal vagal system immobilizes, and attention, memory, and the sense of self can split off from the moment (Porges; van der Hart's structural dissociation). The reflex is then learned: any cue resembling the original threat can trigger the exit.

Dual awareness is Rothschild's term for holding two truths at once: part of me is back there, and I am also here, now, safe. It is the core skill of phase-one trauma treatment in the ISTSS consensus guidelines, because processing memory is only safe when the client can stay partly in the present while touching the past.

Grounding that works for dissociation

Generic grounding fails here

Eyes closed, soft breathing, 'just relax': all of these turn attention inward and lower arousal, which deepens the exit. Dissociation needs intensity and orientation, not calm.

What works

Eyes open, feet pushing the floor. Cold water, ice in the hand, a sour candy. Stand and move. Say out loud: your name, the date, your age now, where you are. Look for three things that did not exist back then.

If you lose time, find yourself somewhere you did not intend to be, or feel unsafe, tell staff or your clinician today. If you are in danger, call 988 or 911.

Trauma · Dissociation & dual awareness

Your Grounding Protocol

One foot here, one foot there

A protocol is a short, rehearsed sequence you can run before you are fully gone. Build it while present. Practice it when you do not need it, so the body knows it.

1 **Learn your early signs**
The moment before: sound going distant, hands tingling, the urge to stare. Dissociation is easiest to interrupt at the first sign, nearly impossible at the last.

2 **Choose anchors in three channels**
One for the body (cold, pressure, movement), one for the senses (a smell, a texture, a taste), one for orientation (date, age, place, what is true now).

3 **Write the dual-awareness sentence**
"Part of me is back in ___, and I am also here in ___, on ___, and I am ___ years old. That was then. This is now."

4 **Tell one person**
Someone who can say your name and the sentence to you when you cannot. Here, that is staff. After discharge, decide who.

My early signs: _____

Anchor — body: _____

Anchor — senses: _____

Anchor — orientation: _____

My sentence: _____

The person who knows the protocol: _____

Rehearse
Run the whole protocol twice a day while present, like a fire drill. Bring it to session and run it with your clinician once.

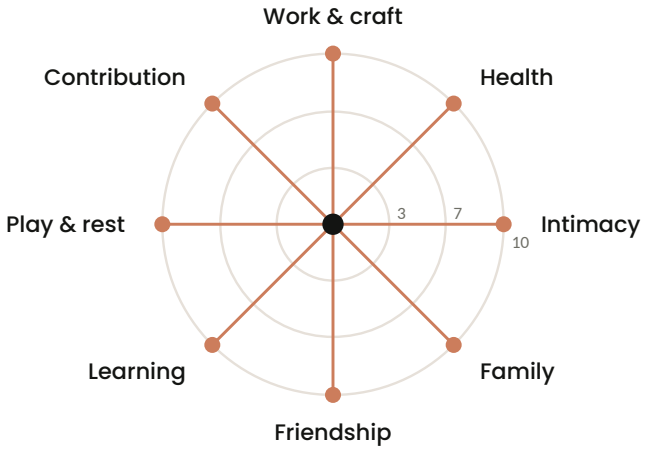
Next · What Do You Want Your Life to Be About?

Meaning · Acceptance and Commitment Therapy

What Do You Want Your Life to Be About?

Most high achievers can name their goals in seconds and their values not at all. Goals are destinations; values are directions. You can complete a goal and feel nothing. You cannot complete a value, but every day you can move toward one, and that movement is what makes a life feel like yours.

The Life Compass



Eight domains, none more important than another by default. The compass asks two questions of each: how much does this matter to me, and how much of my actual behavior this month reflects that. The gap between the two numbers is where the work is.

Why this works

Acceptance and Commitment Therapy (Hayes) treats values as chosen qualities of action: how you want to behave, on purpose, in domains you care about. They are not feelings, outcomes, or other people's expectations. ACT's target is psychological flexibility: the ability to contact the present moment and act on values even when the mind offers reasons not to.

Values matter clinically because avoidance shrinks life. People in pain pull back from what they care about, and the pulling back becomes the larger problem. ACT has broad randomized-trial support across depression, anxiety, chronic pain, and substance use, and is recognized by the APA's Division 12 as evidence-based for several of these.

Values are not goals

A goal

Make partner. Run the marathon. Get the kids into the school. Finish treatment. Achievable, then over. Measured by outcome.

A value

Build things that last. Be someone my body can rely on. Be present with my children. Be honest with myself. Never finished. Measured by direction.

The test

Ask: if no one ever knew, and it brought no reward, would I still want to act this way? If yes, it is a value. If no, it is a goal, or someone else's.

Your Life Compass

Rate each domain

Two numbers per domain, 0 to 10. Importance: how much this matters to you, not to your family or your board. Action: how consistently your behavior in the last month reflected it. Fast and honest. The first number that comes to mind is usually right.

DOMAIN	IMPORTANCE 0–10	CURRENT ACTION 0–10
Work & craft		
Health & body		
Intimate partnership		
Family & parenting		
Friendship		
Learning & growth		
Play & rest		
Contribution & community		

The domain with the largest gap: _____

The value in that domain, in my own words: _____

One committed action this week (specific, small, scheduled): _____

What my mind will say to talk me out of it: _____

Committed action

Small enough that you will do it this week, concrete enough that someone could verify it. Then do it, notice what the mind said, and bring the compass to session. Re-rate monthly; the gaps move.

Next · You Have a Condition. You Are Not One.

Identity · Narrative therapy

You Have a Condition. You Are Not One.

A diagnosis is useful information about a pattern. It becomes dangerous when it stops describing what you have and starts describing who you are. The word 'bipolar' or 'addict' or 'anxious' can quietly take over the story, until every choice is read through it. The story is yours to edit.

Three stances toward a diagnosis

STANCE	SOUNDS LIKE	COSTS AND GIVES
Engulfed	"I'm bipolar. That's just who I am."	Gives an explanation for everything; takes agency, hope, and nuance
Rejecting	"The label is wrong. I'm fine."	Gives pride; takes treatment, support, and the chance to learn the pattern
Integrated	"I have a condition I manage. It is part of my story, not the author."	Gives both honesty and room; costs the comfort of a simple story

Why this works

Narrative therapy (White and Epston) begins from one sentence: the person is not the problem; the problem is the problem. Externalizing gives the difficulty a name and a place outside the self, so it can be examined, negotiated with, and resisted rather than confused with identity. From there the work is re-authoring: finding the moments the problem did not win, and building a thicker story around them.

The research on illness identity (Yanos, Roe, Lysaker) is consistent: when a condition engulfs the self, hope, engagement, and function drop, independent of symptom severity. Recovery identity, the sense of being a person who has a condition and a life, predicts the opposite.

Having versus being

Illness identity

The condition explains the past, predicts the future, and excuses the present. Your strengths become symptoms in disguise. Other people's stories about you become the only story.

Recovery identity

The condition is real and so is everything else: the career, the humor, the loyalty, the thing you build with your hands. Recovery is not the absence of symptoms. It is a life the condition does not run.

Identity · Narrative therapy

A Letter to the Problem

Externalizing letter prompts

Give the problem a name of your own, not the clinical one: the Fog, the Judge, the Pull, the Static. Then answer as if writing to it. Short answers are fine; exact ones are better. If this stirs more than you expected, pause and bring it to session unfinished.

The name I give it: _____

When it first showed up, and what was happening in my life then: _____

What it tells me about myself: _____

What it has cost me: _____

What it has protected me from, or given me, that I should be honest about: _____

A time I did not do what it wanted, and what made that possible: _____

What I want it to know about who I am without it: _____

The thicker story

Write three sentences about yourself in which the condition does not appear. Not denial: evidence. Read them to your clinician. Then add a sentence in which the condition appears as something you carry, not something you are.

Systems Over Willpower

Executive function is the set of mental operations that turn intention into action: holding a plan in mind, starting, tracking time, choosing what matters. When it is strained by ADHD, depression, trauma, or exhaustion, the problem is never knowing what to do. It is doing what you know. That is a systems problem, and willpower is the wrong tool.

Where the executive mind fails

FUNCTION	HOW IT FAILS	EXTERNAL FIX
Working memory	The plan evaporates; the thought is gone before the door closes	Capture everything outside the head: one inbox, always on you
Initiation	Knowing exactly what to do and sitting frozen for hours	Shrink the first move to two minutes; start beside someone
Time perception	Only 'now' and 'not now'; deadlines arrive as surprises	Make time visible: calendar blocks, analog clock, timers
Prioritization	Everything urgent; the important thing never scheduled	Decide once, in writing, at a set time; then obey the list
Energy budget	Spending the whole week's focus by Tuesday	Protect sleep and movement as infrastructure, not reward

Why this works

Barkley's model frames ADHD as a disorder of executive function and self-regulation rather than attention: working memory, inhibition, time perception, and self-motivation are impaired at the point of performance. His phrase for the result is that ADHD is not a problem of knowing what to do but of doing what you know. Time blindness, the inability to feel time passing or sense the future as real, is central.

The same functions degrade under sleep loss, chronic stress, and depression, so the approach helps whether or not a diagnosis applies. Medication has the strongest evidence for core ADHD symptoms; cognitive-behavioral approaches built on external structure (Safren) show moderate RCT support in adults. Structure outperforms resolve.

Why resolve keeps failing

Willpower is a working-memory operation. It draws on the exact circuits that are already strained, and it runs out by afternoon. External systems do not get tired. The goal is to move the decision out of the moment and into the environment: the calendar decides, the capture tool remembers, the body-double anchors, the timer tracks time so you do not have to.

Build One External System

Four systems that hold

1. **Capture**
   One place where every thought, task, and promise goes the instant it appears: a single notebook or a single app, never both. Reviewed once a day at a fixed time.

2. **Calendar as time made visible**
   If it is not on the calendar, it is not real. Block the task, not just the meeting. Put travel and recovery on it too.

3. **Body-doubling**
   Work beside another person who is also working. No conversation required. Presence lowers the initiation threshold; this is why people start tasks in treatment that they have avoided for years.

4. **The two-minute rule**
   If it takes under two minutes, do it now. If it takes longer, do the first two minutes now. Starting is the hard part; two minutes is usually enough to carry the rest.

The task I keep not starting: _____

Which function fails (memory · initiation · time · priority · energy): _____

The system I will build this week: _____

Where it lives (place, app, person): _____

First two-minute move: _____

Build one, not four

Choose the single system that addresses your most common failure. Use it every day for a week before adding another. Bring the result, including where it broke, to session.

Next · The Critic Is a Manager, Not a Verdict

Parts & self · The inner critic

The Critic Is a Manager, Not a Verdict

The voice that tells you the presentation was weak, that you should have known, that you are behind: it is not the truth about you, and it is not an enemy. In the language of the parts map, it is a manager with a job. Fighting it makes it louder. Understanding what it is protecting is what changes it.

What the critic is doing

It protects

From humiliation, from being caught unprepared, from the exile that still carries the memory of being found wanting.

It fears

That without it you would become lazy, arrogant, careless, or exposed. Ask it: it will tell you.

It costs

Energy, risk-taking, and honesty. People who are attacked from inside hide mistakes instead of learning from them.

Why this works

In Internal Family Systems (Schwartz) the critic is a manager: a proactive protector that polices you before anyone else can. Its logic is that if it gets there first, with enough force, you will never again feel the shame, rejection, or failure it remembers. It usually took the job young and has never been updated.

Compassion-Focused Therapy (Gilbert) adds the physiology: self-criticism runs on the threat system, the same circuitry as being attacked by someone else, which is why it produces anxiety and shutdown rather than better work. The antidote is not a nicer voice but a different system: the soothing and affiliation circuit, accessed by a stance Gilbert calls the compassionate self, which is warm, wise, and strong. CFT has a growing trial base for shame-based difficulties.

Fighting it versus working with it

Fighting

Arguing with it. Positive affirmations shouted over it. Drinking it quiet. Each of these treats it as the enemy, so it escalates. Managers do not retire under threat.

Working with it

Unblend: notice it as a part, not as the truth. Get curious about its fear. Thank it for the years of effort. Then answer from the compassionate self and offer it a better job: honest review, high standards, no cruelty.

A Dialogue With the Critic

The dialogue

Write it out. The critic gets to speak first and in full; you do not edit it. Then you reply from a stance that is warm, wise, and strong: the voice you would use with the most talented person who ever worked for you on their worst day.

1. **Let it speak**
   Exact words. Tone. Whose voice does it borrow?
2. **Ask what it is afraid of**
   "What would happen to me if you stopped?" Wait for the real answer, which is usually about shame.
3. **Thank it**
   It has been working since childhood. Mean it.
4. **Reply from the compassionate self**
   Acknowledge the fear. State what is true now: your age, your competence, your resources. Offer the new job.

The critic says (exact words): _____

Tone, age, who it sounds like: _____

What it is afraid will happen if it goes quiet: _____

What it is protecting: _____

My reply, warm and strong: _____

_____

The job it could do instead: _____

In the room

Read both voices aloud to your clinician. Notice which one your body believes. That is the one to practice.

Next · Self-Compassion Is Not Going Soft

Self-Compassion Is Not Going Soft

Most people who run things believe that being hard on themselves is what keeps them sharp. The evidence says the opposite. Self-criticism predicts avoidance, procrastination, hidden mistakes, and relapse. Self-compassion predicts persistence after failure. This is a performance tool, not a consolation.

The three components

Self-kindness

Speaking to yourself the way you would to someone you respect who is struggling. Not indulgence: honesty with warmth.

Common humanity

This is part of being human, not proof that you are uniquely defective. Isolation is the lie pain tells.

Mindfulness

Holding the pain without drowning in it or pretending it is not there. Neither suppression nor a spiral.

Why this works

Neff defined self-compassion as three linked components: self-kindness instead of self-judgment, common humanity instead of isolation, and mindfulness instead of over-identification with pain. Each has an opposite that feels like rigor but is not.

Self-criticism fails as motivation because it runs on the threat system (Gilbert): under attack, the brain narrows, avoids, and conceals. Breines and Chen showed that people induced to be self-compassionate after failure studied longer and tried again more readily than those who were self-critical. Meta-analyses link self-compassion to lower depression, anxiety, and stress, and Neff and Germer's Mindful Self-Compassion program has randomized-trial support. The mechanism is safety, which is the state in which learning happens.

What it is not

Not self-pity

Self-pity isolates and exaggerates. Self-compassion sees the situation clearly, including your part in it.

Not self-indulgence

Indulgence gives you what feels good now. Compassion gives you what you need, which is sometimes the hard conversation.

Not weakness

People high in self-compassion take more responsibility for mistakes, not less. They can afford to look.

The Break and the Letter

The self-compassion break

Neff's core practice, usable in a hallway between meetings. Three sentences, said silently with a hand on the chest or wherever feels steady. Thirty seconds.

1. **Name it**
   "This is a moment of difficulty." Or in your own words: this hurts, this is hard, I am struggling.

2. **Place it**
   "Difficulty is part of life." Other people feel exactly this. I am not the only one, and I am not uniquely broken.

3. **Meet it**
   "May I be kind to myself right now." Or: what do I need in this moment, and can I give myself some of it.

The letter

Think of the thing you are hardest on yourself about. Then write to yourself as a friend who knows everything about you, including that thing, and loves you anyway. Unconditionally honest, unconditionally on your side.

The thing I am hardest on myself about: _____

What that friend sees that I do not: _____

_____

What they would say is human about this: _____

What they would encourage me to do next: _____

Bring both

Do the break once a day for a week; note when it felt false. Read the letter to your clinician, slowly.

Next · The Nervous-System Ladder

The Nervous-System Ladder

Most people are taught that they have one problem — anxiety, or depression, or anger. The nervous system tells a simpler and more useful story: there are three states, you move between them all day, and almost every symptom you have is what one of those states looks like from the inside.

Three states, one ladder

Ventral vagal — safe & social

Engaged, curious, settled. Voice has range, face is mobile, breath is easy. You can think, connect, and tolerate being wrong.

Sympathetic — mobilized

Fight or flight. Heart up, jaw tight, scanning. Irritable, anxious, driven, can't sit still. Thinking narrows to threat.

Dorsal vagal — shut down

Collapse, fog, numb, far away. 'What's the point.' Heavy limbs, flat voice, the urge to disappear. The body's last resort.

Nobody lives at the top. The goal is not to stay ventral; it is to notice where you are, know what moves you up a rung, and stop treating the lower states as personal failure. A dorsal collapse after weeks of sympathetic running is not weakness. It is physiology doing what it was built to do.

Why this works

Polyvagal theory (Porges) describes the autonomic nervous system as a hierarchy: a newer social-engagement circuit that runs on the ventral vagus, an older mobilization circuit (sympathetic), and the oldest immobilization circuit (dorsal vagus). Your state is set below conscious thought by a process Porges calls neuroception — the body reads cues of safety or threat before you know it. That is why you cannot reason yourself calm, and why a face, a voice, or a long exhale can do what an argument can't.

Clinically: state determines what skill is possible. Cognitive work needs ventral. Below that, go body-up first.

What moves you up

From shut down to mobilized

Gentle movement. Sunlight. Warmth. Rhythmic things: walking, rocking, music with a beat. Small, non-demanding contact — someone nearby, not someone asking you to talk.

From mobilized to safe

Long exhale (out longer than in). A regulated person's face and voice. Orienting: look around the room slowly, name what's actually here. Cold water. Then, and only then, words.

Co-regulation precedes self-regulation. The nervous system learned safety from other nervous systems; it still does.

Map Your Own Ladder

Map your own ladder

Fill this in over a few days, not in one sitting. The cues are yours — the list on page one is generic. The most useful line is the third one: the thing that reliably moves you.

Safe & social — I know I'm here when…

Body: _____

Thoughts sound like: _____

What I'm able to do that I can't in other states: _____

Mobilized — I know I'm here when…

Body: _____

Thoughts sound like: _____

What moves me up one rung: _____

Shut down — I know I'm here when…

Body: _____

Thoughts sound like: _____

What moves me up one rung: _____

A day in states

Tomorrow, check in four times — waking, midday, late afternoon, bedtime — and write a letter (V / S / D) and one word. After a week you will see your pattern: when you drop, what precedes it, how long it lasts. Bring the week to session.

Section

Mind

Thoughts are events, not facts, and they are produced by a machinery you can learn. These pages show where thoughts come from, which layer you can work with, and how to loosen the grip of the ones that run you.

In this section

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If you read only one page here

Three Layers of Thought — page 31.

Three Layers of Thought

The thought that shows up in the meeting, 'they can tell I'm not prepared', is not where the problem lives. It is the surface of something older. Beck's model describes thinking in three layers, and most people have only ever worked the top one. That is why the same thought keeps returning in new clothes.

Surface, middle, base

Automatic thoughts · surface
Fast, situation-specific, barely noticed. "They can tell I'm not prepared." "I should have seen this coming."

produced by

Rules and assumptions · middle
Conditional strategies for living with the belief below. "If I am always the most prepared person in the room, no one will find out."

produced by

Core beliefs · base
Global, absolute, formed early, felt as fact. "I am not enough." "People leave." "If they really knew me, they would go."

Working only the surface is pruning. You dispute the thought, feel better for an hour, and the rule underneath produces another one by evening. The layers are not a hierarchy of blame. They are a map of where to dig.

Why this works

Aaron Beck's cognitive model (formalized in Cognitive Therapy of Depression, 1979) holds that emotion follows interpretation, not events, and that interpretations are produced in layers. Core beliefs are global, absolute statements about self, others, and the world, usually formed early. Rules and assumptions are the conditional strategies that make life survivable given those beliefs: if I am perfect, no one will see. Automatic thoughts are the fast, situation-specific output at the surface.

CBT is the most-studied psychotherapy, with strong RCT support across depression and the anxiety disorders. Durable change tracks the deeper layers: when a core belief shifts, the surface stops regenerating.

Why the top layer is not enough

Surface-only work

Thought records that win the argument and change nothing. Reassurance that lasts a day. A hundred disputed thoughts and one unexamined rule, still running.

Working the layers

Treat each automatic thought as a clue. Ask what it would mean if it were true, and keep asking. The chain ends at a sentence that feels like fact rather than opinion. That sentence is the work.

The Downward Arrow

The downward arrow

Take one automatic thought from this week. Ask one question of it, and then the same question of each answer: if that were true, what would it mean about me? Do not argue with any answer. Do not stop at the first one that sounds reasonable. Stop when you reach a sentence that has no 'if' left in it.

1. **Start at the surface**
   Write the thought in the exact words it used. Not the polished version.

2. **Follow the chain**
   Each line: 'If that were true, it would mean...' Four or five steps is typical. The answers get shorter and older.

3. **Mark the base**
   The last line is a core belief. Rate how much you believe it, 0 to 100, and notice how old it feels.

The thought: _____

If that were true, it would mean: _____

And if that were true: _____

And if that were true: _____

And if that were true: _____

The base (belief 0-100 / how old it feels): _____

In session

Bring the chain. The base sentence is where the next months of work point. The rule in the middle is what you will test first, because rules can be tested and beliefs can only be eroded.

Next · Worry and Rumination Are Strategies

Worry and Rumination Are Strategies

Worry runs forward: what if the deal fails, what if the scan is bad. Rumination runs backward: why did I say that, why am I like this. Both feel like thinking, and both feel involuntary. Neither is quite true. Each is something you do in response to a thought, because at some level you believe it helps.

Two directions, one engine

	WORRY	RUMINATION
Direction	Future: what if	Past: why
Feels like	Planning, preparing, bracing	Analysing, understanding, solving
The belief underneath	If I think it through I will be ready	If I understand it I will fix it
What it actually does	Keeps threat active; nothing gets prepared	Deepens the mood; no answer arrives

The test is simple. After twenty minutes, do you have a plan you did not have before, or the same thought and a worse body? Thinking produces output. Worry and rumination produce more of themselves.

Why this works

Metacognitive therapy (Wells, 2009) shifts the target from the content of thoughts to your relationship with them. Sustained worry or rumination, threat monitoring, and unhelpful coping are held in place by metacognitive beliefs: positive ones (worrying keeps me prepared; analysing will find the answer) and negative ones (I cannot control it; it will damage me). The intrusion is not the problem. The hour spent elaborating it is.

MCT for generalized anxiety and depression has good randomized-trial support, in some head-to-head trials outperforming standard CBT. Detached mindfulness and worry postponement are its core techniques: you do not argue with the thought, you decline to work on it.

Two moves

Detached mindfulness

Notice the thought as an event in the mind: a thought has arrived. Let it sit without pushing it away, analysing it, or answering it. Wells's image is a train passing through a station. You do not have to board.

Worry postponement

When a worry starts, write one line and say: not now, at six. Return at six for a fixed fifteen minutes. Most postponed worries have lost their force by then. The ones that have not are usually problems, and problems can be planned.

A Worry Period and a 3-Day Log

Your worry period

Same time, same place, every day, with a hard stop. Not in bed, not in the hour before it. During the day, every worry or rumination gets one line in a notebook and a sentence: not now. At the period, read the list and give each item the attention it has earned, which is often none.

Time (same each day): _____

Place: _____

Length (ten to twenty minutes): _____

What I do at the hard stop (close the notebook, then): _____

Three-day log

Day 1

What I postponed: _____

At the period: still mattered? Plan or let go? _____

Day 2

What I postponed: _____

At the period: still mattered? Plan or let go? _____

Day 3

What I postponed: _____

At the period: still mattered? Plan or let go? _____

What to notice

Count how many postponed items still mattered by the period. Most people find fewer than one in four. Bring the log to session and name the belief that made the other three feel urgent.

Next · Challenge the Thought, or Unhook From It?

Challenge the Thought, or Unhook From It?

Cognitive therapy says: examine the thought and correct it. Acceptance and Commitment Therapy says: you do not have to win the argument, you have to stop being run by it. Both work. The skill is knowing which one the moment calls for, because the wrong tool makes a thought stronger.

Which tool, when

ASK	RESTRUCTURE (CBT)	DEFUSE (ACT)
Is it testable?	Yes: specific, about facts, checkable	No, or you have tested it a hundred times
How old is it?	New, situational	Old, familiar, one of the greatest hits
What happens when I argue?	I feel steadier; the evidence lands	It gets louder, or I win and still feel it
The goal	A more accurate thought	The same thought, with less grip

A rule of thumb from clinical practice: restructure once, properly. If the thought comes back unchanged a third time, stop debating and defuse.

Why this works

Cognitive restructuring (Beck) treats a thought as a hypothesis: gather evidence, weigh it, replace a distorted interpretation with an accurate one. It works best when the thought is specific, testable, and wrong. Defusion (Hayes, ACT) treats a thought as a mental event rather than a claim to be checked: you change your relationship to it, not its content. It works best when the thought is sticky, familiar, or true enough that arguing is pointless. I might fail. People do.

Both have strong RCT support, and component studies suggest they share more mechanism than their founders claimed. Defusion reduces the believability and distress of a thought without changing how often it shows up, which is the point.

Two defusion moves

'I'm having the thought that…'

Say the thought with that prefix. Then: 'I notice I'm having the thought that…' Each layer puts distance between you and the content. The thought does not change. Your position does.

'Thank you, mind'

Treat the mind as an over-eager advisor. 'Thank you, mind, for the warning about the board meeting. Noted.' Not sarcasm: acknowledgment. The mind is trying to protect you. It does not need to be obeyed to be thanked.

One Thought, Two Ways

Run one thought both ways

Pick a thought that has been loud this week. Run route A first, then B, a few hours apart. Rate belief and distress before and after each. The numbers are the answer.

The thought

Exact words: _____

Belief 0-100 / distress 0-100, before: _____

Route A: restructure

Evidence for: _____

Evidence against: _____

A more accurate version: _____

Belief / distress after: _____

Route B: defuse

'I'm having the thought that…' said aloud three times. What shifted: _____

'Thank you, mind, for…': _____

Belief / distress after: _____

Which worked

Not which felt better in the moment, but which left the thought with less grip the next day. Bring both runs to session. Over a few weeks you will learn which of your thoughts are arguments to be won and which are weather to be walked through.

Next · Schema Modes: Who Is Running the Room?

Schema Modes: Who Is Running the Room?

A mode is the state you are in right now: the small frightened one, the furious one, the voice that says you deserve it, the one that has gone cold and competent and feels nothing. They flip in seconds, often without warning. Young's schema therapy gives them names, because a mode you can name is a mode you can step out of.

The five modes

MODE	SOUNDS LIKE	WHAT IT IS DOING
Vulnerable Child	'I'm alone. Nobody really wants me here.'	Carrying the original unmet need
Angry / Impulsive Child	'This is unfair. I want it now.'	Protesting the need, badly
Punitive / Demanding Critic	'Pathetic. Anyone else would have handled it.'	Internalized voice of early caregivers
Detached Protector	Calm, busy, numb; the drink; the late night at the desk	Cutting off feeling so nothing hurts
Healthy Adult	'That hurt. Here is what I will do next.'	Meeting the need; setting limits

Why this works

Schema therapy (Young) integrates cognitive, attachment, and experiential work for long-standing patterns that standard CBT reaches slowly. Early maladaptive schemas are deep themes formed when core childhood needs went unmet: defectiveness, abandonment, unrelenting standards, emotional deprivation. Modes are the moment-to-moment states those schemas produce when triggered. The flip usually runs child, then critic attacking the child, then a coping mode arriving to shut the whole thing down.

The aim is to strengthen the Healthy Adult: the mode that can comfort the child, set limits on the critic, and ask the protector to stand down. Schema therapy has strong RCT support for borderline personality disorder (Giesen-Bloo, 2006) and growing evidence for chronic depression and other personality patterns.

How a flip runs

Trigger (a slight, a failure, being left out) → Vulnerable Child feels it → Critic attacks → Detached Protector numbs, or the Angry Child erupts. Executives spend most of the day in Detached Protector and call it professionalism. It holds for years, then the child breaks through at midnight, the critic pounces, and the protector reaches for something stronger. The exit is always the same: Healthy Adult speaks to the child before the critic can.

A Mode Map of a Hard Day

Map a hard day

Pick a recent bad day, or map today as it happens. At each shift in state, write the mode and what set it off. You will see a sequence, and the sequence repeats. The useful line is the last one: what the Healthy Adult could have said at the first flip.

The day, and the mode I woke in: _____

First flip — mode / what triggered it: _____

Second flip — mode / what triggered it: _____

Third flip — mode / what triggered it: _____

Where the Critic got in, and what it said: _____

What the Protector reached for: _____

What the Vulnerable Child actually needed: _____

What the Healthy Adult could have said to the child, at the first flip: _____

_____

In session

Read the map aloud in the first person for each mode. Your clinician may ask you to let the Healthy Adult answer the child directly. It is awkward the first time and it works.

When Competence Becomes a Cage

You are here, in part, because standards worked. They built the career, the reputation, the house. The question is not whether to lower them. It is whether your worth is riding on every single one, because when it is, excellence stops being a choice and becomes a way of staying safe.

Excellence and its counterfeit

	EXCELLENCE	CLINICAL PERFECTIONISM
Standards	High, flexible, chosen	High, rigid, non-negotiable
Self-worth	Mostly independent of the outcome	Entirely dependent on the outcome
Mistakes	Information	Evidence about who you are
Success	Satisfaction, then rest	Relief, then the bar moves up
Behaviour	Prioritizes; finishes	Overworks, checks, procrastinates, avoids

The overcompensation cycle: the standard, then overwork and checking to meet it, then exhaustion, then a drop in output, then the standard reasserted harder to fix the drop. Burnout is this loop on its tenth turn.

Why this works

Shafran, Cooper, and Fairburn (2002) defined clinical perfectionism as the overdependence of self-evaluation on the pursuit of demanding, self-imposed standards, despite adverse consequences. The key word is overdependence. The standards are not the problem; self-worth riding on them is. Egan and Shafran's CBT for perfectionism targets the cycle: rigid standards, all-or-nothing appraisal, overwork or avoidance, then either failure (self-attack) or success (the bar is raised, because meeting it means it was too easy).

Perfectionism is transdiagnostic: it maintains depression, anxiety, eating disorders, and burnout. CBT-P has good RCT support, and treating it lifts symptoms across those conditions.

What the standard is for

Ask it

What would it mean about me if this were merely good? The answer is usually a core belief: not enough, replaceable, about to be found out. The perfectionism is protecting that belief from ever being tested.

Then test it

Perfectionism survives on prediction, never on data. Do the thing at eighty percent, on purpose, and record what actually happened. The data almost always disagree with the prediction.

The Good-Enough Experiment

Design the experiment

A behavioural experiment, not a resolution. Choose something real but survivable: an email without the third read, a presentation with one slide fewer, leaving at six. Predict the outcome in writing before you do it. Then do it and record what happened, including how you felt a day later.

1. **Choose the task**
   Real enough to matter, small enough that you will actually do it this week.
2. **Write the prediction first**
   Specific and falsifiable: what will go wrong, who will notice, how sure you are, 0 to 100.
3. **Run it and record**
   What happened, who noticed, and how it felt at the time and twenty-four hours later.

The task: _____

My usual standard (time, checks, polish): _____

The good-enough version I will do instead: _____

Prediction: what will happen / how sure, 0-100: _____

Prediction: how I will feel: _____

Actual outcome: _____

Actual feeling, 24 hours later: _____

What this says about the standard: _____

Then again

One experiment proves nothing to a perfectionist. Run three. Bring all three predictions and all three outcomes to session and look at the gap.

Next · Guilt Says I Did Bad. Shame Says I Am Bad.

Emotion · Shame and guilt

Guilt Says I Did Bad. Shame Says I Am Bad.

Guilt is about an action and points toward repair. Shame is about the self and points toward the exit. Most high-functioning people have trained themselves to feel neither, which is why shame arrives as rage, contempt, a drink, or a sudden need to leave the room. Telling them apart is not soft. It is the difference between fixing something and hiding.

Two emotions, two directions

	GUILT	SHAME
The sentence	I did something bad	I am bad
Points toward	Repair, apology, change	Hiding, attacking, leaving, numbing
In the body	Tension, heaviness; you can still look at the person	Heat in the face, eyes down, collapse; the wish to vanish
In relationship	Moves toward	Moves away, or strikes first

Nathanson's compass of shame names four exits: withdraw, attack self, avoid, attack other. Executives favour the last two, because a drink and a flash of contempt both look like strength from the outside.

Why this works

Tangney's research separates the two by their target: guilt evaluates the behaviour, shame evaluates the whole self. Guilt predicts empathy, apology, and repair. Shame predicts hiding, defensiveness, and externalized anger, and it is strongly linked to depression, addiction, and relapse. Brown's work adds the social mechanism: shame is the fear of disconnection, it grows in secrecy, silence, and judgement, and it does not survive being spoken to someone who answers with empathy.

Compassion-Focused Therapy (Gilbert) explains why willpower fails here. Shame runs on the threat system, so the body braces, narrows, and submits. Repair needs the soothing system, which is switched on by warmth: a voice, a face, a hand. CFT has a growing RCT base for shame-prone presentations.

Repair, from the compassionate self

What shame needs

Not an argument. Shame is a body state before it is a thought, and the body needs warmth before it can plan: a slower breath, a hand on the chest, a voice that is on your side. Gilbert's compassionate self is warm, wise, and strong, and it speaks first.

What guilt can then do

Separate the act from the self. Say what you actually did, plainly, to one person who has earned the hearing. Then do what guilt was built for: apologize, repair, change the thing. Shame cannot repair anything. Guilt can.

Emotion · Shame and guilt

A Shame-Resilience Script

The script

Brown's shame-resilience work has four moves. Write your version here while you are not in it, so the words exist when you are.

1. **Recognize it in the body**
   Name your physical tells: the heat, the eyes dropping, the urge to leave or attack. Say 'this is shame' before it says anything about you.

2. **Reality-check the message**
   Whose voice is it? What exactly did I do, stated without adjectives? What would I say to a colleague who did the same thing?

3. **Reach out**
   One person, chosen in advance, who responds with empathy rather than advice or alarm. Shame cannot survive being spoken and met.

4. **Speak it**
   The sentence is short: 'I am feeling shame about ___, and I need you to just hear it.'

The thing I am ashamed of (one line; no detail required): _____

What the shame says I am: _____

What I actually did, stated plainly: _____

What guilt would do with it (the repair): _____

Who I will tell, and when: _____

What I need from them (listen · say it is human · nothing): _____

If shame brings thoughts of not wanting to be here, tell staff or your clinician today, or call 988.

One disclosure

Choose one safe person here and tell them one thing this week, using the sentence in step four. Then bring what happened, in them and in you, to session.

Next · The Distortion Catalogue, Adult Edition

The Distortion Catalogue, Adult Edition

Distortions are not stupidity. They are shortcuts a fast mind takes under load, and the more capable you are, the better you can argue for them. Catching them by name is the skill. The names are a vocabulary, not a verdict.

Thirteen patterns

PATTERN	SOUNDS LIKE	THE QUESTION THAT BREAKS IT
All-or-nothing	Not perfect, so it failed	Where is it on 0 to 100?
Overgeneralization	This always happens	How many real instances?
Mental filter	One bad note of forty	What am I leaving out?
Discounting the good	That doesn't count	Would I discount a peer's?
Mind-reading	They think I'm lost	Evidence, beyond the feeling?
Fortune-telling	This will go badly	How often am I right?
Magnify / minimize	Big error, tiny win	Same scale for both?
Emotional reasoning	I feel a fraud, so I am	Is the feeling evidence?
Should statements	I should be past this	Whose rule, at what cost?
Labeling	I'm a failure, full stop	The act, without the label?
Personalization	The team is flat; my fault	What else is in the picture?
Control fallacy	All on me, or none of it	What is actually mine?
Fairness fallacy	After all I did, unfair	Is fairness the world's rule?

Why this works

Beck described the first systematic errors in Cognitive Therapy of Depression (1979); Burns popularized the catalogue in Feeling Good (1980). Each distortion is a predictable error in information processing under negative mood: the mind over-weights threat and loss, under-weights the evidence against them, and reads the result as perception rather than inference. Mood then confirms the thought and the loop closes.

Thought records are the standard CBT tool for breaking it. They work because they externalize the thought: on paper, a distortion is visible in a way it never is in the head. CBT's randomized-trial base is the largest of any psychotherapy.

The Seven-Column Thought Record

The seven-column thought record

One row per thought. Fill the first three columns at the time, the last four later the same day. Rate the emotion before and after; the number moving is the evidence that the method works for you.

Situation (who, what, when)	Emotion & 0-100	Automatic thought (exact words)	Distortion (name it)	Evidence for	Evidence against	Balanced thought & re-rate 0-100

Common mistakes

Writing a feeling in the thought column (I felt awful) instead of the thought that produced it. Listing opinions as evidence. Writing a balanced thought you do not believe; it should be accurate, not nice.

Done well

The thought is in its original words. The distortion is named from the catalogue. The balanced thought is a full sentence that includes the evidence for and against. The emotion is re-rated honestly, even if it barely moved.

Volume matters

Three records a day for two weeks is the dose in the trials. Bring the sheet to session and look for which distortions recur. Most people have two or three favourites.

Next · Action Precedes Motivation

Action Precedes Motivation

Depression tells you to wait until you feel like it. Behavioral activation says the feeling follows the action, not the other way round, and that the waiting is itself the engine. Avoidance brings relief for an hour and removes, one by one, every source of reward in a life. The treatment is to put them back, on a schedule, whether or not you feel like it.

TRAP and TRAC

	TRAP	TRAC
Trigger	The board email lands at nine at night	The same email
Response	Dread, heaviness, 'I cannot deal with this'	The same; the feeling is not the problem
Avoidance Pattern / Alternative Coping	Pour a drink, scroll, promise yourself six a.m.	Ten minutes on the reply, then stop; or walk, then sleep on purpose

Mastery and pleasure are rated separately, 0 to 10, because depression removes them separately. A hard workout can be high mastery and zero pleasure; a call with an old friend the reverse. Both count. Depressed memory under-reports both, so rate at the time, not later.

Why this works

Behavioral activation (Jacobson, 1996; Martell, Addis, and Jacobson, 2001) came out of a component analysis showing that the behavioural piece of CBT worked as well as the whole package. The model: a loss or stressor lowers reward, the person withdraws to cope, withdrawal removes further reward and adds secondary problems, and mood sinks. Avoidance is the maintaining factor, and it is often subtle: staying busy, ruminating, going to bed early, the drink, the extra hour of email.

In Dimidjian's 2006 trial, BA matched antidepressant medication for severe depression and outperformed cognitive therapy, with lower relapse at follow-up. It is a first-line treatment in NICE guidance and deliverable in a few weeks.

Scheduling by values

Not by mood

'What do I feel like doing' is the question depression has already answered. Schedule from the outside in: the calendar decides, you comply, you rate. Motivation shows up around day four, as a result.

By values

Choose from the domains that matter: health, people, craft, play, contribution. Small, specific, timed. Graded: the first version of any task is the one you could do on a bad day.

Your Week, Scheduled by Values

This week

Fill the grid before the week starts, not each morning. One scheduled activity per block is plenty. After each, rate mastery and pleasure, 0 to 10, in the corner. Blank corners are data too.

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Morning	M__ P__	M__ P__	M__ P__	M__ P__	M__ P__	M__ P__	M__ P__
Midday	M__ P__	M__ P__	M__ P__	M__ P__	M__ P__	M__ P__	M__ P__
Afternoon	M__ P__	M__ P__	M__ P__	M__ P__	M__ P__	M__ P__	M__ P__
Evening	M__ P__	M__ P__	M__ P__	M__ P__	M__ P__	M__ P__	M__ P__

One TRAP, one TRAC

Trigger: _____

Response (the feeling): _____

Avoidance pattern (what I usually do): _____

Alternative coping (what I will do instead, in the same moment): _____

In session

Bring the grid. Look for the blocks you skipped and what you did instead; that is the avoidance map. Look for the highest-rated blocks; that is next week's schedule.

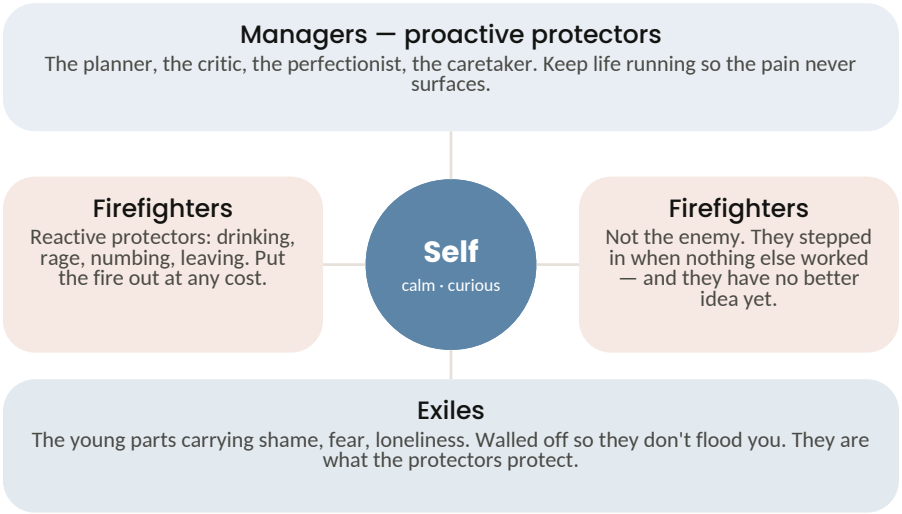
Next · You Are Not One Thing: A Map of Your Parts

Parts & self · Internal Family Systems

You Are Not One Thing: A Map of Your Parts

The voice that says you're fine, the one that wants to burn it all down, the one that still feels eight years old — these are not symptoms and not splits. They are parts: sub-personalities with their own jobs, ages, and fears. Underneath them is a Self that is not damaged. Treatment is helping the parts trust it.

The system



When a firefighter runs the show — the drink, the blow-up, the three-day disappearance — it is usually because a manager failed and an exile broke through. The question is never 'how do I get rid of this part.' It is 'what is it protecting, and what does it fear would happen if it stopped.'

Why this works

Internal Family Systems (Schwartz) holds that multiplicity is normal: the mind is naturally made of parts, and what we call pathology is parts stuck in extreme roles after injury. Protectors (managers and firefighters) organize around exiles — younger parts carrying pain that was once unbearable. No part is bad. Each is trying to help in the only way it learned.

The therapeutic move is unblending: creating enough space between you and a part to be curious about it instead of being it. From that vantage — IFS calls it Self — parts can be heard, updated, and relieved of jobs they took on as children. Research supports IFS for depression, PTSD, and chronic pain, and it is listed in NREPP.

The eight signs you're in Self

Calm · Curious · Compassionate · Clear · Confident · Courageous · Creative · Connected. You do not have to feel all eight. Curiosity alone is enough to begin.

Meet One Part

Meet one part

Choose a part that has been loud lately — the critic, the one that numbs, the one that wants to leave treatment. Go slowly. If you feel flooded, stop and come back to this with your clinician.

1 **Find it**
Where do you feel it in or around your body? What does it look or sound like, if anything?

2 **Unblend**
Ask the part to give you a little space, so you can get to know it. Notice how you feel toward it now. If the answer is anything but curious, that's another part — ask it to step back too.

3 **Ask**
How long have you been doing this job? What are you afraid would happen if you stopped? What do you need from me?

4 **Thank it**
Protectors have usually been working since childhood with no acknowledgment. Thanking a part is not a trick. It is the beginning of trust.

The part: _____

Where it lives / what it looks like: _____

Its job: _____

What it's afraid would happen if it stopped: _____

How old it seems: _____

What it needs from me: _____

Your map

On a blank page, draw your system the way it is right now: Self in the center, managers, firefighters, exiles, and the lines between them. Bring it to session. It will change over the stay — that is the point.

Next · Relationships

Section

Relationships

The pattern you learned early is the one you still run with the people closest to you. These pages make the pattern visible, then give you the moves that change it: repair, boundaries, and a cleaner way to say what you need.

In this section

How You Bond Under Pressure 50

The Four Horsemen and Their Antidotes 52

Boundaries Are Information, Not Walls 54

Observation, Feeling, Need, Request 56

You Were Trained in a System 58

Trust Is Rebuilt, Not Restored 60

Emotional Closeness After Treatment 62

The Cycle Is the Enemy, Not Your Partner 64

If you read only one page here

How You Bond Under Pressure — page 50.

Relationships · Adult attachment

How You Bond Under Pressure

Attachment style is not a personality type and not a diagnosis. It is the strategy your nervous system learned, early, for staying connected to people you depended on. In calm conditions the differences barely show. Under stress and in conflict they run the room, and they decide whether you reach, retreat, or do both at once.

Two dials, four strategies

	LOW ANXIETY · trusts others	HIGH ANXIETY · fears loss
LOW AVOIDANCE seeks closeness	**Secure** Comfortable close and alone. Asks directly, repairs quickly, assumes good faith until shown otherwise.	**Anxious-preoccupied** Wants more closeness than it gets. Monitors, protests, reads silence as leaving.
HIGH AVOIDANCE keeps distance	**Dismissive-avoidant** Values independence, downplays need. Goes quiet, gets practical, calls distance maturity.	**Fearful / disorganized** Wants closeness and fears it. Approaches, then pulls away; no strategy feels safe.

Read the map as two dials: how much you fear being left, and how much you avoid depending. Most people sit near a corner and slide under pressure. Earned security is the term for adults who began insecure and became secure, usually inside one reliable bond.

Why this works

Bowlby proposed that infants are biologically built to seek a caregiver under threat; Ainsworth's Strange Situation showed that what the caregiver reliably did shaped a secure, anxious, or avoidant strategy by the first birthday. Hazan and Shaver (1987) found the same patterns in adult romantic bonds, and Main's Adult Attachment Interview showed that how a person tells the story of their childhood predicts their style better than what happened in it.

Styles are stable but not fixed. Longitudinal work finds roughly a quarter of adults shift category over years, most often toward security inside a relationship that is reliable and repairs well. That is the clinical target: not insight about your category, but new experiences of reaching and being met.

Under stress and in conflict

STRATEGY	UNDER STRESS	IN CONFLICT
Secure	Names the strain; asks for help without apology	Stays in the room; can be wrong; repairs the same day
Anxious	Checks in more; reads delay as distance; escalates	Pursues, protests, escalates to be heard; struggles to drop it
Avoidant	Goes self-sufficient; works more; needs no one	Withdraws, reasons, minimizes; leaves the room or the topic
Fearful	Reaches, then regrets it; mixed signals	Blows up then shuts down; both moves in one argument

Your Attachment History

An attachment history

Main's research found that the coherence of the story matters more than its contents. Write short, concrete answers. If a line brings up more than you expected, stop there and bring it to session unfinished; that is useful information, not failure.

Then

Who I went to when I was hurt or scared as a child: _____

What usually happened when I did: _____

What I learned to do with need (hide it · amplify it · solve it alone): _____

The first adult relationship where I noticed the same pattern: _____

Now

Where I sit on the map today, and which way I slide under pressure: _____

What my partner, family, or closest friend would say I do in conflict: _____

A relationship, past or present, that felt reliable, and what the person did: _____

One earned-secure behavior

Choose a single move that belongs to the secure cell and practice it here, where the stakes are lower: ask for something directly instead of hinting or going without; stay in a hard conversation sixty seconds past the urge to leave; say 'I was wrong about that' without a defense attached. Write which one, and try it three times this week. Bring the results to session.

Next · The Four Horsemen and Their Antidotes

The Four Horsemen and Their Antidotes

Gottman's lab could watch a couple argue for fifteen minutes and predict, with accuracy above ninety percent, whether they would divorce. The prediction did not rest on how often they fought or what about. It rested on four specific behaviors, and on whether anyone repaired after them.

Horseman and antidote

HORSEMAN	SOUNDS LIKE	ANTIDOTE
Criticism	"You never think about anyone but yourself." Attacks the person, not the behavior.	Gentle start-up: "I feel ___ about ___, and I need ___."
Contempt	Eye-rolling, mockery, sarcasm, name-calling. Speaking from above.	A culture of appreciation: say what you respect, specifically and often.
Defensiveness	"It's not my fault. What about when you..." Counter-attack as self-protection.	Take responsibility for your part, even a small part: "You're right about that."
Stonewalling	Silence, looking away, leaving. Usually a flooded body, not a cold heart.	Self-soothing: name the flood, take twenty minutes, come back.

Why this works

John Gottman observed thousands of couples in a laboratory apartment at the University of Washington, coding facial expression, language, and heart rate second by second, then followed them for years. Four behaviors predicted dissolution: criticism, contempt, defensiveness, and stonewalling. Contempt was the strongest single predictor; it signals disgust and, in Gottman's data, even tracks with the partner's rate of infectious illness.

Two other findings matter here. Stable couples kept a ratio of about five positive interactions to every negative one during conflict. And the couples who lasted were not the ones who never used a horseman; they were the ones whose repair attempts were received. Couple therapy built on this work has randomized-trial support.

Flooding: when the body leaves the conversation

What it is

Heart rate climbs above roughly 100 beats per minute, adrenaline rises, and the parts of the brain that listen and reason go offline. Nothing useful is said after this point by either person. Stonewalling is often flooding with nowhere to go.

What to do

Call it: "I'm flooded. I need twenty minutes." Leave, and for at least twenty minutes do something that is not rehearsing the argument. Come back when you said you would. The return is the part that builds trust.

A repair attempt is any move that lowers the tension: a joke, a hand on the arm, "let me try that again." In Gottman's data, what predicted the future was not the attempt but whether the other person let it land.

Your Horseman, Your Antidote

Identify your horseman

Everyone has one they reach for first. Mark the one you recognize, honestly; your partner or family would likely agree. Then write the antidote in your own words, for a real recurring argument, so it is ready before you need it.

- ◯ Criticism: I lead with what's wrong with them
- ◯ Defensiveness: I counter before I've heard the complaint
- ◯ Contempt: I get sarcastic, mocking, superior
- ◯ Stonewalling: I go silent, shut down, or leave

The antidote script

The argument we keep having: _____

What I usually say (the horseman, in my actual words): _____

Gentle start-up, my version: I feel… about… I need… _____

_____

The part I can honestly take responsibility for: _____

Repair phrases I could actually say

_____

_____

_____

Starter list

"Can I try that again." "That came out harsher than I meant." "I'm getting flooded; give me twenty minutes and I'll come back." "You have a point." "I'm on your side here, even though it doesn't sound like it." Choose three that sound like you, write them above, and agree with your partner in advance that a repair attempt gets received, not graded.

Next · Boundaries Are Information, Not Walls

Relationships · Boundaries

Boundaries Are Information, Not Walls

A boundary is a statement about what you will do, not a demand about what someone else must do. People who run organizations are often superb at boundaries with staff and vendors and have none at all with a parent, a spouse, or their own calendar. The skill is the same. The fear is different.

Three kinds

BOUNDARY	LOOKS LIKE	UNDERNEATH
Porous	Says yes while meaning no. Overshares early, absorbs other people's moods, can't end a call. Resentful, then exhausted.	Fear that a no will cost the relationship
Rigid	Says no before the question is finished. Lets no one close, shares nothing, handles everything alone. Safe, and lonely.	Fear that a yes will cost the self
Flexible	Decides case by case. Can say no warmly and yes fully. Shares in proportion to trust. Can hear a no without collapse.	Confidence that the relationship survives honesty

Why this works

The porous-rigid-flexible typology comes from family systems work (Minuchin's description of enmeshed and disengaged families) and was carried into individual treatment through DBT's interpersonal effectiveness module (Linehan), which teaches asking and refusing as trainable skills with a clear script. The mechanism is simple: a boundary that is stated is a piece of information the other person can act on; a boundary that is only felt becomes resentment, and resentment becomes distance or an explosion.

Flexible boundaries track the relationship and the situation. They are firmer with people who have shown they will push and looser with people who have earned it. The aim is not a rule for everyone; it is a decision you can make, say, and keep.

A boundary is not an ultimatum

A boundary

About you, and in your control. "If the conversation turns to shouting, I will leave the room and we can pick it up tomorrow." Said once, calmly, then done. Nobody is being punished; you are describing what you will do.

An ultimatum

About them, and a threat. "If you ever raise your voice at me again, we're finished." Designed to control, usually not meant, and each one you do not follow through on teaches the other person that your words are noise.

The test: can you keep this with no cooperation from the other person? If yes, it is a boundary. If it only works when they comply, it is a request or a threat.

Relationships · Boundaries

Three Scripts for Real Situations

The three scripts

1. **Saying no**
   Acknowledge, decline, stop. "I can see this matters to you. I'm not able to take it on." No reason is required; a reason invites negotiation. If you want to offer something, make it specific and smaller.

2. **Asking for something**
   Describe, feel, ask, one sentence each. "When the plans change the same day, I feel like an afterthought. I'd like a day's notice when you can give it." Then stop talking and let them answer.

3. **Ending a conversation**
   Name the state, name the plan, go. "I'm past the point where I can do this well. I'm going to stop here and come back to it after dinner." Then actually come back.

Script one: a no I owe someone

The situation and the person: _____

What I'll say: _____

Script two: something I need to ask for

The situation and the person: _____

What I'll say: _____

Script three: a conversation I need to be able to end

The situation and the person: _____

What I'll say: _____

Rehearse out loud

Say each script to your clinician or in group before you use it. Notice which one makes your voice go up at the end. That is the one to practice until it is flat and warm.

Next · Observation, Feeling, Need, Request

Relationships · Nonviolent Communication

Observation, Feeling, Need, Request

Most hard conversations fail in the first sentence: a judgment dressed as a fact, a feeling blamed on the listener, and no request at all. Rosenberg's model separates the four parts, so the other person hears what happened and what you need instead of a verdict on their character.

The four parts

O

Observation

What happened, without evaluation. A camera could confirm it.

How: "You arrived at 7:40 for a 7:00 dinner." Not: "late again, as usual."

F

Feeling

One word for what is in you. "I feel ignored" is a judgment about them, not a feeling.

How: "I felt hurt, then angry."

N

Need

The universal thing underneath: respect, reliability, rest, to matter.

How: "I need to know my time matters to you."

R

Request

Specific, doable now, and a request: no is an acceptable answer.

How: "Would you text me if you'll be more than fifteen minutes out?"

Why this works

Marshall Rosenberg developed Nonviolent Communication in the 1960s and used it in mediation and conflict work worldwide. Its premise is that every action is an attempt to meet a need, and that moralistic judgments ("selfish," "lazy," "you always") are needs expressed in a form that guarantees defensiveness. He called the judging voice the jackal and the need-hearing voice the giraffe, the land animal with the largest heart.

NVC is a communication model, not a therapy, and the outcome research is modest; what supports it is the broader evidence that blame and contempt reliably escalate conflict (Gottman) and that stating a need with a concrete request makes it far more likely to be met. The discipline is in the first step: an observation a camera could have recorded.

Why 'you make me feel' fails

Jackal

"You make me feel worthless." Hands them authorship of your inner life, which they will refuse. The fight becomes about whether they did that; the need is never heard.

Giraffe

"When the plan changed without a word, I felt small; I need to be consulted. Would you check with me first?" The feeling is yours, the need is clear, the ask is answerable.

Translate Three Habitual Lines

Translate three lines

Pick three things you actually say in conflict, the lines your family could quote. Write each as it comes out, then rebuild it in four parts. The observation is usually the hardest to strip of judgment; if the word could not be filmed, it is not an observation.

Line one

What I actually say: _____

Observation: _____

Feeling / need: _____

Request: _____

Line two

What I actually say: _____

Observation: _____

Feeling / need: _____

Request: _____

Line three

What I actually say: _____

Observation: _____

Feeling / need: _____

Request: _____

Hearing it the other way

The same four parts work in reverse. When someone attacks, listen for the need under it: "You sound furious; are you needing to be heard on this?" Try it once this week with a staff member or peer and bring the result to session.

Next · You Were Trained in a System

Relationships · Bowen family systems

You Were Trained in a System

The family you grew up in was not a set of individuals. It was a system with its own rules for managing anxiety, and it trained you in a role before you could consent. Bowen's work explains why the role follows you into a marriage, a boardroom, and a treatment program, and what it takes to step out of it without leaving the people in it.

Four concepts

CONCEPT	WHAT IT MEANS	HOW IT SHOWS UP
Differentiation	Holding your own position while staying connected; thinking under emotional pressure	Low: you fuse or you flee. High: you can disagree with your father and still call him Sunday.
Triangles	Two people under tension pull in a third to lower the anxiety	A parent confides in a child about the other parent; a boss and a deputy bond over a third
Emotional cutoff	Managing an unresolved bond by distance or silence	Looks like independence; the intensity is intact and reappears in the next close relationship
Transmission	Patterns of anxiety and role pass down generations	The drinking, the silence, the overwork, the favored child, repeating two rows down

Why this works

Murray Bowen, a psychiatrist at the Menninger Clinic and then Georgetown, built his theory from observing whole families living on a research ward in the 1950s. The emotional system of a family, he argued, is a unit: anxiety in one member moves through the others along predictable paths. His core variable, differentiation of self, is the capacity to stay in emotional contact with the family while thinking and acting from your own principles, rather than from the group's anxiety.

The theory has less randomized-trial evidence than CBT or EFT, but its concepts, especially triangles and transmission across generations, are used throughout family therapy and are supported by research on intergenerational patterns of attachment and conflict.

The roles children are given

Hero / caretaker

The achiever and the responsible one. Holds the family's pride and keeps it running. Cost: an adult who cannot rest, ask, or fail.

Scapegoat

Carries the family's trouble so no one has to look at the system. Cost: an adult who expects blame and sometimes earns it on purpose.

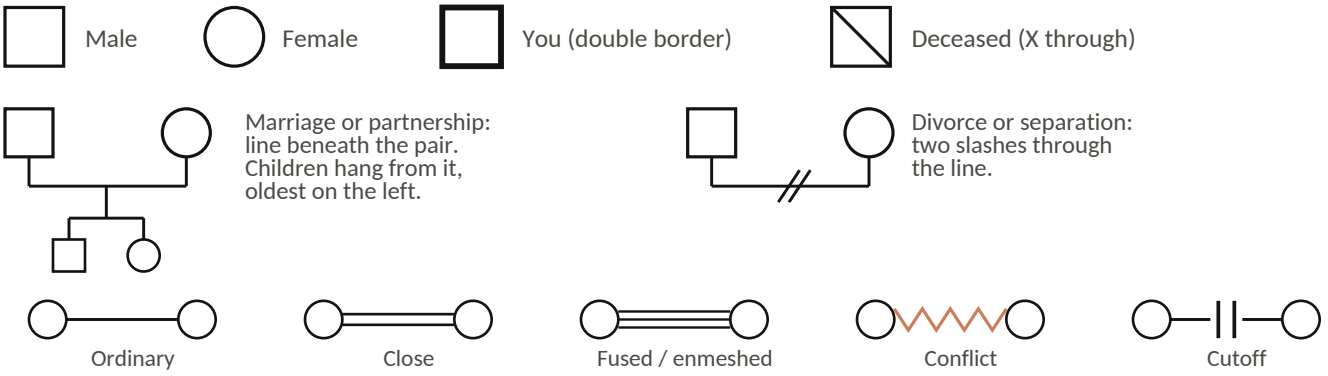
Lost child / mascot

The lost child disappears and needs nothing; the mascot deflects with humor. Cost: adults who are hard to find, even by themselves.

Three Generations on One Page

Genogram legend

A genogram is a family map with the relationships drawn in. Use the symbols below, then draw three generations on a blank page: grandparents at the top, parents in the middle, you and your siblings at the bottom, with your own partner and children if you have them.



After you draw it

Where the conflict lines cluster, and where the cutoffs are: _____

The triangle I was pulled into as a child, and the one I am in now: _____

A pattern that appears in at least two generations: _____

My role then, and where I still play it (work · marriage · here): _____

One place I could stay connected and still hold my own position: _____

Bring the drawing

Mark on it anything you did not know you knew. Genograms tend to show the thing the family does not talk about. Bring it to session and let your clinician ask about the blank spaces.

Next · Trust Is Rebuilt, Not Restored

Relationships · Trust after a rupture

Trust Is Rebuilt, Not Restored

After a crisis, a relapse, a disappearance, or a betrayal, the people who love you have two questions: is it over, and will it happen again. An apology answers neither. Trust comes back only one way: through many small, verifiable, unprompted acts over time, with the hurt person setting the pace.

ATTUNE

LETTER	MEANS	LOOKS LIKE
A	Awareness	Noticing their emotion before they have to announce it
T	Turning toward	Responding to the bid, not the phone
T	Tolerance	Two points of view can both be true at once
U	Understanding	Asking until you could state their case fairly
N	Non-defensive listening	Hearing the hurt without explaining it away
E	Empathy	Letting it land; showing it landed

Why this works

Gottman's trust research (The Science of Trust, 2011) defines trust operationally: the belief that your partner will act in your interest even when it costs them. It is built or spent in ordinary moments, which he called sliding-door moments, when one person turns toward the other's bid or away from it. After a betrayal, trust is rebuilt through attunement, which Gottman summarized as ATTUNE, and it moves at the speed of the hurt person's nervous system, not the repairing person's remorse.

The same principle runs through the relapse-prevention and family literature: what repairs is consistent behavior observed over time, plus transparency the hurt person did not have to ask for. Promises, intensity, and speed do not help and often hurt.

Two timelines

What the hurt person needs

Full information, offered rather than extracted. Consistency they can check. Time, with no deadline for being over it. To be able to raise it again without being told that was already covered. Evidence, not reassurance.

What the repairing person wants

To be forgiven soon. To stop being reminded. Credit for effort. Relief from shame. All of these are understandable and all of them, if acted on, reset the clock. The repairing person's job is to want these things quietly.

Transparency, consistency, time. If a repair plan is missing one of the three, it is a request to be trusted on faith, which is the thing that was lost.

A 90-Day Trust Agreement

The agreement

Draft this alone, then revise it with the person you hurt, ideally with your clinician present. Everything on it must be specific enough that both of you could say at any point whether it happened. Ninety days is a starting term, not a finish line; the hurt person decides what happens after.

Transparency

What I will share without being asked (whereabouts · money · phone · medication · meetings): _____

_____

How and how often (daily text · weekly sit-down · shared calendar): _____

Consistency

Three things I will do every day or week, that can be checked: _____

_____

What I will do when I slip on one of them, within 24 hours: _____

Time and review

How we will raise it when the hurt comes back up, without it becoming a fight: _____

When we will review this, with whom: _____

Signatures, then silence

Both sign. Then stop talking about trust and start doing the list. The hurt person owes nothing yet; the repairing person owes the list. Bring the agreement to session and to family programming.

Next · Emotional Closeness After Treatment

Emotional Closeness After Treatment

Closeness is usually the last thing anyone talks about in treatment and one of the first things that worries people on the way home. Depression, anxiety, and trauma all pull a person inward; the people who love you may have spent months on the outside of that. Coming back to each other is a skill, and it is built in small moments, not big conversations.

What creates distance

FACTOR	WHAT IT DOES	WHAT HELPS
Depression and anxiety	Turns attention inward; makes a partner's bid feel like one more demand	Name it out loud; expect warmth to lag recovery by weeks
Shame after a crisis	Avoids eye contact and the subject; reads kindness as pity	Short, honest check-ins; let the other person see you trying
Trauma	Touch or conflict can trigger shutdown or vigilance	Pacing, permission at every step, clinician involvement
Caretaker fatigue	The other person has been managing, not relating, for months	Thank them specifically; take back one task they carried
Old stories	"I'm not wanted"; "I'm being graded"	Say the story out loud; it is usually wrong

Why this works

Gottman's research on couples (The Relationship Cure, 2001) found that closeness is made or lost in bids: small requests for attention, a comment about the weather, a sigh, a hand reached out. Partners who stayed close turned toward those bids most of the time; partners who drifted turned away or against them. The bids were almost never about the thing they seemed to be about.

Emotionally focused therapy (Johnson) adds the second half: under most distance is a protest about not mattering, and under most withdrawal is a fear of failing the other person. When each person can say the softer thing underneath, the cycle loses its power. Both bodies of work agree on pacing: closeness that is demanded shuts down; closeness that is offered in small, safe steps tends to be accepted.

Rebuilding without pressure

Turn toward the bid

A bid is any small reach: a question, a comment, a look. Turning toward means a response, not a solution: look up, answer, add one sentence. Most of the work of closeness is this small, and most of it is missed by accident.

Permission and pacing

Each step is agreed in advance, and either person can pause any step without explanation or consequence. Pausing is not failure; it is the mechanism that makes the next step safe to try.

Bring any pattern that predates treatment, or any step that keeps stalling, to session or to family programming. Ask your clinician about a couples or family referral if talking about it alone goes in circles.

The Closeness Ladder

Eight rungs

Eight rungs, from the smallest contact upward. Fill the right column with the person you are rebuilding with: what each rung actually is for the two of you, in plain words. Then start at the first rung and stay there until it feels easy, not until it feels like enough. Move up only by agreement, and come down a rung whenever either of you needs to. If you are rebuilding with a parent, sibling, or friend, the ladder works the same way.

RUNG	EXAMPLES	OURS
1	A greeting with eye contact that lasts; a question answered with more than one word	
2	Ten minutes a day with phones away: how was your day, and a real answer	
3	Sitting close; a hand on the back; a long hug, both leaning in	
4	Doing one ordinary thing together, with no agenda: a walk, cooking, a drive	
5	Saying one thing you appreciated about them today, specifically	
6	Telling them one thing that is hard right now, without asking them to fix it	
7	Hearing one thing that was hard for them while you were away, without defending	
8	A weekly check-in: what went well between us, what needs a repair, one plan	

The rung we are on today: _____

What either of us can say to pause, without it meaning anything more: _____

What we will bring to the clinician or to a family session: _____

Weekly, not nightly

Agree on one or two times a week to practice the current rung. Keep it short and keep it bounded. Bring the ladder, and anything that stalled, to session or to a family session.

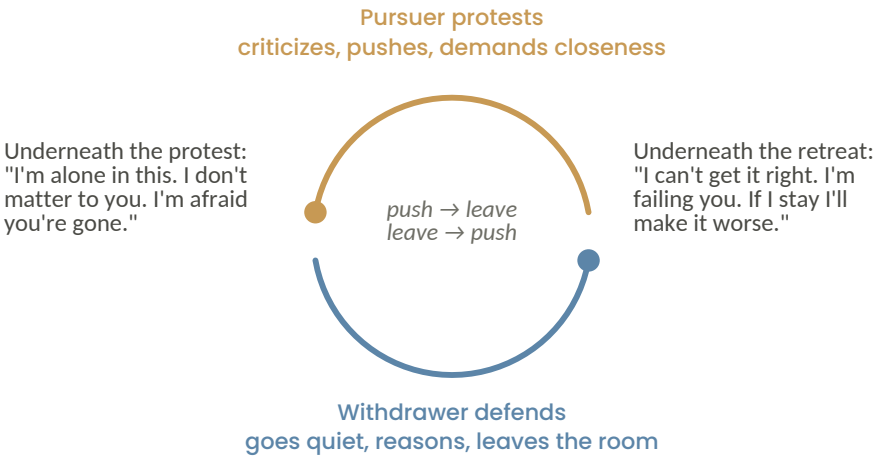
Next · The Cycle Is the Enemy, Not Your Partner

Attachment · Emotionally Focused Therapy

The Cycle Is the Enemy, Not Your Partner

Most couples — and most families — are not fighting about the dishes. They are caught in a loop that runs faster than either person can think, in which each one's way of coping triggers exactly the thing the other fears most. EFT calls it the negative cycle. Naming it is the first move out of it.

The pursue–withdraw loop



Roles are not fixed. People pursue with one partner and withdraw with another; families often have a pursuer parent and a withdrawing child, then swap in adolescence. The physics never change: protest and retreat feed each other until someone steps out.

Why this works

Emotionally Focused Therapy (Johnson) is built on adult attachment research: the distress in a close relationship is attachment panic — the alarm that goes off when the bond feels threatened. Pursuing and withdrawing are both attempts to manage that alarm. One reaches harder; the other protects the bond by not making it worse. Both read the other's strategy as proof of the fear.

EFT has some of the strongest outcome data in couple therapy, with gains that hold at follow-up. The mechanism is not communication skills; it is reaching underneath the protest and the retreat to the primary emotion, and letting the other person see it.

Stepping out

1. **Catch the cycle, not the content**
   "We're doing the thing" — said out loud, by either of you — ends more fights than any resolution of the actual topic.

2. **Name the surface move and the feeling under it**
   Pursuer: "I'm getting loud because I'm scared you're gone." Withdrawer: "I'm going quiet because I'm afraid I'll fail you." The soft emotion is the exit.

3. **Ask for the small thing**
   Not "be different." One reachable thing: stay in the room; say you're not leaving; put a hand on my back; give me ten minutes and then come back.

Attachment · Emotionally Focused Therapy

Map One of Your Cycles

Map one of your cycles

Pick a recent argument — small ones are better than big ones. Work it from the outside in. If you are not in a couple, do this with a parent, a sibling, a close friend, or your relationship with staff here; the loop runs anywhere there is a bond.

What the fight was 'about': _____

When it starts, what I do on the outside (my move): _____

What I think they're doing to me: _____

What I'm actually feeling underneath (scared · alone · ashamed · not enough · unimportant): _____

What they do on the outside (their move): _____

What they might be feeling underneath: _____

Where the loop could break — the first moment one of us could say 'we're doing the thing': _____

The reach

Write the one sentence you would say if you were brave and they were safe: the feeling, plus the small ask. Practice it here before you need it. 'When you go quiet I get scared I don't matter, and I need you to tell me you're still in this.'

Section

Conditions, at depth

What is actually happening in depression, panic, bipolar disorder, psychosis, trauma, OCD, burnout and grief — the mechanism, honestly described — and what treatment does about each one.

In this section

Depression: Two Models, One Illness 67

Panic: The Fear of Your Own Body 69

Bipolar Disorder: Why Sleep Is the Lever 71

Psychosis: Vulnerability and Stress 73

What Trauma Does to Memory 75

OCD Is Not Worry With Extra Steps 77

Burnout Is Not Depression. It Can Become It. 79

Grief Is Attachment, Not a Set of Stages 81

If you read only one page here

The one with your diagnosis on it. If you have not been given one, ask your clinician which page is yours.

Depression: Two Models, One Illness

Depression is not sadness with extra weight. It is a state in which the systems that generate energy, interest, and reward go quiet while the systems that generate self-criticism and threat get louder. Two models describe how it holds itself in place. Both are right, and each points at a different lever.

Two loops that hold it in place

Behavioral model

Low mood, low energy

↓

Do less, see fewer people

↓

Less reward, less contact

↓

Mood drops further

↺ *and the loop restarts*

Cognitive model

Self — *"I am a burden."*

World — *"Nothing is worth it."*

Future — *"This won't change."*

Biased attention and memory keep the triad fed: the slight is remembered, the win is not.

The models are not rivals. Withdrawal starves the reward system; the triad supplies the reasons to withdraw. Behavioral activation enters through the left loop, CBT through the right. Medication enters underneath both.

The honest neurobiology: there is no single chemical imbalance, and the low-serotonin story does not survive the evidence. What is supported is a stress-sensitized system: an overactive HPA axis, reduced plasticity in prefrontal and hippocampal circuits, an under-responsive reward circuit, in some people low-grade inflammation, on a base of genetic and early-life load. Treatments restore plasticity, which is why most take weeks.

Why this works

The behavioral model (Lewinsohn; Jacobson and Martell's behavioral activation) treats depression as lost reinforcement: low mood leads to withdrawal, withdrawal removes the people and activities that generated reward, and the absence of reward deepens the mood. The cognitive model (Beck) describes a negative triad about self, world, and future, held in place by biased attention and memory.

Both have strong randomized-trial support; head to head, behavioral activation and full CBT perform about equally, and each matches medication for most episodes.

What each treatment is actually doing

TREATMENT	MECHANISM	EVIDENCE
Antidepressants	Shift monoamine signaling; over weeks, raise plasticity and dampen stress reactivity	Beats placebo in moderate to severe episodes; modest in mild
CBT	Tests the triad against evidence; weakens the rules that regenerate it	Equal to medication; lower relapse after ending
Behavioral activation	Scheduled contact with reward before motivation returns	Equal to full CBT in large trials
Exercise	Raises BDNF and reward response; improves sleep	Moderate effect in meta-analyses; dose matters

Your Depression Formulation

If first-line is not enough

About a third of people do not remit on the first adequate trial. That is a known branch of the pathway, not a verdict. These are things to ask your prescriber about, in roughly the order they are usually considered.

OPTION	WHAT IT IS	WORTH KNOWING
Augmentation	Adding a second agent to a partial response: lithium, an atypical antipsychotic, thyroid hormone, or a second antidepressant	Often the first move; each adds its own monitoring
TMS	Magnetic pulses to the left dorsolateral prefrontal cortex, daily for several weeks, awake, no anesthesia	FDA-cleared; useful when two medications have failed
Ketamine / esketamine	Glutamate-system agents that act within hours to days; esketamine is a nasal spray given in clinic	Rapid, including on suicidal thinking; effects need maintenance
ECT	Brief seizure under anesthesia, two to three times a week for several weeks	The most effective treatment for severe or psychotic depression; memory side effects are real and mostly time-limited

Your formulation

What I stopped doing, in order (the first thing I dropped, then the next): _____

The triad in my words — self / world / future: _____

_____

The loop I can enter first (activity I could schedule this week, or a thought I could test): _____

What I want to ask my prescriber about: _____

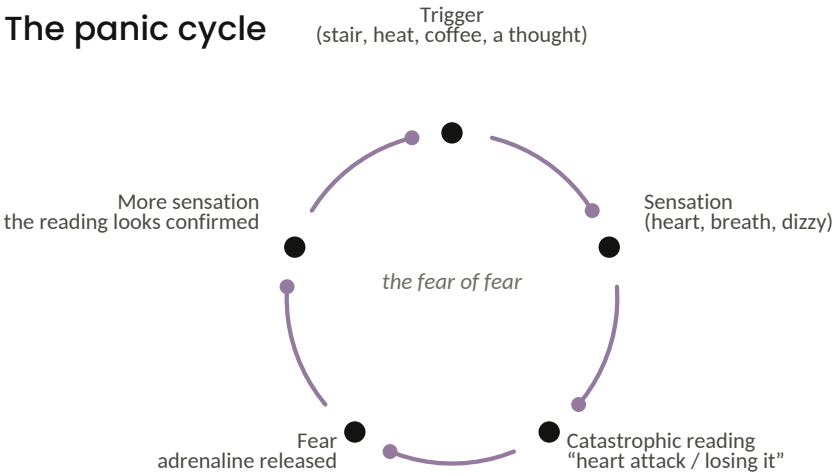
If the future line reads 'there is no point' and you have had thoughts of ending your life, tell staff or your clinician today, or call 988. That thought is a symptom of the illness, and it is treatable.

Next · Panic: The Fear of Your Own Body

Panic: The Fear of Your Own Body

A panic attack is a false alarm: a full fight-or-flight discharge in the absence of a threat. It peaks in minutes and cannot hurt you. Panic disorder is what grows around it: the fear of the next one, and the shrinking of life to avoid it. The attack is physiology. The disorder is learning, and learning can be undone.

The panic cycle



The cycle runs in seconds, below the level of argument. It does not matter that you know your heart is healthy. The body has learned that a racing heart predicts disaster, and it will keep believing that until it is shown, repeatedly and in the body, that it does not.

Why this works

Clark's cognitive model of panic (1986) identifies the engine: a bodily sensation is read as catastrophe, the reading triggers fear, and fear produces more of the sensation. Barlow's work added that the vulnerability is anxiety sensitivity, the belief that arousal itself is dangerous.

Craske's inhibitory learning account changed how exposure is done. Fear is not erased; a new association is learned alongside it, and the new one must be strong enough to win retrieval. That means setting up a specific prediction, violating it clearly, varying the context, and removing anything that would let you credit the safety behavior instead of the evidence. CBT for panic is first-line in every major guideline, with large, durable effects.

Safety behaviors, and why they keep fear alive

What they look like

Carrying the pill bottle you never take. Sitting near the exit. Checking your pulse. Avoiding caffeine, stairs, heat, sex, exercise. Needing a specific person along. Leaving early.

What they do

Each one prevents the disconfirmation. The attack passed, and the mind credits the exit seat rather than the fact that panic always passes. The fear is left intact, with a rule attached.

Interoceptive exposure

Deliberately produce the sensations you fear: breathe hard for sixty seconds, spin in a chair, breathe through a straw, run the stairs. Stay with the sensation, with no safety behavior, until the prediction fails. Then repeat. The first rounds are done with your clinician in the room.

A Hierarchy and a Drop List

Build the hierarchy

Eight rungs, from the sensation or situation you avoid least to the one you avoid most. For each, write the specific prediction, with a number: 'my heart will not slow down and I will faint, 80 percent.' After the exposure, write what actually happened. The gap between the two columns is the treatment.

RUNG	SENSATION OR SITUATION (SPECIFIC)	PREDICTION 0–100 / WHAT HAPPENED
1 easiest		
2		
3		
4		
5		
6		
7		
8 hardest		

The drop list

Safety behavior I will drop first / what I predict will happen without it: _____

Second: _____

Third: _____

In session

Bring the hierarchy. Rung one is run this week with your clinician present; the prediction is written before, the result after. A panic attack during exposure is not a failure of the method. It is the method working.

Panic does not cause heart attacks, but chest pain with no panic history, or that does not pass, needs medical evaluation. Tell staff. If you feel unsafe with yourself, tell staff or call 988.

Next · Bipolar Disorder: Why Sleep Is the Lever

Bipolar Disorder: Why Sleep Is the Lever

Bipolar disorder is a condition of the body's clock as much as of mood. The episodes are real and sometimes dangerous, but between them is a vulnerable system that stays steady when its days are regular and tips when they are not. That makes the hour you get out of bed a clinical decision.

Three diagnoses, one mechanism

DIAGNOSIS	WHAT IT LOOKS LIKE	WHAT TO WATCH
Bipolar I	At least one full mania: a week or more of elevated or irritable energy, little need for sleep, racing speech, risk; often hospitalization. Depressions usually follow.	The first two nights of short sleep
Bipolar II	Hypomania (milder, shorter, often productive-feeling) plus major depression. Most of the illness is spent depressed.	Hypomania mistaken for recovery
Cyclothymia	Years of swings that never reach full episodes but never settle.	Routine, not rescue

Sleep is both the earliest symptom and the trigger. One lost night can start a hypomania; the hypomania then removes the need for sleep. Breaking that loop in the first forty-eight hours is the single most useful thing you can do.

Why this works

Interpersonal and Social Rhythm Therapy (Frank, 2005) grew from social zeitgeber theory: life events disrupt daily routines, disrupted routines disturb circadian and sleep rhythms, and in a vulnerable brain that disturbance triggers an episode. Regular timing of waking, first human contact, activity, meals, and bed is the protective factor the person controls.

Kindling (Post) adds urgency: each episode appears to make the next one easier to trigger, so prevented episodes matter. Medication, lithium above all, remains the foundation; IPSRT added to medication lengthened the time to recurrence in randomized trials, and sleep loss is the most reliably documented trigger for mania.

The relapse signature

Every person's episodes begin the same way each time: the same first changes, in the same order, days before anyone would call it an episode. Sleeping five hours and feeling great. Three new projects. Spending. Talking faster. Irritable at slowness. Family usually sees it first. Writing the sequence down, while well, turns a warning into a plan.

Mania and bipolar depression both carry real suicide risk. If you have thoughts of ending your life, tell staff or your clinician today, or call 988.

Your Social Rhythm Chart

Seven days of rhythm

Write a target time for each anchor, then record the actual time every day. Mood is rated once, in the evening. You are looking for two things: how far the actual drifts from the target, and whether mood follows the drift.

Anchor	Target	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Out of bed								
First contact with another person								
Start of work or main activity								
Dinner								
To bed								
Mood today (−5 to +5)								

My relapse signature

Upswing — first sign, second sign, third sign, in order: _____

_____

Downswing — first sign, second sign, third sign, in order: _____

_____

Who notices before I do, and what I have agreed they can say: _____

What I do within 24 hours of the first sign (sleep, call, medication, cancel): _____

In session

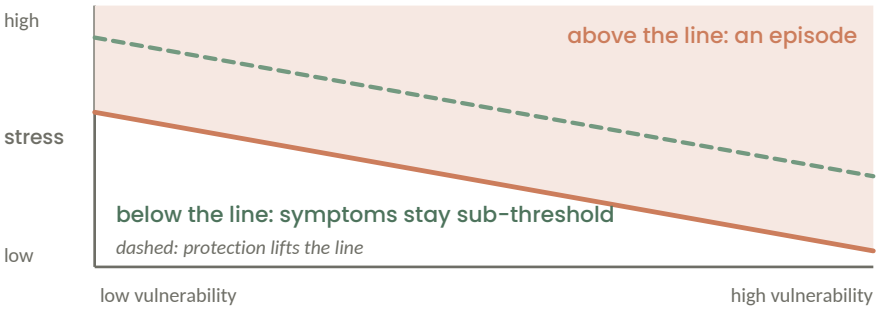
Bring the chart and the signature. The chart continues after discharge; the signature is shared with one family member and your prescriber.

Next · Psychosis: Vulnerability and Stress

Psychosis: Vulnerability and Stress

Psychosis is a loss of contact with shared reality: hearing what others do not, believing what cannot be true, thinking that no longer connects. It is a symptom pattern, not a single disease, and it is often episodic. It runs on the same stress physiology as everything else in this library, in a brain that is more sensitive to it.

The threshold



You cannot change vulnerability. You can change stress and protection: medication, sleep, support, no cannabis. That is enough to keep most people under the line most of the time.

Why this works

Zubin and Spring (1977) proposed that everyone has a threshold for psychosis. Vulnerability, set by genetics, prenatal and developmental factors, and early adversity, determines how low it sits. Stress pushes toward it; protection pushes the line up. That is why relapse is preventable.

The strongest recent evidence is for coordinated specialty care after a first episode: lowest effective medication dose, therapy, family education, and supported work or school, from one team. In the NIMH RAISE trial and the Danish OPUS program this produced better symptoms, quality of life, and engagement, most of all when started early.

Substances, stated plainly

Cannabis, especially high-potency cannabis, is the best-established modifiable risk: it raises the chance of a first episode, brings it earlier, and makes relapse more likely after one. Stimulants can produce psychosis outright. Alcohol withdrawal and sleep loss lower the threshold. None of this is moral; it is dose and timing.

Antipsychotics: what they do and do not do

They do

Dampen dopamine signaling in the pathway that assigns significance to experience, so voices and beliefs lose their grip over days to weeks. Taken continuously, they lower relapse risk substantially.

They do not

Cure the condition, do much for flat motivation or cognition, or work instantly. Weight, metabolic, movement, and sedation effects are real: negotiate them with your prescriber. Stopping suddenly is the most common route back to an episode.

If voices or beliefs are telling you to harm yourself or anyone else, tell staff or your clinician now, or call 988.

Relapse Signature and Action Plan

Early warning signs

Relapse rarely arrives all at once. Most people have a signature: a sequence of changes over one to four weeks that is the same each time. Mark the ones you recognize, then write yours in order.

- ◯ Sleeping less, or at odd hours
- ◯ Pulling away from people
- ◯ Feeling watched or talked about
- ◯ Sounds louder; lights sharper
- ◯ Hard to follow a conversation
- ◯ Preoccupied with one idea or theme
- ◯ Feeling special, chosen, or in danger
- ◯ More irritable or suspicious
- ◯ Skipping medication
- ◯ Using cannabis or alcohol again

My relapse signature, in order

First: _____

Then: _____

Then: _____

Action plan

Who notices first, and what they are allowed to say: _____

What I do in the first 24 hours: _____

Medication plan (what I take, who I call about dose): _____

Who on the treatment team I contact, and how: _____

What I stop (substances, screens, late nights): _____

In session

Bring both lists. The plan is copied to your clinician and, with your consent, to one person at home. The signature gets more exact each time it is used.

Next · What Trauma Does to Memory

What Trauma Does to Memory

An ordinary memory is a story with a timestamp. A traumatic memory is stored differently: in sensory fragments, without the context that would mark it as past. That is why it does not feel remembered. It feels like now. Treatment is the work of giving the memory a timestamp, and it cannot be done by avoiding it.

Four clusters

CLUSTER	LOOKS LIKE	WHAT IT IS
Intrusion	Flashbacks, nightmares, a smell that puts you back there	The unfiled memory returning as present
Avoidance	Not driving that road; not talking about it; staying busy	The thing that keeps the memory unfiled
Negative mood and cognition	Shame, blame, numbness, 'I am permanently damaged'	Appraisals that formed in the event and never got reviewed
Arousal and reactivity	Startle, hypervigilance, sleep, anger, risk	A threat system that never received the all-clear

Avoidance maintains the other three. Every time you steer around the memory, it stays unfiled, and the body learns again that it must be dangerous.

Why this works

Ehlers and Clark's cognitive model (2000) describes the memory as poorly elaborated and poorly integrated with its context, so it is triggered by sensory cues and experienced with a sense of current threat. Foa's emotional processing theory adds the fear structure: stimulus, response, and meaning bound tightly together, which exposure loosens.

Prolonged Exposure (Foa), Cognitive Processing Therapy (Resick), and EMDR (Shapiro) are all strongly recommended, first-line treatments in the current VA/DoD guideline, and trauma-focused treatments outperform non-trauma-focused ones. They differ in method and share a mechanism: approaching the memory, in a safe context, long enough for it to be updated and filed.

What treatment does, and choosing between them

Prolonged Exposure

Retelling the memory aloud, repeatedly, recorded, plus approaching avoided places. The memory loses charge; the brain learns then from now.

CPT

Twelve sessions on stuck points: blame, safety, trust, power, esteem, intimacy. Mostly written and cognitive; the account itself is optional.

EMDR

Holding the image while following a moving stimulus. Mechanism debated; outcomes comparable. Less talking, which some prefer.

Choice is driven by preference and readiness. If you are outside the window of tolerance more than inside it, stabilization comes first: grounding, sleep, the anchors on page two. Processing is not skipped; it is scheduled.

If this sheet brings up more than you expected, stop and tell staff or your clinician. If you are thinking of harming yourself, call 988.

Triggers, Memories, Anchors

Triggers and memories, sorted

A trigger is here and now: a sound, a smell, a tone of voice, a time of year. A memory is then. The brain fuses them, which is why a car door can feel like a threat. Pull them apart on paper, then write what is different now. This is the first move of every trauma treatment.

TRIGGER (HERE, NOW)	WHAT IT LINKS TO (THEN)	WHAT IS DIFFERENT NOW

My anchors

Anchors are what hold you in now while a memory is active. One per channel, chosen while calm, rehearsed daily.

Body (cold, pressure, movement): _____

Senses (a smell, a texture, a taste): _____

Orientation (date, age, place, what is true today): _____

A person who can say my name and the sentence: _____

The sentence — 'That was then. Now I am...': _____

In session

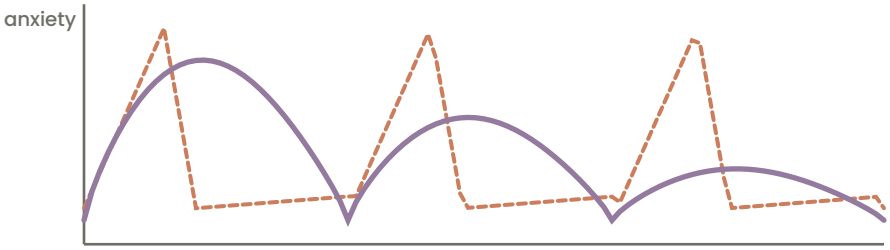
Bring the sorted list and the anchors. Your clinician will use the anchors to decide when processing begins and which treatment fits. You are choosing with them, not being assigned.

Next · OCD Is Not Worry With Extra Steps

OCD Is Not Worry With Extra Steps

Intrusive thoughts are universal: the image of swerving into traffic, the question of whether you locked the door, a thought you would never say aloud. OCD is what happens when the thought is treated as a threat and a ritual becomes the way to cancel it. The ritual works for minutes, and teaches the alarm it was right.

What the ritual does to the fear



dashed: the ritual gives relief and the fear returns intact
solid: no ritual; the peak falls across trials and the prediction fails

Relief is the problem. Each ritual confirms that the danger was real and the ritual averted it, so the next intrusion arrives with more authority. ERP removes the ritual, lets the fear peak and fall on its own, and repeats until the prediction loses its grip.

Why this works

Salkovskis's cognitive model holds that intrusions are normal; what turns one into an obsession is the appraisal: inflated responsibility, or the belief that thinking it is as bad as doing it. The compulsion relieves distress briefly and prevents ever learning that the feared thing would not have happened.

Exposure and response prevention (Meyer; developed by Foa) is first-line, with strong randomized-trial support, comparable to or better than SSRIs alone and strongest combined for severe cases. Under Craske's inhibitory learning account, the target is not calm but tolerance: staying in uncertainty long enough to learn it is survivable.

Compulsions you cannot see

Mental rituals

Reviewing the conversation. Counting. Praying a set number of times. Replacing a bad image with a good one. Checking whether you felt the right feeling. All are compulsions, and all are included in response prevention.

Reassurance

Asking 'are you sure it's fine.' Confessing. Searching the symptom. Re-reading the sent email. A ritual outsourced to another person: same relief, same return. Staff may decline to answer. That is treatment, not indifference.

OCD versus generalized worry

	OCD	GENERALIZED WORRY
Content	Specific, often repugnant or absurd	Realistic: money, health, work, the kids
Feel	Intrusive, alien; demands an action	Feels like thinking; drifts between themes
Response	A ritual that neutralizes	Planning that never finishes

Hierarchy and Reassurance Log

The exposure hierarchy

Each row: the trigger or obsession, the compulsion you will not do, and your distress estimate from 0 to 100. Order from easiest to hardest. Start in the middle, not at the bottom; the evidence favors it, and it builds confidence faster.

TRIGGER OR OBSESSION	COMPULSION I WILL NOT DO (INCL. MENTAL, REASSURANCE)	DISTRESS 0–100

Reassurance-seeking log

What I wanted to ask, and of whom / urge 0-100 / what I did instead: _____

In session

Bring both. Your clinician will run the first exposure with you, and will say 'I'm not going to answer that' when you ask for reassurance. Agree on the phrase now, so it does not land as rejection later.

Intrusive thoughts about harming yourself or others are common in OCD and are not intentions. Still tell your clinician about them; if you feel unsafe, tell staff or call 988.

Next · Burnout Is Not Depression. It Can Become It.

Burnout Is Not Depression. It Can Become It.

Burnout is a work-shaped injury: exhaustion, cynicism, and a collapse of felt effectiveness, produced by a sustained mismatch between a person and their job. Depression is a mood disorder that colors everything. They overlap heavily, and most people who run things arrive here with some of both.

Three dimensions

DIMENSION	HOW IT SOUNDS	WHAT IT IS
Exhaustion	'I have nothing left by ten in the morning.'	Resources spent faster than restored; the first to appear
Cynicism	'None of it matters; they are all idiots.'	Detachment as protection from further demand
Inefficacy	'I used to be good at this.'	The last to fall, and the one that brings people in

Burnout stays at work; depression comes home. Burnout lifts, partly, on a real vacation; depression does not. Depression adds early waking, loss of pleasure in everything, and guilt that is not about the job. If nothing is enjoyable and sleep has changed, ask about both.

Why this works

Maslach's three dimensions, measured by the Maslach Burnout Inventory, are emotional exhaustion, cynicism, and reduced personal accomplishment. Maslach and Leiter mapped six areas of mismatch that produce them: workload, control, reward, community, fairness, and values. ICD-11 classifies burnout as an occupational phenomenon, not a disorder, because its cause is the job.

The overlap with depression is real; exhaustion is nearly identical across the two, and chronic burnout is a risk factor for a depressive episode. The recovery research is consistent: sleep, therapy, and boundaries are necessary, but the stronger and more durable effects come from changing the structure of the work.

The high-achiever route

Competence is rewarded with more load, until the load is set by what you can absorb rather than what the role requires. Identity fuses with output, so rest reads as weakness and delegation as risk. Efficacy, the last dimension to go, is the one you track, which is why the first warning most executives receive is the collapse.

Why recovery means changing the load

Changing the person

Sleep, exercise, therapy, medication if depression is present. Necessary. Alone, it returns a repaired person to an unrepaired job, and the cycle restarts within months.

Changing the load

Headcount, scope, hours, the meeting that should be an email, the relationship that costs more than it returns. Harder to make, and the only changes that hold.

Burnout with depression can bring thoughts that the world would be better without you. If that thought arrives, tell staff or your clinician today, or call 988.

A Load Audit

The load audit

Left column: everything that draws energy in a normal week, with honest hours. Right column: everything that actually restores it, with honest hours. Most people have never written the second column and are surprised by how short it is.

Draws energy: demands, people, hours	hrs/wk

Restores energy: what actually refills	hrs/wk

Two structural changes

Not habits. Changes to the structure of the work that someone else could verify: a role removed, a report moved, a day protected, a client dropped, a decision delegated for good.

Change 1 — what, who decides, by when: _____

_____

What I expect to lose by making it, honestly: _____

Change 2 — what, who decides, by when: _____

_____

Who holds me to this after discharge: _____

In session

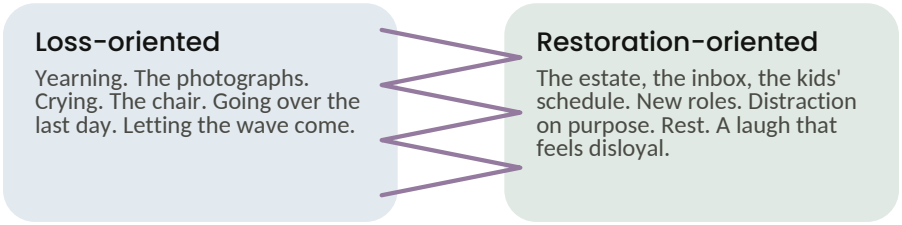
Bring the audit. The ratio of the two columns is the diagnosis; the two changes are the treatment. Your clinician will help you tell the difference between a structural change and a resolution.

Next · Grief Is Attachment, Not a Set of Stages

Grief Is Attachment, Not a Set of Stages

The five stages were written about people who were dying, not people who were bereaved, and they never held up as a sequence. Grief is the attachment system searching for someone who is not coming back. It does not resolve and it is not finished. It is integrated, which is slower and more honest.

The two sides



Oscillation is the health. Stuck on the left is prolonged grief. Stuck on the right is avoidance that will present later as something else.

Most people assume the grieving side is the real work and the rebuilding side is denial. The research says a person who never rebuilds is as stuck as one who never cries. The day spent on the estate is not a betrayal.

Prolonged grief disorder entered the DSM-5-TR in 2022: intense yearning or preoccupation most days, at least twelve months after the death, with identity disruption, disbelief, avoidance, numbness, or meaninglessness, and real impairment. It is distinct from depression.

Why this works

The dual-process model (Stroebe and Schut, 1999) describes healthy grief as oscillation between loss-oriented work, facing the absence, and restoration-oriented work, rebuilding the life around it. Both are grief. Getting stuck on either side is where trouble starts.

Shear's Prolonged Grief Therapy, sixteen sessions built on the dual-process model with imaginal revisiting of the death and work on avoided situations, outperformed interpersonal therapy and antidepressants in randomized trials.

When grief becomes prolonged grief

Ordinary grief

Waves that come less often and less hard over months, with good days that feel like good days. The world still has color.

Prolonged grief

A year on, the yearning is daily and the world is flat. Avoiding every reminder, or unable to leave them. The waves do not space out.

Depression

Low mood that is not about the person. Guilt about yourself rather than them. Pleasure gone from everything.

Grief and substance use

Alcohol and sedatives sit on the loss side as a way to not feel and on the restoration side as counterfeit rest, and they stall the oscillation. Anesthetized grief returns in sobriety as if fresh. That is not going backward; it is the first time the loss has been met.

Wishing to join the person who died is common in grief and worth saying out loud. If it becomes a plan, or you feel unsafe, tell staff or your clinician, or call 988.

Loss Inventory and Oscillation Plan

The loss inventory

Losses stack, and the one you came in with is often not the oldest. Include deaths, but also the marriage, the company, the body you had, the role that ended. For each, note what you have not let yourself feel or do.

THE LOSS	WHEN	WHAT I HAVE NOT LET MYSELF FEEL OR DO

The oscillation plan

For the next two weeks, choose which days lean toward loss and which toward restoration. Neither side is skipped. On a loss day, you plan time to face it on purpose; on a restoration day, you plan something that builds the life, and you let it be good.

Loss-oriented days — what I will do, for how long, and with whom: _____

Restoration-oriented days — what I will build or do, and what I will allow myself: _____

Who knows which kind of day it is: _____

In session

Bring the inventory and the plan. If the yearning has been daily for a year or more, ask your clinician about prolonged grief treatment specifically. It is a different treatment from grief support, and it works.

Next · Medication and sleep

Section

Medication and sleep

How medication works, what the first weeks feel like, and how to talk to your prescriber as a collaborator. Then sleep, which is the first thing to come back in recovery and the first thing to go.

In this section

What Your Medications Actually Do 84

Why Timing Matters: Half-Lives and Stopping 86

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Insomnia Is Learned. It Can Be Unlearned. 90

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The Sleep Diary: Fourteen Nights of Data 94

If you read only one page here

Insomnia Is Learned. It Can Be Unlearned. — page 90.

What Your Medications Actually Do

Most people take a psychiatric medication for years without ever being told, in adult language, what it does and what it cannot do. The classes below are the ones you are likely to meet. None of them installs a feeling. Each changes the conditions under which the brain can recover its own regulation, which is why they work best alongside the rest of treatment.

Antidepressants and mood stabilizers

CLASS	WHAT IT DOES	WHAT TO KNOW
SSRIs / SNRIs	Raise serotonin, and for SNRIs norepinephrine, so circuits that regulate mood and threat can recalibrate over weeks	Depression, anxiety, OCD, PTSD. Early nausea, jitter, sleep change; sexual side effects are common and reversible
Bupropion	Works on dopamine and norepinephrine; activating rather than calming	No sexual side effects or weight gain; can raise anxiety or insomnia; avoided with seizure risk or active eating disorders
Mirtazapine	Blocks receptors that keep you alert; sedating and appetite-raising	Useful when depression comes with insomnia and weight loss; weight gain is the trade
Lithium	The reference mood stabilizer; protects against mania and depression	Narrow safe range: blood levels, kidney and thyroid checks; stay hydrated; NSAIDs raise levels
Valproate	Anti-manic; calms rapid cycling	Liver and platelet checks, weight; not used in pregnancy
Lamotrigine	Prevents the depressive pole of bipolar disorder	Raised slowly over weeks because of a rare serious rash; report any rash the same day

How to read this

A medication's class tells you its mechanism, its usual timeline, and what to watch. It does not tell you how you will respond; genetics, sleep, alcohol, and diagnosis all move the result. Two honest facts: antidepressants beat placebo by a modest margin on average and by a large one for severe depression (Cipriani, 2018 network meta-analysis); lithium is the only mood stabilizer with consistent evidence for reducing suicide risk. Most psychiatric drugs need four to six weeks at a therapeutic dose before a fair verdict, and the side effects usually arrive first. That timing is why people quit early, and why a plan for the first month matters more than the choice of pill.

Lithium and suicide are mentioned above because the evidence is real. If you are having thoughts of ending your life, tell staff or your clinician today, or call 988.

My Medications, On One Page

Antipsychotics, sedatives, stimulants, and recovery medications

CLASS	WHAT IT DOES	WHAT TO KNOW
Antipsychotics	Reduce dopamine signaling in circuits that generate psychosis and mania; second-generation drugs also steady mood	First-generation: movement side effects. Second-generation: weight, glucose, lipids. Metabolic monitoring at baseline, three months, then yearly
Benzodiazepines	Amplify GABA, the brain's main brake; fast relief of panic and insomnia	Tolerance within weeks, dependence, memory effects, dangerous with alcohol or opioids. A bridge, not a destination
Hypnotics	Z-drugs act on the same brake; newer orexin blockers quiet the wake signal	Short-term use; CBT-I outperforms them at follow-up. Next-day fog and complex sleep behaviors are reasons to call
Stimulants and non-stimulants	Stimulants raise dopamine and norepinephrine at the point of attention; atomoxetine, guanfacine work more slowly	Largest effect size in psychiatry for ADHD; watch appetite, sleep, blood pressure, and rebound in the evening
Naltrexone, buprenorphine	Naltrexone blocks opioid reward and blunts alcohol craving; buprenorphine occupies the opioid receptor safely	Both reduce relapse and, for buprenorphine, overdose death. Timing of the first dose matters; your prescriber will plan it

My medications

1. Name · dose · time: _____

   For what · what to watch: _____

2. Name · dose · time: _____

   For what · what to watch: _____

3. Name · dose · time: _____

   For what · what to watch: _____

Bring it

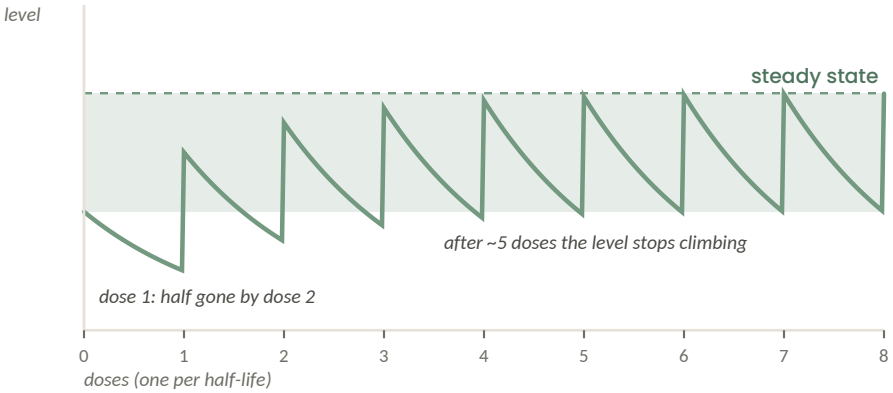
If you cannot fill a line, that is the question for your next appointment. Give a copy to your clinician, keep one in your wallet, and update it whenever anything changes, including supplements.

Next · Why Timing Matters: Half-Lives and Stopping

Why Timing Matters: Half-Lives and Stopping

A medication is not a switch. It is a level in the blood that rises with each dose, falls between doses, and takes days to settle. The half-life, the time for the body to clear half of what is there, decides how fast it builds, how a missed dose feels, and what happens if you stop. Most unpleasant surprises in psychiatry are timing surprises.

Building to steady state



The same curve runs in reverse when you stop. Short half-life drugs, such as paroxetine, venlafaxine, and alprazolam, drop fast and are felt fast. Long half-life drugs fade slowly, which is kinder, but also means a side effect can take weeks to clear.

Why this works

Pharmacokinetics is the study of what the body does to a drug. Two numbers carry most of it. The half-life sets the rhythm: a drug reaches steady state, where intake and clearance balance, after about five half-lives, and it leaves on the same schedule. A drug with a 24-hour half-life builds over five days and is mostly gone five days after stopping; fluoxetine, with its long-acting metabolite, takes weeks either way.

The second number is the therapeutic range. For lithium it is narrow enough that dehydration or an anti-inflammatory can push a safe level into toxicity. That is why some drugs get blood tests and others do not. Discontinuation syndromes are the nervous system catching up with a level that fell faster than it could adapt.

What stopping abruptly does

CLASS	WHAT YOU MAY FEEL	WHY IT MATTERS
SSRIs, SNRIs	Dizziness, brief electric sensations, nausea, irritability, vivid dreams, flu-like malaise within days	Unpleasant and often mistaken for relapse; not dangerous, but a reason to taper over weeks
Benzodiazepines	Rebound anxiety and insomnia, tremor, sweating; after long use, risk of seizures	Medically serious. Never stopped abruptly after regular use; tapers run weeks to months
Lithium	Little at first; the risk is a return of mania or depression in the weeks after	Abrupt stops bring relapse far sooner than a taper over weeks (Baldessarini). Stop only with a plan

Missed-Dose Rules and the Taper Talk

The missed-dose rule card

A general default, to be confirmed for each of your medications with your prescriber. Some drugs, including lithium, clozapine, and MAOIs, have their own rules. Write the confirmed rule for each of yours on the card below.

If you remember within a few hours

Take it. Then take the next dose at the usual time.

If the next dose is close

Skip the missed one. Never double up to catch up; the level, not the count, is what matters.

If you have missed two or more days

Call before restarting. Some drugs need to be restarted low; a benzodiazepine or lithium gap deserves a conversation.

Medication · confirmed missed-dose rule: _____

Medication · confirmed missed-dose rule: _____

Medication · confirmed missed-dose rule: _____

The taper conversation: bring these questions

- ◯ Why now, and what are we hoping changes
- ◯ How long will the taper take, in steps
- ◯ What I may feel at each step, and for how long
- ◯ What tells us to pause or go back one step
- ◯ Who I call, and how fast they answer
- ◯ What replaces the medication's job
- ◯ How we will know it worked, in three months

Stopping a medication is a plan, not an event. If stopping brings thoughts of harming yourself, tell staff or your clinician the same day, or call 988.

Next · The Appointment Is a Collaboration

The Appointment Is a Collaboration

Fifteen minutes with a prescriber goes one of two ways. You describe how you feel and leave with a change you did not understand, or you arrive with precise data and a clear question and leave with a decision you helped make. The difference is preparation, and the preparation is one page.

Reporting a side effect precisely

Onset

When it started, relative to any change: new drug, dose increase, supplement, less sleep.

Severity and course

A number out of 10. Stable, improving, or worsening? Does it stop you doing anything?

Timing

Time of day; relation to the dose, to food, alcohol, caffeine. Patterns are diagnoses.

Why this works

Shared decision-making is the standard the evidence supports, not a courtesy. Elwyn's three-talk model describes it: team talk (we decide together), option talk (the real choices, with trade-offs), and decision talk (what matters most to you). Trials in psychiatry show better adherence and satisfaction, and adherence is where most medication failures happen.

Prescribers decide well from specific data. 'I feel off' cannot be acted on. 'Nausea for an hour after the morning dose, daily since the increase, a 4 out of 10' gets a dose split or a food rule within a minute.

Interactions, stated plainly

COMBINATION	WHAT HAPPENS	WHAT TO DO
Alcohol	Deepens sedation with benzodiazepines, hypnotics, and opioids; undercuts antidepressants; dehydrates on lithium	Say what you actually drink. The plan is built on the truth
Serotonergic add-ons	SSRIs or SNRIs plus tramadol, dextromethorphan, MDMA, linezolid, or St John's wort can tip into serotonin syndrome	Agitation, sweating, tremor, racing heart, fever: an emergency. Call 911
Cannabis	Worsens psychosis and undercuts antipsychotics; smoking anything lowers clozapine and olanzapine levels	Report use, including when you stop; levels rise when smoking stops
St John's wort	Lowers levels of many drugs; adds serotonin on top of antidepressants	Treat it as a medication. Never start or stop it silently
Grapefruit	Raises levels of some benzodiazepines, buspirone, quetiapine, and lurasidone	Ask whether any of yours is on the list

Appointment Prep Sheet

Before the appointment

Fill this the evening before. Short, exact, and in order of importance. Hand the sheet over if words fail; it is designed to be read.

What I want decided today (one sentence): _____

What has changed since last time (dose, sleep, alcohol, stress, supplements): _____

Side effect 1 — onset · severity /10 · timing: _____

Side effect 2 — onset · severity /10 · timing: _____

What is better, specifically: _____

What is not better yet: _____

Everything else I take, including over-the-counter and supplements: _____

Questions that get good answers

- ◯ What is this medication for, in my case
- ◯ How will we know it is working, and by when
- ◯ What are the two most likely side effects
- ◯ Which side effects mean call today
- ◯ What are the alternatives, including none
- ◯ What is the plan if this does not work
- ◯ When do we next review the whole list

After

Write the decision in one line while it is fresh: what changed, why, and when it will be reviewed. Keep the sheet; the next one starts from it.

Next · Insomnia Is Learned. It Can Be Unlearned.

Insomnia Is Learned. It Can Be Unlearned.

Chronic insomnia is rarely caused by whatever started it. A stressful quarter, an illness, a new baby: the trigger passes, and the insomnia stays, because the bed has become a place where you lie awake and try. CBT-I is a structured program that retrains the association and resets the sleep drive. It is uncomfortable for two weeks and then it works.

Stimulus control: six rules

RULE	MEANS	BECAUSE
Bed is for sleep	No work, phone, television, or worrying in bed; sex is the exception	The bed must predict only sleep
Lie down when sleepy	Sleepy, not tired. Eyes closing, not 'it is time'	Sleep onset needs pressure
The 15-minute rule	Awake for what feels like 15 minutes: get up, dim room, dull activity; return when sleepy	Breaks the awake-in-bed link
Fixed wake time	Same time seven days, regardless of the night	Anchors the body clock
No naps	Or one, before 3 pm, under 20 minutes	Protects evening sleep pressure
No clock	Turn it to the wall	Clock-watching is arousal

Why this works

CBT-I (Morin; Edinger) combines Bootzin's stimulus control, Spielman's sleep restriction, and a cognitive component aimed at sleep effort. The model: a predisposition plus a precipitating event starts insomnia, and perpetuating behaviors keep it going. Lying in bed awake teaches the brain that bed means wakefulness. Extending time in bed to compensate dilutes sleep and weakens the homeostatic pressure that produces deep sleep.

The American College of Physicians (2016) recommends CBT-I as first-line treatment for chronic insomnia in adults. Head-to-head trials show medication works faster, CBT-I works as well by six weeks, and only CBT-I holds at follow-up (Morin, JAMA, 1999 and 2009).

Sleep restriction and sleep effort

Sleep restriction

Your time in bed is cut to match the sleep you actually get, then widened in 15-minute steps as efficiency rises. The first week is tiring on purpose; the sleep that results is deep and consolidated.

Sleep effort

Sleep cannot be done; it can only be allowed. Trying harder, bargaining, and calculating hours produce the arousal that blocks it. The cognitive work is giving up the project of sleeping and letting the system do what it does.

Sleep restriction is not used with untreated bipolar disorder, seizure disorders, or safety-critical driving without clinician oversight. Your clinician will adapt it.

Compute Your Sleep Window

Worked example

A week of diary. Average time in bed: in bed at 10:30 pm, out at 7:00 am, 8 hours 30 minutes. Average total sleep: 6 hours 0 minutes. Efficiency: 6.0 ÷ 8.5 = 71 percent. The sleep window is set to average total sleep, never below 5 hours 30 minutes: 6 hours. Fixed wake time 6:30 am, so the earliest bedtime is 12:30 am. Each week: efficiency 85 percent or higher, add 15 minutes to the window; below 80 percent, subtract 15; between, hold.

Your window

Average time in bed per night (from the diary): _____

Average total sleep per night: _____

Efficiency (total sleep ÷ time in bed × 100): _____

Sleep window (equals average total sleep; minimum 5 h 30 min): _____

Fixed wake time, seven days: _____

Earliest bedtime (wake time minus window): _____

Week 2 adjustment (≥ 85%: +15 min · < 80%: −15 min · between: hold): _____

Running it

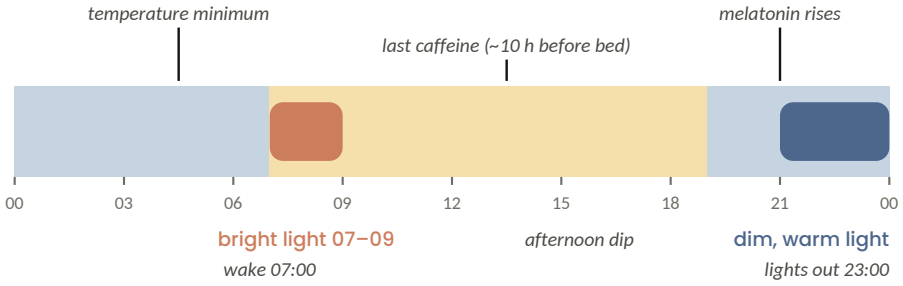
Keep the diary going while the window runs; it is the instrument that adjusts the dose. Expect three to five harder days. Review the week with your clinician before changing anything on your own.

Next · Your Clock Runs on Light

Your Clock Runs on Light

Sleep is governed by two systems: pressure, which builds the longer you are awake, and a clock, which decides when the body is willing to sleep at all. The clock is set each day by light, and almost nothing else. Most people treat light as decoration. It is the strongest drug for sleep that you already own.

One day on the clock



Anchors for a typical adult. An owl's whole strip slides later; a lark's earlier. The rules hold relative to your own wake time, which is why a fixed wake time is the first move in every sleep program.

Why this works

The suprachiasmatic nucleus keeps a rhythm slightly longer than 24 hours and is reset daily by light reaching specialized retinal cells. Light after the body's temperature minimum (about two hours before natural waking) advances the clock; light before it delays it. That is the whole mechanism.

Chronotype is partly genetic (clock genes such as PER3), drifts later in adolescence and earlier with age, and is measurable (Horne-Östberg; Roenneberg). Caffeine blocks adenosine, the pressure signal, with a five- to six-hour half-life. Melatonin is a timing signal: low doses hours before bed shift the clock; large doses at bedtime mostly do not (Lewy).

The levers

LEVER	THE RULE	THE NUMBER
Morning light	Outside, no sunglasses, within an hour of waking; cloudy counts	10 to 30 minutes outdoors (1,000 to 100,000 lux) or a 10,000-lux lamp for 20 to 30
Evening light	Dim and warm after sunset; overheads off; screens low and far from the face	Under 50 lux in the last two hours; a lit office is 300 to 500
Caffeine	Last dose about ten hours before lights out	Half of a 2 pm coffee is still on board at 8 pm
Melatonin	A timing tool for owls, jet lag, and shift work, not a sedative	0.5 to 1 mg, three to five hours before target bedtime
Shift work	Bright light on shift, dark glasses on the way home, blackout at home	Protect four hours of sleep at the same clock time every day, on and off shift

Your Light and Caffeine Schedule

Build your schedule

Start from your fixed wake time and work outward. Everything on this page is relative to that one number. If you are a night owl who must function early, shift in 15-minute steps every few days rather than all at once.

My chronotype (lark · intermediate · owl), and my natural wake time when nothing is scheduled: _____

Fixed wake time I will keep seven days a week: _____

Morning light: where, how, by what time: _____

Last caffeine of the day (wake time + about 7 hours, or ten hours before bed): _____

Evening light: what goes dim or off, and when: _____

Screens: where they live after that time: _____

Melatonin, if my clinician agrees: dose and time: _____

Bedtime window (when I will allow sleep, not force it): _____

Two weeks

Run it for fourteen days alongside the sleep diary; the clock shifts about 15 to 30 minutes a day under consistent light. Note which lever was hardest to hold and bring that to session. It is usually the evening one.

Next · The Sleep Diary: Fourteen Nights of Data

The Sleep Diary: Fourteen Nights of Data

Every sleep intervention worth doing is adjusted from a diary. Memory is a poor instrument for sleep: bad nights are overweighted, good ones forgotten, and the estimate drifts toward the story you already believe. Two weeks of rough numbers, written each morning, beat any amount of recollection, and they are what your clinician will use to set your sleep window.

How to fill it in

1. **Each morning, within an hour of getting up**
   Rough numbers in pen. Do not check the clock in the night to improve accuracy; estimates are the method.

2. **Time in bed**
   From lights out to out of bed, as hours and minutes.

3. **Total sleep**
   Time in bed, minus minutes to fall asleep, minus minutes awake in the night, minus minutes between final wake and getting out of bed.

4. **Efficiency**
   Total sleep divided by time in bed, times 100. Round to the nearest whole number.

Why this works

The consensus sleep diary (Carney, Buysse, Edinger and colleagues, 2012) standardized the morning questions used across insomnia research, and the ten items on the grid overleaf are those questions. The diary is a behavioral measure, not a device readout; estimates are expected, and the trend across nights matters more than any single entry.

Sleep efficiency, total sleep as a share of time in bed, is the number that drives CBT-I. Below 85 percent, time in bed is being spent awake and the bed is learning the wrong lesson. Consumer trackers estimate sleep from movement and heart rate and are reasonably good at timing, poor at staging; keep one if you like it, but the diary is the instrument.

A worked night

ENTRY	EXAMPLE	NOTE
Time in bed	Lights out 11:15 pm, out of bed 6:45 am = 7 h 30 min	Bedtime is when you got in; lights out is when you tried to sleep
Awake time	35 min to fall asleep + 2 wakes totaling 40 min + 25 min awake before rising = 100 min	Count any period you believe you were awake
Total sleep	7 h 30 min − 1 h 40 min = 5 h 50 min	Hours and minutes, not decimals, until the last step
Efficiency	350 ÷ 450 × 100 = 78 percent	Under 85: the window is too wide for the sleep you are getting

Bring the completed grid to session at the end of week two; the averages across both weeks set your sleep window.

Sleep Diary, Nights 1 to 14

One column per night, filled in the next morning. Week one on the left of the line, week two on the right. Rough is fine; blank is not.

Night	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Date														
Bedtime (got into bed)														
Lights out														
Minutes to fall asleep														
Number of wakes														
Minutes awake in the night														
Final wake time														
Out of bed														
Total sleep (h:min)														
Time in bed (h:min)														
Efficiency %														

Efficiency = total sleep ÷ time in bed × 100. Weekly averages: time in bed _____ total sleep _____ efficiency _____

Next · Mindfulness and the body

Section

Mindfulness and the body

Attention is trainable, and the body keeps the score of every stress response it never finished. These pages teach the basic practices — noticing, breathing, meeting a feeling, riding an urge, letting the body complete — that every other page assumes you have.

In this section

Attention Is Trainable 97

RAIN: Meeting a Feeling Without Drowning 99

The Breath Is the One Lever You Always Hold 101

Small Doses: Pendulation and Titration 103

Urge Surfing 105

Let the Body Finish 107

If you read only one page here
Attention Is Trainable — page 97.

Attention Is Trainable

Mindfulness is not relaxing, emptying the mind, or feeling calm. It is noticing where your attention is, and bringing it back, on purpose, without a lecture. That is a skill, it strengthens with repetition like any other, and almost everything else in this library depends on it: you cannot work with a thought, a feeling, or a body state you have not noticed.

Three things it is not

Not relaxation

Relaxation is a pleasant side effect that sometimes shows up. Chasing it turns practice into another performance to fail at. The task is only to notice.

Not a blank mind

Minds generate thoughts the way hearts generate beats. A busy session is not a failed session; every time you notice you drifted and come back, that is the rep.

Not a mood

You can be mindful of rage, boredom, or grief. Mindfulness is the quality of the attention, not the content of the moment.

The three-minute breathing space

1. **Acknowledge (one minute)**
   Stop. Ask: what is here right now? Name the thoughts, the feeling, the body sensations. No fixing, just an honest inventory.

2. **Gather (one minute)**
   Narrow attention to the breath at one place: nostrils, chest, or belly. Each time you notice you have gone, come back. Going is not the problem.

3. **Expand (one minute)**
   Widen out to the whole body, the room, the sounds. Carry that wider attention into whatever you do next.

Use it between things: before a group, after a hard phone call, when you notice you have been scrolling for twenty minutes. It is a hinge, not a retreat.

Why this works

Kabat-Zinn built MBSR (1979) to teach attention as a trainable capacity; Segal, Williams and Teasdale adapted it as MBCT for people with recurrent depression. Kuyken's 2016 pooled analysis of nine trials found MBCT cut the risk of depressive relapse by about a third over 60 weeks, comparable to staying on an antidepressant. The mechanism is not calm. It is decentering: learning to see a thought as a thought rather than as a fact about the world, which breaks the loop that turns a low morning into a relapse.

Seven Days of Three Minutes

Three minutes, once a day, for seven days. The log is not about doing it well. It is about finding out what pulls your attention and how fast you can come back.

The log

Same time each day if you can. Rate how pulled your attention was before (0 = settled, 10 = scattered) and after. Write one word for what kept pulling it.

DAY	BEFORE 0–10	AFTER 0–10	WHAT PULLED MY ATTENTION
Day 1			
Day 2			
Day 3			
Day 4			
Day 5			
Day 6			
Day 7			

After seven days

What pulled my attention most often: _____

How long it took to notice I had drifted (seconds, minutes, never): _____

One moment this week when I used the breathing space without planning to: _____

The point

The goal was never seven calm sessions. It was seven reps of noticing and returning. If you came back even once per session, the muscle is working. Bring the log to session; what pulls your attention is diagnostic.

Next · RAIN: Meeting a Feeling Without Drowning

RAIN: Meeting a Feeling Without Drowning

Most of us have two settings for a hard feeling: push it down or get swept away. RAIN is the third option. Four steps, in order, that let you stay with a feeling long enough for it to change — which feelings do, when they are met instead of managed.

R

Recognize

Name what is here. Not "I'm fine" or "I'm a mess" — the specific thing: dread, resentment, lonely, ashamed. Precision matters; vague feelings stay vague.

A

Allow

Let it be here for now. Not forever, not approved of — just not fought. Try the words "this belongs" or "it's okay that this is here." Notice the urge to fix it and let that be here too.

I

Investigate

Get curious, with the body first. Where is it? What does it want? What is it afraid will happen? Ask from the inside, kindly, like you would ask a frightened kid. Thinking about the feeling is not this step.

N

Nurture

Give it what it needs. A hand on the chest. A sentence you would say to a friend. Sometimes just: "I'm here." Then rest in whatever has shifted, without demanding that it did.

Why this works

RAIN was named by meditation teacher Michele McDonald and developed by psychologist Tara Brach (Radical Compassion, 2019). It packages what affect-labeling research keeps finding: naming a feeling precisely (Lieberman, 2007) lowers amygdala activity, and turning toward an emotion with curiosity rather than away from it is the active ingredient in exposure, ACT and compassion-focused therapy. The N step borrows from self-compassion research (Neff): soothing is not indulgence, it is what lets the nervous system finish.

RAIN is not a trick for making feelings leave. It is how you stop being the thing the feeling is happening to.

One Feeling, Four Steps

Pick one feeling from the last 48 hours that you would normally avoid. Walk it through the four steps in writing. Ten minutes.

Recognize

The feeling, in one or two precise words: _____

What was happening when it showed up: _____

Allow

The words I used to let it be here: _____

What I noticed wanting to do instead (fix, numb, argue, leave): _____

Investigate

Where it lives in my body, and what it feels like there: _____

What it believes, or is afraid of: _____

What it wants from me: _____

Nurture

What I offered it (a touch, a sentence, a breath): _____

What shifted, even slightly, and what did not: _____

Next time

Do it in real time, without the pen, when the feeling is a 4 out of 10 rather than a 9. Skills learned at a 4 are the ones available at a 9.

Next · The Breath Is the One Lever You Always Hold

The Breath Is the One Lever You Always Hold

Of everything your autonomic nervous system does, breathing is the only function you can take over by hand. Each exhale taps the vagal brake and slows the heart; each inhale lifts it. That means the shape of a breath — longer out than in — is a direct line to the state you are in. Not a metaphor. A control.

Three patterns

1 The physiological sigh

Two inhales through the nose — one full, then a short top-up — and one long, slow exhale through the mouth. One to three of these. The double inhale pops collapsed air sacs; the long exhale dumps carbon dioxide and slows the heart. The fastest off-switch known.

How: Use when: panic rising, before a hard conversation, waking at 3 a.m.

2 Extended exhale

Breathe in for four counts, out for six to eight. Keep it quiet and low in the belly. Five minutes. This is the daily-practice version of the sigh.

How: Use when: winding down, between groups, any time you want the brake on.

3 Box breathing

In four, hold four, out four, hold four. Steady rather than sedating. Holds give the mind a job.

How: Use when: you need to be sharp and calm at once — before a meeting, a test, a call you have been avoiding.

Why this works

Heart rate rises slightly on the inhale and falls on the exhale (respiratory sinus arrhythmia), which is why a long exhale calms and a sharp inhale alerts. Balban, Huberman and colleagues (Cell Reports Medicine, 2023) compared five minutes a day of cyclic sighing, box breathing, cyclic hyperventilation and mindfulness meditation over a month: all improved mood, and cyclic sighing improved it most and lowered resting respiratory rate. The effects were modest, daily, and cumulative — a practice, not a rescue.

If breathing exercises make you more anxious — common after panic or trauma — start with the sigh only, eyes open, feet on the floor, three breaths, and stop. Build from there with your clinician.

Five Days, Three Patterns

Five days. One pattern a day, five minutes, rating your state before and after. You are looking for the one that works for your body, not the one that is supposed to.

The five-day trial

Rate your state 0 (flat or frozen) to 10 (flooded) before and after. Note what you were doing. Day five: your choice of pattern.

DAY · PATTERN	BEFORE 0–10	AFTER 0–10	WHAT I WAS DOING
1 · Sigh			
2 · Extended exhale			
3 · Box			
4 · Sigh again			
5 · My choice			

What I found

The pattern that moved my number the most: _____

The pattern that made things worse, if any, and how: _____

One place in my day I can anchor five minutes of this: _____

Make it automatic

Pair the pattern with a cue you already meet daily: the kettle, the car seat, the lock on the bathroom door. A skill attached to a cue is a skill you will still have in six months.

Next · Small Doses: Pendulation and Titration

Small Doses: Pendulation and Titration

The body does not heal by being flooded. It heals by touching a hard sensation briefly, returning to something steady, and touching it again — the way you would warm cold hands at a fire by approaching and pulling back, not by holding them in the flame. Somatic work has two words for this: titration, the small dose, and pendulation, the swing between the hard place and the resource.

Three ideas

Resource

A place in the body, or a memory, image, or person, that produces even a small sense of okay. The feet on the floor. Your dog. The weight of the chair. You find it first and return to it on purpose.

Titration

Touch the hard sensation for seconds, not minutes. The amount you can feel while still knowing you are in the room. Smaller than you think.

Pendulation

Swing: resource, then the edge of the hard place, then resource again. Each swing the body learns that activation rises and falls — that it is a wave, not a wall.

Why this works

Peter Levine's Somatic Experiencing (Waking the Tiger, 1997; In an Unspoken Voice, 2010) is built on the observation that the nervous system has a natural rhythm of contraction and expansion, and that trauma is what happens when that rhythm jams. Titration and pendulation restore it. A 2017 randomized trial of SE for PTSD (Brom et al.) found meaningful symptom reduction versus waitlist; the broader evidence base is smaller than for exposure therapies, so this page is a complement to treatment, not a substitute for it. The principle is well supported: interoceptive attention plus a felt sense of safety widens the window of tolerance.

Signs it is working

- ◯ A spontaneous deeper breath or sigh
- ◯ Warmth returning to hands or feet
- ◯ A yawn, a stretch, a settling
- ◯ Trembling or tingling that passes
- ◯ The sensation moving or changing shape
- ◯ Wanting to look around the room

Those are discharge signs — the nervous system completing something. Let them happen. Do not analyze them while they do.

Mindfulness and the body · Somatic

A Pendulation Practice

Fifteen minutes, somewhere you feel reasonably safe. The practice is the swing, not the arrival. If at any point you feel further away rather than closer, stop and orient to the room.

1. **Orient**
   Look slowly around the room. Let your eyes land where they want. Name three things you see. Feel your weight in the chair.

2. **Find the resource**
   Scan for the place in your body that feels most neutral or okay. Rest attention there for thirty seconds. Describe it: temperature, weight, texture.

3. **Touch the edge**
   Let attention go toward the hard sensation — but only to its edge, for about ten seconds. Notice what it does: tightens, spreads, pulses.

4. **Swing back**
   Return to the resource. Stay until something settles, even a little. Notice the difference between the two places.

5. **Repeat two or three times, then stop**
   Stop while it is still working. End by orienting to the room again.

Afterward

My resource, in words: _____

The hard sensation, and where it lives: _____

What changed across the swings (size, heat, movement, breath): _____

Any discharge signs I noticed: _____

Bring this to session

If a sensation would not shrink, or you lost the room, that is exactly the material your clinician needs — not a sign you did it wrong.

Next · Urge Surfing

Urge Surfing

An urge — to use, to text them, to leave, to eat, to check, to cut — feels like a command that will only grow until obeyed. It is not. It is a wave. It rises, it crests, and if you do not feed it, it falls, usually within twenty to thirty minutes. Every time you ride one out, the next one is smaller. Every time you obey one, the next one is bigger. That is the whole arithmetic.

The ride

1. **Notice it as an urge**
   Say it: "an urge is here." Not "I need." The label puts a sliver of space between you and it.

2. **Find it in the body**
   Where exactly? Chest, throat, hands, gut? What is its texture — tight, hot, hollow, buzzing? Describe it the way you would describe weather.

3. **Breathe into it and watch**
   Long exhales. Watch the sensation change second by second. It will. It gets bigger, then it does not.

4. **Ride the crest**
   The peak is the hardest sixty to ninety seconds. Keep watching. You are a surfer on a wave, not a swimmer under it.

5. **Notice it falling**
   It always does. Mark the moment. That moment is the evidence you will need next time.

Why this works

Alan Marlatt developed urge surfing in the 1980s for relapse prevention and later built it into Mindfulness-Based Relapse Prevention (Bowen, Chawla and Marlatt, 2011), which in a 2014 randomized trial outperformed standard relapse prevention and treatment as usual on drug use and heavy drinking at one year. The mechanism is extinction: an urge that is observed and not reinforced loses its grip, while white-knuckling (suppression) tends to rebound. The body component is essential — urges are felt before they are thought.

If you cannot stay with it alone

Ride it next to someone. Tell a staff member "I'm surfing an urge" and sit in the common area. An urge watched by two people is half the size.

The Urge Log

Log every urge you notice for one week, acted on or not. You are learning the shape of your own waves: how high, how long, and what starts them.

URGE (WHAT FOR)	TRIGGER	PEAK 0–10	MINUTES	RODE / ACTED

After a week

My most common trigger (time, place, feeling, person): _____

How long my urges usually last from first notice to falling: _____

The highest one I rode out without acting, and what helped: _____

Read the log honestly

Count the ones you rode and the ones you obeyed. Neither is a verdict. The ridden ones are proof the wave falls; the obeyed ones tell you where the plan needs a person, a place, or a different hour of the day.

Next · Let the Body Finish

Let the Body Finish

A stress response is a physical event that wants a physical ending — to run, to fight, to shake it off. Modern stress rarely gets one, so the charge stays in the muscles as jaw tension, shallow breath, a back that will not unclench. These are three ways to give the body the ending it was waiting for. None of them require fitness or flexibility.

1 Progressive muscle relaxation

Tense one muscle group hard for five seconds, release all at once, and notice the difference for fifteen. Feet, calves, thighs, belly, hands, arms, shoulders, face. Twelve minutes. The release teaches the body what let-go actually feels like.

How: Best for: sleep, chronic tension, a body that does not know it is braced.

2 Shaking

Stand, knees soft. Let the legs tremble, then the hips, then the arms and shoulders, loose like a dog out of water. Two to five minutes. Let the jaw go slack; make noise if you want. Then stand still and feel what is moving on its own.

How: Best for: after a confrontation, a bad phone call, a panic spike that has passed.

3 Walking meditation

Walk slowly enough to feel every part of a step: heel, roll, push. Attention on the feet. When it goes to the story, back to the feet. Ten minutes, anywhere, including a hallway.

How: Best for: when sitting still is impossible; rumination; the hour after waking.

Why this works

Edmund Jacobson's progressive muscle relaxation (1938) remains one of the best-evidenced relaxation methods, with consistent effects on anxiety and sleep across decades of trials. Animals that shake after a threat recover; those prevented from shaking show lasting stress effects — the observation behind Levine's somatic work and Berceli's tension-release exercises, which have promising but still early evidence. Walking meditation is taught in every mindfulness tradition and in MBSR; moving attention through a body in motion is simply easier for many people than sitting still.

Shaking can bring up emotion or memory. That is the body finishing something. If it is more than you want today, stop, orient to the room, and use PMR or walking instead.

A Week of Finishing

One practice a day, your choice, ten minutes. Rate tension before and after. By the end of the week you will know which one your body answers to.

DAY · PRACTICE	TENSION BEFORE	TENSION AFTER	NOTES
Mon			
Tue			
Wed			
Thu			
Fri			
Sat			
Sun			

What my body answers to

The practice that dropped my tension the most: _____

What I noticed in the hour afterward (sleep, mood, appetite, breath): _____

Where I will keep one of these in my week after I leave: _____

Why this matters for relapse

A body that never finishes its stress responses is a body that goes looking for a chemical ending. Giving it a physical one, daily, is relapse prevention that does not look like relapse prevention.

Section

Recovery

Your plan for leaving and for after: the relapse-prevention plan, the first 90 days, the weekly rhythm that keeps you well, and a letter to the person who will struggle.

In this section

A Lapse Is an Event. A Relapse Is a Decision. 110

The First 90 Days 112

The Week That Keeps You Well 114

Write to the Person Who Will Struggle 116

If you read only one page here

A Lapse Is an Event. A Relapse Is a Decision. — page 110.

Recovery · Relapse prevention

A Lapse Is an Event. A Relapse Is a Decision.

The research on relapse is unusually clear about one thing: the people who stay well are not the ones who never slip. They are the ones who planned for the slip. This page is that plan — for mood, for psychosis, for substance use, for whatever brought you here.

The four ideas

IDEA	WHAT IT MEANS	YOUR MOVE
High-risk situation	The states, places, people and times when you are most likely to slip. Usually fewer than five.	Name them before you meet them.
Seemingly irrelevant decisions	'I'll just drive past.' 'I'll skip group this once.' Small choices that stack toward the risk.	Catch the first one, not the last.
Lapse vs. relapse	A lapse is one bad night, one missed week of medication. A relapse is the slide that follows if you decide the lapse means you are done.	Treat a lapse as data. Call someone within 24 hours.
Abstinence-violation effect	The shame spiral: 'I blew it, I'm hopeless, I might as well.' It does more damage than the lapse.	Expect the thought. Have the counter-sentence written.

Why this works

Marlatt's relapse-prevention model (Marlatt & Gordon, 1985) came from addiction and transfers cleanly to mental health. Its core findings: relapse is a process with identifiable high-risk situations; a lapse becomes a relapse through the abstinence-violation effect — the shame-driven conclusion that one slip proves you have failed, so why stop; and 'seemingly irrelevant decisions' walk people toward risk long before the moment of choice. Planned responses to each of these reduce relapse rates in controlled trials across conditions.

The action ladder

Green — well

Anchors in place. Sleep, meds, movement, contact. Nothing to do but keep going.

Yellow — early signs

Two or more of your signature signs. You act: use the plan, tell one person, cut the load.

Orange — lapse

It happened. 24-hour rule: contact your clinician or support within a day. No shame spiral; read the counter-sentence.

Red — relapse risk

Signs for a week, or any danger to self or others. Others act: the people you named below call your clinician, 988, or 911.

Recovery · Relapse prevention

My Relapse Prevention Plan

My relapse signature — the first three things someone would notice: _____

My high-risk situations (people · places · states · dates): _____

The 'seemingly irrelevant decisions' I make on the way there: _____

My yellow-zone plan (what I do, who I tell, within 24 hours): _____

The counter-sentence to 'I blew it': _____

My orange-zone rule (who I contact after a lapse, by when): _____

Red zone — who acts and what they do: _____

Medications and the one habit I tie them to: _____

Appointments that are non-negotiable: _____

Signed, with my clinician: Date: _____

Give a copy to two people

The plan only works if the people on it know they are on it. Hand it to them and say what you want them to do at yellow, orange and red. That conversation is part of the practice.

Recovery · Life after discharge

The First 90 Days

Discharge is not the end of treatment; it is the transfer of treatment from a building to a schedule. The first three months carry most of the relapse risk and most of the opportunity. This is how high-functioning people usually get it wrong, and how to not.

The predictable pattern

1

Week 1: the drop

The house ran your day. Now nothing does. Energy and mood dip, sleep shifts. This is withdrawal from structure, not relapse. Keep the anchors rigidly for seven days.

2

Weeks 2–4: the honeymoon

You feel good. Family is relieved. The temptation is to prove you are fine by doing everything. This is where high achievers overload and skip the follow-up.

3

Weeks 5–8: the test

The first real stressor — a fight, a bad week at work, an anniversary. The first bad day. It is expected. The plan is for this moment, not for the honeymoon.

4

Weeks 9–12: the new normal

A rhythm you can sustain. Reduced but not zero contact with treatment. This is when the maintenance rhythm (EX-72) takes over.

Why this works

Across diagnoses, the weeks after discharge from residential or inpatient care are the highest-risk window for relapse and for suicide — the structure disappears faster than the nervous system can adapt. The protective factors are well replicated: a scheduled follow-up within seven days, medication continuity, a daily structure, and at least one person who knows the plan. Programs that build the transition deliberately see substantially fewer readmissions.

Returning to work

A graded return beats a full one: shorter days, then full days, over two weeks. Decide in advance what you will say — one sentence, true, not detailed. 'I took medical leave; I'm back.' You owe no one the chart.

Family re-entry

They were scared and are watching. Say what you need them to do at yellow and red (EX-70), and what you need them to stop doing. Expect a honeymoon, then friction. Friction is normal; it is not a sign the stay didn't work.

Recovery · Life after discharge

90-Day Checkpoints

CHECKPOINT	NON-NEGOTIABLE	DONE / DATE
Day 1–2	Medications filled and in a pillbox. Phone numbers in the phone. Sleep anchor set.	
Day 7	First appointment attended (clinician or prescriber). Signature signs reviewed with one person.	
Day 14	PHQ-9 / GAD-7 scored and compared to discharge. Anchors held at least 5 of 7 days.	
Day 21	Work or role re-entry started on a graded plan. First weekend reviewed: what worked.	
Day 30	Prescriber follow-up. Medication side effects and sleep reviewed. Support map checked — who have I actually seen.	
Day 45	The first bad day debriefed with clinician (if it hasn't happened, plan for it anyway).	
Day 60	Scales repeated. Relapse plan (EX-70) revised with what you now know.	
Day 90	Maintenance rhythm (EX-72) in place. Frequency of treatment contact agreed for the next 90.	

The thing that will be hardest, and my plan for it: _____

_____

One sentence I will say about where I was: _____

Who holds a copy of this page: _____

Next · The Week That Keeps You Well

Recovery · Maintenance

The Week That Keeps You Well

Staying well is less dramatic than getting well. It is a weekly rhythm with a few fixed points, protected on purpose, that the rest of life bends around. Most relapses begin when the rhythm quietly erodes — one fixed point at a time.

Six fixed points

FIXED POINT	MINIMUM DOSE	WHY
Sleep anchor	Same wake time, seven days.	Sets the clock everything else runs on.
Movement	Three sessions of 20+ minutes.	Completes the stress cycle; antidepressant-level effect at moderate intensity.
Connection	Two real conversations, one in person.	Co-regulation. Isolation is the first sign and the first cause.
Meaning	One block of work, service, craft or study you chose.	Values in action (EX-14). Mood follows.
Medication	Every dose, tied to a habit.	Steady state. See EX-51.
Treatment contact	One hour: therapy, group, or prescriber.	The feedback loop that catches drift.

Why this works

Social rhythm research (Frank; Ehlers, Frank & Kupfer) shows that regularity of daily routine — wake time, meals, activity, social contact — stabilizes mood directly, with the strongest evidence in bipolar disorder and clear benefit in depression and anxiety. Behavioral activation adds the second principle: scheduled, valued activity sustains mood when motivation does not. A written weekly structure is one of the simplest, best-supported relapse-prevention tools there is.

The minimum viable week

When a week goes wrong — illness, travel, a crisis — you do not need the full rhythm. You need the wake time, the medication, and one conversation. Three fixed points, held through anything. Decide now that those three are not optional, so you never have to decide it in a bad week.

Recovery · Maintenance

Design Your Week

MY WEEK	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Wake time							
Movement							
Connection							
Meaning block							
Medication							
Treatment contact							
Bed by							

My three non-negotiables for a bad week: _____

The fixed point I am most likely to drop first (watch this one): _____

Who notices if I drop it: _____

Next · Write to the Person Who Will Struggle

Protect the fixed points.

Recovery · A letter to your future self

Write to the Person Who Will Struggle

At some point after discharge you will have a day when none of this feels true. That version of you cannot think clearly, and will not remember what you know now. So write it down for them, today, while you can.

What makes it land

1. **Address it to the bad day, not to yourself in general**
   'You are reading this because today is hard.' Name what the bad day usually looks like for you so the reader recognizes themselves.

2. **Say what the illness says, and that it is lying**
   Write the exact sentences — 'nothing will change', 'you're a burden' — and answer each one from today's vantage with evidence you have now.

3. **Give instructions, not encouragement**
   'Call Maria. Take the walk. Do not decide anything tonight.' A struggling mind needs a list, not a pep talk.

4. **Remind them what you promised and why**
   The values from EX-14. The people. The reason you came here. Specific, not noble.

Why this works

Two lines of research meet here. Self-distancing (Kross & Ayduk): addressing yourself in the second or third person, or from a future vantage, measurably reduces rumination and emotional reactivity compared with first-person immersion. Future-self continuity (Hershfield): people who feel connected to their future self make better long-horizon decisions. A letter from a well self to a struggling self uses both — and it is the one document that speaks in a voice the struggling self already trusts, because it is their own.

Seal it, date it, and give a copy to one person on your support map with instructions to hand it over at yellow. Write a new one every six months; you will have more to say.

The Letter

Dear _____,

You are reading this because today looks like this:

Here is what the illness is probably telling you right now:

Here is what I know today that answers it:

Do these three things before you decide anything:

1.

2.

3.

Call this person; they already know what to say:

What you promised, and who you promised it to:

What I want you to remember about who you actually are:

— Written on _____, when I could see clearly.