Rich: So David Burns began his therapy career as a burnt out biological psychiatrist. Having gotten on board the psychopharm train early in the 70s sold, he says, by the glowing promises of drug company presenters, he was soon disillusioned. The drugs didn't live up to their expectations. In his experience, most patients taking them showed no more improvement than patients undergoing standard talk therapy.

But he soon joined the next mental health revolution, the then relatively new cognitive behavioral approach. In fact, as an early student of Aaron Beck, who developed his cognitive approach based on the work of Albert Ellis. David could be called one of the founding fathers of CBT, Ellis begat Beck who begat Burns. But unlike some eminent figures in the field, David apparently never much liked sitting on his laurels. Not only is it boring, but he has a questioning, skeptical, empirically driven mindset not easily satisfied with the status quo. Particularly when the status quo seems to be producing only so-so results and taking a hard look at his own cases, he had the integrity to see that even the approach with which he was identified and which he himself had made famous didn't seem to be living up to its billing.

He found that many of his clients, particularly those suffering from anxiety would achieve a certain reduction in symptoms about 50 to 60 percent, but then stall out and not improve any further. So David went to work, doing what he does. Asking questions, getting feedback, exploring with his clients what was keeping them stuck long past the time they should have been celebrating complete victory over their phobias and fears. Eventually, this work paid off.

And David discovered something that all of us in this field keep discovering in different ways over and over again, never underestimate people's complexity. No matter how powerful our techniques appear to be, people will stubbornly refuse to quit having symptoms just because we apply our particular clinical formula. It's an old story, every new therapeutic approach even or particularly those trotted out as the ultimate solution to human physiological miseries over time comes to seem less magical, the gold grows more tarnished.

And once again, we are left with people seemingly perfuse refusal to march to our therapeutic tune. No matter how nicely it plays in psych research departments. So what David – what – so what did David find was keeping his patients from getting better? No matter how powerful the clinical tool, it can be neutralized if there's

something in clients' lives, in their relationships, in the way that they need to see themselves that prevents them from wanting to get better.

The real issue wasn't whether CBT worked or not, it did work. But it only worked if the patient wanted it to work. So it wasn't a question of method, as much as it was a question of motivation. It was both. In short, whatever their merits, and they are considerable, a lot of the newer, faster methods and models can be amazing vehicles for change, but the patient has to be willing to get in the car.

Without that willingness, that motivation propelling change, the model regardless of its research bona fide doesn't move anybody. This afternoon, David is here to talk about what he calls the motivation revolution and how to apply it in your practice whatever model you follow. But first a word of warning, if you're a CBT true believer and have been offended by David's irreverence towards the model he helped create or indeed any other therapeutic orthodoxy, you will soon have plenty of company.

As he has put it, to me, the schools of therapy compete much like religions or even cults all claiming to know the cause and to have the best method for treating people. And new schools of therapy seem to be created every week always with a guru, always with enthusiastic followers who are sure that they've found the answer. But he's here with us today simply to challenge us and encourage us to apply to our own practices the same exacting standard he applies to his own.

The determined search to find out what fits the specific needs of an individual client. It is my pleasure to introduce to you one of our fields most dedicated practitioners, David Burns.

David Burns: Well-done, thank you. Well it's great to be here. It's a little bit intimidating after the morning routine that Rich put on, which was mind blowing. I'm going to be pretty humble by comparison. But I am excited to talk to you about what I'm calling the motivation revolution. And in the mid-1970s, I was very excited to be a part of the cognitive revolution. I think cognitive therapy has made a tremendous impact on how physiotherapy is practiced worldwide as well as a tremendous impact on research and the emphasis on measurement.

And the basis of cognitive therapy is very simple going back to the Greek philosopher Epictetus who said you know our thoughts create our feelings. It's not so much what happens, but the way you think about it. And I don't know if there's ever been a more excited and dedicated cognitive therapist than David Burns.

And I'm probably as excited today about these wonderful techniques as I once – as I was when I first learned about them in the 1970s. But as Rich pointed out, and I'll show you some data of that cognitive therapy, like pretty much any school of therapy, falls short of the mark. A lot of people seem to resist treatment. And this – and so today I'm going to be talking about a second revolution, the motivation revolution.

Which I think is as exciting and potentially as powerful as the cognitive revolution. And the motivation revolution is based on the idea that motivation resistances play at least a great a role in how we think, feel and behave as cognitions. And that if we integrate traditional cognitive behavioral therapy with some of the new motivational techniques you can really have a kind of a one plus one equals three or in some cases, one plus one equals 100, a very potent new way of doing psychotherapy.

Now my interests and motivation came from both some research I did – my main career has been as a clinician. But I've collected a lot of data and published in different psychology journals, trying to understand how psychotherapy works. And my clinical experience has fed my understanding along with the research. Now, in the late 1980s, there was a lot of buzz around coping. You know, everyone thought that people come to psychotherapy to learn coping styles to cope with whatever problem they've got. And people were developing coping inventories to try and measure different coping styles.

And so I modified an existing research instrument that listed 45 coping behaviors that people do when they're depressed. But I asked people three questions about each coping behavior. The first is how often do you tend to do this when you're depressed. Now it might be something like talk things over with a friend, or do something pleasurable and satisfying like go to a movie or just simple coping behaviors. So the first thing is how often do you do this? The second question is how helpful do you think it would be if you did this if you were depressed? And the third question is, how willing would you be to try this out, if it was suggested by

your therapists or a trusted friend. And so people rated these 45 behaviors in the three different dimensions.

Those three dimensions were our behavioral dimension, I – it separated the super coppers from the passive patients. A cognitive dimension, what's your expectation? Your belief that these things will be helpful? And a motivational dimension, how willing would you be to try this out? Well, I did some pilot studies and published in one of the research journals just a cross sectional study. And as expected, I think we had a couple of 100 depressed women, people had a whole range of depression. And then people who were – women who were the most depressed, scored low on all of the scales.

They didn't use a lot of coping behaviors, they didn't expect their coping behaviors would help them and they weren't particularly willing to try out these coping behaviors. Well as you know, correlations tell us nothing about causality and the only thing of importance in treatment is causality. If something's having a causal effect on depression that's something we want to focus on and work with clinically.

So then, I began doing longitudinal studies that I published in the Journal of Consulting and Clinical Psychology giving these three scales to 500 patients at intake to my clinic in Philadelphia. And then following them for the first 12 weeks of a treatment to say, do any of these scales predict changes in depression when controlling for the initial when controlling for the initial severity of depression because if any of the scales did then you could argue this could very well be a causal effect.

And so, we got a particular result and then replicated it with a new group of patients. Got the same result and what we discovered is that the cognitive scale did not predict changes in depression patients who had this great expectation that they would be helped, didn't recover any faster than those who were very pessimistic. The cognitive dimension seemed to have no causal effect on changes in depression.

Nor did the behavioral dimension. The patients who came to treatment who were super copers who were very active in fighting their depression, they didn't get an – better any quicker than those who were very, very passive. But surprisingly, the willingness scale had a large causal – appeared to have a large causal effect on depression. And the patients who were the most willing to pick up

tools, to do homework, to do things to try to help themselves, were the ones who got better the quickest.

The magnitude of the antidepressant effect of the willingness scale seemed to be large and mediated by psychotherapy homework the causal path seemed to be the most willing patients were the ones who did the most psychotherapy homework and they were the ones who recovered. We've replicated this now in five different samples. I recently replicated it at the Stanford Hospital using a very different population, patients admitted for psychiatric difficulties to a primarily biological psychiatry unit.

I condensed the scales down, gave it to 170 patients entering our psychiatric unit. And once again, the behavioral scale had no predictability on changes in depression. The cognitive scale had no predictability, but the willingness scale had a large causal effect on changes in depression. And you can see here in the – in the chart, this is a scale that we use for measuring depression. You can norm it from zero to 100 percent, 100 would be the most severe depression. And I've broken the patients into two groups, and this is changes in depression the first week of hospitalization approximately.

These are patients getting very little psychotherapy, primarily electroconvulsive therapy or medications. And you think in that group, psychological variables wouldn't be important. But you can see on the left, the patients with the highest willingness scores started out with a mean of 70 on depression, which is moderate to severe. And one week later, they were almost depression free. In contrast, the patient's with low willingness scores had almost no significant changes in depression.

And I think this is the first variable that I know of in the world literature. There could be others, but in my review of the world literature, I'm not aware of any other variable that's ever been documented as having a causal effect on depression. We have a lot of theories about what causes depression and what accounts for changes in depression in therapy. I'm not aware of any – that any of those series have ever been validated.

This research hasn't gotten a lot of press. The latest article that I published last year in Cognitive Therapy and Research. But to me, it's been tremendously important because it also reflects my clinical experience with patients. That those who seem willing, and as Rich says to get in the car, show fantastic effects. But it's the

patients who were fighting the therapists who are showing –at technique you're using.

This is the latest scale. We've boiled it down from 135 items scales to a five-item scale that patients can complete and score in 15 seconds. And you can give it to patients at the beginning of therapy and it will tell you right away how fast the patient is going to improve. This patient is scoring 11 out of 20 on the scale, which is a very poor willingness score. And we can say that unless we melt away this patient's resistance, no matter what treatment you use drugs or psychotherapy this patient is unlikely to improve.

Another line of research and then I'm going to bring it to life clinically, because I'm a clinician, and most of you are clinicians. And so I don't want to go to heavy on the research, but I recently saw the results of the British CoBalT trial. They were saying what happens to chronically depressed patients in clinical practice situations. And so they assigned roughly 469 chronically depressed patients, randomly to usual care, which is psychopharmacology, antidepressant after antidepressant versus usual care, plus cognitive therapy.

And asked how many of the patients are going to improve in six months? And their definition of improvement was a 50 percent reduction in scores on the Beck Depression Inventory. Now to me, that's pathetic. When we're working with patients, we're looking for 80 or 90 percent reduction in scores in one or two therapy sessions. We're trying to develop new high-speed psychotherapy techniques. So a 50 percent reduction in the Beck scores is not – it's just horribly good.

But what did the data look like? Well, only 22 percent of the usual care patients showed improvement. That's why I left full time psychopharmacology. This was my experience also. I didn't see a lot. We were given bushel barrels full of pills to patients, in Philadelphia; we had one of the top psychopharmacology teams in the – in the world. And I wasn't seeing a lot with my patients.

And so that's very poor. Now, 46 percent of those who got usual care, plus CBT improved. You say, wow, isn't that great for CBT. It's way better than usual care. Well that was also my experience, that's why I left full time psychopharm to become a cognitive therapist. But that isn't very good either. Because less than half the patients are getting a pathetic level of improvement. So it shows

that CBT is making an improvement, but both groups are unimpressive. And there's something missing from the model.

When you see that your, you know, favored creation is falling short, you can either get depressed and discouraged. Or you can be excited, because this shows that there's something new to be discovered. And if we're willing to check our egos at the door, maybe we can lead to a breakthrough to find out what is that missing component or what are those missing components and work together using science and measurement to improve our level of skill.

And so we've evolved a new approach I've been talking about it in my workshops called TEAM therapy. And what it is roughly – it's not a new school of psychotherapy. It's kind of based on our research and the research of others on what are the effective ingredients of psychotherapy regardless of what school of therapy you're in. T stands for testing. We test patients at the beginning and end of every therapy session. How are you feeling at this moment?

So we can see for the first time, exactly how much we're – improvement we're getting in depression, suicidal urges, anger, anxiety. We also measure therapeutic empathy at the end of every session therapeutic helpfulness, so we have – it's a totally data driven form of therapy, and in terms of the lectures that you're getting on learning and expertise. You can't develop expertise without getting feedback, constant feedback. And we get feedback at the end of every session from every patient from the beginning to the end of the session.

And it's shocking to therapists to see the information that you get. And you've got to check your ego at the door to do it, but it's a powerful tool. Empathy was my workshop this morning. How can we improve the warmth the therapeutic relationship? And then, A is what we call paradoxical agenda setting. That's what I'll be bringing to life for you a little bit now and in my afternoon workshop. That's where we're bringing the patient's resistance to conscious awareness and then melting it away using a variety of newly developed paradoxical techniques.

And then methods is you know I've developed 50 to 100 techniques for helping patients break out of depression or troubled marriages or panic disorder. Only after you've melted away the resistance do we then come in with methods. And in the old days,

it was kind of jumping from empathy to methods. And that's the formulation that I think is missing and in this vitally important dimension of paradoxical agenda setting.

Now, I think that agenda setting is the most important key to therapeutic success or failure. And when therapists come to me for consultation with patients they're stuck with, patient's they're not doing well with, I would say at least 99 percent of the time, the problem is that they have not set the agenda in a meaningful way or they made an agenda setting error. The problem is rarely a problem of techniques not being sufficient, but the problem that the therapists is doing all of the pushing, the patient is doing all the resistance and they're at a kind of impasse.

Now the goals of agenda setting or paradoxical agenda setting is to bring resistance to awareness and to melt away the resistance and make the patient accountable before you try to help the patient. And the – I just can't emphasize the importance of this enough in – and the outcome of psychotherapy. Now, I've coined the term, outcome resistance and process resistance to describe two radically different types of resistance. And they'll be different for depression versus anxiety versus relationship problems versus habits and addictions.

Now outcome resistance can best be described with the concept of the magic button. And the magic button works like this. Let – let's say, what is your name? Bill, let's say Bill is coming for treatment. And he has many problems. He's severely depressed; he has panic disorder and obsessive-compulsive disorder and agoraphobia. And a terrible marriage, yeah, and you get drunk every night and pass out. And the concept of outcome resistance is let's imagine there's a magic button there on the table and if you press that magic button you'll be instantly cured with no effort. And you'll walk out of today's session in a state of euphoria. You'll never have another panic attack; you'll have the most loving marriage in North America. And you'll never drink another drop of alcohol.

Well, you say to the patient are you going to press that button, the patient says yes, I'll press that button. And then you say, but I can think of a lot of reasons not to press that magic button. And then you bring out all the sources of resistance – and not the kind of resistance you read about in textbooks. Like – in textbooks they make resistance seem like the patient is kind of pathetic. Oh, yes, you like feeling sorry for yourself don't you. Yeah, fun to get blasted every night.

But actually, make the patient proud of the resistance to show how the resistance to change reflects something beautiful and awesome about the patient. And if you do this skillfully, and I'll give you a couple of examples now and then my afternoon workshop, we'll actually show you a video from a real therapy session, how this works. And if you melt away the patient's resistance, well we used to think then when we come in with these techniques like externalization voices or acceptance paradox or whatever. They're going to work much more quickly because the patient will be on your team.

But now, we have a new way of looking at it and we think that the paradoxical agenda setting techniques themselves have massive antidepressant effect. So by the time you get to your first method, the patient is already 90 percent symptom free. And that can happen very quickly in just a few minutes in many cases. Well, that's outcome resistance.

Now, and you have to learn to understand why someone with depression might want to cling to the depression. Why someone with panic attacks might want to cling to the panic attacks and so forth. Process resistance is different. Process resistance is well Bill, there is no magic button. And there's certain things you're going to have to do that you might not want to do to get over the depression. To get over the panic attacks, to get over the drinking or whatever. Like the process resistance for depression is going to be written psychotherapy homework.

If you want me to help you with your depression, you're going to have to do that even if you don't want to do it. Even if you're not in the mood, the process resistance for all anxiety disorders of course is going to be exposure. If I agree to cure your social phobia and your OCD, your panic disorder, what would it be worth to you? I might ask you to confront your fears in a way that's going to freak you out if I agree to work with you. Would you be willing to do that?

And so forth, process resistance for relationship problems; would you be willing to stop blaming your spouse and focus entirely on your role in the problem. Focus entirely on changing yourself. And then the process resistance for alcohol or addictions, you're going to have to give up something intensely pleasurable drinking as you say it's the greatest thing in your life. And instead, you're going to have to do something that sucks. You're going to have to start

going to AA, go through a certain deprivations, start dealing with problems, you've been avoiding.

And so these are the things that you need to negotiate. So because outcome and process resistance differ for these four targets, depression, anxiety, relationship problems, and habits and addictions, there's eight completely different kinds of resistance. Now, I'm just going to give – bring this to life with a couple of vignettes – I can't teach you all about this in a short period of time. But maybe get you excited about it.

Now, let's say someone is severely depressed. The outcome resistance often is that person is going to have to accept something about themselves that they don't want to accept. Process resistance, you're going to have to do psychotherapy homework. Now an example of outcome resistance for depression, a woman came to me with – let's say she was from California. Let's – just to disguise things, say she was – had been raised in oh, let's say El Salvador then moved to California. Had kind of a traumatic childhood, and when she was 18, she had an abortion.

And after that became severely depressed, but in spite of that, she – she went to UCLA. She got a job in marketing. She got married; she had two children of her own. But she came to be after 10 years of horrific depression. She had taken every known antidepressant. She'd had all kinds of conventional psychotherapy and no one could help her. And I ask her, what's the thought that goes through your mind when you're feeling depressed. She said, well, I'm telling myself that I murdered my baby. I deserve to suffer forever.

And now you think about that. What she's really telling you is that her depression is a part of her value system. And so if you go in there and you try to use your latest CBT or DBT or EBT, or EMDR or LSMFT or whatever the latest gizmo is, she's going to fight you. And so instead I said to her, you know, Martha – we'll call her Martha. I've got some wonderful tools to share with you. I handed her a list of 50 techniques I often use and I said there's different kinds of emotions. Some are really difficult to get rid of and others are really easy. Anger is the toughest one, because it makes us feel empowered.

Shame and self-loathing and guilt and – that's – those are the easiest ones to change. And those are the ones that you've got. And I have no doubt that if we work together, I could show you how to get back to joy and self-esteem and get over this shame and

guilt and self-hatred. But I'm really reluctant to share these tools with you. I'm not so good – it would be – I'm not so convinced it would be a good idea. In fact, I'm thinking it would not be a good idea.

Now, right away, there's a shift in the dynamics because I'm not chasing her. And then, she said, well Doctor Burns, I've never heard of any of these tools on this list of methods that you've got. If this is what I want, why won't you help me? It's unfair if you won't help me. And I said, well, I'm not saying that I won't work with you. I really hope to work with you. I'd love to work with you, but here's my problem and you've got to help me with it. To me, your depression is an expression of your spirituality. You're saying that you murdered that baby and you deserve to suffer forever. So before I would agree to use these tools, you would have to convince me what would be the justification from a spiritual perspective.

Now, who's trying to persuade who? See, she's got to do the persuading. And then she said, well couldn't we look at it this way? Couldn't we say that even a murderer, they let them out of prison after 10 years? They try to rehabilitate them. And couldn't we say that if I got over my depression I'd have more love for my husband and for my children. And more creativity at work. She worked in marketing and was doing great work. And I said, okay. So you'd be willing then if I could show you how to overcome this guilt and shame to do that? You feel it's spiritually time to end this suffering?

She says yes doctor; I hear what you're saying. But yes I think I've suffered enough. I'm ready now, I'll press that magic button she said. I said, yeah, but before you press that magic button, there's one more thing that we haven't taken into account. I said, you see, that baby hasn't died yet. He's still alive. You're keeping him alive. Your depression is your love for that baby. And you spend every minute with him of every day and you've been doing that for 10 years. And if you wanted my help, it's time – you're going to have to grieve and say good bye to him. And are you ready to do that?

And then she's – she started sobbing and all that. That pain came out. And then she worked hard and eventually we found the technique that worked for her. But that's a good example of outcome resistance. You've been going to therapist who viewed her as having a so-called DSM disorder. A brain disorder or – you

know this type of thing. But actually, her suffering was showing something really beautiful and positive about her. And that's what we try to do with paradoxical agenda setting.

Now I'll give you another example with a really difficult resistant patient. And then maybe we'll have a little time for a couple of questions, see how we're doing on time here. I'm trying to keep on schedule for Rich. When I was in Philadelphia, I moved my practice to a kind of an inner-city hospital, Presbyterian, because they had a new office building. And then the hospital president asked if I'd help them create a department of psychiatry, if I'd be the chief of psychiatry. I said, well I'll do that for free if you want as part of my volunteer work for the medical school.

But I'd like you to create a whole new way of doing psychotherapy. I said there's research on my book *Feeling Good* that if you just hand it to people who are depressed with no treatment, two thirds of them seem to get a lot better within four weeks. And I could write a little group manual, we could treat everybody in the hospital in groups. We'll make individual psychotherapy be illegal and – and I bet we'll – and we'll treat people not an hour a week. But we'll treat people eight hours a day, seven days a week.

So we'll give everyone at least 50 or 60 hours of psychotherapy every week. And I think we'll see some remarkable, remarkable effects. And so they created a program like this. It was all inner-city people. No one had any insurance. A quarter of our patients couldn't read or write and we put thousands of patients through this – through this program. We diminished the costs of psychiatric treatment by more than 90 percent. If managed care referred to a university hospital, someone with major depression, it would cost $25,000.00 to $30,000.00. They'd be in there for three or four weeks getting ECT and bills. And go out usually as depressed as they came in.

They sent us to our program, the total cost was $1,600.00 and almost all of our patients were symptom free within three days. So it was a pretty exciting program. I – then I'd go in once I created – I developed a manual for the patients and a manual for the group leaders. And I would go in to see how is it working with this very tough crowd, brainy cognitive therapy, how could it work with this difficult population. A lot of them were homeless people and that type of thing.

So I went in this one day and of course, I wasn't one of the staff therapists, I was just administrating it. And they'd tell me about the patients – are going to be in your group today from the one to four PM group. They said you're going to have this guy in there named Benny. And watch out for him because he's a violent local heroin addict. And he's a cocaine and heroin dealer. And it's rumored that he's very violent. And he's hostile. And if you cross him, it could be – you could be in trouble. So I said, don't worry, I won't confront Benny.

So as the group began, there were about 12 patients seated in a circle and then there was this young tough guy looked like he was from South Philadelphia, Italian neighborhood. And he had a T-shirt with his cigarettes rolled up in the sleeves, he had tattoos, you know death and all of this all over. And that must be Benny and he was pacing back and forth looking at me in this hostile way. And I said, oh – I said, oh you must be Benny. Would you like to sit in one of the chairs and join us in the group?

And he said, I'm not sitting in one of your f-ing, GD chairs. And I want to see what the f you intend to do about it doc? And the group was 15 seconds old and I was already in a major standoff with this fellow. And I said, well, Benny, we've got these two rules here. One is that during the group, you must sit in the chair or stand and pace about or both. And if you decide to pace about, you've got to stay here in the room so you can hear what's going on. Or pace out in the hall or both. As long as you obey those rules, we'll get along just fine.

And then I started doing a demonstration with a woman who was very depressed, had low self-esteem. Oh, also, then I asked the people's scores on the mood tests. Because in the workbook, you know they take – we tested people four times a day. For depression, suicide, anger, etc. So the patients would shout out their scores at the beginning of the group, you put them in the FLU sheet – flow charts as – so you see how everyone's doing.

When I came to Benny, he wouldn't say his scores. And I said, well, I can understand you don't want your scores to be public, could I at least look at your workbook and copy them down quietly? And then he threatened me if I tried to look at his workbook you know he was going to blah blah my fucking or my f-ing blah, blah, blah type of thing. So I backed off right away and I said, well would you at least tell me your score on the depression

tests? Just that one? And he said, okay if you want to know the truth I scored a goddamn 78.

So I said wow, that's the highest score of anyone Benny. And I'm thinking to myself, that test only goes from 0 to 45. This guy is literally – you know off the charts. So then he was talking about – I was talking about self-esteem and I did a demonstration on unconditional self-esteem and it was pretty moving and a lot of people were crying. And I thought this is a great group. And I was talking about how we always think we have to earn our self-esteem by being smart or loved or whatever. And then Benny started shouting at me again.

And he said, I'm so tired of hearing about this g-d- f-ing self-esteem. And how you have to follow all of society's rules to be a good little boy and do what you're supposed to do. And all of that bullshit. And as far as I'm concerned doc, you can take your self-esteem and stick it up your f-ing ass. And that deflated me a little bit. And I says, well Benny, as a matter of fact, what you're saying is similar to what I was just trying to teach.

And you seem to know this stuff already. In fact, you could practically be my co-leader, you know, and help me teach this stuff to the rest of the patients. As a matter of fact, what I'm talking about Benny is based on Buddhist teachings. That there is no such thing as self-esteem, there's not even any such thing as a self. Those are just myths that we use to make ourselves miserable. And I think Benny, you know all of this already. Tell me Benny, were you raised as a Buddhist?

He says, I'm not goddamned Buddhist. I'm in the f-ing Mafia if you want to know the truth. And I said, well you know Benny, Mafia and Buddhism, those are very similar concepts. That – then he got excited at that point and he jumped into the middle of the circle – I was using a chair in the middle for role-play and, being narcissistic, he had to sit in that one. He says, okay doc, if you're so smart, you're talking about all of these cognitive distortions, how we fool ourselves when we're depressed. See if you can prove that my thought is wrong.

I'll be glad to Benny. What's your thought? He says, I'm a hopeless case and there's nothing you can do about it. So I start – my mind is spinning through my 50 techniques. Like which one am I going to use. And I thought well, maybe – and when I'm working, I put the patients thought in what I call a recovery circle.

And then I will select mentally 10 or 15 or 20 techniques. And I decided; let's try a cost benefit analysis. That's a motivational technique. And this guy seems pretty unmotivated.

And so, I said, like what are some advantages Benny of telling yourself I'm a hopeless case, because if you want to believe it, you're going to believe it whether it's true or false. And I'm thinking there's a lot of advantages to you telling yourself this Benny. He says, doc there ain't no disadvantages. No advantages, I've been through every drug abuse program in Philadelphia. I've flunked out of all of them – I've – five times, I've flunked out of every drug abuse program here.

And I'm going to be dead in two years doc. You put that in your disadvantages column. And I said, okay Benny, but I think you're missing the point. What are some of the advantages, group? And then I called on the group and that's why I like working with groups, because they can see it when the patient is stuck. And they started coming up with all of these advantages. Well, if you tell yourself you're hopeless, Benny, you don't have to do any work.

We're busting our butts in these groups all day long and working in the workbooks. But you don't have to do that work. And then someone else says, yeah and he can get stoned all the time. Yeah, that's another advantage Benny. I've never once had heroin or cocaine. I understand that you have the best stuff in Philadelphia, unlimited supply. You can just get plastered and stoned all day long and it sounds like a lot of fun to me.

What are some other advantages? And then he started to get on board. And he says, well, I get laid all the time. And I said, yeah, handsome bad boy, sure you get unlimited sex. That's a big advantage. And then people said, yeah, he does – he makes tons of money, that's another advantage. And then someone said, he's the big man on the street. Everyone admires him. And we started listing advantages and – then somebody said, he can be irresponsible.

And I says, you know Benny, that's right. You can be irresponsible. I said, Benny you remind me of James Dean. You're this handsome bad boy and you know you ride your motorcycle and you sell your drugs. You make the rules. You do whatever you want whenever you want. Well, you're the kind of man I always wanted to be. In fact, I've heard that when you don't – when

someone crosses you, you just beat the shit out of them. I said, now I've always wanted to do that.

I said, but I'm not allowed. I was a minister's son, so I have to be so nice to everybody. You know what's it like Benny? Is it fun? He said, oh, it's awesome. So I put the joys of violence and added that to his cost benefit analysis. And so together with the group, we came up with 17 advantages of this so called distorted belief. And then, at the end, I just brought it to closer. I ignored the disadvantages column. And I just said, you know Benny, 10 minutes ago you were asking for help with this I'm a hopeless case – this thought. But look at all the benefits to you. You're – it gives you tremendous prestige, you're the top man in this part of town, everyone admires you and respects you, you get laid constantly, you got unlimited sex, unlimited money, unlimited euphoria, unlimited admiration, freedom, you're like a prince, you make the rules, no one is going to try to tell you what to do.

That's – Benny, forgive me for saying this, but I'm not sure why you'd want to change that. It seems to me like you've got it pretty damn good thing going here. And then he softened for the first time and he looked up at me and he says, doc, you read me like a book. And then he said can I – can I share something with the group? And I said, yeah, Benny. We'd like to hear anything you want to say. And he says, this is something I've never talked about before. But when I was little, I felt closest to my grandfather. Because he was the one who would talk to me. And like me, I think he went in and out of severe depressions.

And he was involved in the same line of work that I'm involved in. But one day doc, I was sitting on the floor and he was talking to me in this dark way and it really scared me doc. And I don't know if people should do that to a little boy. Because he had the sawed off shotgun in his lap. And he told me he was having trouble with the family. By that I don't think he meant his wife. And he said there was – there was no way out. And then doc, he took that shot gun and he put the barrel in his mouth. And isn't that a cruel thing to do to a little boy? Isn't that a wrong thing?

And I loved him. He was the only one who loved me. And then doc he pulled the trigger and he blew the back of his f-ing head off. And when he said that, he just started sobbing and crying. And snot was coming out of his nose and tears were coming down his cheeks and he was just crying and crying. And after a while, a lot

of people in the group started crying and then he pulled himself back together.

And then he said, doc, do you remember early in the group I wouldn't show you my workbook? I says, yeah Benny, I remember that. You threatened me. I didn't know why you didn't want me to see your workbook. And he said, do you want me to tell you doc? I said, yeah, I'd like to know. You were pretty mad at me when I wanted to look at your workbook. He says, doc, I can't f-ing read or write. And I'm so ashamed of it. I didn't want the people here to see that about me. And then he just started sobbing again.

And that would be an example of paradoxical agenda setting. You see, who became the voice of Benny's resistance? Who was the voice of the status quo in that exchange? I was. You see, so you have – it's hard for therapists to learn this, because of our co-dependence here and narcissism our compulsive need to fix people. You have to let a part of your ego die so I became Benny. You have to see through the patient's eyes why he or she really shouldn't change, and why the negativity actually reflects something about them that makes perfect sense, like the woman who had an abortion, shows most elegant part of them.

And the paradox is that when you do this, 9 times our of 10, the resistance suddenly melts away and then you've got someone who wants to work with you. Now for someone like Benny, the prognosis is probably guarded at best for someone like that would need a tremendous amount of work. Going to NA meetings, seven days a week, twice a day initially to have any chance at all, plus a lot of therapy as well, but for patients with less severe prognosis, it seems to have opened up new worlds for us. And we're very, very excited about this – these techniques. We've developed roughly 15 of these techniques to melt away therapeutic resistance.

The advantages is that extremely high speed change now seems possible for many patients. We need to get a controlled outcome of some type to document that, see if it's real or if we're just fooling ourselves. But we're seeing changes that I would have thought 10 years ago were impossible. If you said people can change – and I'll show you a video – you'll see someone with 10 years of suffering recover almost instantly in the afternoon workshop. I would have thought it was impossible.

It also gives you a deeper and more authentic understanding of the complexities of the patient's concerns. And it transforms the

patient's problems into assets and created collaboration and trust. The disadvantages, it's hard for therapists to learn this. I – we have – I've developed a lot of free psychotherapy training groups in the Bay Area. So if you're ever in the Bay Area, you can visit some of our evening training groups and therapy – private practitioners like yourself can come forever and get unlimited free training.

And – but they find it hard – each group last two and a half hours and we do role playing with feedback the whole time. And it's tough for them to learn. And your rule about 10,000 hours or something, really seems to be true. It's awfully hard for therapists to learn how to do this because the emotional challenges – co-dependency, narcissism, conflict phobia, conflicts of interests, things like that. Really, really get in the way.

But a number of therapists do seem to be learning it and we're quite excited about it. And so that's pretty much it. I put in the handout – I guess a lot of people aren't printing your handouts for the presentations. But there's a lot of additional resources for those of you who were wanting to learn more about this. So do I have time to take a question Rich?

Rich: They can ask the questions in your workshop.

Dr Burns: They can do what?

Rich: They can ask it in your workshop –

Dr. Burns: Oh, in the workshops, yeah. In other words, no you can't ask questions. You're screwed. But anyway, thank you so much. It's been great. I appreciate it.

[End of Audio]

Duration: 51 minutes