Rich: Welcome, everyone. My name is Rich Simon. I am editor of *Psychotherapy Networker*, and I'm your host for this series on mind-body approaches in psychotherapy. And what we're exploring is essentially, for many therapists, a new language. A way of going beyond talk, and a way of being effective in a different kind of way than many of us are used to being effective. So throughout this series, we've been exploring a variety of approaches. And a number of them we'll be talking about with today's guest. And the focus of today's conversation is the presenting issue in psychotherapy that's often very challenging for talk psychotherapists, which is when a client comes, and they're presenting with depression. We'll be talking about what we mean by depression, alternatives to psychopharmacological approaches to depression, and perhaps looking at another – some unconventional perspectives on understanding the meaning of depression.

We're very fortunate to have with us today as our guest someone who is a clinical professor with the Department of Psychiatry and Family Medicine at Georgetown University School of Medicine, and the author of *Unstuck*: *Your Guide to the Seven-State Journey Out of Depression*, my friend, and a friend of the *Networker*, psychiatrist Jim Gordon. Hi, Jim. How are you?

Jim: Hi, Rich. It's good to be here.

Rich: So let's start off. So your critique in your book and in your work, your launching point of your perspective, is that really it's an error for us to think of depression primarily as a disease. What's wrong with thinking of depression as a disease?

Jim: Well, first of all, we don't have the evidence that it really is a disease. It's often compared in the psychiatric literature in the medical literature generally to Type I insulin dependent diabetes. And so the story goes if you're deficient in insulin, and you need exogenous insulin to replace the insulin you don't have for Type 1 diabetes, so with depression, you're deficient in presumably serotonin or norepinephrine. And you need external replacements of those neurotransmitters or augmentation of those neurotransmitters. Well, the analogy doesn't hold. We don't have the same kind of pathological findings in the brain or in the bodies of people at autopsy for depression as we do for Type 1 diabetes.

There's no consistent biochemical or even physiological abnormality in depression. So the analogy is misplaced and, at least as important, the treatments that that analogy has facilitated that have become $10 or $20 billion a year industry. Those treatments, when you look at them closely, don't work particularly well for depression.

Rich: Yeah. So the standard – so what we've – the standard treatment of depression are antidepressants. Principally, these days, SSRI's. And what's wrong with – so part of the issue is that they don't seem to work. And that's always a tricky thing to define what exactly we mean by work. What's your quarrel with the psychopharmacological approach to treating depression?

Jim: Well, there are many problems. I think the fact that they don't work, and we know that because the original studies, which made everyone feel well, yeah, there are side effects, but they have real benefit. It turned out those studies were very much cherry-picked by the drug companies so that when investigators went back and looked at the Food and Drug Administration files and came up with all the studies on antidepressants, the negative as well as the positive, the results came out very differently. So in some of those reviews, it looks like antidepressant drugs, SSRIs, are no better than placebo sugar pills.

In one of the reviews, it says they looked like they're better for extremely severe cases of depression. So if they don't work, why give them – why expose people to all the side effects, which 70 percent or so of people who take antidepressants over any length of time have one side effect or another, including gastrointestinal problems, nervous system disorders, sexual dysfunction, weight gain, all of which can make you more depressed. Plus, getting off of them is no picnic either. The drug companies talk about – use a euphemism. They talk about discontinuation syndrome. Well, that's a polite word for withdrawal.

And people who withdraw from SSRI's have very serious withdrawals, often. Often as serious as people who are withdrawing from heroin or cocaine or other drugs, alcohol. So this is not a sort of treatment without significant hazards. And my position – and other people will say well, yeah. But it worked for this patient and that patient. Well, that may be placebo effect or maybe it did work. But the point is these drugs should not be used

as the so-called treatment of choice. They should be used as a last resort.

And we now have 20 million people who are being prescribed these drugs each year for depression in the US and a total of about 30 million people who are on these drugs for one condition or another. And it's a really very serious mistake that is being pushed by the pharmaceutical companies and being exceeded to by the medical establishment for reasons that are not – really have nothing to do with science and very little to do with the welfare of the patients.

Rich: So let's look at some alternatives. And this is the series and this interview, let's look at what is it that someone who does not have – is not a psychiatrist, does not have a grounding in medicine or biology, what are the alternatives? What is it that you're proposing? Is the way you like to work as a therapist, in what way is that reconcilable with the background and the inclination of most talk therapists?

Jim: Great question. I think the first thing though is for those people to take a look, whether by reading on the stock or reading the literature directly, at what the actual literature is, because that way, when they look at alternatives and they speak to their patients, there will be an authenticity and a conviction that you won't get just by having an idea. They need to know that that's solid research.

Rich: It's really grounded in something, yeah.

Jim: Second thing is to understand that it is possible for people to move through depression, and successfully move through, without antidepressant drugs. Now, at first, that may come from reading other people's accounts. But the more experience they have, and I had the experience both personally moving through a state of clearly diagnosable major depressive disorder without using medication, and then I began to have it with many patients. And the more people with whom I worked, and the more I paid attention to my own experience, the more clear it became to me that this could happen.

And so conveying that idea to the people who come to you is absolutely critical because what they often hear is the only way to go is to take the antidepressant drugs. And psychiatrists are

increasingly saying this, you may have to be on these for years or your whole lifetime. There's absolutely no evidence for that either. So having some sense that it's possible, conveying that hope, makes a huge difference to the people who are coming to see you. Call it whatever you want. Call it confidence in your therapist. Call it placebo. People really take it to heart, and it helps them go through the inevitable difficult times that there are when you're working with depression.

So that's No. 1. The second, and there are many parts to this, is what I say right from the beginning is that there are – it's not only possible, but there are significant things that you can do to make it possible for you, and I will teach you these things. So what I'm saying is that people can have an active role in their own treatment and in their own healing that it may be important, hopefully it is important, for them to come see me in my office. But it's at least as important for them to take what I have to say to heart and to make it a part of their life.

Rich: Yeah. So give us a flavor, if you could, of how you work. So someone is coming in. They're depressed. This is their first interview with you. You've gotten whatever information that you've gotten over the phone. And perhaps you should say a little bit about that. And then in your – and if there's some preamble to the face-to-face encounter that we should know about, please let us know. But just give us the flavor of what happens in the first interview when a fresh face comes to you.

Jim: I think what you mentioned about the phone is very important. I talk with people before they come to see me. I don't charge them. I talk with them 10, 15 minutes on the phone. I explain to them what my approach is. Basically, that they're going to be taking an active role in helping and healing themselves. I suggest to them that they read *Unstuck* to get an idea of how I work. Before I had a book out, I would send them a brief article describing how I work, which I think every therapist should do for clients or patients. And so people know when they're coming to me, they know what they're getting into.

And that makes it so much easier on me as well as on them because there's no misunderstanding. And I'm not going to give them the magic bullet. The history that I take is probably quite recognizable with a few exceptions to most therapists. That I'm interested in when did this start? What was going on in the

person's life at the time? Has this happened before? What do they think is going on? That's a very important question. Why do you think this happened? You're giving me data, but why do you think it happened? And then I take a family history and a social history. One of the things that I think doesn't happen often enough, usually therapists are pretty good about looking at close relationships.

At least here in Washington DC, work is enormously important. And the difficulties of work and the vagaries of what happens with the government and dealing with bureaucracies and everything else. And I think it's true in a lot of other places as well. So I make sure that I ask them significant questions about work. I take a general medical history, which a therapist can as well. We talk about a review of systems. What kind of conditions? What kind of illnesses? What kind have you had in the past? Are there illnesses that run in your family? When was the last time you had a physical? What showed up on the physical? So kind of very global history.

And what do you think – I will also say at some point in the first session, sometimes right early on when I'm taking the history, what do you think – not only what do you think is causing what's going on with you? What do you think you need to do to make a difference and to come through this experience of depression and to move out on the other side? Now, I also say, either on the phone or in person, I don't regard depression as a disease. I don't see it as the endpoint of a pathological process. I see it as a wakeup call. This has come to you because things are not working, whether you're on a biological, psychological, social, spiritual level, or all of those, things are not working.

So invite people to explore with me what's not working, and also right from the beginning, I'm engaging them in thinking about what they need to do to make a difference. And very often, most people will say well, maybe I can do this or maybe I can do that. Those who don't – I mean, for example, medical students will say if you ask them why they're stressed out and depressed, they'll say well, I'm a medical student. Isn't it obvious? Well, it's not that obvious. And of course, it may have to do with a girlfriend being 500 miles away, or not being in the top 10 percent of your class, or your roommate is better looking than you are. Whatever it is.

So I try to get very specific with people about what's going on and what the issues are. And then together, we formulate a plan for

what to do next. Now, I do things in my practice that nonmedical therapists are not likely to do. I do acupuncture, for example, and I do adjustments that are associated with osteopathic medicine or chiropractic. But aside from that, what I'm doing each time that somebody comes to see me is I'm also teaching them just about every time something that will be helpful to them that they can then take home. So my prescription is for things that people can do to help themselves, some of which I will teach them in that very first session.

So for many patients, for example, I teach a quieting, slow, deep breathing meditation, soft belly meditation. Breathing in through the nose and out through the mouth with the belly soft. And I talk them through this, and it maybe takes five or six minutes. And I explain to them as I'm talking with them that breathing slowly and deeply, more oxygen comes into the bottom of the lungs. You get better oxygen exchange. Oxygen fuels the cells in the body. Letting your belly be soft and breathing deeply activates the vagus nerve, which runs up from the abdomen through the chest back to the brain. And the vagus nerve is the antidote to the fight or flight response and the stress response.

And stress is the major factor in depression. I explain also that as you breathe slowly and deeply with your abdominal muscles relaxed, all the other muscles in the body relax as well. And I do that. Then we breathe together for about five or six minutes. And I would say 90 or 95 percent of the time, people feel at least a little bit better at the end of those five or six minutes. So they have a sense –

Rich: I already feel better in our interview, Jim. I've gone through a couple of minutes of this. Thank you.

Jim: Incidentally, this is not only in *Unstuck*, it's on the Center for Mind-Body Medicine website where I'm teaching it and talking it through, CMBM.org. And people can listen to it, download it, do whatever they want, share it with their partners.

Rich: At the end of our conversation, we'll give people – remind them of these links.

Jim: What that does is it gives people the direct experience in the very first session that they can do something to quiet themselves. So they'll say oh, my shoulders feel more relaxed. I'm breathing more

deeply. My heart rate is slower. The room seems a little clearer. I feel more present. So they have a direct experience of making a physiological and a psychological shift themselves. And so I assign this to them to do at home on a regular basis. Maybe five minutes two or three times a day. Now, those few people for whom it doesn't make a difference, I usually ask them are you willing to do it? See if it will make a difference next time.

Most of the time, people are – if they're too agitated, say I can't possibly sit still, which of course is true of some depressed people. Then I say you've got to do something active first. And then we figure out – because actually, I do with pretty much everybody something active they can do when they go home as well. So almost always at the end of our first appointment, I've assigned a quiet meditation of one kind or another. And I've assigned an active experience. It could be what are called expressive meditations like fast, deep breathing. It could be walking. It could be swimming.

It could be hitting a punching bag. But something to raise the energy and get rid of tension.

Rich: All right. So it's your goal – so by the end of the first session, you've taken this history. You've introduced some form of mind-body practice. Your emphasis is going beyond simply history taking and talk. So you've described that's an element in what you're doing. So is there anything else? What's your goal? Where do you want to be at the end of a first session, which by the way, lasts about how long? How long is the first session?

Jim: My first session, the talking part of it as opposed to the acupuncture part, which is separate, is about an hour to an hour and a quarter. So at the end of the first session, what I want to do is make sure that somebody is really up for this kind of partnership with me. They've already said it on the telephone, but I want to make sure they're still with me at the end of the first session. I want to make sure that they've had their concerns and their questions answered about their anxiety or their sleeplessness or their suicidal feelings.

That somehow they feel reassured enough and connected enough with me so that I know that they're going to come back, and I know that they're going to make, as one of my teachers used to say in grade school, an honest, sincere effort. That they're really going

to experiment with what I'm suggesting to them. So we have a partnership already. In addition to the quiet and the active experience, I usually make a nutritional prescription. Now, this is within – much of this is within the reach of most therapists. It doesn't have to be a very fancy prescription. There's a basic set of nutrients that most people can benefit from that are not going to do any harm.

And you can suggest that to people and say that one way to do it is if you're concerned about prescribing without a license is you can have them read about it. And I send people to Unstuck. I have a program in there of nutrients that are likely to be beneficial to people who are depressed that have virtually zero chance of causing any unpleasant side effects.

Rich: Just say a little bit about that before you go on, Jim. So just give us some examples of what you're referring to.

Jim: Well, the thing is that when – there are a number of nutrients that when they're deficient, they can be significant causes or contributors to depression. B vitamins are some of the most obvious ones, particularly B1, B2, B6. There's a rich scientific research literature on this. Selenium, again, selenium is a mineral. It's often depleted in the soils and the food that we consume that's grown on soils here in the United States. Prescribing 200 or 400 micrograms of selenium a day, which I do, is not going to do anyone any harm and may well benefit some people. Vitamin D is important.

I also suggest that most people who come to see me, not necessarily the 18 year old kid whose girlfriend has just walked out on him who is depressed about that, but most people who have lived a little longer and have complex problems, I do suggest they get a basic physical exam. And one of the things I'm looking for on the physical exam lab tests is vitamin D levels. I've seen several people who were extremely depleted in vitamin D. And up to 30 to 60 percent of most populations in the United States are significantly low in vitamin D.

And I've seen a few people who, when they've been supplemented adequately with vitamin D, the depression is just lifted with nothing else involved regardless of what's going on in their lives. So that's something I always want to check for. I prescribe omega-3 fatty acids. There have been a number of studies done on EPA

and DHA. Studies are slightly contradictory about how much of one or how much of the other. I prescribe several thousand, up to 6,000 milligrams of omega-3 fish oil containing about 2,000 milligrams of EPA and DHA, these two fatty acids.

There are many studies, both clinical studies and epidemiological studies, showing that these contribute significantly to depression and that adequate supplementation can improve moods significantly. So those are some basics for – chromium is another one. Again, chromium is crucial to sugar metabolism. I make sure people are getting adequate chromium as part of a multivitamin/multi mineral. I think that if therapists will read up on these things, then mostly, you can feel very comfortable making the kind of prescription in have in *Unstuck* or other prescriptions that other people have made based on lots of experimental evidence and clinical experience.

Can I stop for one second? I've got to blow my nose.

Rich: Yes.

Jim: Okay.

Rich: So you're modeling self care first, congratulations. So two questions for you. No. 1 is we're talking about this, at this point, amorphous condition called depression that is explained and is from many different perspectives. So are there distinctions? What is it that – when somebody is coming in, and their mood is low, they're not sleeping so well, their appetite is lousy, they're feeling grim and pessimistic about life, what are the distinctions that – what are you looking for in terms of understanding – do you have whatever it is, if it's not a medical diagnostic system, are there significant categories or dimensions that are important for you in understanding what this depression means for somebody?

Jim: I think for me, I look at it more – I'm not sure what the label is. Maybe to say more existentially. What caused it? Because if we can figure out what caused it, then we're going to have an arrow toward what's going to relieve it. So I'm exploring the different dimensions of people's lives. Work, love, losses of various kinds, physical illnesses. And then I want to address the causes rather than – and the symptoms are kind of arrows leading me back to the causes. So I'm not so concerned with – I'm sorry?

Rich: You're trying to – so what's important for you is this whatever their distress is about, or whatever the nature of the distress, you want to understand the context in terms of their present life, perhaps some historical information as well.

Jim: And then, to start – the crucial thing to me is not sort of differentiating their diagnosis in terms of agitated depression, retarded depression. It's much more – it's the phenomenology, and it's what they feel has caused it. And what we, putting our heads together, think may bring relief and engaging people in an adventure. I mean, it's an adventure in a difficult time. But that's often when we have to go on adventures anyway. It's a journey. That's why I like that metaphor. So I want to engage them on this journey and then see what they need to take the journey. Make sure they're getting the support they need from me, perhaps from others in their lives.

So I help them look around for what else they might need, who they might go to, who they might connect with. Helping them right from the beginning to begin to use their own imagination and intuition. And often in depression, we feel so shut down. I can't think of anything. My mind just keeps going over the same ruminative, catastrophic ideas. So I will help them engage their imagination and look at what might be possible. So doing that, using guided imagery, teaching them to relax, and then taking them on a mental journey so that they can begin to inquire of their whatever you want to call it.

Right brain, imagination, intuition, inner guide, what they should do for themselves. So I'm looking to engage them and to see where that engagement is possible. For example, I remember one young girl who was brought to me. She was diagnosed bipolar. She was about 17 years old. She had been hospitalized a couple of times, been on a bunch of medications, some called her depressed, some called her bipolar. Everybody was focused on her behavior. Well, when I talk with her, her real interest was her weight. She felt she was too heavy. So that's where we worked. That's where the action was.

And as we began to work, I began to give her tools to deal with her weight, she began to use those tools in a way that made her feel better about herself. And then little by little, she talked about some of the other issues with her family. In her case, at a certain point, it became clear to me that individual therapy was not what she

needed right now. She had been labeled a patient for years. That the action was between her and her mother. So from that point on, I began to work primarily with her and her mother and helped them sort out the miscommunication, the deception in their relationship. And that, for her, was the royal road. So I take the lead from the person.

What is the issue? I could have seen that – that girl had seen three perfectly competent individual therapists over the previous five years, and she said that one was nice. That one wasn't so nice. None of them did her any good because they weren't willing to look outside of that narrow kind of diagnostic box and the vision that kept her as the identified patient with either depression or bipolar disorder, depending on your diagnostic preference.

Rich: So here's kind of the crucial – people who are coming in, they're feeling depressed. They want relief. Often, they're in extreme states of distress. Part of the reason that the psychopharmacological interventions have become so common is at least they promise to be able to bring more immediate level of relief than a more long term or a non-medication form of treatment. So how do you deal with that issue, and the patient is coming in, and their idea is that they want to have medication. They want relief. They want to have a pill that's going to help them to sleep and help them feel better. How do you deal with that issue?

Jim: Well, the way I deal with it is upfront. I say I'm not going to prescribe medication. I tell them that on the phone. That's not what I'm doing. And I would say most of the people who come to see me have already been on medication. And either it hasn't done any good, or it's done some good, but they don't like the side effects. And so they want to get off. So they come medicated. Now, at certain points in treatment, people do say – they say – a small number of them say I want the medication. I want it now. I want to change right now. And so there, it's a question of looking. Sometimes, you can feel the frustration and the anger.

And so I give them techniques and experiences to get out that frustration and get out that anger. Fast, deep breathing sometimes, pounding pillows, hitting heavy bags. I was just up in Newtown where all the kids were shot, and I happened to be working with a guy who was feeling very depressed and very angry. And he wasn't sure of medication, no medication, what should he do? I

said hit a heavy bag. So he began to do that, and his energy began – because he was just so angry at everybody for many, many reasons. So I sometimes work – that's the way I work. The other is that I tend to use – if I feel somebody really is not moving doing all the things that I'm doing, either if they've decided they don't want to do that, then I'll refer them to somebody else for medication.

And I may well continue to see them. If they have really, genuinely made an effort – if they haven't made that effort, I'll say well, what about trying this that we agreed you would do? And let's see what happens. Let's say that doesn't work either. Then I sometimes use precursors that are less harmful to people than the SSRI's or the other antidepressant drugs. Like adenosylmethlonine. So I'll prescribe that. It also raises neurotransmitter levels but has, or seems to have, significantly fewer side effects. Occasionally, I've used St. John's wort for similar reasons. So on occasion, I will do that.

But mostly, what my focus is is on getting people to see what it is there, something, that they have been, to use that overused word, resisting that might make the change. Something in the things that we've talked about. Something in the actions in their life. If they're still in a job that they hate enormously, but they're there for various – because they make money at it or they don't want to disappoint their parents or their wife or whoever it is, I said you're doing something every day that you hate. I mean, something has to shift here, or it's going to go on. And you can try antidepressants if you want, but I don't think it's getting at the root cause of what's happening.

So I really keep coming back to what's really going on and what might be possible to make the change. Now, physical exercise, for example, looks like it's absolutely as good as or better than antidepressants in altering neurotransmitter levels like serotonin and norepinephrine. So if somebody says I absolutely refuse to do that, well, they're making a choice. And there are people who will prescribe the antidepressants. I say it without judgment, I hope, that it's okay. You go there. If you want to keep seeing me, we can still keep working. But I'm not going to prescribe them. This is the way that I work.

And I think that if we worked – if you were able right now to work in this way, you might be able to move through it. But right now,

you can't. So go ahead. Do what you need to do. And let's keep working. Let's keep seeing what we can do.

Rich: So we have started here – you were talking about at the end of this first session, some of the questions you ask, some of the ways you want to engage people, certain practices, exercises, things that they can do at home. So as you look at where you go from there and kind of the art of treatment, and perhaps there are a number of patterns here that you might want to show us, but give us the flavor of where – of how treatment with you proceeds. What structures it? What's the shape of what happens? Or what are some of the typical patterns of what goes on when people are helped by working with you?

Jim: Well, the first thing, and I think therapists already know that, but unfortunately, physicians – and many physicians, including psychiatrists who prescribe drugs don't – is I always see the person soon after the first session. Ideally within a week after the first session. And it's really important for them to feel the contact with me and to feel the continuity. And I also say if anything comes up anytime, you call me. I make that very explicit. Almost nobody calls. And I think that's largely because they know that I'm there, and they know that I am available if they need me, and I'm going to see them again.

When I see them for the second time after just saying how are you, what's going on, I will inquire about what they did with the prescription that I gave them. So let's say I said do soft belly breathing five minutes three times a day, and I wrote it down on a prescription pad. And I say go for a walk 40 minutes 6 times a week. And they come back, and I say what about that? How did you do with that? And they will tell me. And the idea is whether they did it or not, it's fine. If they did it, how did it work? What were the benefits? And usually, if they do it, they're feeling some benefits. If they didn't do it, the inquiry is how come?

Again, not with any judgment, not with any criticism of them. But we can learn from this. And then they will tell me what it is. So if they're not able to do something, we often work with what that is that's kept them from doing something that we have both agreed could be useful for them. If they have done it, then I want to know what's happening and how things are moving ahead, and what the next thing is that's coming up for them. What is the issue that's of concern to them at this point? I have also often said that they

should get a physical. They should get lab tests. We're waiting for that as well.

And then the session unfolds with me – I had a patient this morning, and she said you know, after the last session with you, I left feeling really bad. Normally, when I leave sessions with you, I feel much better. She said but then, over the next hours and by the next day, I felt really good because – and what I realized was two things. One of the things you showed me was that the situation I was facing now is actually one I had dealt with before in my life successfully. But the other thing that was even more important is you accepted me as miserable, as pessimistic, as depressed, as whiny, as complaining as I was. And I said great.

And she said, "I never allowed myself to be that way. I'm a strong woman. That's not how I am." So I think that the feeling throughout is a balance between accepting people exactly as they are and believing that they can rise to the challenge of engaging in practices that will move them through depression that will help reveal to them what their deepest concerns are, what their deepest challenges are, and help them meet them. So it's a combination of both accepting totally vulnerability and, at the same time, appreciating and working with their strengths. And that's the feeling that I think I convey throughout my work with people.

Rich: So let's continue to focus on some of the specific tools that you use as you're engaged in the kind of process you just described. What are some of the tools that you're using that are outside the talk therapy repertoire that you find are especially helpful with depressed patients?

Jim: When people come up against the problem that seems insoluble, and of course, when you're depressed, many problems seem insoluble, and everything seems like a problem. What I do is some people work with and work well with cognitive behavioral approaches. I work with accessing the imagination, the intuition, inner guidance. And there are several ways that I do that. One I mentioned briefly earlier is through guided imagery. Taking people to a safe or comfortable place. Encouraging them to find in that place an inner guide or a wise guide with whom they can have a dialogue about the problem that's coming up for them at that moment.

And 80 to 90 percent of people are able to use that technique successfully, find it relaxing, helpful, and also find that they discover things that weren't coming to them as they kept ruminating about what was bothering them. A second technique that I use is I work with drawings, and often a set of three drawings. And the first drawing is draw yourself. Second is draw yourself with your biggest problem. And the third is draw yourself with your problem solved. So what that does is it gets people out of their left brain into the sort of more imaginative, creative, maybe slightly self-conscious, but hopefully after a while playful self. And there are no grades.

So they draw whatever they draw. It helps them identify a problem. And often, the biggest problem is not what they thought it was going into the exercise. Because I tell them just draw whatever comes to you. Don't think about it. Just do it. And so for example, a depressed woman with cancer drew a huge, red area in her belly. She had uterine cancer. So of course, my thought was is that your cancer? She said no, that's my husband. Forget about the cancer. She was more profane than that. She said my husband is the one who is really causing me this angry, bleeding state that I'm in.

And the third drawing is, as you draw yourself with your problem solved, it gives people the opportunity against all of their rumination to actually imagine that the problem could be solved. And sometimes, it's very surprising. It may be – in that woman's case, I don't actually remember what her third drawing was. But it could have been going home and yelling at her husband. Or it could have been sitting and meditating. Or it could have been going for a walk, or 10 other things. But something will come out of her unconscious that gives her a sense of what she should do.

The third technique that I sometimes use is dialogue with a symptom problem or issue in which you do a written dialogue kind of like a Gestalt technique in a way, except it's a written dialogue between you and your symptom. And low and behold, in many, many cases, your symptom – after a symptom tends to be often a little snide, sardonic, sarcastic, or at least teasing, not always, but the symptom ultimately usually gives some good guidance. If you want to get rid of me, you've got to stop taking me so seriously. Or whatever it might be. And then the person will say what does that mean?

And say well, why don't you look in a mirror and laugh at yourself. You're ridiculously serious now. But they've gotten it from – in all of these instances, it's not something that I've told them to do, which in their mind, they may say it's fine for you to say. You're a doctor. You're not depressed. At least you're not depressed right now. You don't really know what it's like. They're experiencing it themselves. They're getting an answer from the inside. And my role is to encourage them to act on the answer that they've received. To take that guidance or that advice seriously. So I might – those are three of the techniques that I might use to help people deal with something that's really got them stuck.

Rich: Yeah. And so what's the shape of what happens? Do you find in terms of duration, in terms of how much time – of duration of treatments, how much time it takes before people can really begin to respond and feel like they're feeling significantly better? And overall, your sense of success and working in this way.

Jim: One other thing I should mention that I didn't is in the beginning, I do go over what people are eating. What their diet is. And that can have a significant effect on depression. There are people, for example, who are sensitive to sugar. There are indeed people with sensitivities to gluten and to dairy and to other foods. And so I take a history. And I'm thinking of one 14 year old girl who became very depressed. And one of the things that she actually became very depressed and couldn't sleep at night, was angry and irritable, after she was hit in the head with a soccer ball.

So I had to do something to get her head a little relaxed and a little released, which if the therapist can't do it, they can refer to a chiropractor or an osteopath. It's very obvious that after an injury, these symptoms just blossomed. But then I also took a history from her, and it turned out that her breakfast was wheat cereal with milk and sugar. Her lunch was grilled cheese sandwiches. And her favorite dinner was fettuccine alfredo. So she's essentially on an all wheat and milk diet. And in her giving me the history, she started getting nervous when she finished the history because she knew what I was going to say.

And what I said to her was no wheat, milk, or sugar for three weeks. See what happens. And she looked at me as if I were a vampire, and she had to put up a cross to stop me. And she said two weeks. I said okay. Within three days, there had been a shift. She had a lot of the symptoms of depression. The sleeplessness,

constipation, immobility. Those began to clear in three days. Within five days, her mood was better. She said after two weeks, what happens if I eat those foods again? I said try and see. So she had a big meal of pasta with olive oil because I just wanted her to test one at a time. The next day, she was down. So she knew for herself.

So anyway, that's just another piece by way of saying that sometimes, with her, three or four sessions, it was over. She was back on track again. A lot of it had to do with her diet. Some had to do with the head injury. Some had to do with just some self consciousness, but that was a really small thing. Other people, it may take weeks or months. People generally feel better within a couple of weeks. That's what I've found, and that's a combination of the mind-body approaches, diet, of re-conceptualizing what's going on with them, supplementation. I'm not always sure which of all of these makes a difference.

But usually, within a few weeks, people see a significant difference. And as they do these things, as they do these techniques, they not only get a specific benefit from whether it's going for a run or going for a walk or meditating or eating a more healthy diet, they also get the meta message that I can help myself. And of course, helplessness and hopelessness are the hallmarks of depression. And they're overcoming both of those. The other thing that I often do fairly quickly with people is I'll refer them to a mind-body skills group. So they can – a small group in which they can practice these techniques and other techniques in which they're with other people with similar or different problems.

A group that gives them support as they're making the changes in their lives. So after a few weeks, I usually see a fairly significant change. And within – some people have lost a child, or they've lost a relationship that's truly important to them. It may be many months before they come through the experience. So I'm prepared to work with them over a period of many months. I don't know in advance. I don't say in advance it's going to take this long or that long because I really don't know. The other thing that I would suggest to therapists that I do myself is it's often very helpful to improve both physiology and psychology to refer people for acupuncture and also for Chinese herbs.

That both acupuncture and Chinese herbs seem to have a significant effect on improving mood, quieting stress, and helping

people have more energy in general. So I think the other thing I would say to a therapist is you don't have to do the whole job yourself. You can bring in other people. And those other people don't have to be psychopharmacologists. They could be for somebody you've assigned some active technique, and they really can't do it very well. You might suggest that they have a coach who works with them or that they go to a class that's teaching a particular technique or a particular meditation. I use yoga a great deal.

And suggest to people classes, not just mind-body skills group, but classes also provide support. So as time goes on, I'm working out a kind of comprehensive program for all aspects of that person's life. And I don't have to be the one to implement it all. It doesn't all fall on me.

Rich: So your role then, you're an educator. You're a bit of a coach yourself. How would you distinguish, if you would, the kind of stance that you're describing here, the role that you're occupying in these folks' lives, and the more traditional role of psychotherapist?

Jim: I think a couple of distinctions. One is that more of my approach depends on the person acting on her own behalf, either individually or in concert with a group of people than most – some psychotherapists I know do that. But right from the get go, that's what I'm saying to people and that's what's happening. Second is, I don't know if this is universally true, but in therapists who come to my workshops, I'm much more optimistic about people's capacity to move through depression without medication to have those inner resources than most therapists are. Third, this is something that I do that not all therapists feel comfortable with, I actually touch people.

You can't adjust somebody's neck or back without touching them. At least I can't. You can't put in acupuncture needles without doing that. So there is a hands on connection, which I think makes a difference to people. Fourth, and again, I don't know – I think some therapists do this, and some don't. I'm very interested in all aspects of their life and all aspects of their therapy, all aspects of any interventions that they may use. So I'm inquiring about what the doctor said or what happened in the yoga class or what the nutritionist said. Or if I send somebody – if somebody else is

going, and some people come to be seeing an acupuncturist, what did the acupuncturist have to say?

So I'm very interested in all these other approaches. I don't regard that as outside of my purview. And maybe more than some therapists, I really appreciate the power of groups. I think unfortunately, I mean, when I was in training, groups were very, very important. And we all got trained to lead groups. I don't think that's as common now. I don't see that. At the Center for Mind-Body and Medicine, our focus is really not only on training people to work with individuals but to work with groups. And finally, maybe it's not finally, I see depression as a kind of spiritual crisis. And I don't think all therapists do that. That the salt has lost its savor.

Interesting. Depressed people, food is kind of tasteless to them. So that Biblical quote has a certain resonance. Life is not worth it for them. And this I regard as a spiritual crisis, which is both threatening and painful but is also potentially the beginning of a tremendous process of growth as one discovers one's purpose and meaning. So I am very, without pushing any particular kind of religious path or even any particular kind of spiritual practice, I very much see depression as a spiritual crisis. And it helps people to see it that way. It dignifies it. And I think it deserves that dignity.

They've come to the end of their road going down a particular path, and now it's time to look for something larger, to look for something that's going to give their life more meaning, more purpose, more connection to something beyond themselves. So I encourage that.

Rich: And we just have a few more minutes. So how is it that you – what are some of the things you might say? How do you encourage people to get that bigger picture of what their journey is?

Jim: Well, I think the first thing is by appreciating its power that it already has for people. A patient of mine, I remember so vividly, was depressed and had terrible psoriatic arthritis, arthritis that goes with psoriasis. And he had been to see doctors and therapists. And two things that nobody really focused on with him are No. 1, his work situation. He liked the work he was doing. He couldn't stand the place he was working at. So that was one avenue. But the other was the importance of his Catholic faith to him. And nobody really

inquired about that. Nobody really helped him to appreciate how important and how sustaining it was, and how he could work within the context of that faith.

So I encourage people to look at where they found strength and sustenance before. I also ask them to think about, given how they're feeling, what might make them feel better. And one of the things, and this has nothing to do with any particular religion, although it certainly has to do with connecting with something larger, is people have lost their connection with nature, with the natural world. And they'll say I really felt great when I was in the country. So on the prescription pad, go to the country every weekend. Walk around for three hours. Walk by water. Enjoy that time there.

I give them – sometimes it will come to me to assign somebody a particular reading, a particular – it could be any of a dozen different traditions. In *Unstuck*, I write about this airplane mechanic whom I told to read the *Tao Te Ching* because he was very depressed. He was very angry at his ex-wife. He was angry at his kid. He was angry all the time. And it just came to me from my own experience, from my own time I've spent with that book as well as many other books that would be really good. He needed to let go. And the *Tao Te Ching* is all about letting go and letting be. And I said read it. And so he spent – he was a man who was enraged all the time.

One of the pilots had referred him – of the plane he serviced had referred him to me. And he spent a long weekend reading not only the copy of Steven Mitchell's translation, which I really like, but he read half a dozen other translations. He spent three days reading the *Dao Tai Ching*. By the end of it, he got it. He was a different man. He was treating his ex differently. He was treating his kid differently. He understands that you can't hold onto people. You can't make them do anything. You have to let go. Now, that was an amazing experience. And he said doc, I'm fine. See you later.

But I will often either work within the tradition that people already have, or sometimes, it will come to me to suggest something from a different tradition that they might read like this man. So that's a way. But often, their wise guides will tell them. Often, that space will open up to them from looking inside and going inside. And I just encourage them.

Rich: You recruit lots of co-therapists. So you've given us a picture of a very capacious approach to change and therapy that goes way outside of your office.

Jim: Let me say one more thing, Rich, because I think it's important that just came to me. I really don't let people go over the same ground over and over and over and over again. I don't think that helps. I see so many people. They've been talking about the same thing, the same thing, the same – so they've got to get another perspective on it, or you've got to change the subject. So when I'm sitting with them, if I'm getting antsy and totally bored, I check inside. Is this real? Is this me? Is it them? If it's them, and they're really just going over the same ground, and they're really stuck, that's when I look for something to do to help bring them out of that state.

And that's when techniques like some of the active techniques or the expressive techniques, either moving the body or working with drawings, can be enormously helpful. So this way of doing things is really a pleasure. I don't get tired. I don't get bored. I don't get impatient because I don't let myself. I engage the person completely in working with me to do something that's going to make a difference.

Rich: Yeah. You don't get caught in the trance. All right. We're almost out of time. Folks out there who have been listening to this who really want to get more information, find out more about your approach, to begin with, there is your book that we've heard about a few times here, *Unstuck*. Let's –

Jim: Okay. Here's the book.

Rich: Okay. There we go.

Jim: It's called *Unstuck*: *Your Guide to the Seven-Stage Journey Out of Depression*. And it's out in paperback. And it's practical in all the techniques that I described. And many, many more are here in the book with clinical examples and the research evidence about why I use them. And I think it will be very helpful as a kind of manual for people to use to supplement what they're doing as well as to help them understand that there really is significant science there for these approaches. And the other thing that people who are interested in learning this approach, they can come to the

professional trainings that the Center for Mind-Body Medicine does here in the United States and around the world.

And you can look on our website at www.cmbm.org, and the trainings will be on the website. And we welcome anyone who is doing any kind of therapy, anyone who – we have about 30 percent physicians, about probably 40 to 50 percent psychotherapists, and then other kinds of nurse practitioners, nurses, acupuncturists, administrators, community organizers in the training each year.

Rich: Great. And let's invite all of you who have been listening to this, there's a comment board at the bottom of your screen. As always, share what is it that stood out for you about this conversation, what connections you made, what questions you may have. The important thing is to continue this conversation. If you want to address some questions to Jim, he'll agree to at least look at the comment board. If he is so moved, he may well respond. Let's keep this conversation going. It's a very important conversation.

Jim: That's great. Thank you, Rich.

Rich: Thank you, Jim. So thank you for this very vitalizing, very broad ranging view of all the possibilities of being in healing relationships. Thanks so much. That's it for this time. We look forward to seeing you at the next installment of –

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Duration: 64 minutes