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The Man Who Thought He Killed His Son

I recently treated a businessman named Jacques who'd suffered from relentless depression for eight years. Twelve years earlier, Jacques had begun dating a divorced physician named Madeline who had a thirteen year-old son named Timmy. Timmy's grades were falling and he was starting to run with the wrong crowd. Jacques felt that all Timmy really needed was a strong and loving father figure—someone who would care about him and spend time with him. Jacques was a very caring individual, so he devoted himself to Timmy.

Extreme skiing was Jacques' greatest passion in life. Extreme skiers are daring individuals who ski down impossibly steep cliffs to get a rush. Jacques introduced Timmy to the sport, thinking it might be a source of self-esteem. Timmy ***loved*** skiing and the two of them became the best of pals. Within a year, Timmy had won a local skiing competition and had turned his life around. Jacques and Timmy were even featured in a national magazine article about extreme skiing. Jacques was so proud of Timmy that when he and Madeline got married, Jacques made Timmy the best man at his wedding.

Four years later, after Jacques and Timmy had been skiing all day, Jacques said it was time to head home because they had plans to celebrate

Madeline's birthday. Timmy begged Jacques to go on one last run on an especially challenging slope. Although he was exhausted, Jacques didn't want to let Timmy down, so he reluctantly gave in. As they started down the slope, there was a small avalanche, and Timmy tumbled off a 200-foot cliff. Jacques was terrified and immediately called for the rescue team. Then he climbed down the cliff to provide first aid and comfort until the helicopter arrived. But it was too late. Timmy had broken his neck and died in Jacques' arms.

With tears streaming down his cheeks, Jacques told me how Timmy had saved up his money for months so he could buy the same kind of goggles that Jacques wore. He explained that Timmy had been extremely proud of his goggles and said, "Timmy looked at me lovingly through those goggles right up to the moment he died. That picture still haunts me. It seems like only yesterday."

Jacques kept hoping that it was a nightmare and that he'd soon wake up, but he never did. He said that the worst part was having to call Madeline and tell her that Timmy was dead. Jacques kept telling himself, "I've killed my wife's son and ruined her life." He couldn't get this thought out of his head and felt intensely guilty and ashamed. Madeline had also been depressed for the past eight years.

Jacques and Madeline had just had their tenth anniversary but weren't in the mood to celebrate. Of course, it was also hard to celebrate Madeline's birthdays. Jacques said, "This horror is always in our faces, and I constantly torture myself with what-ifs. What if we hadn't gone on that one last run? What if we'd gone home earlier, as I'd planned? What if we'd stuck to a less challenging slope?"

Jacques was afraid that other people would blame him for Timmy's death and was surprised when they didn't. He said:

> "I feel stupid, like Timmy's death is something to be ashamed of. It feels like a huge failure. A failure is something to be embarrassed about. I know that people can be irrational, and I expected people to be enraged and tell me that I'd been irresponsible. But no one criticized me or said that Timmy's death was my fault. Maybe they felt that way on the inside and just didn't tell me.
>
> "I was devastated, and friends told me that I had to grieve. They said it was the only way to get through the pain, so I cried for six months. There was no end to the tears, but it didn't do any good. Now I feel like there's no grief left, but I'm still depressed. When I think about Timmy, it's too much for me. It just kills me."

Jacques had also lost most of his motivation at work. He explained:

> "The biggest problem I have is not going for it at work. I'll probably make $100,000 this year, but I'm not focused and I'm not doing my best. I could earn a lot more. So this seems like another failure. I've just been in survival mode since Timmy died. Life gets long, and you can't always power through it."

Although he hadn't been throwing himself into his work, Jacques had been working with a volunteer organization raising money to buy wheelchairs for people in third-world countries. Many of the people who received wheelchairs had had their limbs blown off by American land mines. Jacque often delivered the

wheelchairs personally and had just returned from Afghanistan. He became animated as he described the gratitude of the people when they received their wheelchairs. He said that this activity, along with is skiing, had consumed his life. Earning money just didn't seem important any more.

Jacques had tried Prozac at the suggestion of his physician. At first, it seemed to be somewhat effective, but it soon stopped working, so he tapered off of it. He said he wasn't a great fan of pills, and wondered if there were any other ways to deal with his depression. I told Jacques that there were new psychotherapy tools that usually didn't require pills and explained that it wasn't unusual for people to recover quickly, sometimes in just a session or two. However, I told Jacques that in his case, I was reluctant to use these techniques. He seemed puzzled and asked why. I said:

> "Jacques, I have tremendous respect for you and what you've been doing with your life. Maybe the problem is not so much the fact that you've been depressed and grieving for the past eight years, but rather, that the rest of the world is not. It seems like an awful lot of people are out for themselves or busy waging war. And here you are responding to the suffering in the world. I'm thinking that the world needs more people like Jacques."

Jacques seemed touched by my comment. I added that his depression might also be his way of honoring Timmy and keeping Timmy's memory alive. After all, if Jacques got over his depression, he might have to say goodbye to Timmy and move forward with his life. Was that what he really wanted? Did he

feel ready to say goodbye to Timmy?

I suggested that there might be other reasons not to change as well, and asked Jacques if he could think of any. He said:

> "Oh yes, there's definitely a comfort in my depression, and I think I do have a fear of moving on. It feels safe, like I have something to hang on to. I'm afraid of loss of control. What if I take on too much? If I expanded my business, I'd have to hire a new employee. I don't want to have to take care of anyone. What if I let them down? I'm terribly afraid of that.
>
> "My worst nightmare is being responsible for more children, going broke, and living in a car, like a homeless family. That's a dominant theme in my life. What if I took on a commitment and couldn't keep it?"

I pointed out that these concerns showed us another positive aspect to his depression. He was being responsible and making sure that he didn't take on any risky commitments that he couldn't keep. Given all this, was he so sure that it would be wise to defeat his depression? Did he really want to give it up?

Jacques had come to me for the treatment of depression because he was suffering and stuck. Now I was telling him that it might not be a good idea to change. Why was I pursuing this theme?

First, I wanted to develop trust and rapport. I wanted Jacques to feel like he could open up and vent without being judged. Second, I wanted to head off any resistance at the pass. Although most patients are suffering, many of them have mixed feelings about change. They have one foot in the water and one foot

on the shore. Often, there are many compelling reasons ***not*** to change. If these reasons remain hidden, they can sabotage the therapy. If you bring them out into the open, they'll often lose their power.

Jacques had been telling himself that his depression was bad and that he ***shouldn't*** feel that way. He was telling himself that he ***should*** have gotten over it by now. He was also telling himself that he ***should*** be more involved in his career and earning more money. All these "should statements" intensified his depression because they made him feel like a failure. I used the opposite strategy. I told Jacques that it might not be smart to put an end to his depression. Paradoxically, the moment the patient sees that there are lots of good reasons ***not*** to change, they'll often feel much more motivated to change.

I call this process Agenda Setting. When you set the therapeutic agenda, you conceptualize the nature of the problem that the patient wants help with and pinpoint the most likely sources of resistance to change. Agenda Setting is more subtle and challenging than you might think. It doesn't just involve asking patients about their goals for therapy. You probably learned how to do that in your first psychology class in graduate school, and it's simple, like arithmetic. Agenda Setting is more like the advanced calculus of psychotherapy, and most therapists have a tough time learning it. It seems simple, but it's not. When therapy fails, it's nearly always because of errors the therapist has made in Agenda Setting, or the complete failure of the therapist to establish a meaningful therapeutic agenda in the first place. In contrast, if you've developed a warm and trusting therapeutic alliance, and headed off the resistance at the pass, the patient will respond much

more positively to the treatment.

My comments seemed to heighten Jacques' motivation. He said that he felt like he'd suffered enough, and that he could easily continue his charitable work and other activities even if he weren't depressed. This was the message I was hoping to hear.

Now imagine that you were Jacques' therapist. What would you do next? Remember, this is your first therapy session. You've evaluated the problem and developed a therapeutic alliance. Jacques seems ready and willing to change, but he's still depressed. How will you help him overcome his depression? Put your ideas below before you continue reading. Even if you don't yet have a clear treatment plan, just put something down.

Answer

There are many schools of therapy, and many ways of attacking any problem. From a cognitive therapy perspective, Jacques' depression was not the result of Timmy's death, but from the way he was thinking about it. As you probably know, cognitive therapy traces it's origins to the Greek philosophers, such as Epictetus who said: "People are disturbed, not by things, but by the views they take of them." Modern cognitive therapists have added an important twist to this theme: When people are suffering from depression, anxiety, or excessive anger, the negative thoughts that upset them are nearly always distorted and illogical.

I asked Jacques to record his negative thoughts and feelings about Timmy's death on a form I call Daily Mood Log (DML). Jacques' DML appears on pages 10 – 11. At the top of his DML, Jacques described the Upsetting Event as "Thinking about Timmy's death." I asked him to circle his negative feelings and rate how strong each one was, on a scale from 0% (not at all) to 100% (the worst). As you can see, he felt sad, anxious, guilty, worthless, lonely, embarrassed, discouraged, frustrated, and angry. His ratings indicated that all of these feelings were strong.

Each patient will have their own unique pattern of negative feelings. Some patients may be overwhelmed by one type of feeling, such as inferiority, anger, or anxiety, but most will have a blend of many different kinds of feelings. I call this their emotional architecture. Although the DML is a highly technical instrument, it allows you to develop incredibly accurate empathy because you'll see exactly

how each patient feels in a variety of dimensions, and precisely how intense each feeling is.

Next, I asked Jacques to record his negative thoughts (NTs) and indicate how strongly he believed each one, from 0% (not at all) to 100% (completely). You can prompt patients with questions like this: "When you're feeling guilty, what are you telling yourself? What negative thought is flowing across your mind?" You can ask similar questions for each of the patient's feelings, such as anxiety, hopelessness, or anger. According to Aaron Beck's theory of cognitive specificity, each type of feeling results from a specific type of cognition, or thought. For example, feelings of sadness or depression result from the perception of loss. Anxiety results from the prediction of danger. Guilt results from the belief that you've done something bad. Hopelessness results from the belief that things will never change and your suffering will go on forever. Anger results from the perception of unfairness, and frustration results from the idea that the world ***should*** measure up to your expectations.

You can see Jacques' NTs on pages 10 – 11. He was telling himself that he'd ruined Madeline's life, tainted his marriage, and failed Timmy. He was also telling himself that he didn't deserve to be happy and should be doing better in his career. Finally, he was telling himself that it would be selfish to share his feelings with Madeline. He believed all of these thoughts 100%. Asking patients about their negative thoughts provides you with another powerful empathy tool, because you'll see exactly what they're telling themselves and why they feel the way they do.

Jacques' Daily Mood Log*

Upsetting Event: Thinking about Timmy's death.

Emotions	% Before	% After	Emotions	% Before	% After
Sad, blue, depressed, down, unhappy	90%		**Hopeless,** discouraged, pessimistic, despairing	50%	
Anxious, worried, panicky, nervous, frightened	50%		**Frustrated,** stuck, thwarted, defeated	75%	
Guilty, remorseful, bad, ashamed	100%		**Angry,** mad, resentful, annoyed, irritated, upset, furious	50%	
Inferior worthless, inadequate, defective, incompetent	80%		**Other (describe)**		
Lonely, unloved, unwanted, rejected, alone, abandoned	90%		**Other**		
Embarrassed, foolish, humiliated, self-conscious	100%		**Other**		

Negative Thoughts (NTs)	% Belief Before	% Belief After	Distortions	Positive Thoughts (PTs)	% Belief
1. I ruined Madeline's life.	100%			**1.**	
2. This has tainted our marriage.	100%			**2.**	
3. I failed Timmy.	100%			**3.**	
4. I don't deserve a happy, normal life.	100%			**4.**	

Jacques' Daily Mood Log (cont'd)

Negative Thoughts (NTs)	% Belief Before	% Belief After	Distortions	Positive Thoughts (PTs)	% Belief
5. I'll never have a happy life.	100%			**5.**	
6. I'm using Timmy's death as an excuse.	100%			**6.**	
7. I should be doing a lot better with my career.	100%			**7.**	
8. It would be selfish to tell Madeline how I feel.	100%			**8.**	

Checklist of Cognitive Distortions *

1. All-or-Nothing Thinking. You look at things in absolute, black-and-white categories.	**6. Magnification and Minimization.** You blow things way out of proportion or shrink them.
2. Overgeneralization. You view a single negative event as a never-ending pattern of defeat.	**7. Emotional Reasoning.** You reason from your feelings: "I ***feel*** like an idiot, so I must ***be*** one."
3. Mental Filter. You dwell on the negatives and ignore the positives.	**8. Should Statements.** You use "shoulds," "shouldn'ts," "musts," "oughts," and "have tos."
4. Discounting the Positive. You insist that your positive qualities don't count.	**9. Labeling.** Instead of saying, "I made a mistake," you tell yourself, "I'm a jerk" or "I'm a loser."
5. Jumping to Conclusions. You jump to conclusions not warranted by the facts. • **Mind-Reading.** You assume that people are reacting negatively to you. • **Fortune-Telling.** You predict that things will turn out badly.	**10. Blame.** You assign fault instead of trying to solve the problem. • **Self-Blame.** You blame yourself for something you weren't entirely responsible for. • **Other-Blame.** You blame others and overlook how you contributed to the problem.

After patients record their NTs, they can identify the distortions in each one, using the Checklist of Cognitive Distortions on the second page of the DML. Check off all the distortions you can find in Jacques' NTs in the table below. You can refer to the definitions of the cognitive distortions on page 11.

Distortion	(✓)	Distortion	(✓)
1. All-or-Nothing Thinking (AON)		**6.** Magnification and Minimization (MAG / MIN)	
2. Overgeneralization (OG)		**7.** Emotional Reasoning (ER)	
3. Mental Filter (MF)		**8.** Should Statements (SH)	
4. Discounting the Positive (DP)		**9.** Labeling (LAB)	
5. Jumping to Conclusions • Mind-Reading (MR) • Fortune-Telling (FT)		**10.** Blame • Self-Blame (SB) • Other-Blame (OB)	

Answer

As you can see on page 13, Jacques NTs contain all ten distortions. This is not unusual. Patients can list the distortions in each NT in the Distortions column of the DML, using abbreviations, such as AON for All-or-Nothing Thinking and OG for Overgeneralization. Here are the distortions that Jacques identified in his first NT.

Negative Thoughts (NTs)	% Belief Before	% Belief After	Distortions
1. I ruined Madeline's life.	100%		AON; MF; DP; MR; MAG / MIN; ER; SH; LAB; SB

The most important and challenging step comes next: helping patients challenge their negative thoughts. I always ask patients what thought they want to work on first. Some therapists have told me that they always select the NT to

work on first, but this can be a mistake because challenging the thought suddenly becomes your agenda. This increases the likelihood that the patient will feel the need to "yes-but" and resist you. In contrast, if the patient selects the NT, this puts them in the position of asking for help and increases the probability of productive collaboration.

Jacques selected the first thought, "I ruined Madeline's life." Could he talk back to that thought? Was there another way to think about it? The patient can record the new thought in the Positive Thoughts column and indicate how strongly she or he believes it, between 0% (not at all) and 100% (completely).

In order to be helpful to the patient, the positive thought (PT) has to fulfill the necessary and sufficient conditions for emotional change:

- **The necessary condition.** The positive thought has to be 100% true. Rationalizations and half-truths won't be helpful.
- **The sufficient condition.** The positive thought has to put the lie to the negative thought. The moment the patient stops believing the negative thought, she or he will immediately feel better.

My colleagues and I have developed more than 50 techniques that can help patients develop positive thoughts that fulfill the necessary and sufficient conditions for emotional change. If you're curious, you can review these techniques on pages XX – XX. It's impossible to predict which technique will work for any patient or negative thought, so trial-and-error will be necessary.

Jacques Cognitive Distortions

Distortion	Yes	Explanation
1. All-or-Nothing Thinking (AON)	✓	Jacques is thinking about Madeline in black-and-white extremes. She was devastated by the tragic death of her son and may still be struggling with depression, but her life is not "ruined."
2. Overgeneralization (OG)	✓	Jacques generalizes from one event to his entire self. He believes that he failed Timmy and therefore, ***he*** is a failure.
3. Mental Filter (MF)	✓	Jacques ruminates about Timmy's death and all the things he might have done differently the day Timmy died. He also thinks about all the times Madeline has seemed to be feeling down when he tells himself that he ruined her life.
4. Discounting the Positive (DP)	✓	Jacques discounts the fact that he gave his heart to Timmy and helped him turned his life around. He also discounts the value of all the things he does for other people.
5. Jumping to Conclusions • **Mind-Reading (MR)** • **Fortune-Telling (FT)**	✓	Jacques assumes that others will blame him for Timmy's death (**Mind-Reading**) and also predicts that he'll never be happy again (**Fortune-Telling**).
6. Magnification and Minimization (MAG / MIN)	✓	Jacques magnifies the impact of his behavior on other people and overlooks the fact that he didn't actually cause the avalanche. He may also minimize other people's coping skills.
7. Emotional Reasoning (ER)	✓	He ***feels*** guilty and ashamed, so he assumes that he really ***is*** to blame for Timmy's death.
8. Should Statements (SH)	✓	Jacques believes that he ***should*** be more motivated and more productive, and should never fail or let anyone down. He also tells himself that he ***should not*** have gone on that final ski run with Jimmy.
9. Labeling (LAB)	✓	He tells himself that he's "ruined" Madeline's life.
10. Blame • **Self-Blame (SB)** • **Other-Blame (OB)**	✓	Jacques blames himself for all kinds of things he's not responsible for.

With a motivated patient like Jacques, one or two techniques will often be sufficient. If you have a really tough patient with Borderline Personality Disorder and multiple failed efforts at therapy in the past, you might need to try 15 or 20

techniques, or even more, before you find the one that works.

I tried the Straightforward Technique first. It's the most humble technique of all. When you use the Straightforward Technique, you simply ask the patient if they can think of a way to talk back to the negative thought. Here's how it went:

David: Jacques, when you tell yourself, "I ruined Madeline's life," how do you feel?

Jacques: I feel terrible. I feel guilty and ashamed.

David: Do you want to feel guilty and ashamed?

Jacques: No. I'm tired of feeling this way.

David: Would you be willing to feel happy if I could show you how?

Jacques: Definitely.

David: I want to make sure about this. Are you saying that you'd be willing to feel happy in spite of the fact that Timmy died?

Jacques: Yes, I think I've suffered enough.

David: Can you see that your negative thoughts, like "I ruined Madeline's life," are the real cause of your depression? In other words, although Timmy's death was a terrible tragedy, that's not why you're depressed. Your negative feelings result from the messages you're giving yourself. Does that make sense?

Jacques: I can see that. It hurts when I tell myself that I killed Timmy and ruined Madeline's life.

David: And even though those thoughts seem valid, they're not. In a way, you're fooling yourself. For example, we identified nine distortions in

the thought, "I ruined Madeline's life," so it's probably not nearly as valid as you think. Is there another way to look at it that would be more positive and realistic? What you could tell yourself instead?

Jacques: Maybe I could tell myself that Madeline and I have fun, and that I do bring good things to our marriage. I could also remind myself that I didn't cause that avalanche and couldn't have predicted it, and that I didn't really ruin Madeline's life.

David: That sounds good to me, but I want to know if you believe it. That's all that really counts. Do you believe what you just said? In other words, is it ***true*** that that you bring good things to your marriage, and that you and Madeline have fun? Is it true that you didn't cause the avalanche and couldn't have predicted it? Or are you just rationalizing?

Jacques: Those things are all true. I didn't cause the avalanche. In extreme skiing, you try to be careful, but there's always some risk involved.

I told Jacques to write these ideas in the Positive Thoughts column and indicate how strongly he believed them, from 0% to 100%. Here's how his DML looked now.

Negative Thoughts (NTs)	% Belief Before	% Belief After	Distortions	Positive Thoughts (PTs)	% Belief
1. I ruined Madeline's life.	100%		AON; MF; DP; MR; MAG / MIN; ER; SH; LAB; SB	**1.** Madeline and I have fun and I bring good things to our marriage. Timmy's death was a terrible tragedy, but I didn't cause that avalanche and I haven't really ruined Madeline's life.	100%

Jacques put 100% in the "% Belief" column because he believed what he'd written down. That meant that the positive thought fulfilled the necessary condition for emotional change. However, a PT will not be helpful unless it also fulfills the sufficient condition for emotional change. Do you remember what the sufficient condition is? Put your answer here before you continue reading:

Answer

In order to be helpful, the PT must put the lie to the NT. I asked Jacques how strongly he now believed the NT. As you can see on page 19, his belief in the NT fell to 0%. This meant that the PT fulfilled the sufficient condition for emotional change. In fact, Jacques told me that he was suddenly feeling better.

Because the Straightforward Technique worked so well, I used the same

technique to help Jacques challenge the rest of his NTs. As you can see on pages 19 – 20, he was able to put the lie to all of his negative thoughts. As a result, there was a significant reduction in his negative feelings. In fact, his feelings were in the normal range at this point.

You're probably aware that cognitive therapists focus on two different types of cognitions that can cause emotional distress. Negative thoughts trigger negative feelings in the here-and-now, but Self-Defeating Beliefs (SDBs) make people vulnerable to emotional distress in the first place. You'll find a list of common SDBs on page 21. Once you've pinpointed patients' SDBs, you'll understand why they became depressed, anxious, or angry.

For example, let's say that a patient has the Love Addiction. As long as she or he feels loved, this patient will probably feel reasonably happy and fulfilled. However, there's a good chance that rejection or the loss of a loved one will trigger feelings of depression. NTs and SDBs both play important roles in the treatment. When you change patients' NTs, they'll feel better. When you modify their SDBs, they'll become less vulnerable to painful mood swings in the future.

In the 1970's, I developed a neat way to identify Self-Defeating Beliefs called the Downward Arrow Technique. There are two versions: the Individual Downward Arrow Technique and the Interpersonal Downward Arrow Technique. The Individual Downward Arrow Technique leads to the SDBs that cause depression and anxiety, such as Perfectionism and the Achievement Addiction. These SDBs are nearly always self-esteem equations along these lines: "To be a worthwhile human being, I need X." X might be achievement, love, or approval.

Jacques' Daily Mood Log*

Upsetting Event: Thinking about Timmy's death.

Emotions	% Before	% After	Emotions	% Before	% After
Sad, blue, depressed, down, unhappy	90%	5%	**Hopeless,** discouraged, pessimistic, despairing	50%	0%
Anxious, worried, panicky, nervous, frightened	50%	5%	**Frustrated,** stuck, thwarted, defeated	75%	15%
Guilty, remorseful, bad, ashamed	100%	0%	**Angry,** mad, resentful, annoyed, irritated, upset, furious	50%	10%
Inferior, worthless, inadequate, defective, incompetent	80%	0%	**Other (describe)**		
Lonely, unloved, unwanted, rejected, alone, abandoned	90%	10%	**Other**		
Embarrassed, foolish, humiliated, self-conscious	100%	0%	**Other**		

Negative Thoughts (NTs)	% Belief Before	% Belief After	Distortions	Positive Thoughts (PTs)	% Belief
1. I ruined Madeline's life.	100%	0%	AON; MF; DP; MR; MAG / MIN; ER; SH; LAB; SB	**1.** Madeline and I have fun and I bring good things to our marriage. Timmy's death was a terrible tragedy, but I didn't cause that avalanche and I haven't really ruined Madeline's life.	100%
2. This has tainted our marriage.	100%	20%	AON; DP; MR; ER; SH; LAB; SB	**2.** Timmy's death was an enormous loss for both of us and it's been a terrible burden. Maybe Madeline and I need to talk about how we've been feeling instead of avoiding the issue.	100%
3. I failed Timmy.	100%	0%	AON; DP; MR; ER; SH; LAB; SB	3. I gave Timmy the best that I had. He died because of an avalanche and not because of any failure on my part. Our relationship was very loving and hardly a failure. I helped him turn his life around.	100%

Jacques' Daily Mood Log (cont'd)

Negative Thoughts (NTs)	% Belief Before	% Belief After	Distortions	Positive Thoughts (PTs)	% Belief
4. I don't deserve a happy, normal life.	100%	0%	DP; ER; SB	**4.** That's ridiculous.	100%
5. I'll never have a happy life.	100%	10%	AON; DP; FT; ER	**5.** I'm feeling better already. Furthermore, there are many things I enjoy a lot, like skiing.	100%
6. I'm using Timmy's death as an excuse.	100%	25%	ER; SH; SB	**6.** There's some truth in that. I've felt pretty depressed since Timmy died and that's made it a lot harder to do some of the things that used to seem important.	100%
7. I should be doing a lot better with my career.	100%	25%	DP; SH; SB	**7.** It would be great to be doing better with my career, but I'm actually doing reasonably well and I'm involved in lots of activities that are important to me.	100%
8. It would be selfish to tell Madeline how I feel.	100%	10%	MR; FT; SH; SB	**8.** It would be scary, but we might end up feeling closer. I don't have any real evidence that telling Madeline how I feel would be selfish. In fact, talking things out might be helpful to both of us. She might appreciate the chance to open up and feel close.	100%

Common Self-Defeating Beliefs (SDBs)*

Achievement

1. **Perfectionism.** I must never fail or make a mistake.
2. **Perceived Perfectionism.** People will not love and accept me as a flawed and vulnerable human being.
3. **Achievement Addiction.** My worth depends on my achievements, intelligence, talent, status, income, or looks.

Love

4. **Approval Addiction.** I need everyone's approval in order to be worthwhile.
5. **Love Addiction.** I can't feel happy or fulfilled if I'm not loved. If I'm not loved, then life is not worth living.
6. **Fear of Rejection.** If you reject me, it proves that there's something wrong with me. If I'm alone, I'm bound to feel miserable and worthless.

Submissiveness

7. **Pleasing Others.** I should always try to please others, even if I make myself miserable in the process.
8. **Conflict Phobia.** People who love each other shouldn't fight.
9. **Self-Blame.** The problems in my relationships are bound to be my fault.

Demandingness

10. **Other-Blame.** The problems in my relationships are bound to be the other person's fault.
11. **Entitlement.** You should always treat me in the way I expect.
12. **Truth.** I'm right and you're wrong.

Depression

13. **Hopelessness.** My problems could never be solved. I'll never feel happy or fulfilled.
14. **Worthlessness / Inferiority.** I'm basically worthless, defective, and inferior to others.

Anxiety

15. **Emotional Perfectionism.** I should always feel happy, confident, and in control.
16. **Anger Phobia.** Anger is dangerous and should be avoided at all costs.
17. **Emotophobia.** I should never feel sad, anxious, inadequate, jealous, or vulnerable. I should sweep my feelings under the rug and not upset anyone.
18. **Perceived Narcissism.** The people I care about are demanding, manipulative, and powerful. It's too dangerous to tell them how I really feel.
19. **Spotlight Fallacy.** Talking to people feels like having to perform under a bright spotlight on a stage. If I don't impress people by being sophisticated, witty, or interesting, they won't like me. But I won't be able to impress them, so they'll get turned off.
20. **Brushfire Fallacy.** People are clones who all think alike. If one person looks down on me, the word will spread like brushfire and pretty soon, everyone will be looking down on me.
21. **Magical Thinking.** If I worry enough, everything will turn out okay.

Other

22. **Low Frustration Tolerance.** I should never be frustrated. Life should always be easy.
23. **Superman / Superwoman.** I should always be strong and never be weak.

In contrast, the Interpersonal Downward Arrow Technique leads to the SDBs that trigger relationship problems, such as Entitlement and Submissiveness. These SDBs are generally expectations about personal relationships, and they typically include three components: the role that you think you're supposed to play in the relationship, the role that you think the other person plays, and the rules that connect the two roles.

When you use either version of the Downward Arrow Technique, you always start with an NT that's causing distress. I ask patients if they'd like to examine one of their negative thoughts more deeply so we can take a peek at what's under the surface. You may recall that Jacques hadn't been feeling very motivated about his work, even though he'd been doing fairly well and felt he could easily expand his business. However, this would mean that he'd have to hire a new employee. He'd been feeling anxious about this prospect because of his thought, "What if I took on a commitment and couldn't keep it?" I wanted to know why this thought was bothering him, so I asked him to write it down in the NT column of a new DML and draw a downward arrow underneath it. The arrow is shorthand for these kinds of questions: "Let's assume that this was true. Why would it be upsetting to you? What would it mean to you?"

When you ask these questions, a new negative thought will pop into the patient's mind. Tell the patient to write the new thought under the arrow and draw another arrow underneath it. Ask similar kinds of questions and a new thought will pop into the patient's mind. Repeat this process over and over until you reach a statement like, "That would mean I was worthless," or "Then I'd be miserable forever." When you review the chain of negative thoughts that the patient has

generated, it will usually be easy to identify his or her Self-Defeating Beliefs. Here's what happened when Jacques and I used the Downward Arrow Technique:

David: Jacques, you seem to be afraid that if you took on a new commitment, you might not be able to keep it. Let's assume that this happened. You take on a new commitment, but you can't keep it. Why would that be upsetting to you? What would it mean to you?

Jacques: That would mean that I wasn't a responsible man.

David: Good. Write that thought down and draw another arrow underneath it. Now, let's assume that you weren't a responsible man. Why would that be upsetting to you? What would it mean to you?

Jacques: Other people would see me that way and I'd be humiliated.

David: Write that down and draw another arrow underneath it. Let's assume that other people decided that you weren't a responsible man. Why would that be humiliating to you? What would you be thinking?

Jacques: People would look down on me.

David: Okay, write that down. And if people really were looking down on you, what would that mean to you? Why would that be upsetting to you?

Jacques: I couldn't face them. I couldn't stand it.

David: Write that down, and then tell me why you couldn't face them. What would you be telling yourself? What would you be afraid of?

Jacques: I'd be ostracized. No one would respect me. I'd be alone.

David: That sounds upsetting. Write it down, and we'll see if we can take this one step further. Let's assume that all of this happened. You couldn't

keep a commitment, so everyone loses respect for you and you end up all alone. Why would that be upsetting? What would it mean to you?

Jacques: It would mean I was worthless, and I'd be miserable forever.

With this thought, we'd finally hit the bottom of the barrel. Now let's see if we can identify his SDBs. First, review the chain of thoughts that Jacques and I generated on page 24, and then look at the list of SDBs on page 21. List a few of Jacques' SDBs here. When you're done, you can see my list on page 25.

1. _____

2. _____

3. _____

4. _____

5. _____

Jacques' Downward Arrow Chain

1. "What if I took on a commitment and couldn't keep it?"

↓

2. "That would mean that that I wasn't a responsible man."

↓

3. "Other people would see me that way and I'd be humiliated."

↓

4. "People would look down on me."

↓

5. "I couldn't face them. I couldn't stand it."

↓

6. "I'd be ostracized. No one would respect me. I'd be alone."

↓

7. "That would mean I was worthless, and I'd be miserable forever."

Answer

Here are some SDBs that Jacques and I identified:

1. **Perfectionism.** Jacques believes he must never fail or make a mistake.
2. **Perceived Perfectionism.** He believes that others will judge him as harshly as he judges himself.
3. **Achievement Addiction.** Jacques seems to base his self-esteem on his work.
4. **Approval Addiction.** He also seems to base his self-esteem on getting everyone's approval.
5. **Fear of Rejection.** He believes that if anyone rejected him, it would mean he was worthless and doomed to a life of misery.
6. **Self-Blame.** He blames himself for things that he's not entirely responsible for.
7. **Brushfire Fallacy.** He believes that any disapproval or criticism will spread like brushfire, and soon everyone will feel the same way about him.
8. **Superman / Superwoman.** He feels like he should always succeed and never fail.

As you can see, most of Jacques' SDBs are yardsticks he uses to measure his value as a human being. He's telling himself that he has to be perfect, a kind of superman who always finds a way to help people in distress. He also imagines that others are intensely judgmental and will ostracize him if he fails to live up to their expectations.

We can also use the Interpersonal Downward Arrow Technique to look more deeply into Jacques' beliefs about the role he plays in his relationships with others. When you use the Interpersonal Downward Arrow Technique, you ask the patient three types of questions:

1. What do these thoughts tell us about the role you play in your relationships with other people?

2. In your mind's eye, what role does the other person play?

3. What do these thoughts tell us about your view of intimate relationships?

How would you answer these questions for Jacques? Jot your ideas here before you continue reading. Don't worry about getting it "right." There really are no "correct" answers, so you can't go wrong.

1. How does Jacques see his role in close, personal relationships?

2. How does Jacques see the other person's role?

3. How does Jacques view the nature of an intimate relationship? What are the rules that connect him with the people he cares about?

Answer

There are no purely "right" or "wrong" answers, and I always brainstorm about these questions with the patient. It's a collaborative effort. Here's what Jacques and I came up with. He thinks that it's his duty to take care of other people. He sees himself as the strong one, the protector, the caregiver. At the same time, he sometimes thinks that the people he cares about are weak and needy. In his mind's eye, the nature of a close relationship is to help others, much like a mentorship. In other words, he nurtures, and the other person feels appreciative and grows. For Jacques, loving and helping are closely intertwined.

SDBs aren't purely good or bad. They represent a mixture of healthy and unhealthy elements. On the positive side, Jacques' beliefs about relationships boost his self-esteem and make him feel important. After all, he's always playing the role of the strong one. In addition, he ends up doing thoughtful, loving things for others, like Timmy, as well as people in third-world countries who are suffering.

On the negative side, Jacques feels that if he doesn't take care of other people, there may be catastrophic consequences. He'll be branded as a failure, cast out, and ostracized, so this mindset puts him under tremendous pressure and makes his relationships feel burdensome and dangerous. In fact, this belief seems to be holding him back in his career, because he's afraid of taking on a new employee and letting that person down. This may be why it's been so hard for him to resolve his grief about Timmy's death. Timmy's death feels like a personal failure to Jacques.

This mindset may help to explain his concerns about his marriage as well.

Jacques thinks that he's ruined Madeline's life, so he carries enormous guilt. In his mind's eye, he's always supposed to be the strong one, so we might wonder how he receives support when he's feeling down. That may be why he's never discussed his feelings with Madeline—because he thinks he's not allowed to be weak or ask for anyone else's support. He always has to tough it out alone.

Before the session started, I'd asked Jacques to complete an assessment instrument called the Brief Mood Survey, which you can see on page 29. It only takes about a minute to fill out. Jacques' scores indicated that he was feeling moderately depressed, mildly anxious, and somewhat angry at the start of our session. He said that he'd been feeling that way for the previous eight years. His responses on the Relationship Satisfaction test at the bottom indicated that he was also experiencing some marital dissatisfaction. I asked him to complete the Brief Mood Survey again in the waiting room before he left, using the "After Session" section, and to leave it in my box so I could review it. If you compare Jacques' "Before Session" and "After Session" scores on page 29, you'll see that all of his symptoms had disappeared by the end of the session.

I ask all of my patients to complete the Brief Mood Survey immediately before and after every therapy session. They do it on their own, in the waiting room, so it doesn't detract from the time we spend together during the session. You'll notice that the instructions ask patients to indicate how they're feeling ***right now***, at this very moment, so it will show you precisely how much progress you made—or failed to make—during each session.

Name: _____ **Date:** _____

Brief Mood Survey*

Instructions. Use checks (✓) to indicate how you're feeling ***right now***. Please answer all the items.

How depressed do you feel *right now?*	Before Session					After Session				
	0—Not at all	1—Somewhat	2—Moderately	3—A lot	4—Extremely	0—Not at all	1—Somewhat	2—Moderately	3—A lot	4—Extremely
1. Sad or down in the dumps				✓		✓				
2. Discouraged or hopeless			✓			✓				
3. Low self-esteem			✓			✓				
4. Worthless or inadequate			✓			✓				
5. Loss of pleasure or satisfaction in life		✓				✓				
			Total ➔	10				Total ➔	0	

How suicidal do you feel *right now*?										
1. Do you have any suicidal thoughts?	✓					✓				
2. Would you like to end your life?	✓					✓				
			Total ➔	0				Total ➔	0	

How anxious do you feel *right now*?										
1. Anxious			✓			✓				
2. Frightened		✓				✓				
3. Worrying about things		✓				✓				
4. Tense or on edge			✓			✓				
5. Nervous			✓			✓				
			Total ➔	8				Total ➔	0	

How angry do you feel *right now*?										
1. Frustrated		✓				✓				
2. Annoyed	✓					✓				
3. Resentful	✓					✓				
4. Angry	✓					✓				
5. Irritated		✓				✓				
			Total ➔	2				Total ➔	0	

Relationship Satisfaction*

Put the name of someone you care about here:

_____

Use checks (✓) to indicate how satisfied or dissatisfied you feel about this relationship.

Please answer all five items.

	Before Session							After Session						
	0—Very Dissatisfied	1—Moderately Dissatisfied	2—Somewhat Dissatisfied	3—Neutral	4—Somewhat Satisfied	5—Moderately Satisfied	6—Very Satisfied	0—Very Dissatisfied	1—Moderately Dissatisfied	2—Somewhat Dissatisfied	3—Neutral	4—Somewhat Satisfied	5—Moderately Satisfied	6—Very Satisfied
1. Communication and openness					✓								✓	
2. Resolving conflicts and arguments						✓								✓
3. Degree of affection and caring					✓									✓
4. Intimacy and closeness				✓									✓	
5. Overall satisfaction				✓									✓	
				Total ➔	19							Total ➔	27	

Evaluation of Therapy Session*

Instructions. Use checks (✓) to indicate how you felt about your most recent therapy session. Please answer all the items.

Therapeutic Empathy

		0–Not at all true	1–Somewhat true	2–Moderately true	3–Very true	4–Completely true
1.	My therapist seemed warm, supportive, and concerned.					✓
2.	My therapist seemed trustworthy.					✓
3.	My therapist treated me with respect.					✓
4.	My therapist did a good job of listening.					✓
5.	My therapist understood how I felt inside.					✓
				Total ➔		**20**

Helpfulness of the Session

1.	I was able to express my feelings during the session.					✓
2.	I talked about the problems that are bothering me.					✓
3.	The techniques we used were helpful.					✓
4.	The approach my therapist used made sense.					✓
5.	I learned some new ways to deal with my problems.					✓
				Total ➔		**20**

Satisfaction with Today's Session

1.	I believe the session was helpful to me.					✓
2.	Overall, I was satisfied with today's session.					✓
				Total ➔		**8**

Your Commitment

1.	I plan to do therapy homework before the next session.					✓
2.	I intend to use what I learned in today's session.					✓
				Total ➔		**8**

Negative Feelings During the Session

1.	At times, my therapist didn't seem to understand how I felt.	✓				
2.	At times, I felt uncomfortable during the session.	✓				
3.	I didn't always agree with my therapist.	✓				
				Total ➔		**12**

Difficulties with the Questions

1.	It was hard to answer some of these questions honestly.	✓				
2.	Sometimes my answers didn't show how I really felt inside.	✓				
3.	It would be too upsetting for me to criticize my therapist.	✓				
				Total ➔		**12**

What did you like ***the least*** about the session? It was painful talking about Timmy's death.

What did you like ***the most*** about the session? I felt a tremendous sense of relief when we challenged my negative thoughts. My depression has finally lifted!

I also ask patients to complete the Evaluation of Therapy Session at the end of each session. As you can see on page 30, this instrument assesses patients' perceptions of therapeutic empathy, the helpfulness of the session, their feelings of satisfaction with the session, and their commitment to doing psychotherapy homework between sessions. It also assesses any negative feelings that surfaced during the session as well as patients' honesty and openness when completing the survey. At the bottom, they can tell you what they disliked and liked about the session. The information is invaluable. It's like having a superb psychotherapy supervisor at every session who will tell you what you did right and what you did wrong.

As you can see on page 30, Jacques' ratings indicated that he felt cared about and understood and found the session helpful. He was satisfied with the work we did, committed to doing the psychotherapy homework, and seemed to have no negative feelings about me during the session. He also indicated that he had no trouble being honest and open when he completed the survey.

Jacques called the next day to say that he'd been on a high ever since our session. He said that he'd been feeling incredibly happy and more in love with Madeline than ever. He was talking to people all day long and enjoying everyone he interacted with. He was also feeling extra-creative, and several new business opportunities had already begun to develop even though he wasn't pushing himself to work any harder. I encouraged him to use the Daily Mood Log whenever he felt upset so he could practice the skills he'd learned during our session, and promised I'd review his work with him the next time we met.

The following week, Jacques was still doing well. He explained the changes he'd experienced like this:

> "I was a little dazed at the end of our session, but there was such a sudden and huge shift in my point of view. My depression felt like an earth ball—it seemed so huge that I just couldn't control it or get my arms around it. I was focusing on every little negative thing in my life. Now I see that a bad month in business is just that—a bad month. That doesn't mean that you're doomed or that the next month will be the same. I just ask myself what I can do to fix the problem."

Jacques also explained that Madeline had an older son, Alfred, and that Alfred's wife, Julie, was pregnant for the first time. Since Julie's father had recently died of cancer, this meant that Jacques would be the baby's only grandfather. Jacques said he was excited about the prospect of having a grandson. In addition, he'd read in the paper that a local civic group was sponsoring a "Fishing Day" for boys and girls without fathers, and they needed men who were interested in adopting a child for the day. Jacques showed up early Saturday morning and spent the entire day fishing with a seven year-old Korean boy named Bae, which means "inspiration" in Korean. Jacques said that they didn't catch a single fish, but they had a ball. In fact, it was one of the happiest days of his life. Jacques planned to spend more time with Bae.

Jacques said that he'd only worked on one DML since his last session since there wasn't much of anything that he'd been feeling upset about. As you can see on page 34, the Upsetting Event was simply "Receiving a complement

from Dr. Burns during our last session." Jacques was feeling a bit down, anxious, guilty, inadequate, and frustrated. He was telling himself that he was lazy, that he didn't care about other people as much as he should, and that he'd been fooling all the people who respected him. After he identified the distortions in these thoughts, he tried to talk back to the first one, "I'm lazy." As you can see, he came up with this PT: "I do a lot with my life. I'm physically fit, I've accomplished a lot, and I make a good living." Although he believed this thought 100%, it didn't reduce his belief in the NT very much. This is common. It means that the PT fulfilled the necessary, but not the sufficient, condition for emotional change.

You can use one of two strategies when you challenge a negative thought, and they're the opposite of each other. I call them the Self-Defense Paradigm and the Acceptance Paradox. When you use the Self-Defense Paradigm, you argue with the NT and try to prove that it's false. Sometimes, this strategy is effective. In fact, Jacques had used this strategy effectively during our first session. However, the Self-Defense Paradigm isn't always effective.

When you use the Acceptance Paradox, you use the opposite strategy. Instead of arguing with the NT, you befriend it and find some truth in it. You accept the thought with a sense of humor and inner peace. For many NTs, the Acceptance Paradox is far more effective than the Self-Defense Paradigm. I decided to illustrate the Acceptance Paradox with the Externalization of Voices. The Externalization of Voices was one of the first CBT techniques I developed in the mid-1970s, and it's arguably the most powerful CBT technique of all. It helps transform intellectual understanding into emotional change at the gut level.

Jacques' Daily Mood Log*

Upsetting Event: Receiving a complement from Dr. Burns during our last session.

Emotions	% Before	% After	Emotions	% Before	% After
Sad, blue, depressed, down, unhappy	20%		**Hopeless,** discouraged, pessimistic, despairing		
Anxious, worried, panicky, nervous, frightened	25%		**Frustrated,** stuck, thwarted, defeated	25%	
Guilty, remorseful, bad, ashamed	20%		**Angry,** mad, resentful, annoyed, irritated, upset, furious		
Inferior, worthless, inadequate, defective, incompetent	25%		**Other (describe)**		
Lonely, unloved, unwanted, rejected, alone, abandoned			**Other**		
Embarrassed, foolish, humiliated, self-conscious			**Other**		

Negative Thoughts (NTs)	% Belief Before	% Belief After	Distortions	Positive Thoughts (PTs)	% Belief
1. I'm lazy.	90%	80%	AON; MF; DP; MR; ER; SH; LAB; SB	**1.** I do a lot with my life. I'm physically fit, I've accomplished a lot, and I make a good living.	100%
2. I'm not nearly that great.	80%		ER; LAB; SB	**2.**	
3. I've fooled all the people who respect me.	80%		MR; SH; SB	**3.**	
4. I won't be able to keep all this success and approval going.	80%		FT	**4.**	
5. I'll fail.	70%		FT	**5.**	
6. I don't really care that much about other people. In fact, I could have done more when my Mom was sick.	90%		AON; DP; MIN; ER; SH; SB	**6.**	

When you use the Externalization of Voices, tell your patient that you're going to engage in an unusual kind of role-playing exercise, and that the two of you will represent the two voices in the patient's mind—the negative, self-critical voice, and the positive, self-loving voice. I told Jacques that I wanted him to play the role of his negative thoughts, and I'd play the role of his positive thoughts. His job would be to attack me, using the second-person, "You." In other words, he'd verbalize his NTs, but would talk to me as if I were another person and say things like "You're lazy." I explained that I'd respond in the first-person, using "I," and show him an entirely different way of defeating his NTs. I emphasized that although it would sound like two people engaged in battle, this really Jacques battling with himself. Here's how our dialogue went:

Jacques (playing the role of Jacques' NTs): You know, Jacques, you're really kind of a lazy guy.

David (playing the role of Jacques' PTs): As a matter of fact, you're right. Lots of people are far more ambitious and hardworking than I am. In fact, laziness is one of my lesser flaws. I have lots of others that are far worse than that!

This response tickled Jacques' funny bone and he started giggling. He said that he liked the Acceptance Paradox and could see that it was more effective than trying to defend himself, so I asked him to continue to attack me:

Jacques (as NTs): But you have to face the truth about yourself. You're not nearly as great as people think you are. You've fooled a lot of people.

David (as PTs): You're right again. I'm not really great at all. I'm just an

ordinary human being, and if anyone thinks I'm great, then I've ***definitely*** fooled them.

Jacques started laughing again, and I did, too. Laughter can be infectious! I told Jacques to keep attacking me and to say the worst possible things he could think of, and that I'd continue to play the role of the positive, self-loving voice in his mind.

Jacques (as NTs): But you're not committed to your career. All you want to do is put in the minimum amount of time at work and then go skiing. If we let you, you'd probably spend all your time skiing and never do any work at all, like some kind of ski bum!

David (as PTs): Boy, I'll have to plead guilty as accused on that one. Skiing every day without having to work sounds like paradise. I'd ***definitely*** be a ski bum if I had the chance.

Jacques (as NTs): But you pretend that you care for other people when you really don't. You don't care for other people nearly as much as you should.

David (as PTs): You're right. I'm not nearly as caring as I ought to be. In fact, there are a fair number of people I don't like at all. And sometimes, I even ***enjoy*** not liking them!

At this point, we both started laughing so hard that we couldn't stop. Jacques laughed so hard that he practically fell out of his chair. I believe that laughter can be a healing force that teaches us something on a deep level that cannot easily be communicated in words. In fact, the Buddhists call this type of

experience "laughing enlightenment."

To make sure that Jacques had really grasped the Acceptance Paradox, we did a role-reversal. I played the role of his NTs, and he played the role of his PTs. He did well and easily defeated every criticism I threw at him. That's one of the great things about the Externalization of Voices. It produces dramatic changes rapidly and provides you with a kind of quality control, because you'll find out right away if the patient really "got it."

That was our last therapy session. All of Jacques' scores on the Brief Mood Survey remained at zero, which meant that he was completely symptom-free, and his ratings on the Evaluation of Therapy Session were extremely high as well. Although it certainly isn't possible to help every patient in two sessions, fast and dramatic changes are far more common than they used to be due to several innovations in the treatment methods.

Let's briefly review my two sessions with Jacques so I can highlight a few of these new techniques. First, I measured how depressed, anxious, and angry Jacques was feeling at the start and end of each therapy session using the Brief Mood Survey. This allowed me to see precisely how upset he was and assess how much progress we made at each session. More than anything else, I believe that the assessment of symptoms at the start and end of every session, along with the patient's perceptions of the therapeutic alliance at the end of every session, has revolutionized the treatment.

You may be concerned that your patients will not be honest when they fill out these scales and will simply tell you what they think you want to hear. This

concern is not consistent with clinical experience. The real problem is that your patients will probably tell you what you ***don't*** want to hear. For example, when clinicians use the Evaluation of Therapy Session for the first time, most of them receive failing grades from nearly all of their patients on all of the subscales, including the Therapeutic Empathy scale. This can be a shock to the system. Many clinicians have told me that they feel ashamed, embarrassed, or even angry when they review the way their patients' rated them at the end of the session. In fact, it's so upsetting that some clinicians have refused to use these instruments. However, the good news is that if you use these instruments regularly with all your patients, and work with the empathy and agenda setting training exercises that I'll describe later on, your ratings will improve dramatically, along with your therapeutic effectiveness and satisfaction with your clinical wok.

Second, I attempted to establish a warm and trusting therapeutic alliance. I wanted Jacques to feel that he could trust me and tell me how he was really feeling inside. It requires a high degree of therapeutic skill to establish a warm therapeutic alliance with patients who feel angry, hopeless, and mistrustful. Jacques was friendly and outgoing, so it was easy to establish a good relationship with him.

Third, I headed off Jacques' resistance at the pass. Although he'd been suffering from feelings of depression and guilt for eight years, there were lots of reasons ***not*** to change. When we brought them to conscious awareness, they seemed to lose their power over him.

Notice that I didn't try to cheer Jacques up or persuade him to change.

Instead, I pointed out that his depression had many real benefits. This reduced some of the shame he was feeling, since he'd been telling himself that he ***shouldn't*** feel so depressed. It also put Jacques in the driver's seat and allowed him to decide what he wanted from the therapy. When I became the voice of his resistance, he had to persuade me to work with him. This paradoxical strategy prevented us from locking horns and intensified his determination to move forward with his life. However, I wasn't using paradox in a gimmicky way. I genuinely admired Jacques and felt that the benefits of his depression were real.

Fourth, I used a variety of methods to help Jacques modify his negative thoughts and Self-Defeating Beliefs. These included Identify the Distortions, the Individual and Interpersonal Downward Arrow Techniques, the Straightforward Technique, the Externalization of Voices, and the Acceptance Paradox, as well as a few others. There were many more techniques I could have used, but they weren't necessary because Jacques' depression dissolved quickly.

My work with Jacques also illustrates some changes in the structure of the treatment. I met with him for two hours at each session instead of an hour. I've never been convinced that hour-long sessions made much sense, at least for the type of work I do, and I'm not aware of any research that has ever supported the efficacy of weekly meetings for an hour. It often takes patients 45 minutes or more just to talk and get things off their chests. By that time, you only have five or ten minutes left to do any cognitive restructuring, behavior modification, or communication training because the session is almost over. By the time the next session rolls around, you and your patient can barely remember what you talked

about the week before, so you have to start all over again. This is a very inefficient way of doing psychotherapy, particularly if you believe that learning is an essential element of effective treatment.

If, in contrast, you meet for two hours, you'll have time to listen while the patient vents, and you'll still have time to do productive technical work using CBT techniques. The treatment becomes far more efficient, and most patients will recover quickly, often in just a few sessions, as opposed to the months or years of slow sledding and frustration that characterize conventional psychotherapy.

If Jacques and I could have met daily, instead of weekly, I'm convinced that he could have completed his treatment in two days rather than a week. This intensive approach actually lowers the cost of treatment, because many patients will recover quickly. All of Jacques' symptoms had disappeared by the end of the first session, and the entire course of treatment only required two sessions. You may wonder whether rapid recovery lasts, or whether it's just a flash in the pan. In fact, Jacques has continued to do well since we completed our work together, and has not needed any further treatment. Of course, no one can be happy all the time, and if Jacques needs a tune-up at any point in the future, we'll do it.

The long-term prognosis for any patient seems to depend on two factors. First, rapid and complete recovery predicts sustained, long-term improvement with fewer relapses, as compared with patients who fail to achieve total remission. In contrast, prolonged treatment without complete recovery predicts frequent relapses and a poor prognosis. This may be because ineffective treatment reinforces patients' feelings of hopelessness and helplessness.

Second, patients who receive effective Relapse Prevention Training prior to termination do far better in the long-term than patients who do not receive this training. I define a relapse as one minute or more of feeling lousy. Given this definition, we'll ***all*** relapse from time to time. That's just the human condition. No one can feel happy all the time. The question is not whether this patient will relapse, but rather, will she or he have the tools to deal with painful mood swings in the future?

The Relapse Prevention Training techniques only take about 30 minutes and seem to be effective. I'll describe these techniques in a future chapter, and I hope you'll start using them in your clinical work. I've had more than 35,000 therapy sessions with patients who were suffering from depression and anxiety disorders, and I've ***always*** done Relapse Prevention Training at the last session, prior to termination. I can count on two hands the number of patients who have returned for tune-ups following the completion of treatment. In nearly all cases, these patients were able to overcome their relapses within one or two additional sessions. Although my clinical experiences obviously do not have the stature of a controlled outcome study, the data are certainly encouraging.