

Can Depression Be Treated Successfully in Two Hours?

TEAM-CBT Therapy Provides Hope for High-Speed Recovery Without Drugs*

An Interview with David D. Burns, MD

I am deeply indebted to Lisa Kelley for this interview. Lisa is a certified TEAM-CBT therapist and former news reporter from Littleton, Colorado. Before attending one of my recent workshops, Lisa asked whether depression could really be treated in two hours. Based on the lively dialogue that ensued, we decided to create an interview to address that question and others that people may have about the new TEAM-CBT therapy.

Lisa: You recently asked this question in a survey on your website, www.feelinggood.com: “Do you believe that a depressed individual could experience a complete elimination of symptoms in a single, two-hour therapy session?” How did people respond?

David: Nearly 5,000 individuals have responded so far, indicating quite a bit of interest in this question. However, nearly 70% of them thought that single-session recovery was unlikely or impossible, and many of those individuals also thought the notion sounded just plain “crazy.”

Fewer than 30% of the respondents thought it *could* happen, but almost half of those were convinced that the results would not last.

It looks like most people were quite skeptical.

Absolutely. Most people assume that the treatment of depression has to be a long, slow process.

What’s your opinion? Can depression be treated in a single session?

If you had asked me ten years ago I would have said definitely not, and I would have thought that anyone who made such a claim was a con artist. But based on my recent therapy experiences, I would have to say that sometimes it *is* possible. I am aware that this claim may sound bizarre, and I hope people won’t think I’m some kind of nut!

Why do you think it’s possible?

I believe it’s possible because I’ve seen it happen repeatedly. Although I’m no longer in private practice, I still do a lot of therapy. Much of the therapy I do is in the context of my teaching. For example, in my workshops for mental health professionals, I often do a live demonstration with a volunteer from the audience on the evening of the first day of the workshop.

Because my most recent workshop is on the topic of trauma, the volunteers for these sessions are usually individuals with significant depression and anxiety who have experienced severe traumas.

What kinds of traumas?

Just about anything--rape, childhood sexual abuse, horrific medical problems, serious injuries from auto accidents, heart-wrenching family tragedies, homelessness, vicious assaults, and so forth. In most cases, these individuals have experienced a complete, or near-complete, elimination of symptoms in a single session lasting approximately two hours.

What do you mean by “in most cases”? Can you be more specific.

I've done at least 50 of these live therapy demonstrations in the last few years, and I've seen pretty dramatic results roughly 90% of the time.

You say you've seen dramatic reductions in symptoms. What kinds of symptoms are you referring to?

The symptoms usually include moderate to severe depression and anxiety, along with feelings of worthlessness, defectiveness, loneliness, humiliation, hopelessness, frustration and anger. Many of these individuals have experienced years, or even decades, of failed treatment with psychotherapy, and sometimes medications as well, prior to attending the workshop.

And you are claiming that these symptoms improve significantly in just one session?

Yes. And the changes can be profound.

How can you be sure?

In the last few years, I have developed a new, data-driven form of psychotherapy called TEAM-CBT. TEAM stands for the key elements of therapeutic success or failure: T = Testing, E = Empathy, A = Paradoxical Agenda Setting, and M = Methods.

One of the unique features of TEAM-CBT is that we measure the severity of depression, anxiety, and anger, as well as suicidal urges, at the start and end of every therapy session using brief, sensitive scales. That's the T = Testing component. It's like having an emotional x-ray machine, so therapists can see, for the first time, exactly how effective, or ineffective, they've been in every therapy session.

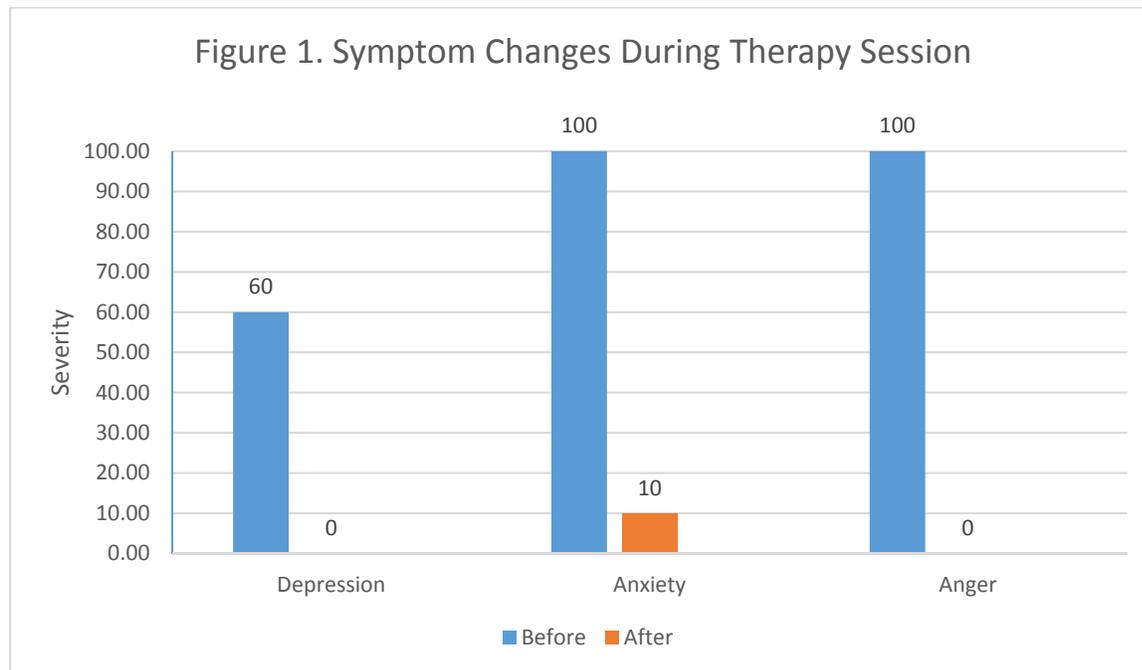
Can you give me an example of the kinds of changes you've seen?

Sure. I recently treated a mental health professional I'll call "Christine." Christine is an Asian-American clinical social worker from San Francisco who had been the victim of decades of domestic rape and violence. At the time Christine volunteered for the live demonstration in the workshop, she'd been divorced and was no longer the victim of abuse, but was still very depressed and anxious.

In Figure 1, you can see Christine's scores on the depression, anxiety and anger scales at the start and end of the session in the chart below. The scores on these scales can range from 0 (no symptoms at all) to 100 (extremely severe). Scores of 10 or less would be considered normal. Christine's initial mood scores were all in the range of severe to extreme.

You can also see that her scores at the end of the session were drastically reduced. For example, her depression dropped from 60 (severe) to 0 (no depression), her anxiety

dropped from 100 (extreme) to 10 (minimal), and here anger also dropped from 100 (extreme) to 0 (no anger).



That's impressive.

I agree, and it was great to see that happen. Christine also completed my Positive Feelings Survey (PFS) at the start and end of the session. This test asks to what extent you feel worthwhile, hopeful, close to people, productive, peaceful, and so forth. The total score on this test can also range from 0 (no positive feelings at all) to 100 (extremely positive and joyful). As you can see in Figure 2, Christine's score at the start of the session was only 39. This score saddened me. It meant that she had very few positive feelings about her life. She had little or no self-esteem, hope, or joy, and hadn't been experiencing meaningful or loving relationships with others.

Given what she'd been through, it's no surprise. What was her score on the Positive Feelings test at the end of the session?

As you can see in Figure 2, Christine's score was 98, indicating extreme feelings of joy, productivity, peacefulness, hope, motivation and so forth.

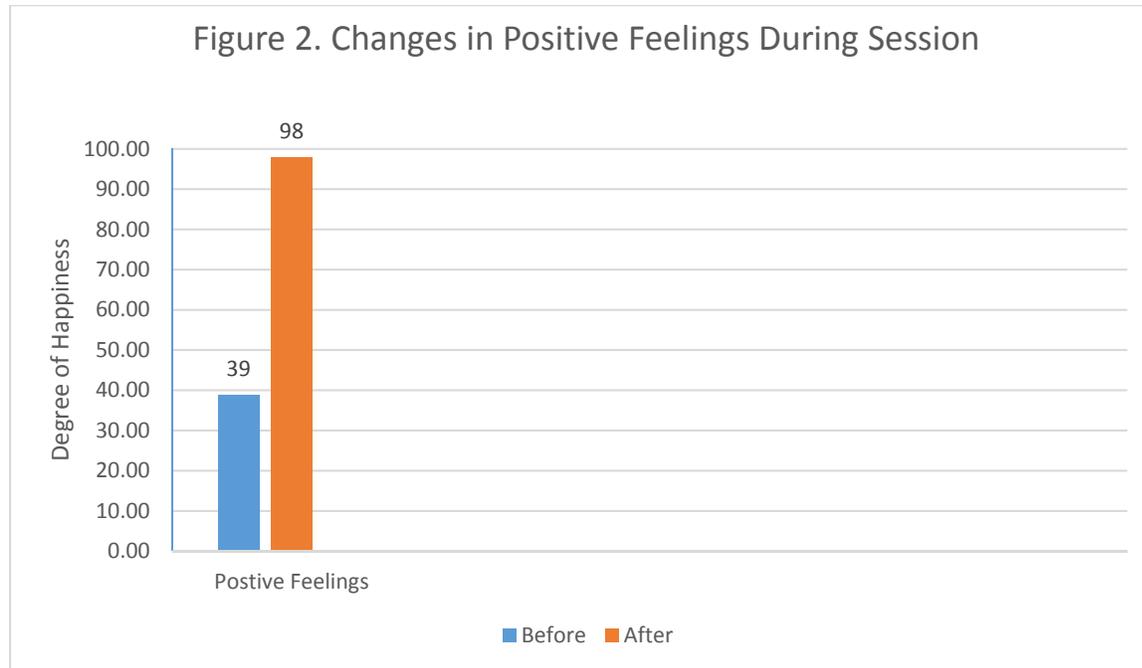
Are these extreme changes unusual?

No, the changes are similar to what I'm seeing most of the time. I don't always get such spectacular results, but we usually come pretty close.

Are the changes real?

Absolutely, and this was obvious to those who watched the session live. Christine was in tears on several occasions during the first part of the session as she recounted the

horrors she'd been through. In fact, at one point she was so anxious she had to forcefully resist the urge to run out of the room; but toward the end of the session she was laughing a lot and seemed overjoyed. The changes in body language were obvious.



How did you bring about such rapid changes?

I used a combination of cognitive and motivational techniques.

How did these techniques work?

Cognitive therapy is based on the ancient idea that our thoughts create our moods. This notion goes all the way back to the Greek philosopher, Epictetus. Two thousand years ago, he wrote that people are disturbed, not by what happens to us, but by our thoughts about what's happening. So, although Christine's traumas were very real and horrific, her feelings result entirely from her negative thoughts about what happened.

This notion may seem politically incorrect—since it might sound like we are blaming the victim—but it is potentially liberating because Christine cannot change what actually happened, but she might be able to change the way she's thinking about it.

What were Christine's thoughts about the trauma?

I asked Christine to write them down on a form called the Daily Mood Log. This is what she had been telling herself:

- I'm not safe. 100%
- I can't trust men. 95%
- I should have stopped the abuse. 90%

- I victimized myself. 100%
- I must be defective. 90%
- I was cowardly. 100%
- I was too afraid of him. 100%
- I am nothing without an important man. 80%
- I lived a lie and I shouldn't have. 100%
- The therapists in the audience will judge me and think I let myself be a victim and should have left him long before I did. 100%
- They'll ask, "How can she be a therapist and help others when she can't help herself?" 100%

What do the percentages after each negative thought mean?

The percent figures indicate how strongly she believed each thought, on a scale from 0% (not at all) to 100% (completely). From a cognitive therapy perspective, two things are necessary to experience a negative emotion. First, you have to have a negative thought. And second, you have to believe it. Those are the necessary and sufficient conditions for emotional distress.

By the same token, the moment Christine stops believing these negative thoughts, she will experience profound relief. But that's not going to be easy, because she's been beating up on herself with these kinds of hurtful thoughts for decades.

How did you get her to stop believing her negative thoughts?

Several TEAM-CBT techniques proved helpful to Christine, such as Empathy, Self-Disclosure, Identify the Distortions, Examine the Evidence, the Semantic Technique, the Externalization of Voices, the Acceptance Paradox, and the Survey Technique, among others. However, you can't just jump in and expect success from any of these techniques because most patients will resist and "yes-but" you.

Why is that?

There are two reasons. First, Christine was convinced that her negative thoughts were absolutely valid. For example, Christine believed that she really *was* defective. So if you try to reassure her or persuade her that this thought is distorted or unrealistic, it won't work. It might even annoy her because it will seem like the therapist is trying to cheer her up with some kind of false reassurance.

But that's what friends, family members, and therapists often do. They try to reassure the patient, and the patient doesn't buy it, so everyone ends up feeling frustrated.

What's the second reason you can't jump in and try to challenge the patient's negative thoughts?

Although Christine has been suffering for decades, and desperately wants help, she may subconsciously resist change. The Jesuit mystic, Anthony De Mello, said that we

yearn for change but cling to the familiar. If you ignore the resistance, and don't know how to deal with it, you may get stuck.

Don't most therapists deal with resistance fairly skillfully?

Very few therapists understand resistance, or know how to address it. In fact, the failure to deal with the patient's resistance is by far the most common cause of therapeutic failure. If the patient is resisting the therapist, even partially, it will nearly always sabotage the treatment.

But why would Christine, or anyone who's suffering, resist change? Doesn't everyone want relief from pain so they can feel good, like the title of your book, *Feeling Good*?

To understand resistance, it can be helpful to understand Outcome Resistance and Process Resistance. These are two terms I've coined that describe two different types of resistance. Outcome Resistance simply means that there are powerful and compelling reasons why the patient might *not* want a good outcome from the treatment.

Help me understand these terms. What would Outcome Resistance mean in Christine's case?

Christine has been depressed for decades. Let's say that a miracle occurs in today's session, and Christine's depression completely disappears and she suddenly feels tremendous joy, optimism, and self-esteem. Obviously, that would be a really good outcome. In fact, it would be a *great* outcome! Outcome Resistance would mean that she might not actually want this to happen.

What would Outcome Resistance for anxiety look like?

At the start of the session, Christine's anxiety was pretty much at the level of sheer panic. A good outcome for anxiety would mean that Christine's anxiety disappears in today's session, and she suddenly feels courageous, peaceful, and confident. Outcome Resistance would mean that she might not really want her anxiety to disappear.

What would Outcome Resistance for anger look like?

It's the same thing. At the start of the session she was enraged. A good outcome might mean that Christine's feelings of anger and rage would disappear during the session. Outcome Resistance would mean that she doesn't want this result and might fight against it. In other words, she might *want* to feel angry—or depressed, or anxious, or ashamed, or whatever.

I get it. Outcome Resistance means that the patient doesn't want a good outcome. What, exactly, does Process Resistance mean?

Process Resistance means that the patient might, or might not, want a good outcome, but doesn't want to do what will be necessary to make that happen. For example, research has shown that psychotherapy homework between sessions greatly

accelerates recovery from depression, but many depressed individuals fiercely resist doing their homework.

Why would a depressed individual resist doing psychotherapy homework?

There are lots of good reasons why depressed patients resist doing psychotherapy homework, and I've listed 25 of them in a memo I give to all my patients at the beginning of treatment, so they can indicate which ones resonate the most with them.

What are the reasons they resist homework?

Well, they may say that they're too overwhelmed and don't have time, or insist that they're hopeless, so they think nothing will work, so there's no point in doing the homework. Or, they may be used to a model of therapy where they just come and vent while the therapist nods and listens and provides support. Some patients may believe they have a chemical imbalance and think they could only be helped by a pill, and some may feel angry and blame others for their problems, so they don't think that they should have to change. And some say they just don't feel motivated.

There are lots of additional excuses patients give as well, but here's the bottom line: I've never seen significant improvement, much less recovery, in a depressed patient who refused (or consistently "forgot") to do psychotherapy homework. And I can't recall any patient who did reasonably consistent psychotherapy homework who failed to improve.

My research has also born this out. There appears to be a massive causal effect of psychotherapy homework on recovery from depression. I've published this finding in the *Journal of Consulting and Clinical Psychology*.

I see. It sounds like Process Resistance for depression has to do with psychotherapy homework. Is the Process Resistance for anxiety the same?

No, it's different. Anxious patients will have to confront their worst fears using exposure techniques if they want complete recovery; but most anxious individuals resist exposure because it's so frightening and uncomfortable. And complete recovery from any form of anxiety is virtually impossible if the patient refuses to confront his or her fears.

That makes sense. Let's talk a bit more about Outcome Resistance, because I still don't get it. Why wouldn't Christine, or any patient who's feeling depressed, anxious or angry, want a good outcome from the treatment?

Let's start with Christine's anxiety, because it's pretty easy to understand Outcome Resistance for anxiety. At the start of the session, Christine was extremely anxious, and the negative thought that triggered her anxiety was, "I'm not safe." She believed this thought 100%.

Let's try a little thought experiment. Let's assume that a miracle happens and Christine recovers in today's session—she walks out at the end of the session feeling completely free of anxiety. Can you think of any reasons why she might *not* want that to happen? Are there any benefits from her intense anxiety?

Well, for one thing, the anxiety keeps her safe.

Of course. Good call!

The anxiety *does* keep her vigilant and safe. Christine mentioned that she'd recently flirted with an attractive man she'd met, and she sensed there was some chemistry between them. But if her anxiety suddenly disappears, she might let down her defenses and end up in another abusive relationship, like the one with her ex-husband. If you look at it from that perspective, her anxiety is definitely a positive. It reminds her to be careful. You could even think of her anxiety as an expression of self-love, since she is protecting herself so she doesn't get hurt again.

That makes sense. It's pretty easy to see that her anxiety is a good thing. But how about her depression? Why would she cling to her depression? How can depression be a good thing?

Sometimes, sadness and depression are healthy and appropriate. After all, awful things have happened to Christine. If a miracle happens in today's session, and her depression suddenly disappears, she'll feel joyous, and maybe even euphoric. Would it make sense to feel joyous and euphoric after decades of horrific abuse?

I see what you mean. That doesn't make sense. How do you deal with a patient's Outcome Resistance?

I use many methods, but one of the most helpful is called Positive Reframing.

How does that work?

I told Christine that I had many powerful tools to reduce or even eliminate her negative thoughts and feelings, but wasn't convinced it was a good idea, and maybe we should make list of the positive aspects of her negative thoughts and feelings before we tried to modify them. She was initially puzzled, but agreed to give it a try. "The anxiety keeps me safe" was #1 on our list.

And #2 on our list of positives was, "My sadness and depression are healthy and appropriate." Can you think of any additional positive aspects of her severe depression?

I think you'll have to help me with this!

No problem, it is a little hard to grasp at first. You have to kind of get the hang of it! But here's another positive—her depression also shows her intense passion for life what she's lost during the past 40 + years. So we added that as #3 on the list of positives.

Now I think I'm getting it. Could we also say that her suffering makes her more compassionate?

Absolutely. Her depression has given her far more compassion and understanding in her clinical work with her patients who have been hurt and abused, so we added that as #4 on our list of positives.

That also makes sense. But how about her negative thought, "I must be defective." How can defectiveness be a good thing?

Well, for one thing, when Christine says that she's defective, it shows that she is being honest with herself, because she does have many flaws, like all of us. So "honesty about my flaws" was #5 on our list.

In addition, she seems very willing to examine her flaws, and to be accountable, rather than blaming everyone else for her problems. So that was #6 on our list. And that's huge. Lots of people take comfort in blaming others because they don't like to examine how they may have contributed to a conflict with a friend or family member.

Can you do this Positive Reframing with negative thoughts as well as negative feelings?

Sure. If you review her list of negative thoughts, you'll see that there are numerous self-criticisms. Can you think of anything else that's positive about Christine's self-critical thoughts?

Perhaps that she has high standards?

Yes, exactly, we're on the same page now. Christine acknowledged that she does have high standards, so that was positive # 7 on our list.

She also said that her high standards have motivated her to work hard and accomplish a great deal, in spite of her horrible circumstances. After she finally got divorced, she went back to graduate school, received a master's degree, and blossomed into a superb therapist with a successful clinical practice.

So we added hard "work and productivity" as #8 on our list of positives.

This is starting to make sense. Were there any other advantages of her self-criticisms?

Absolutely. Christine's self-criticisms also show that she is a very humble person. Some people deny their flaws, thinking they are better than other people. They may come across as judgmental, arrogant or narcissistic. Christine is just the opposite. Her humility and warmth were quite obvious and appealing. The therapists who were present during the session will know exactly what I mean. So "humility" was #9 on our list.

Furthermore, humility is a spiritual quality, so we added that as positive #10.

How about Christine's anger? Is that also a positive?

Of course. Given her circumstances, and what she's been through, some anger is absolutely appropriate. Christine's anger also shows she has a strong sense of justice—and fairness—a good moral compass.

In addition, her anger also shows that she's willing to stand up for herself and to say, "It's not right for a woman—or a man—to be abused."

I'm beginning to see how Positive Reframing works.

Great. It can be remarkably helpful. When you do Positive Reframing, you ask one of two questions about each of the patient's negative thoughts and feelings:

- What does this negative thought or feeling show about the patient that is awesome and positive?
- What are the benefits, or advantages, of this negative thought or feeling?

Can you use Positive Reframing with any negative thought or feeling?

Pretty much—yes, you can.

Christine is afraid of being judged by the therapists in the audience. What could be positive about that?

Her fear of being judged shows her strong desire for good relationships with her colleagues. Christine has been hiding out for decades and feeling incredibly lonely. She desperately hopes that she can be open and honest about her experiences with her colleagues so she can develop deeper and more meaningful relationships. After all, getting up on the stage and being vulnerable in front of so many mental health professionals required enormous courage and an intense desire for change!

I see what you mean, and that's all very true. How about hopelessness? Aaron Beck, one of the early pioneers of cognitive therapy, said that hopelessness leads to suicidal urges, because the patient is convinced there will be no end to his or her misery. So how can hopelessness be a good thing?

Dr. Beck was a terrific teacher and he got that right. Hopelessness *can* trigger suicidal urges, and suicide is a tremendous tragedy. At the same time, there are *lots* of good things about feeling hopeless.

Such as what?

Well, for one thing, hopelessness shows a sense of integrity. Many of the patients who sought treatment at my clinic when I was still living in Philadelphia had failed to respond to years and years of treatment with antidepressant medications as well as psychotherapy. In fact, one woman who came all the way from Europe for treatment had had dozens of electroconvulsive treatments, and even two lobotomies that did not help with her incapacitating depression and anxiety. So when patients insist they are hopeless, they are usually taking an honest look at the painful facts of their lives and saying, "Nothing has helped me, and that's the truth."

I don't want to meander here, but what happened to that lady? She really *does* sound hopeless!

She was treated by an Irish psychologist who was working in our clinic. I felt sorry for him, having to treat such an impossibly challenging case, and sheepishly asked him how she was doing a couple days later. I was shocked to learn that she'd already improved dramatically, and was nearly symptom-free. I couldn't believe it. He added that she was not even difficult to treat. We were just beginning to develop what later evolved into TEAM-CBT, and she'd never received any treatment like that before. All she'd had was drugs, drugs, drugs, ECT, and lobotomies, along with conventional talk therapy.

It's so hard to predict the future. Sometimes, patients who seem very complicated and difficult at first respond really fast; and sometimes, patients who seem like they're going to be easy to treat turn out to be extremely challenging.

Her story is amazing. But can you talk more about the positive aspects of hopelessness? I want to hear more about that. You say it shows a sense of integrity, and a willingness to face the facts. Are there any other positive aspects of hopelessness?

Oh yes. Feelings of hopelessness can protect patients from getting their hopes up and then being disappointed yet again—crushed, really—if the new treatment does not help. In fact, hopelessness about any aspect of your life can protect you from disappointment.

Hopelessness also shows a kind of skepticism, or critical thinking, which is a form of intelligence. Instead of being a sucker, the patient who feels hopeless is saying, “I’m not convinced this new treatment can help me.”

Hopelessness can also be a way of conveying to therapists and family members just how intense your suffering is, so they don’t minimize what you’re experiencing or try to cheer you up. Hopelessness may communicate a desire for support and genuine understanding.

So, are you saying that therapeutic resistance is actually a good thing?

Absolutely. TEAM-CBT involves a radical shift in our understanding of the concept of “resistance.” I now see the negative thoughts and feelings, and the patient’s resistance, as really *good* things. I side with the patient’s resistance and encourage it!

How does this differ from the approach most therapists use?

Usually, therapists think about resistance as a bad thing—a kind of character flaw or defect. For example, we may tell ourselves that patients resist because they want to feel sorry for themselves, or because they’re afraid of change, or because they want to complain and receive endless sympathy and support from others. But those views of resistance sound judgmental, although they sometimes contain a grain of truth. They are really put-downs, even though the therapist may not be aware of this.

In TEAM-CBT, my colleagues and I have gone in the opposite direction. We conceptualize resistance as something positive and flattering to the patient. So instead of feeling put down, the patient feels complimented and respected, admired really, by the therapist.

Positive Reframing involves a radical re-thinking of the role of the therapist. Instead of trying to sell the patient on change, the therapist becomes the patient’s subconscious resistance and tries to sell the patient on the status quo. We encourage the patient to resist change.

Why would the therapist want to do that?

It’s because at the very moment the patient begins to feel proud of his or her symptoms—as opposed to feeling ashamed—and sees the many positive aspects of the resistance, it nearly always seems to disappear. This is a paradox.

And once the resistance disappears, recovery is usually just a stone’s throw away. That’s because when the therapist and patient are working together as a team, the therapy becomes vastly accelerated. It is a remarkable thing to experience.

I am worried that I may not have made this sufficiently clear, but it is a powerful and consistent effect. Reading about it can help, but viewing it in real time in a real session or on a video really makes it crystal clear how and why this works.

Does it always work? What if the patient says that he or she *doesn’t* want to change or recover? Couldn’t your approach backfire?

That's where the concept of "Sitting with Open Hands" comes in. In TEAM-CBT, we don't assume we are experts in how the patient *should* feel. That's up to the patient. If the patient wants to maintain his or her symptoms, that's okay with me in most instances. I simply ask if there's anything he or she *would* like to work on.

This puts the therapist in a much less powerful and important role. When I was a psychiatric resident, I was trained to see myself as an expert who knew what the patient *should* or *shouldn't* do. I assigned diagnoses and used a variety of tools to try to correct the patient's deficiency or "brain disorder." Most therapists are trained to think like this, no matter what the therapist's training or persuasion happens to be.

I now see my role as a therapist in a radically different light. I feel more like a plumber. If you have a broken pipe in your bathroom, I'll be glad to stop by and fix it. But I don't go from house to house evangelizing about copper pipes.

I love this analogy, David!

Thanks, Lisa. It took me years of clinical practice to figure this out, and it has been like enlightenment. And the paradox is that although I am now far more helpless—I have become a far more powerful therapist. That's because patients can no longer stump me or frustrate with me their resistance.

When I sense the patient is fighting me, I simply say, "Maybe this is not something we should change. Let's look at all the reasons NOT to change." That almost always has a powerful impact on the patient. It's pretty amazing, actually.

But you have to discipline yourself not to take the hook, so to speak, when the patient starts to "yes-but" you. And this is hard for therapists to learn, because they usually try to persuade or "help" the reluctant patient. This is just human nature, but it almost never works, and the therapy gets stuck.

In my workshops, therapists often ask me how I'd deal with some impossibly difficult patient, like a hoarder who wants to keep hoarding. I'd simply tell the hoarder, "Hey, go for it. You might need that stuff some day! Is there anything I *can* help you with?"

The capacity to "Sit with Open Hands," in a kindly and respectful way, has eliminated most of the burden and frustration in my career as a therapist, and has given me far greater personal joy, and far greater healing power.

How often do patients decide that they *don't* want to change?

I have seen that a few times, but it is rare in my experience. I suspect it is probably more common among therapists in clinical practice, since they may see patients coerced by others to get treatment when they don't really want to be there.

And, of course, there are exceptions to every rule. If a patient is actively suicidal, or in danger of dying from anorexia nervosa, involuntary treatment may be required to save that person's life. In this case, you *don't* sit with open hands!

Where did you get the name, "Sitting with Open Hands"?

I've often asked myself why the Buddha is so often portrayed as sitting with open hands. To my way of thinking, it means "I can accept you and show you the path to

enlightenment, if that's what you want. But I can also let you go if that's not what you want. My ego is not tied up with helping you."

What are the goals of the Agenda Setting tools in TEAM-CBT, like Positive Reframing?

There are several goals. One goal is to find out what, if anything, the patient wants help with. Another goal is to minimize resistance and maximize collaboration if the patient does want help.

In addition, my colleagues and I are trying to turn the field of psychiatry and psychology upside down to a certain extent. We are saying that depression and anxiety do not need to be viewed as "defects," but rather as the expression of the patient's strengths. That way, patients no longer have to feel ashamed of their symptoms, as if they were the manifestation of some "mental disorder" or defect.

For most patients, it is a pleasant shock to suddenly discover that their painful negative thoughts and feelings are actually a healthy manifestation of their core values. This discovery can have significant antidepressant effects, although when I created these methods I thought of them primarily as resistance busting techniques. I did not realize they also had potent mood-altering effects as well.

What did you do next, after you and Christine listed all the positives aspects of her negative thoughts and feelings?

Then I asked Christine why in the world she'd want to eliminate the negative thoughts and feelings, since all of the positives we'd listed would disappear at the same time. For example, if she could press a Magic Button and her anxiety would suddenly disappear, she might let her guard down and rush into another relationship and get hurt again. And if her anger disappeared, it would be like saying it was okay for her ex-husband to rape and abuse her.

And if her depression disappeared, she'd no longer feel sad about the abuse, and all the years she lost. Instead, she'd feel happy, or even euphoric. But that would seem bizarre.

It does sound like you're trying to persuade her NOT to change. Is that what you're doing?

Exactly. Even though I am the therapist, I have actually become the voice of the patient's resistance, and emphasize all the GOOD reasons NOT to change. And the, oddly enough, the patient seems to take the opposite role and insists that he or she really *does* want to change.

Are you trying to trick or manipulate the patient?

No, not at all. This has to be done in a genuine and respectful way. If the therapist uses these techniques as an attempt to manipulate the patient, they won't be effective. Paradoxical Agenda Setting, when done properly, is really a deeper form of empathy. You are truly seeing things through the patient's eyes. In most cases, the patient experiences a profound feeling of support and warmth.

But it isn't easy for therapists to learn how to do this, because these techniques are the opposite of how most of us were trained to think about our patients, and how to treat them.

What did Christine say when you suggested that she might not want to give up the negative thoughts and feelings?

She immediately argued that in spite of all the good things that her negative thoughts and feelings showed about her, and in spite of the many positives and advantages that we'd listed, she really *did* want to change because the negativity was just too much. She insisted it was interfering with her life and robbing her of happiness.

Then what did you say?

At that point, I used a technique called the Magic Dial. I said,

“Christine, let's imagine that we had a Magic Dial and we could dial down your negative feelings down to some healthier level, instead of making them disappear completely. Then you could still have the benefits of them, but without being so totally overwhelmed and defeated. Let's start with the anxiety. At the start of tonight's session, you said you were 100% anxious. If we could dial it down to some lower level that we be enough to keep you vigilant and protect you from doing something foolish, how much anxiety would you need?”

What did she say?

She said she would dial the anxiety down to 2%, and that would be enough to keep her safe. I tried to persuade her to keep it at some higher level, like 30%, but she insisted that 2% was plenty!

Once again, you can see that I am arguing for *more* symptoms, and she is arguing for *less*! That's not the typical therapeutic relationship!

What did she say about the rest of her feelings? Did she want to dial them down as well?

Absolutely. She said that she wanted to dial down her feelings of depression from 80% to 5%, and her feelings of defectiveness from 95% to 10%, and the anger from 100% to 10%, and the shame and guilt from 80% to 0%, and so forth.

What is the purpose of the Magic Dial?

What we are doing is making a “deal” with Christine's subconscious mind. We are telling her that we will only lower each negative feeling to a level that she chooses, a level that she's comfortable with. That way, she's in control, and I'm not going to do something “to her.” She is the one who is calling the shots, and I'll be working *for* her and *with* her. In addition, her subconscious mind—her resistance—has been honored and does not have to lose face, so to speak.

Now, change becomes *her* agenda, rather than *my* agenda. This seems to make all the difference in the world. Once there is little or no resistance left, recovery usually unfolds rather quickly.

How long does it usually take to reduce the patient's resistance?

It varies, but in most cases it does not take a long time. This was my first session with Christine. At the start of the session, I spent about 40 minutes just empathizing while she told her story. That's crucial, because you have to form a warm and trusting bond with your patient before you can use any of these techniques.

Then we did the Paradoxical Agenda Setting to reduce her resistance, using Positive Reframing and a few other techniques. That took about 25 minutes.

Then what did you do?

So far, we've talked about the first three letters of a TEAM-CBT therapy session, so we were ready for final portion which involved M = Methods.

Can you remind me what the first three letters of TEAM stand for?

Sure. T = Testing—You will recall that I measured the severity of her symptoms at the start of the session, and found that she was extremely depressed, anxious and angry, with very few positive feelings about her life.

E = Empathy—I encouraged her to tell her story and vent, without doing anything to try to cheer her up or “save” or “rescue” her.

A = Paradoxical Agenda Setting—I brought her resistance to conscious awareness and melted it away using the techniques we've just discussed.

What happened in the Methods part of the session?

I used a variety of cognitive techniques to help Christine challenge her negative thoughts, like “I must be defective,” and “I can't trust men,” and “The therapists in the audience will judge me.”

How long did that portion of the session take?

That only took an additional 20 or 30 minutes.

That doesn't seem like nearly enough time to eliminate decades of intractable depression and anxiety. Are you telling the truth?

Yes, and the reason it happened so fast is because we eliminated her resistance. Christine is a very smart and capable individual, and if we're working together as a team, we'll have a powerful healing force.

In fact, the actual “ah ha” moment, when the big shift occurs, may unfold quite rapidly. The change is sometimes sudden. When we began to use techniques like Identify the Distortions, the Semantic Method, and the Externalization of Voices, Christine suddenly found the power to defeat her negative thoughts, and her negative feelings pretty much disappeared. She found an incredible, powerful, healing voice inside of her, a voice that had always been there, just waiting to emerge.

What was that like for you, the therapist?

It's amazing and inspiring to see Christine's metamorphosis unfolding before your very eyes.

This is shocking to most therapists who are trained to believe that recovery from depression happens slowly, if at all, over the period of years. It is a little like believing

that the speed of light is the fastest anything could travel in the universe, and so you “know” it will take hundreds of years to reach some distant destination.

What we’ve done with TEAM-CBT is more like finding a wormhole, so you can get to your destination with incredible speed in many cases. It’s exciting!

Christine was able to defeat almost all of her negative thoughts in a convincing manner, and then we came to the final two. You’ll recall that she was telling herself that the therapists in the audience were judging her and questioning her competence as a therapist. To find out if this was true, I suggested we might try a technique Aaron Beck created called the Experimental Technique.

How does that work?

Beck saw depressed patients much like scientists who have a theory, so they do experiments to test their theory. For example, in the time of Christopher Columbus, lots of people thought the earth was a round disc and believed you could fall off if you sailed all the way to the edge. But Columbus discovered that wasn’t true, and stumbled upon a new land. We can sometimes encourage patients to do experiments as well.

I asked Christine if she could think of an experiment we could do to test her belief that the therapists in the audience were judging her. She said, “we could ask them,” so we invited therapists to come up on the stage with us so Christine could ask them how they felt. This was extremely frightening to her, because she was certain they were judging her.

What happened?

Therapists came up to the stage, one by one, and told Christine that they were filled with praise, gratitude and admiration for her courage. Most had tears flowing down their cheeks as they told her how much the session had meant to them. Some described the abuse they’d endured when they were growing up, or when they were married. One man said he’d even take a bullet for her! It was pretty mind-blowing.

After the session, the next day, many more of them sent her the most gentle and warm emails imaginable. She was more than recovered, she was euphoric, almost giddy.

It *is* exciting. But here’s the big question. Do the results last? Maybe this was just a flash in the pan.

In my experience, the results do last reasonably well, but you have to do Relapse Prevention Training immediately after the patient has recovered. Fortunately, Relapse Prevention Training is fairly easy and only takes about 30 minutes in most cases.

It’s vitally important to make sure the patient knows that he or she *will* relapse—not once, but many times. In fact, I define a relapse as one minute or more of feeling crappy—anxious, irritable, insecure, or defective. Given that definition, we will all relapse forever. I usually relapse several times every week. Something happens and I get upset. This is the human condition. No one is entitled to feel happy all the time.

But it's not a problem if you know how to pop out of these so-called "relapses." It's okay to be upset for a minute, an hour, or even for several days. But I don't want my patients to slip back into months or years of misery again. And if you have trained your patients to deal with relapses, they tend not to be a problem.

If you like, we can do a follow-up interview on Relapse Prevention Training, and I'll show you exactly how it works.

That would be great. Do you have any specific follow-up information on Christine?

I do. I emailed her several months after the session to see how she was doing. Here's what she said,

Dr. Burns, I am a changed woman! Now I can easily form laser arguments against the negative thoughts that are more and more afraid to speak up. . . I am doing well as are many of my clients, thanks to your good work!

Sincerely, Christine

Recently, I emailed her again and asked her to fill out the Brief Mood Survey, so I could get some follow-up data six-months after our session. Her scores were identical to her scores at the end of the session. Her depression score was still 0 on a scale from 0 to 100, her anxiety score remained at 10, and her anger was also 0.

Did she comment on how she was doing?

Yes, she sent the following email along with the survey, because I asked if she'd mind my writing up her case in this article, disguised of course:

Hi Dr. Burns, Good to hear from you. Love my new identity. ☺ You are welcome to blog about "her" as you wish as long as my identity is disguised. I am doing very well even with the demands of a very busy life. I am seeing negative thoughts as weeds in my garden that get pulled as soon as they sprout. I am much less tolerant of them than I would have been in past.

The reason being is that I now know and love the feeling of being without the negative thoughts. The feeling reward is almost immediate which is highly reinforcing.

I'm asking my much more technically literate secretary to fax my Brief Mood Survey in a separate email.

Take care, Christine

Clearly, she's still doing great!

Absolutely, and it is so heart-warming and inspiring. It makes me grateful to be in this profession and to have the chance to witness this so often.

You are talking about live demonstrations you have done in workshops in front of audiences. Would the approach be different in a clinical setting?

In clinical settings, most therapists would want to do a thorough initial evaluation at the beginning of treatment. Obviously, I don't do that when I'm doing a live demonstration in a workshop. And of course, in a clinical setting, the patient may want to come back for a tune-up or to work on other problems after his or her initial recovery from depression and anxiety. In addition, most therapists don't have the luxury of an extended therapy session, like the two-hour block of time I have in a workshop.

I was wondering about that. Most clinicians are limited to the traditional 50-minute sessions once per week. Is it possible for them to do TEAM-CBT? Or do you have to have an extended session initially?

It can be done, but you have to make it clear to the patient that you're going to work on one specific issue for four or five sessions, and the patient has to agree to do psychotherapy homework between sessions. Then you can move systematically through the same T-E-A-M steps I described in my session with Christine.

Can other clinicians get the same kinds of results that you've been experiencing?

Some are beginning to see improved outcomes as well, but it takes a lot of training and commitment to learn TEAM-CBT.

Sunny Choi was a student at my weekly psychotherapy training group at Stanford during the past two years. When he started, he was a novice. He had just given up a high-paying high-tech career in Silicon Valley so he could get a degree in clinical social work because he's always wanted to help people. That was a dream he'd had since he was a child.

He is now completing his clinical training, and is working with immigrant populations in the San Francisco bay area. Most of his patients are depressed and anxious, and Sunny is limited to 45-minute sessions which are scheduled back-to-back by the clinics where he works. Given the time needed between sessions for paperwork and such, this means that he typically only has about 35 minutes to do the actual psychotherapy in each session. And although he speaks Cantonese, he has to work with an interpreter when treating Spanish-speaking patients.

Sunny recently gave a presentation at our Tuesday training group describing his experiences doing TEAM-CBT in these somewhat challenging circumstances. He reported that he is also seeing a substantial or dramatic reduction in symptoms in four to six sessions in most cases. So his total time with patients is similar to my own, perhaps just a bit longer given that he has to break the treatment up into smaller units of time. I found this extremely encouraging.

After reviewing the draft of this article, Sunny made a couple additional comments that might be of interest:

In some cases, a few of my very motivated patients have gotten better in two sessions. However, I want to emphasize that TEAM-CBT is not as easy as it looks. Since TEAM-CBT is so methodological, one can learn it well with commitment and lots of practice. As I practice more, my TEAM-CBT skills have gotten much better.

Since TEAM-CBT is such an awesome technology, even novice therapists can get lots of benefits from it. Even at the beginning of my TEAM-CBT training, I was able to heal many patients fairly quickly. As I have become more experienced, I have been able to use TEAM-CBT with more difficult cases and help my patients heal even faster.

That *is* encouraging. Do you have any idea why you and some of your colleagues are getting such rapid results?

There are many possible explanations. The way therapy is set up initially may have a significant impact on the duration of the treatment. When patients work with me before a live audience in workshops, they know they'll only get one shot, one chance, to work with me. If there are any loose ends, I tell them that they'll have to work that out with their own therapists after the workshop. So we move as fast as possible to get right to the heart of the problem and work on it. Sunny also dives in really fast, and this seems to work for him as well.

But when most patients go to a psychiatrist or psychotherapist, they typically sign up for weekly sessions over a long period of time. So the expectation is set up right away that the treatment will be slow. And that expectation will tend to function as a self-fulfilling prophecy. In fact, I did not realize that recovery could happen so rapidly until I started doing live demonstrations in workshops.

In addition, Sunny mentioned that most of his patients do not have the cultural expectation that therapy will be a long, drawn out process. They do not find it unusual that their healing could be completed in just a few brief sessions. We need more research to find out if the expectations of the patient and therapist do play a causal role in the speed of recovery.

That makes sense. Are there other factors that might also facilitate rapid recovery?

Absolutely. I'm convinced that the innovations we've created in TEAM-CBT have vastly accelerated the rate of recovery from depression and anxiety. In particular, the techniques to lower resistance seem to be a game-changer.

Another factor is the testing. I've tested every patient at every session since I opened my clinical practice around 1978. And this has helped me enormously. I've really worked at improving my therapy skills, and my patients have been my best teachers by far. Their feedback has been invaluable, but it is often painful, too.

You see the importance of immediate feedback in sports. For example, NBA players get feedback every time they shoot a basket. They can see if the ball went through the hoop, and this helps them hone their skills. Without the feedback, they would never improve.

But most therapists do not yet use the kind of testing methods I've developed, so they don't have an accurate idea of how effective they were in each session. They're not getting accurate feedback. I'm convinced that significant improvement in your therapeutic skills is not possible without testing every patient at every session.

Doesn't that take too much time to do all that testing?

No, not at all. As I mentioned, the patients complete the tests in the waiting room immediately before the session begins and once again after the session is over, and they leave the evaluation for the therapist to review when the session is still fresh in mind. That only takes about ten or fifteen seconds.

The innovation of measuring symptoms at the start and end of every therapy session, as well as empathy and helpfulness at the end of sessions, has been huge. Every single session becomes a powerful training experience for the therapist. But as I mentioned, the information is often painful, because you become vastly more aware of your therapeutic errors. But if therapists have the courage and humility to use these scales, and to work at improving their clinical skills, it can make an enormous difference.

Is the rapid recovery you've observed limited to trauma patients?

No, I've seen the same results with most depressed and anxious patients, whether or not their symptoms were triggered by a traumatic event. But in my experience, severely depressed and anxious patients who've endured some kind of horrible trauma are actually a bit easier to treat than those without a history of trauma.

Can all patients recover rapidly?

No, some will still require a more extended treatment period, but it is very encouraging that so many depressed and anxious individuals can now be treated at a speed I would have thought impossible as recently as 10 years ago.

What kinds of patients do not recover rapidly?

Patients with relationship problems, such as a marital conflict, can be much more difficult to treat, as well as those with habits and addictions. In addition, patients with schizophrenia will usually require medications, and the prognosis is still rather poor.

You can use TEAM-CBT to help an individual with schizophrenia develop greater self-esteem and function more effectively, but he or she will still have schizophrenia, which is sad. And, of course, patients with full-blown Bipolar I Manic Depression will probably need medications during episodes of mania, along with good psychotherapy. And I think it is fair to say that elderly patients with full-blown dementia cannot be treated with these techniques.

In addition, I would point out that the patients I treat in workshops are volunteering to do intensely personal work in front of a live audience of peers, and so they are pretty motivated to get help. They are paying a steep price to get my help, because it is not easy to bare your soul in front of so many people you don't really know. Of course, this just points to the enormous importance of resistance and motivation in treatment.

You're known throughout the world for your work on Cognitive Behavior Therapy (CBT). Why did you develop TEAM-CBT, and how does it differ from traditional CBT?

I've always been a great enthusiast for CBT, and include many CBT techniques within the structure of TEAM. However, I created TEAM-CBT to address and correct some of the shortcomings with CBT that I became aware of through research and through my clinical experiences treating tremendous numbers of patients over the years.

CBT made a great impact on psychiatry and psychology starting in the 1950's, with the pioneering work of the noted New York psychologist Dr. Albert Ellis, and in the 1960s with the work of Dr. Aaron Beck, a psychiatrist at the University of Pennsylvania School of Medicine. The field is deeply indebted to both of those brilliant mavericks.

But like any new technology, the treatment methods have evolved significantly over time. You could think of TEAM-CBT as CBT on steroids, although that might sound disrespectful. One of the main differences between CBT and TEAM-CBT, is based on my discovery, through research and clinical work, that motivation also has an *enormous and immediate* impact on how people think, feel, and behave.

In TEAM-CBT I have preserved all of the good features of CBT, but added powerful new techniques to eliminate resistance and boost motivation. These tools have made all of the difference.

Do you think most therapists will be able to learn to do TEAM-CBT and get comparable results?

It remains to be seen. I am hopeful, but not overly optimistic.

Why is that?

First, TEAM-CBT is quite sophisticated and challenging to learn. I make it look easy when I do live demonstrations in workshop or teaching, but it's not. It takes a tremendous amount of dedication, time, and practice to learn how to do it skillfully, along with reasonable degree of intelligence and aptitude for human interactions. It is not formulaic, and must be individualized for each patient.

Second, many therapists are devoted to the way they've been trained and understandably reluctant to change and learn something that is so new and so different. In fact, novice therapists, like Sunny Choi, are sometimes easier to teach than experienced therapists because they are humble and open to learning, and don't have to unlearn lots of bad habits they've fallen into.

Third, there are conflicts of interest. If you are in private practice and have a full-fee patient, you may both like to schmooze behind closed doors for months or even years. That provides you with a steady source of income. You may not want to your patients to recover in just a few therapy sessions because you will get punished financially. I've never had a patient who wanted to stay in therapy once he or she became completely undepressed and happy.

Fourth, TEAM-CBT therapists **MUST** use the assessment scales at the start and end of every session with every patient. This is very threatening to many therapists because they will see, for the first time, how effective they were, or weren't, in every single therapy session. The scales I've developed are extremely sensitive, so most therapists receive failing grades initially from almost all of their patients on all of the scales at every therapy session. This can be shocking and disturbing for therapists. Many therapists just can't take it.

In fact, there are huge segments of the mental health community who are intensely dead-set against any kind of measurement or accountability in therapy! For example,

I've had many students who were told by other psychiatric supervisors that the use of my scales was forbidden because this would "disturb" the "transference."

What does that mean?

That could be a topic for another interview, I think! But the short answer is—I have no idea! It makes no sense to me! But I'm sure it means something.

Are there any other reasons why TEAM-CBT may be hard to learn?

Sure, there are other barriers as well. Most therapists rebel against the very notion that rapid, sustained recovery from depression is possible. This goes against the grain of what they've been taught in graduate school and what they've come to believe. So they may dismiss the very possibility, or even react to the notion, not only with skepticism, but in some cases, hostility.

When I describe rapid recovery in my teaching, but I have not yet demonstrated it live, many therapists say that they simply do not trust me. They think I'm conning them, or a fool, or some such thing.

Does that change after they see a live demonstration like the one you did with Christine?

Oh, yes, this can help a lot. That's why live demonstrations and videos are so important. For most therapists, seeing is believing. But I've even had some therapists who didn't believe what they were seeing on the video! They think the patient is faking it, or an actress, or something like that.

Are there any other barriers to learning TEAM-CBT?

Yes. TEAM-CBT requires a complete and radical change in the role of the therapist, and therapist narcissism and co-dependency can get in the way. Some therapists simply do not want to give up their roles as "experts" who "rescue" the patient.

If therapists are interested in learning more about TEAM-CBT, what resources are available?

There are many. One of my former Stanford students, Maor Katz, MD, and several former students of mine have developed a Feeling Good Institute in Mt. View, California. They are offering a TEAM-CBT certification program and are working as fast as they can to train more therapists in the model. They also offer a variety of live and online classes so that therapists around the world who are interested will have a chance to learn these techniques.

I also have an interactive TEAM-CBT training manual for therapists called *Tools, not Schools, of Therapy*, and, as you know, I conduct workshops around the country for mental health professionals.

We also have a many weekly in-person or online TEAM-CBT training groups in many cities throughout the US and Canada, including the free training groups I lead every week at Stanford for mental health professionals in the San Francisco Bay Area.

Is there any research that backs up why and how TEAM-CBT works?

The development of TEAM-CBT was based on quite a lot of published studies on how psychotherapy actually works. These studies are listed and described on my website, www.feelinggood.com, and I will also list some of them at the end of this interview. But much more research is needed.

A former student, Kim Bullock, MD, who is now on the Stanford faculty in the Department of Psychiatry, is developing a TEAM-CBT outcome study so we can assess the effectiveness of TEAM-CBT in the hands of clinicians who are working in the trenches. Maor Katz, MD and his colleagues at the Feeling Good Institute are collaborating in this exciting study.

I'm encouraged by what I'm seeing in my own work with courageous individuals like Christine, but we have to be cautious until we see the results of more research.

-end-

About Dr. Burns



David D. Burns, MD is Adjunct Clinical Professor Emeritus of Psychiatry and Behavioral Sciences at the Stanford University School of Medicine, and has received numerous awards for his research and teaching. He graduated magna cum laude from Amherst College, received his M.D. from Stanford University School of Medicine and completed his psychiatry residency at the University of Pennsylvania School of Medicine. He has served as Acting Chief of Psychiatry at the Presbyterian / University of Pennsylvania Medical Center (1988) and Visiting Scholar at the Harvard Medical School (1998), and is certified by the National Board of Psychiatry and Neurology.

Dr. Burns has written a number of popular books on mood and relationship problems. His best-selling book *Feeling Good: The New Mood Therapy* has sold more than five million copies in the United States, and many more worldwide. It is the book most frequently “prescribed” for depressed patients by American and Canadian mental health professionals. His website, www.feelinggood.com, has many resources for therapists and for the general public, including his exciting weekly *Feeling Good* podcasts.

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