Paradoxical Agenda Setting (PAS)—Basic Concepts and Techniques*

By David D. Burns, M.D.

Do You Need Paradoxical Agenda Setting? At the risk of over-simplification, we could say that there are two basic approaches to, or philosophies about, psychotherapy that I call “passive / non-specific” and “active / specific.” In non-specific psychotherapy, the patient talks and the therapist listens, asking occasional questions to guide the patient in a particular direction. There’s no psychotherapy homework, and few specific tools. The goals, too, are somewhat general, focused perhaps on personal growth.

During the first half of the 20th century, most schools of psychotherapy were of the non-specific type. Psychoanalysis and psychodynamic therapy would be classic examples of non-specific therapy, as was the “Emotive / Supportive” brand of psychotherapy I was trained in as a psychiatric resident. Karl Rogers said it best when he proposed that empathy is the necessary and sufficient condition for personality change.

About mid-way through the 20th century, things slowly began to change, with the emergence of numerous specific forms of psychotherapy, such as Behavior Therapy, Cognitive Therapy, and a host of others. Now the approach to treatment was completely different in at least six critical areas. First, specific “disorders” were diagnosed and the symptoms of those disorders became the target of the treatment—general growth was no longer the focus. For example, the goal of the therapy might be to eliminate the patient’s panic attacks or feelings of depression.

Second, the patient’s symptoms were measured with brief, accurate assessment tests so that progress, or the lack of progress, could be tracked and documented. Third, the therapist and patient worked together actively and collaboratively, almost as co-equals. This involved a fundamental change in the nature of the therapist / patient relationship. Fourth, the therapist used specific tools such as Exposure, Response Prevention, or a large number of cognitive restructuring techniques, to facilitate change. The choice of tools depended on the nature of the patient’s symptoms. Fifth, the patient was required to do psychotherapy homework between sessions so as to accelerate learning and progress. And finally, the treatment was time-limited and brief.

Although the concept of “resistance” was always important in the non-specific therapies, it loomed even larger in the emergence of the new specific therapies because of the intense emphasis on collaboration, homework, measurement, and accountability. If the patient will not pick up the tools and use them, the treatment is doomed to failure. And the failure becomes far more obvious because of the overwhelming push for rapid and measurable change.

The techniques in this memo will hopefully be illuminating and of great importance to you if you are using one of the newer, specific forms of psychotherapy. But if you are doing a more non-specific type of therapy, where the patient talks and you simply listen or occasionally offer some advice, you will probably find these concepts relatively irrelevant to the type of work you do.

Paradoxical Agenda Setting is designed to enhance therapeutic collaboration by reducing two powerful types of resistance, Outcome Resistance and Process Resistance. Outcome Resistance
means that even though the patient may want a positive treatment outcome (e.g. help with depression, anxiety, a relationship problem, or a habit or addiction) there are likely to be many internal and external factors that keep the patient stuck. As a result, he or she may resist change and appear unmotivated. Often, these factors are not in the patient’s conscious awareness, but they can be brought to conscious awareness fairly easily.

Process Resistance means that even if the patient does want a positive treatment outcome (e.g. recovering from depression or anxiety), she or he may not want to do what will be necessary to bring that change about.

Outcome Resistance. Here are some examples of Outcome Resistance:

- A depressed man may think that he deserves to suffer because he did something morally bad or failed in some way.
- An intensely anxious woman may feel that her anxiety serves a protective function, and may think that something terrible will happen if she gives up the compulsive worrying.
- A woman with a troubled relationship may not want to get close to the person that she’s complaining about and may not be asking for help.
- A man with a habit or addiction, like alcoholism, binge eating, or an internet porn addiction may not want to give up his greatest, and perhaps only, source of pleasure and reward in a life that feels stressful and unrewarding.

Initially, most patients won’t be aware of these outcome resistance factors. If you bring them to conscious awareness with skill and compassion, there often will be a kind of an “ah-ha” experience for patients and therapists alike. It can be extraordinarily freeing for the patient and for the therapist as well. That’s because any techniques you use to help the patient will become far more effective after you’ve melted away the patient’s resistance.

Outcome Resistance may be somewhat unintuitive and difficult to grasp at first. After all, the patient is coming to sessions, and may be paying for the sessions, so we naturally conclude that he or she wants help. Most of our training is predicated on this notion as well. For example, if the patient has OCD, we may recommend Exposure and Response Prevention, or think about prescribing certain types of medications that might be helpful.

But what if the patient isn’t really asking for help, or has mixed feelings about change? Then your efforts to “help” may trigger resistance. The patient may “yes-but” you, insisting that nothing could possibly help, or may simply “forget” to do the psychotherapy homework. The harder you push, the more the patient pushes back. You may conclude that the patient is being stubborn, unreasonable, or oppositional, and the patient may conclude that you just don’t care or understand.

Both you and your patient may begin to feel frustrated and burned out, and a subtle struggle may evolve. The patient seems to want to talk endlessly, while you keep trying to “help.” In a moment of annoyance, you may label your patient as a “help-rejecting whiner.”

Once you suddenly “see” why the patient is resisting, you will have much deeper empathy and far greater power to help the patient. Here’s a simple example. A psychologist came to me for help with test anxiety. Her licensure examination was coming up in six weeks, and she was bombarding
herself with distorted thoughts, such as, “They’ll only ask about the things I don’t know and none of the things I do know.” Or, “I just know I’m going to flunk the test.” On the Daily Mood Log, she rated her feelings of panic, anxiety, and worrying at 100%.

Her negative thoughts were clearly unrealistic. In the first place, it was not true that the test would only contain questions about things she didn’t know with no questions about things she did know. In addition, although the psychology licensure examinations were challenging, she was a top student and had never once flunked a test in her entire career. Her negative thoughts were classic examples of several cognitive distortions, including “All-or-Nothing Thinking,” “Mental Filter,” “Discounting the Positive,” “Fortune-Telling,” “Emotional Reasoning,” and “Other-Blame.” There were also some hidden “Should Statements.”

When I encouraged her to challenge these thoughts she became oppositional and defiant. She claimed that her negative thoughts were realistic. We began to argue about who was “right” and who was “wrong,” but that was going nowhere. At this point I had to back off, empathize, and ask myself why she was fighting me so vigorously when I was simply trying to help.

My therapeutic error was a common one. I wasn’t taking Outcome Resistance into account. Although she was suffering and feeling miserable, maybe she had some good reasons for making herself anxious.

I suggested we might list the advantages and disadvantages of her worrying on a Cost-Benefit Analysis form. Together, we came up with many advantages. For one thing, her self-criticisms showed that she had integrity, since the test would be difficult, and she wasn’t going to fool herself with some kind of phony Pollyanna positive thinking. The worrying also showed that she had high standards for herself, and wasn’t going to settle for mediocrity. In addition, she listed this advantage: “My worrying has always motivated me to work hard, and it’s paid off. It’s the price I’ve had to pay for my success. If I stop worrying, I may get so complacent that I’ll flunk the test.” These powerful advantages of her anxiety made it clear why she was fighting me so intensely.

Then we listed several disadvantages, including this one: “My worrying has gotten so severe that I haven’t done one minute of study or preparation in the past five weeks. I’m totally stuck.” When she wrote that down, it was like turning on a light bulb in her brain. Yes, there were many advantages of worrying, but there was an elephant in the room that she’d been ignoring.

We resolved this motivational impasse with the Magic Dial. I pointed out that some anxiety can be productive and healthy, but she was so anxious that she was paralyzed. I pointed out that she’d rated her anxiety at 100%, and asked how much anxiety she’d want, between 0% and 100%, if we had a Magic Dial and could set the dial to the optimal number. She said that 20% would probably be plenty. I suggested that we could work together to lower the anxiety to that level, and promised her that if the anxiety fell below 20%, I’d show her how to become more anxious so she wouldn’t get overly complacent.

At this point, she was able to challenge her negative thoughts successfully. There was an immediate reduction in her anxiety, and she began studying for the test, which she passed with flying colors several weeks later. She told me that once she started studying, her anxiety actually dropped all the way to 0%.

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In this case, I used two PAS tools: the Cost-Benefit Analysis and the Magic Dial. If I had not used them, I don't believe the treatment would have been nearly as effective, and may even have failed.

**Process Resistance.** This concept is a little easier to understand. Process Resistance means that even if the patient does want a positive treatment outcome (e.g. recovering from depression or anxiety), she or he may not want to do what will be necessary to bring that change about. For example:

- A depressed man may not want to do psychotherapy homework between sessions because he feels so hopeless, unmotivated, and overwhelmed.
- An anxious woman may not want to confront her fears using exposure techniques because the exposure seems so dangerous and terrifying.
- A man with a troubled marriage probably won't want to examine his own role in the problem because he's totally convinced the problems are all his wife's fault.
- A woman with an addiction may not want to have to go through withdrawal. A student with a habit, like procrastination, may not want to face the anxiety of studying or doing the tasks he's been putting off.

The four patterns of Outcome and Process Resistance are independent and separate from each other. Furthermore, a patient could experience either Outcome or Process Resistance for a problem, such as depression, or both, or neither. And sometimes you may conceptualize the patient's problem as having more than one component: For example, if the patient is struggling with depression following a romantic rejection, it could be conceptualized as an individual mood problem and a personal relationship problem as well. So there could be two potential forms of Outcome Resistance and two potential forms of Process Resistance.

You can learn more about the eight most common patterns of Outcome and Process Resistance in my two-page memo entitled, “Why Our Patients Resist Change.” In addition, the one-page memo entitled “The Five Steps in Agenda Setting” will show you the overall structure of Agenda Setting during therapy sessions. Finally, the chapters and written exercises in my eBook, *Tools, Not Schools, of Therapy*, will be very useful.

PAS may be very challenging for you to learn, for technical and emotional reasons, because you will have to let go of your own agendas and become far more aware of your blind spots and biases. It is well worth the effort, because PAS is arguably the most powerful, exciting, and liberating tool in all of psychotherapy.

Below, you will find brief descriptions of four categories of techniques: Basic PAS Techniques, Techniques that Target Outcome Resistance, Techniques that Target Process Resistance, and Additional Motivational Techniques. You may notice that there is some overlap among the techniques. Some are just different ways of saying the same thing or achieving the same goal. Once you have grasped Paradoxical Agenda Setting, you may find that you will create new techniques that will be suitable to your personal therapeutic style and your treatment setting.
Basic PAS Techniques

1. Empathy

It is crucial to empathize without trying to “help” or “solve the problem” at the start of every therapy session, before you begin Agenda Setting. The amount of time each patient needs for empathy will vary. Some patients will be satisfied with just a few minutes of skillful listening. Other patients will need much more empathic listening and support before they’ll feel ready to roll up their sleeves and get to work on one of the problems they’ve described.

In addition, once you begin Agenda Setting, the patient may resist or get upset, angry, or overwhelmed with emotion at any time. Your best initial response will always be empathy, using the Five Secrets of Effective Communication: The Disarming Technique, Thought and Feeling Empathy, Inquiry, I Feel Statements, and Stroking. Once the patient feels accepted and relaxed again, you can go back to Agenda Setting, starting with the Invitation Step.

Many therapists who read the two paragraphs above will feel they understand them when they don’t. When I observe seasoned or novice therapists working with real or simulated patients who express tremendous pain and suffering, the therapists nearly always jump in prematurely with reassurance or advice, without paraphrasing the patient’s words (Thought Empathy) and exploring the patient’s feelings (Feeling Empathy). Reassurance has the effect of turning the feelings off, much like a faucet, and may indirectly convey the message that the therapist is afraid of the patient’s feelings. This common error can result from a problem I call emotophobia (the therapist’s fear of intense negative feelings) as well as from codependency (the therapist’s need to help or rescue the patient).

Overcoming this problem requires systematic practice as well as a significant shift in the therapist’s mindset. I have developed powerful role-playing exercises that are described in the Empathy chapters of my book: *Tools, Not Schools, of Therapy*. Video examples of the Empathy exercises will also be available soon at TeamTherapyTraining.com.

2. The Invitation

Although the Invitation is the first step in Agenda Setting, it’s also a useful motivational tool you can use at any time. For example: "Is this problem (with your husband, your depression, your OCD, your drinking, etc.) something you'd like help with? Or did you simply want me to understand how painful this has been for you?"

Here’s another example: “You’ve been describing some extremely painful problems, and my heart goes out to you. I’d like to offer you more than just listening and support, and I have some wonderful tools I’d love to share with you. I have no doubt that if we work together, we can bring about some tremendous changes in your life. I’m wondering if this would be a good time for us to roll up our sleeves and get to work on one of those problems, or if you’d like to vent some more first? Talking and getting support can be tremendously important and helpful, and I don’t want to jump in before you feel ready.”

3. Sitting with Open Hands

Sitting with Open Hands means that although you’re eager to help your patient, if she or he wants to change, you don’t have a need to help him or her. It means that you are truly willing to have your patients remain symptomatic. For example, if a patient has OCD and is a hoarder, or washes his hands 50 times...
a day to prevent contamination, you are okay with that. You don’t see it as your job to persuade him to change. You are emotionally at peace with his hoarding or compulsive washing, even though this might not be your preference for him. Your job is to find out if there is something he does want help with, and not to impose treatments on him based on his diagnosis or some problem he might have.

Sitting with Open Hands is important for one reason: If you try to help patients who have not asked for help, you will usually run into a wall of resistance and the therapy will be unsuccessful.

Many therapists struggle with the idea of Sitting with Open Hands. They feel the need to jump in, trying some technique they think might help, without taking the time to find out what, if anything, the patient wants help with, and without resolving the patient’s Outcome and Process Resistance. While this always results, in part, from the therapist’s benevolent desire to help the patient, it can also result from an intense need to rescue patients and can be an expression of the therapist’s narcissism or codependency.

Sitting with Open Hands means that we are not experts in how people should think, feel or behave. We are not trying to sell patients on some model of ideal mental health. Patients have to tell us what they want help with, and let us know how much the solution would be worth to them. When patients don’t want help, we can open our hands and let go.

This is a vitally important concept. You may be reading about it without truly comprehending what it means. Or, you may understand it without being able to implement it.

Sitting with Open Hands means mean letting go of your need to help. But this need to help is so basic and automatic that it’s almost like a knee-jerk reaction. We may jump in to rescue or help a patient almost without noticing what we’re doing. I have seen many therapists struggle with this tendency; some have found that personal work can help them prepare for Sitting with Open Hands. Sometimes, something inside of us may have to change before we can help our patients change.

4. Fallback Position

This is related to the concept of Sitting with Open Hands. What will you do if the patient is not ready, willing, or able to pick up and use the tools she or he needs to recover? For example, a depressed patient might be unwilling to do psychotherapy homework (HW), or a shy, anxious patient might be unwilling to use exposure techniques until she feels more confident. This is where your “Fallback Position” comes into play. Your Fallback Position is how you make patients accountable.

There are several approaches. First, you can tell your patient that you really want to work with her, and would love to show her how to overcome the depression or crippling shyness that’s been making her life so miserable. In addition, you feel convinced that the two of you could achieve those goals if you worked together (this is called Dangling the Carrot). But the tools you use will not be effective without doing psychotherapy HW between sessions, such as the Daily Mood Log or Pleasure Predicting Sheet, or exposure techniques for anxiety. You could suggest that the patient might want to seek treatment from a local therapist who does not require psychotherapy HW or exposure, while at the same time emphasizing that you like her and hope to work with her, but the HW and exposure would not be negotiable. This approach is especially powerful at the initial evaluation, before you have accepted the patient for treatment.

The following approach may be more suitable for student therapists who have less therapeutic autonomy, as well as for clinicians who have already accepted unmotivated and resistant patients into...
treatment. You could say something along these lines, "I'd really love to help you with your depression, but the tools I use for depression are not likely to be effective without the psychotherapy HW. Perhaps there's some other problem we could work on instead."

Here's another way to express a Fallback Position: "I'd really love to help you with your depression, but for us to bring about meaningful change you'll need to do daily psychotherapy homework, and you're saying this is too much for you right now. We could spend a few sessions just talking and I could offer you support, but I'm concerned that this may not help your symptoms of depression. And you've told me that you've had years of talk therapy, and you're still feeling worthless and hopeless. Overcoming your depression will take quite a bit of work, but it could be life-changing, what do you think?"

### 5. Changing the Focus

This is an advanced empathy technique that can be a vitally important PAS tools as well. Although it is extremely simply, it is surprisingly hard to grasp and implement. When you use Changing the Focus, you focus on the process, rather than the content of the interaction, or conflict, between you and the patient. In other words, you might gently point out that the two of you are arguing, or getting derailed, and not working together as a team. You bring the conflict to conscious awareness in a kindly way, so you can focus on feelings, rather than trying to figure out who's right and who's wrong.

In a sense, there's an elephant in the room, but everyone's ignoring the tension pretending it isn't there. When you use Change the Focus, you point to the elephant and say, "Do you see what I see?"

Suppose, for example, that the patient has been venting and complaining about all the problems in his life, and you've been empathizing, using the Five Secrets of Effective Communication. After a while, you issue the Invitation Step of Agenda Setting. For example, you might ask if the patient would like some help with one of the problems he has been describing, or if he needs more time to talk while you listen and provide support.

Instead of answering this question, he may simply ignore you and continue to complain. You might feel frustrated, annoyed, or shut out. Many therapists would simply repeat the question and ask if there is a problem the patient wants help with—but that ignores the tension and might lead to a power struggle, because the patient will probably continue to be slippery and avoid answering the question. That because some patients do not come to treatment for help, in the sense of working hard to solve some problem in their lives, but simply to vent, complain, and get occasional support.

If you use "Changing the Focus," you might say something like this instead: "Jim, I'm not sure if you noticed what just happened. I asked you if you wanted some help with one of the problems you've been describing, and it seemed to me that you didn't answer the question, but just kept talking. Did you notice that? I'm feeling a bit awkward right now, and I'm wondering how you're experiencing our interaction. Can you tell me what's going on from your perspective? Are you feeling frustrated or annoyed with me? Have I perhaps jumped in too quickly to ask if you want to work on one of the problems without providing enough warmth and support while you've been talking?"

It's important to deliver this type of message in a curious and supportive tone of voice, and not in a defensive or adversarial way. If you use Changing the Focus skillfully, it can have a powerful effect of ending any kind of game that's going on between patient and therapist. Instead of playing the game, you bring the game to conscious awareness. You can use Changing the Focus whenever tension emerges during a therapy session. It is not just an Agenda Setting technique, but a more general therapeutic skill.

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Techniques that Target Outcome Resistance

6. Dangling the Carrot

When you are offering to help a patient, you can indicate optimism about what might happen if the two of you work together as a team. The way you express this will depend on your own personality, experience, and level of training, but you must offer patients something tangible if you are asking them to work hard and engage in the therapeutic process. Successful use of this technique may serve as a “hook” to encourage the patient to commit to the necessary work to achieve recovery.

For example, when I’m working with a shy patient, I might say something like this: “Jim, I’d love to help you with your shyness so you can start dating and find someone to love. I’d also enjoy helping you with your public speaking. I also used to struggle with both of these problems, and now I talk to people everywhere I go, and I make my living doing public speaking. I believe I can show you how to overcome these problems, and I have some powerful techniques to share with you. Would you be interested in working on your shyness and public speaking anxiety?”

Novice and experienced therapists sometimes have trouble Dangling the Carrot because they feel insecure and aren’t convinced they really can help the patient overcome depression, panic attacks, a trouble marriage, or an addiction to alcohol. In my eBook, Tools, Not Schools of Therapy, I describe 50 powerful treatment techniques you can use to help patients with practically any kind of problem. In addition, when you role-play and practice with colleagues, or get consultations on patients you feel stuck with, you will gain more confidence, since you’ll know you have many specific tools available for different kinds of problems. Then you’ll be able to offer the Invitation step and Dangle the Carrot with greater conviction.

7. The Miracle Cure

This is both a data gathering step as well as a useful Agenda Setting tool that may give you some important insights about why the patient is stuck. Once the patient has described the problem (such as procrastination, feelings of inadequacy, or a troubled relationship), you can ask what a “miracle cure” might look like. You might say something like this: “Suppose today was the most amazing session, and you walked out of the session thinking that our work together had changed your life in some fantastic, wonderful way. What would that change look like? What would be different? What would the solution to this problem look like?”

Of course, the way you ask this question will depend on the nature of the problem the patient wants help with. A student who procrastinates may say that he would suddenly feel motivated to study and work on his dissertation. A woman who feels inferior and inadequate may say that she’d suddenly have great accomplishments. A man with a troubled relationship with his brother might say that his brother would suddenly stop his constant criticizing, whining, and blaming. You may notice that in all of these examples, the patient is asking for magical results that we cannot provide without hard work and accountability on the part of the patient.

In these instances I might say, “I’d love to offer you that kind of solution, but I can’t. What I can offer you would be quite different.” Then you could point out that the student who procrastinates isn’t entitled to feel motivated until after he’s gotten to work, and that getting to work is going to be very anxiety-provoking. At this point, you could ask if he’d be willing to tackle the task he’s been putting off in spite of
how boring and anxiety-provoking it’s going to be.

Or you could point out that you don’t have the magical ability to create any amazing accomplishments during today’s session for the woman who feels inferior—so that if she does want to walk out of today’s session, or any session, feeling tremendous joy and self-esteem, it will probably involve a tremendous change in her standards and expectations and ways of thinking about herself. Then you could ask if she’d be willing to do that? Would she be willing to learn how to love and accept herself as she is right now, warts and all, if you agreed to teach her how?

Or, you could point out that the man with a troubled relationship with his brother would have to stop blaming his brother for the problems in their relationship and focus all of his energy on pinpointing his own role in the problem and changing himself. That’s because his brother isn’t here asking for help. You could also point out that it may seem awfully unfair that he should have to do the changing when his brother is the one who’s screwed up. You could also let him know that you’ve got some terrific tools to share with him, but if he feels strongly that he shouldn’t have to change, or doesn’t want to change, it would be entirely understandable and you’d be more than happy to work with him on some other problem instead.

A colleague made this comment after reading about the Miracle Cure technique: “This is important so you don’t ASSUME that you know what your patient wants help with, or how much the patient wants his or her life improved. I have used this technique a ton and am often shocked at what the patient’s “miracle cure” would look like.”

8. Magic Button

This is another wonderful tool for Outcome Resistance. You tell the patient to imagine there’s a Magic Button on the desk. If they push it, all their symptoms will suddenly and totally disappear with no effort at all. For example, if they have been seeking treatment for feelings of depression, shame, and worthlessness, the moment they press the button they’ll immediately feel joy and self-esteem, with no effort whatsoever. They’ll walk out of today’s session in a state of euphoria. You ask them if they want to push the button.

Most patients will immediately say yes. Then you can point out all the reasons NOT to press the button. This is a way of bringing their Outcome Resistance to conscious awareness. If you do this skillfully, the patient will nearly always try to convince you of all the reasons to change.

Generating reasons the person may not want to push the button requires a familiarity with the eight most common sources of Outcome Resistance for depression, anxiety, relationship problems, and addictions, which I’ve summarized in the table called “Why Our Patients Resist.” However, in most cases, the resistance will be somewhat unique to each patient, so you’ll have to think creatively and individualize the Magic Button for each person you work with.

You may worry that you may guess at a source of outcome resistance and be wrong. This is very common. As long as you suggest reasons not to change with empathy, humility, and curiosity, you can be creative in offering possibilities and trust that your patient will correct you if an idea does not fit.

9. Acid Test

Most patients will immediately agree to push the Magic Button. It sounds great to have all of your negative feelings suddenly vanish, just by pushing a button. However, the patient hasn’t yet grasped
what we’re really offering. We’re offering to help patients feel happy and fulfilled in spite of their problems and shortcomings. We can’t change the facts of any patient’s life in today’s session. We can only help the patient develop greater happiness and self-esteem in spite of those facts. When you do the Acid Test, you make the patient suddenly aware of the implications of pressing the Magic Button.

For example, let’s say you’re treating a college freshman who was raised in Hong Kong. She is severely depressed because she’s way behind in her studies, and she has been procrastinating and lying around in bed instead of attending classes, taking careful notes, and studying hard. She feels lonely, ashamed, and frustrated, and constantly criticizes herself. She graduated at the top of her high school class, and her father expects her to major in electrical engineering and take over his computer chip company in Hong Kong some day. She’s perfectionistic and she’s not living up to his expectations or her own.

So she says she’d gladly press the Magic Button and walk out of today’s session feeling joy and self-esteem. Then you say, “But keep in mind that when you press the Magic Button, your feelings will change dramatically, but the facts of your life won’t change. You will STILL be way behind in your studies and you will STILL be getting Bs and Cs instead of As, but you’ll no longer be feeling depressed and worthless. Is that what you want, to be a happy mediocre student?”

That’s the Acid Test. She might say “yes.” This will probably mean that she’s ready to go to work talking back to her self-critical negative thoughts. She may already understand that her relentless self-criticisms won’t help her catch up in her studies, and may even make things worse. But she’ll probably say “No! That sounds terrible. I don’t want to be happy unless I’m really doing well in my studies.”

Then you might say something like this: “I think you might be telling me that you WANT to feel miserable today, as a way of punishing yourself, or motivating yourself. And it seems like you’re already doing a pretty good job of punishing yourself. So perhaps that’s not something you need help with.”

Now you’ve placed her in a paradox. You can help her escape from the trap she’s fallen into with a little psycho-education, or with the Magic Dial. Like all powerful tools, this one takes practice, and must be done with genuineness and warmth or it will backfire.

A colleague asked for a little clarification on why these techniques might backfire, and that’s super-important to understand. As therapists, we are human, and it’s easy—in fact, inevitable—that we will at times feel frustrated and annoyed with patients who appear to “resist” our efforts to help them. For examples, some patients may “yes-butt” us over and over as we keep bombarding them with our “helpful” or “logical” advice.

In these circumstances, you may be tempted to use PAS sarcastically, as a weapon to put the patient down, or to encourage the patient to drop out of therapy. For example, you might say, “Oh, it sounds like you really want to feel sorry for yourself, don’t you? So I guess you don’t want to get better!”

Well, on some level these statements are true. We all get to feeling resentful and sorry for ourselves at times, but if you confront the patient with this in an uncompassionate manner, the patient will feel hurt and outraged, and may even drop out of therapy. PAS has to come from the heart, and it has to be done with kindness, genuineness, and compassion or it won’t be effective.

PAS works best when it actually makes sense to you why the patient might not want to change, and you’ve been able to use empathy to truly understand the dangers of changing from the patient’s perspective.

10. Positive Reframing

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When you use this technique, you become the voice of the patient’s subconscious resistance and verbalize all the reasons NOT to change, but you cast them in a flattering light. In essence, you make the patient proud of his or her resistance.

A businessman named Samuel sought treatment after ten years of refractory depression. Prior to his depression, he had been dating a divorced woman with a teenage son named Timmy. Timmy was hanging out with the wrong crowd and getting into trouble with the law. Samuel took the boy under his wing, and was determined to change his life for the better. He taught Timmy extreme skiing, a sport Samuel excelled in. The boy felt in love with the sport and turned his life around. The bond between Samuel and Timmy was fantastic. When Samuel married Timmy’s mother, he made Timmy the best man at his wedding.

One year the two were skiing together down a dangerous and challenging slope, and there was a sudden avalanche. Samuel managed to swerve and escape, but Timmy was swept off a 60 foot cliff. Samuel called for the rescue helicopter, and skied down to Timmy. Sadly, Timmy had a broken neck and died in Samuel’s arms.

And for the next ten years, this negative thought continued to plague Samuel: “I killed my wife’s only son.” He felt depressed, worthless, guilty, ashamed, lonely, and hopeless. Psychotherapy and antidepressants had not helped at all. He said that friends told him he had to grieve, so he cried almost constantly for two years, but that hadn’t helped either.

I asked Samuel how well he’d been functioning during those ten years of depression. He said he’d lost interest in his work, and had barely earned enough money to squeak by each year. Instead, he’d been using most of his time and energy raising money to buy wheelchairs for people in third world countries, such as Viet Nam who had lost their limbs in explosions that were caused by American landmines. He described the excitement and gratitude of the people when he would travel abroad to deliver the wheelchairs in person. Even though they were basic and inexpensive wheelchairs, they meant everything in the world to people who had lost their legs.

Samuel wanted to know if there was any hope for a successful treatment for his depression. I pointed out that I had many powerful techniques that we could use that would probably reduce his guilt, shame, and depression, and perhaps even make all of his negative feelings disappear entirely. And although it was hard to predict how long it would take, the change might even happen quickly, conceivably even in today’s session, which was our first. I explained, however, that I was reluctant to show Samuel how to use these techniques.

Samuel was puzzled and asked why. I said, “It’s because I have so much respect for you. If this is depression, maybe the real problem isn’t the fact that you’re depressed, but the fact that the rest of the world is not. There is so much real suffering in the world, and you’re the one who’s responding to it with compassion and with your entire heart. And look at what your depression says about your relationship with you step-son. Your depression is your love for him. You’ve been keeping him alive, in your heart, the entire time. I am filled with admiration for you. Are you so sure you’re ready to let go of your depression now? Are you ready to say goodbye to Timmy?”

This is an example of positive reframing, because I wanted him to feel a sense of pride in his symptoms and to see what they showed about him that was truly wonderful. This is the opposite of current approach of moist mental health professionals, who see depression as a form of pathology, rather than a sign of moral strength. And the paradox is that once the patient becomes proud of the symptoms, the
resistance to change always disappears.

In fact, Samuel did recover completely in that first session, using the Daily Mood Log along with basic techniques such as the Paradoxical Double Standard, Externalization of Voices and Acceptance Paradox. He came in one week later for his final session, when we did Relapse Prevention Training.

Positive Reframing is not a formula or gimmick. You have to be able to see why the symptoms really do reflect something positive and admirable about the patient. Initially, this will be difficult for most therapists, because of our training. Over time, you will develop much greater skill and will be able to “see” things that may have been invisible to you in the past.

11. Magic Dial

This is another useful tool to melt away Outcome Resistance. When you fill out the Daily Mood Log, you ask patients to circle and rate all their negative feelings, such as inferiority, guilt, anxiety, or anger, on a scale from 0% (not at all) to 100% (the worst). Typically, these ratings will be in the range of 75% to 100%. You can point out that in many cases, some negative feelings can be healthy and helpful. For example, if you’re trying to prepare for an important exam, some anxiety might motivate you to study harder. But 100% may be more than you need, and may even paralyze you.

Here’s the kind of thing you can say to the patient: “If you had a Magic Dial and could adjust your feelings to the ideal levels, what would those levels be? For example, how much anxiety would be enough to motivate you to study hard, so you do well on the exam? Right now, you estimate your anxiety at 95%. Would 50% be enough? Or 20%? What’s the optimal level of anxiety for you right now?”

The patient might say 20%. Then you can both record the ideal level in the “Goal” column on the Emotions table of the Daily Mood Log. Now you have a therapy goal that won’t threaten the patient. I also reassure patients that if we are too successful, and the anxiety drops below the ideal level (in this case 20%), I will help them generate some anxiety once again so they don’t get too complacent, or too happy. This often triggers some laughter and relief.

Paradoxically, once the negative feelings start to decrease as you use techniques like the Externalization of Voices and Acceptance Paradox, the feelings will frequently drop all the way to 0%. This is because the patient’s perceptions change so radically when they have a breakthrough that they no longer see any valid need for negative feelings. But of course, sometimes some healthy negative feelings will be indicated, so a drop to 0% is not always necessary or even desirable.

12. Straightforward / Paradoxical Cost-Benefit Analysis (CBA)

**Straightforward CBA.** Ask the patient to list the advantages and disadvantages of believing a Negative Thought (“I’m such a loser”) or maintaining a Self-Defeating Belief (“I should be perfect”), feeling (like anger, guilt, inferiority or anxiety), relationship problem (such as blaming your spouse for your marital problems), or habit (such as drinking, using drugs, overeating or procrastinating) on a CBA form.

In each case, you can ask the patient, “What are the advantages and disadvantages of this having this thought, belief, feeling or habit? How does it help you, and how does it hurt you?” After the patient lists all the advantages and disadvantages, ask him to balance them against each other on a 100-point scale so he can see whether the costs or benefits of that mind-set are greater.

**Paradoxical CBA.** If the patient is motivated and easy to work with, the Straightforward CBA will usually be effective. If the patient seems unmotivated or oppositional, the Paradoxical CBA usually works better.
When you do a Paradoxical CBA, you have the patient list only the advantages of a negative thought, belief, feeling, habit, or relationship problem, such as blaming your spouse or sibling for all the problems in your relationship. Now ask the patient, “Given all these advantages, why should you change?” This will make you and your patients aware of the powerful forces that keep them stuck, and will help you avoid trying to persuade reluctant patients. Instead, they will have to persuade you to work with them.

13. Externalization of Resistance

This is a way of combining a powerful role-playing technique with the paradoxical Cost-Benefit Analysis (CBA). First, you can list all the reasons for the patient to maintain the status quo and resist change in the Advantages column of a CBA, or you can simply list them on a piece of paper. Then you can become the voice of the patient’s subconscious resistance, and verbalize all those reasons NOT to change, using the second-person, “You.” For example, consider the college freshman from Hong Kong who was beating up on herself for doing poorly in her classes. With your help, she might be able to list advantages of self-criticism, depression, and shame such as these: 1. My self-criticisms show that I have a good value system and that I won’t let myself off the hook. 2. They show that I love my parents and honor them. 3. They may motivate me to study harder and get caught up. 4. If I’m severely depressed and ashamed, others won’t feel the need to criticize me. 5. My self-criticisms show a high degree of integrity, since I’m facing my shortcomings instead of denying them. Together, you can probably come up with even more advantages.

After explaining the procedure to your patient, you can take the role of her resistance, and verbalize all the reasons NOT to change, one at a time, using the second-person, “You.” For example, you might say, “Your depression shows how much you love your parents,” or “If you feel happy, you may lose your motivation to study,” or “If you feel happy, you’ll be settling for mediocrity,” etc. Then see if she can defeat you, speaking in the first-person, “I,” as she argues back against the resistance thoughts you are verbalizing.

If she CAN defeat you, she’ll be well along the road to recovery, although other techniques will also be needed. If she cannot defeat you, she may be saying she WANTS to remain depressed. In this case you can “sit with open hands,” and ask her if there’s something else she does want help with instead.

14. Devil’s Advocate Technique

This is a Role-Playing Technique. Let’s say you’re working with a patient who is struggling with some habit or addiction, such as drinking too much, overeating, procrastinating, or dating the wrong person. You can ask your patient to describe a situation where she feels tempted and typically gives in to the temptation. For example, she may be struggling unsuccessfully to stick with a diet, and one extremely difficult situation for her might be walking through the food court of a mall amid the smell of freshly baked cinnamon buns or chocolate chip cookies. Ask her to list the tempting thoughts and list them yourself at the same time. For example:

- Gee, those cinnamon buns really smell terrific.
- They just came out of the oven, and they’d taste SO GOOD. Mmm!
- I’ll just go take a closer look.
- I really deserve one because I’ve had a tough day.
I can just eat one tiny little bite. One little bite won’t hurt.
I can have a salad later on so it won’t make any difference.
I’m not getting anywhere in my diet anyway.
I just CAN’T control myself, no matter how hard I try.
Tomorrow will be a better day for dieting.

Now tell her to imagine being in a mall and smelling the sweet smell of sticky cinnamon buns. Explain that you’ll play the role of the Devil and try to tempt her. You’ll be the voice in her mind that tries to trick her into giving in. She can play the role of the strong, self-loving, voice that resists the temptation. The Devil (initially played by the therapist) will use the second person, “You,” and the resisting voice (initially the patient) will speak in the first person, “I.”

When you use this technique, it’s important to use the patient’s exact words. Don’t get carried away using your tempting thoughts because they won’t carry any weight with the patient. That’s why it is so important to ask them to list the tempting thoughts that generally defeat them on the Addiction / Habit Log. You will need to write them down as well, so you’ll have them handy for the role playing.

For example, let’s say the patient is struggling with overeating, and has written down the first four tempting thoughts on the bulleted list above. As the Devil, you might ask the patient to imagine being in the mall and smelling the cinnamon buns. They you can say, “Gee, why don’t you take a look at those hot, buttery cinnamon buns? They just came out of the oven and smell terrific. They’d taste SO GOOD, and you deserve it!”

The patient might fight back and say, “I don’t need a cinnamon bun, and I’ll feel terrible if I give in. I’m determined to stick with my diet, and I’m looking forward to wearing more attractive clothes. I may deserve a sticky bun, but I also deserve some dignity and self-esteem.”

Now, as the Devil, try to tempt her with another of her seductive thoughts, giving her another chance to fight back again. Continue until the patient has convincingly defeated all the tempting thoughts.

If the patient gets stuck, and cannot effectively defeat one of the tempting thoughts, you can use role-reversals to model more effective responses. You can let her play the role of the Devil, and you can show her how to combat the tempting thoughts. Alternatively, you can become the voice of the patient’s subconscious resistance, and ask, with genuine curiosity, why the patient wants to change, giving all the benefits and rewards of continuing the habit or addiction.

You can use the Devil’s Advocate Technique for patients who feel tempted by any kind of habit, such as drinking, using drugs, procrastinating, dating the wrong person, having affairs, or internet pornography. This method can be surprisingly powerful, especially if you express the tempting thoughts in a seductive and convincing manner. If patients cannot defeat the Devil, the likelihood of successful treatment may be low, so the Devil’s Advocate Technique also becomes an innovative and dynamic assessment tool.

Techniques that Target Process Resistance

15. Gentle Ultimatum

Let’s assume the patient wants help with his depression, and you’ve melted away any Outcome
Resistance. You can use the Gentle Ultimatum to deal with the Process Resistance. First, you need to be clear in your own mind about what the patient will have to do to recover. For depression, Process Resistance revolves around the issue of doing psychotherapy homework.

Using the Gentle Ultimatum, you might say something along these lines in a kindly way:

“Pedro, I’m looking forward to working with you to overcome the feelings of depression and worthlessness that have been plaguing you for so many years. However, if you want me to help you, you’re going have to do daily psychotherapy homework for 15 to 30 minutes, even when you’re not in the mood or feel convinced that it couldn’t possibly help. It’s a little like going to a tennis coach to improve your tennis game. You’d have to practice between sessions to get the real benefit. And if you’re willing to do the homework, I believe I can show you how to change your life. That would be exciting to me.

“However, if my suggestion does not appeal to you, and you don’t want to have to do psychotherapy homework, I can absolutely understand and accept that. But then we’ll have to move in a different direction together, since I don’t know how to defeat depression without the homework. If you want to continue working with me, perhaps we could work on some other problem instead. Or, if you want help with your depression without doing having to do psychotherapy homework, perhaps I could refer you to a respected colleague who doesn’t require psychotherapy homework. Of course, I’d hate to lose you as my patient, and I’m eager to work with you, but I do want to be clear that the homework requirement is not negotiable.”

Or, let’s say the patient is anxious, but doesn’t want to have to use exposure. You could point out that most therapists in the community offer long-term talk therapy without exposure for patients struggling with anxiety. You could also say, “If you feel strongly that you’re looking for that approach, I feel that you have every right to pursue it—but I don’t have those kinds of skills.” You can emphasize that you have great respect for the patient and hope she or he will decide to work with you. You can also let the patient know that you feel convinced that you can do some tremendous work together (Dangling the Carrot again.) However, they should know that the exposure requirement would not be negotiable.

You can also express the ultimatum in an apologetic way, like this: “Harold, I’d really like to help you with your PTSD, and I can see how much you’ve been suffering. But at the same time, I’m aware that recovery will require us to use a technique called Cognitive Flooding, where I would ask you to focus vividly on some of the horrible events from the past and allow yourself to feel flooded with intense anxiety, which can be tremendously uncomfortable. I’d hate to ask you to do that, but I realize that it would be absolutely necessary to defeat the horrible flashbacks that have been plaguing you. What do you think about that?”

16. Paradoxical Inquiry (PI)

Paradoxical inquiry can be helpful for Outcome and Process Resistance. When the patient resists, you can ask a paradoxical question that may lead the patient to the irrationality of the resistance, rather than using persuasion in an attempt to change the patient’s mind. For example, the patient who’s describing a conflict with his brother may say, “Why should I have to change? He’s the one who’s screwed up.” Using PI you might say, “Certainly, you shouldn’t have to change and you don’t have to change. Are you saying that you don’t want to?” You can also point out that he may be saying that he doesn’t really want to work on the relationship, and perhaps just wanted you to know how difficult and irritating his brother is. If so, you can then ask if there’s something else he’d prefer to work on.
PI questions must be delivered with warmth, respect, and authenticity. Tone of voice can make a huge difference. Avoid sarcasm. Try to see the world through the patient’s eyes. Try to be okay with the fact that the patient may not want to change, or may not want to risk changing. If you’re not truly “sitting with open hands,” and your secret agenda is to persuade the patient to change, then this method will be ineffective.