"Depression, anxiety, substance abuse, PTSD, personality disorder—
a single common pathway?"

Abstract: Depression, anxiety, substance abuse, PTSD, and personality disorders, although treated as unique and separate conditions, rarely exist in pure form. Their symptoms and behavior problems overlap so much that the diagnosis often depends most on where the client enters the treatment system. All these conditions are marked by serious self-destructive behavior, and they all appear to be in part an effect of malfunctioning reward systems in the brain. The patients' histories are usually marked by trauma, abuse, and/or neglect. This talk will review these commonalities, and the need for modifications to the engagement and treatment process in order to gain these clients' full participation in their own recovery.

(One hour)

Intro

I've been in the therapy business for almost 40 years now, and in the first 25 in a wide array of settings, from an inner city clinic responding to the first effects of deinstitutionalization to the supposedly nice suburbs to a clinic in a farming and manufacturing area. The last 15 have been in private practice, both in New York City and in rural Connecticut. So I have some variety of experience, and I've always tried to have an open mind, not to be too doctrinaire. I've written about my battle with depression, and I'm proud to consider myself a consumer as well as a helper. For the past few years most of my patients have come to me for treatment of depression, because that's what I'm known for. But you know that saying you have depression is sort of like saying you have a cough—it can be a manifestation of a lot of other things. So most of my patients, and indeed most consumers in the real world, suffer a lot of anxiety along with their depression, and it often is sort of a crapshoot to say which is the primary diagnosis. So it is, I find, with addictions; most people with addictions, I think, are trying to cure themselves or soothe themselves with a substance or a habit, which hides a lot of pain and yearning underneath. And personality disorders; now we increasingly understand that they too are trying to recover from the scars of childhood. These people, too, have grown a rigid defensive structure that usually is self-defeating—and again they've grown it in an attempt to avoid or minimize pain. Eating disorders, cutting, and other compulsive self-destructive patterns that may have various diagnoses. Much of this is also true for PTSD—people have undergone an extraordinary ordeal, and it's left scars on the brain and the mind, and they have triggers and flashbacks and think they're crazy or defective, but a great deal of their residual misery comes from their efforts to avoid, deny, forget about, the traumatic situation.

Childhood experience and the brain

In my experience, with a few exceptions, one thing almost all these people have in common is a rotten childhood. Just to get the exceptions out of the way—there are two types.

1. One is the PTSD sufferer who has really led a fairly comfortable life until they've experienced their trauma. But the traumatic event may be uniquely damaging to them because of their childhood experience.
2. The other is the unfortunate person who has some wiring in the brain screwed up as a result of genetics or fetal trauma or something like that. This can manifest itself early on, in childhood disorders. Or there are some who have a genetic time bomb in their brains, set to go off at some developmental crisis, which can result in schizophrenia or manic depression or perhaps an addiction.

But let me emphasize that these people are the rare exceptions. I would bet that whether you're working in behavioral health or addictions or the penal system or schools or just the public welfare system, 90 percent of the people who will come to your attention will have had a rotten childhood that has marked them for life. The useful thing about this knowledge is that we are learning more about the effects of this kind of experience on the developing brain and mind, knowledge that we can put to use in helping the people we work with.

What do I mean by a rotten childhood? Most basically, I mean feeling unloved. Or, perhaps worse, being told you're loved but not being treated like it. Along with this goes feeling unsafe, unprotected, scared, alone, unable to trust, not taught to control feelings, not trained in how to learn or interact socially. Why? For one thing, there are just a lot of bad parents out there. I'm sure you've run across them: parents who can't assume the adult role or take responsibility; parents who are just sadistic and abusive; parents who can't control their rage; parents who resent their children or are jealous of them; parents who were never parented themselves; substance-abusing parents. Some parents are victims of circumstance, of poverty and hopelessness, of depression and mental illness, of abuse, of physical illness, of working 70-hour weeks. Sometimes there is a "bad fit" between parent and child: a colicky, needy baby and an overwhelmed mother; an assertive 3 year old boy with a depressed mother and absent father; a child who needs tact and sensitivity and a noisy, bossy father. Sometimes loving and empathic parents can't insulate a child from the world outside; look at the refugee crisis in Europe or Hurricane Katrina or sometimes just growing up as a member of a minority group. Sometimes the damage is done by siblings or the peer group. There are many ways to have a rotten childhood. These are not the reasons why people seek treatment, but they're often the reason why people can't get better.

We're learning more about the effects of a rotten childhood on the developing brain. I've read a fair amount about this, but I'm no expert; still, there seems to be a growing consensus that **a rotten childhood leads to physical brain damage**, as well as damage to the mind and the human spirit. Let me just quote from Allan Schore, someone who is a recognized expert on the neural development of the child, whose three books beginning with Affect Regulation and the Origin of the Self contain enough research to convince anyone of these truths:

Childhood experience—not only trauma and neglect, but also simply a poor relationship betwee and child—results in:

- Damage to the structure of the brain itself, and hence
- Damage to the *adult's* ability to experience and control emotions
- Damage to our ability to have a self-concept of confidence and stability
- Damage to our ability to protect the body from psychological stress
- Damage to our ability to develop rewarding relationships
- Damage to our ability to focus, concentrate, and learn
- And damage to our capacity for self control

So that's the first major takeaway for today:

Adverse childhood experience results in damage to the physical brain, and most of our clients—depressed, anxious, substance abusing, personality disorders, and many with PTSD--have had plenty of those kinds of experiences. But the good news is that the converse is also true: With enough deliberate practice, we can rewire ourselves. We know now that developing motor skills like juggling or playing the guitar results in visible changes in gray matter. The results of successful psychotherapy are visible in brain scans. If you have obsessive-compulsive disorder, certain areas of your brain light up on scans; with good treatment, those areas gradually dim and others light up more. Treatment of depression leads to regrowth of endorphin receptors. Learning and practice forms new neural networks that embody and contain our paradigms.

Two neurons dissected out from a brain, kept alive, and crossed in a petri dish will begin to form connections—develop a web of axons and dendrites--at the point where they are crossed. That's how learning happens. "Neurons that fire together, wire together." Every time you do something, you've just made it more likely you'll do it again, because you've reinforced those neuronal connections. They become more potentiated and more myelinated and they become the default circuitry. That's one of the basic reasons it's so hard to break bad habits.

That's the big new news in science that's still creeping into how we understand ourselves. the idea of the plastic (changeable) brain, the recognition that our brains change and grow physically in response to life experience. In just the past 15 years, we've learned that new brain cells are constantly being formed; stem cells, that can take on the function of any particular neuron, generate deep in the brain and migrate out to specialized locations. New networks between cells keep growing as we learn new things. Neuroscientists know now that bad habits have a physical existence in the structure of the brain; they become the default circuits when we are faced with temptation. Depression burns out joy receptors; anxiety develops a hair trigger. But now we also know that we can rewire the brain to develop healthier circuitry. Scientists can see this happen with the latest imaging equipment. Healthy habits become easier with practice; neurons that fire together, wire together. People believe they lack will power, but will power is not something you either have or don't, like blue eyes. Instead, it's a skill, like tennis or typing. You have to train your nervous system as you would train your muscles and reflexes. And this knowledge should affect how we conduct therapy.

The second major takeaway

is that we have two minds, which don't work well with each other.

Most theorists and researchers today seem to accept the idea that we have, in effect, two minds. In fact, it's just about impossible to explain self-destructive behavior without some concept of the divided self, of motives and feelings that we hide from ourselves. Put very simply, it seems as if we have (1) a thoughtful, conscious, deliberative self, and (2) an automatic self that does most of the work of living without our attention. The conscious self learns by accumulation of knowledge, and can make decisions by reasoning or logic. The automatic self learns from experience, or conditioning, and makes decisions below the level of awareness. The conscious self can certainly make mistakes, but it's our automatic self that usually causes trouble; it's guided by motives and prejudices we're not aware of, our own unique frames of reference that are not in sync with reality, old unconscious habits, feelings we try to deny. The automatic self directs most of our behavior, especially spontaneous actions. The conscious self is in charge when we take the time to think about our choices, but it can only focus on one thing at a time; meanwhile, we're making many other decisions, both for good and for ill. The conscious brain has the job of checking facts and correcting our automatic responses when they lead to bad outcomes, but the truth is that it has much less control over our actions than we want to believe. The automatic self just doesn't hear the conscious self; it doesn't pay attention to logic or rational processes. It takes a great deal of consciousness-raising and self control for us to listen to the conscious self and make decisions rationally.

Compared to the automatic self, the conscious self is much more open to new information and able to be flexible in its response. It's what enables us to be patient, plan for the future, and not respond instinctively to whatever's going on right now. When we think of ourselves, we're thinking of this part of the brain. We like to think we're in charge, and that we live our lives deliberately—but in fact our decision-making and reasoning are deeply influenced by the nonconscious parts of the brain.

So what's the difference between the automatic self and what we commonly call the unconscious? When Freud introduced the concept of the unconscious mind more than a hundred years ago, it was one of those ideas that changed the world. Freud's unconscious is now part of our everyday thinking. When we forget someone's name or miss an appointment, we wonder if it was a Freudian slip. We know that we deny or conveniently forget uncomfortable facts and memories. We know that our dreams are messages from our unconscious. We can see others being "defensive." We don't expect them to fully understand their own motives. While much of the Freudian technique of psychoanalysis has fallen by the wayside, the idea of the unconscious has permanently changed the way we understand ourselves.

But now we think of the unconscious as something <u>much</u> bigger than Freud envisioned. It includes things like motor skills and perception, the fight-or-flight response and falling in love, systems that evolved before consciousness developed. It includes many things that were never repressed, but that were learned unconsciously—prejudice, for instance, or pessimistic thinking; habits and frames of reference. It includes much from social psychology—how our perception is affected by assumptions, our self-image, and the current environment. We depend on the automatic self for 99 percent of getting through the day, and on the whole it's pretty reliable. On the other hand, the conscious self kicks in automatically when we are faced with a difficult problem or a moral dilemma, or when we want to be careful about how we are seen by others.

Here's a good illustration, driving down a road and a ball bounces across in front of you.

So the Freudian unconscious can be seen as part of the greater automatic self, consisting only of what we've repressed due to emotional conflict—feelings that are unacceptable to the conscious self. Then there's yet another subsection of the automatic self, which I call the *assumptive world*. The assumptive world includes our most basic beliefs—conscious and unconscious—about how the world works, and the particular lenses we see the world through. It's not totally unconscious; we can probably express these beliefs, if we're prompted, but we rarely think about them. The assumptive world includes the givens we were born with—our race, our class, our gender, our nationality—and how they bias our point of view. It's much of what we absorbed unconsciously from our parents and our childhood interactions, such as attitudes

toward our own competence and expectations for ourselves, control and freedom, generosity and self-centeredness, optimism and pessimism. None of us can view the world with anything like perfect objectivity, though each of us tends to think we're more objective than the next guy. These perceptions about the world that we have learned from the cradle on up all distort reality to some extent, so everyone's assumptive world is unique, and some fit reality better than others. When you have a rotten childhood, your assumptive world is likely to be self-blaming, to lack hope, trust, and confidence, and to lack the ability to control impulses.

The automatic self—all of its parts—is like a well-programmed computer, able to do many tasks at the same time with little effort. But it doesn't know how to handle anything strange or unfamiliar; to do that requires conscious thought. However, we have a strong tendency to make unfamiliar things fit into our preprogrammed assumptions—the conscious self passing the buck to the automatic self—so we respond to new situations with old habits. The snake in the grass looks like a garden hose, until it moves.

So our choices and actions are much more influenced by processes that we're unaware of than we feel comfortable admitting to ourselves. Scientists are finding new respect for hunches and intuition. People are forever getting involved with and hurt by others—when they were aware from the start of a gut feeling of danger or risk at the moment they met. You all probably know about Antonio Damasio's finding that, when we're being cheated, our GSR goes up (we start to sweat) before we have a conscious perception of danger; the amygdala is secreting stress hormones before we "know" that we're under stress. One of the most common methods of self-destructive behavior is outsmarting ourselves by not paying attention to these warning signs. The problem is that gut feelings can also be dead wrong, and we can't know. Best illustration of distinction: flip a coin five times, get heads every time. Your conscious self will know that the odds of the next flip being heads are 50:50, because each trial is unaffected by what's happened before. But if you *do* flip a sixth heads, your automatic self is going to feel surprised, a little eerie.

And finally, what about that Freudian unconscious? I believe there's still a need for it in our psychology. It's the repository of the repressed, the hidden truths about ourselves we don't want to face, the use of defenses like denial to help us not see uncomfortable reality. But the feelings we repress can have pervasive effects throughout the automatic self. That repression distorts how we perceive reality and influences our feelings and our behavior in ways we literally can't see. When we don't face a reality that will eventually hurt us, that is by definition self-destructive behavior. And repression rarely works perfectly, so the feelings we're trying to stuff can leak out and affect our actions unintentionally—so we're too angry, or too easily hurt, or too

needy; we don't see it but others do. When we overuse our defenses, we become brittle, we don't feel our feelings, and we go through life pretending to be someone else. We develop a personality that interferes with acquiring some of our basic needs—for love, acceptance, success, a sense of meaning.

The third major takeaway is that most self-destructive behavior is a result of these two minds not working well together.

Very often, we know the right thing to do, and we want to do it, but we find ourselves doing the wrong thing. Philosophers and religious thinkers had been trying to figure this out for millennia before psychology was even born, and psychology is just starting to figure it out.

For example, say you've been eating unhealthily for years. You start out on a diet hoping to lose five pounds in two weeks. When you don't, you get discouraged and give up. This is where the thinking brain should take over; you wouldn't expect to learn to play the guitar after only a few weeks' practice, or speak a foreign language. Learning to eat right is no different; yet because we "know" perfectly well what we have to do to change ourselves, and it seems so simple, we expect to overcome a lifetime of bad habits in only a few weeks. But as Alcoholics Anonymous says, just because it's simple doesn't mean it's easy. The thinking brain has no direct influence over our cravings. Habits die hard. **Each time we engage in a bad habit, we make it more likely we'll do it again in the future. But in the same way, each time we engage in a good habit, we make it more likely that we'll do it again**. Focused attention and practice, repeated over and over, will change the brain's reward system, so that bad habits will lose their appeal and be replaced by new, self-constructive behavior patterns. It just takes longer than we want.

Childhood experience and the mind

Besides brain damage, a lot of the effects of a rotten childhood are more near to our experience. Of course it hurts a great deal to feel unloved, unsafe, or unwanted. What do human beings do with pain like that? Usually we try to push it out of consciousness somehow, dull it, distract ourselves. 2500 years ago Buddha taught us that life is hard, but that we add to our suffering by refusing to accept that fact (dukkha). Bad things happen to us, but we use defenses (habits or substances) to distract from the pain or provide temporary escape and comfort. We form our experience into beliefs and unconscious assumptions that literally determine what we see and what we don't. We try to preserve the myth that life is good and fair—or that our parents loved us--by casting our misfortune as exceptional. *If only I do better, I'll get what I want*—**maybe—***but not if what you want is peace of mind or relief from*

unconscious guilt or to be loved. This avoidance of reality makes us dishonest with ourselves and only adds to our suffering. The only way out of this circle, Buddha said, is to accept that life is hard, and try to live a righteous life anyhow, something that we have a lot of trouble with. Freud taught that the purpose of treatment is to help people accept "the reality principle." The reality principle is that life is hard and not fair. The automatic self usually has a lot of trouble with that.

Defenses and paradigms

When our feelings are in conflict with each other, or are unacceptable to us, we use *defense mechanisms* like denial, rationalization, projection, to put them into the unconscious part of our minds or to send them somewhere else. We can also use drugs or other compulsive behavior like gambling to distract us from our feelings. Our pride might not let us be aware of feelings of jealousy; our conscience might suppress sexual attraction to someone other than our partner; and it could be dangerous to fully experience our anger at authority figures. Memories and feelings like these may not be accessible to us but still exert a powerful influence. These memories and emotions pop up in dreams and daydreams, anxiety attacks and depressed moods, sometimes in a deep reverie. And they result in self-destructive behavior, because these troublesome emotions are still active within us, even when we're not aware.

So we try not to feel, but this is a self-destructive strategy. Our emotions are central to our experience; we try to seek happiness and avoid pain, and we can't do that without the signal functions of feelings. Anger, joy, rejection, sexual attraction, sadness, jealousy, satisfaction, and so many other feelings are vital information about our world. They tell us about our values and ethics; we *feel* what is right or wrong, good or bad, and then the conscious self explains to us why we feel that way. When we're confronted with a moral choice, we should pay special attention to our feelings, because if we think too much, we can rationalize doing the easy, convenient thing instead of the right thing.

Emotions in themselves are absolutely value-free. They are reflexes, like salivating when hungry or pulling your hand away from a hot iron. The point is that although we have some control over how we express emotions, many of us seem to have concluded that we shouldn't even feel some feelings—an almost impossible task. And then having these unacknowledged feelings introduces guilt and shame, major sources of misery.

Emotions are hardwired, instinctual responses to stimuli--chemical, electrical, endocrine events in your brain and body, reactions we seem to share with higher animals—joy, pride, sadness, anger, desire, shame, nurturing, excitement, guilt. Serotonin and oxytocin motivate worms and crayfish. Our emotions arise in the automatic self and may or may not come into

consciousness. Even if not conscious, they affect our behavior. In the psych lab, subjects primed to think about elderly people walk down the hall more slowly after the experiment; those primed with anger-laden words are ruder to the experimenter; those primed to think about money are more selfish. In everyday life, it's a common experience to snap at someone and only then realize we're cranky. But we keep trying to pretend we don't **feel** all those things that are unacceptable to us—with self-destructive consequences.

Defenses are perfectly natural and often helpful. We rely on them to help us regulate upsetting feelings and prioritize our actions. They are habits of the mind that gradually become part of the brain's circuitry, essential building blocks that are part of our character. They can serve very useful purposes, enabling EMTs to remain calm at accident scenes and helping mothers cope with squalling babies. They help us calm down and choose our battles wisely, instead of being guided by sudden impulse. But they're also used to keep vital information away from consciousness.

Denial is the classic example of a defense blinding us to the consequences of our own self-destructive behavior. In denial, you *don't see* the problem or its effects. The alcoholic denies the evidence of his own senses—that it's harder and harder to function without alcohol—and doesn't hear the entreaties or warnings of his wife, friends, and employers. When his wife leaves him, he'll blame her; when he gets fired, he'll blame his boss. He'll blame anything but his drinking. In passive aggression, we can use denial to block awareness of our hostility, like the adolescent who doesn't understand why his mom yells at him as he's watching TV while she's trying to vacuum the floor under his feet.

When defenses are used to blind us to a difficult reality, four bad things usually happen:

1. We'll miss the useful info that the emotion was telling us about.
2. The emotion we're trying to block will leak out in some way. We'll yell at the kids instead of the boss. We'll focus our fears on procrastination instead of responsibility.
3. Reality catches up to us in the end. Your term paper will come due. Your liver will fail. You will lose your job—or at least not get ahead.
4. Our character becomes warped by overuse of the defense. We become dishonest with ourselves, and therefore untrustworthy to others. Instead of confronting authority, we get sneaky. Instead of accepting that we make mistakes, we get depressed and keep on trying to be perfect. Our twisted assumptive world means that we value self-protection above honesty and adventure.

How therapy works

Enough background. It should be clear by now that if we want to help people change, give up their bad habits, whether behavioral, emotional, or interpersonal, we have to work on both the conscious self and the automatic self. The most common mistake we make, because we're verbal, logical people, is focusing too much on the conscious self, on what we say, what the client says, and assuming the automatic self will follow. It usually doesn't. Insight alone doesn't change behavior, though it's helpful for the client to develop the kind of cognitive understanding that will keep reminding him of what he needs to do. Instead I think we need to help people have the right kind of experiences that can lead to changes in the automatic self. And we need to help our clients find a new explanation for their troubles. Their understanding is faulty, blaming, depressed, guilty. Much of the talk in therapy still has to be about why; the client needs a new narrative that helps them take genuine responsibility and move away from neurotic self-blame.

I find it a useful hypothesis that the presenting problem is a current manifestation of the childhood experience. "The present and chronically endured pain," in the words of James Mann, who explored time-limited therapy. Another dynamic therapist, David Malan, talked about the "triangle of insight"—the link between the old wound, the presenting problem, and the countertransference (the difficulties of engaging with the therapist). As in: my patient with two Holocaust survivor parents, very depressed and just barely alive, whose function it was as a child to watch TV with his silent mother when he wanted to be out playing with the neighborhood kids. He got in trouble as an adult for downloading child pornography—as his wife, who was very much alive when healthy, was dying of cancer--but his interest seemed to be in fantasizing that he was part of an idyllic childhood world, mankind before the fall, if you will, with the oedipal element thrown in. The old pain of a deprived, hopeless childhood manifests as a crime (expressing his rage) that he saw as somehow innocent.

The old injury leaves scars in our brain, neural circuitry that makes us afraid in the present. We interpret this, often wrongly, to mean there's something to be afraid of now. The old injury—which we work to keep out of consciousness—still makes us feel vulnerable. The current fear, which again is usually unconscious, derives from the old injury and drives the patient into the crisis that brings him to our door. Maybe it's fear of being reinjured, worse, in the same way, but it can also be our fear of our own rage. We load present circumstances with the baggage of the past.

Anyway, the link between the presenting problem and the childhood wound is a useful hypothesis. Even in PTSD cases, the patient may have had a vulnerability to this particular

trauma due to his childhood damage. And when it is the case, and it often is, you have a great tool for engaging the client. When you say something like "it seems like your wife is making you feel the way your mother made you feel as a boy," or "you've felt unhappy and misunderstood since childhood, though you don't like to think about that, and alcohol helps you forget it," if you're on target you are communicating that you "get" the client in a way that perhaps no one ever has before. And when you're encountering resistance, it's useful to remember that the "present and chronically endured pain" probably has something to do with the obstacles that the client is throwing up to avoid engaging with you.

The environment

The therapeutic environment is another element that helps get change going. There is a great deal about the therapeutic situation that we tend to take for granted, but really makes this a unique and powerful experience. Probably most of you have had the experience of a client disclosing something to you that he's never told anyone else before. This is partly due to your skill, but it's also a lot to do with the special conditions of the therapeutic situation. We work hard to create an atmosphere of privacy and trust. We will not disclose the client's secrets. We will not judge him. We will pay very close attention. We are there to serve him, and we put aside all our own needs. Very few relationships are like that. Most relationships are reciprocal: I talk, you talk; I reveal, you reveal; I brag, you brag. If it's a good relationship, there's a rough balance and we both get something out of it, but <u>we're always concerned with the other guy's feelings.</u> In the therapeutic situation, the patient will gradually learn that those concerns aren't necessary and he really can just think about himself. We don't reveal, show off, gossip, talk trivia, change the subject (except for therapeutic purposes), express our needs, or judge, and that's really unique. I realize that some of you here probably work in positions where you have some power over the patient, and that will be an obstacle to trust; but absolute honesty will help a lot.

The patient comes to your office wanting help, yet not wanting to change. We can label this "resistance" and blame the patient, if we don't understand what's going on. All he wants is relief from his troubling symptoms, but he doesn't know yet that it's his own behavior (largely) that's causing those symptoms, and therefore he's going to have to change. Besides, he's anxious because past relationships mean he can't trust you entirely. Therefore his answers aren't totally honest; he can't be truly honest to himself; we can't be totally honest with ourselves. He uses defenses, which create his symptoms and his presenting problem. He may abuse substances to help avoid the pain, but he's not likely to be totally honest about that.

If he does express a feeling, we encourage him to go deeper, to get to know himself better. One of my most revealing experiences in graduate school was a summer job listening to recordings of my fellow students' sessions. I was trained to listen very carefully and code every interaction. It gradually dawned on me that over and over again I would hear the client express a feeling and the novice therapist change the subject. We were being taught to "go with the feeling," and it seemed like no one could do it. Sometimes the client would spend the entire session trying to talk about something and the therapist would keep avoiding it. Then I started listening to everyday conversation in the same way and I realized this is the way we're built. With a few exceptions of people who are naturally empathic and fearless, **we don't want to hear about other people's pain.** We don't want too much intimacy. If you work with couples or groups I'm sure you hear this all the time. To become good therapists, most of us have to overcome this innate fear of intense emotional connection. So our stock responses—"how did that make you feel?" "Tell me more"—although they may seem mundane to us, are likely going to create a very powerful experience for the patient. Habitual defenses begin to come down all by themselves. The opportunity to tell your story in a way that someone else will understand, without fear or pressure, means you're putting your feelings and thoughts into words for maybe the first time; and maybe for the first time the conscious self is hearing the automatic self. Just that can be a wonderfully clarifying, organizing experience.

If the patient is too anxious, we help him with the anxiety and then go after feelings. If he uses a defense, we help him see the defense and its cost, and then go after feelings. This is the basic method of most psychotherapy. And this is one of the reasons why it's important to take a history, all the way back through childhood, to understand the unique rottenness of this person's experience. When we feel he's being stubborn, when our empathy is being tested, it can help a lot to remember that frightened, unloved, unsafe child that still exists within this adult. The distorted perceptions and defenses that avoid reality and lead to trouble are there in the first place to protect him from a reality he fears. As therapists, we have to respect that fear, help the client face reality more directly a little at a time. We're not in the business of attacking defenses, but of removing the need for them.

A friend of mine uses the phrase "compassionate curiosity" to describe the ideal therapeutic stance. We begin therapy with a much more compassionate, kind, understanding stance toward the patient and his problems than the patient has himself. And we are curious, in a calm, unafraid way—we want to understand how things got to be so bad, and we assume that by fearlessly facing reality we will help the patient find relief from his distress. And of course we're

modeling this attitude for the patient: though he fears his feelings, we're showing that there's nothing to fear.

Methods

So—the automatic self and the conscious self. Does therapy work by "making the unconscious conscious?" Yes and no. Though the conscious self usually makes better decisions, there are far too many decisions we make every day for us to depend on it to run our lives. We work to make the automatic self more effective, realistic, observant, less complacent.

So I give a lot of homework:

- The mood journal. *Nothing comes out of the blue.* The patient is scared because his feelings don't seem to connect to reality; but this is because his defenses blind him. Learn to spot your triggers. And maybe how they have their origins in the rotten childhood. Trace especially guilt and shame, and apply conscious reasoning
- Honesty lessons. Helps you become more aware of your automatic use of defenses to project a desired self-image.
- Assertiveness training.
- Empathic listening.
- Get out in the world and interact with people.
- Find a purpose.
- Practice will power, when fighting a temptation or trying new behavior.
    - Avoid triggers
    - Avoid enablers
    - It's worse than you expect, but not as bad as you fear.
    - Don't try unless you're ready to go to the mat.
    - Keep practicing Think of developing will power like practicing the guitar every day: After a year's practice you'll be pretty good, but you will still be far from perfect. This is a lifelong task.
    - Baby steps
    - Rewards
    - Don't obsess, distract. You can't use the logical brain to stop obsessing. You can't not think of a pink elephant. Change the scene. Mindfulness and Gore-tex suit.
    - Don't let a slip kill your resolve. If you slip up on day 30, you've still got 29 days of practice rewiring the brain. Get back on the horse.

- Savor the results.

- Spotting self-hate.

And the new narrative, new points of view, new paradigms become something mindfulness practice can focus on. So I do some education.

- Teach the client how bad habits are formed in the brain, that he's unaware of his self-destructive decisions, that he has to become more aware. And the good news is that the brain rewires itself as we practice new experiences.
- Teach the patient about the mind's complacency (as it come up in the narrative). Challenge assumptions.
- Emphasize the subjective and objective results of trying new behavior or thinking. Patient isn't likely to notice, complacent paradigm will resist.

I think that mindfulness training is a very useful tool, no matter what's the problem. Mindfulness to me is the ability to look at yourself calmly, objectively, and compassionately. It means stepping back a little from disturbing thoughts and powerful impulses and emotions—fear, anger, guilt, shame, blame—so that you can experience them a bit without acting on them in haste. It requires the confidence to experience these things and know that they won't destroy you. It requires teaching the conscious self to look objectively at the automatic self. With enough practice, though, mindfulness becomes an unconscious habit. It's a skill of the mind to be developed through practice. Being mindful means becoming so aware of the unconscious mental habits and paradigms that we assume are the only reality that it's like opening a door into another dimension.

And practice mindfulness meditation. I can simplify it to five steps.

1. Find a quiet place.
2. Focus on your breath.
3. You will have distracting thoughts, feelings and impulses. This is natural. Just refocus attention on your breath.
4. When you feel discouraged, or that you're not doing it right, return your attention to your breath.
5. Visualize yourself out in a gentle rain. The rain is all the thoughts, feelings, etc. that keep trying to distract you. Visualize meditation practice as a Gore-Tex suit that keeps you dry.

Without meditation practice, you may develop a cognitive understanding of mindfulness, but you won't be able to <u>do</u> it. It takes practice, it's a body/mind skill. So download a good mindfulness meditation exercise, and have your clients practice it.

Summary

So—let me summarize

- Childhood experience changes the basic structure of the brain. Especially for our clients who have had rotten childhoods, they have trouble trusting and being intimate, they have trouble with self-control, they can't maintain a positive image of themselves, and they have a lot of trouble experiencing and controlling emotions.
- We have two minds, an automatic self that makes most of our decisions below the level of consciousness, and a conscious self that is only used when we're paying attention. The automatic self is subject to a lot of biases, prejudices, and fallacies. It isn't changed by listening to the lessons learned by the conscious self, it's only changed through practice. The good news is that practicing better life skills rewires the brain; it just takes more practice than we want it to.
- Some of that automatic self resists learning those lessons because they cause anxiety. We don't like to face painful memories, or feelings that are in conflict with how we want to see ourselves. We use defenses to stuff these experiences out of awareness, but that usually leads to trouble. We don't see reality correctly and our character gets warped. Like the Buddha says, life is hard but we make it worse by trying to pretend that it isn't.
- In therapy, it's a good working hypothesis that the old pain of childhood experiences is being activated by something about the presenting problem. And that link may also have something to do with why the patient has trouble engaging in treatment; again, the patient is only trying to avoid pain; our job is to bring that pain out into the open, gently, so he can deal with it directly.
- We shouldn't take for granted the effects of the therapeutic situation—the privacy, trust, and intimacy. Often this is enough to enable the client to carry the ball.
- But when it's not, we have to remember that we're trying to change the automatic self, and that insight doesn't do it. Insight is useful in helping the client forgive himself, develop a new self-image and narrative, but it's not enough. We have to get the client, ultimately, to face his fears. And we do this by encouraging new behavior and new experiences, and reflecting on them with the client. Homework is a very good idea, one that we should prescribe more, and always remember to follow up on.