David Allen

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David M. Allen, M.D. is the author of a new book for general audiences, *How Dysfunctional Families Spur Mental Disorders: A Balanced Approach to Resolve Problems and Reconcile Relationships*, and three books for psychotherapists: *A Family Systems Approach to Individual Psychotherapy, Deciphering Motivation in Psychotherapy*, and *Psychotherapy with Borderline Patients: an Integrated Approach*. He is a Professor of Psychiatry and the former Director of Psychiatric Residency Training at the University of Tennessee Health Science Center in Memphis, a position he held for 16 years. Prior to that he was in private practice in Southern California during the advent of managed care. Additionally, he has done research into personality disorders and is a psychotherapy theorist. He is associate editor of the *Journal of Psychotherapy Integration*.

Serge Prengel, LMHC is the editor the *Relational Implicit* project (http://relationalimplicit.com).

For better or worse, this transcript retains the spontaneous, spoken-language quality of the podcast conversation.

Serge Prengel: This is a conversation with David Allen. Hi David.

David Allen: Hi, how are you doing?

S P: Good, thanks. So, you have been interested for a very long time about psychotherapy integration.

D A: Yeah, it started when I was a resident, I was more interested in psychotherapy than I was in the biological aspects of it, but it was in the 70s and the analysts were in charge, and they were very arrogant as far as I could tell, and if you started questioning what they were advancing, you were told that you needed to get in therapy to find out why you were resistant to the ideas, which is like three logical fallacies all in one, and then I came across all these different schools and I had a very naïve view of science at that time, and it didn't seem like one built on another, like I'd pick up something by Fritz Perls, and he would say, "The first thing we have to do is throw out everything Freud ever said", and I thought that was just really bizarre, and so I thought, I had this naïve view of science, that builds on previous knowledge, but I really didn't understand it. So I started out, after my residency, doing biological psychiatry until I got bored to tears writing scripts and decided well, maybe I might want to give psychotherapy another chance, and a psychologist friend of mine gave me the book by, the famous book by Kuhn about paradigm shifts, and he was talking about how there's always various competing models in the young science, and I realized that psychology not only is the young science, but our subject matter is not directly accessible. I didn't agree with the behaviorists, who were saying that-

S P: So, David, I just wanted to slow down a little bit because you're talking about an enormous amount of things in this time, but really essentially that sense of really strong interest in psychotherapy, and a disappointment about this discordant voices that didn't seem to be very logical

in a way where there wasn't a sense of pathology in the way they were going about talking about what they were doing

D A: Exactly.

S P: And then that big shift was about realizing that actually, these discordant voices, it was okay to have them, and it was not about, it didn't have to be all logical and all integrated that you were going to actually try to make sense of this whole mess.

D A: Right, and I was sort of narcissistic or grandiose or something, and I thought that I'd start writing a book about trying to put all of this together, and the same psychologist who gave me the book by Kuhn also introduced me to family systems thinking, which I thought seemed a bit more logical in a way because humans are social organisms, and behaviorists would talk about food pellets and electric shocks as primary reinforcers, but not other people, which I thought was really strange, plus I was building a practice and I was always really interested in borderline personality disorder, because they were sort of a microcosm of everything wrong psychologically that could possibly be in one person without being brain damaged or psychotic, and I built a practice because nobody else wanted to treat them basically, and people would apologize to me for sending them to me and I said, "No, no, I don't mind", and I gradually tried to figure out why they were acting that way because I realized that half of what almost all of what they were doing was an act, they could turn it off and on like a faucet.

S P: So again, if you don't mind, I would interrupt you here to say that what strikes me in what you're saying is it's very nice, as you're talking about integration and as you're talking about your search for a theory, what you're describing is also grounding this process in the various events and realities of your life. So we're not talking about you having a disembodied sense of a theory, but you're saying, "This is what happened first in terms of my encounter with psychiatry", and the dissatisfaction as being somebody simply writing prescriptions- "My dissatisfaction was with the science, or so-called science of psychotherapy at the time. My experience in the fact that I was dealing with borderline personality people, the chance encounter with family systems therapy", and so in a way that integration is something that happened to you as a way of dealing with separate experiences and making sense of them.

D A: Correct, and in the meantime, whenever I had a No Show or something, I'd pick up one of the many theorists, I went through all of them, and I actually got to family systems kind of late in the business, and I got to Murray Bowen's theory last in the series, and it was like a revelation, he sort of put it all together. But I was still a little troubled by Bowen's stuff because again, he didn't really focus enough on the individual, like all of the system, plus he would train his patients to what he called "differentiate" themselves from their family of origin, which means they would not participate in the usual triangles and feedback loops, and he would train them to be strategic family therapists with their own family, rather than Bowen therapists, was pointed out by a guy named Dan Wile in a book called "Couples Therapy", so I said, "Yeah, well why not train people to be Bowen therapists with their family of origin, and use collaboration, cooperation, understanding the genograms and how these patterns developed over time and why people were acting out and mistreating each other with the goal of them understanding their position in the family, and I found that people having insight into why their families acted the way they did was actually more helpful than having insight into why they acted the way they did because they could understand why they

acted the way they did if they understood why the family members were giving them all these double messages.

S P: So that's a very, very strong sense of what human being is, a social animal, how we come from a family environment, and paying attention to all that the family environment does to us, which is important to us, not using this idea to simply eliminate the individual development but looking at the interaction and the context, and paying attention to this context not just as a therapist, but also sharing it with your clients as a way to help them think in this way and see things in this perspective.

D A: Absolutely, but in order to do that, you have to understand what the family was actually doing, and borderlines have this reputation for distorting everything, but some of my borderline patients were annoyed at constantly being accused of distorting everything, so they would record, and I'm talking about adult patients, not children, they would record conversations with their parents, when the parents didn't know that they were being recorded, which is illegal in some states but it's not illegal for me to listen to them, and they would bring the tape back to me to sort of prove that they weren't distorting. And I started hearing the most amazing things, and I realized that I wasn't asking the right questions. And even in couple's therapy, if I started saying, "Well what does your mother-in-law say about this?" I would get all this information that they'd never thought to volunteer. Sometimes I've found that the spouse knew more about their in-laws than the child of those people, on certain subjects, and I was wondering why that is. So I started getting interested in feedback loops, but not in the circular sense, but in a dialectical sense, I didn't know what dialectics was at the time, so I kind of reinvented the wheel. And so looking at all of this mutual, simultaneous change going on by people affecting each other, and I also knew that the family was way more powerful than I could ever be, for good and bad, in affecting my patient's behavior. When I was doing behaviorist interventions, I would do assertiveness training, and they would be all ready to go, confront their dad or whatever like that, and they would come back the next week with their tail between their legs, and that was just pretty consistent. And I realized "I'm no match for these people", and then all this biological information which I wrote about recently started coming out about early fear tracks and things like the amygdala and how there's cells that respond to familiar faces but not unfamiliar faces, and I realized, what I alluded to earlier, that it's not only people that are the most important reinforcers of maladaptive behavior, but primary caretakers were more powerful, even as people reached adulthood, than any other people. And they were the most potent reinforcers, and it worked on a variable intermittent reinforcement schedule, so you didn't even have to have a lot of contact with them, it's like the feeling you get when you've been away from your parents for a long time and you walk in the door and you feel like an adolescent again, it didn't take very much. And I also noticed that these patients were very good at getting me to sound just like their parents, when I listened to the tapes, I go, "My god, I sound just like them! How did they get me to do that? Man, they're good!" and I realized what was going on there.

S P: So what is very striking there is that way of finding a way to include in this therapeutic process the whole context of the family, listening and finding ways to understand more how the family works, understanding that simply talking about it, or talking about assertiveness in the session does not take into consideration the difficulty of finding these powerful figures, noticing how these same cycles, these same games can be replayed, and how you can be dragged into it, and also how this fits within a behavioral model of this intermittent reinforcement.

D A: Exactly, and one last piece of the puzzle came. I read "Escape From Freedom", by Erich Fromm, which talked about the evolution of individuality from collectivism over history, and I realized that

there were cultural changes going on that were impacting the family, and as some family therapists had pointed out, that some people were kind of stuck with old rules and homeostatic mechanisms for reinforcing those rules, but what they didn't talk about was how people could be ambivalent about those rules because the culture was changing at a more rapid clip than it used to, so that the demands for more individuated behavior are escalating. So some people, some families would really get stuck using old rules, but would be highly ambivalent about it, for instance it's obvious in the case of the role of women in particular, during World War II, the Rosie the Riveter phenomenon lead to women joining the workforce, and they suddenly realized that "Hey, maybe there's more to life than being a housewife and mother", but then after the war there were actually government propaganda films that said "Great job girls, but time to go back and get barefoot and pregnant again", and then they all did, which lead to the baby boom, and their daughters though, grew up in the 60's, when the feminist movement was first exploding, so the daughters would come and say, "Oh! We can have it all! We can be astronauts, and we're going to have fewer kids", and they would come home talking about this to Mom, and Mom would faint because it reminded her that she didn't get to do that, but she had never been validated, or consensually validated or mirrored, to use the Kohutian term for being career-oriented, so the daughter's success was, in a way, problematic for her. On one hand, people live vicariously through their kids, so they kind of want their daughter to go out and have a career, but at the same time it reminded them A: they didn't get to, and they really couldn't endorse it without upsetting their family of origin and their family structure, so they couldn't do it themselves because it reminded them, plus they had all these fears that women would end up with the short end of the stick if they did that. There was an article in Newsweek that said that the odds of the 34-year-old career woman getting married were somewhat akin to the odds of being hit by a terrorist (this was way before 9/11), and that created this huge cultural stir, and everybody was kind of freaking out, and "Men don't like women that are smarter than they are", and all this. So the women would, if it was a healthy family, the mother and the daughter would agree that they just wouldn't talk about it very much, but if the mom got too upset, the rest of the family would gang up on the daughter and say, "How could you treat your mother this way? What is the matter with you?", and you can just imagine everybody you know and love and care about coming at you like that, how powerful that would be. But the daughters were still conflicted because they were also getting positive vibes from their moms about their careers, because of that vicarious thing I was talking about earlier, so they would either think their mom was mad, bad, or stupid, basically, and they'd have no idea because the mom wouldn't talk about why she was giving off these crazy double messages.

S P: And so it's a very powerful example here how change is not just processed by an individual, but is processed by society as a whole, and is processed within the family unit. In a way, all these different ways of processing influence each other, and when you see somebody in the therapy room, you're not just dealing with their own processing, but the result of all of this group processing.

D A: Right, and the whole history of the relationship is more important than any single element within that relationship. So people say, "Well, if these people are sacrificing themselves for family homeostasis, how do you explain oppositional behavior?" Well, that's easy. If you think that's what the family wants you to do, be oppositional, then the oppositionality is more apparent than real, because you're actually cooperating.

S P: That's the paradox that oppositional behavior is a form of cooperation. It is the form of cooperation that you believe is expected of you in the family.

D A: Yeah, you're expected to be the black sheep but that's your view of what's happening in the family, so it's not just what people are doing, but it's how you interpret it, but it's a perfectly logical interpretation when you're kind of getting a "wink-wink, nod-nod" when you start acting out. One patient, a mother, kind of had borderline traits, and when her kids would act out and get into trouble and she would describe that in therapy, she'd have a big smile on her face. And I'm thinking, "Well, if I'm seeing that, so are the kids." So the psychoanalysts used to call this phenomenon "superego lacuna"- holes in the mother's superego where she would tell them "You shouldn't act like this", but then when they did she would seem to get off on it. That's an example of a really extreme double message, and the whole context of the mother's behavior is going to be more important than any single thing that the mother says. So actions speak louder than words, but words are also actions so you have to take that into consideration as well.

S P: So as you put this very strong view of how the importance of the context, society as a whole, what happens in the family, what the double message of the parents can give, the different ways in which the message is given and delivered, we get into a really strong importance of the context, yet you also started as a biologically-oriented psychiatrist, you are a psychiatrist, you teach psychiatry, so how do you reconcile, how do you navigate the part that is somatic, that is genetic, that you can act on the body, and the part of interactions that come form more context or purely psychological phenomena?

D A: Again, I don't view that as a difficulty, because the medicines that we have treat symptoms, they don't treat diseases, with the possible exception of lithium. So if someone's having panic attacks, and we have a medicine that stops panic attacks, in order to do psychotherapy with a borderline, like 40% of borderlines have panic disorder as well, I'm asking them to think about really, really upsetting stuff, and when I get to the homework phase, when I'm actually teaching them how to discuss family dynamics with very resistant, defensive primary attachment figures, if they're having panic attacks, they're not going to do very well. So luckily we have medications for that, so I can put them on medication, which helps lower the bar, if enough upsetting things happen, they're going to get upset no matter what, but medications like SSRI anti-depressants decrease neuroticisms, they lower the bar so it takes more for them to get to an emotionally-disregulated state. So I'm using the medication as a way to help me do the therapy. There's certain conditions in which I think are brain diseases, I get into big arguments with the anti-psychiatry folks on my blog, I think the whole sphere of what's a brain disease and what's a conditioned response gets really murky with all the debates on the DSM-5 and I don't want to get into that too much, but I do think there are certain brain diseases, I think real melancholic clinical depression is a disease, and the antidepressants they don't cure it, we don't even know how they work, frankly, and then when the patient is in the euthymic state they have to reevaluate them to see if they also have Axis 2 issues, personality issues, just because you're not in a clinical depression doesn't mean that you're a happy camper, which is another mistake that the so-called "biological psychiatrists" make, they assume that if someone's unhappy after you treat them with an anti-depressant, it must be a partial response to the medication when in fact you're just returning them to their baseline. So they add more medication, and you get these people coming in on incredibly stupid combinations of drugs, and they get changed over and over again because they don't work, obviously, and because of other forces that I write a lot about in my newer book. Psychiatrists are being sort of brainwashed into thinking that everything's biological, in the sense of abnormalities and brain functioning, but we know the brain is plastic and changes in shape and size and a lot of other parts of the brain, and certainly in neural connectivity because of social interactions. So every time they find a difference

between, say borderlines and normals, they automatically label it an “abnormality”, when in fact it may just be the brain’s conditioned response, and an adaptive one, to a particular environment.

S P: And so therefore, the possibility of actually the brain changing as the conditions are changing.

D A: Right- borderline patients tend to react very quickly, and that’s the pathology, but there’s something called error management theory. So let’s say you’re walking through the woods, and you see an animal. Now, if you mistake a bear for a raccoon, and you run away you’ll live. But if you make the opposite mistake, you’ll die. So if you mistake a raccoon for a bear, and you run away, well you’ve expended a little energy, no big deal, but if you mistake a bear for a raccoon, you end up being dead, so the brain conditions itself to respond quickly because that makes sense, in terms of your ultimate survival. There’s more of a cost if you underreact than if you overreact, so the brain programs itself to overreact, over years. So you’ll see changes in the amygdala size with patients with borderline, but it’s a conditioned response, and there’s some data, which I wish would get published but I keep hearing rumors about it using something called schema therapy, that that can be reversed, but I don’t know if it held up or not because I haven’t seen it published, but I’m hopeful that that’s in fact true, that that would mean that some of these things, at least, might be reversible.

S P: So you’re talking about the fact that, in a way, a lot of these things that seem strange are actually logical conclusions of the body, of the organism, to the circumstances that are around them, and that as they are reactions, side effects, symptoms, adaptations, they can also be changed, either by changing the environment or changing how this person adapts to the environment.

D A: Right, they can be overridden by the thinking parts of the brain, they never go away, you can learn to override them, but if your environment changes long enough, then maybe some of them might be reversible, but I imagine that would take a lot of time. What I find is the patients that do well with my type of therapy, their neuroticism level stays high, even though they feel a lot better and they’re doing a lot better, which tells me things haven’t reversed yet in terms of the underlying biology, they’re just better able to override it, which is okay, there’s nothing wrong with being sensitive, when you think about it, that’s not a problem per say, it’s how you respond to the sensitivity that creates the problem.

S P: So in a way we’re talking about here is in a very general way, a sense of the human being as this social animal that is subject to influences in the environment, that in turn affects the nervous system that in turn affects the behavior, and that psychotherapy, in lots of ways, is understanding those things that create the problems were observing, and the possibility of retraining the nervous system to better adapt, and there is al line about certain limitations that people may have, but essentially the possibility of retaining the nervous system.

D A: Okay, again, but if the parents are reinforcing the old ones, they’re going to be more powerful than the therapists, so that has to change first, and old habits die hard. It’s interesting that the show *Supernanny*, which I’m a fan of it, she always has to go back to reinforce what she said, she changes the family dynamics, and then she leaves and they automatically start reverting back to their old habits and she has to come again and get them back on track, and I know they may be picking and choosing what they show and it’s a TV show, but that’s kind of very in line with my experience with the way families operate.

S P: And what you're talking about is having a healthy respect for the fact that the changes, the way people are, is really strongly implanted because we've had this intermittent reinforcement by very important people and we can't just assume that it's going to suddenly disappear just because it's been pointed out.

D A: Exactly, I think that's the big mistake of the psychoanalysts, they think that the transference cure, the transference relationship changes is going to generalize to the other important relationships in the patient's life, but the other people in the patient's life don't act like the analyst. So a patient can have a lot of insight and be very adaptive to being in the analytic situation, but then when they go out in the world…well again, it depends, if the family accepts the change, or creates a little bit of a ripple, nothing too bad happens, then great. And that's why people who aren't very disturbed get better with just about anything you do, because family doesn't start to overreact, but with borderline families, you could get people killed. If you start getting people to change, their reactions are just incredible, or the parents could commit suicide. If you change your behavior and your mom sticks her head in the oven, that's going to have a stronger effect than anything.

S P: Yeah, or even if there's a possibility that's going to put a damper on it. Let's talk a little bit about what happens, the way you do therapy and maybe an example that gives a little sense of how you deal with this kind of situation.

D A: Well it's a staged therapy, it's hard to give examples because I'd have to give a whole case to really understand it. The first thing I do with borderlines is get them to stop acting out with me, I've learned there's certain types of responses, they do this, you do this, and people that deal with borderlines from all schools all start with the same basic strategies, we have different theories about why they work, but they're survival skills for therapists, so that the patient doesn't act out with you. And except in very severe cases, it turns out that's amazingly easy to do, once you know the tricks of the trade. They're still going to test it and be difficult a little bit, people ask me, "How can you treat several borderlines?" and I go, "Well it's not really a big problem", in really bad cases they can still act out no matter what you do. So the first day you sort of get their cooperation and get them to quit screaming at you, and trying to undermine you, and trying to entice you into boundary violations, trying to make you feel helpless, that's one of the reasons I got interested because I was challenged because they made me feel so helpless, I couldn't stand it and had to figure out a reverse, and I realized, "Well, you are kind of helpless", it's sort of anxious about being helpless is what they're really trying to go for, but if you admit helplessness, that sort of doesn't give them anywhere else to go. So that's the first stage, and then I actually start with a kind of free association instruction to have them start talking about, but I don't tell them to free associate about anything but basically about their chief complaint, which I frame as either affective or anxiety symptoms of unknown etiology, any repeating self-defeating or self-destructive behavior pattern, or overt family discord. And in personality disorders, if you see one of those, if you wait long enough you'll see the other two. So I frame therapy as a two-art deal. First you have to figure out what's going on, and then you have to figure out what you're going to do about it. So there's the free association, I tell them to free associate about their chief complaint, or the particular frame, and I'm listening for certain types of patterns and kind of asking questions about family dynamics when they pop up, which they invariably do, I'll start asking certain types of questions. Now I already took a complete social history so I have a skeleton I can hang facts on. So once I find out what the double messages are, what's reinforcing the self-defeating behavior, then the next step is to figure out well why are your folks acting like this? Because it's not enough to point out what's happening, you have to understand why, so that leads-

S P: And just for a moment, in that part, you say you're figuring out what the messages are, these conflicting messages. At that moment, your patient is aware of that nature, or is in a way reporting them without having awareness of it?

D A: Awareness of what?

S P: Of the mixed messages, or the complexity of it, or of the role…

D A: Yeah, they sort of know that they're getting it, but they don't necessarily conceptualize it in those terms, but I'm starting to point it out, and I'm being very empathic with how confused they must be. I literally have a patient who when she turned 12 or 13, her dad raped her and then bought her a pony the next day, how do we explain Dad's behavior? That's so bizarre.

S P: So even at that part when you're collecting information, there is also an educational and containing role in that?

D A: Yeah, it's very psychoeducational, the whole thing is really. I ask people about their previous therapy and I'll say, "Well what did you learn?" and they look at me like "Huh? I was supposed to learn something?" maybe they did and they just don't realize it ,to me you're really teaching them about what's going on. So when we identify the patterns and figure out why they're happening, that leads to the genogram, when you start exploring the parents' background. And we're not just digging up skeletons to examine the past, the dichotomy between the here and now and the historical is to me nonsensical because what's going on in the here and now is based on how we reacted and changed the things we've learned over the entire history of things. So the past is still here, it's in our heads, and people don't lead disconnected lives when they're different people from one second to the next, it's kind of a false dichotomy. So not only are we looking at your background, we're looking at your parents' background, and then I start having them research, usually by interviewing relatives, so we can come up with hypotheses about why the family is acting the way it is, which might be something similar to what I was talking about the evolution of women's rights, but the main purpose of that is so the patient can be empathic with the parents instead of being angry about it. When I was starting in therapy and trying Gestalt techniques, always trying to get people in touch with their anger, and all I got was denial, denial, denial, so instead I tried being real empathic with their parents to them, and then guess what I got? Anger, anger, anger.

S P: So if you hold one pole, the other one is going to show up.

D A: Right, right, because they're ambivalent, if you focus on one side, the other one is going to rear its head. And I define empathy as different from sympathy. Sympathy means you're saying, "Well I understand why you did what you did and it's okay. If you've been abused, it's okay", and that's not empathic. Empathic is just understanding why they had to do it without necessarily agreeing with them, and if you're sympathetic to a child abuser then that's not empathic because they know that you're full of crap if you're trying to say, "Well it's okay if you raped me", these people aren't idiots, some of them seem to brag about it but that's all an act too. They know how people feel about child abusers and they feel horrible about it and their biggest fear is that their children hate them, but then they also feel that their kids are better off without them, so they push them away and drag them in at the same time, and that sort of leads to the borderline, well not all borderline families are

physically or sexually abusive, but they all sort of have these wicked double binds that are going on in the family, and putting people in these positions where the parents seem to need them to be around all the time, but seem to hate their guts at the same time. And that's what I find as a consistent pattern in borderline families, is that the parents seem to be highly ambivalent about the whole idea of being parents, several studies have shown that they oscillate between hostile and over-involvement and hostile under-involvement. And in some families one or the other may predominate, but if you wait long enough, you'll see the other side.

S P: So really a key consideration is that difficulty integrating these two poles of the ambivalence, really wanting to be there and hating the guts-

D A: Well yeah, and that leads to something which was identified by Melanie Klein, who I think was really sort of crazy, something called spoiling behavior, and she had an explanation that had something to do with primitive envy of the mother's breast which made no sense to me, but spoiling is when they seem to never want to let you grow up but then they the your guts, and if you destroy and ruin everything they did and make them feel bad and constantly tell them how awful they are, then that allows the parents to maintain the parental role. At the same time, it gives them the excuse to be angry, so its like the perfect solution, so they think they're giving the parents exactly what they need, and if the parent gets too angry then they make them feel guilty, and if the parent starts feeling guilty then they switch over to the anger side, so they're in a sense regulating the parents' emotions. And it's really chaotic, but it would be even worse if they didn't do that.
And there's another piece of this called kin selection, we've inherited a tendency to sacrifice ourselves for our collective group because whether a genetic adaptation is passed down is not based on individuals because the person with the great adaptation might be killed before they reproduce, but the survival of the largest number of people with that adaptation, and Darwin wrote about this. It's not accepted by a lot of evolutionary biologists, but I think it's more for political reasons because it might be misused, like eugenics, or something like that. It's better for the group if the weaker members don't destroy the group, but we've all passed that so I don't think that's the issue. We all have the tendency to-

S P: Do you know what you were saying there, the example of the kid who is acting, you say, seems strange what he is doing but in a way the kid is regulating the family's behavior. So it's very interesting because the way the brain is essentially a regulatory organ and if you look at not just one person, but the family as an organism, you end up having, in that family, the kid who is deputized as the regulatory organ.

D A: Yeah, Minuchin talked about that too, he would get a family and a kid would be acting out and at the end of the session the kid would be playing nicely and the parents would be arguing because it was really a marital problem and the kid was triangulating himself into the marital problem in order to prevent the parents from tearing each other apart. When you see that, and you realize that a lot of therapists are getting a really skewed view of what their patients are doing, just because their only looking at their behavior in the office, they don't know what's going on the other 6 days and 23 hours of the week, and if you don't know the right questions to ask, patients won't necessarily tell you.
One example I gave of a patient who complained of anxiety and mild depression which responded to antidepressants, and we were trying to identify what triggered them, and she never told me, for months, that she'd have a conversation with her mother every single day and feel nauseated afterwards, this is a lady with a PhD. "Why didn't you think to tell me that before? You have anxiety

and get nauseated every time you have this conversation with your mother every day? You didn't think that was important?" But it's sort of "Don't ask, don't tell", that's how I refer to it. If you don't know to ask about this stuff, they won't bring it up. People are very protective of their families, contrary to what a lot of people will try and get you to believe, and if you look all uncomfortable talking about, say, child abuse, they're not going to tell you. And it's because you're uncomfortable, it's not because they won't tell you. You were recreating the situation where people in their family say, "well you're not supposed to talk about this", inadvertently recreating. So how you react and what questions you ask and how comfortable you are asking them leads to what kind of information and how accurate the information is that you're going to get.

I was going to finish the general arc of therapy. So after we establish some empathy, then we figure out, well how are you going to discuss the family dynamics so we can change this when we have all these powerful emotions to deal with. So I use role-playing to figure out the best approach, I have several different possible approach strategies, and I have them play the parent and I try out the strategy, and I warn them "Don't do this until we both decide that this is a good idea, and that you've had a chance to practice it." So I sort of see what they're up against, and I tell them to play their parents, and borderlines sometimes don't like to play their mothers but they'll say, "But she would say such and such", and that's not quit as good but that's almost as good, and I'll try different strategies and I'll push them and I'll see what kind of defenses and what sort of sensitivities I'm going to run up against, plus I have the genogram data, we know the interactional pattern, I get a pretty good idea with that and I usually invite a parent in for a conjoint session if they're available, and I have a strategy for doing that as well, so I have a pretty good idea about what kind of reactions they're going to get and if not, the patient has been living with these people for most of their life usually, so they're pretty good at predicting how a parent will respond, so they sort of show me what they're up against and I keep trying a strategy until I find one that gets to where I want to go so we can talk about, "When you do this, I feel this way, so I need you to quit doing that", and "This is why we are doing that", and when we get a strategy we change places and I have them practice on me.

And I do sort of method acting where I try to get in character what the parent is like, play the parent as the worst possible way the parent could be as a worst case scenario, so if they go and talk to they parent they'll A: be prepared if it does turn out to be that bad, but luckily most of the time I'm the worse version of their mother than their mother, if we come up with a good strategy. So the patient has an initial success in metacommunicating, you're talking about the way that the family interacts, and they have to confront each primary figure one at a time, otherwise you have people ganging up against them which is a really difficult thing to stand your ground when you have more than one parental figure trying to get you to shut up because the message they're getting is, "You're wrong to do this, change back", so they have to do it one at a time and people can triangulate in.

So even before we do that we have strategies for detriangulating interfering relatives, which could be the other parent but could also be uncles, sometimes we've had relatives pop out of the woodwork that they haven't talked to in years come up and say, "How could you treat your mother that way?" It's really amazing how this communication goes through the whole family. And if we're successful, and we can get a change in the family behavior, then a lot of times that's enough to get people to stop these self-destructive patterns. The hardest part, of course, is getting them to do it, that can take a long time, because even people in functional families are loathe to talk about family dynamics, it's just not something we're comfortable doing, and a dysfunctional family, especially if there's been violence or abuse, in fact sometimes this has to be done over the phone because I'm afraid there could be violence, it's very difficult. So people say, "So what's your success rate?" Well, it's really hard for me to say. If they do it, it's very high. But I don't always get them to do it. And they have to stick with this for a while, this takes a while to get through this and overcome the

resistance, but if they do it, sometimes that's enough and sometimes you have to do sort of simple cognitive behavioral techniques to get people to start dating different kinds of people instead of alcoholics or whatever, but a lot of times they already really know how to do that anyways, they just act like they don't know how to do a lot of these things. And so they may spontaneously start doing these things, but if not you can sort of help them along, and then doing straight CBT is very effective because you're not fighting the system anymore, you're not opposed to what everyone else is trying to get them to do, or behavior, I really shouldn't say they're trying to get them to do, I don't mean parents are necessarily trying to get them to act this way. So because they're more powerful than I am, if I can get them to quit reinforcing the old behavior patterns, then it's much easier for people to do the new patterns. So that's basically the arch of treatment, and it can take a while, because I was an academic and only had a few patients, the ones that were the most difficult tended to be the ones who stuck with me, so I ended up with all the difficult patients so it looked like my success rate was absolutely horrible, because the other ones had left, they got better and moved on. So yeah, doing psychotherapy research I found out is very difficult stuff. I admire people that do it, but I don't think it gives a good flavor to what really happens in therapy.

S P: So David, as we're coming to the end, is there a though or something that we can conclude with?

D A: Well, I think empathy is really important in trying to see the logic in what looks like crazy. Trying to find the underlying sense that it makes, given what we're working with in terms of how the human mind and brain work, instead of looking at it as pathological, that's one of the tricks borderlines behave, you find something to be empathic about, like, say, a trust issue. You have a big problem, you don't trust people, well if you came from a world where everyone is a backstabber, you would be an idiot to trust people. So I would say, 'Of course you don't trust anybody, why would you trust anybody? That would be stupid, I could see why that issue, of course", instead of criticizing them, and it really hooks them in. So trying to see the logic in terms of how people interact, and how the behavior fits into the pattern, like a puzzle piece almost, to me is more important than any particular technique.

S P: So it feels very important in the way you described empathy it also feels like seeing the context, and so it's that sense of knowing the family stems and all of this is part of finding context or what is happening make sense, and once you find a context or its happenings make sense there is a possibility of change.

D A: Right. Absolutely.

S P: Thanks David.

This conversation was transcribed by *Savanna Keator*.

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