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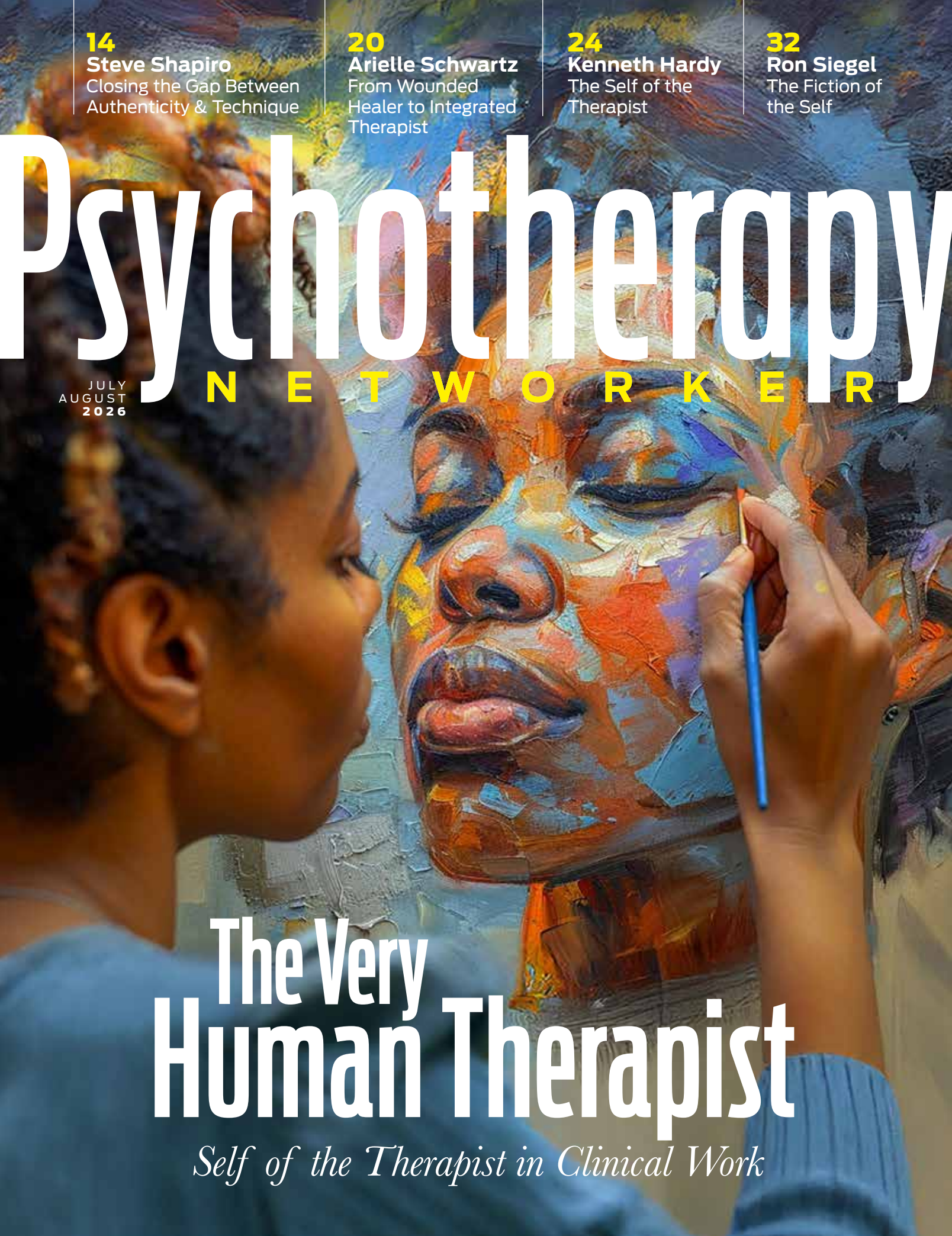

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Editor's Note

As our field buzzes with anxiety about AI chatbots luring clients into a black hole of never-ending digital validation, this issue—The Very Human Therapist—seems particularly salient. I don't think most therapists are lying awake at night, worried about being replaced by an algorithm, but I'm certain many feel a new urgency to articulate the kinds of human experiences that shape us into being uniquely effective clinicians. Here's one that's been on my mind lately:

No chatbot will ever work hard (really, really hard) to make sure their own stuff doesn't seep into the therapy room, only to discover all that stuff—the painful childhood, the still-tender scars, even the wry sense of humor born of more recent disappointments—might actually be their greatest clinical asset.

I'm not advocating for a tsunami of self-disclosure to flood the therapy room. I'm talking about Self of the Therapist (SOTT) work—which, despite its unfortunate acronym, is not an approach you get trained and certified in. Rather, it's a framework you believe in. Or as renowned family therapist Ken Hardy explains in this issue, it's a worldview that holds that who we are—the totality of our identities, joys, losses, relationships, challenges, wounds—forms the prism through which we see our clients. And whether that prism illuminates or distorts the therapy process depends on the personal work we do on ourselves. *The implications are simple and profound:*

Because your issues make you who you are, you don't need to "get over them" to be an effective therapist, but you do need to be "in relationship with them."

As clear-headed as this idea may seem, most of us weren't trained to see our use of self as a clinical tool. Instead, we learned to follow maps—theoretical methodologies and evidence-based protocols—that have nothing to do with who we are. Those maps are essential; that's not in dispute. But there comes a point in many of our careers when something—perhaps witnessing master therapists being exactly who they are in a session and being utterly brilliant at it—inspires us to step out in front of our therapeutic techniques and show up more fully as real people.

Feeling our own presence so powerfully can be liberating, invigorating, elucidating. But as clinical psychologist and trainer Steve Shapiro warns us, consciously interweaving technique and what we call the Person of the Therapist (POTT) is actually a hard-won achievement. Steve's piece in this issue is a grounded, practical take on the moment-to-moment balancing act of bringing ourselves into the room—and I'm convinced it's essential reading, regardless of where you are in your career.

Also essential reading is trauma expert Arielle Schwartz's touching personal story of how she moved from being a wounded healer—an identity so many of us inhabit—to being an integrated therapist, and what that journey requires. Elsewhere in the issue, RLT therapist Desirae Ysasi shares how her identity as a Mexican-American woman living in Trump-era South Texas deepened her clinical practice, but only after some hard personal work. We've also included the thoughts of Salvador Minuchin, "the father of family therapy," who championed the self as the therapist's most important tool long before SOTT was a formalized concept.

In an interesting twist, famed mindfulness therapist Ron Siegel writes about how the Buddhist idea of non-self can help clients loosen their grip on the "me" that's causing their pain. And we revisit a still-salient piece from trauma therapy legend Babette Rothschild about experiencing ourselves through our bodies and how somatic resonance can reshape the therapeutic relationship.

There are many more articles to peruse in this issue, too: all personal, all practical, and all about how the humbling, never-ending work of knowing ourselves—as healers and as humans—affects our clinical practice.

Although the articles are finite, the work itself is not. The more honest we're willing to be as we engage with it, the more we discover there is to uncover. So I predict there will be more stories on this topic coming your way. I only hope that by then, someone will have come up with better acronyms than SOTT and POTT for the beautiful ideas explored here—because I think they deserve a little better than to sound like two bumbling children's book characters making mischief in a therapy room.

Livia Kent · EDITOR IN CHIEF

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BY CHRIS LYFORD

Borderline Personality Disorder, Revisited

Why Everything You've Heard about BPD is Probably Wrong

In 1967, a 38-year-old psychoanalyst by the name of Otto Kernberg penned one of the first major assessments of borderline personality disorder (BPD). The piece, which appeared in the *Journal of the American Psychoanalytic Association,* proposed a theory that would change the course of BPD research forever—and likely shock most therapists today.

"These patients," he wrote, "must be considered to occupy a borderline area between neurosis and psychosis." Kernberg went on to describe their "chaotic behavior," "regression to primitive cognitive structures," and "consistent devaluation of all human help received."

Of course, Kernberg was a product of his time. The BPD diagnosis was still in its infancy, and wouldn't be added to the *DSM-III* for another 13 years. Until he began shining a light on the relational and attachment aspects of BPD, most clinicians had been referring to it by a completely different name: "*pseudoneurotic* schizophrenia."

But even after BPD gained mainstream attention, Kernberg didn't hold back. Clients with BPD, he wrote in his 1992 book *Aggression in Personality Disorders and Perversions*, display "an unconscious sense of guilt, the need to destroy what is received from the therapist because of unconscious envy of him," as well as "the need to destroy the therapist as a good object."

It's easy enough to cast stones at Kernberg for his early takes on BPD (which, to be clear, have aged like milk), but consciously or unconsciously, many modern-day clinicians regard BPD with a suspicion or fear that's not all that dissimilar. How many therapists can confidently say that the prospect of working with a client with borderline traits—the emotional intensity, rapid mood shifts, rejection sensitivity, relationship instability, impulsivity, paranoia, dissociation, and self-harm, to name a few—doesn't make their stomach sink?

Sure enough, numerous reports show that therapists actively avoid working with BPD, seeing it as much harder to treat than other diagnoses. A 2015 study published in *BMC*

Psychiatry surveying 710 psychiatric hospital staff members found that BPD patients are seen as more difficult and less deserving of hospitalization than those with depression. And a 2022 systematic review of 37 studies, encompassing more than 8,000 clinicians, found that negative attitudes toward BPD are widespread in the mental health field, with strong evidence of stigma, pessimism about outcomes, and emotional distancing. Descriptions like "difficult," "manipulative," and "emotionally draining" are common among those surveyed.

But stigma isn't the only factor thinning the pool of willing clinicians. BPD treatment is highly specialized due to the rarity of the diagnosis: less than three percent of the U.S. population meets the criteria. And individuals with BPD commonly suffer from co-occurring conditions that may divert the treatment focus or contribute to the client's perceived difficulty, including major depressive disorder, bipolar disorder, PTSD, anxiety disorders, eating disorders, ADHD, and substance use disorders.

Meanwhile, formal, advanced training in Dialectical Behavioral Therapy (DBT)—widely considered the frontline treatment for BPD—is not only rare, with between four and eight percent of the global therapist population trained in it, but time-consuming and expensive. Trainings associated with DBT developer Marsha Linehan and the Behavioral Tech Institute (the world's leading organization of DBT trainers) typically cost over $15,000 per treatment team and require 60 hours of instruction, usually spread out over several months. To boot, most insurance companies don't fund full DBT programs.

The state of BPD treatment is bleak, to say the least. Not only is stigma rampant, dissuading many therapists from working with clients with BPD in the first place, but many of those who would step up lack the time, money, or skills to capably do so. Which brings us to a sobering reality: most of what your average clinician has heard about BPD—how it functions and how to treat it—is probably wrong.

The Trauma Connection

Child psychiatrist and neuroscientist Bruce Perry, who specializes in treating the impact of trauma, abuse, and neglect in children, still remembers how his colleagues used the BPD label back when he was a new clinician, almost 30 years ago.

"Clinicians were throwing the BPD label around to describe patients they found difficult," he says, "patients who one day would think you were the greatest doctor in the world and the next would think you were trying to kill them. You'd hear their doctors say things in passing like, 'Oh, they're just borderline.'"

But in the early 1990s, Perry and his colleagues at Yale had found something interesting: similar biomarkers between BPD and PTSD.

"We'd been looking at the development of PTSD in adults, and we started to notice that a lot of the physiological reactivity presentations were very similar in people who had BPD," he explains. "When we started to look at the history of developmental trauma in that group, it was very, very high. And when we looked at the nature of the developmental trauma, it was frequently relational."

Perry and his team at the Neurosequential Network, an interdisciplinary clinical community, continued to tug at this thread, eventually concluding that there was, in fact, a relationship between trauma and BPD traits. Just as someone with PTSD from a combat injury or car crash might be triggered by loud noises, Perry says individuals with "relational sensitivity," where early life experiences were characterized by "unpredictability, inconsistency, or overt humiliation or shaming," are triggered by close relationships, where the threat of betrayal feels significant. This includes the therapeutic relationship.

"One of the things you hear about when you're working with someone who has 'borderline features,'" Perry says, "is that they have this exquisite sensitivity and interpretation of interactive cues. They essentially grew up with a worldview that made intimacy feel overwhelming and even threatening. So it's understandable that when they do get into relationships with people, they want to have absolute control over the process."

But how should therapists respond to this behavior? Perry again uses a developmental lens. "In normal childhood development, children are gradually trying on independence—how it works, how it fits—and ultimately develop a sense of mastery and comfort as they separate from the caregiver." But the therapeutic process with someone with BPD, he says, is the complete opposite. "They feel safest *away* from people," he explains, "and as they approach intimacy, they get more dysregulated. So what you need to do is be present, patient, and parallel. You need to give the client control over the process of emotional intimacy in therapy"—what he calls "a 'desensitizing' process that slowly builds in the capacity to be comfortable in relational proximity."

So what does this mean, practically speaking? "Rather than having a conventional face to face with the client, you'd do something regulating in parallel, like walk-and-talk therapy, or working on a piece of art together. There are lots of different ways to do this, but it all involves repetitive, rhythmic regulation paired with relational intimacy and proximity."

The therapist should prioritize transparency as well, Perry adds. "When our team works with clients, we like to talk about what we think is going on with them, and tell them why we're doing something. It's very revealing to have them say, 'Well that's not exactly it, it's more like this,' and then we get more clarity about the things that get them stirred up or overwhelmed." Essentially, he says, the client fine-tunes and guides the treatment, becoming a co-therapist in a collaborative process.

"When a relationship is where the injury took place, a relationship is

what you need in order to heal," he explains. "You have to pay a lot of attention to the circumstances under which you begin, grow, and maintain the relationship, but it works. It's easier for people to do just about anything if they feel safe and in control."

BPD By Another Name

Renowned trauma expert Janina Fisher has a more pointed name for the type of relational injury Perry is describing: attachment trauma.

"All of the symptoms make sense as those of a traumatic attachment disorder," she says. "The client's preoccupation with separation and abandonment is a traumatic attachment response. So is their anger when somebody fails them." Concerningly, Fisher says the trauma connection is lost on most clinicians.

"The first research that showed a connection between borderline personality disorder and trauma was published in 1990, and then completely ignored," she says. "Even Otto Kernberg, the godfather of ideas about BPD being manipulation and attention-seeking, said that BPD was often associated with a history of severe trauma, including attachment trauma."

So what does a trauma-informed approach to BPD look like? Fisher says it starts with a little humanizing. "These clients don't get diagnosed borderline by me," she explains. "I diagnose them as *traumatized*. And when the symptoms are treated not as bad behavior, but as the result of being triggered and having survival defenses constantly activated, clients do much better."

Fisher's treatment approach diverges from Perry's in a notable way: rather than lean into the relational component of the work, she recommends treating BPD using a modality that's *not* relational, lest it trigger the client's desire for attachment or fear of separation, which in turn can stir up anger and self-destructive behavior. She says it's the non-relational style of DBT, heavily comprised of skill-building techniques, that explains why it works so well for these clients. But Fisher uses her own modality when it comes to treating BPD: trauma-informed stabilization therapy, or TIST, a model that asks the client to notice, with curiosity, their feelings, impulses, and beliefs as expressions of inner parts.

"Typically the part that's afraid of abandonment and wants desperately to be loved is a very young part," she says. "The angry part that says 'you're screwing this up, you're doing a terrible job' tends to be more of an adolescent part. What changes the relationship to the feelings and impulses is to notice them rather than react to them, to see them as young and traumatized—and the prognosis for someone treated this way is very good."

"The Wild Group"

DBT expert Eboni Webb summarizes her introduction to BPD in just a few words. "My first exposure to it was the languaging that my grad school professor used about the cluster of diagnoses where borderline is, referred to as 'the wild group.' And that was it."

As Webb continued her clinical career, working in various community mental health settings, she found that even fellow DBT therapists were unlikely to take on clients with BPD. "They'd get a sense of what was going on and refer out," she says. "Or they'd get burnt out and wouldn't have supervision or consultation, so they'd terminate treatment"—which, Webb adds, often communicated to the client that they were unfit for therapy.

Eventually, Webb came across the work of Janina Fisher and Bruce Perry, which she says left an indelible mark on her clinical approach and solidified the BPD-trauma connection. "I think all personality disorders are rooted in relational developmental trauma," she says. "The primary defense for the borderline client is the attachment cry—the hyperaroused response to abandonment that Fisher talks about—which is a survival defense. That intensity they carry of, *Help me or I won't be able to survive without you* can feel so overwhelming, so I knew I'd need the tools to address that."

The result was what Webb refers to as "embodied DBT"—a blend of neuroscience, trauma theory, and sensorimotor psychotherapy ("the special sauce," as she calls it). She says one of the hallmarks of her approach is helping clients with BPD rewrite their story, which begins with explicitly naming the attachment trauma.

"Many of them don't have an awareness of that," she explains. "I'll say, 'You didn't come in with a blank slate, but you did come in with an open map, and your experiences and your parents and the social environment laid out the territory. We aren't going to question the strangeness of this map; what we're learning is this is what it means to be in the world."

The response, Webb says, is often a kind of softening. "They'll tell me that nobody has ever said something like this, that it makes so much sense."

The goal, she adds, is to help her clients finally develop some grace for wherever they are. "I want to lift the inner critic out of them," she explains. "We know that what drives the success of treatment is having a coherent understanding of your story and how treatment will actually help you. That goes a lot further than just saying, 'You have borderline personality disorder,' which doesn't really tell the client a lot about what's going on."

The Diagnosis Problem

In their criticisms of the prevailing thinking around BPD, Perry, Fisher, and Webb have all touched on perhaps its biggest problem: diagnostic bias. It's not just that the BPD diagnosis is seemingly associated with every mental health issue under the sun—or that it's sloppily used as a substitute for clients branded as difficult or resistant. Research shows it's disproportionately applied to women, minoritized populations, and neurodivergent individuals.

In clinical settings, women are two to three times more likely to be diagnosed with BPD than men. "Women will get thrown into a lot of anxiety-based disorders without looking at the trauma that's informing the presentation," Webb says, "so there's a disproportionate number of women who get the

BPD diagnosis. We know 80 percent of them actually have childhood trauma, so is their response pathological, or is it the wisdom of trauma survival?"

Meanwhile, transgender and gender-diverse patients are more likely to be diagnosed with BPD than cisgender patients, according to a 2024 report published in the journal *Transgender Health,* namely due to pathologizing experiences of rejection and discrimination.

And BPD is also the most common misdiagnosis assigned to Autistic people, according to a 2026 report conducted by researchers at the UK's Department of Population Health and Policy, namely due to overlapping symptoms of emotional dysregulation, social difficulties, sensory overload, meltdowns, and self-harm.

"I've frequently observed Autistic patients, mostly women, misdiagnosed with BPD," says psychiatric nurse practitioner Lindsey Burd, who has specializations in both DBT and autism spectrum disorders. "They may have difficulty maintaining interpersonal relationships, feel chronically misunderstood, or appear emotionally unstable due to rejection sensitivity dysphoria and meltdowns. But taking a deeper look at lifelong patterns like communication difficulties, sensory sensitivities, intense and deep special interests, social masking, social exhaustion, and burnout can help elucidate if autism is the more accurate diagnosis."

Clinical social worker and autism specialist Kory Andreas agrees that BPD misdiagnosis is a problem in the neurodivergent community. "High-masking Autistic adults are frequently mislabeled as BPD when assessed using behavioral observation alone," she says. "Emotional dysregulation may look like a personality trait in these clients, but it's actually a nervous system response. When Autistic clients encounter predictability, proper accommodations, and a clinician who can support their unique nervous system needs, the distress that gets misread as behavioral problems often shifts. That's not what we see in BPD."

A Cognitive Reframe

Improving BPD treatment isn't just a matter of rethinking our interventions. Some clinicians say it needs to start with reconceptualizing the problem we're treating, that the term *borderline personality disorder* is problematic in itself.

"I've long believed that BPD isn't a personality disorder," Fisher says. "It's a trauma-related disorder. But all the research showing that hasn't budged the way it's treated a single bit. Until someone with authority definitively says attention-seeking and manipulation aren't the cause of so-called 'borderline' behavior, that's not going to change."

Perry agrees that the name is misplaced. "I'm not a fan of any DSM labels," he says. "I think we have a real problem with how we understand and categorize people when it comes to their mental health struggles. That's why we think about our work the way we do. We'll say to clients, 'Listen, you've got this sensitivity to relational intimacy,' and we'll talk about where we think it comes from—and we'll make a correction if they think we're off."

Perry, Fisher, and Webb all have novel and effective approaches to treating BPD. But they're also outliers fighting an uphill battle against stigma, misunderstanding, and outdated treatment approaches. Even so, there's room for optimism. Slowly, more clinicians seem to be waking up to the reality that BPD isn't as scary as we've been told. Even Otto Kernberg made an about-face as he approached retirement.

"We have made tremendous strides in only a few decades," he wrote in 2009 in the *American Journal of Psychiatry*, taking BPD "from a pejorative label for disliked patients to a carefully defined diagnostic category; from the subject of almost no systematic study to one of the most intensively researched personality disorders, and perhaps most important, from a hopeless prognosis to a hopeful one."

With seemingly little regard for his earlier writings, he added a caveat: "There is also the residue of professional bias against the diagnosis and, unfortunately, stigma for those who suffer from it, that has hampered progress in the field."

Better late than never, Otto.

In addition to a growing body of research on BPD, powerful organizations are not only calling attention to best practices, but countering old, pessimistic attitudes about the condition. In 2023, the American Psychiatric Association published *Practice Guideline for the Treatment of Patients With Borderline Personality Disorder*, which not only covers evidence-based psychotherapies, but emphasizes the need to address misconceptions that have contributed to stigma and barriers to care. This marks the first major revision of these guidelines in over two decades.

Individual therapists can do their part, too. Fisher says it starts with taking an honest look at your emotional response to BPD and how you conceptualize it. "If I sent out an email to my closest colleagues today asking if they'd be willing to take such and such client who had BPD, I'd get nothing but no. But if I said I wanted to refer a 30-year-old woman with a traumatic attachment disorder, I'd get lots of yes. Think of them as traumatized, not as personality disordered," she says.

Yes, Perry acknowledges, BPD *is* one of the harder issues to work with. But if you find yourself sweating in session with a client who fits the diagnosis, he says one of the most powerful things you can do requires no advanced training, money, or time: just be yourself.

"Positive transference followed by negative transference can make you twist or shift in the way you behave," he says. "Even experienced clinicians find it difficult. But the more stable you stay as yourself—the more consistent and present and decent you are—the easier it is for the client to organize around you."

Finally, when in doubt, remember your guiding principles, Webb adds. "What's helped me immensely isn't just thinking about borderline personality as an attachment disorder," she says. "It's working with a lens of care and compassion."

Chris Lyford is the senior editor at Psychotherapy Networker.

BY JOSEPH DELVEY

7 Benefits of Concurrent Couples Therapy

HOW SEEING PARTNERS SEPARATELY EMPOWERS THERAPISTS

Q: I was trained to meet with partners together at the start of couples therapy to avoid potential issues (like holding secrets). Is it ever okay to meet with partners separately at the start of treatment?

A: In recent years, I've started to take note of an interesting trend among my couple clients: roughly half had been to other couples therapists and dropped out, often after just two or three sessions. This led me to consider how early treatment failure in couples therapy might be addressed with a different approach.

My solution has been to meet with the parties *individually*—a strategy that psychologist James Framo described in the 1970s as "concurrent" couples therapy. Today, there's a strong expectation among therapists and prospective clients that couples therapy follow the more traditional "conjoint" model, meaning therapy takes place with three people in the room. In my experience, there are advantages to starting treatment differently.

When someone calls me for couples work, I simply say I'd like to start out with some individual meetings. Not only do I receive a ready acceptance of this plan, but I also sometimes hear a sense of relief. Starting couples therapy can be intimidating. A common concern is that something unexpected will happen, that one's partner will blindside them with complaints and criticism that they've been holding back, and indeed, sometimes this is the case. Arranging for individual sessions alleviates this concern.

I want to be able to share with the partner information and impressions I get in the individual sessions, and I always ask permission to do so. Generally, such permission is readily granted. But I know that sharing too many details may interfere with the establishment of a trusting boundary, so I'm careful about this.

I'm also willing to keep my client's confidences unless it's around something so egregious that the other party would feel betrayed by my keeping it secret. For example, if I hear "my spouse has poor hygiene and this is an obstacle to our physical intimacy," I'll look for a way for this to be addressed, but not necessarily immediately. However, if I learn of an ongoing affair in a traditionally defined marriage, I will likely tell the offending party that they'll need to disclose this to their partner. If the person refuses to come clean, I'd consider ending the treatment, saying that progress under such circumstances would be impossible. Similarly with ongoing sex addiction, I would typically insist this be disclosed and addiction treatment become an ongoing part of the treatment plan.

I may be strategic about sharing other kinds of information I've learned if I believe it will help the relationship, like "I know things between you and your wife are tense right now, but she's told me in our meetings that she's never stopped loving you." In the concurrent model, the therapist has the opportunity to manage the flow of information. In contrast, the therapist using conjoint sessions often finds it challenging to curtail words blurted out with no purpose other than to wound.

Here are some other advantages of the concurrent model:

Meeting a therapist one-one-one for the initial session is less threatening than meeting a therapist for the first time with your partner present. In such a structure, the chance of being blindsided or shamed by one's partner is essentially eliminated. This threat may be

more acutely felt with a quieter or more introverted person who fears their partner will race ahead with a therapist and paint them in a negative light.

Concurrent sessions minimize the "transparency problem." Some clients experience censorship in conjoint sessions. For example, they may have directly or indirectly been told by their partner, "Be careful what you say or there will be a price to pay when we get home." I'm surprised so little attention is given to this phenomenon in the literature. It goes without saying that with the privacy of concurrent meetings, at least some of this threat is minimized.

The less psychologically savvy partner may benefit from concurrent sessions. In a society that reinforces gender stereotypes, women sometimes present with a level of emotionally literacy that can intimidate men (or less emotionally literate same-sex partners) in a conjoint session. Furthermore, the therapist may unconsciously find themselves preferentially engaging the more psychologically minded party, which is never helpful when trying to establish an even-handed rapport with a couple. Seeing clients separately allows the less psychologically savvy partner to have the therapist's undivided attention.

Individual sessions make it easier to conduct a diagnostic interview that can shed light on couples' problems. Because many diagnoses (like ADHD, substance abuse disorder, mood disorders, and autism spectrum disorders) can have a major influence on the course of couples therapy, those who practice couples therapy of any orientation need to think about diagnosis early on. The concurrent format lessens the shame of being asked personal questions about one's psychological functioning and allows a candid discussion about a partner's symptoms and behaviors, which can give the therapist crucial information about diagnosis. It's also important to identify personality disorders like narcissistic personality disorder and borderline personality disorder (BPD) early on, as this increases the potential for successful conjoint treatment. Depending on the condition's severity, BPD can present management issues so significant that enlisting a co-therapist—perhaps one trained in DBT—may be necessary.

The therapist can compassionately reference character issues, limitations, or skill deficits. When a therapist can sensitively reference such issues about the partner who isn't in the room, it can be validating to the partner in a concurrent session who lives with the emotional fallout. For example, "I know Jeremy's ADHD leads him to procrastinate. That must be hard on you. Can you tell me more what it's like?" It can also start an in-depth conversation about how to manage these flaws. This kind of potentially wounding work is more challenging in the context of a conjoint session. The language of such a discussion must never be disparaging of the partner who isn't in the room and needs to be informed by the therapist's compassionate understanding of the issues referenced.

The perception of favoritism is lessened. In every conjoint couples session, the therapist risks being seen as indulging in favoritism—siding with one of the parties such that their feelings or perceptions are granted more validity. This is a significant and ongoing management issue inherent in conjoint therapy. However subtle this phenomenon may be on the surface, the fantasies it produces weaken the therapeutic alliance with the partner who feels discounted. Although every couples therapist aspires to be fair-minded, complicated unconscious forces make this hard to achieve. Concurrent therapy lessens this problem because the therapist forms an alliance with each partner separately. Also, favoritism—real or perceived—is less likely to be witnessed in the initial sessions.

It may be easier to regulate partners in the event of infidelity. It goes without saying that when discovered, an affair can throw any couple into immediate crisis. Not only is the future of the relationship at stake, but for fragile individuals, there's a risk of self-harm. Perhaps a conjoint session is best for managing this situation, as you can observe how heated the interaction becomes. On the other hand, this may not work out with all couples. As all clinicians know, when emotions run high in a session, it's more difficult to think. For example, the therapist might fail to curtail a brutal verbal assault, acting on an unconscious wish for the betrayer to be punished "because he/she deserves it." If threats and destructive interactions cannot be contained in a conjoint session, concurrent sessions might be beneficial. The latter can allow the therapist to siphon off some of the most extreme emotions. Creating a sympathetic and supportive environment for the betrayed party is often helpful.

■■■■■

Our professional training, traditions, and histories tend to lock us into habitual ways of practicing—some of which are so deeply ingrained we rarely stop to question them. However, we can be respectful of our training and treatment orientations and still consider new—and perhaps less habitual—ways of working, such as incorporating a concurrent couples format into our couples practice. Although couples may not expect concurrent sessions when they reach out for an initial appointment, they rarely object to giving it a try. Once rapport is established with each partner, the therapy can transition to conjoint sessions. pn

Joseph Delvey, Jr., PhD, ABPP, is a board-certified clinical psychologist in private practice in Bucks County, Pennsylvania and a former faculty member of Temple University Health Sciences Center. His private practice is currently dedicated to couples work.

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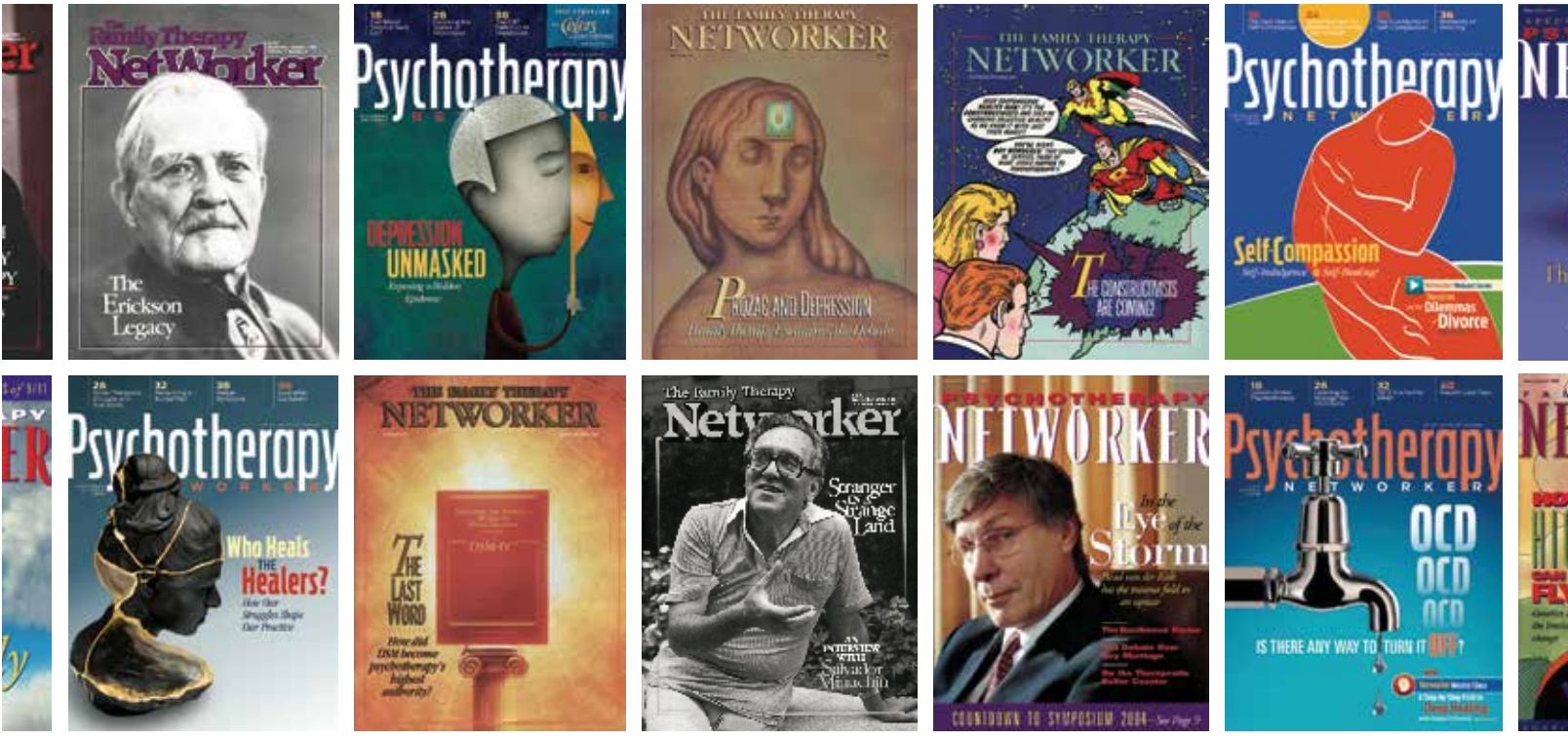

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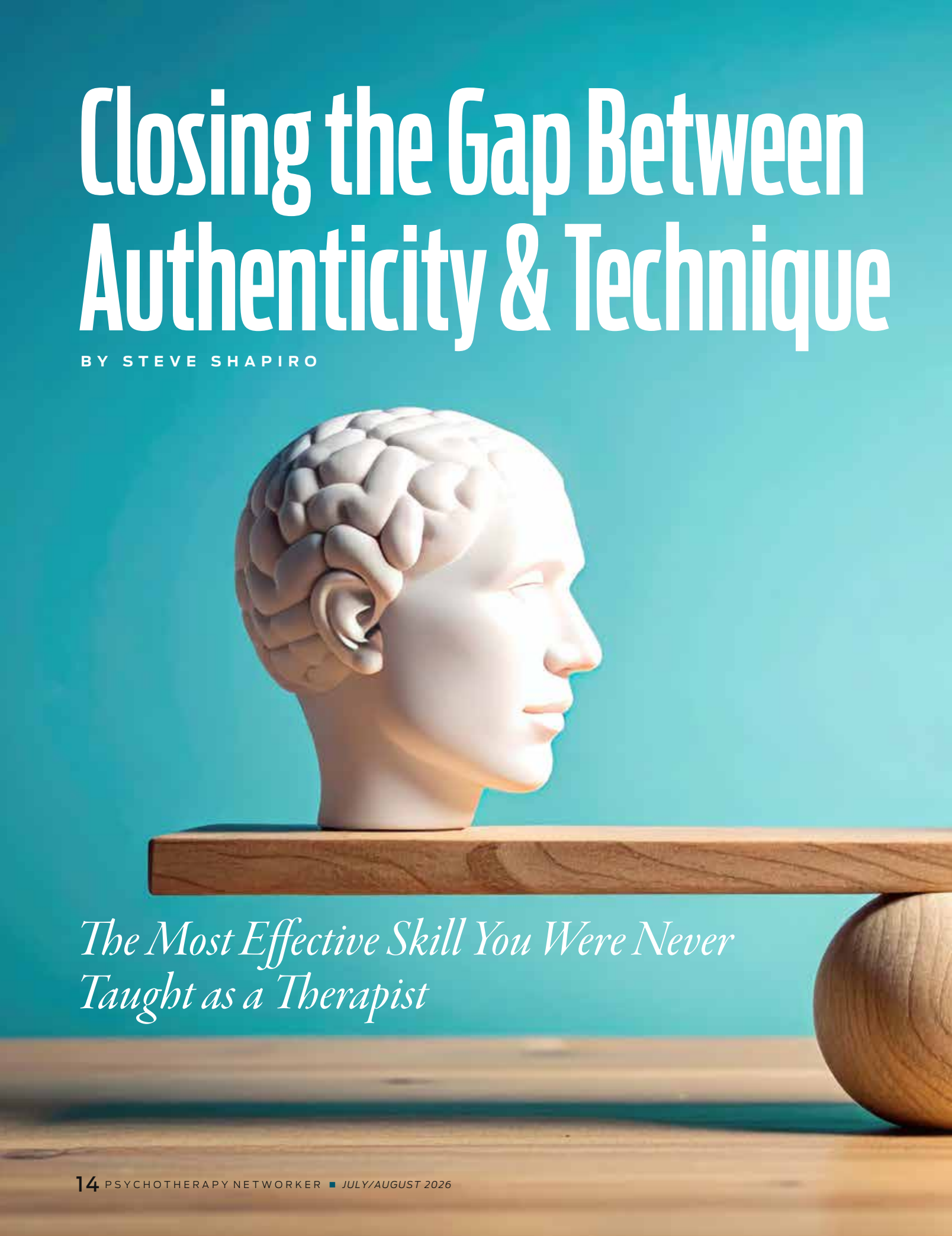
Closing the Gap Between Authenticity & Technique

BY STEVE SHAPIRO



The Most Effective Skill You Were Never Taught as a Therapist

One fall afternoon in Manhattan, walking to lunch with my core training instructor, AEDP developer Diana Fosha, she perceptively mentioned, "You might consider letting more of yourself show up in sessions with clients."

"What do you mean?" I asked. To me, the psychoanalytic model I was trained in and the associated neutral, abstinent stance were inseparable, a package deal.

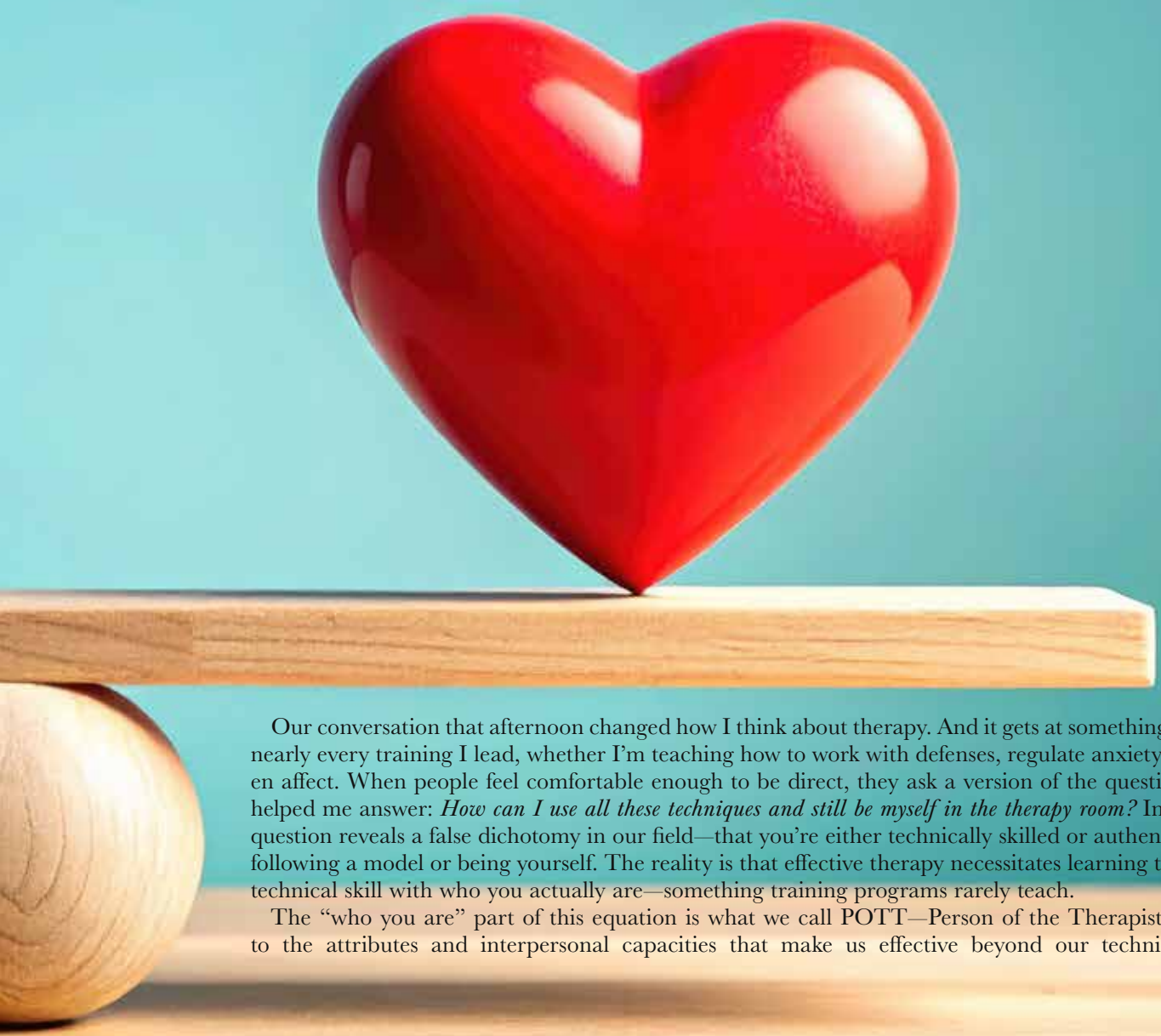
"Well, you could let your clients experience more of your *personal* self—your empathy, sense of humor, and playfulness," she explained.

"Oh, no, that's a very bad idea!" I responded with a touch of self-deprecating humor. "I can be judgmental, controlling, and stubborn." In my view, my job was to apply the models I'd been trained in correctly, not bring my personal self into the room. Besides, I explained, I didn't want to lose sight of my clinical map, because it kept me grounded and on track.

"Your map is solid," she reassured me. "And furthermore, there's room for the map *and* you."

I wasn't convinced, but the seed had been planted.

Gradually, I started experimenting with bringing more of myself into sessions. My work became increasingly effective and efficient. I began seeing how two modes, technical precision and authentic presence—which I'd always considered incompatible—could actually work together. Diana had seen a professional trajectory for me I couldn't. Over time, my theoretical framework gave me the confidence to reincorporate what I'd left behind: the warmth, humor, and authentic presence that had led me to become a therapist in the first place.



Our conversation that afternoon changed how I think about therapy. And it gets at something I hear at nearly every training I lead, whether I'm teaching how to work with defenses, regulate anxiety, or deepen affect. When people feel comfortable enough to be direct, they ask a version of the question Diana helped me answer: *How can I use all these techniques and still be myself in the therapy room?* In fact, this question reveals a false dichotomy in our field—that you're either technically skilled or authentic, either following a model or being yourself. The reality is that effective therapy necessitates learning to balance technical skill with who you actually are—something training programs rarely teach.

The "who you are" part of this equation is what we call POTT—Person of the Therapist. It refers to the attributes and interpersonal capacities that make us effective beyond our technical skills:

warmth, ability to tolerate ambiguity or conflict, authenticity, humor, directness, flexibility, presence. In our field, POTT has an almost mythical quality, as if it were psychotherapy's version of The Philosopher's Stone, a legendary and rare alchemical substance believed to cure illnesses and grant immortality. But when POTT remains mythical rather than practical, clients pay the price. And so do we: in work dissatisfaction, self-doubt, and burnout.

This is why closing the gap between the concept of POTT and how it plays out moment-to-moment in our work is so important.

Over the 25 years I've conducted advanced psychotherapy training, I've noticed a pattern. By and large, clinicians fall into one of two camps when it comes to how we show up in the therapy room. Some therapists—who I'll call *technicians*—favor precision, structure, metapsychological maps, and systematic exploration, just as I once did. They tend to relate in a more challenging or anxiety-provoking manner versus in a supportive, validating, anxiety-regulating manner. Technicians are most comfortable relying on "specific factors," or the technical aspects of a particular therapy model, believing the foundation of change is the interventions themselves. Other therapists—who I'll call *connectors*—tend to favor warmth and supportive presence over precision. They draw on "common factors," meaning personal attributes and interpersonal capacities, like honesty, humor, directness, and attentiveness. They tend to favor a more supportive or anxiety-regulating manner of relating and believe change is primarily activated by genuine presence and care. They're most comfortable attuning to emotional states and building strong alliances. Connectors believe the foundation of change is the relationship itself.

Each style has strengths and limitations. When technicians lean too heavily on their models, they risk losing out on moments of personal vulnerability and deeper human connection, which impacts the therapeutic alliance and ultimately, therapy outcomes. On the other hand, when connectors lean too heavily on validation and support to avoid eliciting a "negative" reaction from clients, they risk missing out on opportunities to challenge maladaptive behavior.

Errors of omission are still errors. A connector failing to challenge a client who needs to be challenged is just as much a "mistake" as a technician failing to communicate empathy and support. What we don't do in sessions matters just as much as what we do. Therapy requires presence and technical skill, art and science. So how do we learn to embrace both? And when we tip too far in either direction, how do we recognize it and adjust?

> "Most training programs focus on what to do, not how to be—yet the right stance typically strengthens your interventions."

Because we're rarely taught the skill of balancing both modes in training, when things aren't going well, technicians tend to get more technical and connectors tend to double down on support. It's like stripping a screw by pressing and twisting harder when what we should've done was back off and use plyers. Which is to say, the question we should be asking ourselves isn't whether it's better to be a technician or a connector, it's: how do you flexibly toggle between the two to best serve *this* particular client in *this* particular moment?

The Technician and The Connector

Let's look at two therapists seeing different clients on the same evening. Each is entrenched in a therapeutic style that suits their preference for either analyzing or relating but limits their range of effectiveness with clients as well as their own satisfaction with their work.

"So the trigger is your boss's criticism?" Judy, the technician therapist, asks. Her client Colin nods. "Are you open to looking at how this anxiety sequence unfolds?"

"Sure," Colin says. "But honestly, I'm usually so overwhelmed I can't think straight."

"What's the first physical sensation you notice when he's critical?"

"My chest tightens?" Colin shrugs and glances at the window.

"I notice you're looking away," Judy points out. "Is exploring this making you uncomfortable?"

"I don't know." Colin's eyes have gone flat. "I guess I'm afraid of getting fired."

Judy guides Colin to challenge his automatic thought. Colin complies but seems detached. By the end of the session, she feels a familiar sinking feeling. Nothing much is changing in Colin's life between sessions. By attending only to the model-specific content and avoiding the process between them and her own sinking feeling, Judy's missing something crucial.

Meanwhile, down the hall, Benjamin—who's more aligned with the connector style of doing therapy—leans toward his client Fabiola. It's their fourth session, and she's just shared a memory of caring for her

younger brother while her mother worked double shifts at a local hospital. She begins to cry.

"Let yourself feel this," Benjamin murmurs. "This is so hard."

"What I don't understand is why I'm still taking care of him 20 years later and why I always cry when I talk about him," Fabiola says. "I want to move on and be happier!"

Benjamin, concerned about showing adequate empathy, nods, missing these comments as signals of Fabiola's emerging awareness of a pattern that isn't working. Fabiola returns to listing complaints about the many ways her brother takes advantage of her. Benjamin, in connector fashion, has followed her lead—listening, offering validation, trying to help her understand why her brother acts the way he does. While his focus is supportive and comforting, it explores *her brother's* patterns. In this case, following the client's lead and allowing an external focus aren't helping Fabiola change *her* maladaptive patterns.

The Seasoned Therapist Myth

There's a common idea in our field that as you gain experience, technique runs on autopilot in the background while you do powerfully transformative work just by being yourself. So a seasoned therapist might notice a client's defense mid-sentence, track a shift in their own nervous system, note what phase of treatment they're in, and invite exploration—all while maintaining warm eye contact and a conversational tone.

This may look effortless, but it's a hard-won achievement based on countless hours of practice. The therapists at this level of mastery are sometimes viewed as "supershrinks." But even here, effective use of POTT hasn't replaced technique. The art and science have merged in a way that appears seamless when in reality, the therapist is toggling deliberately between analyzing and relating, making constant micro-adjustments. They're being themselves, yes—but they're doing so within a systematic protocol they've learned to use flexibly.

This kind of mastery is the exception, not the rule—and aspiring to it is a bit like planning your retirement around winning the lottery. Focusing on what we need to do consistently to facilitate change will serve us better than banking on the random arrival of effortless expertise. Otherwise, we're left waiting for those rare moments of synergy where our natural inclination happens to be a good match with the client's need of the moment.

Without a theoretical framework that provides accountability and rigor, simply being yourself is necessary but not sufficient. Some of us default to an intuitive manner of conceptualizing—what therapist Jon Fredrickson calls "folk concepts." This natural and instinctive approach is based more on our own psychological idiosyncrasies and emotional conflicts than on clinical principles. We resort to familiar moves and rely on what feels right to us, but a highly personalized, subjective view, while warm and well-intentioned, tends to be reactive and off-track when it comes to the needs of another. It's reflexive and lacks the objective structure and precision needed for deep change.

Part of what fuels this thinking is a misinterpretation of therapy effectiveness research. What therapist hasn't heard about the therapeutic relationship being the most important change agent? This finding, originally called the Dodo bird verdict after psychologist Lester Luborsky's 1975 research comparing different therapy approaches, showed no clear superiority of one approach over another, which is sometimes misconstrued as meaning techniques aren't essential. But what it actually means is that common factors like authentic presence and kindness require the structure of specific techniques to land and support change. What's critical is mastering your specific approach while cultivating your personal common factors.

Which raises a key question: how do our training programs prepare us to both master our craft and show up as a person? The short answer is, generally, they don't.

Missing Pieces

Training programs often emphasize one domain at the expense of the other. As a result, many early career therapists view "the technique" and "the person" as separate when they're actually overlapping circles—distinct but interdependent. When we train one without the other, we risk producing therapists who analyze well but struggle to connect, or connect well but feel clinically adrift.

So, what does integrating them look like? Counterintuitively, it involves returning to the basics.

After leading hundreds of trainings, I've noticed an interesting pattern: advanced therapists tend to forget the fundamental common factors they possessed before any formal training. Without these fundamentals as a foundation, advanced techniques fall flat. For instance, some of these fundamentals include being a good interviewer, asking for specifics in the face of vagueness, highlighting what's happening before inviting exploration, joining with a client before challenging a defense, using a conversational manner that puts clients at ease, and being transparent to build the alliance and enhance safety. The basics don't become less important as you advance, they become more important and more available when you regularly practice and internalize them.

And one of the hardest fundamentals to master is knowing what to do with your own reactions. Clients bring intense emotions into the room, and sometimes they're directed at us, which can be activating. But trying to ignore or suppress what you feel toward clients doesn't make you neutral; it makes you defensive and anxious. It's hard to help clients navigate their own internal experience when you are fighting your own. A far better approach involves paying close attention to your reactions, letting them inform your thinking, and being judicious about what you choose to share. The critical question isn't, *Should I have this reaction? It's, What does this reaction tell me clinically, and could sharing part of it serve my client's goals?*

In the words of psychologist David Wallin, we ourselves are the tools of our trade, and as a result, our blind spots and unresolved issues enter the room with us. Through tone, pacing, and the questions we either ask or avoid, we transmit messages about what makes us comfortable and uncomfortable. If we're not aware of these signals, we may inadvertently condition clients to comply with our emotional preferences, potentially reenacting the very damaging relational patterns that brought them to therapy.

Here's an example I see often in consultation. A therapist tells me a client wasn't ready to address a painful feeling. When I ask for the signs that support this view, there aren't any. After a brief pause, the therapist realizes that *they* were the one who wasn't ready—not the client. Whatever was taking place triggered something in the therapist. Although not explicitly stated, the client picked up on this, and they both colluded to avoid productive exploration.

When we're defensive about our own reactions and can't access or acknowledge what we're feeling, we tend to become intellectual, punitive, anxious, or withdrawn instead. You might think of this position as *therapist at worst*. When we're able to relate from a grounded, unconflicted place and compassionately use the healthy action tendency that goes with our emotional responses while consulting our clinical maps, we get into the zone of *therapist at best*. In order to accurately establish what's happening within our clients, we must first be present, grounded, and clear on what's happening within us.

This is why paying attention to your reactions is critical. They're as much a part of the clinical data as your client's history or the patterns you're observing. Your own frustration, curiosity, boredom, anxiety—whatever's coming up—informs you and gives you choices.

I saw this clearly with a client I'll call Deborah. After I'd pointed out patterns in the way she responded to my interventions that seemed to interfere with our work, she asked, "Are you frustrated with me?"

My gut reaction? A resounding yes.

Still, I paused and asked myself, *Am I frustrated because of something happening between Deborah and me, or am I just having a bad day?* I mentally reviewed our recent exchanges and felt that click of congruence, when my personal reaction matches my clinical assessment.

Rather than saying, "Yes, you're frustrating me," I got specific: "I *am* frustrated. You've dismissed the last three things I said without considering whether they might be useful. How long did you think about each one before deciding it didn't apply?"

She laughed. "Not even a second!"

That precision and pattern recognition—naming the specific sequence of responses, rather than expressing general frustration—shifted us from interpersonal conflict to working together on her internal conflict about depending on others.

Paying attention to your reactions gives you information, keeps you regulated, and strengthens the alliance. It also helps you remain authentic, which is particularly important given that most clients, because they've been chronically invalidated in some way, are highly sensitive to what's real versus performance. And since we spend so much time encouraging clients to explore their reactions with curiosity and openness, it's only fitting that we do the same.

Stance and Delivery

In martial arts, "stance" is your foundational starting position or home base that you return to between specific techniques. In therapy, it's your characteristic manner of delivery: being consistently warm and inviting, being matter of fact and direct, being gently affirming, being curious and intellectually probing.

Most training programs focus on what to do, not how to be—yet the right stance typically strengthens your interventions. We spend so much time thinking about and practicing how to intervene and so little on how we relate, when in fact, the words we use account for less than 10 percent of what we communicate.

If we're excessively soft and gentle, demanding, intellectual, or visibly hurt by a client's response, what are we communicating? Are we conveying ambivalence through mixed messages—warmly inviting exploration of anger while subtly tensing when it emerges? Is our rapid speech a covert way that we control what happens in the room? Does our tone imply that certain topics are off limits?

When we consider stance, we also need to be mindful of how much we're leading versus following. When a client is anxious or defensive, it's often useful to take a more leading stance: providing structure, being direct, addressing what's being avoided (leaning on technician skills). If the therapist is conflict avoidant—as many connectors are—leading in this manner may be difficult. When feelings or new material emerge, we're better off following, creating space, staying curious, letting the client guide us (leaning on connector skills). It's a flexible, reciprocal dance between your internal experience and the technical choices you make—between leading and following, analyzing and relating.

If clients feel connected to us and motivated to do the work, the question of who's leading matters less: you're working collaboratively toward a shared goal. But much of the time, clients are ambivalent, both motivated and resistant to address painful material.

Toggling in Real Time

Judy the technician, and Benjamin, the connector, have each been practicing what doesn't come naturally to them. In Judy's consulting room, Colin is talking about his boss again, but mid-sentence, his eyes drift to the window. Judy notices a subtle contraction in her chest. Because she's been paying attention to her own reactions, she recognizes this as a cue that Colin may be feeling conflicted or uncomfortable.

Her old instinct would have been

to intervene immediately, saying, "I notice you're looking away. Is this uncomfortable to talk about? Are you avoiding something?" Direct, technically sound, but potentially alienating. Instead, she pauses.

"Colin," she says softly, "You were right there with me, and then ... something happened. I'm curious about that."

Colin's eyes return to hers.

"Yeah," he says quietly. It's a small moment, but it's a new place for them. He's staying engaged rather than withdrawing. "I started feeling ... I don't know. Exposed, I guess."

Down the hall, as Benjamin listens to Fabiola talk about her brother, he feels a familiar warmth in his chest. He cares about Fabiola and senses her pain, but he also likes being needed.

"I notice we keep coming back to this dynamic with your brother," Benjamin says warmly. "We've talked about this several times now. Is understanding why he acts this way actually helping you respond to him differently?"

Fabiola looks surprised. "Not really. But I keep hoping that if I understand him better, something will shift."

"I get that," Benjamin says. "Understanding is important. And I'm wondering what might be getting in the way of moving from understanding to action."

They've taken an important first step to addressing what's keeping her stuck.

Doing What's Unnatural

What we do in exploratory, character-change psychotherapy goes against the grain of ordinary human interaction. How natural is it to sit with someone who's devaluing you and calmly respond, "It sounds like you're really frustrated with me—can we look at that?" Not at all! But that unnatural response is part of what makes therapy therapeutic and emotionally corrective. Here's the paradox: even these unnatural clinical responses have to start somewhere natural: with you.

Interpersonal defenses are intended to keep us at an emotional distance. Generally, respecting other people's defensive behaviors means you're attuned and considerate. If you inquire about a friend's divorce and she responds curtly, it would be inconsiderate to press for more information. But with a client in therapy, you'd lean in and gently explore what she's avoiding, what feelings are getting stirred up, what meanings she's making of the experience. That's part of our role, stance, and function. People wouldn't hire personal trainers if they could achieve fitness goals on their own, and therapists wouldn't exist if clients could resolve their own issues.

Without explicit permission to do so, pointing out others' problems is rude. Respecting unspoken or undeclared problematic behaviors by steering clear of them serves us well in friendships but prevents us from addressing the very patterns our clients enter therapy to change. Just like a surgeon, therapists have special permission to cross conventional boundaries. It takes courage to point out the "elephant in the room" precisely because it's unnatural. Yet doing so is often a turning point when the client realizes this is not an ordinary conversation, and the therapist will do whatever necessary to help them reduce their suffering and reach life-altering goals. Sometimes, when I'm feeling reluctant to address something difficult with a client, I ask myself, *If I don't do this, who will?*

Once, one of my supervisees told me, "God, I just wish my client would shut up! He talks endlessly. It's impossible to help him!"

"Well, let's go with that," I said. "What would you say if you could just express your anger directly?"

"I'd say, 'Shut up! Just shut up, already! You hired me to help you, but you won't let me get a word in edgewise!"

"Good," I said. "Now shift into being a therapist and put that in clinical language."

My supervisee paused. "Hm. I guess I'd say, 'Do you notice how you're talking right over me and your own feelings? How will you get the help you so desperately want if I'm not an equal participant here?"

■■■■■

Toggling between who you are and the technical aspects of therapy takes practice—the same way you learn tennis or the piano. You stay with discomfort, tracking your reactions without being hijacked by them, remaining present when your instinct is to retreat, attack, or defend yourself. You wait for that click of congruence, when your natural reaction and clinical reasoning coincide. Over time, you learn to analyze and relate simultaneously, sometimes from one moment to the next.

After almost three decades of practice in which I started out as a pure technician, I still take the therapy process very seriously, but now, the person I am as a therapist is the same person I am in life. I enjoy my clients more than I did at the start of my career and feel more energized by my work. The entire process of therapy—not just the moments of success—feels deeply rewarding, and I recognize the privilege of being entrusted with material that's so consequential. What a relief to have granted myself permission to bring my authentic presence to the work while still maintaining a strong reliance on my clinical organizing map! Nothing needs to be excluded. Some days toggling between these two modes is quite deliberate and challenging: other days, it's seamless.

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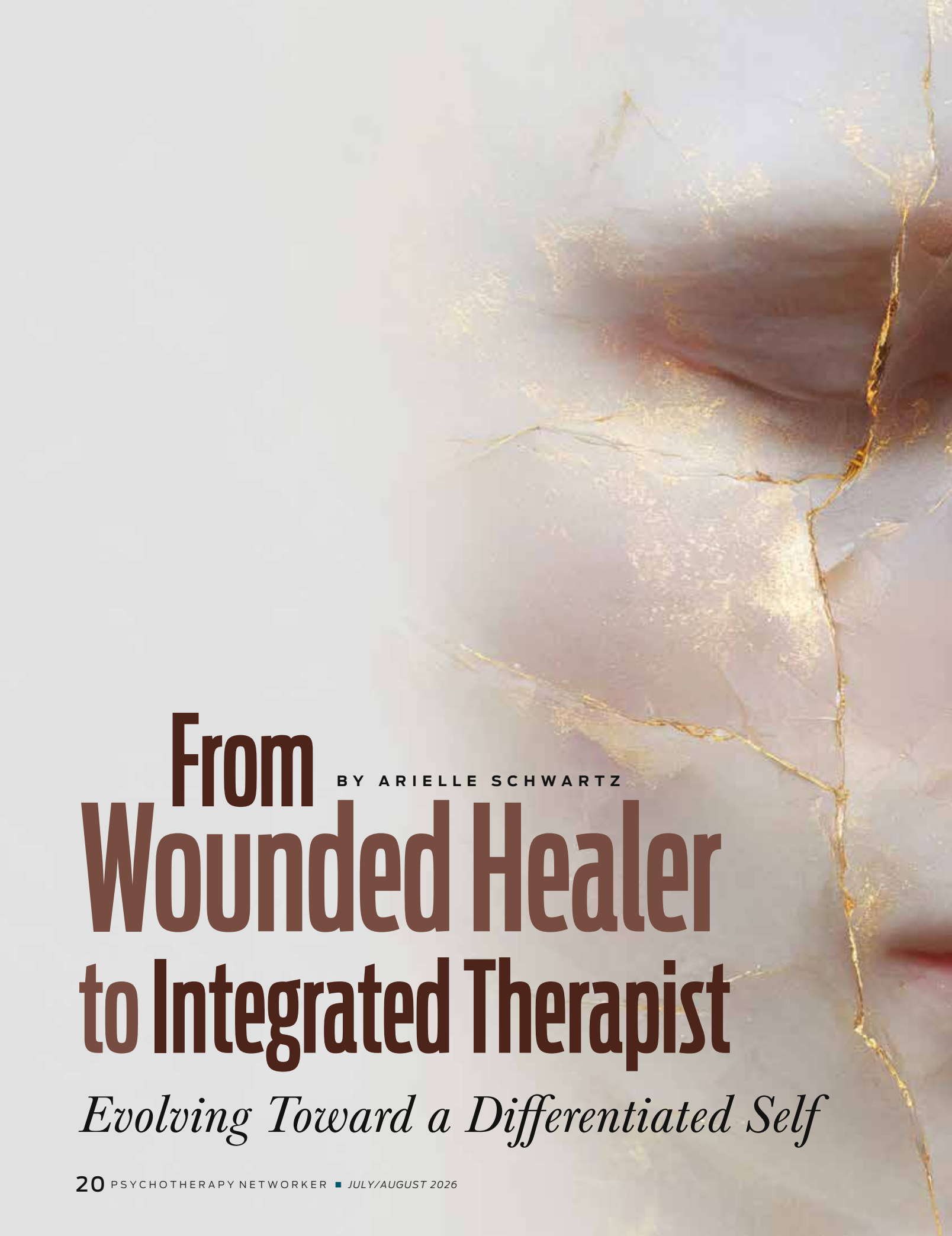

From Wounded Healer to Integrated Therapist

BY ARIELLE SCHWARTZ

Evolving Toward a Differentiated Self

My earliest conscious memory is a recollection of sitting in the dark on the stairs of my childhood home, listening to my parents fight downstairs. At three years old, I was afraid to tell them I was there. So, I sat alone and cried. Soon after, my mother told my father she wanted a divorce. My next memory is the day my father didn't come home. I simply couldn't understand why he would leave me. I sat by the window near the front door. *Where had he gone?*

Slowly, we found a new normal, which included visiting my father in his temporary apartment. He was my hero who picked me up for weekend visits to get ice cream and go to the beach. There was so much tenderness in him. He was hurting, and he was kind to me. I sensed his pain and felt a deep resonance with him. As a Harvard-trained chemist, he was profoundly intelligent, but he was emotionally underdeveloped. He didn't have a strong capacity to identify or speak about his own emotions, nor could he recognize or provide words to help me understand mine.

In contrast, my mother was a psychologist who valued emotional safety, connection, and communication. She specialized in helping mothers cultivate healthy emotional attunement to their children. Thus, she was skilled at helping me feel and eventually talk about my inner world. After my father left, my mother introduced me to the man who later became my stepfather. He was a kind, gentle social worker who intuitively knew how to relate to me. My home with my mother and stepfather became quiet and safe.

When I was five, my father introduced me to the woman who'd become my stepmother. She and her son moved in, and the three of them formed a family unit, leaving me to feel like an outsider entering and leaving their house. I so badly wanted to be the "good" little girl, but I was reserved and cautious. Rather than understand my tentativeness, my stepmother grew irritated with me. Over time, she became increasingly cold and critical, and I became increasingly fearful and withdrawn.

My father didn't notice my fear and confusion. Even when I told him I felt scared, I was told I should just be able to cope. Moreover, I was made responsible for my stepmother's feelings, and I grew to expect frequent reprimands each time she complained to him about me. Her bitterness continued unchecked and remained unrecognized by my father. This was a profound betrayal of my trust.

The rest of my childhood was defined by the rhythms of moving back and forth across two radically different households. Weekends at my father's house left me with a buildup of unexpressed emotions. Then I'd return home to my mother's house on

Sunday nights feeling robotic and checked out. Initially, I felt stuck in this frozen state unable to talk or know what I was feeling. My mother would rock me until I eventually cried and thawed from the freeze. My mother witnessed me and knew something was wrong, but she was unable to change the custody agreement or get through to my father on my behalf. She felt helpless and was unable to protect me.

My world fractured. I was caught between the fault lines, which left me without a sense of solid ground. As a sensitive child, I picked up on the nuanced emotional expressions of the adults around me. I sensed resentment, guilt, fear, and anger, but had no ability to speak to what I was experiencing. My vigilance around emotions began to generalize to the larger world. I was hyperaware of my surroundings but lost awareness of my own emotions. Most significantly, my grief and anger went underground.

As an empathic child, I had to compartmentalize parts of myself to survive. I didn't have the language or understanding to recognize that disconnecting from my body and emotions was a natural response to feeling increasingly powerless. As I write about this now, I compassionately recognize that compartmentalization and dissociation are built in survival mechanisms.

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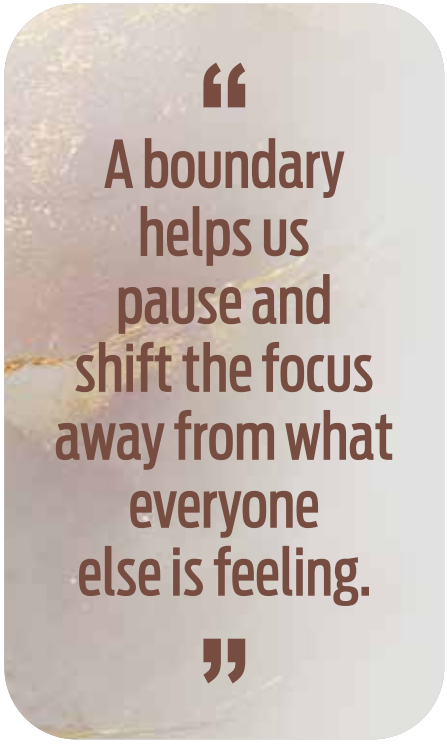
When people experience childhood trauma or neglect, they tend to grow up too fast, taking too much responsibility for the feelings or actions of their parents while suppressing their own authentic feelings and needs. Often, this empathic child becomes a wounded healer, who may be highly attuned to the needs and emotions of clients, but whose tendency to prioritize others' needs over their own can easily lead to burnout and compassion fatigue.

The good news is, if we're committed to doing our own inner work, we can evolve into an integrated therapist capable of witnessing other people's feelings without merging with them and absorbing their pain.

My chosen role as a psychotherapist felt like a natural fit. People sensed my ability to listen and benefitted from my care. I was often given the feedback that I was an "old soul" and a "natural healer." But there came a time when I realized that being over-focused on other people's needs or pain had consequences for my well-being. I was exhausted. I was diagnosed with irritable bowel syndrome at the age of 25. I suffered from my own anxiety and shame. I had to turn toward the wounds of my past.



Part of my healing journey involved reclaiming awareness of my own true feelings to counterbalance the tendency to become overly focused on the emotions and needs of others. Nonetheless, re-enactments are a common occurrence in therapy, and I certainly experienced my fair share.

Early in my career, while still in my 20s, I worked with a woman in her 50s whose high standards often manifested as harsh self-criticism and perfectionism. While she was accomplished in her work, she struggled in her relationships and described feeling exasperated by other people's inadequacies. Within a few sessions, I noticed my own insecurities arise when I was with her. I anxiously tried to be the "good therapist," but no matter what I offered, each session ended with her expressing disappointment in me. I found myself doing all that I could to avoid her anger during sessions, scanning her face for signs of coldness, distance, or aggravation and feeling as though I couldn't do right by her. I also began feeling resentful and anxious before sessions.

I brought our work to my supervisor, who invited me to place the client in an empty chair and dialogue with her. In doing so, I recognized the feelings within me as familiar. The desire to get it right, my fear of her anger, and my longing to withdraw in self-protection. I was in a re-enactment. I felt like I had as a little girl with my stepmother. And I sensed the even younger girl, too, sitting on the stairs of my childhood home, feeling as though my whole world might fall apart. I also knew that this client had felt profoundly rejected by her mother and that her anger had never been held.

Through well-guided supervision, not only was I able to attend to another layer of my own anger and grief, but doing so changed my work with the client. I grew less afraid of her anger, which allowed me to bear witness to both her rage and her grief without collapsing into or bracing against her pain. Now, I could offer the essential healing ingredient, compassion.

As I uncoupled my countertransference from our work, I became more sensitive to the underlying dynamics contributing to my client's bitterness, and we were able to explore how her childhood had pushed her to become prematurely self-reliant. She'd learned to suppress her needs for care, tenderness, and affection. Being the "strong one" had left little space for her feelings of hurt and anger. Letting her know that I welcomed her anger was the repara-

tive experience she needed—the missing ingredient of pure acceptance that's at the foundation of profound change. Ironically, welcoming her anger reduced the intensity of her criticism of me and our work.

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A somatic, relational approach to psychotherapy allows us to address the complexity of two minds and two bodies in a moment-to-moment exchange. As therapists, our failure to attune to somatic and nonverbal cues can inadvertently communicate the very rejection our clients anticipate and fear. Sometimes "resistance" in the therapy room is a therapist's own unwillingness to be present with the emotional and somatic experience of the client, which leads to small ruptures that, over time, result in a loss of faith in therapy—for both the client and the therapist.

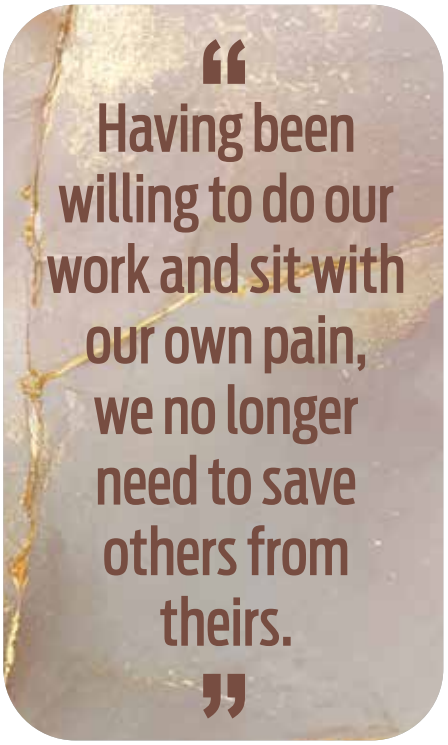
Supervision gives us an opportunity to explore these ruptures in the therapeutic relationship, and be accountable for our role in them. By embarking on this kind of work for ourselves, we can then transcend the wounded healer archetype. And we can heal by cultivating boundaries, working with the shadows of our unhealed wounds, and embodying a differentiated self. Having a boundary allows us to place an invisible barrier between ourselves and others, which then allows us to distill clarity from confusion.

A boundary helps us pause and shift the focus away from what everyone else is feeling, so we can turn inward to discover the emotions that had to go underground when it wasn't safe to show how we felt as a child. A boundary helps us see that we are not other people's emotions, nor are we always who they want or need us to be.

Psychoanalyst D. W. Winnicott described the development of a "false self" as a defensive reaction that leads a child to adapt compliant behavior in place of actions derived from authentic feelings. In other words, when a child modifies their behavior to be loved by a parent, they're disconnecting from their true, authentic presence. Conversely, Winnicott suggested that well-cared-for children develop a unique and authentic sense of self, a "true self," felt as a congruency and unification of mind and body, that links us to an accurate perception of both internal and external reality.

As I went back and forth between my mother's and father's homes, I alternated between my authentic self and a disconnected version of myself. It took me a long time to heal that fracture, but looking back, I carry profound love and compassion for my young self, who found ways to disconnect in order to cope. I appreciate the sensitivity I've carried throughout my life and see this as a strength rather than a deficit.

I believe all therapists are tasked with cultivating a sense of personal identity that's rooted in a sense of unshakable self-assuredness but allows for fluidity and flexibility. Once we're free from merging with the pain of others, we can be compassionately responsive to the world around us and offer unconditional and nonjudgmental acceptance. Of course, this must begin with a deep and unconditional acceptance of ourselves.



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Now, as a seasoned clinician and supervisor, it's an honor to help others navigate the sometimes sticky dynamics of transference and countertransference. When we have space to unpack this material, we not only enhance the efficacy of our work for clients, but reduce our vulnerability to vicarious trauma and compassion fatigue.

Awareness of our somatic and emotional experiences is of paramount importance. It provides us with a tether back to our selves as a counterbalance to the attention we offer our clients. Once we've found the solid ground of the self, we can soften our boundaries without having to rigidly defend our sense of self as a fixed identity. Consciousness itself becomes a fluid state that helps us sense the space between us and others without feeling threatened by the loss of self.

We can safely express love we've always been capable of bringing to the world. We show up with a depth of compassion for others—not as the wounded healer but as a whole person capable of wisely, lovingly holding a clear, undistorted mirror that helps others see themselves more clearly.

Having been willing to do our work and sit with our own pain, we no longer need to save others from theirs. Instead, we transmit a depth of safety and acceptance that emboldens others to courageously attend to their wounds within the secure harbor of a trustworthy relationship.

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The SELF of the Therapist

BY KENNETH HARDY

Learning to Be in Relationship with Our Issues

"In the family you grew up in, how was conflict expressed and resolved?" I asked Tamika, my supervisee and an experienced clinician at a residential youth facility for girls.

Her response was quick, stark, and unexpected. She sat motionless and seemingly stunned as her eyes began to quickly fill with tears. "I feel really triggered by that question," she noted after a few seconds. "I want to leave because I *really* don't want to answer that. But I'll feel like a loser and a hypocrite if I walk out."

My question is rooted in a Self of the Therapist framework, which is at the heart of my clinical, supervisory, and consultative work and involves encouraging practitioners to engage in an intensive personal process of self-exploration, self-interrogation, and self-reflection. Self-exploration asks what we carry, self-interrogation asks why we carry it, and self-reflection asks how it moves through us into our work.

After a pause, Tamika blurted out: "Okay, you want to know how anger was expressed and resolved in my family? Violently! That's how!"

This was a breakthrough moment in our work, and it illustrates why the Self of the Therapist approach is both essential and challenging. This framework is designed to encourage people to see their own complexity and become acquainted with all the sociocultural dimensions of their identities: the parts of themselves that have been shaped by family-of-origin experiences, gender, race, class, sexual orientation, and so forth. It recognizes that each of

us has an infinite number of selves that shape us and that can be extraordinarily beneficial to our clients if we do our personal work, and harmful therapeutically, if we do not.

The work also encourages practitioners to explore their relationship with past and present trauma, conflict, and other life-defining experiences. Thus, the work that a Self of the Therapist approach entails is by definition and design, personal. It explores and uncovers *the person within* that existed before the therapist did, as well as during and after one has become a clinician. In other words, it's a process that encourages us to consider who we are and how the totality of all our experiences—good, bad, joyful, painful, past and present—provide a prism through which we see the world, including and especially the process of therapy.

The framework holds that these valuable and enduring life experiences are not to be discarded, ignored, or dismissed as unrelated, worthless, personal residue. Instead, with proper attention and personal interrogation, they can be dissected, processed, understood and accessed to create pathways to connect with those we serve, even when there seems to be an abyss between "us and them."

Contrary to the traditional way in which I was trained, the Self of the Therapist worldview refutes the popular training notion that you must "get over your stuff," or eradicate whatever adversities you've experienced in your life, in order to be an effective therapist. Instead, it embraces the idea that you must be *in relationship* with your stuff. You may never truly get over it, but as long as you understand yourself through the three tenets of self-exploration, self-interrogation, and self-reflection, your use of Self can be a valuable therapeutic tool.

Ultimately, the therapist's use of Self determines whether therapeutic relational arteries are clear, open, and flowing—or blocked. The work *must* be personal because it *is* personal, and that's why it often feels too personal for some therapists, like it initially did for Tamika.

Getting Personal

Tamika, who was 44 years old, worked at a residential youth facility for girls. She'd come in to see me because she'd been having issues with her coworkers, who described her as abrasive and difficult to work with. Although she was deeply committed to the girls she served, her effectiveness in sessions frequently broke down as well. Often, this happened at the moments when one of the girls expressed frustration or anger toward her, as young people in pain sometimes do toward trusted adults.

To help guide our supervision process, I relied on my usual Self of the Therapist framework. Initially, she responded to the process with skepticism, lamenting that it seemed too much like therapy, too personally intrusive, and not appropriate or relevant to her work. Although we continued to work together, she routinely questioned what her family-of-origin experiences or wide range of sociocultural identities had to do with her work as a therapist.

In her view, the approach didn't pay proper homage to the appropriate boundaries that must exist between the personal and the professional. In my view, her critique was astute, because an aspect of the approach is in fact designed to blur those boundaries, albeit in an ethical way.

Tamika was raised by a single mother who'd physically abused her until the age of 30. She'd never been able to find relief or release because no one, including therapists, believed that someone at such an advanced age could be the victim of parental abuse. Prior to the session when she'd answered my question about how conflict was expressed in her family, she'd been adamant that her work with the girls in her care was unaffected by her life-altering experiences with an abusive mother or a rejecting, absent father.

After that pivotal session, our work focused on helping her envision and embrace how the gravity of her pain and suffering could equip her to work even more compassionately and effectively with her clients. Not only did she have a window through which she could intuitively "see" the girls' invisible trauma wounds, but she also likely had some good ideas about what they needed in their relationship with her.

I assisted her in exploring how her family-of-origin experiences, as well as those rooted in the sociocultural trauma she grappled with on a daily basis as a dark-complexioned black woman, could empower her to deeply and viscerally understand the emotional-psychological needs her young clients struggled to identify and express. Within her was an unrecognized power—one that could be accessed to unlock therapeutic and healing possibilities for the girls she supported.

Through our Self of the Therapist work, she also developed a keen sense

about how the experiences with her mom had hardened her heart. And still, she felt tremendous pain and frustration because her insights about these matters didn't easily translate into changed behavior. In other words, she couldn't seem to get over her stuff, which seemed to hang around her life like an albatross!

Once she embraced that the painful experiences with her mom were a conduit to her potential as a therapist/healer, she began to show up differently in all her relationships. She found herself sitting with others' frustration and anger rather than growing defensive—and in that groundedness, many of the girls she treated were better able to move through difficult feelings and trust her support.

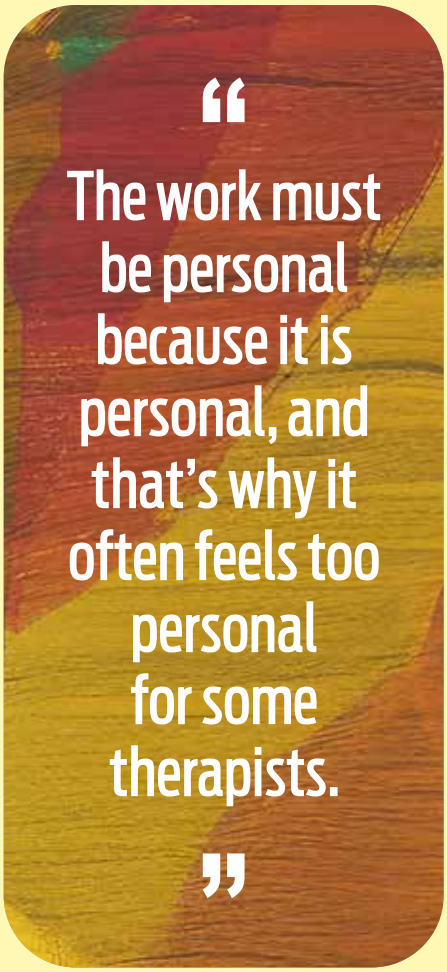
At one point, a new girl she'd begun working with yelled at her, "You're paid to sit there and listen to me. You're just like everyone else!" In the past, Tamika would've grown defensive, saying something like, "Believe me, I didn't become a therapist to get rich." But this time, she said, "A lot of people have let you down. You're right to be skeptical." Hearing that, the girl's face softened.

Because her own story became one of survival, hope, and transformation—not *just* suffering—Tamika also discovered ways to hold hope for the survival and transformation of the girls she supported. We devoted time to assisting her in developing new strategies rooted in this approach that she could employ in her clinical work and beyond.

Soul Work

The Self of the Therapist framework is multifaceted. Yes, it's a supervisory and training tool, as it was in Tamika's case, but it's also a worldview as well as a clinical stance that helps shape the contours of interventions. It positions the Self of the Therapist as a therapeutic tool that has the potential to unlock clinical impasses and birth new possibilities. And it can unclog relational arteries, softening the blockages that impede meaningful connection between clinician and client.

A core tenet of this approach invites us to question the robustness of a universal, objective reality. It asserts that each of us is a prisoner of our prism and context. What we see, who we see, and how we see, are all, to some extent, dictated by where we stand and the angle from where we gaze. The notion that there is only room for one reality and that the therapist or supervisor or consultant is the holder of that reality is antithetical to a major premise of Self of the Therapist work: that clinicians, no matter how much we try, can't weed out or divorce ourselves from ourselves.



The value of this work is that it retrains our eyes to see that which we ordinarily can't see. In so doing, it repudiates the *manufacturing of other* and promotes the *imagining of other.* To manufacture other is to construct difference as distance; to imagine other is to search for commonalities among differences. The manufacturing of other virtually always culminates in creating an "us" and a "them." Our daily rhetoric about "those immigrants" who are stealing "our" jobs is a powerful example of manufacturing other. While the manufacturing process may be convenient and expedient, when we fail to imagine that there are parts of you that are also in me and vice versa, it's destructive and poses a threat to all of us.

Having the capacity to hold multiple, often seemingly contradictory, perspectives is crucial to this work and rooted in the tenet that the Self is multidimensional. The goal is to help trainees, supervisees, and therapists become intimately familiar with as many of their selves as possible—all the identities and life circumstances that converge to shape us into who and what we are, not only as therapists, but as human beings. In the spirit of true Self of the Therapist inquiry, this is essentially work with a definable beginning and no discernible end—a type of soul work that's essential to life and living well beyond the walls of therapy and supervision. When therapists actively engage in the process, they often discover that dimensions of the Self are endless, as are the possibilities for change and deeper human connections—even when and while we're skeptical of them.

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BY DESIRAE YSASI

The Courage

On Culture, Relational Re

to Confront

covery, & Speaking Truth to Power

I'm nearly an hour into my first session with a couple when I interrupt the wife. "Wait a minute," I say. "You're screaming at him in front of everyone as you're about to board a plane? What led up to that?"

She covers her face and sobs.

"I know it's wrong, but he absolutely refuses to discuss anything! It's been so many years of him shutting down and ignoring issues in our household, and I just can't go on like this anymore!"

After listening to both partners share what they think is the main problem in their relationship, it's become quite clear to me that while the wife has been acting out her anger and frustration in some pretty boundaryless ways, it's actually the husband's stance—walled off and grandiose—that's at the heart of their issues.

"We have a good life," he says, his tone flat. "Why can't she just be nice and enjoy our life together? I don't want to fight." As he says this, I notice his jaw is set and his arms are crossed. There's an absence of warmth and compassion in his face and body. His words say he doesn't want to fight, and yet his energy is fighting.

The husband, I learn, has been dismissive, minimizing, argumentative, and self-focused. He's failed to set appropriate limits with his adult son, who has lived with them without paying rent or contributing financially to household bills. His son has backed over her freshly planted flowers with his truck and made no offer to pay for the damages. He leaves messes for the wife—his stepmom—to clean up. When she has tried to share these issues with her husband, he downplays his son's actions or tells her, "That's between y'all. I'm not getting in the middle of it."

It's enough to make anyone want to tear their hair out and scream at him in frustration. And that's exactly what his wife has done—scream at him. A lot. Once you understand the context, the scene at the airport makes sense. I don't condone the wife's behavior, but I get it! And now the husband has stubbornly dug his heels into his position as the angry, entitled, self-righteous victim of her reactive behavior. *Oh boy....*

As I ponder my next move, I remind myself that as a certified Relational Life therapist, I've been trained to speak truth to power—to confront the more grandiose partner (called "the blatant") and take sides with the disempowered one ("the latent"). Terry Real, the founder of Relational Life Therapy, has taught me to do this by joining through the truth and waking the grandiose partner up to how their behaviors are perpetuating the exact dynamic they're complaining about.

However, swirling in my mind alongside my clinical training, is my experience as a 45-year-old Mexican-American woman living in South Texas. This man I'm about to confront is more than 10 years older

than me, white, and living in a rural town known to be largely conservative.

Not only that, the cultural backdrop of this session is Trump’s America. ICE is targeting Latino immigrants in my community, carrying out raids and detaining people in an attempt to identify and deport undocumented people. People who look just like me. People with whom I have a shared ancestry and culture. People who’ve been demonized, criminalized, and stripped of their humanity. People who are being told they don’t belong in this country. Right now, I’m carrying this reality in my body alongside my clinical training. And the man I’m about to challenge is, in every way that would have mattered to my grandparents, exactly the kind of man my family doesn’t cross.

To help move this couple out of their shared misery and into shared intimacy, I know what I need to do. But what I need to do as a clinician is the exact opposite of what I need to do to keep this white man from blowing up at me. For a moment, I feel these two contradictory pulls in my chest.

And as if the pressure of that isn’t enough, this session is also being live-streamed to hundreds of RLT practitioners and trainees as a real-time demonstration of the model. They know as well as I do that the next powerful move entails confronting this man and waking him up to his bad behavior. I can’t wimp out now.

I look down at my notes, close my eyes, and take a breath, allowing the silence to fill the space between us. *Am I really going to speak up and tell this man the truth in front of his wife and all these other people?*

I smile internally. *Damn right I am.*

Little Brown Girl

In the ’80s and ’90s, long before this counseling session, I lived in a town on the Texas Gulf Coast called Corpus Christi, home of Whataburger (iykyk). Depending on your generation, you might know it as both Farrah Fawcett and Eva Longoria’s hometown. For me, it will always be the hometown of Selena, the slain Tejano singer who managed, in her short 23 years of life, to change an entire industry, inspire millions of Latinos around the world, and leave a legacy that extended far beyond her music career.

My grandparents owned their own business—still do, as a matter of fact—and my dad worked alongside them. But in the early years, they’d tell customers they were “just the workers” because in the ’60s white people wouldn’t support a business owned by Mexicans. They feared that taking up their authority as shop owners would anger their white patrons, or at least inspire distrust. So they stayed silent to survive.

I should mention that my grandparents always referred to themselves—and to us, their children and grandchildren—as Mexican, despite being born in the US. In fact, several generations before me were US-born, making us full-fledged, natural-born citizens. We’re Americans. But it always seemed like the adults in my family felt more connected to their cultural and ethnic community than to the community around them. Maybe, despite loving this country, they never truly felt accepted as Americans. It’s only in the last 10 years that I’ve begun to identify as Mexican-American myself, as a way of embracing the multidimensional aspect of my identity.

While I learned from my grandparents that telling white people what they wanted to hear was a way to avoid incurring their anger and mistrust, I also learned it was important to be strong and stand up for yourself. Strength, resilience, and not taking any shit from anyone were survival strategies, too. So growing up, I fluctuated between accommodating and dominating. While being a “fiery Latina” is a trope, it was one I could live with. Being a fighter felt powerful. It was admired and reinforced in my family and in my Latino community. When I moved into accommodation, I felt small, powerless, and scared.

Years later, during my RLT therapist training, Terry Real told me, “You saw that you could either be the hammer or the nail. You chose to be the hammer.” That changed everything for me.

I walked into that training wanting to become a better couples therapist, and I walked out with a complete reset on how I'd been approaching intimacy. It was the first day of my own relational recovery.

In the coming months and years, I learned about soft, loving power, the kind that allows you to stand in your own truth and advocate for yourself while staying connected, that allows you to communicate authentically without sacrificing the relationship. Soft power showed me how to assert the I without losing the thread of connection to the we.

Fierce intimacy, I discovered, began with remembering love and holding myself and others in warm regard. It required me to get off the seesaw of accommodation/domination and stand firmly in my healthy self-esteem. I began cultivating a more complex internal boundary system that gave me agency over what I allowed in or kept out. I also got better at sitting with big emotions, difficult conversations, and tension without reflexively yielding or controling.

I'll never forget the first time I exercised soft power in my own relationship with my husband. A dynamic was playing out the same way it had a thousand times before. He did something I didn't like. I got loud and demanding and told him he was doing it all wrong. He went cold and silent, shutting himself off from me completely. But this time, instead of continuing to escalate, I took a deep breath. I remembered that I loved the man in front of me dearly and that I'd vowed to cherish him.

"I shouldn't have spoken to you like that," I said. "I'd like to talk about this if you're willing, but I don't want to fight with you. I love you. Can I start over?"

His shoulders relaxed and his eyes met mine. "That would be great," he said.

Finding my relational voice in my marriage gave me confidence to try this in sessions with clients. I could relate to them as a fellow traveler, rather than as some all-knowing, perfectly-attuned-at-all-times relational expert.

"Listen," I'd say. "I've been where you are, fighting to get control or over-accommodating to avoid the stress of conflict. It will protect your ego in the moment, but it will cost you your marriage over time. I learned a better way, and I can teach that to you if you'll let me. What do you say?"

And like all healing, my relational recovery deepened my connection to a larger community. I found and confided in mentors, colleagues, and friends. Some offered embodied examples of what it looked like to use a healthy, relational voice. Others offered encouragement and support when I felt myself retreating into a smaller version of myself. Because like all recovery journeys, mine is subject to relapses. And on a bad day, I can still hear a voice in my head whispering an old narrative: *You're just a little brown girl from South Texas. What do you know?*

When I shared this story with a childhood friend, herself a "little brown girl" who grew up in Corpus Christi, she said without hesitation, "Oh yeah? You're just a little brown girl from South Texas? Well, so was Selena."

Speaking the Truth with Love

I think of that now as I look up from my notes and make direct eye contact with my white, male client. "Can I be direct with you?" I ask.

"Yeah. That's why we're here, isn't it?" he replies with a shrug and an air of sarcasm.

"Alright," I calmly tell him. "Take a breath because this might sting a little." He does. "As I see it, you've been incredibly dismissive, unsympathetic, and minimizing of your wife's experience," I begin. "You've indulged your son far too long and have contributed to your wife and son's failing relationship by neglecting to set reasonable limits with him. After years of this, she's fed up and angry and acting out that resentment by yelling at you. And the more she yells, the more you shut her down. This is eating up all the love and care between the two of you."

I pause to let these words sink in.Then I ask for confirmation. "Do I have that right?"

He stares me dead in the eye. I don't flinch. I take a deep breath and tilt my head a bit. I wait for him to speak as the silence stretches between us. He opens his mouth and shuts it quickly. Finally, he says, "Yeah, you're 100 percent right."

There's a softness in his voice that I haven't heard yet. The energy shifts. His wife, surprised, whips her head up to look at him. Then she turns to look at me and begins to cry softly. Her energy has also shifted. The palpable despair she carried into the session has transformed into something lighter: hope.

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Healing my self-esteem and cultivating healthy boundaries were absolutely necessary so that I could speak truth to power. Because you can't speak truth to power from a one-down, over-accommodating place. You can't do it from a one-up stance of domination and control, either. You can only do it from a place of "same-as." My worth is the same as your worth. I'm no better and no worse than you or anyone else on the planet. It's not about bravado or grandiosity. It's about choosing to take the risk of authenticity and sit in the vulnerability of honest sharing. This man took in what I had to say not because I was right and out-argued him, but because I was intimate with him. And it felt good.

From a much softer, more vulnerable place, the husband says, "I know I build walls. And I've let my wife in more than anybody else. But when she yells at me, I don't know what else to do, so I put that wall right back up." He takes off his glasses and wipes away tears with his t-shirt. "It's lonely behind those walls," he adds.

I smile internally. *Now we're getting somewhere.*

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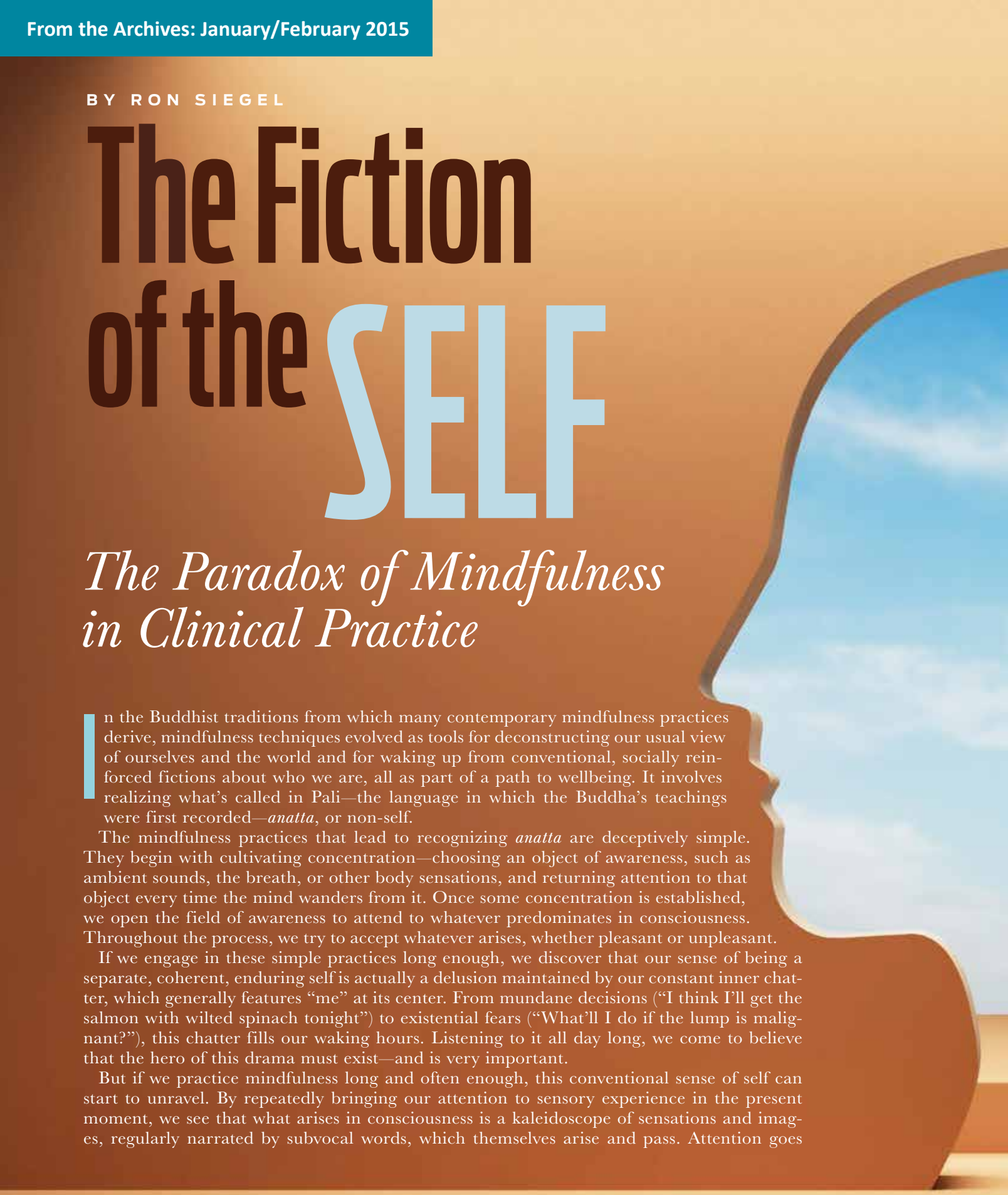
BY RON SIEGEL

The Fiction of the SELF

The Paradox of Mindfulness in Clinical Practice



In the Buddhist traditions from which many contemporary mindfulness practices derive, mindfulness techniques evolved as tools for deconstructing our usual view of ourselves and the world and for waking up from conventional, socially reinforced fictions about who we are, all as part of a path to wellbeing. It involves realizing what's called in Pali—the language in which the Buddha's teachings were first recorded—*anatta*, or non-self.

The mindfulness practices that lead to recognizing *anatta* are deceptively simple. They begin with cultivating concentration—choosing an object of awareness, such as ambient sounds, the breath, or other body sensations, and returning attention to that object every time the mind wanders from it. Once some concentration is established, we open the field of awareness to attend to whatever predominates in consciousness. Throughout the process, we try to accept whatever arises, whether pleasant or unpleasant.

If we engage in these simple practices long enough, we discover that our sense of being a separate, coherent, enduring self is actually a delusion maintained by our constant inner chatter, which generally features "me" at its center. From mundane decisions ("I think I'll get the salmon with wilted spinach tonight") to existential fears ("What'll I do if the lump is malignant?"), this chatter fills our waking hours. Listening to it all day long, we come to believe that the hero of this drama must exist—and is very important.

But if we practice mindfulness long and often enough, this conventional sense of self can start to unravel. By repeatedly bringing our attention to sensory experience in the present moment, we see that what arises in consciousness is a kaleidoscope of sensations and images, regularly narrated by subvocal words, which themselves arise and pass. Attention goes

from the sensations of breathing, to a sound, to an itch on the scalp, to an image of a client, to remembering an upsetting email.

We never actually find the little homunculus, the heroic man or woman inside, the stable and coherent "I" so regularly mentioned in our passing thoughts. Rather, there's just a continual flux of changing mental contents.

If we cultivate sufficient mindfulness, we may even see how we create our sense of self, and our understanding of the world around us, out of this flux. Seeing this in action can pull the rug out from under us in alarming—though potentially liberating—ways.

How We Construct Reality

Ancient Buddhists described the process by which we construct reality and our sense of self much as modern cognitive scientists do. It all begins with sense contact: the coming together of a sense organ (the eye or ear, for example) with an object of awareness. These sensations are then immediately organized into perceptions, conditioned by language, personal history, and culture.

The mind doesn't stay at the level of perception for long, however. It immediately adds a hedonic or feeling tone to all experience ("I like this" or "I don't like this"). And almost as soon as the feeling tone enters consciousness, intentions arise. We have an impulse to hold onto pleasant experiences and push away unpleasant ones. Over time, we develop habits of intention that we might call dispositions or conditioned responses—collections of habitual responses to our likes and dislikes.

These dispositions become important elements in our identities ("I'm a progressive," "I listen to classical music," "I hate jet skis," "I'm into mindfulness," and so forth). We may imagine that as sophisticated psychotherapists we've moved beyond this kind of primitive identity formation—but just ask a room of clinicians who listen to NPR how many drive a pickup truck or own a gun and not many hands go up. What we see through mindfulness practice is that creating a sense of self is actually an impersonal process. And this impersonal process—involving sensation, perception, feeling, and intention—unfolds moment after moment, relentlessly narrated by thoughts that themselves arise and pass.

> "Seeing how our sense of self is constructed isn't just a topic for abstract philosophy."

Our sense of self has other dimensions, too. These turn out to be equally insubstantial. Most of us identify with the body as "me." Outside the skin is the world; inside is me. But what happens when we eat an apple? At what point in the journey from your hand, to pulp in your mouth, to gastric mash, to sugar in your blood does the apple become "you"? And what about the cellulose, or fiber, aggregating and getting ready to enter a familiar white porcelain receptacle? Is that you? Is it still the apple? Or is it something else? (Most of us pick "something else" because we don't like to think of feces as either "me" or "my food.") Upon examination, our cherished division between "me" and the rest of the ecosystem in which we reside falls apart.

Most of our clients may never practice intensively enough to see clearly how their sense of self is constructed from these elements, but if we therapists can awaken to this reality, it can help us take ourselves less seriously, be less preoccupied with our personal pleasure and pain, and provide a therapeutic attitude that can help our clients do the same.

Non-Self in Psychotherapy

Seeing how our sense of self is constructed isn't just a topic for abstract philosophy. In Buddhist psychology, awakening to *anatta*, or non-self, is central to psychological freedom. And even glimpsing *anatta* in our mindfulness practice can have profound implications for how we practice psychotherapy.

What might treatment look like if there's no coherent self to be found or developed? What if trying to establish a coherent sense of self is itself a central source of suffering, as Buddhist teachings suggest? What does this mean about developing self-esteem? Identity? Authenticity?

Some implications are simple. Instead of asking in therapy, "How did that make you feel?" we could inquire, "What's happening right now?" Instead of helping our client identify his or her authentic self, we could highlight how everything changes moment by moment, including who the client thinks he or she is.

Glimpsing *anatta* also supports parts work. The notion of a self composed of many parts is not new.

From the Greeks' pantheon of gods to Freud's ego, id, and superego; Jung's shadow and persona; and more recently Richard Schwartz's Internal Family Systems, our therapeutic traditions have long suggested that the self is plural rather than singular. While seeing oneself as made up of many parts may feel a bit more like having a self than seeing oneself as a fluid organic process, all these models point to something we see in mindfulness practice: if I objectively observe consciousness moment by moment, I discover a continually changing landscape.

The Ron Siegel who appears to be a balanced, knowledgeable professional leading a workshop or treating a client is quite different from the Ron in an argument with his wife or daughter. Shockingly different, in fact. Angry Ron, frightened Ron, greedy Ron, generous Ron, and loving Ron may all share a common social security number, driver's license, and physical appearance, but that's where the coherence ends. Without the glue of a narrative about "me," these selves are different organisms.

Mindfulness practice can dissolve this glue, with profound implications for psychotherapy. For example, my client Gretchen recently found herself stuck in a depressive funk. She'd lost hope again that she'd ever have a meaningful job or relationship and was ruminating about her inadequacies. Highlighting the fluidity of her sense of self helped her gain perspective.

"How are the thoughts and feelings arising now different from a few weeks ago after your promising date with the architect?" I asked.

"I was just fooling myself back then," she answered. "He seemed like a great guy and I got carried away, imagining a great future. Now I see things more clearly."

"Do you remember that you were struck back then by how negatively you see yourself when you're down? How depressed Gretchen is so different from okay Gretchen? It sounds like depressed Gretchen is back," I said.

"I guess so," she replied. "It feels like she'll be around forever. But that'll probably change, too."

Psychological treatments strive to move clients toward health. But this health is determined in large measure by cultural norms. Anthropologists have long noted that Western cultures tend to be more individualistic than Eastern and nonindustrialized societies. So it's no accident that Western models of health include being aware of boundaries and one's own individual needs, and having a clear identity and sense of self.

> "But if we practice mindfulness long and often enough, the conventional sense of self can start to unravel."

This is in marked contrast to cultures in which identification with nature, family, the tribe, or even ancestral lineages is emphasized and honored. As South African social-rights activist Desmond Tutu has said, in many African cultures, if someone asks, "How are you?" the answer is either "We're fine" or "We're having trouble." Individual well-being outside of the group's experience is inconceivable.

One effect of mindfulness practice is to dismantle our modern Western sense of autonomy, yielding several positive—albeit initially disturbing—consequences. If I'm identified with certain traits or dispositions as "me," I'm going to have trouble when other aspects of my humanity appear. For example, if I like to think of myself as generous, hardworking, and intelligent, I'm going to have difficulty when my greedy, lazy, dumb sides show up. Indeed, this is what Jung called our shadow—split-off elements of the personality that aren't acknowledged as part of our conscious identity. As long as I'm denying or resisting these elements and seeing them as "not me," I'll be in constant tension, inclined to project them onto others and be judgmental when I see them there.

So one result of embracing *anatta* is recognizing that it's all part of a passing show. We can accept every aspect of this organism, rather than identifying with some elements as "me" while rejecting others. The alternative to accepting our varied states is dissociation, whether the mild form that we call having a clear identity and sense of self, or the stronger version, in which we completely split off unwanted contents—only to be haunted by them.

The Failure of Success

I had the privilege several years ago of traveling through an African wildlife park. Time and time again, our guide would point out scenes of a dominant male surrounded by a pack of healthy, fertile females. Somewhere nearby were other females, perhaps not at the peak of fertility, and the young kids. Off

in the distance were adolescent males, honing their skills to compete for the dominant male position. It brought to mind what stress physiologists like Robert Sapolsky at Stanford point out: "It's particularly bad for your health to be a low-ranking male in a primate troop."

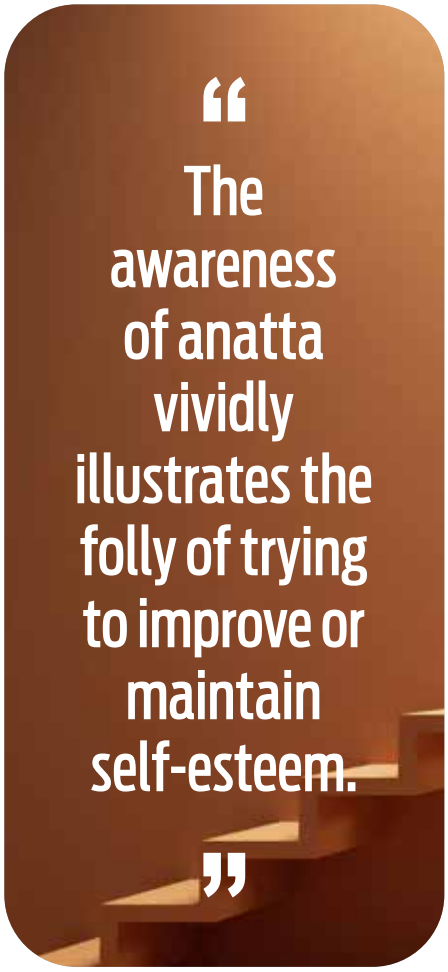
By helping us observe—rather than identify with—our thoughts, mindfulness practice reveals how often we're concerned with our rank in our particular primate troop. Other species may stick to a few variables, like who's stronger or more fertile-looking, but we compare ourselves to one another in a remarkable range of domains. For one person, it's who's smarter; for another, it's who's richer; for someone else, it's who's more popular. Then there's who has the better body, the better-behaved child, the better clinical practice, the more developed sense of style, athletic ability, or social graces.

My client David was an anxious, episodically dysthymic young man with clear goals. He'd read all the latest books about success and had enthusiastically crafted his strategic-objective vision: a big house, a big car, and a beautiful wife, all of which he intended to acquire in the next five years.

I suspected that while he may indeed achieve his external goals, he'd soon recalibrate and be left feeling inadequate. So we began to explore in therapy how he came to believe that these achievements would bring him happiness. It took a while, but he eventually connected with a series of traumatic humiliations, including being dominated by an older stepbrother and cheated on by a college girlfriend. On top of this, he recalled his father's oft-repeated disparaging names for the "losers" of the world.

As therapy unfolded, David finally got relief from his anxiety and dysthymia, not by fulfilling the imperatives of his vision, but by seeing them as attempts to insulate himself from the pain of feeling inadequate and noticing how winning made him feel good for a few moments but soon left him needing more.

Indeed, despite its obvious limitations, most of us persist in trying to bolster our own—or our kids'—self-esteem through pursuing countless goals. But as Joseph Campbell famously put it, we often "climb the ladder of success only to discover that it's leaning up against the wrong wall." Mindfulness practice and the awareness of *anatta* vividly illustrate the folly of trying to improve or maintain self-esteem. We see repeatedly that what goes up must come down, and we notice that eventually we all succumb to illness and death.



The alternative, which arises naturally out of the awareness of *anatta*, is self-compassion. Instead of trying to regain our competitive position after a fall, we acknowledge the painful feeling of disappointment and offer ourselves loving understanding. For example, if my daughter doesn't make the soccer team, instead of reassuring her by saying, "But you're better than other kids in math, and you're a great ice-skater," I might share with her, "I was disappointed when I wasn't chosen for a part in the school play. I remember that it hurt, and I felt really bad about myself when it happened." Then I might give her a hug.

Instead of pointing to a compensatory strength, we comfort others and ourselves with acceptance and a reminder of our common humanity—the awareness that we're together in this life of winning and losing, joy and sorrow.

By seeing how our sense of self is constructed, how our quest to enhance self-esteem makes us miserable, and how we're part of a larger whole anyway, we become less concerned with egoistic aims and feel more connected with others.

It's Really Not Personal

Virtually every school of psychotherapy helps clients identify or "own" their feelings. Most therapists hold authenticity, genuineness, and being true to oneself among our highest aspirations. But when we glimpse *anatta*, these aspirations start to lose their importance. In fact, we discover that there are distinct advantages to not owning any feelings as ours.

As mindfulness practice deepens, we see emotions in greater and greater refinement. Rather than being vitally important, meaningful aspects of ourselves, with names like love, anger, fear, or longing, they increasingly look like patterns of bodily sensations, perhaps along with visual images, accompanied, like everything else, by the mind's persistent narrative.

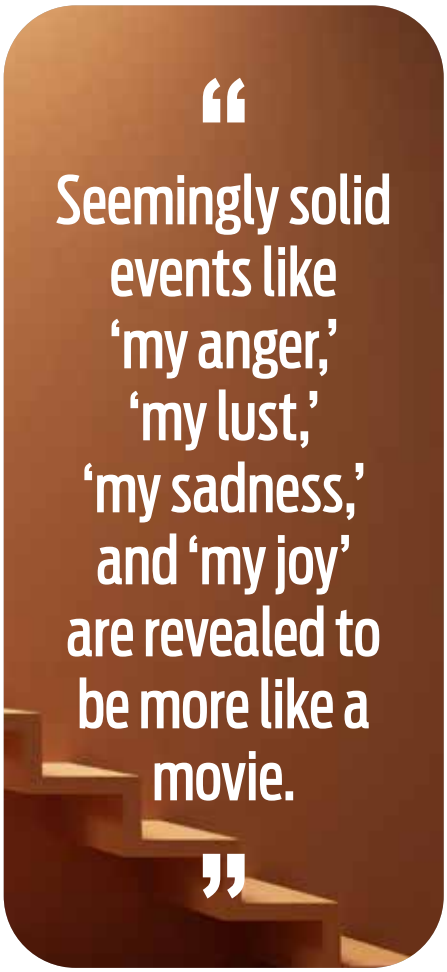
It's said in Buddhist traditions that with enough practice, we can observe mind-moments. These are the briefest experiences of which a person can be conscious. Traditionally, a mind-moment is defined as 1/10,000 of the time it takes a bubble to burst. At this level of refinement, seemingly solid events like "my anger," "my lust," "my sadness," and "my joy" are revealed to be more like a movie, actually made up of many separate frames strung together, producing the illusion of continuity.

Let's say a friend to whom I've been extraordinarily generous treats me badly. In an ordinary state of mind, with a coherent and well-developed sense of self, I'd think, "I can't believe he did that to me after all I've done for him." And with each repetition of that thought, I'd feel more anger and review more reasons why he's bad and I'm good.

If, in contrast, I've cultivated enough mindfulness to glimpse *anatta*, I might simply notice my back and neck muscles tensing, my heart and respiration rate increasing, and images of decapitating my former friend dancing across the screen of awareness. It'll all unfold as an impersonal process—waves of psychophysiological arousal accompanied by images and subvocal words. Experienced in this way, as impersonal bodily events, emotions are easier to manage. Also, they don't get reinforced continually by ruminative thoughts, so they tend to pass more quickly.

But what about "owning" feelings, and being "genuine"? Isn't this an important part of psychological health? Indeed, if a fellow walks into my office and says, "You know the way your friend can piss you off sometimes?" or, even more removed, "Doc, I know this guy who has trouble performing in bed," there's certainly merit to helping him eventually say, "I feel angry at my friend" or "I've been having trouble maintaining an erection." However, insight into *anatta* suggests an additional, more advanced therapeutic step that isn't usually part of treatment. We can also help our clients observe emotions as events arising in consciousness, not experiences "owned" by anybody.

In the context of *anatta*, we can tolerate a broader range of feelings with greater intensity than from our habitual framework of "self-ing." Having practiced being with, rather than fixing itches, aches, and pains in meditation practice, we develop the capacity to tolerate, or even embrace, the bodily sensations of strong emotions. Experiencing them as simply states of somatic arousal drains them of their personal, narrative meaning. We then no longer feel compelled to do something about them. Rather, we can feel them arise and pass, like other contents of the body-heart-mind. And the more fully we accept them, the more readily they transform.



Of course, this attitude has potential pitfalls. In relationships, identifying and communicating the emotions that arise in response to one another are an important part of intimacy. Posturing as though we're experiencing our emotions with awareness of *anatta* when we can't actually do it experientially becomes just another defensive, intellectualized stance. Our underlying identification with the emotion will no doubt manifest in some other way, as our hurt, anger, or fear finds expression. In contrast, connecting with feeling while genuinely seeing its impersonal nature can allow for deep intimacy. We can share our experience with another person fluidly and openly, with less of the shame, righteousness, fear, or clinging than we might otherwise experience if we were identifying with or "owning" the emotion.

Copernican Therapy

As we come to see the reality of *anatta* and experience the relief and freedom that this realization brings, our orientation toward treatment may shift as we come to see how our hardwiring to enhance self-esteem, pursue pleasure and avoid pain, and identify with our thoughts and feelings causes endless, unnecessary suffering. As the 20th-century Taoist philosopher Wei Wu Wei said, "Why are you unhappy? Because 99.9 percent of everything you think, and everything you do, is for yourself. And there isn't one."

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BY LAVINIA MAGLIOCCO

Three Ways the Therapist's Self Shapes Therapy

Using Our Selves as Instruments to Catalyze Change

In a recent session, after a client described feeling devalued at work, they looked at me and said, "Your expression—I feel so validated."

I was surprised. I hadn't been aware of my face revealing any emotion. But as we'd talked about it, it became clear that they'd registered the anger and indignation I'd been feeling on their behalf.

This incident wasn't the first time a client had caught a glimpse of my internal reaction without my being aware of what I was revealing. A part of me felt a bit sheepish for being so easy to read. A colleague I know uses Botox so that she can maintain a calm expression when working with inmates who often share frightening stories of violence with her. But is a neutral affect even something I should try to cultivate? In other words, is my way of being as much a part of the treatment as my interventions? Carl Rogers would say yes, asserting that congruence, empathy, and unconditional positive regard—qualities of the therapist's person—are crucial catalysts of change.

In another session where I was obviously moved, a different client said, "Your responsiveness makes me able to trust enough to share things I haven't shared with other counselors." This reaffirmed for me that what we experience internally as therapists doesn't always need to remain private: it enters the relational field.

While a therapist's unregulated expression can disrupt the work, suppressing our responses can produce something equally problematic—a relational environment that feels thin or unreal. From an attachment perspective, this matters. Clients orient to safety and meaning through accurate mirroring. When my reactions are attuned—neither excessive nor absent—they confirm that you're having an impact on me. You exist here. What you feel registers. In philosopher Martin Buber's terms, the client becomes real in the presence of a responsive other. The therapist's person is not incidental to treatment. It's one of its primary instruments.

This question points to something broader and much harder to pinpoint and define than any choice or technique: how much of what happens in our work with clients is shaped not by what we *do* as therapists, but by who we *are*? In my practice, I've noticed how identity and experience enter treatment through several distinct channels. My training, history, and identity are always shaping what I pick up on and what becomes clinically meaningful as a result.

Different therapists sitting in the same room with the same client won't end up experiencing the same session. They'll notice different narrative contradictions, track attachment patterns differently, and register distinct bodily movement or symbolic cues that lead them to intervene in their own way. The person of the therapist shapes perception as well as interpretation.

How Life Experiences and Training Shape What We Notice

Before becoming a therapist, I was a professional ballet dancer. Subsequently, I became a Pilates and yoga teacher who specialized in analyzing movement and adapting it for injured and disabled clients. These previous roles and training experiences left me with a habit of watching people's feet and gait. In my office, clients remove their shoes, which facilitates grounding but also provides information on *how* they connect with the ground.

During my counseling internship, Donna, a 36-year-old woman came to therapy with chronic pain in her hips and lower back. She'd suffered sexual abuse and had been in foster care with several placements in childhood before her adoption. Donna described feeling as if she always had to "tiptoe around"—in foster families and with her adoptive mother who'd "saved" her life, but who could be emotionally volatile.

As she walked across the room, I noticed two things immediately. Her feet were locked in high arches that never pronated when she bore weight, and her pelvis barely moved when she walked. The gait pattern suggested minimal floor contact, more like walking on a precarious surface: rigid, cautious, controlled.

My background made these details hard to miss. When I brought this to her attention, we connected it with her metaphor of walking on eggshells and tiptoeing as a child to be inconspicuous. She admitted she also suffered from plantar fasciitis. I explained how optimal foot mechanics (pronation when loading, supination pushing off) have repercussions in pelvic mobility, providing natural movement in three dimensions throughout the entire body.

The idea that hips are supposed to move surprised her. "Really?" she exclaimed. "I thought you shouldn't move your hips when you walk," alluding to pelvic movement being naughtily suggestive.

I guided her in performing a few simple exercises to mobilize the feet and allow her hips to respond more freely. Nothing elaborate—just basic work to restore pronation/supination rhythm and pelvic motion. I was able to incorporate these interventions into our conversation about how fear and tension manifest in the body.

By the next session her pain had largely disappeared. She began experimenting with a looser, more playful way of moving that visibly shifted both her mood and affect. As therapy progressed, she was also able to explore the complicated emotional reality of her adoptive mother: rescuer and tormentor at the same time. While foot exercises alone may not resolve trauma, they can significantly change a client's relationship to their body and to gravity, which may then facilitate experiences of freedom, empowerment, and self-trust.

In the training model and book called *The Person of the Therapist,* family therapists Harry J. Aponte and Karni Kissil delineate methods for developing and training clinicians' therapeutic use of the self through targeted self-exploratory questions that heighten awareness of individual experience as both a resource and potential risk.

In this case, my movement training shaped what entered awareness when I first met Donna and informed what became clinically actionable. Many therapists would've heard the phrase "tiptoeing around my mother" as a metaphor and worked with it symbolically or relationally. My training allowed me to notice a literal motor pattern that matched the metaphor and expressed the feeling somatically. Because perception is trained, different therapists inhabit different clinical worlds even in the same session.

What Becomes Meaningful

Therapists also differ in what they treat as symbolically meaningful. Although I don't work with children, stuffed animals are prominent in my office. They sit on shelves, and I keep a basket of them next to a chair my clients often use. Adults will reach for them during sessions, and I pay close attention to which objects clients gravitate toward.

Courtney came to therapy grieving the loss of a professional athletic career that had not only provided them with an identity but served as a primary mechanism of emotional regulation. When over-efforting finally led to a serious injury, both their career and the regulatory system they'd developed collapsed.

In one session they picked up a stuffed otter from the basket and held it while we talked. Rather than ignoring the gesture, I asked about it. They shared feeling vulnerable as a child and compensating by pushing themselves athletically to gain both the love and recognition they desperately needed. At the end of that session, I suggested they take the otter home as a reminder to care for what the poet Mary Oliver calls the "soft animal of the body," from her poem *Wild Geese.* Courtney had read the poem out loud in a previ-

ous session, and it had meant a lot to them.

The otter became a transitional object which served as a reminder of Courtney's tender, "soft" self when the impulse to overtrain or push through pain arose. Over time it came to represent two important aspects of their life: the vulnerable inner child who'd suffered emotional neglect, leading them to perform to prove their worth, and a reminder to relate to their body with care and love.

My love of stuffed animals comes from growing up in a household where objects carried historical, cultural, and relational meaning. In therapy, they can become tangible images of the psyche—companions, protectors, talismans—that clients can hold in their hands. These objects sometimes provide security and grounding, giving form to feelings that are otherwise difficult to name.

Containing and Disclosing Identity

Sometimes the therapist's person enters the work through identity rather than perception. My 19-year-old client Bruce expressed extremist political views, including open admiration for Nazi ideology.

What he didn't know was that I'm Jewish, and that on my father's side, a member of my family was prominent in the Italian military which, at that time, was under a Fascist regime. These two dichotomous ancestral tensions are present in my family history, my DNA, and my awareness.

During our first year of treatment, I simply contained my reactions. At times, I felt myself harden internally when I was triggered by his stance or a particular comment. I used breath, self-compassion, and mental reminders that his stance was the result of suffering. My internal adjustments happened quickly and hopefully, invisibly. These were auto-interventions that help me maintain spaciousness when I assessed that disclosing my reactions to him wasn't clinically appropriate.

I appreciated Bruce's intelligence, vulnerability, and dedication to showing up. He had extensive trauma that included being the victim of both physical violence and emotional neglect, and once even had to call the police when his father tried to strangle his mother. However, I had to exercise significant emotional labor when working with him: holding anger, grief, and disbelief while maintaining warmth and curiosity. The goal was not neutrality in the classical analytic sense but the preservation of a relationship in which connection remained possible.

At the same time, I was mindful that my internal world was part of the diagnostic instrument I was using with him. Psychiatrist Paula Heimann and psychologists Nancy McWilliams and Jessica Benjamin reframed countertransference from something that contaminated sessions to something that offered clinical data about clients' unconscious communication, highlighting that the therapist's internal experience can become information about the relational system.

Toward the end of our work together, when Bruce and I were discussing his tendency toward black-and-white thinking, I decided to disclose the dichotomy between my maternal Jewish ancestry and paternal military history. The moment functioned less as confrontation than as reality testing. The person sitting across from him—someone he'd come to trust—was also a member of the groups he spoke about abstractly.

When therapy concluded two years later because he was leaving town, he told me something striking. My appearance, he said—bald, tattooed, "weird"—had initially led him to assume I'd be "one of those people who yell at me in protests and call me a fascist." Instead, he felt my acceptance and lack of judgement. He added that the experience had changed him somewhat, even though our political views would never align.

My identity had been present in the room from the beginning. Perhaps because I already held the tension between these two familial narratives, I was able to sit with him more easily. The disclosure simply made explicit what had already shaped the relational field.

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Psychotherapy training often emphasizes technique: models, interventions, protocols, and measures. These matter. But they operate through a more fundamental medium—the therapist, the instrument in the room. Of course, there are always pitfalls when it comes to leveraging the self of the therapist in our work. Biographical resonance can lead to over-identification. Symbolic sensitivity can tempt us to see meaning where none exists. Identity conflicts can provoke reactions we struggle to contain. The same perceptual habits that make certain interventions possible can also create blind spots. For that reason, the concept of the person of the therapist isn't simply an invitation to authenticity. It's an invitation to study ourselves as instruments.

Our lived experience, histories, and emotions train our attention. Our identities shape the emotional field, influencing the atmosphere in which clients think and feel. The person of the therapist doesn't merely color the work. It determines what becomes visible. And once something becomes visible, therapy can begin.

Lavinia Magliocco, LPC, CRC, is a 2nd generation therapist, writer, and former professional dancer. Specializing in somatic and psychodynamic approaches, their work emphasizes embodiment, nervous system regulation, and cultural fluency, supporting clients in reclaiming vitality and choice after trauma, illness, or prolonged adaptation.

BY SALVADOR MINUCHIN

The Therapist's Most Important Tool

Salvador Minuchin on What Today's Trainings Are Missing

We tend to think that modern-day therapy is more advanced than ever when it comes to therapists using themselves in the room with clients—that earlier generations prized restraint, neutrality, and the idea of the therapist as a "blank slate," quietly reflecting rather than actively shaping the process. Intervening, especially in the charged terrain of family dynamics, was often seen as unprofessional—even harmful. But the truth is far more nuanced.

Many of yesterday's therapists didn't just sit back; they stepped in. They guided, challenged, slowed things down, and, at times, offered clear, direct insight. In the 1960s and 1970s, at teaching hospitals and clinics across the country, they were laying the groundwork for what we now recognize as a more engaged, relational form of therapy—one that sees the therapist not as a passive observer, but as an active agent of change, a catalyst, and a companion in the client's healing journey.

Few figures embody this shift more than Salvador Minuchin, the Argentine-born psychiatrist and pioneer of structural family therapy. Trained in medicine before turning to child psychiatry, Minuchin developed his approach while working with underserved families in New York, where he began to map the invisible structures—alliances, hierarchies, and boundaries—that shape family life. His work revealed that symptoms don't exist in isolation, but are often embedded in relational systems. Widely considered the father of modern family therapy, he'd go on to shape the work of some of psychotherapy's most influential voices, like Jay Haley and Virginia Satir.

At age 92, Minuchin was still challenging the status quo in what was to be his last book, *The Craft of Family Therapy: Challenging Certainties.* Shortly after the book's release in 2013, *Networker* writer Mary Wylie reflected on Minuchin's craft and contributions.

"Minuchin and the other family therapy pioneers didn't merely inject a bit of fresh air into this hothouse," she writes. "They blew the roof right off, taking all the furniture and psychoanalytic tomes along with it. Not only was the focus of their new therapy different, but so was their view of the therapist. No longer the self-contained cipher, sitting mostly silent and sometimes invisible behind the patient's head, this new kind of therapist—dazzlingly exemplified by Minuchin himself—was brash, interventionist, bossy, and frequently in clients' faces. In fact, the therapist's personality—the 'self of the therapist,' as it eventually came to be called—was considered a key player in the sometimes rowdy goings-on in session."

"The idea was to help the dancers dance, and the therapist would be the one leading the do-si-do," Minuchin recalled later.

It's precisely this kind of active, in-the-moment engagement—part intuition, part technique—that continues to shape how therapists think about their role today. Contemporary clinicians, including Esther Perel, often point back to Minuchin as not only a role model, but a continual source of inspiration. "I cannot even tell you how completely revolutionary your work was in my thinking," Perel told Minuchin at a 2017 Networker dinner event honoring his legacy. "What you taught us was the use of yourself, that you will never be the same person two sessions in a row…. All of us carry you inside of us in so many ways."

There is still much we can learn from Minuchin's work—from his candor, his humor, and his willingness to step into the unknown with clients. "Students today are buried under an avalanche of textbooks and subject to a cacophony of different lectures," Wylie wrote. "They learn all about theory and technique. They're taught to become highly proficient technicians, experts in the deployment of many methodologies. But where and when do they learn who they are and how to deploy their own selves in therapy?" When it comes to therapists using themselves as instruments in the therapeutic process, few have done so as skillfully as Minuchin, or with as much clarity, creativity, and courage.

The following is an excerpt we originally published in 2013 from *The Craft of Family Therapy.* Over a decade later, Minuchin's words feel more important than ever. His willingness to adapt, step forward, and meet clients where they are is no less relevant today.

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When a family comes into your office, what do you do? What's the correct way to start the session? Do you ask about the problem? Do you offer your services as a healer? Do you smile and ask about the trip to the office? Are you silent until one family member begins to talk? Yes, yes, and yes. Therapy is an encounter between strangers preparing themselves for a significant journey together. Therefore, the early joining in the process will be idiosyncratic, depending on the particular family and the particular therapist. It's a journey that starts in uncertainty.

Most new therapists tend to fall back on theory as a way to reduce their anxiety so they can function. But how do you choose a theory that'll enable you to be effective? These young therapists look at therapy as a course of action in which the therapist observes a family and implements techniques to help them with their problems. They don't understand the complexity of the process. The craft of therapy includes not only an understanding of the characteristics of the family and a grasp of techniques that can facilitate change, but an awareness of how they, the therapists, are functioning within the therapeutic system.

There are many ways of learning how to become a family therapist, and these methods have changed over the last 50 years or so. When family therapy first began, in 1957, there were no family therapy theories. There were no introductory textbooks on different family therapy approaches. The field was not yet established, and the ideas and understandings of how families functioned and what to do with them were hidden within the families that were being seen. Practitioners learned by viewing and doing. The originators of the field—people like Nathan Ackerman, Murray Bowen, Jay Haley, Virginia Satir, Carl Whitaker, and others—developed their understanding through meeting with families and then evaluating what happened in the session.

Over time, these experiential learnings developed into theories of how to therapeutically engage families, and institutes were created where therapists could learn how to work in this new way. To get training as a family therapist, a clinician, who was probably originally an individual therapist, might attend one of the institutes of family therapy, such as the Mental Research Institute, the Philadelphia Child Guidance Center, the Georgetown Family Institute, (now the Bowen Center for the Study of the Family) or the Ackerman Institute. The therapy room was the classroom, where the learning took place by doing. These institutes mainly provided a particular view of why families have difficulties and what therapists could do to help them. The people who came to learn were offered training that was grounded primarily in one approach. They weren't bombarded with the multitude of different theories that the present generation of students is struggling to assimilate.

Currently, new practitioners in family therapy are trained in university settings, not institutes. Learning comes from textbooks for classes that try to provide a wide foundation for the field, so that people have the knowledge designated as necessary by state licensing boards. The brunt of learning comes in the classroom, rather than the therapy room. Students are expected to digest a variety of approaches, then are asked to use one or more of these theories as a guideline for their practice when they begin to see families.

A few years ago, I was invited by colleagues at Nova Southeastern University to conduct an informal training practicum for graduate students, who were just beginning their experience as practitioners. My goal was to offer an alternative to the type of training generally provided, in which they first learn the theories that are the foundations of the diverse schools of family therapy, and then apply theory to practice. Through this procedure, trainees are learning to be restrained, protective, and respectful of the client, to avoid entering into conflict with patients, and to search for the techniques that "truly fit" the problem that the clients present. In effect, they're training for cautiousness, guarding against the imposition of their own framework on problems that the family presents. If my view about this training is correct, it's a training that discourages students from looking at themselves as resources in the therapeutic practice.

In accepting the invitation of my colleagues at Nova, I joined them in exploring a different, more inductive process of training. We started out without a clear curriculum, simply asking the students to bring videotapes from the therapy sessions they were conducting in practicum situations. We observed the style and nature of their work and talked with them about their experiences. Over time, we were able to move toward the development of a method for training in

the craft of family therapy.

Our first observations of the students at work provided important building blocks for this development. As they began to interview families, their styles of interviewing presented some common characteristics. They were, of course, anxious, since they had scant experience with encounters involving more than one person, and they usually proceeded with caution and were polite. They asked questions that were frequently a paraphrasing of the client's last statement, such as "So you said that it troubled you when you saw what your daughter was doing?" They also asked questions that encouraged clients to continue explaining, as well as questions directed at tracking the narrative but without opening up new explorations. Paradoxically, they also became quickly engaged in trying to explain, support, protect, or improve the family drama.

The combination put these new practitioners in a quandary. They were engaged in monitoring narrow aspects of the family presentation before they had a clear knowledge of how the family members related, their history, or their efforts at problem solving. They felt the need to do something to demonstrate their competence and responded to family problems before knowing the family. Most didn't know how to be silent or how to use silence as a tool. And, noticeably, they focused mostly on the pathology the family offered as the reason for requesting help, ignoring the exploration of strength, resilience, and resources by which family members might become helpers of each other.

Our students came with different life experiences, but we noticed a major commonality in their presentation of cases: they didn't include themselves in the process. They'd describe the family dynamics, sometimes with surprising clarity, but always as if they were objective, neutral observers. When we asked for feedback from students observing the tapes, they responded with alternative descriptions of the family's transactions, but the participation of the therapist in producing this behavior wasn't mentioned.

These lacunae, empty spaces in observing and describing the therapeutic process, were surprising to me. I remembered that at the beginning of the family therapist movement, all training programs struggled with the issue of the participation of the therapist in the therapeutic process, and with the therapist's awareness of that reality. At that time, most trainees in family therapy came with some experience in psychodynamic individual therapy, and many had undergone their own psychotherapy or psychoanalysis. The family therapy trainers needed to address the necessity of providing an alternative to the long, intensive involvement in self-observation that psychodynamic therapy provided.

Many institutes began to include a focus on the self of the therapist in the first year of training. Virginia Satir scheduled retreats with her students and their families, in which the students explored their participation at different stages of development in their families of origin, using the techniques of psychodrama. Carl Whitaker promoted the idea that therapists should access and utilize themselves in the therapy room, and that to do this they'd need to come to terms with their own thoughts. Murray Bowen stated in his 1974 book, *Toward the Differentiation of Self in One's Family of Origin,* "I believe and teach that the family therapist usually has the very same problems in his own family that are present in families he sees professionally, and that he has a responsibility to define himself in his own family if he is to function adequately in his professional work." In other words, all these master therapists believed that training to become a family therapist started with an exploration of one's own self, which would then aid the trainee inside the therapy room.

The university training programs of today, it seems, have shifted from a focus on the self of the therapist to a focus on what has become known as core competencies. These competencies are concerned primarily with how to conceptualize cases and how to structure and engage in therapy sessions. There are several competencies that refer to the therapist's awareness of the impact the family is having on him or her, but, overwhelmingly, the trainee is expected to be thinking about what to do, rather than who they are.

Throughout my professional career, I've considered the therapist's awareness of an intervention to be an essential part of the formation of an effective therapist. In our program, the students started their presentations by describing relevant aspects of their own life and the ways in which these experiences molded their therapeutic style. Only then did they describe the characteristics of the family they were presenting. After that, they examined the techniques and strategies they'd used. In our discussions throughout the training, I continuously invoked the metaphor of a therapist who has formed, on his or her left shoulder, a homunculus who's engaged in observing the therapist's mental processes and is involved in silent dialogues with the therapist as she or he works.

All therapists need a range of tools in order to master their craft, but tools are just that—a means to accomplish an objective. When the carpenter begins with a piece of wood, he has an end goal in mind: to change that wood into something else. The saw, chisel, hammer, and nail are a means of transforming what the carpenter first sees into what he wants it to become. The effective family therapist also uses tools as means to an end, not as ends in themselves. The craft of family therapy lies in how these tools are used to produce a difference in the family—a useful change. An enactment on its own doesn't move the family. But a therapist who understands that the enactment is a way to view the family's interaction is able to help shift the process.

The most important tool is the therapist's use of self in guiding the process of change; and understanding how to use that tool is the biggest obstacle for beginning therapists. Ultimately, learning how to use the silent dialogue with the homunculus on one's shoulder is central to mastering the essential craft of family therapy.

Minuchin, S., Reiter, M., & Borda, C. (2013) The Craft of Family Therapy: Challenging Certainties, *Routledge, NY. Reprinted with permission.*

When Countertransference Hits Too Close

The Thin Line Between Empathy & Projection

BY ELLEN HOLTZMAN

"Greg is having an affair," Lisa said, her voice quivering. She leaned forward in the blue easy chair my clients often refer to as "the comfy chair," and perched on the cushion's edge. She was in her mid-40s, well-dressed, and normally vivacious. But today was different. Her cheeks looked hollowed out, and her eyes were round and wide, encircled by dark rings. She looked practically shot through by the shock and grief of her husband's infidelity—which reminded me of the same grief I'd felt many years earlier.

Tears began to stream down Lisa's cheeks. "I'm sorry," she said, her voice growing hoarse. "I feel so betrayed."

Suddenly, the fingers on my right hand twitched. It was a muscle memory, and I was now time-traveling back three decades. I was 32, and my husband had just left me. Here, *I* was the client sitting across from the therapist, pulling out a tissue before putting my head in my hands and sobbing.

I blinked a few times and pushed the grief-stricken younger version of myself back into a dark corner of my mind, where I wanted her to stay.

As Lisa continued to cry, a thought kept running through my mind: *I know how she feels.* But I also cautioned myself: *Careful.* Our assumptions about the similarities between a client's experience and our own can be a double-edged sword. On the one hand, they can strengthen the therapeutic alliance, which multiple studies have shown improves treatment outcomes. On the other hand, a client's story can unexpectedly trigger our own feelings—in my case, the loss related to my divorce—causing us to react from a place of emotion rather than objectivity and reason. I had made this mistake earlier in my career, and I didn't want to make it again.

A Marriage Unravels

"Tell me more about what's going on," I said to Lisa.

"I just kicked Greg out of the house for the fourth time," she said. "He's been sleeping with his coworker."

Lisa told me that each time her husband left, he'd call and promise to break off the affair, after which she'd let him move back home—only to discover he was still seeing the other woman and kick him out again. "I'm almost 50 years old," she said. "I can't believe I'm in this situation. I have to decide what to do about my marriage."

In our next session the following week, Lisa told me Greg had asked for another chance, but she didn't know whether to let him come home again. She stared at me, waiting for me to say something. I pictured my ex-husband and imagined telling her what I really thought: *Get rid of this guy immediately before he hurts you again.* Then, a word flashed in my mind—*countertransference*—and I remembered the mistake I'd made with Angela.

Angela had come to see me because she was unhappy in her marriage. She'd been married to her husband Harry for 15 years, and they had two preteen daughters together. Each week, she'd tell me a different story about Harry—how he spent little time with the family and yelled at her in front of the kids. Once, she noticed him scrolling through a dating site. After two months of hearing these stories, I *hated* Harry. A sharper tone edged into my voice each week, and finally, I asked her why she'd stayed married to him.

The day of our next appointment, Angela didn't show, and she didn't return my call when I phoned to see if she'd forgotten. I immediately realized I'd done a poor job with her. My anger at Harry, a selfish man who reminded me of my ex-husband, had crept into my voice, and I'd failed to empathize with Angela's need to stay with her husband—even though she could barely tolerate him.

I didn't want to make a similar mistake with Lisa.

An Abrupt Ending

At first, therapy with Lisa seemed to be going well. When I asked her to tell me about her family, she said that her parents' divorce—the result of her father's affair—had made her teenage years difficult, and she didn't want her kids to suffer as she had. She described a fear of turning into her mom, who was never able to put her life back together after the marriage ended.

> "A client's story can unexpectedly trigger our own feelings—in my case, the loss related to my divorce."

As our third session drew to a close, Lisa dropped a bombshell: "This will be my last appointment."

My head jerked back. "Your last appointment? How come?"

"Greg and I have been talking on the phone every night," she replied. "We miss each other. We thought we'd spend more time together and eventually live together again."

I fought the urge to scream, "Don't let him back into your house!" Then, Angela's face appeared in my mind, and I didn't say anything at all. I tried to make sure my mouth wasn't curling into a deep frown.

"I wonder if you're moving too quickly," I replied in my softest, most gentle therapist voice. "Are you sure you don't want another appointment?"

"I'm sure," Lisa said. She picked up her purse, shook my hand, and walked out the door.

Over the next six weeks, I reflected on the work I'd done with Lisa. I'd tried hard not to repeat the error I'd made with Angela. But maybe a harsh tone had inadvertently crept into my voice, giving away my feelings that reuniting with Greg was a mistake. Months later, I saw a voicemail on my phone from Lisa. She wanted to book another appointment.

A few days later, I ushered her into my office, and she sat down and told me what had happened. The first few "dates" with Greg had gone well. But one night, after a goodnight kiss, she told him she wanted to discuss her unanswered questions about the affair.

"Greg told me the affair was over, that there was nothing to talk about because he'd already admitted he'd made a mistake." She'd pushed back several times but got the same answer: "There's nothing to talk about."

Frustrated and angry, Lisa had suggested they see a couples therapist, and during the first session, Lisa had told Greg that if he wouldn't talk about the affair, then he should at least leave his job since his affair partner still worked there. Greg agreed to look for another job, but several weeks later, he told Lisa he hadn't found anything that paid him enough to start over, and would be staying at his current job. For Lisa, this was the last straw.

"What are you thinking of doing now?" I asked.

"I have a feeling this separation is going to be permanent," she replied. "That's why I made an appointment with you. I have to decide if Greg and I are going to divorce." Her voice trembled, and her face grew pale. It was as if she was standing on a fault line, watching the world around her sway back and forth.

A Slow Change

In our session the following week, Lisa and I discussed whether she should hire a lawyer and file for divorce. She admitted picking up the phone several times to make the call and putting it down without dialing. She spent the next six months wavering, trying to decide whether she should reconcile with Greg or end the marriage. Each week I encouraged Lisa to explore the issues that were preventing her from moving on. Was it a fear of being alone? Concerns about her kids? She answered yes to both. But even though she could identify the obstacles, she remained stuck.

Sometimes in our sessions, my right hand would clamp into a fist and my neck muscles would tighten. I was growing impatient. Lisa's husband seemed as untrustworthy as mine had been. When I put the evidence together—Greg's repeated infidelity, his refusal to answer Lisa's questions, and his unwillingness to continue looking for a new job—I believed it was time for Lisa to move forward on her own.

Don't repeat the mistake you made with Angela, I thought. Then, I took a deep breath and relaxed in my chair. "I'm sure you'll reach a decision when you're ready," I said to Lisa, reassuring myself as much as her.

As the months passed and Lisa continued to struggle with her dilemma, I kept in mind what I'd learned about therapy over three decades of practice. Our clients sometimes zigzag left, then right. They backtrack, make U-turns, and go in the opposite direction. All of this is part of the process of exploring their mind.

After nine months of treatment, Lisa made a surprising admission that changed the course of therapy. Several years earlier, Greg had been convicted of a white-collar crime and spent a year in prison. "Prison?" I said, clamping down my jaw to keep it from dropping open. Lisa blushed and nodded. "What was that like for you?" I asked.

"A big change."

Before Greg went to prison, Lisa had been a stay-at-home mom. Afterwards, the family needed income and health insurance, so Lisa got a job as a teacher's aide. As the head of her household, she'd paid the bills, handled the house repairs, and disciplined the kids. In the summer, she'd mowed the lawn. In the winter, she'd shoveled snow.

"Sometimes you talk about wondering how you'll survive without Greg," I said. "You did fine when he was in prison."

"I hadn't thought about it that way," she said.

For a psychotherapist, there are few better words to hear.

Over the next month, Lisa told me more stories about her achievements, anecdotes that highlighted strengths she'd previously ignored and obstacles she'd overcome. It made me think about the work of narrative psychotherapists, who use rewriting a life story to encourage positive behavioral changes.

As they had before, these stories reminded me of something I'd experienced many years ago. I'd been sitting cross-legged on the floor of my apartment, trying to assemble a clothes rack—a task I would've left to my then-husband had he not moved out a month earlier. I'd reread the instructions several times, made a bold, black checkmark next to a seemingly important step, and finally made a move, sliding Tube A into Tube B. When the two plastic pieces clicked into place, I was thrilled, proud of my newfound assembly skills.

With that excitement still in mind, I said to Lisa, "Wow, those are big accomplishments!"

Nearly two years after we'd first met, Lisa hired an attorney. Despite feeling anxious about the decision, she told me she felt more empowered, an emotion I remembered from my own divorce. "I'm standing up to Greg," she announced decisively.

I was happy with Lisa's progress. But I was also pleased with mine: I hadn't made the same mistake twice. The irritation and impatience I'd experienced when working with Angela hadn't seeped into my work with Lisa. Instead, I'd been able to draw upon the similarities between our stories to deepen my understanding of her dilemma and build a therapeutic relationship that eventually contributed to her healing.

"I don't think I need any more appointments," Lisa told me after her divorce was finalized.

Her eyes were clear that day, and her smile was wide. She looked like a different woman than the one I'd met so many months earlier. I fought the urge to say, "I like seeing you, and I'll miss you when you go," and instead said, "I agree, you're doing great."

We smiled at each other. "You can always come back," I added, and my voice cracked a little. I wondered if Lisa noticed it, too.

"I know," she said, before giving me a hug and walking out the door.

Ellen Holtzman, PsyD, is a psychologist in private practice outside of Boston, Massachusetts. She's the author of the award-winning book, Bouncing Back: How Women Lose & Find Themselves in Marriage & Divorce, *which explores the struggles of psychotherapy clients in failing marriages and the dilemmas Holtzman faced as she faced treating them.*

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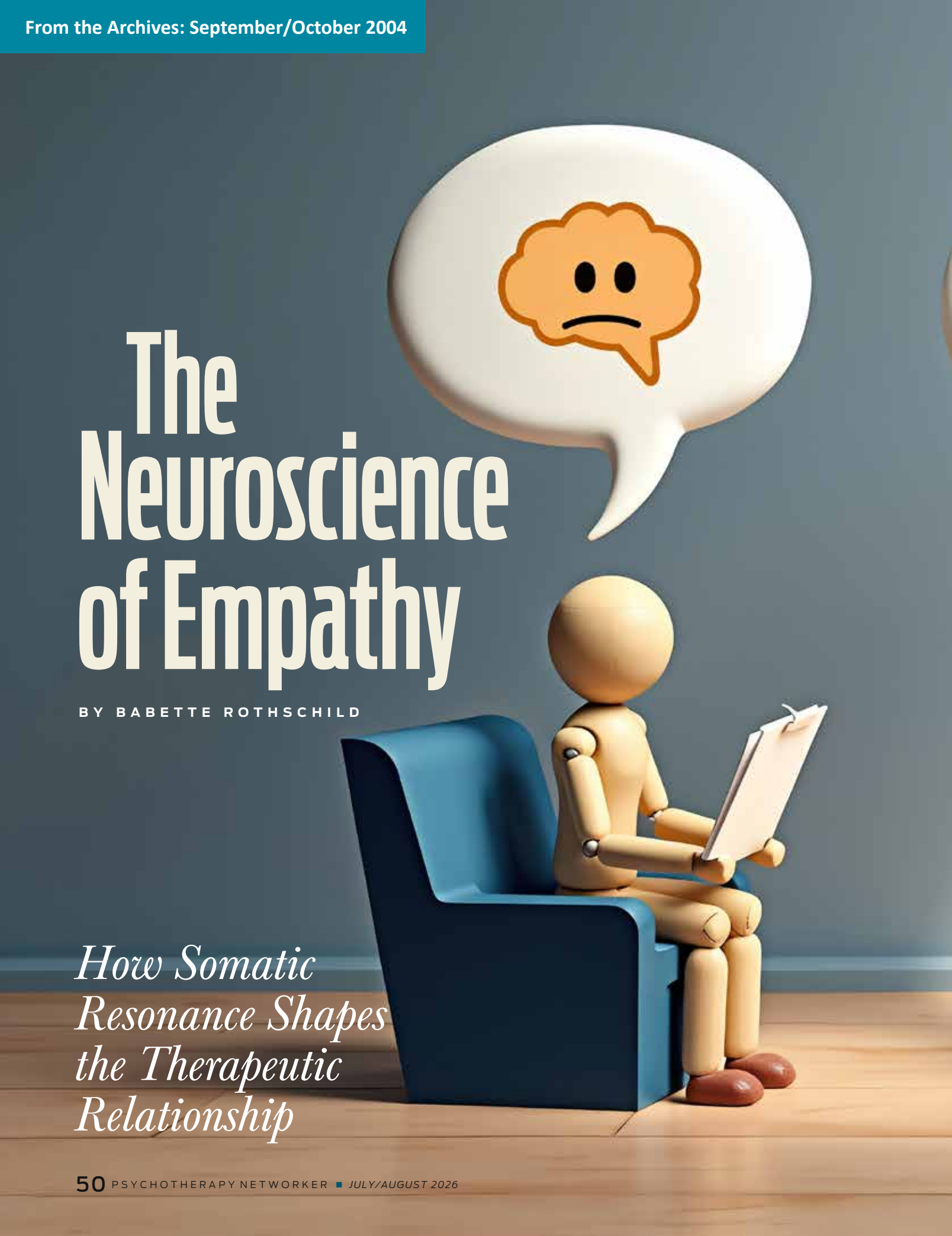


The Neuroscience of Empathy

BY BABETTE ROTHSCHILD

How Somatic Resonance Shapes the Therapeutic Relationship

Most of us know: empathy is the connective tissue of good therapy. It's what enables us to establish bonds of trust with clients, and to meet them with our hearts as well as our minds. Empathy enhances our insights, sharpens our hunches, and, at times, seems to allow us to "read" a client's mind.

Outside the therapy room, brain scientists have long been exploring how certain clusters of neurons may be primed to respond to others' bodily movements and expressions, suggesting that the road to empathy is through the body, not the mind. Notwithstanding the river of words that flow through the therapy room, research tells us it's the sight of a client looking unhappy, or tense, or relieved, or enraged that really gets our sympathetic synapses firing.

This news is both exhilarating and scary. The good news—for therapists, their clients, and the world at large—is that human beings may be more deeply capable of empathy than we ever imagined. If we're truly born to connect, perhaps there's hope for us all. The scarier news: if we're truly designed to mirror each other's feelings, we therapists may be exquisitely vulnerable to "catching" our clients' depression, rage, and anxiety, and succumbing to the ravages of "compassion fatigue." Given the embodied nature of empathy, is it possible to say yea or nay to its effects on us? What steps might we take to harness and channel our natural-born empathy for the good of our clients—and ourselves?

I first recognized the physical force of empathy as a college student, with the help of my friend Nancy, who was studying to be a physical therapist. As we walked down a street together, she'd follow total strangers and subtly mimic their walking style. Copying a stranger's gait, and feeling it in her own body, gave her practice in identifying where one of her patients might be stiff, or in locating the source of a limp.

Intrigued by this mysterious way of "knowing" someone, I asked her to teach me to do it, too. I began to surreptitiously mimic the walks of all manner of unsuspecting folk, from unsteady older people to cooler-than-thou teenage hipsters. What startled me was that not only did "walking in someone else's shoes" change the way I felt in my body, but it often altered my mood as well. When I copied the swaggering gait of a cocky young man, for example, I'd momentarily feel more confident—even happier—than before. I found this secret street life fascinating and fun, but I didn't think much about it until a few years later, when I started practicing clinical social work.

Breathless

On my first job in the mid-1970s working in a family service agency, I began to notice peculiar things happening in my body when I sat in my office with clients. Some of my responses could be blamed on newbie jitters, but I strongly sensed that there was more to it than that. I particularly remember my bodily reactions to a young client named Allison. As she recounted the crises of her week in a spacey, disconnected way, she kept her body very still, and I had to lean forward to hear her whispery, almost inaudible, voice. As we worked together, I noticed that I often felt lightheaded with her. When I began to pay attention to what was happening in my body, I found that my breathing had become very shallow—in fact, nearly undetectable. No wonder I was feeling lightheaded and spacey: I wasn't getting enough oxygen!

Turning my attention back to Allison, I noticed that her chest was barely moving. I was taken aback: we were breathing alike! I remembered then how my mimicry of walking patterns in college had often affected my bodily sensations and moods. Were my lightheadedness and general feelings of disconnectedness just the result of new-therapist nervousness, or the direct result of my imitation of Allison's breathing?

In all of my graduate-school discussions on the therapeutic relationship, including the fine points of transference and countertransference, I couldn't remember anyone who'd ever mentioned the possibility of "catching" bodily behaviors. Intrigued and a bit bewildered, I took my observations to my supervisor. I still remember her look of startled skepticism. "What an odd hypothesis," she finally remarked, her cool tone clearly implying that my experience wasn't to be taken seriously. I was dumbfounded by her lack of curiosity, but I never doubted my own sensations. On the contrary, increasingly fascinated with the role of the body in relational and emotional life, I began a serious study and practice of body psychotherapy.

In contrast to my suspicious supervisor, my body psychotherapy colleagues and teachers seemed to accept readily that their bodies were "in tune with" or "resonating with" those of their clients. Like actors, they regarded their bodies as essential, finely honed instruments of their craft. From these practitioners, I learned "postural mirroring," a technique instigated by dance therapists, wherein I'd attempt to get a reading on a client's emotional state by copying the way he sat, stood, or moved. There wasn't a lot of debate about the usefulness of such a technique: body psychotherapists simply assumed that "the body doesn't lie."

Monkey See, Monkey Do

While I was heartened by the confirmation of my own observations, I was concerned about body psychotherapy's uncritical acceptance of a link between a therapist's and client's body states and emotions. I needed to know more: Where does our ability to resonate with each other, with such stunning immediacy and accuracy, come from? What core processes drive the dancelike synchronizations of movement and mood that I kept encountering?

Throughout the 1990s, I became a voracious student of neuroscience—at first, as a way to learn about the physiology of trauma. In the course of those studies, I dis-

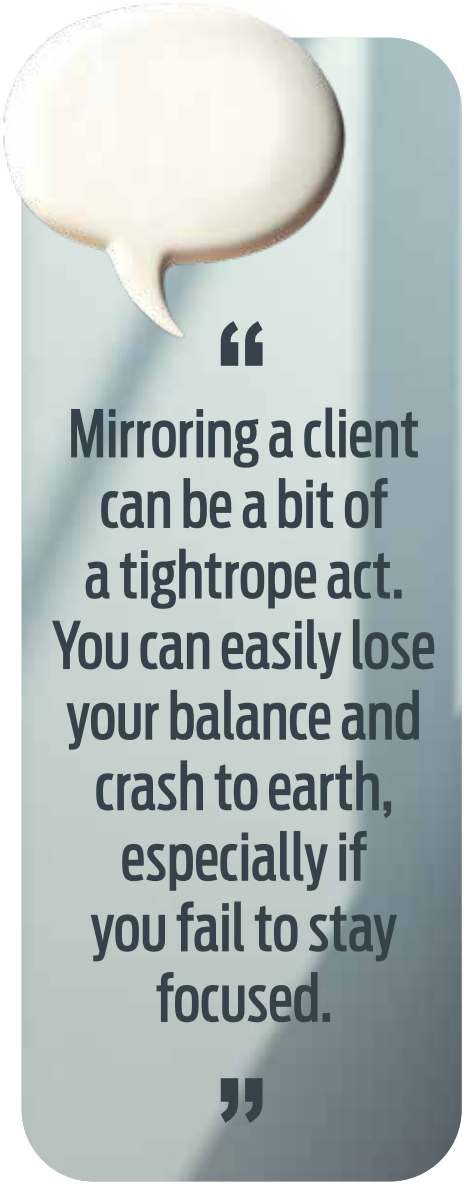
covered the term "vicarious traumatization" and documentation that therapists could actually suffer symptoms similar to their traumatized clients. I was both concerned and excited. I learned that facial expressions were contagious—when baby smiles, Mom usually does, too—and that such synchrony affects the nervous system. I also learned that people commonly, if unconsciously, copy each other's posture and synchronize breathing patterns.

As exciting as that research was, I still felt something was missing. The writings of neurologist Antonio Damasio, attachment specialist Allan Schore, interpersonal neurobiologist Daniel Siegel, and others told me that scientists could locate the effects of empathy in the brain. But, astonishingly, until the mid-1990s, no one had looked for a source of empathy in the brain. And, as I was to find out, the later discovery of the source of brain-to-brain empathy happened by accident.

In 1996, an Italian neuroscience research team led by Giacomo Rizzolatti and Vittorio Gallese was studying grasping behaviors in monkeys. They attached electrodes to the monkeys' brains to observe precisely which neurons fired when a monkey grabbed a raisin with its hand. The research was routine: monkey grasped, specific neurons fired.

Then, during a break, one of the researchers hungrily reached out for a raisin. His fellow researchers coincidentally noticed something extraordinary on the monitor: neurons in the monkey's brain fired—the exact same neurons that had fired earlier when the monkey grasped a raisin itself!

The team was astonished: nothing like this had ever been seen before. Their serendipitous finding was the first clue to the existence of what scientists now call "mirror neurons," so called because they appear to reflect the activity of another's brain cells. The monkey's response wasn't just simple recognition, as in "I know what the researcher is doing." That kind of observation activates other areas of the brain. What happened between monkey and researcher suggested something more immediate: the monkey's neurons fired as if it had made the same movement itself. This was a promising clue, researchers believed, to the neural basis of social resonance and empathy.



Subsequent neuroimaging research in humans suggests that we, too, may have a similar mirror-neuron system that allows us to deeply "get" the experience of others. When people watch other individuals drumming their fingers, kicking a ball, or biting into an apple, the sectors of their brains that turn on are the same sectors that activate when they perform these behaviors themselves. Gallese has hypothesized that this mirroring mechanism may extend to sensations and emotions—suggesting we may be wired to resonate with one another at deep emotional levels.

Orchestrating Empathy

Because empathy is rooted in the body, the more mindful therapists are of their own somatic responses, the more skillfully they can use that awareness to gain valuable information about a client's emotional state. Equally important, a therapist can choose to slow down, or even halt, the brain's rush to resonate when it might overwhelm the client—or the therapist.

Let's begin with the body's gift for sleuthing. When you want to get a literal feel for what it's like to be in your client's skin, you can consciously mirror some aspect of his or her behavior or expression. I tried this when I worked with Fred, a new college graduate who'd come into therapy to address his anxiety about dealing with authority in his first "real job." Though he'd grown up with a tyrannical father who'd beaten him regularly as a child, Fred couldn't see or feel any relationship between his childhood trauma and his current fear of standing up to his boss.

One afternoon, Fred arrived for his session deeply depressed. He'd been thinking about suicide, he said, but had no idea why. I wasn't sure either. As I asked him to describe what "suicidal" felt like in his body, I tuned in by copying his flat facial expression and slumped posture. Almost immediately, I began to experience in my own body the sense of deadness he'd just described to me. It reminded me of the "freeze" response that's an instinctive reaction to inescap-

able threat.

All at once, a light bulb flashed in my mind. "Fred," I asked, "have you ever seen a mouse that's been caught by a cat?" He nodded yes. "What does the mouse do?" I prodded. "It plays dead," he replied, his face beginning to brighten with interest. We then discussed the protective function of freezing for all prey, both animals and people. Finally, I asked Fred if he'd ever reacted that way himself.

"Yeah," he said softly, "when my dad beat me." As his father hit him, he told me, his body would lose all power and "go dead." For the first time, he made a felt connection between his childhood horrors and his current emotional state. It seemed a light bulb was also flashing in Fred's mind. As he began to talk thoughtfully about his own "internal mouse," his body posture gradually became more upright and animated, and by the end of the session he reported that his thoughts of suicide had receded.

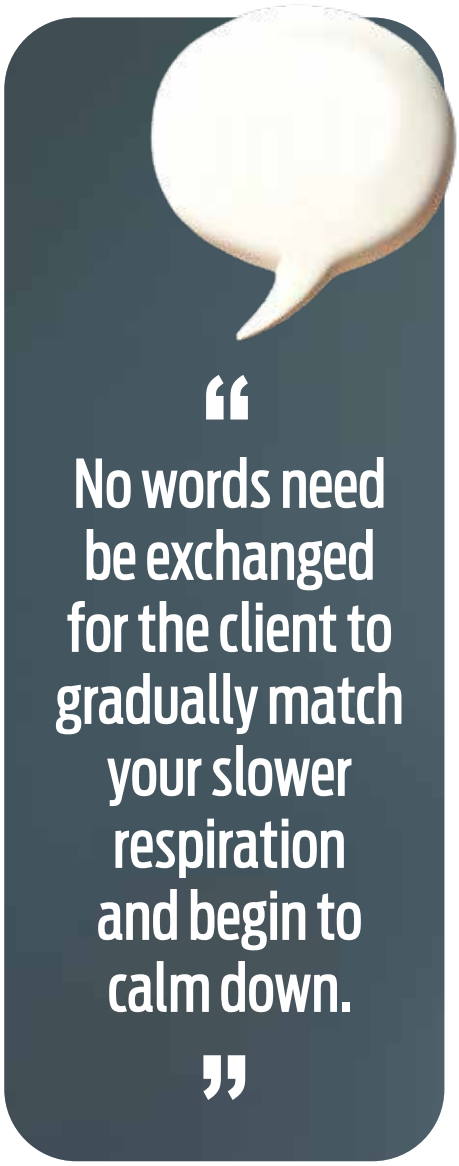
Could I have helped Fred make this breakthrough with talk alone? Perhaps, but it would likely have entailed several more sessions full of the usual conversational roundabouts, byways, and detours. Instead, by mirroring him, I could quickly feel and then understand Fred's deadness.

While purposefully synchronizing with your client can often provide added insight or even jumpstart a stalled session, be aware that the data you pick up isn't "pure" information. Just as gaps can occur between speaker and listener in verbal communication, so can somatic communication be distorted by your own filters. If, for example, you mimic your client's head tilt and get a feeling of anxiety in your chest, your client may indeed be anxious. But it also could be that you habitually tilt your head when you're anxious, so that repeating this action triggers the emotion. So be sure to check out your bodily hunches with your clients.

The Risks of Resonance

Mirroring a client can be a bit of a tightrope act. You can easily lose your balance and crash to earth, especially if you fail to stay focused. I learned this lesson the hard way.

A few years ago, my client Ronald was angry with me because I was leaving town for a few weeks. He was so full of fury that, for the first hour of a double session, he wouldn't talk at all. He sat half-facing away from me, tense and seething. From time to time, his eyes would fill with tears. Repeatedly, I tried to make verbal contact with him, using such standard gambits as "You seem very angry" and "This looks very difficult for you." But I had the unmistakable feeling that my words projected about a foot from my mouth and then thudded heavily to the floor.



Finally, I decided to hold my tongue and let Ronald work it out himself. With my mind emptied of fix-it schemes and nothing much else to do, I began to consciously copy my client's hypertense posture. I clenched my jaw, clasped my hands tightly in my lap, and scrunched my shoulders forward, knowing that mimicking another's posture can nonverbally convey understanding.

Two things happened. The first was that within a minute or so, Ronald's posture began to loosen up a little and he began to talk about his feelings of impending abandonment. As he aired his rage and hurt, I was able to acknowledge his feelings and explicitly let him know that I could understand and accept his anger. By the end of the session, he reported feeling somewhat calmer.

But not me. After Ronald closed the door behind him, I realized that I was very uncomfortable. Actually, that's an understatement: I was practically unhinged with fury. But why? Was I angry at Ronald? Had the session triggered something from my own life? I tossed around a half-dozen possibilities in my mind, but nothing seemed to fit. Only later, when I talked it over with a colleague, did I remember: I'd copied Ronald's infuriated posture! My body had done its job too well. Once I made this crucial connection, the "infection" began to drain—I could almost feel the fury leaking out of me. I returned to myself again in a matter of seconds.

To some therapists, what happened between Ronald and me may look like a textbook case of projective identification—a case of Ronald's "putting" his uncomfortable feelings into me and thereby "inducing" my fury. I couldn't disagree more. I was a full participant in the process: only after

I actively mirrored Ronald did I begin to feel angry. But while my mimicry was entirely conscious—if later forgotten—I believe that this kind of brain-to-brain communication occurs at an unconscious level between clients and therapists all the time.

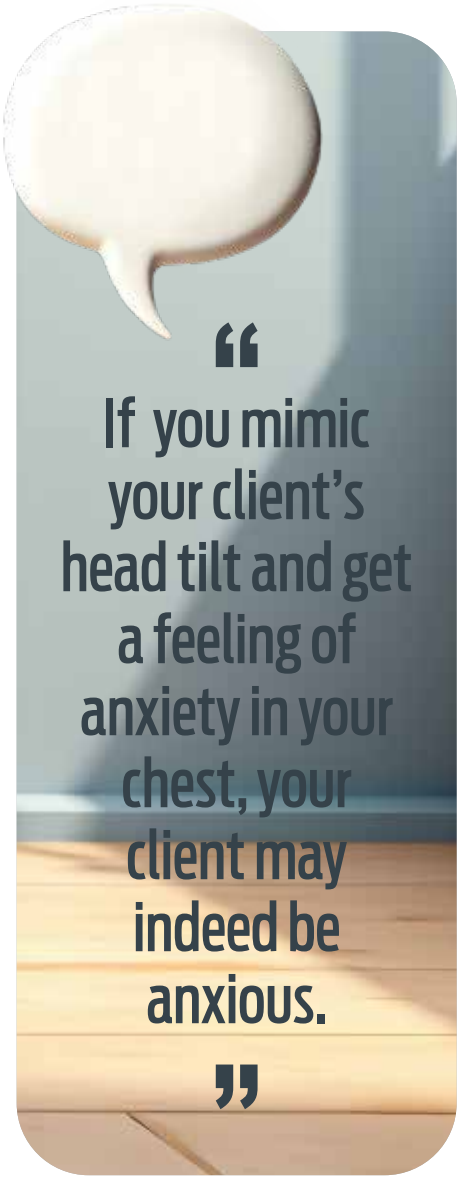
The next time you feel that you may be suffering from the impact of a projective identification, you may need to look no further than your own body to discover whether you've mimicked your client's posture, facial expression, or breathing pattern. Routinely adding such a simple step could eliminate the blaming of clients for feelings that are, in fact, rooted in our own, naturally responsive, neural circuitry.

There's liberation here, particularly for therapists who often find themselves on the edge of emotional overload. Active awareness of your own neurally-mediated role in absorbing clients' feelings can help you control the contagion. Once you become aware of your mimicry, any behavior that brings you back to the sensations and feelings of your own body, and out of synchronization with the client, will help you to apply the "empathy brakes." You might stretch, take a drink of water, get up to fetch a pen, or write some notes. These steps won't short-circuit empathy, but rather will allow you to return to yourself—to a place of clarity, presence, and helpful attunement to your client.

When a Client Feels Your Pain

Empathy, of course, is a two-way street. Our clients often unconsciously mimic our body patterns and take on our corresponding emotional states. Many therapists instinctively foster this process. When, for example, you slow your own breathing and your anxious client subsequently slows his, you're engaging the body's capacity for resonance. No words need be exchanged for the client to gradually match your slower respiration and begin to calm down.

But if clinicians' serenity is contagious, so, too, is their agitation. One morning, upon returning to Copenhagen (my then home) after a long visit to the United States, I was suffering from a particularly nasty case of jet lag. Though exhausted and headachy, I jumped right into my usual work schedule. At the end



of my session with Helle, I asked her, as usual, "How are you feeling?" Helle proceeded to describe my jet lag in precise detail. "I feel very tired, and there's a feeling of pressure in my forehead," she said, rubbing her eyebrows. "I also feel an odd heaviness in my chest. And I'm hungry, though I shouldn't be: I ate a good lunch just before I came."

I suggested to Helle that she stand up and walk around the room, hoping that the physical activity would move her out of my somatic sphere of influence and back into her own body. After pacing for a minute or two, she returned to her chair, noticeably more energetic. "My exhaustion and hunger have disappeared!" she reported. I then told her how I was feeling, that she'd described my sensations precisely.

Since consciousness is an important part of the process of controlling the neuronal dance, we spent a few minutes tracking how Helle had "caught" my state. In retracing her postures, she realized she'd rested her head on her hand as I'd tiredly done. That ordinary act of unconscious mimicry was enough to make her vulnerable to feeling my jet lag and the untimely hunger that accompanied it.

Psychiatrist and early attachment expert Daniel Stern calls the moments of true meeting in therapy a "shared feeling voyage." Though each voyage may last but a few seconds, we've all experienced its potent rush—the sudden throb of feeling not just for but with a client, a sensation of jolting connectedness that can be both exhilarating and fearsome in its intensity. It may be that this embodied resonance—whatever its precise neural underpinnings—encapsulates one of the most exciting challenges of psychotherapy—attuning two brains, and two hearts, so that they warmly vibrate together without melting into one.

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Where You End & The Client Begins

BY RACHAEL CHATHAM

Using Your Issues in Clinical Work Without Making It About You

Katie, an emergency department nurse, arrived for her session a few minutes early, still dressed in teal scrubs. We'd been working together for about a month. I was tying up loose ends from a busy morning with clients and a lunch break cut short by a consultation call.

"Okay, I'm just going to take a moment here so I can be present with you," I said as Katie entered my consulting room and sat down. I made a subtle but important clinical choice based on what I knew about Katie, her goals in therapy, and my own past struggles with self-sacrifice. I sensed this was an opportunity to have her witness me engaging in a moment of micro self-care that could serve not just me, but maybe even our work together.

I closed my eyes and took a deep breath, noticing the feeling of the firm cushion beneath me. As I exhaled, I felt myself slowing down. I took another breath in and out, giving myself an opportunity to settle. About a minute later, when I opened my eyes, Katie was waiting patiently, gazing at me with a curious expression on her face.

A hardworking mother and wife, Katie was sensitive and thoughtful. She tended to feel hyper-responsible for other people, a trait that kept her hopping from one person's need to the next. She knew she was depressed but couldn't put her finger on why. My sense was that Katie had relinquished her inner knowing from a young age, keeping her feelings buried so as not to burden those around her. Over time, her chronic self-sacrifice had turned into self-abandonment, and she'd lost confidence in her ability to know her preferences, needs, and feelings.

"It's really good to see you," I said, feeling more present and available. "How are you?"

"I'm… good." She was smiling.

"I'm glad to hear it. Where would you like us to start?"

"Well, it's been a crazy day. This morning, my son forgot his lunch, so I had to swing by his school with something I picked up on the fly," she said. "I ended up late for work, which I felt terrible about. Then we were slammed all day, and during my lunch break, my mom called in a panic about her health again, so now I'm feeling like I should make a trip to spend time with her." Katie sighed as she looked around the room. "I was hoping to get a weekend to do what *I* want to do, but I guess that's out." As she looked at me, tears welled up in her eyes.

In some ways, listening to her pattern of self-sacrifice was like looking in a mirror. Katie's issue was also my issue—one I'd been working on for years.

In moments like this, some therapists might feel compelled to "join" Katie in her frustration, as part of me felt pulled to do, saying, "Oh, I'm so sorry this is happening! I feel

frustrated on your behalf!" But Katie had told me that with previous therapists, she'd always ended up feeling like *she* was helping *them*. She needed my help understanding where and when the emotional lessons feeding this pattern of self-sacrifice had taken place, so she could shift her focus away from overgiving and toward self-compassion.

My studies and training undergirded my work with Katie, but an important part of what I had to offer her also came from having done my own work around similar patterns.

Person of the Therapist

At our next session, after settling onto my couch, the first thing Katie did was close her eyes and take a few deep breaths. As her eyes fluttered open, I waited, careful to allow her to speak first.

"That moment last week was huge," she said. "When I saw you breathe."

"Say more about that," I invited.

"I realized it's okay to pause and breathe to slow myself down." She shrugged shyly. "I did it a lot between patients this week, and it helped."

I've worked with clinicians and teachers who practice brief centering meditations. Witnessing them give themselves space to breathe and become more present has had a greater impact on me than being given directives like "slow down" or "practice self-care."

My own formation as a therapist has been shaped by this kind of relational learning, which is inseparable from who I am. And in my practice, my race, religion, spiritual philosophy, and cultural norms have intersected with my clients' at times, raising questions I return to often. Knowing that my life experience informs how I do therapy, when do I disclose parts of my own story in the service of a client and when do I refrain? How do I bring my own experience of being a person into the therapeutic relationship in a way that's helpful rather than harmful?

These questions demarcate what our field calls the Person of the Therapist (POTT)—how clinicians incorporate their own life experience, including their values, into work with clients. And yet, how we operationalize POTT remains slippery, elusive, and nebulous—more of an art than a science. The guidelines on how to do this safely and ethically aren't generally taught in graduate school.

Although family therapist Harry Aponte formalized POTT as a framework for understanding how our life experiences shape our clinical work, the idea of it is threaded through multiple therapeutic traditions, and I was learning about the therapist's use of self long before Aponte's book was published.

My graduate program emphasized mind–body–spirit integration and required weekly individual therapy and group process sessions. The coursework included writing reflective papers that encouraged us to look inward at our experiences and articulate them in pairs and small groups. Class discussions were engaging and deep. Teachers were accepting and invested. With a small cohort of students of varying ages and socioeconomic statuses from different parts of the country, I felt safe enough to be vulnerable and share, even when my classmates' perceptions and perspectives were different from mine.

In one of my earliest sessions in our process group, my teacher asked for a volunteer. My hand shot up; I was eager to dive in and experience the work. Then, as I felt the entire cohort turn their caring attention toward me, a massive lump rose in my throat, and I broke down and cried.

In debriefing the experience, a classmate inquired about my sadness. "What made you so sad?" I felt myself grow teary again. I didn't have words to explain it and felt guilty for taking up the group's time with something I couldn't articulate.

"I don't know," I said. "It just erupted."

Later, I realized my sorrow was related to a lifetime of feeling unseen and suppressing my voice and emotions. Being witnessed and held by the collective energy of the group touched a deep wound—even as it also provided healing.

Over time, reparative training experiences like these helped me pay attention to my values, access somatic cues, and use my voice to connect authentically. I grew increasingly aware of my body and mind not only as a way of understanding myself, but as tools to use in the therapy room.

Had I not had this training experience, I imagine I would've been inclined to empathize with Katie without supporting her to attune to her own values or access her internal somatic cues. I might've commiserated with her identity as a daughter and mother, in a sandwich generation, or suggested being assertive with her husband about taking on more childcare responsibilities. But for women like Katie, the deeper work is about how she relates to herself. Pausing and attuning to our own feelings, sensations, and thoughts is how we begin undoing our conditioning to default to external cues.

Learning to Skillfully Use Oneself

In sessions, I often ask myself, "How might presenting a new perspective or sharing some of my own experience support my client's goals?" This could mean disclosing that I, too, am a stepparent, or naming the value I've found in paying attention to the gut-squeezing reaction that lets me know something's amiss. It could mean empathizing with the challenge of deciding to go no-contact with a family member. Discernment is the key when it comes to knowing what to share. The reality is that the same disclosure—"I know how hard it can be to lose a parent"—might validate a lonely client while leading a self-sacrificing one to disconnect from their grief and shift into caretaking mode.

Because I knew Katie's goals for therapy included prioritizing her own needs and developing a stronger sense of self, I was on the lookout for opportunities to demonstrate what had worked for me on both these fronts. Witnessing me make space for myself, which helped me make space for her, gave Katie permission to do the same.

Aponte's POTT model highlights the idea that each person has a "signature theme"—a core pattern related to cul-

ture, early family-of-origin experiences, traumas, and personal struggles that show up in the work. The schema of self-sacrifice is one of mine.

Growing up with caregivers who were sometimes volatile and at other times aloof, I became hyper-responsible, monitoring others' moods to keep the peace, anticipating their needs, and making myself small to stay safe. Katie's story echoed my own. I knew from experience that helping her recognize her own needs could jumpstart the healthy self-interest she hadn't been able to access in her family of origin.

Katie had told me in our first session that she didn't know what she wanted other than to "feel better" and "be less tired." She feared the guilt of letting others down and felt pulled in different directions by commitments and relationships that no longer felt satisfying. I wanted to help Katie see that her perpetual self-sacrifice was creating her depression and fatigue. And, according to Aponte, it's okay that my own self-sacrificing tendencies weren't entirely resolved as I helped Katie work with hers.

We don't have to completely resolve our issues to use ourselves and our experiences in service of clients' healing. As one of my favorite grad school teachers used to say, "Sometimes we're just a single step ahead of our clients."

"Last night, Mike got upset as he was getting the kids ready for bed, and I just took over," Katie admitted with a sigh. "His frustration made me uncomfortable—like he was upset with *me*—and even though I'd just come off a 12-hour shift, I told him I'd handle it."

She could have been recounting bedtime in *my* house not all that long ago. *Stay focused on Katie*, I reminded myself. The smash-the-patriarchy feminist in me wanted to shout, "Women do endless amounts of childcare and emotional labor—what about what *you* need?!" The Mama Bear in me wanted to commiserate. And the Buddhist psychologist in me wanted to offer, "Mike is also a suffering being." Luckily, the recovering self-sacrificer in me knew that gently confronting her and helping her see what she herself was doing to perpetuate her resentment and exhaustion would likely be most helpful. I knew this because during my graduate school days, being compassionately challenged by my own therapist to consider my part in self-betrayal had made a big impression on me.

"And how was that for you?" I brought awareness to my body to center myself. "What'd you notice when you took over?"

"Honestly, it didn't feel great. I was tired. I wished he'd just handled it. Once the kids were in bed, he wanted to hang out and watch a show, but I felt annoyed and exhausted and wanted to be alone."

"So, you jumped in to save him because his anger felt uncomfortable," I said, "even though you were running on empty. And this led to feelings of isolation and resentment." I spoke slowly, hoping to convey through facial expressions and body language that I was familiar with the shame of self-betrayal. "In saving him, you sacrificed yourself." I kept my voice gentle as I tracked the impact of my words on her.

Her tense shoulders softened and she looked down.

"You're right, I just…" She slowly shook her head and reached for a tissue. "I don't know why I do that or what I should do differently."

"What you're doing makes sense for the inner child part of you. As you've shared before, that part found a way to stay safe and connected by taking responsibility for your mom's overwhelm. But today, taking *too much* responsibility creates a disconnect with Mike. When you're over-giving, you end up resentful."

Katie nodded. I could feel her tenderness and grief. We took several quiet moments together before moving on. "When you're ready, let's talk about other ways of responding that might help you stay in your emotional lane rather than swerving into Mike's."

A few weeks later, Katie shared a similar incident. This time, the outcome was different.

"I could tell Mike was getting irritated with the kids again, but I reminded myself that he's allowed to have his feelings and experience of parenthood. That's not my responsibility to manage. So, I closed my eyes, took a breath, and felt my aching muscles. Then, I said, 'You've got this,' and went to take a bath. After he got the kids to sleep, we cuddled and watched some television." She smiled and her eyes sparkled. "It was nice."

This was a major shift for Katie.

■■■■■

As therapists, we're trained to listen for content, track patterns, and formulate interventions. But there are moments when what heals isn't just what we say, but how we are. Moments when the client isn't taking in our words so much as watching how we show up, both for them and for ourselves.

The paradox of POTT is that our lived experience becomes most useful not when we *share* it, but when we *metabolize* it—when we've worked with our own patterns enough that they show up as steadiness, restraint, or the ability to stay with our clients even as they grapple with strong emotions, painful beliefs, and self-sabotage.

I still have moments when I self-abandon. My body tenses and I feel pulled into old, familiar patterns. At other times, I slow down long enough to feel my breath and body and a subtle space opens up within me where I find freedom to choose how I want to respond. This is what we invite our clients to do, too.

Katie's growth reminded me of why who we are as people is never really separate from our work. How we show up in the clinical space, with all our issues—resolved and unresolved—is what has the greatest impact on those we serve. Ultimately, the question isn't *whether* our struggles belong in the therapy room. It's relating to them in new ways that help us show up skillfully for the people we serve.

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BY SHERRY HAMBY

The Ordinary Magic of Thriving

Making Resilience Accessible in the Therapy Room

One night, the emergency room summoned me at 3 a.m. When I arrived, two nurses and two police officers were waiting for me. I recognized one nurse. Everyone knew she was one of the meanest people at the hospital. The other nurse was a man, tall and strong. The police officers, in full uniform with batons and holstered guns, were stockier but still huge. They explained that a mother had brought her adult daughter to the ER. They gestured to the mom, sitting patiently in the waiting room. Her daughter, Vanessa, had just been released from rehab, detoxing from heroin and who knows what else.

The scenario before my arrival had gone something like this: The mean nurse tried to force Vanessa to take an injection of Ativan, an antianxiety drug that can take the edge off withdrawal symptoms. Vanessa freaked out. The mean nurse could not subdue her, so she called the male nurse for help; Vanessa fought them both off. They called the police. Vanessa took on all four of them—and won!

They pointed to a door. Vanessa had barricaded herself in a supply closet. That closet contained not only gowns and blankets but also glass supplies and a disposal bin for used needles and other hazardous waste. Not a safe space.

No sound came from the closet.

They turned back to me. "So we thought this would be a good time for Behavioral Health to help." A better guess is that they probably just wanted to catch their breath. I wouldn't even be surprised if they planned to use me as bait to distract the patient while they went in for a final attack. "So go therapize her."

I looked at the door, thinking of all the ways I could make weapons out of what was in that closet. But my client was on the other side, so I opened the door and walked in.

What I found surprised me. Vanessa was sitting on the floor in the corner, knees pulled toward her chest, under a beige open-weave hospital blanket. She was rocking back and forth. She didn't react when I came in. When you pull an open-weave blanket close to your face, you can see pretty well through the holes. So I knew she could see me, even though I couldn't see her.

My mind was racing. My heart was racing. I didn't want to leave this woman to the brute force waiting outside the door. However, I worried that I wouldn't be any more help. It was easy to see that conventional therapy approaches would not work—she was not ready to hear any reframing of her situation or suggestions about steps to take. What did the person in front of me need right now? She needed to feel better and less threatened. So I dropped to the ground on the other side of the supply closet and curled

up in the same position as Vanessa, but without a blanket over my head.

I didn't introduce myself. I didn't ask her any questions about her past, how she started using drugs, or her current symptoms. I didn't ask her to remove the blanket.

Instead, I took a deep breath and in a low, soft voice started a mindfulness meditation. "Inhale and feel the breath flow in, expanding your chest and belly. Exhale and feel the chest and belly relax and any stress flowing away from you." I exhaled audibly as I said this, inhaled, and continued: "You may notice that the air feels cool as it enters your nostrils, flows into your lungs, and warms slightly as you exhale. As you breathe, you may find that the exhale lasts slightly longer than the inhale. Inhale . . . 1 . . . 2 . . . 3 . . . 4 . . . Exhale 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6. As you exhale, feel your stress leave your body and flow into the ground."

Ten minutes passed like this. Then twenty minutes. Vanessa didn't move or speak. I kept chanting the meditation. Thirty minutes passed, then forty. We were still breathing together.

Suddenly, Vanessa yanked the blanket off her head. "Who are you?"

"I'm Dr. Hamby, and I'm from Behavioral Health. I heard you were having a tough time tonight. I understand you just got out of rehab?"

She nodded.

"It looks like you are still experiencing withdrawal symptoms. That can happen. Detox can be unpredictable. But if you want, they can give you something to take the edge off those symptoms. Then you can go home with your mother."

"My mother is still here?"

Truthfully, I didn't know if her mother was still there or not—after all, I'd been in the supply closet for almost an hour. But I figured that the kind of mom who waits patiently in the ER at 3 a.m. is the kind of mom who would still be there at 4 a.m. So, more confidently than I felt, I said, "Yes, yes, your mother is here. If you let them give you something, you can go home with her and get some rest."

"I can go home?"

"Yes."

We left the supply closet together. Her mom was still there! So were the nurses and police. Their four jaws hit the ground in what I will admit was a most gratifying fashion. Vanessa calmly accepted the Ativan and went home with her mother. I saw her the next day when she came to follow up with her regular therapist. Vanessa warmly thanked me and said she felt a lot better.

This encounter left me with questions about our standard approaches to trauma—and it points to something the field has been slow to recognize.

The Third Revolution

The first two revolutions in trauma science showed the world the true impact of exposure to trauma. The first revolution established that violence and abuse of all kinds are major public health problems with lasting consequences; the second showed that it's the cumulative lifetime burden of trauma—not any single event—that most shapes our health. The findings from this research changed the world. From trauma-specific therapies to new laws and specialized agencies and courts, society was transformed by an awareness of the widespread prevalence of trauma and its many harms.

However, we still didn't know much about healing. In fact, if you read a lot of this literature, you might think healing is rare, if not impossible. One big problem of the first revolution in trauma science has been the split into specialized areas of research (silos) that overlooked the cumulative impact of trauma over a lifetime. The second revolution addressed this problem by uncovering the connection between trauma dosage—our lifetime experience of different types of trauma—and adverse health consequences.

The first revolution also had another problem: its portrayal of trauma survivors. Even now, survivors are often portrayed in remarkably negative terms. Media images can play up injuries like bruises and cuts, even though most interpersonal violence does not lead to that kind of visible injury. Victims are often portrayed as helpless and in need of saving. Or worse, doomed to a lifetime of depression and PTSD.

These portrayals help some people. They help researchers and advocates convince policymakers to invest in grants and programs for trauma survivors. Dramatic images help journalists get eyeballs on their articles. As they say, "If it bleeds, it leads."

I don't think these portrayals are helpful to survivors, though. For years, people with disabilities have pushed back on being used as "poster children" for fundraising. What good is the money if it creates new problems of stigma and pity? It's the same for trauma survivors. All that public awareness has come with a cost. Further, stereotypes about what trauma looks like can make it hard for us to recognize our own traumatic experiences, which come in many forms.

Research has shown that most survivors of the 9/11 attacks in New York never developed PTSD. Their story is not an unusual one: The most common response after trauma is resilience. Resilience scientists have shown this again and again. We generally find that more than two out of three people are doing well, despite exposure to trauma. Many are not just below the thresholds for a formal diagnosis of PTSD or depression—they are experiencing true well-being. For instance, many children who are trauma survivors are still meeting developmental goals as they should.

More than twenty years ago, resilience scientist Ann Masten coined the phrase *ordinary magic* to describe how many people manage to thrive after trauma. Yet for years we didn't have a good understanding of how people accomplished this, especially considering all the harms that are caused by trauma. This is not some kind of automatic or lucky occurrence. It's not just a matter of waiting around until we feel better. We were missing the ways that people harness assets and resources, often without professional help. People who thrived after trauma were already building strengths, although they weren't aware of the science behind it. The resilience-portfolio approach (leveraging our toolkit of assets and resources for dealing with trauma) can help you to more consciously build these strengths, now that you know they make a real difference.

This is where the third revolution comes in.

Dosage for Resilience

The third revolution in trauma science, going on now, brings the concept of dosage to the strengths side of the resilience equation. We now know that if you can harness enough assets and resources, you can counter even high dosages of trauma. It is still possible to put together a good life even after a lot of very bad things.

Like early research on trauma, early research on resilience was also often siloed and hyper-specialized. Researchers frequently looked at only one kind of trauma (like a flood or an assault) rather than people's full lifetime dosage, making it harder for them to understand why some people were doing better than others. Early resilience researchers also often studied one strength, such as social support or emotion regulation, at a time. Although there are lots of assets and resources available to us, what most people want to know is which ones help the most. If you have limited time, should you focus on beefing up your social support, your emotion regulation, or something else? Therapists and teachers also have limited time and resources to help someone, so they need to know what is most useful as well. This is the key to the resilience equation. We need to know which strengths will help us recover and how to get enough of them.

This is a radically different way to think about healing. Most therapy and psychiatric medications focus on taking away symptoms. If you have PTSD, then remove hypervigilance and avoidance. But the resilience equation points to bringing more good things into your life in order to heal. This connects to work in the relatively new field of positive psychology, which is the study of the good things about being human. We can use some of the tools from positive psychology to build our dosage of good stuff and learn to thrive after trauma.

A Different Approach to Healing

A lot of conventional trauma therapy does not look very different from therapy for depression or other problems. The basic script is the same—sit in an office and talk about your past. Even many domestic-violence shelters, which often have numerous rules and curfews, are not too different, in some ways, from inpatient psychiatric hospitals.

Although these kinds of services have helped a lot of people, they have their limitations. There's no such thing as perfect therapy, any more than there is such a thing as a perfect scientific study. There is always room for improvement. For one, much classic therapy spends most of the time looking backward and focusing on symptoms. I've heard some people in long-term therapy say that they find themselves making mental notes about the hassles of their week to discuss in their session. There are limits to how much any of that helps people put together the pieces of a good life. Some scholars even think that our focus on the negative consequences of trauma is basically telling people to expect depression and anxiety.

There are, fundamentally, only three ways to help trauma survivors. Two of these—the *mobilization* and *better-coping* pathways—are strongly linked to the old ideas about helping people overcome trauma. The first, mobilization, focuses on taking direct action to address the presenting problem; the second, better coping, helps people swap harmful or ineffective strategies for healthier ones. The third, the *positive* pathway, emphasizes interventions that build strengths, which, as we're learning, directly support well-being. For most of us, focusing on the positive pathway is the best way to enhance our resilience portfolios. And you can follow the positive pathway at any time—you don't have to wait for a crisis.

With Vanessa, I met her where she was and didn't try to make her play her part in the therapy script. Although I am not suggesting that a single meditation transformed her life, this crisis intervention is a good example of the third approach to helping people: the positive pathway. Sometimes the best way to help people is not by processing what happened to them. Sometimes what helps doesn't even involve mentioning prior trauma. In this case I helped her feel well enough to consider a better coping strategy in the form of using Ativan as a temporary alternative to heroin or other drugs.

However, the positive path is not just about getting ourselves ready to cope—it's about making our whole lives better. Sometimes our focus on insight and past problems can keep us looking backward. We can't lose sight of our real goals. Everyone wants to achieve well-being despite what has happened to them.

The goal is not to pretend that the trauma didn't happen but to recognize that you are going to get only so far by revisiting the past. Never mind why you need help. Where do you want to end up? For decades, psychologists like Abraham Maslow, Carl Rogers, Joseph White, Barbara Frederickson, and Martin Seligman encouraged us to think beyond mental illness and symptoms and focus on well-being and meaning. In the last twenty-five years, the positive psychology movement has been gaining steam and is now one of the dominant fields in psychology.

Although positive psychology does not focus on trauma, insights in this field have much to offer trauma survivors. With the positive pathway, we can shift our focus from what happened to developing the psychological, social, and environmental strengths we need to thrive now. These are essential elements in your resilience portfolio.

From Stronger Than You Think *by Sherry Hamby, published by Penguin Life, an imprint of Penguin Publishing Group, a division of Penguin Random House, LLC.*

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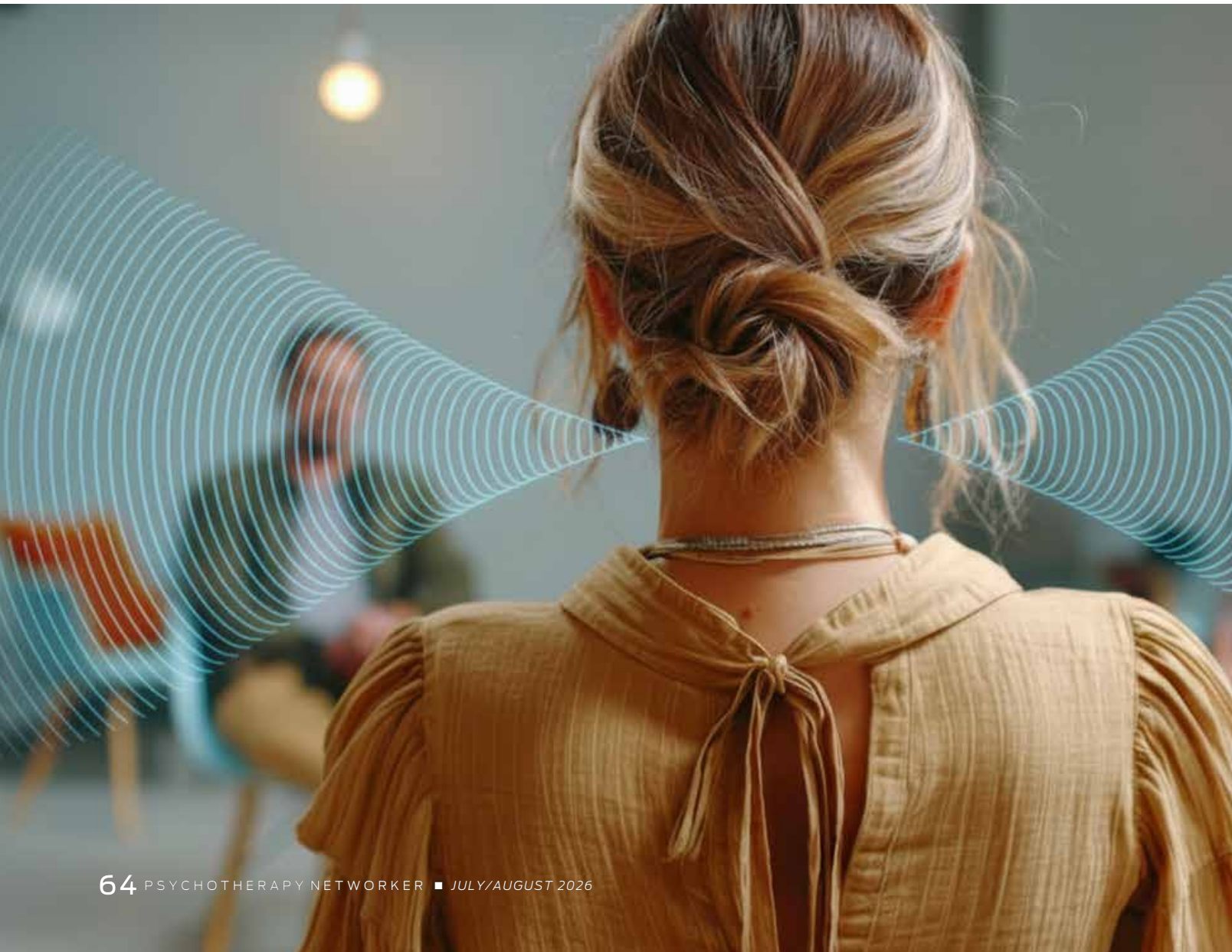
The Art of Confrontation in Therapy

BY ELLYN BADER

6 Ways to Gain Traction with Couples



Twenty years ago, late on a Friday afternoon, I was feeling drained and exhausted after a long day of seeing clients. I only had one couple left to see: John and Susan—and I certainly wasn't looking forward to it. John tended to be incredibly domineering, unmercifully rude, and obnoxious toward Susan. He frequently told her she needed to lose weight and act sexier around him. Our sessions often felt volatile, and many times when John went on the attack, I could barely get a word in.

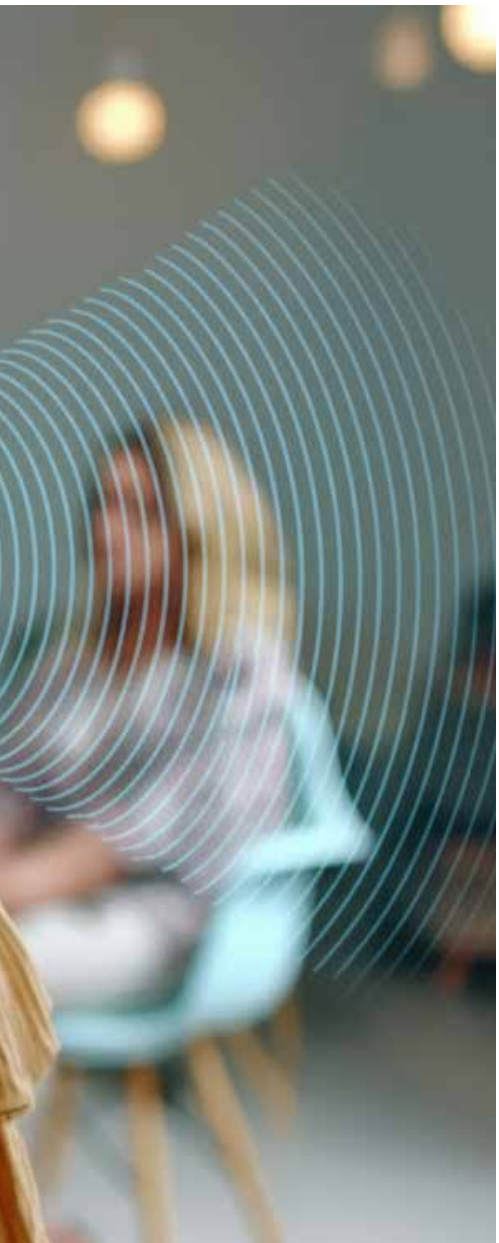
Here we go again, I thought to myself as the two walked through the door, sat down on my couch, and John almost immediately went into attack mode. After hearing him complain yet again about how Susan "needed to hit the gym," I couldn't hold back.

"You know, John, if you keep talking to Susan like this, she won't want to have sex with you at all!" I blurted out in a not-so-neutral tone. John sat in stunned silence, and quickly changed the topic.

Two days later, I got a phone call from Susan. "John is furious after that last session," she told me. "We won't be coming back."

Susan's words hit me right in the gut—and sat with me for a long time. *I really blew it,* I thought to myself—and I knew I had. I'd been tired and not thinking clearly, but I'd also let countertransference get the best of me. As a child, my mother used to nag me about losing weight and would drag me to weight specialists. I knew I was still angry at her, and I'd directed this anger at John.

Certainly, there must've been a way to challenge John, to confront him without evoking defensiveness and losing him entirely. But how?



As one of the early founders of modern couples therapy, I've been working with partners for over 40 years. And if you see as many couples as I do, you know how the work can get heated. Sometimes partners come to sessions locked in patterns of unrealistic expectations, as John was, while others are entrenched in cycles of hostility, deception, betrayal, or emotional withdrawal. Often, neither partner fully recognizes the role they're playing in sustaining the dynamic, and even when they do have some awareness, they struggle to change it.

This is precisely where the therapist is called to step in and explicitly call out negative thinking and behavior. Confrontation becomes part of the work—not as aggression or correction, but as a way of interrupting entrenched relational cycles that the couple can't see from the inside.

But for so many therapists, confrontation feels dangerous. We hesitate, waiting for the perfect phrasing or the perfect moment. We worry about rupture or losing the clients. We tell ourselves that good therapy means showing restraint, or that insight will emerge without pressure. But what's often underneath this is avoidance, which always comes at a cost.

Over the years, I've come to see confrontation not as something to fear, but as one of our most powerful clinical tools. When used skillfully, it doesn't damage the therapeutic alliance; it deepens it. It creates moments of clarity that polite reflection alone cannot. It's a way to nudge partners toward the healthy relationship they've been seeking all along.

Rethinking Confrontation

When I first started doing couples therapy, I thought confrontation was synonymous with conflict. It felt like something that would escalate tension or threaten the therapeutic relationship. Over time, that view shifted completely.

I came to realize that skillful confrontation isn't conflict—it's more like holding up a mirror to a system that's malfunctioning, calling attention to the beliefs and behaviors that are keeping clients from growing. It fosters awareness and lets clients know they have a choice, rather than simply letting their unconscious reactions take the lead.

At its core, confrontation isn't an act of aggression, but an act of care. It's a refusal to let destructive dynamics like unspoken resentments and emotional avoidance continue unchecked simply because they're familiar. It's especially valuable when work-

ing with highly dysregulated couples, whose negative patterns have become so ingrained that they've become oblivious to their toxicity.

Confrontation compels partners to wake up, forcing them into honest conversations that demand they pay attention to the issues keeping them trapped. I'm a firm believer that honesty is a cornerstone of a loving relationship, and without hard, honest, confrontational conversations, there is atrophy; partners disengage, and fall out of love. Conversely, confrontation helps partners get clear about their vision for the future of their relationship, and the new behaviors it will take to bring that vision to fruition.

It's worth noting that there are situations where confrontation becomes necessary rather than optional, like when there's a chronic failure to take responsibility for bad behavior, repeated patterns of deception or betrayal that have eroded trust, significant deficits in conflict or relational skills, and persistent denial about the impact of one partner's behavior on the other or the family system.

But there's another indication that confrontation is necessary: stagnation. When couples repeat the same arguments without meaningful progress, what looks like communication is actually just spinning the wheels. At this point, dysfunction has become normalized, routine for partners but intolerable to an outside observer. Confrontation becomes the mechanism that disrupts this false stability, a catalyst for change and growth.

The Six Types of Confrontation

Over time, I've come to understand confrontation as existing along a continuum of intensity rather than as a single technique. Each level serves a different function, and each can be used flexibly depending on the couple's capacity in the moment. The work often begins at the lowest level of intensity and moves upward only as needed.

Soft Confrontation. The first level is what I call *soft confrontation*, which you might use early in therapy or as you're getting to know your clients. This involves gentle curiosity and early attempts to bring patterns into awareness without increasing emotional arousal. A therapist might use soft confrontation by asking why the couple believes they're in therapy, or by gently noticing a pattern such as one partner withdrawing while the other pursues.

You might say, "I notice that when you withdraw, your wife starts making more demands of you. Have you noticed that too?" If the client is receptive, you might add, "I wonder if you've noticed that your withdrawal may play a part in her asking for more from you."

This intervention is designed to create space for reflection. Even just doing a little psychoeducation, like sharing a framework for relational development (I've developed one called Stepping Stones to Intimacy with my husband, Peter Pearson) can function as soft confrontation, allowing couples to recognize their own stuckness.

Empathic Confrontation. The second level is what I call *empathic confrontation*, where emotional experience is named more directly. This often involves identifying underlying feelings that are obscured by more reactive emotions. Anger may be reframed as loneliness, or criticism may be understood as attachment longing.

To use empathic confrontation, you might say to a partner, "You sound very lonely in your parenting role. It seems like you're looking for more collaboration, more togetherness. I wonder if you could speak more about your loneliness and less about your anger?" Or, "Could you speak about what felt hurtful before you got angry?"

Sometimes the therapist's own emotional response can be used to highlight what's happening between the couple.

Not long ago, I was doing therapy with a husband and wife, the former a very perfectionistic company executive. At one point in our session, I told him, "I'm feeling a lot of dread right now that I might not get this right. And I wonder if I'm the only one here feeling this." I turned to his wife. "Do you ever have this experience with your husband?"

Gentle but Tough Confrontation. The third level, *gentle but tough confrontation,* is firmer, but still contains warmth. It targets blind spots directly, but without shaming or escalating defensiveness. The tone is calm and matter-of-fact, and content is clear. It often names the gap between what a client wants and what their current behavior actually makes possible.

I used a gentle but tough confrontation recently while working with a couple in which the husband had started opening up and describing emotions he'd hidden for years, and his exasperated wife just rolled her eyes.

"I've had enough of this," she said. "I want someone who *adores* me. I deserve that. If he can't do any better than this, I'm out of here."

"Many people want that," I responded. "But only a few get it, especially after decades of marriage and kids. Unless you allow your husband to be more open—to do more of what he just did—he will live with resentment, which will never allow the kind of loving partnership you're looking for to unfold."

She was silent for a moment. Then, she exhaled, looking at me with an expression that said, *I don't like what you just said, but I get it.*

Indirect Confrontation. The fourth level is *indirect confrontation*, where the therapist speaks to one partner, but what's being said is actually meant for the other. This approach is particularly useful in couple dynamics where there's high reactivity or avoidance.

I used this in one session where the husband was often passive and disengaged in treatment. His wife was highly verbal with lots of complaints. "Megan," I said, "when you have so many issues with Marcus each week, you're actually making it *easy for him to hide.* I wonder what would happen if you left more space for him to show up? You actually make it so easy for him to not work on himself."

By addressing one person, the therapist can highlight dynamics that involve both partners without triggering immediate escalation. Indirect confronta-

tions often address systemic patterns or chronic resistance in real time, like how one partner's over-functioning enables the other's withdrawal.

Tough Confrontation. The fifth level is *tough confrontation*. This is rarely delivered before you've built a relationship with a client. Here, the therapist intentionally introduces discomfort in order to prevent avoidance. After all, anxiety can be motivating! The goal here isn't to punish, but to increase clarity and decrease minimization. Behavior is described in a way that makes it difficult to bypass or rationalize, especially when clients persist in deflection.

An example might be saying something like, "Are you willing to give your partner what you want so badly from him?" or, "Do you realize how big the thing is that you're asking for?"

Bombshell Confrontation. The sixth and most intense level is what I call *bombshell confrontation*. This is reserved for moments when denial structures are deeply entrenched or when destructive behaviors haven't shifted despite prior interventions. It might be used in cases where there's been repeated lying, addiction, or partners are incessantly demanding. It's best used only after all other types of confrontation have failed, since it's a lot harder for a client to hear a bombshell without anger or defensiveness if it comes dramatically and unexpectedly.

I once used bombshell confrontation with a female partner who'd developed a habit of cheating on her husband—and then repeatedly lying about it. In the midst of all this, she also said she wanted to have a baby with him.

"He was making me feel so alone," the wife said. "I thought he hated my guts."

"Are you telling me," I replied, "that because you thought he hated your guts, that it was okay for you to lie and hide for two years?"

"No, but it's the context I was coming from," she said.

"I'm going to say something tough," I replied. "And I want you to hear this: you may not have time left with him to get back to where things were. He's nearly done, and so much of what you've said today is about you and your experience. While that matters, if you two are going to move forward, you'll need to take a real deep look at what made it okay for you to lie and hide for the last two years."

These statements often articulate consequences or future trajectories that the client has been avoiding. When used well, they don't escalate conflict; they crystallize reality.

The Therapist's Responsibility

Effective confrontation depends less on technique than on the therapist's internal state. Before doing any confrontation, I assess my own regulation, my motivation, and my level of clarity. I center myself, asking, *What's my affect and mood right now?* Confrontation that arises from frustration tends to create defensiveness, but confrontation that arises from grounded observation tends to create reflection. Before I begin, I also want to have some idea of *how far* I will be pushing.

Timing is equally important. The therapist must consider each partner's current emotional capacity, the strength of the therapeutic alliance, and the likely impact of the intervention before speaking. I also *expect* pushback. Pushback isn't a sign that the confrontation has failed; it's often part of the process.

Last, know that some confrontations are built over time. You can always dial up confrontation—to increase discomfort or reveal deception, regression, destructive behavior. It's much more difficult to dial it down.

Of course, it's not always the therapist who is doing the confronting. In some cases, it's more effective for one partner to confront the other. You can assist with this by encouraging the confronting partner to trust their judgment and instincts or keep describing the problem. Meanwhile, you'll want to make sure they don't come from a "gotcha" or one-up position, which isn't constructive. However, if safety or emotional regulation is compromised, then the therapist should be doing the confronting.

Ultimately, confrontation is uncomfortable. But it can be delivered skillfully, with your intentions made clear—whether it's to help save a relationship, save a partner, ensure one partner or both partners' health, challenge addiction or raise concerns about the well-being of children. The aim isn't to win an argument or establish authority, but to increase the couple's capacity to see themselves and each other more clearly and to motivate them to build new emotional capacities.

Beyond Problem-Solving

Many couples enter therapy with a strong desire for immediate problem-solving. They want relief from conflict, reduction of distress, and a return to stability. While problem-solving has value, it's rarely sufficient for deep relational change.

The deeper work involves helping couples shift from a reactive, problem-focused stance to envisioning a new, better future for their relationship. When couples begin to imagine themselves not just as people trying to fix what's broken, but as partners building something new together, the entire therapeutic process changes. The relationship no longer becomes a battlefield, but a foundation for something greater. Confrontation becomes easier to receive because it's no longer experienced as blame, but as something that unlocks a shared future. In this way, confrontation isn't a lack of compassion, but one of its purest expressions.

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Can Being a Therapist Wear You Down?

BY MICHAEL GLENN

The Occupational Injury No One Talks About

Lately I've started to notice something about myself in social gatherings—even modest ones, where there are just six people around a table. Several conversations unfolding at once can leave me feeling oddly overwhelmed. Four people feels manageable. One or two is best. But large groups? When I can, I avoid them. For a long time, I assumed this was social anxiety. But it doesn't quite feel like that. I'm not especially worried about what other people think of me or afraid of saying the wrong thing. The discomfort comes from somewhere else. It feels more like flooding. But it wasn't always this intense. Five decades of practicing psychotherapy seems to have amplified it.

The feeling shows up in small, ordinary moments. I'll be at a dinner with friends and notice I'm not really "at dinner" in the way they are. Instead, I'm monitoring tone and tempo, tracking the emotional subtext in the room. It's not that I want to analyze, it's that the information arrives uninvited, and lands in my body before I can decide what to do with it. I've even caught myself reacting this way in public places, like in waiting rooms and checkout lines. I'll notice a tired face or a brittle voice or a subtle tightening of posture between two people, and feel a flicker of sympathy and concern. In crowded spaces, it's even worse: it feels like dozens of emotional radio stations all broadcasting at the same time, and I find myself tracking them all. Again, not intentionally—it just happens.

Everywhere I turn, it seems there's another emotional signal, another small drama to register. Everyone else seems relaxed, skimming along the surface of things, while I feel as if I'm absorbing the entire emotional weather of the room. After a while, it's simply too much input. My system feels saturated. I start looking for a quieter corner, or for a single person to talk to—one nervous system at a time. The relief of narrowing my focus is immediate. And I sometimes wonder: *Does anyone else experience this?*

Maybe, on some level, I've always felt this way. But the feeling has grown stronger with time, which led me to a question I hadn't considered before: What if this isn't just temperament? What if it's the work?

Medicine has long recognized that the work we do shapes our bodies. Housemaids develop swollen knees—housemaid's knee. Writers develop cramped, unreliable hands—writer's cramp. Computer workers develop numb fingers and burning wrists from carpal tunnel syndrome. Repeat demands lead to adaptation, and adaptation carries a cost. Our jobs leave marks on us. We accept this easily when the strain is physical. But when I recently sat down at yet

another dinner table and immediately felt overwhelmed by the sheer volume of emotional information in the room, I began to wonder whether the same principle might apply to therapists. What if some occupations leave their imprint not on the knees or wrists, but on the emotions?

Psychotherapy demands something unusual. Most professions teach you to toughen up, to develop thicker skin and screen things out. But therapy asks the opposite. We're trained to notice everything: subtle shifts in tone, things that aren't being said, and feelings beneath and between the words. To do this, we lower our defenses. We open ourselves, deliberately, to other people's inner worlds. Over time, we get very good at it. We turn up the volume and fine-tune. We become exquisitely sensitive instruments. It's a professional strength. But what if that sensitivity has an occupational cost? What if the attunement that helps me detect a client's barely perceptible sadness is the same attunement that leaves me overwhelmed at a dinner party? The knobs don't seem to reset.

I've come to think of this as a kind of occupational emotional dysregulation, the emotional equivalent of writer's cramp. Just as a writer's hand can stiffen after years of repetitive motion, a therapist's emotional boundaries can grow increasingly permeable after years of deliberate openness. Our injuries are quieter, but just as real: boundaries that don't quite close off and emotional openness that doesn't quite reset. The very capacities that make us effective in the consulting room can make us more vulnerable everywhere else.

Once I started looking for this, I began to notice its signs everywhere, in myself and in my colleagues. A thinner skin than we once had. Picking up subtle shifts in others' feelings. Coming home from a day of sessions feeling oddly porous, as if the boundary between ourselves and others had softened. A colleague once said to me half-jokingly, "My spouse thinks I'm reading their mind. I'm not. I'm just picking up the tonal changes they don't even know they're making." Another admitted that social gatherings had become work: "I can't stop tracking who feels left out, who's performing, who's angry." Many of us joke about "therapist conditioning," the way we can't stop analyzing or tracking emotional currents. But what if it's not funny? What if, after years of opening ourselves to other people's pain and longing, our emotional screening systems simply stay "on"? Early in our careers, it was easier to lean in and recover, to open the door and then close it again. We could go home and feel like ourselves. But I've found that after decades, the door doesn't always latch. The volume stays turned up. The skill becomes the setting, and everyday life starts to feel louder.

There's also something particular about the kind of attention psychotherapy requires. We don't only listen for content. We listen for tone, rhythm, what's being avoided, and what's emerging. We track facial expressions, posture, and pauses. We notice when a client's voice tightens, or the small shift from anger to shame. In the consulting room, this is part of the craft. But outside, the same sensitivity can become exhausting. A crowded room isn't just a room. It's an orchestra of emotional micro-signals, and if your instrument has been trained to hear them, you hear them.

Psychiatrist Ernest Hartmann described people as having "thick" or "thin" psychological boundaries. Those with thinner boundaries tend to be more permeable, more sensitive, and more easily immersed in others' experience. It's not surprising that many of these people are drawn to become therapists. Some may have had to develop their emotional "fine-tuning" to feel safe in the emotionally challenging environments of their childhood. Others are naturally drawn to the work because they can more easily relate to others. But the job may thin us further. What begins as a flexible professional stance—opening ourselves deliberately for a session—can gradually become a trait. We don't just open when needed, we stay that way.

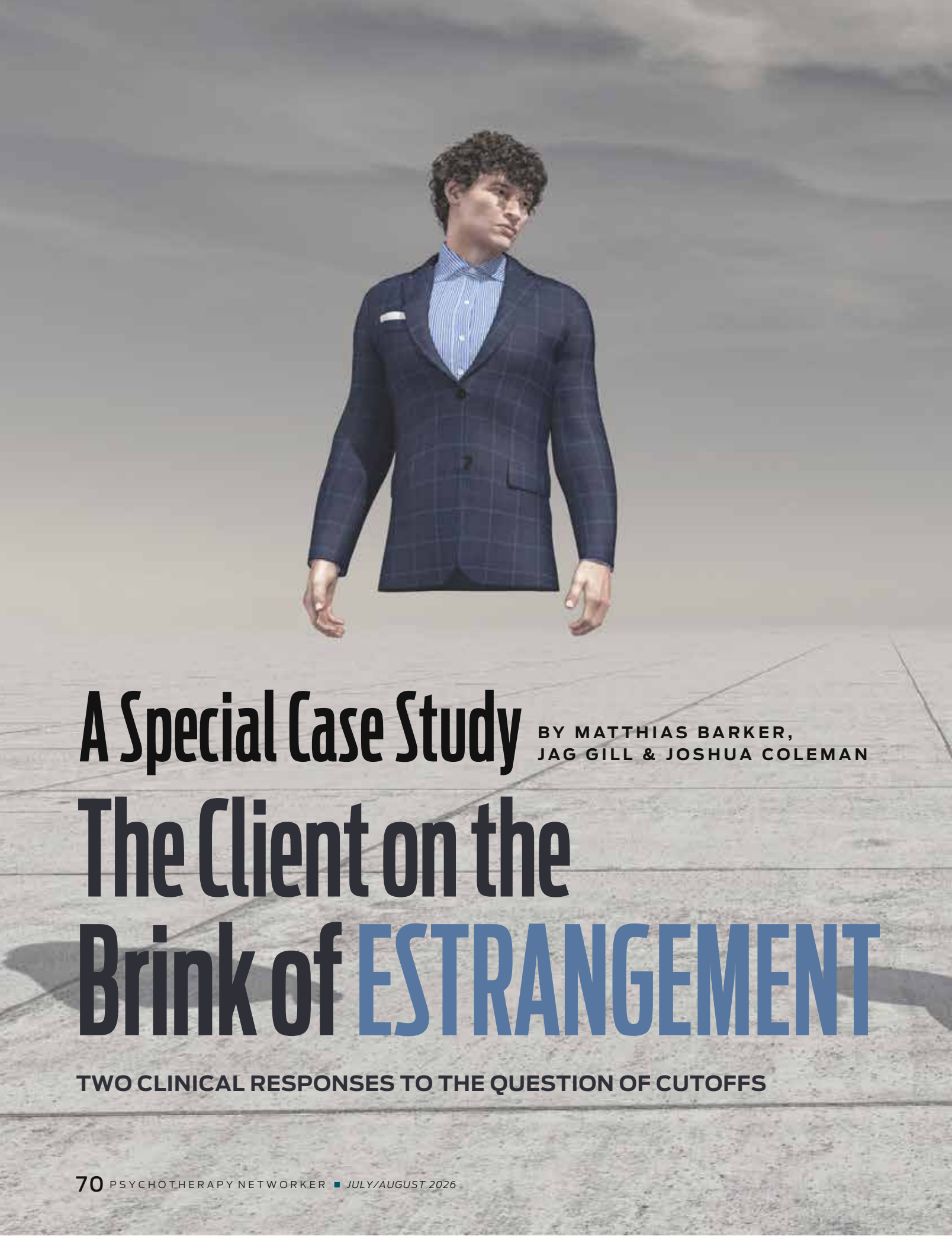
There's a quiet relief in naming this. Because it's easy to interpret our over-responsiveness as a personal flaw: being "oversensitive," or being "burned out." But it's often something simpler and less judgmental. It's occupational. Just as the runner's knees wear down, the therapist's boundaries grow more porous. This isn't pathology, and it isn't weakness. It's just adaptation. And if this is true, then the remedy is something practical, and self-care isn't just about vacations or exercise, but also emotional recovery: time without attuning, spaces where we're not responsible for anyone else's feelings, and moments when the volume knob can slowly turn back down.

For some therapists, the remedy may be more literal, like a quiet drive home with no phone calls, or a brief walk before entering the house. It's a deliberate transition that says "work is over." For others, it might mean protecting part of the week from having to relate, unstructured time where nothing is being asked of the nervous system.

Recovery also means realizing that it's not our job to manage every emotional field we enter. As therapists, we often carry the responsibility for holding and containing. Outside therapy, that responsibility can become almost automatic. But intimacy and friendship don't require the same stance. Sometimes the most restorative act is to simply let the room be the room.

Professional longevity isn't just learning how to open deeply but learning how to close again. Empathy, like any muscle, can be overused. Even the most finely tuned instrument needs to be put back in its case. So lately, when I find myself edging toward the quiet corner of a crowded room, I'm a little gentler with myself. I no longer assume something is wrong. I simply think, *This is what decades of listening look like.*

Michael L. Glenn, MD, is a retired family physician and psychotherapist who practiced in the Boston area for more than three decades. He is the author of Collaborative Health Care *and, with Barry Dym,* Couples: Exploring and Understanding the Cycles of Intimate Relationships.



A Special Case Study

BY MATTHIAS BARKER, JAG GILL & JOSHUA COLEMAN

The Client on the Brink of ESTRANGEMENT

TWO CLINICAL RESPONSES TO THE QUESTION OF CUTOFFS

Owen is a 28-year-old new father who starts his first session with you by leaning close to his webcam and whispering, "My parents were supposed to visit for a few days, and they've been here three weeks. I've tried setting boundaries since I got sober three years ago, but it doesn't work. I think I need to break away from them once and for all."

When you ask what's been happening, he describes his parents creating chaos in his marriage. His mom finagled her way into the delivery room, which his wife Cynthia, a lawyer born in El Salvador, hasn't forgiven. And most mornings, his dad listens to super conservative Christian talk shows that vilify immigrants while Cynthia tries to feed the baby in the next room.

Owen reports, "I've told my dad I'm working on myself and want to find ways we can all respect each other and get along, but he just says things like, 'Therapy is just brainwashing you' and 'If your wife respected us, she'd be more welcoming to us and more willing to put her career aside for the sake of our grandson.'"

Taking a breath, he adds, "My last therapist suggested I cut off contact with them, and I told her I'd never do that. But the more I think about it, the more it seems like the only real option." He hesitates. "I know they love me. But they're making my life hell."

Find Your Own Center

BY MATTHIAS BARKER & JAG GILL

I can see the tension in Owen's forehead, his searching eyes, his sunken chin. He's hunched over, leaning against the arm of the couch as if he's looking for something solid to press against. I feel the pull in my own chest to lean in, reassure him, tell him what to do.

That pull is worth paying attention to, because it's almost certainly what everyone in Owen's life has been feeling around him for years. His parents tell him what to do. His previous therapist told him what to do. Now he's essentially asking me what to do.

Maybe that's the deeper problem here.

He didn't stop his mother at the delivery room door, although he wanted to. He's whispering to me from behind a closed door in his own home, three weeks into his parents' most recent visit, which he hasn't yet ended. And when his previous therapist suggested cutting contact with them, he said he'd never do that—then showed up here reconsidering it. Each of these moments has the same shape: a situation that calls for Owen to act from his own values and results in him feeling unable to move.

My intuition is that this isn't just a conflict with his parents. It's a war inside him—a wrestling match between two valid parts of his identity, two sets of values that have yet to be differentiated and reintegrated. One part of him still strongly identifies with his family of origin. And then there's the emergent part: husband, father, co-head of a household with different ways of holding gender roles, decision-making, trust, and agency. When those two parts push him in opposite directions with equal force, the result isn't movement. It's stasis. What looks like inaction may be paralysis.

I also find myself curious about Cynthia—and not only because of the harm she's absorbed. She's navigated something relevant here. Growing up in El Salvador, building a life across cultures, continuing her career while becoming a mother, she's likely already done some version of the differentiation work Owen is facing now. How did she integrate her heritage with her identity as an adult? How have she and Owen worked through that together as a couple? Have they even discussed it?

Sociologist Rin Reczek uses the term *democratized kinship* to describe the framework that many young couples like Owen and Cynthia have acculturated into—one in which family bonds derive their legitimacy not from blood or role, but from ongoing mutual respect, accountability, emotional safety, and chosen investment. Owen has likely been drifting in this direction for years. It's the natural current of a secularizing Western culture, one where personal autonomy and coming to an authentic understanding of the self take priority over complying with family expectations.

This democratized kinship framework affects not just bicultural families like Cynthia's but culturally homogenous families like Owen's, ones living in rural, religious, or otherwise traditional environments. Therapy and recovery may have pushed Owen further and faster than he would have traveled on his own, but he may still have one foot in his parents' world, and that's exactly the kind of internal dynamic that produces paralysis. "Setting limits" feels both right and wrong at the same time.

When Owen says he wants to "find ways we can all respect each other," he doesn't seem to realize that he and his father have fundamentally different conceptual frameworks built around that single word: *respect*. For Owen's father, someone operating from a patriarchal, role-based framework, respect isn't negotiated and reciprocal. It's hierarchical. Owen's father isn't overreaching when he instructs his daughter-in-law to leave her career. He may mean it as an act of guidance and stewardship, a patriarch doing right by his family. When Owen talks about mutual respect, his father hears a challenge to the natural order, and perhaps even to his value or identity within the family. They aren't speaking the same language.

These themes need careful handling, and I know I need to pace myself. Explaining to Owen his father's cultural logic can easily start to sound like defending it, which will only deepen his guilt and experience of paralysis. But understanding is not excusing, so making visible what's been operating invisibly—giving Owen a map of the collision he's already inside—may be exactly what the work requires.

His previous therapist's recommendation to cut contact was a surface fix to what may be a deeper problem. Estrangement won't resolve what's unresolved inside him. If my read is correct, he'll carry this same tension and paralysis into his marriage, his relationship with his children, and every future moment that asks him to act from his own center.

The immediate priorities are practical: Owen's parents need to leave, conjoint sessions with Cynthia are indicated, and his sobriety infrastructure needs direct attention. But underneath the practical work is something deeper. Owen needs to finish the process of understanding what he actually believes about how a household is governed, who he is with his wife, what kind of environment his son will grow up in, and who he is in the face of his father's expectations.

When those values are genuinely his own, chosen rather than vaguely inherited, he can begin negotiating his relationship with his parents from solid ground. The results of that negotiation will likely determine the kind of relationship that's possible with his parents.

And the conversations leading up to it will likely be more direct than his parents are used to and require Owen to speak in a language they can recognize. Not a list of boundaries or "I feel" statements, but language that leads with relationship and what's best for the collective. Something like: "I want to talk about visits in a way that honors my wife and our family. Let's pick dates now so I can protect that time for us. Also, I found an Airbnb close by. Tell me what you think. While I love having you stay, this will best serve my wife as she settles into these early days with a newborn. I'm genuinely looking forward to time together."

That kind of language won't eliminate the tension, and his parents may still push back, but it's far more likely to land than democratized kinship vocabulary like "this is my boundary," which his parents will experience as their son pushing away the family, rather than finding ways of establishing healthy closeness.

The goal isn't to help Owen find the right answer about his parents, or even to help him set boundaries in a way that won't upset them. It's to help him become someone who can act from his own center and tolerate the result: good or bad.

Matthias Barker, LMHC, is a psychotherapist and founder of Estrangement.com, an online psychoeducation and support program for parents and adult children navigating long-term family disconnection. He's widely recognized as one of the most followed voices on family estrangement in the world, reaching an audience of over four million people across social media platforms. He is currently conducting research on the patterns and pathways to healing that have emerged from his work with families, and is writing a book on the subject. He lives in Nashville with his wife and three children.

Jag Gill is a doctoral student in Clinical Psychology whose research focuses on parent-child estrangement. His work explores how parents and adult children cope with family disconnection, the pathways through which they reconnect, and the broader cultural, relational, and intrapersonal dynamics that contribute to its rise. His work bridges the lived experience of

relational rupture with clinical approaches that support meaningful repair and healing on both sides of the divide.

Set Limits First

BY JOSHUA COLEMAN

There are a number of parental behaviors here that increase the risk of eventual estrangement as an outcome for this family. Owen's mother and father seem unable to abide by their agreement to only visit for three days and have now stayed three weeks. Owen hasn't enforced the limits they agreed on. He's in recovery and needs to protect that. His mother has acted in a way that disrespected his wife during the birth of her child. His father listens to talk radio vilifying immigrants, knowing Cynthia is an immigrant herself, and demeans his therapy.

Any one of those actions on the part of the parents could trigger an estrangement today.

What to do?

I'd start by exploring why it's so hard for Owen to enforce the limits he's already set. I assume there's nothing new or unusual in the self-centered way that the parents are behaving both toward him and his wife. From that perspective, he likely has years of experiencing his feelings as not mattering to them. In addition, he believes—perhaps correctly—that if he tries to assert himself, he'll be shamed, humiliated, or rejected in the process.

But he's no longer a child and needs to stop giving his parents so much power.

If the agreement was that mom and dad were only going to stay three days, then they need to get out after day three and not one day more.

Should he cut them off?

Estrangement should be the last decision on the decision tree—and he has a long way to go before such an action makes sense.

Here's what he should say instead, either directly or in a letter:

Mom and Dad, I love you both and am very grateful for the positive ways that you've contributed to my life. However, we need to have a very different kind of relationship going forward.

Mom, my wife made it clear that she didn't want you in the delivery room, and you went anyway. I get that it's your first grandchild and you wanted to be there. And I can see how you might've felt hurt or rejected that she didn't want you there. But this was her decision to make, and by not respecting it, you treated an important event in her life like she and her feelings didn't matter.

She's too nice to tell you that herself, and I'm not confident you'd be sufficiently respectful or apologetic if she did, which is why I'm telling you. I'd like you to apologize to her for what you did and to commit to being more careful in the future.

In addition, you both said you were only going to stay here for three days, and it's now been three weeks. I hate having conflict with you, so I haven't really raised it. Perhaps that's why you assumed that I was more okay with it than I am. But the visit has gone on too long. In the future, if we have an agreement about how long you're going to stay, I'd like you to keep your word and not put me in the uncomfortable position of having to kick you out. It's not my nature, and I don't like hurting your feelings.

In that vein, I'd like you to start being more sensitive to my feelings. I get that you've never had therapy and think it's some kind of weak indulgence. But I've benefited a lot from it. It's helpful to my recovery. And I don't want to hear any more about why you think it's bullshit. You're welcome to your opinions, I just don't want to hear them again.

Finally, Dad, my wife is an immigrant and I love her. She's also the mother of your grandchild. It's incredibly disrespectful and hurtful to both her and me for you to listen to programs in our home that vilifies immigrants. Do what you want in your own home but not in mine.

I'm sure this is a lot, as you're not used to me pushing back on you in this way. Over the years, I've learned that it's easier to get along with you both if I don't, but I'm at a very different place in my life now.

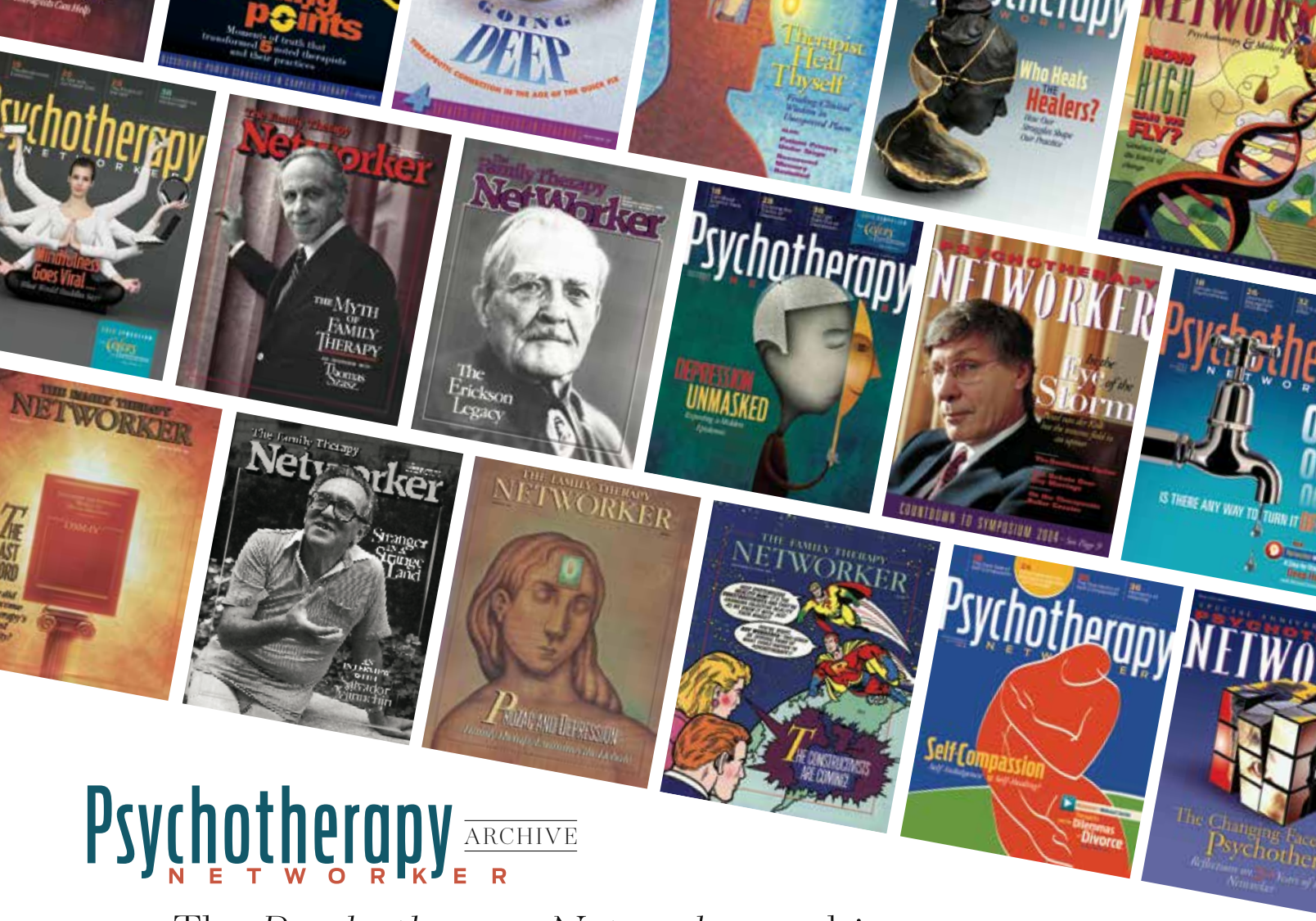
The therapy that follows the delivery of this message would be based on how willing and able Owen is to enforce those limits with his parents and on how much resistance he gets from them.

Estrangements sometimes occur prematurely because the client doesn't have the strength or support to enforce the limits they set without collapsing under guilt or fear. While estrangement is always an option, supporting it prematurely denies clients the opportunity to develop the kind of resilience and musculature that will carry over into their other relationships.

In addition, there are several other problems with recommending or supporting estrangement at this stage. Since Owen is obviously conflict avoidant, acting like the parents are hopeless before he's faced them with his limits is unfair to them. They likely have always assumed he was a good-natured guy who isn't bothered by whatever it is that's actually bothering him. From that perspective, they'll need some time to get up to speed with the new assertive him, which will require patience from Owen and Cynthia.

While estrangement can sometimes and reasonably be cast as a virtuous act of self-care, it can also reflect an unwillingness or inability to do the hard work of communicating needs and feelings when the outcome is uncertain. We do a disservice to our clients when we make it all about the parent's inability to change without considering how able or willing the client is to learn to communicate more effectively, set limits, and take risks.

Joshua Coleman, PhD, is a clinical psychologist in the Bay Area, keynote speaker, author and senior fellow with the Council on Contemporary Families. His newest book is Rules of Estrangement: Why Adult Children Cut Ties *and* How to Heal the Conflict. *His Substack is* Family Troubles.



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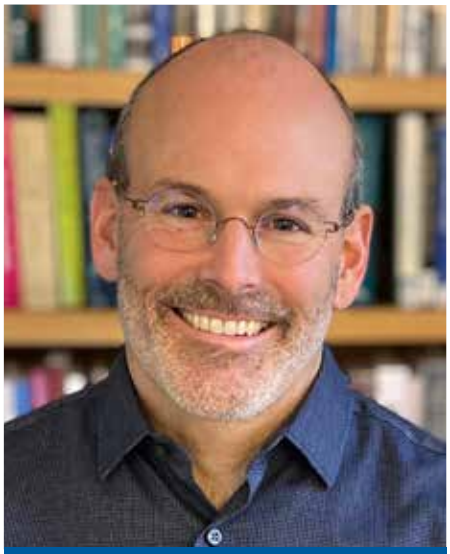
BY RYAN HOWES & JUDSON BREWER

The Neuroscience of Habit Change

USING REWARD-BASED LEARNING TO TRANSFORM ANXIETY & CRAVINGS



JUDSON BREWER

Among all the issues clients bring to therapy, few are stickier than addictive behaviors and worry-driven habits. How do we not just challenge bad habits, but help enact lasting change? How do we retrain the underlying mechanisms driving them—and in a way that avoids the traps of guilt and shame?

These questions were on my mind as I sat down to chat with Judson Brewer, a psychiatrist and researcher at Brown University, as well as a leading voice in the science of habit change. Combining cutting-edge neuroscience and the timeless wisdom of mindfulness, Brewer's work explores how deeply ingrained behaviors—whether they're driven by anxiety, addiction, or cravings—are formed, and more importantly, how they can be *un*formed. Rather than trying to force change, Brewer's approach invites us to explore our natural curiosity, to work with the mind instead of against it.

In his *New York Times* bestselling books *The Craving Mind* and *Unwinding Anxiety*, Brewer translates complex brain science into practical tools that therapists and non-therapists alike can apply in their everyday work and lives. His groundbreaking perspectives have not only been featured in *Time Magazine, The Washington Post, The New York Times, Forbes,* and more, but his TED Talk, "A Simple Way to Break a Bad Habit," has more than 15 million views on YouTube to date.

Ryan Howes: What drew you to focus on anxiety and habits in your work?

Jud Brewer: Suffering. A lot of people are suffering, and there are a lot of subpar treatments that have been the gold standard for years.

CBT, for example, has been the gold standard for what, 50 years? And it's primarily focused on changing our cognitions. But from a neuroscience perspective, the essential elements of habit change are related more to reinforcement learning and reward processing than changing cognitions.

We know that habits change based on how rewarding something is, so we can't really think our way out of a problem. We have to feel our way out of it. And when we feel how unrewarding a behavior is, then we naturally become disenchanted. That's how we change it. That's what *Unwinding Anxiety* is about—approaching anxiety from a neuroscience perspective, rather than thinking our way out of it or trying to figure out why we're anxious by going back into our past.

As humans, we're attached to the idea that we can reason our way out of problems. That's not to say that reasoning isn't helpful, but when it comes to changing emotionally based habits, we believe we have more control over our destiny than we probably do.

RH: A lot of your work focuses on the relationship between shame and food. Can you say more about that?

Brewer: People often eat to soothe themselves emotionally. It's called *hedonic hunger* as opposed to *static hunger*. But that can feed spirals of shame, where we feel ashamed about not being able to control our eating, and often what we look like based on the caloric intake.

RH: How is craving different from hunger?

Brewer: When we have static, or physiologic, hunger, we can have a craving for food, which is normal. That urge to eat is dopaminergically driven. It creates a restless itch, making me want to go get some food. Hedonic hunger is not really hunger, but it describes how we learn to eat as a way to regulate our emotions. And that craving can feel exactly the same.

For years, I ran a group for patients with binge eating disorder. It took me a while to figure out that they didn't know the difference between true physiologic hunger and hedonic hunger. One of my patients put it succinctly: "I just have an urge and I eat." And she was like, "What's hunger?" Often the signals can have a lot of overlap in terms of how they feel, but what drives them is very different.

RH: Is that "mindless eating"?

Brewer: Exactly. And the antidote

is mindfulness and awareness. It fits so perfectly with what we understand from a neuroscientific standpoint of how habits change. It's knowledge that's been around for a while, since back in the '70s, when researchers Rescorla and Wagner talked about positive or negative prediction error. Basically, if you pay attention and see that something is more rewarding than expected, you're going to do it more. And if you pay attention and see that it's less rewarding than expected, you're going to do it less. It's the same formula that can be used to help people form healthy habits like kindness, generosity, gratitude, and compassion. You can form healthy habits in the same way you can break unhealthy habits. The primary driver here is awareness.

RH: You need to be aware of the outcome?

Brewer: Absolutely. You notice you have a craving for food, but you introduce an extra thought: *What am I getting from this?*

RH: You use the acronym RAIN, which is similar to the one originally coined by meditation teacher Michele McDonald and later adapted by psychologist Tara Brach.

Brewer: Yes, though in my version, the "n" stands for "noting" based on a practice popularized by the late Buddhist monk Mahasi Sayadaw. One way to bring the awareness to cravings is to use RAIN. *Recognize*: if you're on autopilot and can't recognize a habit, you can't pinch it. *Allow*: if we don't allow whatever feelings are driving the habit, we're not going to be able to work with it. You have to get up close to the sensations of the habits to be able to change them, turning toward our experience, rather than running away from it.

Investigation brings an attitude of curiosity, which is the key attitude of mindfulness. So instead of resisting our experience where we're like, "Oh no, if it's happening again, I have to fight it" we instead ask, "Oh, what does this feel like?" It brings us into the present moment and helps us start to investigate what our physical sensations are, what a craving feels like, and how to sit with it and see these as simple physical sensations that aren't terrible. They might be unpleasant, but we can actually be with them.

Noting is a pragmatic practice for helping people stay with their experience moment to moment, so they know the tightness, tension, itching, burning. Whatever the feeling of a sensation is—whether it's anxiety or craving—they note it.

RH: Do anxiety and food habits have a similar root cause?

Brewer: They do, and we've identified mechanistically where both are driven through reinforcement learning. Anxiety is driven through negative reinforcement: the feeling of anxiety drives the mental behavior of worry, and then the feeling of doing something about it, or the illusion of control, is rewarding enough that it feeds back.

People often falsely associate problem-solving with worrying because if somebody is worrying a lot and they happen to solve a problem, they'll get a false association where they think that because they worried, they solved the problem. In reality, they just happened to be worrying when they solved the problem.

RH: What are you working on now?

Brewer: We just created a scope-based program for anxiety called "Going Beyond Anxiety." It's available to anyone, and people can use their HSA to pay for it.

And we've found you can use a reinforcement learning process to help people develop healthy life skills, like practicing gratitude, generosity, kindness, integrity, and ethical conduct. We developed a skills-based program where we can actually incorporate all of this through lessons in audio and video formats. We pair this with an AI-based learning assistant that can check their comprehension and then through experiential education help employ it in their lives. It's something I would do in my clinic, but scaled. We pilot-tested it last fall, and clients were saying they loved it.

RH: What would you recommend to therapists who encounter clients with problematic habits?

Brewer: This might sound controversial, but I'd say watch out for spending too much time on the *why*. When we focus more on the *what*, people can learn to work with anxiety as a habit, instead of something that they have to solve or discover from their past or childhood. They can bypass the stereotypes that people associate with psychotherapists.

RH: Yeah, that will ruffle some feathers.

Brewer: I'm happy to ruffle feathers because that's what the data show. Whether it's from our randomized control trials or in my clinic, focusing on the *what* really helps people a lot. And I think ultimately, psychotherapists are just trying to find the best way to help their patients.

Judson Brewer, MD, PhD, is an addiction psychiatrist, neuroscientist, and bestselling author whose research explores the neural mechanisms of mindfulness and behavior change. He's the author of Unwinding Anxiety *and* The Craving Mind*, and serves as Director of Research and Innovation at Brown University's Mindfulness Center. He's been featured in* TIME Magazine*, NPR, and* The New York Times*, and his TED Talk has over 38 million views.*

Ryan Howes, PhD, ABPP, is a Pasadena, California-based psychologist, musician, and author of the Mental Health Journal for Men.

BY RAMANI DURVASULA, TERRI COLE, LISA KLEYN & ELI HARWOOD

4 Clinicians Decode Films Every Therapist Should Watch

ON THE PSYCHOLOGY OF NARCISSISM, GASLIGHTING, ATTACHMENT & SHAME

Like a great therapy session, a great movie doesn't end when the credits roll. It lingers with you. It sparks reflection, challenges assumptions, and sometimes even changes the way you walk through life. Readers loved our last two pieces on therapists' favorite films so much that we asked four more therapists to share their favorites—ones that stayed with them long after the screen went dark.

"Succession"

BY RAMANI DURVASULA

Watching *Succession* would seem like a busman's holiday for a person whose career is focused on understanding antagonistic personality styles, such as narcissism, and their impact on relationships, but it's still one of my all-time favorite shows. The plot of the series centers around the Roy family, a billionaire-class media-owning family (think Rupert Murdoch's clan), and the machinations of a tyrannical father and his four adult children.

It's easy to write one-dimensional narcissistic characters: the malignant villain, the arrogant charming playboy. But the writers of *Succession* brought a nuanced understanding of the vacillations between grandiosity and vulnerability, the shame, the punching down, and the sycophancy up. The patriarch, Logan Roy (played by Brian Cox), presents with malignant narcissistic patterns—coercive, exploitative, menacing, triangulating, and sadistic—and has a backstory characterized by significant adversity. Each one of his children evinces their own narcissistic profile—grandiose, vulnerable, with sprinkles of malignancy—and are locked in a permanent vacillating re-enactment between winning over or destroying the subjugating father. (It plays as a gilded version of *Arrested Development* meets *Hamlet*.)

The narcissistic relationship cycle is fueled by intermittent abuse and perpetual hope, as well as the human desire for attachment to a person who's governed by self-interest, superiority, and little interest in mutuality. In most cases, especially for a child, the only path forward to attachment with a narcissistic parent is the fawn-self-abandonment cycle, dissociation from the true self, silencing of wants and needs, self-devaluation, fragmentation, capitulation to the parent, and the eternal misplaced hope of being attuned to by the parent.

Logan Roy engages in the perpetual narcissistic patriarchal tactic of future faking, the psychological carrot on the stick: fostering the possibility in his children of their father finally bearing witness to them, and anointing them with the familial crown, but like Charlie Brown's Lucy with the football, always pulling it away. The net result of this is that none of them are capable of maintaining a healthy adult relationship. They're chronically dysregulated, juggling substance use and addiction, struggling with sexual difficulties—and not surprisingly, they go on to abuse and subjugate others. Their single-minded quest to vanquish their father while simultaneously getting his love, becomes their life's work.

But where the series simulates what happens in a real-life narcissistic relationship is how it takes the viewers on the wild ride of reviling, then being concerned for, then empathizing, and then going back to reviling these narcissistic characters. We, in essence, become trauma-bonded to them as viewers.

The most compelling character is Roman Roy (played brilliantly by Kieran Culkin), the youngest son, who initially presents as an entitled, insolent, arrogant, insouciant perpetual adolescent. He's the prototype of a racist, classist, privileged trust-fund brat. As the series unwinds, we observe in this deeply immature man, the child who endured the physical abuse of their brutish father, who despite his vitriolic attacks, passive-aggressive commentary, and contempt for others, is panicked at the thought of betraying his father. His father plays this vulnerability expertly, drawing his ne'er-do-well son into triangulated gambits. Ultimately, we recognize that Roman doesn't give a damn about running the company: he's lost in winning over his father. The 5-year-old boy wants to be seen.

The theme of "loyalty tests," a common tactic in antagonistic relationships plays out consistently through the show, too—with Logan chronically testing his children, pushing them to ethical and personal limits, encouraging them to wantonly destroy the lives of others to prove their love to their father (a dynamic often perpetrated in cultic systems). In one affecting scene, the patriarch Logan, who has once again future faked Roman with grandiose promises, wants to isolate Roman from his siblings, who want to vote in a bloc against the father. Logan asks Roman to fire a longstanding corporate executive in the company with whom Roman has had a complicated sexualized maternal-in-nature relationship. Roman's physiological response to such a level of self-betrayal, and betrayal of an "ally," is to become, in a word, "squirrely," crawling out of his own skin, highly irritable, and buried under shame and grief. (It's a profound piece of acting by Culkin.)

Ultimately, betrayal becomes normalized in antagonistic systems, almost expected, and the themes of vindictiveness, dominance, secrecy, triangulation, manipulation, gaslighting, and abject selfishness are laid bare in *Succession.* Despite all the wealth, privilege, and plenty, everyone is starving for attunement, attachment, and safety. It's a reminder that everyone in systems characterized by antagonistic leaders or patriarchs is hurt. *Succession* is a master class that intergenerational cycles die hard, and that money and resource may simply make the malevolence more Machiavellian.

Succession plays like theater and reminds us that maybe Shakespeare (and perhaps the epic poets and mythmakers before him) understood narcissistic abuse before anyone else.

Dr. Ramani Durvasula (Dr. Ramani) is the New York Times *bestselling author* of It's Not You: Identifying and Healing from Narcissistic People. *She's a psychologist, professor emerita of psychology, and the world's leading expert on narcissistic relationships.*

"The Woman in Cabin 10"

BY TERRI COLE

The psychological tension in the Netflix movie *The Woman in Cabin 10* isn't just about whether a crime occurred. (Spoiler Alert: It did!) It's about what happens to a person's sense of reality when their perception is repeatedly denied by those around them. As you watch the murder mystery unfold, you're also watching what happens when self-trust is slowly worn down in real time.

At its core, gaslighting is a form of psychological manipulation in which someone's reality is questioned, minimized, or outright denied. Over time, this can destabilize a person's confidence in their own perceptions, memories, and instincts. In the film, the main character, Lo, played by Keira Knightley, believes she's witnessed something deeply disturbing. But instead of receiving support or even curiosity, she's met with consistent dismissal. The more she insists, the more her credibility is undermined.

What makes this dynamic especially potent is that Lo is already positioned as someone whose reliability can be questioned. She's anxious and has had a recent trauma. Too often, when a person has a history of anxiety or emotional distress, others may consciously or unconsciously use that as a reason to doubt them. We see this play out in clinical settings, in families, and in intimate relationships. The narrative becomes less about what actually happened and more about whether the person reporting it can be trusted—especially when that person is a woman.

This is where the film becomes psychologically accurate in a way that's recognizable. Gaslighting doesn't always look dramatic. It often shows up as a calm, confident denial; as subtle redirection; as "Are you sure?" or, "That doesn't make sense." Over time, this can lead someone to turn against their own internal knowing. The mind starts searching for alternate explanations because the social pressure to conform becomes stronger than the internal knowing.

There's also something important happening in the body. Before the mind organizes a coherent narrative, the nervous system often registers that something is wrong: a sense of unease, a spike in vigilance, or a feeling that doesn't quite resolve. When those signals are dismissed or overridden, especially in a high-pressure environment, such as the isolated setting of a boat, the internal conflict intensifies. Part of the self is saying, "Something happened." Another part is saying, "No one believes you, so maybe you're wrong."

That internal split is one of the most damaging effects of gaslighting. The person begins to doubt not only the external reality, but themselves. The ship's closed environment amplifies all of this. There's limited access to outside perspectives, which increases reliance on the dominant narrative in the group. When everyone around you appears certain, it becomes much harder to hold onto a dissenting perception. This is a dynamic we also see in family systems and controlling relation-

ships, where the absence of external validation reinforces the power of the gaslighter.

What's compelling about Lo's experience is that her persistence becomes an act of psychological resistance. Even as her credibility is challenged, she continues to return to her original perception. This doesn't mean she's unaffected. We see her question herself and the impact of isolation and doubt. But there's still a thread of self-trust that she doesn't fully abandon.

From a therapeutic perspective, this is the point of intervention, where we help clients reconnect with their internal cues, support them in distinguishing between anxiety-driven narratives and grounded intuitive knowing, and validate that it's disorienting, even destabilizing, to have your reality questioned repeatedly. We can then slowly help them rebuild the capacity to say, "I believe what I experienced happened," even when others do not.

The Woman in Cabin 10 captures something many people have lived through in less dramatic ways: being told you're overreacting or being dismissed when something feels off, and learning, over time, to override your own perceptions to maintain connection or avoid conflict. Ultimately, the story is about uncovering the truth of what happened on the boat. But the more interesting revelation is the much more personal process of reclaiming trust in oneself. And that, in many ways, is the real resolution.

Terri Cole, MSW, LCSW, is a licensed psychotherapist and global relationship and empowerment expert and the author of Boundary Boss *and* Too Much. *For over two decades, Terri has worked with a diverse group of clients that includes everyone from stay-at-home moms to celebrities and Fortune 500 CEOs. She inspires over a million people weekly through her blog, social media platform, signature courses, and her popular podcast,* The Terri Cole Show. *Contact: terricole.com.*

"Marriage Story"

BY LISA KLEYN

There's a pivotal scene in Noah Baumbach's *Marriage Story* that will probably rattle you. It's the moment Charlie, one of the main characters, screams at his estranged wife, Nicole, *"I wish you were dead!"*

Charlie lets loose this statement midway through the film, in the sterile apartment he's rented while he fights for custody of their son. My partner happened to be watching with me, and instinctively, I gripped his hand. Charlie's words echoed through my body with a familiar pain, the same kind I've felt while sitting with clients and community members who've talked about their marital discord—and as a daughter who saw it in her own family.

By this point in the film, Charlie and Nicole have crossed a point of no return. He crumples to the floor, wrapping his arms around her legs as if for survival, overtaken by shame and grief he can't metabolize alone. She collapses toward him in shock. And I felt the reflex every couples therapist feels when they see conflict reach a boiling point: the urge to press pause and call the fight.

"How do two people who love each other ever get here?" I whisper to my partner.

After years of studying relationship science, working as a clinician in global trauma recovery, and contributing to policy reform to prevent child abuse across communities, I'm still shocked by how routinely we wound the people we love most.

If Charlie and Nicole were in my consulting room, I'd walk them back to the frightened parts of themselves that fired those missiles. But *Marriage Story* isn't a therapy session; it's one of the most clinically precise depictions of relational rupture in cinematic history. It shows what happens when two people who love each other never lower their protective defenses long enough to feel seen, safe, or soothed.

The film opens with a devastating scene disguised as tenderness. A mediator has each partner write down what they love about the other, and the lists (read to us by each of them in voiceover) are specific and alive. Charlie loves how Nicole makes him feel like the most important person in the room; Nicole loves his patience with her and how effortlessly he seems to parent their son. Love and admiration remain palpably intact. I exhaled, daring to think they might make it after all. Mutual positive regard is still within reach, and that's what repair is made of.

But a moment later, when the mediator asks them to read their lists aloud to each other, Nicole can't do it. The vulnerability feels intolerable; she's been carrying too much hurt for the exposure to feel safe, so she shuts down and storms out of the room. What looks like defiance is really the only shape her hurt can take in a space where it no longer feels safe to reveal it. From this point on, the film becomes a chronicle of every repair attempt smothered before it can fully surface.

I often recommend this film to therapists and clients who are convinced the problem lives inside their partner. Baumbach captures the

opposite: the negative cycle lives *between both* partners. Charlie is the classic avoidant, regulating through competence, control, and intellectualization. Nicole's pursuit, once the engine of the marriage, has collapsed into flight; her move to the other side of the country is the last protest of an unheard attachment need. What makes this film essential—for clinicians and anyone who's ever found themselves throwing punches at a loved one they never meant to throw—is that it gives you a ringside view of what every couple is capable of. You can see exactly where Charlie and Nicole lost their footing, and exactly where they could have found their way back. If you're in the ring, you're too close to see it.

In the scene where Charlie and Nicole are fighting in the apartment, we see that the more Charlie leans into his reactive part, the more Nicole disconnects from the part of her that still loves him. The more she retreats behind cold logic and cutting words, the more his dysregulation escalates. This is what John Gottman calls *diffuse physiological flooding*—the moment the nervous system becomes so overwhelmed that no bid for connection can be received, and all Four Horsemen—contempt, criticism, defensiveness, and stonewalling—arrive at once.

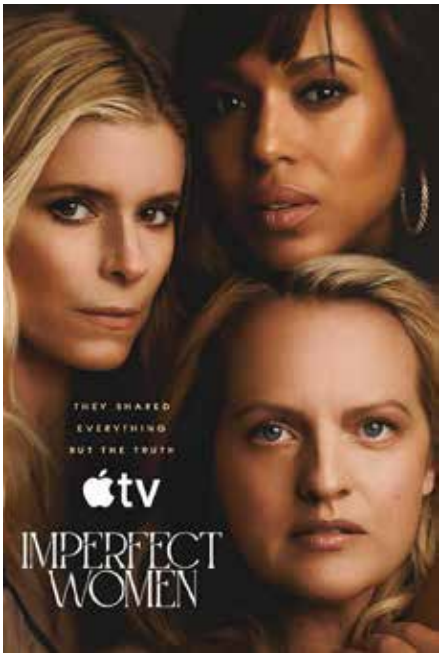
The longing underneath never disappears; it just becomes impossible to reach. They're trading blows, each one landing harder than the last, pulling them further from the only thing that could have saved them: one of them stopping the swinging and saying, "I'm scared, and I need you." You can see the solution. They cannot.

Only once their divorce is almost finalized does Nicole tell Charlie she read his emails and knows about the affair. His response isn't a defense as much as a diagnosis: he'd been sleeping on the couch for months. Nicole had withdrawn, subsumed by Charlie's ambition. But her withdrawal had registered in Charlie's nervous system as loneliness—and he'd sought solace from another woman. In the end, he and Nicole suffered the same wound, each feeling abandoned but unable to articulate it in a way the other could hear.

Marriage Story doesn't let viewers off the hook. In the film's final moments, Charlie's hands are full as he carries their son, so Nicole kneels to tie Charlie's shoelace. The gesture is so small, yet so reminiscent of their love lists that it gets me every time. For me, the saddest part of the film is knowing that everything Charlie and Nicole needed to save their marriage was right in front of them the whole time. They just couldn't lower their armor long enough to see it.

I see this every day in my consulting room: couples who aren't failing in love, but failing under the weight of what we've asked love to carry alone. Sometimes therapy itself is part of the problem, when individual narratives are validated at the expense of the relationship. We expect more from our relationships today than any previous generation, yet we've stripped away the communal scaffolding that once held them in place. We're better informed about love, but less supported in sustaining it, and the cost is visible everywhere: rising loneliness, declining marriage rates, and falling birth rates. Charlie and Nicole aren't an anomaly, they're a mirror. That's what makes this film so hard to watch, and so hard to look away from.

Lisa M. Kleyn, PhD, is a relationship scientist-practitioner, published researcher, and internationally accredited family legal mediator specializing in attachment trauma and relational repair. She's the founder of the SECURE Method and Secure Love Lab, an attachment-based framework helping individuals and couples break destructive relational cycles and build more secure, enduring relationships. Clinically, she's worked within residential trauma recovery settings at Khiron Clinics and in the NHS supporting refugees and asylum seekers living with complex PTSD.



"Imperfect Women"

BY ELI HARWOOD

I'm currently in the stage of parenthood and therapisthood where I rarely have time to sit down and binge-watch a good show. Between emails and laundry and dishes and herding my three wonderful-but-sleep-allergic children into bed, I usually just want to go the f*** to sleep at the end of each day.

But earlier this year, during a school break, I took my twin daughters to an aquarium where we ran into the incredibly talented actress Elizabeth Moss, most known for portraying Peggy Olsen in *Mad Men* and June Osborne in *The Handmaid's Tale*. She was there with her toddler, and we kept ending up at the same exhibits at the same time. I awkwardly verified her identity somewhere around the stingrays, and then tried to act normal as we continued to bump into each other throughout the sea life adventure.

Naturally, as soon as I got home, I Googled her and went down an internet rabbit hole that led me to the discovery of her newest show, a psychological thriller called *Imperfect Women,* also starring Kerry

Washington and Kate Mara. The series is based on the 2020 best-selling book of the same name by Araminta Hall. And boy oh boy was it worth the sleep loss it took to watch it.

The story revolves around the mysterious murder of one of the women, Nancy, and the reckoning that comes from her death and complex revelations she never shared with her very closest friends. The show chronicles some steamy drama and betrayals that I won't spoil for you, but more importantly, it asks a deeply important question: why do we often hide huge parts of our lives from the people we care about the most?

Spoiler alert: The answer is the crippling shame that emanates from the unresolved traumas, social inequities, and dysfunctional dynamics in our relationships and rhythms that we aren't yet ready to acknowledge.

As a clinician who specializes in attachment, this question and its answer are so deeply rooted in early relationships and the impacts they have on our comfort (or discomfort) with being authentically known. Whether we believe we are worthy of support and closeness affects whether we reveal ourselves to the people we most desire support from.

Before her death, we see Nancy wrestling with the impacts of her profound childhood trauma. Her mother, a severe alcoholic, clearly neglectful of Nancy in childhood, is shown going into a violent jealous rage when she discovers that Nancy is being abused by her stepfather. We see Nancy desperately seeking approval and validation as she tries to silence the haunting questions that come with her childhood abuse: *Did I participate in this? Was it my fault? Do these circumstances define me forever?*

We see Eleanor living under the pressure that comes from being a Black woman who grew up with financial wealth and status but without emotionally close family relationships. She has means, but growing up, lacks meaningful support to navigate her life experiences in primarily white schools. Eleanor creates deep meaning for herself in her career (she runs an international relief nonprofit), that brings her into proximity of more diversity, but as a boss, without the camaraderie she craves.

And last but not least, there's Mary, a housewife who feels inadequate and pines for a career she left behind for her family. We see Mary struggling to be honest about herself, her desires, and her use of illegally obtained stimulants. We witness her uncover that her husband has been lying to her for their entire relationship, and even more profoundly, that she's been lying to herself. When Mary seeks the counsel of her husband's ex-wife, the woman poignantly says to her, "You believed him over your own eyes."

On top of reminding us why we hide our emotional baggage, *Imperfect Women* also invites us to question our obsession with watching women betray each other (hello *Housewives* series!) and to dig deeper into understanding and addressing what keeps us from the closeness we need and deserve from each other. Because it isn't our imperfections; it's the lies we were told about what makes us valuable and loveable.

After watching this group of friends grapple with the past and its impact on the present, anyone who's thinking about the intersection of attachment patterns in friendships will find themselves with plenty to reflect on.

Eli Harwood, LPC, is a licensed therapist, creator of Attachment Nerd, and author of the books Securely Attached, Raising Securely Attached Kids, *and* How to Deal with Your (__) So Your Kids Don't Have to. *She has over 19 years of clinical experience, over 1.5 million followers across her social media platforms, and is on a mission to make the world a more secure place one attachment relationship at a time.*