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Editor's Note

Thirty years ago, when ADHD was the new diagnosis on the clinical block, it fit a very narrow picture: young, impulsive boys who couldn't seem to stop moving, stop talking, or stop getting in trouble. Back then, those four letters were surrounded by a fog of stigma so thick you could barely see the struggling kid behind the behaviors, much less the desperate parents begging teachers and therapists for help and understanding. But as the number of kids diagnosed with ADHD began to climb, that fog started to lift—and more and more adults got diagnosed too. Then, as tends to happen when our field listens closely to people's lived experience, the clinical picture of ADHD grew fuller and more nuanced.

We started figuring out how ADHD shows up in girls and women (think: fawning, depression, anxiety), how it runs in families and affects relationships, what the ADHD brain needs to thrive, and how it shifts across the lifespan.

Recently, bestselling author Gabor Maté even released an updated edition of

his very first book, *Scattered Minds: The Origins and Healing of Attention Deficit Disorder*, originally published in 1999 shortly after he and his kids were diagnosed with ADHD. In his interview with us, he unpacks what the research says about how stress and our environment affect ADHD, and he responds to the controversy his perspective has stirred among critics.

If you're still brushing off ADHD as just the latest diagnostic fad—one that doesn't involve you or your practice—I hope you'll pause and read this issue anyway. Many of the authors featured in it are ADHD clinicians, who specialize in working with ADHD clients, and their stories opened my eyes to the complexity, intensity, and even trauma of the ADHD experience.

I now see why rejection sensitivity dysphoria, which often co-occurs with ADHD, is not just a crippling neurobiological reaction, but an understandable response to a lifetime of correction, criticism, and negative judgement. I get why, despite the ubiquity of the ADHD diagnosis, many people still get missed and end up carrying around a corrosive self-narrative that they're broken, lazy, over-reactive, overly sensitive, and careless. I've come to understand why experts have argued that, even though it's not part of the official diagnostic criteria, emotional dysregulation is a core component of ADHD.

And I've also come to understand why, as licensed professional counselor and author Nyck Walsh argues, given all the creativity and inherent passion that come with having an ADHD brain, we might consider calling it something else entirely that doesn't have the words *deficit* or *disorder* in it. Walsh's article, "The Case for Autistic Self-Diagnosis," lays out the most vivid and valuable list of qualities or traits that could indicate a person is Autistic I've come across. It goes hand in hand with the case for moving beyond standard diagnostic tests for autism and toward more narrative-based measures, which neurodivergent specialist Kory Andreas outlines in her piece, "How Assessments Fail High-Masking Adults."

But wait—why are we covering autistic traits in an issue about ADHD? Because we now have research indicating that up to 80 percent of Autistic people may also meet criteria for ADHD, and up to 50 percent of people diagnosed with ADHD also meet criteria for autism. The overlap of these two diagnoses is what's being called AuDHD, a term barely a decade old but already reshaping how we think about attention, regulation, and self-understanding.

For many therapists, it might be tempting to think that if you know about ADHD and you know about autism, then you know about AuDHD. But you'd be wrong. In this issue, AuDHD clinical psychologist Megan Anna Neff explains why a growing number of researchers and clinicians consider AuDHD to be its own distinct neurology, which she describes as autistic sensory overstimulation and ADHD understimulation "ping-stress colliding with each other" as they fight to pull the nervous system in different directions at the same time.

Neff's piece, "The AuDHD Paradox," provides an illuminating clinical description of the AuDHD mind, as well as a window into the extraordinary creative hyperfocus and layered insights that mind produces when it can find peace. Other pieces in the issue speak to the benefits a neurodivergent mind can bring to clinical work with clients, the all-too-common burnout and trauma AuDHDers experience, the neurodivergence often missed behind mood disorder diagnoses, and the harm that can follow when psychiatric caregivers unfamiliar with the nuances of autism prescribe medication.

Why should any of this matter if you don't believe you work with a neurodivergent population? Because, as Neff points out, since our field is only now gaining widespread awareness of autistic and ADHD masking—the often unconscious work of suppressing neurodivergent traits to appear more allistic—"there's a lost generation of Autistic and ADHD adults who've been in our therapy rooms for years," struggling with the wrong supports, the wrong diagnoses, and especially the wrong stories about themselves and how they should function in the world.

We hope this issue helps all therapists change that picture.

Livia Kent • EDITOR IN CHIEF

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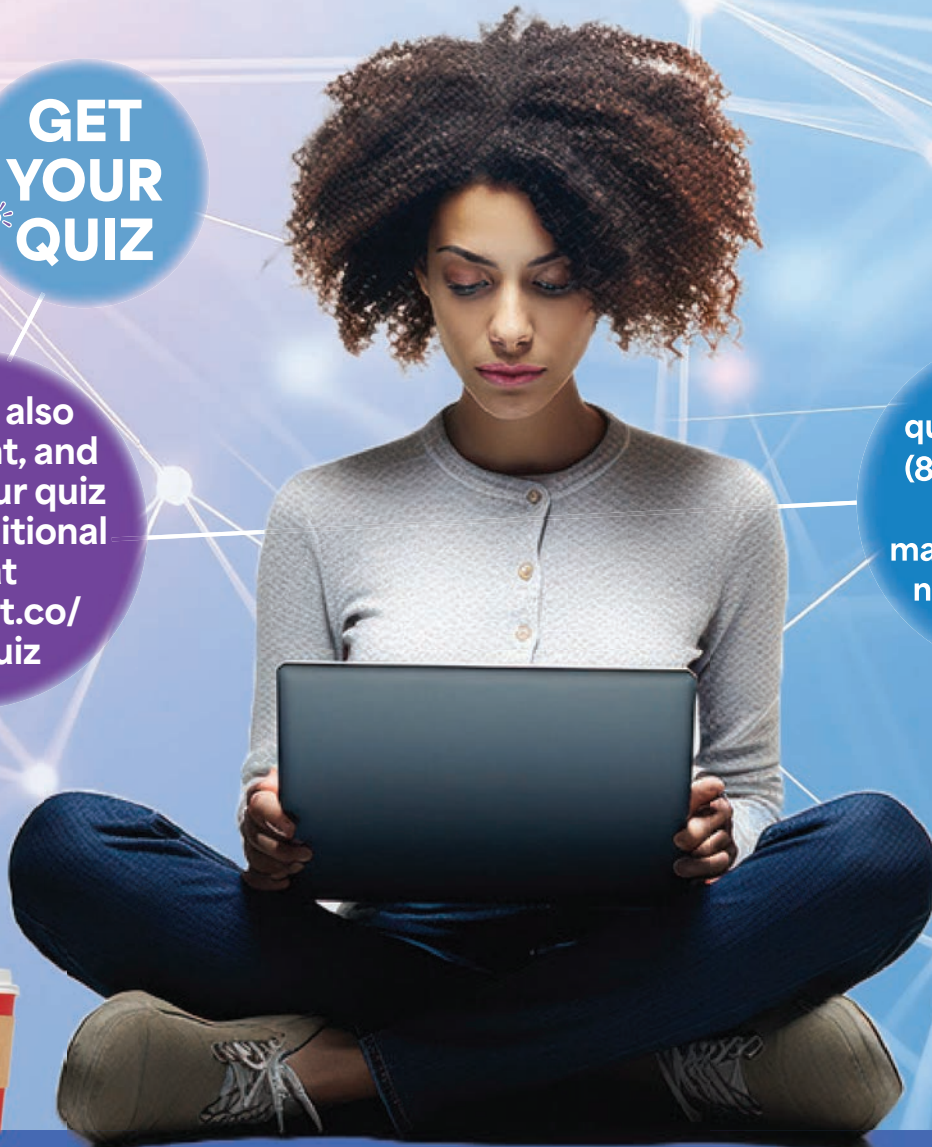
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Does The Body Really Keep Score?

One of Trauma's Most Contentious Debates Has Returned



Over the nearly 13 years I've spent writing about therapists and their work, there's a funny analogy I've found myself coming back to again and again: the field behaves a little like a family at Thanksgiving dinner. Its different disciplines are a (mostly) functional cast of characters, supporting and challenging one another, brought together by mutual respect and a shared mission.

There's the patriarch at the end of the table—Psychoanalysis, of course—who leans back and lights up a cigar. A few seats over, Sex Therapy whispers a raunchy secret in the ear of Nature Therapy, who feigns interest and stares out the window at a flock of geese. Ericksonian Hypnosis shares

a card trick with Play Therapy, who claps excitedly. Outside, Psychedelic Therapy lies in the grass, blissfully watching the clouds pass overhead. Attachment Therapy keeps a watchful eye over the kids table, where the newcomers have gathered. And Gestalt Therapy is having an animated conversation with an empty chair. You get the idea.

Like any family gathering, these characters follow a familiar set of rules: keep politics to a minimum, don't overshare, and listen well. There are consensuses, too: shared gripes about the DSM, a reverence for the therapeutic relationship, and an understanding that "the body keeps the score."

But what if that last concept—the

idea that the body, not just the mind, plays an invaluable role in treatment—isn't as universally accepted as we think? What if, in this dinnertime scenario, some uninvited guests—four brash researchers—barge into the dining room, decidedly announce that the body does *not* keep the score, and then mic-drop a thick stack of papers in the center of the table? What if, as the declaration lands with a thud, our cast of characters begins to wonder whether they actually see eye to eye on this body stuff after all?

It turns out this isn't far from reality. In April, four university researchers—including renowned British neuroscientist Karl Friston—dropped a bombshell report in the journal *Frontiers*

in *Systems Neuroscience*, provocatively titled, “The body does not keep the score: trauma, predictive coding, and the restoration of metastability.” Within days, it had sparked a firestorm of debate among therapists and non-therapists alike, reviving decades-old tensions over whether trauma is a problem of the mind, the body, or both—and what this means for treatment.

The *Frontiers* paper opens with a bold challenge to one of the most influential ideas in modern trauma treatment: Bessel van der Kolk’s argument that traumatic experiences continue to affect the body and nervous system long after the original danger has passed, a concept he introduced in his 2014 bestseller, *The Body Keeps the Score*.

“It’s an enticing metaphor,” the *Frontiers* authors write, “implying that experience is literally inscribed in flesh, that the body bears the scars of what the mind cannot face.” While emotionally compelling, they continue, van der Kolk’s claim is “biologically inaccurate.” The body proper does not store trauma, they add, but rather, “the brain dynamically reenacts it through maladaptive inference.... Trauma is a disorder of *prediction*, not *storage*; and thus why we believe it is inaccurate to say the body is somehow ‘keeping score.’”

But reading further, it soon becomes clear that the authors aren’t actually challenging van der Kolk’s assertions about the body’s importance in trauma treatment. Instead, they’re contesting the literal interpretation of his metaphor—the idea that trauma actually *lives* in muscles, organs, and tissues as a stored memory, like data on a hard drive.

“Our argument is less an outright refutation of van der Kolk than an updated reframing,” they write. “Van der Kolk’s framing obscures the central role of the nervous system in constructing, maintaining, and—crucially—transforming emotional experience. It can inadvertently imply that

somatic intervention is the primary or only path to healing, sidelining the computational and inferential processes through which the brain generates the body’s apparent ‘score.’”

Van der Kolk hasn’t responded, maybe because he doesn’t need to. Or maybe it’s because what he did or didn’t write 12 years ago isn’t really under fire. Rather, the paper’s authors suggest, the problem lies with the field, which over the years has reduced van der Kolk’s complex ideas down to a simple catchphrase.

Regardless, simply calling this out—and *appearing* to challenge van der Kolk in the process—has created a raging debate on podcasts, nightly newscasts, and, of course, online. Suddenly, it feels like a long-settled battle in the old trauma wars is back on.

“Every somatic coach on the internet is having a meltdown,” said health and wellness guru Beau Kuhberg in a May 2026 Instagram video. “But here’s the part nobody’s saying out loud: it doesn’t fucking matter. Your brain *is* in your body. Drawing a line between brain trauma and body trauma is like arguing whether the music is in the speaker or the air.”

“Is trauma in the brain?! Is it in the body?! Who’s right?” asked an Instagram post from Somatic Experiencing practitioner Karden Rabin. “It’s obviously both, and even that is an abstraction, trying to make sense of the age-old dilemma of us humans trying to conceive ourselves a ‘whole being.’”

Some took aim at the *Frontiers* article’s authors. “The title is deliberately provocative, misleading, and misrepresenting of [van der Kolk’s] beliefs,” wrote one Reddit commenter.

Others, siding with the *Frontiers* authors, fired back. “The body is not a hard drive,” retorted another Reddit commenter. “Stop trying to delete a file that was never there.”

Some suggested body work had become overhyped. “I worry that we’re entering an era where trauma recovery is being marketed as something you can ‘release’ purely through body-based tools,” wrote trauma-informed

child psychologist Robyn Koslowitz on Instagram. “A massage can help regulate your nervous system. A calming tool can lower stress. That’s real. But regulation alone is not the same thing as cognitive reprocessing.”

And of course, some took aim at van der Kolk himself. “The body does *not* keep the score,” said child psychiatrist Michael Scheeringa on a July 2026 episode of Alex Clark’s podcast, *Culture Apothecary*. “I believe van der Kolk started with the conclusion, and then cherry-picked the data to fit it.”

Whether you’re Team Mind, Team Body, or somewhere in between, the debate comes down to a deceptively simple question: When we say that the body keeps the score, what do we even mean?

The Somatic Divide

Over the dozen years since *The Body Keeps the Score* was published, enough praise has been heaped on it to fill books on its own—accolades from therapy legends like Pat Ogden, Jack Kornfield, Dan Siegel, Stephen Porges, Dick Schwartz, Peter Levine, and Jon Kabat-Zinn. Meanwhile, its publication coincided with a huge spike in the popularity of body-based trauma treatments, with methods like Somatic Experiencing and Sensorimotor Psychotherapy establishing international training networks since its introduction.

But there’s a disconnect: most clinicians have *not* jumped on the body bandwagon. According to a 2024 international survey published in *Frontiers in Psychiatry*, although roughly 78 percent of clinicians say mind-body therapies are “the most promising” category of treatment for psychiatric conditions, only 38 percent agree that they should be integrated into mainstream practice, 43 percent say clinicians should receive formal education in mind-body therapies, 47 percent said they’d feel comfortable talking with clients about mind-body therapies, and 37 percent said they’d recommend them to clients.

In sum, the enthusiasm is real, but it hasn’t translated into actual practice.

The field, it would seem, is split. And it has Ruth Lanius worried.

“I fear we’re back at Descartes—seeing the brain and body as distinct entities,” says Lanius, a prominent clinician-scientist, researcher, and author who’s been studying trauma for over 30 years. “When I read the *Frontiers* article, which implies that they’re separate, I thought, *Wait a minute, the brain, mind, and body are one*. All the sensory information we experience in our bodies gets transported through the spinal cord into the brain, which makes sense of it and regulates the body.”

Is the mind-body connection lost on most therapists, as the *Frontiers* authors suggest?

“My sense is the authors are getting caught up in semantics,” Lanius says. “Saying ‘the body keeps the score’ doesn’t mean we’re just treating the tissues. The tissues *could* be affected—we know that stress is associated with inflammatory processes. But that’s just one piece.”

So if the issue with the *Frontiers* article is just a matter of semantics, then why are so many therapists so worked up? Lanius says it’s because, even in this seemingly Golden Age of trauma treatment, the field remains deeply divided—and those divisions go well beyond terminology.

“There are the top-down people, and there are the bottom-up people. We need to bring them together, because our clients need both. Thoughts are critical, but when you’re severely traumatized, the language and awareness parts of your brain aren’t fully online. Sometimes you need a bottom-up treatment to get the full effect of a top-down treatment.” Embracing both isn’t just nice in theory, Lanius adds—it can drastically shift the outcome of therapy. After all, only about half of clients respond to talk therapy alone.

If that wasn’t enough to sway skeptics of the idea that the body keeps the score, there’s another reason Lanius says it’s worth taking seriously: It perfectly describes what many trauma survivors actually feel.

“It was actually Bessel’s patients who came up with the concept of the body keeping the score,” she says. Lanius has heard similar descriptions from her own clients—like the one who’d been stabbed and continued to feel blood dripping down his neck long after the wound had healed, or the assault victims who, when triggered, said they felt like they were being forcibly held down all over again.

“Traumatic memories can be experienced as sensations in the body,” Lanius explains. “Hence clients feel that the body keeps the score. After treatment, that changes. It’s like the body lets go of the memories.” None of this may be visible under a microscope, but Lanius says the experience of trauma living in and leaving the body feels very real to clients—“and we need to take that subjective experience seriously.”

Setting the Record Straight

Psychologist Arielle Schwartz still remembers when the words *somatic psychotherapy* were met with raised eyebrows, even from fellow therapists. “Thirty years ago, they’d look at me a little cross-eyed and say, ‘semantic therapy?’” She says the uptake since then has been dramatic—and when *The Body Keeps the Score* debuted, it confirmed what she’d long known as an EMDR specialist and yoga practitioner: tuning into the felt experience could provide crucial feedback about the process of healing from trauma.

The *Frontiers* article, she says, felt like a step backward.

“Unfortunately, I think it gets mired in the old Cartesian error that the mind and brain aren’t part of the body. When you look at the interaction of the nervous system and every other system of the body, you see how deeply they’re intertwined. That you can’t possibly separate the mind or brain or nervous system from the fascia, the cardiovascular system, the endocrine system, or your digestive system. Do the issues live in our tissues? Absolutely. And does the brain contribute to the problem with predictive processing? Absolutely. So it’s

both/and, not either/or.”

As reasonable as this may seem, Schwartz admits that focusing on the body at the expense of the psyche happens frequently in our field, and it can be problematic.

“If we’re only focusing on the felt sense and not realizing that we need to unpack where the mind gets caught in feedback loops, or if we don’t know how to interrupt the mental processes that become our self-confirming biases, then that also contributes to the problem,” she says.

For Schwartz, the solution is an integrative mind-body approach. In her own work with trauma survivors, she often begins with a memory reappraisal and reconsolidation process. When the client notices a sensation, she asks them to notice the automatic interpretations their mind is making about it. *It’s bad. I can’t handle it. It’s never going to go away. There’s something wrong with me.* Then, she introduces a somatic intervention that allows the client to stay with the sensation and notice that none of their worst-case-scenario beliefs came true. *I could handle it. It ended. I’m okay.* With repetition, they eventually “update” how the memory and sensation are held in the brain.

“Over time, how we relate to our body begins to change,” Schwartz explains. “We get to befriend it, and think *Oh, I’m not so scared of that feeling anymore. I’ve got this.*”

For Schwartz, the integrative mind-body approach makes intuitive sense—“and that’s what Bessel’s been saying all along,” she adds. “That’s where I think it got misconstrued. He never meant to say the body only.”

Shiny Objects

Just when it seemed the trauma field had settled the brain versus body debate, psychotherapy researcher Scott Miller offers a dissenting take: Maybe these tidy concepts of brain and body are more appealing than they are accurate.

“Research is the great leveler,” he says. “And frankly, I don’t see the scientific support for much of what van der Kolk claims. I see the interest, and his book title is definitely memorable.

But the evidence is limited.”

Miller doesn't side with the *Frontiers* authors either. “We're talking about two takes that are highly questionable,” he says. “It's like, which narrative do you want? I do think that Bessel's work is still primarily understood as trauma being stored in the tissue. If you listen to his early talks, it sure sounds like that.”

Miller clarifies that he isn't questioning the importance of the body in trauma treatment. “There's no reason *not* to focus on the body,” he says. “But mediums and psychics and tarot card readers have outcomes that are just as good.”

So why has the idea that the body keeps the score had such staying power?

“Our field is prone to generating new ideas,” he says, “and my theory is that they tend to reflect the cultural interests of the time. This is true of psychodynamic therapy, CBT, EMDR, and EFT. They *feel* relevant, and are attractive as such. And the claim is always ‘If you don't know this or do this you're going to be less effective.’ That's not supported by the science. To paraphrase an old expression, ‘Culture eats psychotherapy for lunch.’”

The dilemma, Miller adds, is that most of these interventions work. But over the last 50 years, he says there's been virtually no improvement in clinical outcomes, regardless of the approach. And over time, these ideas—like the body keeping the score—are prone to totalism and oversimplification.

“Concepts meant for the therapy room have escaped, aided and abetted by algorithms on social media,” he says. “We're no longer in control of them, and that's alarming. You don't see the same kind of drift in other sciences, like physics or mathematics.”

So what's the solution?

“To me, this isn't about the *Frontiers* article or the question of whether the body keeps the score,” Miller says. “It's about something bigger: We need to take a hard look at whether our interventions are actually helping our clients, to monitor and measure them over time. Without evidence, these

ideas are just stories,” he says. “They're neither good nor bad. But all stories have the potential to help and heal.”

Doing Our Part

Therapists like Morgan Starr-Riestis, a holistic nervous system regulation expert whose practice pulls heavily from the work of somatic therapy pioneers, have been tracking the mind-body debate closely.

But regardless of where the field lands, she says her clinical foundation feels sturdy. *The Body Keeps the Score* was part of her clinical upbringing—and she believes it's still incredibly relevant—but she also draws inspiration from other approaches, like Peter Levine's Somatic Experiencing and Dan Siegel's Interpersonal Neurobiology. Taking these multiple perspectives into account, she says the importance of the body in trauma treatment is undeniable.

“Stress and trauma cause an *unfathomable* amount of measurable change. Literally every organ system—our nervous system, immune system, cardiovascular system, respiratory system, musculoskeletal system, and reproductive system—is impacted. Trauma increases your risk of heart disease and stroke. It increases your risk of cancer. So I don't think van der Kolk's claim of the body keeping the score is grossly inaccurate.”

As someone who also boasts a considerable online presence, with over 750,000 Instagram followers, Starr-Riestis says there's something else about the *Frontiers* article that gives her pause: how it was marketed.

“I'm in the belly of the online beast,” she says. “So my first thought was, *This is just for clicks*. It makes sense that it blew up. Imagine if it had been titled differently. I think it was made to be sensationalized.”

Starr-Riestis acknowledges that complex ideas often get watered down on social media. But even in limited formats like Instagram posts, where brevity is not only encouraged but rewarded, she says clinicians have the room—and the responsibility—to offer context.

On her Instagram page, Starr-Riestis shares the proactive nervous system regulation routine she offers clients, in which she helps them customize their mornings and evenings using a palette of nervous system regulation tools, like humming while brushing your teeth or doing bilateral stimulation while brewing your morning coffee. They work, she says, but there's also more to the story.

“It's unethical to think I can solve people's problems with a one-minute post,” she explains. “So at the end of almost every video, I'll try to direct people to my program where my team and I can offer the nuance and customization needed to get results. I try to be transparent by saying there's more to the equation than what we can fit into one-directional social media posts.”



The mind-body debate has hardly been settled. But maybe that's not an entirely bad thing. Psychotherapy works, at least in part, because of the friction between competing ideas. Because no single theory gets to operate without being questioned, tested, and held accountable when it goes off the rails. Sure, it's frustrating, but it's also protective. It keeps us from mistaking an enticing explanation for a complete one.

Maybe the goal isn't to decide which guest at the Thanksgiving dinner table has been right all along. Maybe it's to keep the conversation going, to make sure no single voice drowns out the others. To bring our combined strength to the table. Heated debates will continue to occur, but like most families, we usually find our way back to each other. If not for us, then for those we serve.

“We need to move into conversation and connection,” says Lanius. “To resist the polarizing pull of choosing one viewpoint over another. We live in polarized times, but when we move toward reconnection, it ripples outward—from individuals, to groups, to the world.” 

Chris Lyford is the senior editor at Psychotherapy Networker.

Tapping into Trauma

ENERGY PSYCHOLOGY GOES MAINSTREAM

Q: I have a client who's made real progress processing his trauma, but some symptoms just won't budge. A colleague keeps urging me to look into EFT "tapping," but I'll admit I've been skeptical—it's always sounded closer to magical thinking than treatment. Is there anything to it?

A: You're right to be skeptical. Tapping for psychological change seems implausible on its face, and for years the evidence behind it was thin enough to justify real doubt. I felt that way myself the first time I encountered it. Plus, it looked absurd. But it turns out there's something real here. The research base has crossed a threshold over the past decade, including consistent findings of rapid change in exactly this kind of situation, where some symptoms haven't improved. Rather than talk about this in the abstract, let me tell you about Diane.

Diane had been in therapy for three years following a horrific automobile accident. She was smart, motivated, and had done serious work—CBT, neurofeedback, medication. Yet she was still taking back roads to avoid driving on highways. Every attempt to get on a highway ended in a panic attack, her body reacting as if the pile-up were happening all over again. Then, in what her therapist later described as a Hail Mary—using a technique she'd only recently learned—she guided Diane to tap on acupuncture points on her face and body while staying focused on the memory.

Twenty minutes later, Diane drove home on the highway. She called her therapist that evening, laughing in disbelief. The fear, she said, was simply gone.

I've heard versions of this story dozens of times over the past two decades—sometimes unfolding in a single session as it did for Diane, often building across several, and in cases of chronic depression or complex PTSD, extending over months

of sustained work. I've also written about the approach, researched it, defended it before skeptical colleagues, and watched tapping therapies move—slowly, now more quickly—from the fringes of our field toward the mainstream, carried there by evidence that's becoming harder to ignore.

While the psychotherapy community has been deliberating, the public has been voting with its fingertips. A single phone app—the Tapping Solution—has more than four million users. Kate Winslet, Nicole Kidman, and Whoopi Goldberg are among the well-known figures who've spoken openly about tapping's role in helping them navigate stage fright, grief, and fear of flying.

What is Tapping?

Emotional Freedom Techniques (EFT), the most widely used and studied form of energy psychology, has clients tap gently with their fingertips on a standardized set of acupressure points (acupoints) on the face and body while staying mentally focused on whatever happens to be distressing them. It's simple, but it looks strange enough to make many clinicians wince. I thought it was absurd the first time I heard about it. But several months later, I watched a woman who'd been battling severe claustrophobia—with years of failed treatments behind her—walk calmly into a closet and close the door after a single 30-minute session. A group of therapists who had just heard her say, "I can't even step into an elevator," witnessed it with me. None of us had a ready explanation. Now, we're much

closer to one.

When a client focuses on a fear or troubling memory, the brain's threat system activates—the amygdala fires, cortisol rises, the body braces. In standard exposure work, we try to hold that activation long enough for it to habituate, or for the memory to eventually update in a less reactive form. Tapping appears to offer a distinct, often more rapid path: while the distress is activated, the physical stimulation of acupoints sends deactivating signals through the nervous system and connective tissue that directly counteract the alarm response. The conflicting signals meet, and the calming signals win—the body's present-moment experience of safety overrides the brain's stored record of danger. This is the same updating process that exposure therapy aims for, but tapping achieves this by sending a deactivating signal directly to the nervous system, bypassing the slow work of waiting for it to gradually learn that the danger it had encoded no longer exists.

Brain imaging studies have reported rapid reductions in amygdala activity and corresponding increases in prefrontal engagement. What seems to be happening is a kind of neurological updating: the brain learns that this memory no longer requires a threat response. The fear pathway weakens, and a new association—safer, neutral—takes its place.

That may be one reason the changes tend to be so direct and so durable. You're not reasoning your way past the fear, you're intervening at the level where the fear lives—in the body's alarm circuitry.

What the Evidence Now Shows

The research base has crossed a threshold. The Association for Comprehensive Energy Psychology catalogs more than 200 clinical trials in English-language peer-reviewed journals, plus over a hundred more in other languages. Nearly all show statistically significant improvement on at least one targeted symptom. For instance, a study of 218 veterans and their spouses found that 83 percent met PTSD criteria before a week-long treatment program where EFT was the primary intervention; afterward, only 28 percent did. Their spouses, who also received treatment for secondary trauma, showed comparable gains.

Multiple meta-analyses, dismantling studies, and head-to-head comparisons with conventional treatments have told a surprisingly consistent story. Meta-analyses focusing on PTSD, anxiety, and depression have found unusually large effect sizes—a statistical measure of how strong a treatment's impact is, with results showing tapping among the highest reported for any psychological intervention. The clinical trials underlying these meta-analyses span two generations of research—early studies with serious methodological limitations and later trials whose designs have been far more rigorous. The consistency of positive findings across independent research teams and multiple countries is difficult to dismiss. Meanwhile, the U.S. Department of Veterans Affairs has approved EFT as an evidence-based practice that VA therapists may use for conditions including PTSD, depression, anxiety, and pain. Kaiser Permanente, the largest U.S. health-care provider, offers instruction on EFT through its health education materials. UNESCO recommends EFT for parents and children during and after disasters.

Alongside the clinical findings and institutional approvals, a separate body of research has looked for biological fingerprints—measurable, objective physical changes, not

just self-reported improvement—and found them. Studies have documented reductions in cortisol following a single session—significantly greater than reductions seen after talk therapy sessions of equivalent duration. Favorable epigenetic changes have been documented—specifically involving down-regulation of stress-related genes and up-regulation of those associated with immune response. Preliminary EEG studies show brainwave shifts associated with emotional regulation.

A Familiar Story

Those of us who've been in this field long enough remember when EMDR was derided as a pseudoscience. The eye movements seemed implausible, the explanations felt thin, and the early proponents were regarded with polite skepticism or outright derision. EMDR is now a staple of trauma treatment, taught in graduate programs and included in the APA clinical practice guidelines. Energy psychology is following a similar arc—perhaps a bit more slowly, in part because the early research was less rigorous and in part because we're asking our colleagues to make a larger conceptual leap. Besides moving beyond a strictly top-down, talk-based paradigm and toward a somatic one, the name itself—"energy psychology"—carries baggage that strikes a professional nerve. After a long struggle for scientific legitimacy, it can feel like a step backward to invoke unmeasurable forces such as the "subtle energies" described in traditional healing systems. Whatever the role of subtle energy in tapping's effectiveness, however, the current scientific literature has developed neurophysiological accounts that explain why it works without requiring mechanisms that can't be measured.

Where Tapping Works—and Where It Doesn't

Tapping works best when the problem has an emotional charge attached to a memory, situation, or belief—which describes a large

share of what brings clients to our offices. PTSD and trauma-related conditions are where tapping has the strongest effect. Phobias, performance anxiety, chronic pain with an emotional component, cravings, and deeply held limiting self-beliefs also respond well. The technique also reaches clients who have insight into their problems but can't seem to change their emotional responses—people who know intellectually that they're safe on the highway, for instance, but whose bodies haven't gotten the message.

One of tapping's distinctive strengths is its reach and effectiveness during mass crises. Deployments using energy psychology protocols have been documented in more than 30 countries following earthquakes, hurricanes, and war—contexts where existing emotional support infrastructures are rapidly overwhelmed. The method can be taught quickly to paraprofessionals, can be delivered in groups (where the benefits flow to the whole group even while only one person's story is being addressed—a dynamic researchers call "borrowing benefits"), and can be self-applied after minimal training. That combination of trainability, scalability, and self-sufficiency is rare among evidence-based treatments.

Tapping works less well for problems that are primarily situational rather than emotional, or for psychiatric conditions with strong biochemical underpinnings—though it can be a valuable adjunct to treatment in those cases. And despite demonstrated efficacy when applied on one's own, it should not be self-administered without professional guidance for trauma-based disorders, severe depression, or other serious psychiatric conditions.

What This Means for Therapists

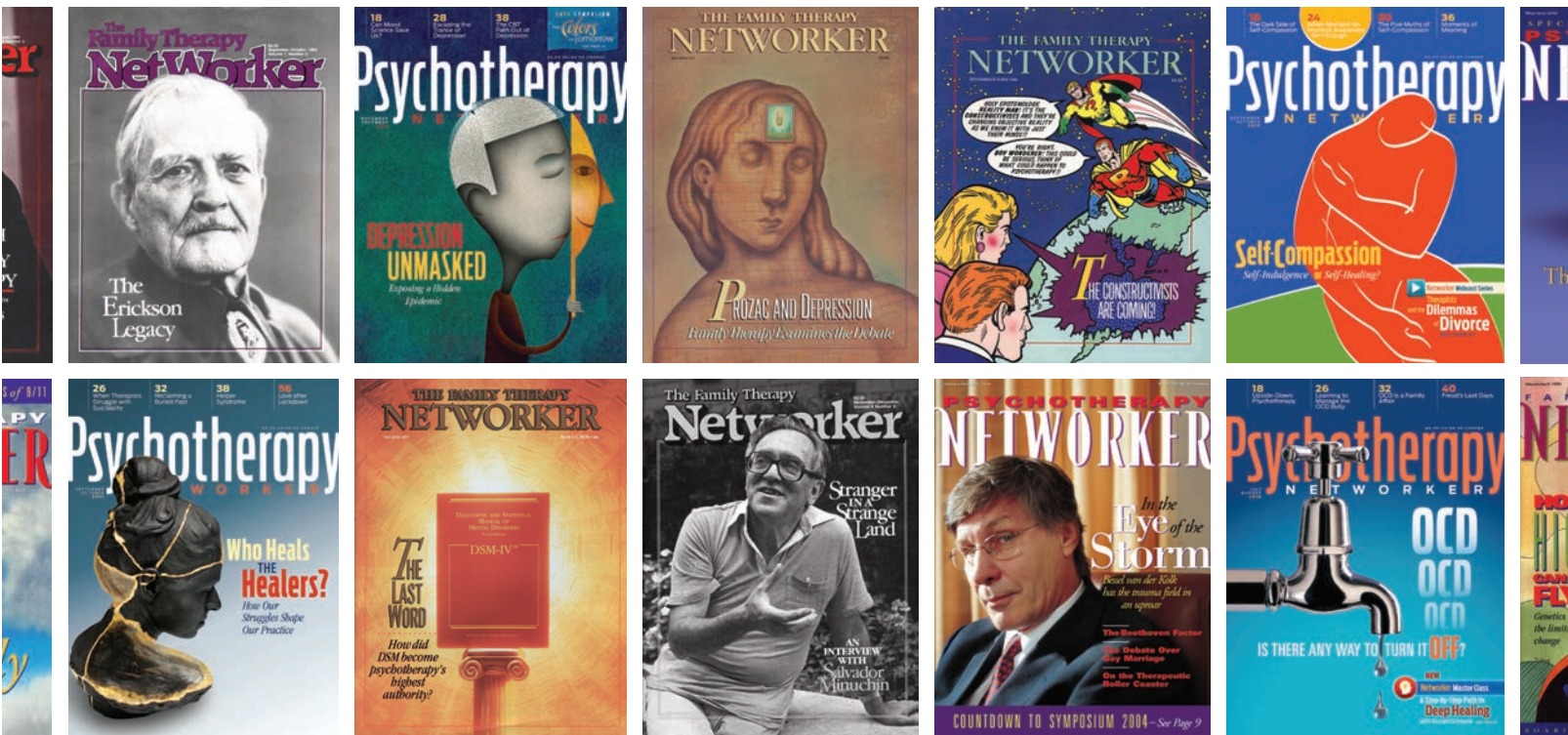
When therapists first incorporate tapping into their practice, the reaction is remarkably consistent. Almost universally, they begin reporting results—sometimes dramatic, sometimes incre-

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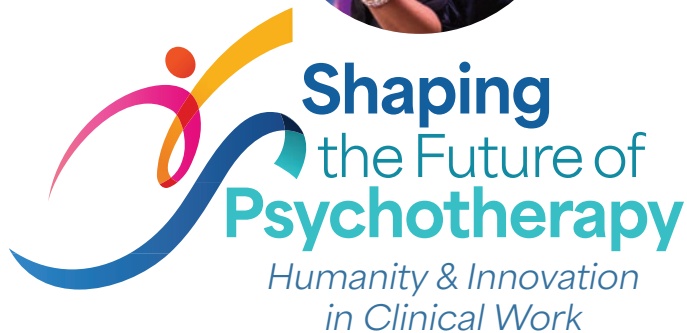
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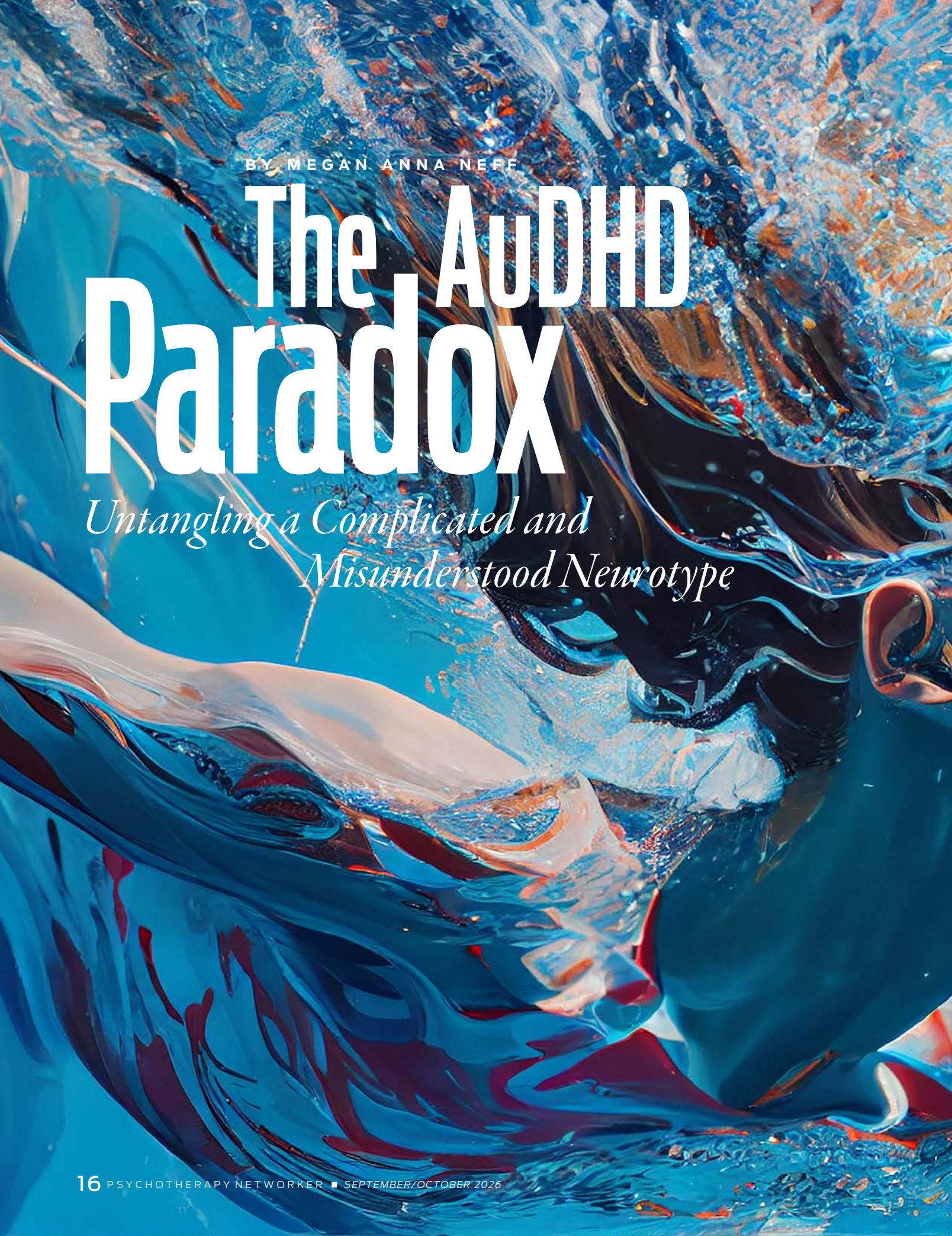
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BY MEGAN ANNA NEFF

The AuDHD Paradox

*Untangling a Complicated and
Misunderstood Neurotype*



As a child, I loved water. I was obsessed with *The Little Mermaid* and fantasized about building a life under the sea. But summer pools were a sensory storm: shrieking kids, cold water splashing in unexpected bursts, glaring sun, asphalt lava under my bare feet. I wanted to swim, but the chaos was overwhelming.

So I found a workaround. I'd sink to the bottom of the pool, eyes closed, sitting cross-legged for as long as my lungs would allow. Down there, the world quieted. Sounds dulled, the sun's glare couldn't reach me, time slowed. Under the water, I could breathe, in a manner of speaking.

When my lungs began to burn, I'd float back up, needing to take in air but also dreading the chaos above. Underwater was still, predictable, and peaceful, but I couldn't live there. I wasn't, in fact, the Little Mermaid, and I couldn't build a world down there. So I learned to hold my breath.

Throughout my life, I've had many narratives to explain my inner experience, many of them unkind. The language that's finally helped me make sense of it is AuDHD. That underwater space is what deep AuDHD hyper-focus and flow feel like. When I'm in it, the noise of the world fades, my thoughts line up, and I can think, feel, and just be.

The moment I'm forced to surface (by a notification, a task switch, a loud room, a demand I didn't plan for), it all hits at once: the brightness, the noise of external demands, the pressure of task switching, and the internal noise, too. The ADHD pinging starts firing the second I lose the steady line of deep focus, with thoughts rushing in, my mind jumping ahead of me, everything moving too fast and feeling like too much.

This, for me, is the core experience of AuDHD. In the right environment and in our flow state, we find a warm cocoon that makes life feel livable. Unfortunately, to fall into deep, monotropic focus requires ideal sensory conditions and space that doesn't fit with modern life, which asks us to navigate unpredictable sensory environments, unstructured social experiences, constant task switching, and so much noise.

Under these conditions, autistic sensory overwhelm and ADHD ping-stress collide with each other, and the more they collide, the more we get pushed back into internal cocoons where it's safe, albeit isolated. That ebb and flow—between trying to engage life in a way that's livable and retreating to a version that soothes—has been one of

the constant tensions of my life.

Many AuDHDers know this tension well: the need to isolate and go deep within oneself to cope while also needing to come up for air and function in a world that asks for more than we can sustainably give.

More Than Autism Plus ADHD

So what is AuDHD? It's a community-created term that captures the experience of being both Autistic and ADHD. There's still some debate among researchers and clinicians, but the growing view is that AuDHD isn't simply ADHD plus Autism (think of a chocolate-and-vanilla cake with the two flavors layered on top of each other), but its own distinct neurology with its own signature—more like a swirl cake, where the two flavors create a third taste that isn't quite either one. Part of why it's diagnostically tricky to spot is exactly that swirl: it's harder to detect the chocolate or the vanilla when they've blended. And it's that blended third taste where what I call the AuDHD paradoxology lives: the push and pull of two neurologies addressing different needs at different times.

The swirl is also why so many AuDHD adults arrive in our offices undiagnosed or partially diagnosed. Autism and ADHD co-occur more often than the diagnostic categories let on. Research estimates that roughly 30–80 percent of Autistic people also meet criteria for ADHD, and 20–50 percent of people diagnosed with ADHD also meet criteria for autism. Until the *DSM-5* was published in 2013, clinicians weren't formally allowed to diagnose the two together, which means a whole generation of us trained in a system that made AuDHD literally impossible to name.

Both autism and ADHD are missed more often in girls and women, in people with high IQs, and in Black and Brown communities. We're also living through a wave of new understanding of autistic and ADHD camouflaging and masking—the work of suppressing neurodivergent traits to appear more allistic or to fit into neuronor-

native expectations. In other words, there's a lost generation of Autistic and ADHD adults who've been in our therapy rooms for years and are only now beginning to be recognized.

As if identifying ADHD or autism in adults with non-stereotypical presentations weren't challenging enough, AuDHD adds another layer of complication. When ADHD is identified first, it's been shown to delay the recognition of autism. In a 2018 study, children who received an ADHD diagnosis before autism were identified as Autistic about 1.8 years later, on average, than children whose autism was recognized from the start. For girls, the gap stretched closer to 2.6 years. And because racialized children, particularly Black and Brown children, are less likely to receive timely diagnoses of either and more likely to be misdiagnosed, their AuDHD delay may stretch further still.

In adults, the same overshadowing shows up in our therapy rooms. Autistic sensory overload gets read as ADHD overwhelm or as emotion dysregulation, and predictability needs stay invisible. Executive function struggles get filed entirely under ADHD, missing the bottom-up processing piece. A meltdown around a schedule change gets labeled “emotional reactivity” rather than an Autistic person meeting sudden disruption. Sensory seeking gets read as hyperactivity. Special interests get folded into ADHD hyperfocus, missing what the interest is doing for the person. And autistic social differences—literal communication, direct interaction style, hyposensitivity to unspoken context—get folded into ADHD impulsivity and inattention.

When this happens, years of ADHD-only strategies (which often don't account for sensory safety or transition scaffolding) and years of accommodations that target attention but not predictability needs translate into years of “I should be able to do this,” when the supports were never designed for the wiring underneath. By the time AuDHD comes into the conversation, many of our clients have absorbed a

story about themselves built around the wrong frame, and we end up working with that story as much as we're working with their actual experience.

When ADHD is on the chart and something doesn't quite fit, autism is worth asking about, especially in adults whose presentation doesn't match the stereotype most of us trained on.

Eight AuDHD Paradoxologies

As part of an upcoming book I'm writing on AuDHD, I've surveyed more than 3,200 AuDHD-identified adults across a series of community surveys. In one of these, 681 adults described where they felt the most intense internal push-pull. The 18 themes that emerged show up as a tangled web, and cluster into five broader domains: executive, social, sensory, structural, and identity.

Often one side of a paradox is doing autistic work: protecting from overwhelm, holding predictability, going deep. The other is doing ADHD work: chasing the next spark of interest, following creative associations, going wide. The two systems aren't exactly arguing with each other, even though it often feels like they are. They're addressing different needs, and both are in the service of keeping us alive. Here are eight paradoxes that surfaced most often along with some of the ways they show up in the therapy room.

Perfectionism, Ideas, and an Inability to Execute. For many AuDHDers, the elaborate project lives in our heads in vivid detail: the book we'd write, the room we'd reorganize, the holistic plan to improve our health. The project is detailed, often perfectionistic. And then months or years pass without us starting it.

This was the most common tension our community named, with 34 percent of respondents describing some version of it. The autistic system generates detailed, often perfectionistic plans, and the ADHD system struggles to initiate, sequence, and finish them. One respondent called it “the old ‘unmet potential’... wonderful creative ideas and then not being able to hold onto them, break them down and

see them through.” Many of us build core schemas around this gap, knowing we should be capable of doing the thing and experiencing deep shame when we can’t build momentum.

Clinically, this often shows up as a client describing avoidance, low motivation, poor self-trust, or what looks like perfectionism—needing every condition to be “just right” before starting. The elaboration of the plan itself is part of what pins the person down: the more detailed the vision, the harder the first move becomes.

Appearing Fine While Internally Struggling. Another paradox that many AuDHD adults know well is the double mask. We hold it together at the meeting, in the email, in the school pickup line. We laugh at the right beats, hide the panic, and then collapse the moment the door closes behind us.

Twenty-seven percent of survey respondents named some version of the double mask: Autistic social camouflage layered with ADHD compensation. The Autistic side is doing the work of suppressing stims, scripting responses, tracking facial expressions, and modulating tone, while the ADHD side handles a different arena: pretending to follow along when attention has wandered, over-preparing for visible moments to appear competent, or hiding mistakes in front of others for fear of judgement.

To people who know us casually, we look capable, funny, articulate, fine. Underneath, two performances of safety are running, and they’re exhausting. Beyond being exhausting, both masks function to hide the intensity of struggle. That gap between how the mask is interpreted and the struggle being hidden creates a cognitive dissonance for the person living it, and for the therapist trying to understand what they’re hearing. Respondents who were also gender-expansive, trans, or BIPOC named the compounding load of the AuDHD double mask alongside code-switching or gender masking, which means three or four performances of safety running simultaneously.

In the therapy room, these clients can be slow to open up. The same skills

that have kept them safe in workplaces and families also keep them at a careful distance from other people, and the mask doesn’t drop just because they’re told it’s a “safe space.” These people have learned that their authentic selves get them in trouble, and that acceptance comes through hiding who they are. Truly feeling safe enough to show up as themselves takes time, attunement, and the ongoing experience of being read accurately.

Longing for Social Connection While Socially Exhausted. Many of us crave the experience of belonging deeply, and we also know that a two-hour gathering will cost us three days of recovery. So perhaps we say yes and then dread the date as it approaches. Or we say no and then mourn what we’ve missed.

A quarter of survey respondents described some version of this. The ADHD side reaches for stimulation, novelty, and emotional contact, while the Autistic side gets quickly overwhelmed by the unpredictability and sensory demands of socializing. What emerges isn’t a lack of social interest, which was the older clinical framing for autism; rather, it’s someone who experiences rapid social depletion.

The other current in this paradox is cost versus reward. Socializing is high-cost for AuDHDers, energetically and sensorially, and the reward for that high-cost activity isn’t always worth it. Many of us carry a long history of social experiences that didn’t go well: critique of our impulsivity, missed allistic social cues, invalidation, rejection. Over time, this negative reinforcement erodes what I think of as social hope—the underlying belief that connection and belonging are findable. Clinically, this often shows up as diffuse social struggle alongside core beliefs that either the self is fundamentally wrong or the world is fundamentally unsafe.

Sensory Overwhelm and Sensory Seeking. Many of us have what appear to be contradictory sensory instincts. We turn the music up to think but we can’t hear ourselves think over the running tap. We need the weighted blanket to sleep and the weighted blanket

is too hot.

The AuDHD sensory system often lives in two contradictory states at once. Twenty-three percent of survey respondents named this pattern: needing loud music to focus while being unable to tolerate background conversation, craving deep pressure while flinching from light touch, or swinging moment to moment between under- and over-stimulation. The ADHD nervous system reaches for input to increase arousal (I’ve come to think of ADHD as a dysregulation of arousal as much as a dysregulation of attention, with the system reaching for stimulation to avoid being locked into hypoarousal and boredom). The Autistic nervous system, in contrast, has lower thresholds for overload and a higher need for predictable, reduced input. The AuDHD body is constantly reaching for the just-right Goldilocks window of stimulation: enough to feel engaged, not so much that it tips into overwhelm.

When this isn’t understood through a sensory lens, it often shows up as an existential and bodily ache, a restlessness, a fight to get comfortable in one’s own skin. It can present as food or substance misuse, where the person is trying to stimulus-seek and sensory-block at the same time. It can look like someone living in a chronically traumatized nervous system, because in fact they are: enduring and navigating real sensory trauma without language for it.

Needing Routine and Seeking Novelty. This paradox lives adjacently to the sensory one. The ADHD novelty-craving is seeking stimulus to feel alive, and the autism is craving sameness to feel grounded in that life.

Seventeen percent of survey respondents named this paradox directly. The ADHD system runs on novelty: newness flips the dopamine switch and makes engagement possible. The Autistic system runs best on predictability: sameness reduces arousal, decreases prediction errors, lowers sensory load, and tells the body it’s safe to come down from the hypervigilance. While these two impulses look contradictory, they actually aren’t. They’re two solutions to two differ-

ent needs. Novelty makes us feel alive. Predictability lets us stay grounded in that aliveness.

Clinically, this can look like inconsistency or “they don’t know what they want.” It can also show up as wanting structure and resisting it at the same time, asking for routine then struggling to stick with it, or protesting the constraints of the routine. The client who insists on the same coffee shop every Tuesday and also quits their job to move across the country isn’t being contradictory. They’re feeding two different parts of the system, and part of the work is helping them notice which needs get neglected when others are fulfilled.

High Competence and Basic Dysfunction. At work, I look organized. Behind closed doors, my bathroom sink is littered with half-finished coffee cups, some forgotten long enough to grow mold. I can present eloquently at conferences and then come home, crash on the couch for three days, and find it hard to speak. I can spend 10 hours writing this article about AuDHD while struggling to take five minutes to log into my health portal and reorder ADHD medication.

Twenty-two percent of survey respondents described some version of this gap: being seen as capable or even exceptional in some areas, while spectacularly failing at tasks others treat as routine. Special interests and hyperfocus open up islands of unusual performance, while executive dysfunction and sensory demand make ordinary tasks hard. This visible contrast tends to erode our credibility when we ask for support.

Clinically, these clients often wonder what’s wrong with them. If their values were in the right place, the story goes, they’d care more, and if they cared more, they’d be better parents, partners, and humans. Part of the work is interrupting that story and helping the person see that this isn’t a failure of character: it’s about a mismatch between brain architecture and the environment.

Wired and Tired. Here’s another common scenario many of us know:

It’s 2 a.m. We’re tired. We’re awake. The brain is still pinging even while the body aches from fatigue. The mind has produced four new project ideas, a to do list, and a memory of something embarrassing from 2003.

One in five respondents described a mind that can’t rest on top of energy reserves that are perpetually empty. Autistic people tend to need a lot of rest, because the work of camouflaging, sensory overload, and navigating unclear expectations takes enormous energy, and many of us experience autistic burnout when we’ve been doing too much with too little support for too long. ADHDers can also experience burnout, with our hyperfocus bursts tending to be followed by crashes. And ADHD can make it hard to rest in ways the world recognizes as rest. Boredom can feel like a deep ache; I call it the “I want to crawl out of my skin” feeling. Finding the balance between rest and stimulation is one of the harder navigations in an AuDHD body.

The autonomic system ends up stuck somewhere that’s neither fight-flight nor rest-digest—a dysregulated middle ground. Clinically, this is often where we see chronic insomnia coexisting with chronic fatigue, and the kind of low-grade dysregulation that doesn’t fit cleanly into anxiety or depression while borrowing the worst of both. The pattern intensifies in burnout, exactly when we need it not to.

Feeling Too Much and Too Little. Our experience of emotion is also fertile ground for the AuDHD paradoxology. Sometimes the emotion comes in hot, and we’re reacting before we can register what hit us. Then there are days we feel flat, unmoved, watching ourselves from behind a thick pane of glass. Autistic emotional processing collides with ADHD emotional flooding, and a nervous system that’s already carrying a chronic sensory and social load doesn’t have much room to downregulate.

Many Autistic people experience delayed emotional processing and need time and space to find the words for what we’re feeling. We also experience

alexithymia (as do ADHDers, but to a lesser extent), meaning difficulty identifying or naming our own emotions, which can lead to emotional suppression or minimization while we take the cognitive time to process. ADHD, on the other hand, is associated with emotional dysregulation tied to impulsivity, a brain that struggles to hit the brakes, and rejection sensitivity dysphoria (RSD)—closer to emotional maximization and externalizing emotions.

An AuDHD person may tend toward one of these emotional profiles, or oscillate between feeling everything (sometimes catastrophically, often with RSD as the accelerant) and feeling nothing (sometimes for days or longer stretches of burnout). We also feel big things over small things (routine disruptions) and small things over big things (loss and grief).

Clinically, this can be the client whose emotional world looks explosive or chaotic, or the one who’s highly rational and intellectual about emotion while describing intense moments of losing control. It can be the client whose intensity in session is disorienting to sit with. The work tends to involve gradually expanding the window of tolerance, somatic regulation followed by emotional naming, and a steady, predictable therapeutic presence that creates space for the whole spectrum of feeling.

Not every AuDHDer will see themselves in all eight of these paradoxologies, and some will identify more with some than others. My survey respondents skew toward a particular slice of the community: Autistic adults with lower traditional support needs but high mental health needs, aged 30-60, with the literacy and access to complete a long online survey. The push-pulls I’ve described are common threads throughout the community, but the way they show up in clients will be shaped by demographics, support context, gender, race, class, and life stage.

And there’s an added twist: for most AuDHDers, these paradoxes are only part of the clinical picture.

AuDHD and Alphabet Soup

Complicating things for mental health providers, many AuDHDers live with a handful of sidekicks that accompany these paradoxes. In our community, we sometimes lovingly refer to this as our “alphabet soup.” For me it looks like OCD (I’ve ebbed and flowed out of meeting diagnostic criteria throughout my life), PTSD (recovered), anxiety, and bipolar 2 (which was originally misidentified as depression).

The DSM would have these things live in neat categories and checkboxes, but AuDHDers lived experience isn’t so neat, and neither is treatment. Many AuDHD people live with mental health conditions whose symptoms breed off and feed off what I call neurodivergent woundings: the organic harm that comes from being AuDHD in a world that often misunderstands us.

For example, when I struggle to remember a deadline, my keys, my phone, or whether I turned off the stove (thanks to executive function and working memory challenges), it’s easy to grow anxious about what I might be forgetting and whether someone will be upset with me. It becomes hard to trust my memory, and that mistrust creates fertile ground for more anxiety to grow. CBT or other anxiety approaches that don’t honor the AuDHD soil my anxiety has grown from will only get so far in helping me manage it. What I need is an approach that treats my anxiety as partly accurate and helps me tease apart which parts are which. For the anxiety that points to an underlying neurodivergent need, what helps is external scaffolding and accommodations that support my working memory (alarms, visual cues, lists). For the anxiety that has taken on a life of its own, what helps is mindfully noticing and unhooking the scripts while mapping them onto the core wound or raw spot they’re bumping into (a mixture of meta-awareness, mindfulness, and parts work).

When my energy system goes from excited bursts (fueled by interest and novelty) into collapse because I’ve burned out in a hyperfocus spell, I lose interest, curiosity, energy, and yes,

happiness. The depression that takes root after I’ve lost access to my interest-based nervous system has a different shape than classic depression, and treating it the same way will only deepen the collapse (behavioral activation, for instance, can re-trigger the very depletion that started the slide). What’s needed instead is gentle structure, nourishment, time with special interests, and strategic social withdrawal. I need help recognizing when my withdrawal has tipped from restorative to something feeding the depressive cycle. For an interest-based nervous system, interest isn’t the reward for getting better. It’s often the way back.

When my scrupulosity OCD rages, it usually comes from the context of having misstepped socially (scrupulosity is a subtype of OCD characterized by intrusive thoughts and compulsions related to ethical, moral, or religious concerns.) I’ve lost relationships, been chastised and punished, and even fired for the way I managed situations I didn’t understand. But my lack of understanding hasn’t done much to mitigate my shame and sense of culpability. When the world is uncertain and social norms are hard to decipher, OCD scrupulosity comes in as a way to manage rules I can’t otherwise read. How can we treat the OCD if we don’t know what it’s trying to protect against?

For years I walked through life in a foggy, dreamlike state. I explored with my therapist whether this dreaminess was repressed trauma. Why did I lose myself constantly, feel as if I were experiencing life from behind plexiglass? Without factoring in my sensory awareness issues as part of the clinical picture, the only available lenses I had were anxiety and trauma, and so I continued to disappear from my life rather than understanding my sensory shutdown.

Toward AuDHD Self-Understanding

The unfortunate reality is that AuDHD people fall through the cracks easily—and it’s not because of bad therapists. Fortunately, we’re living through a season of great discovery, and a whole

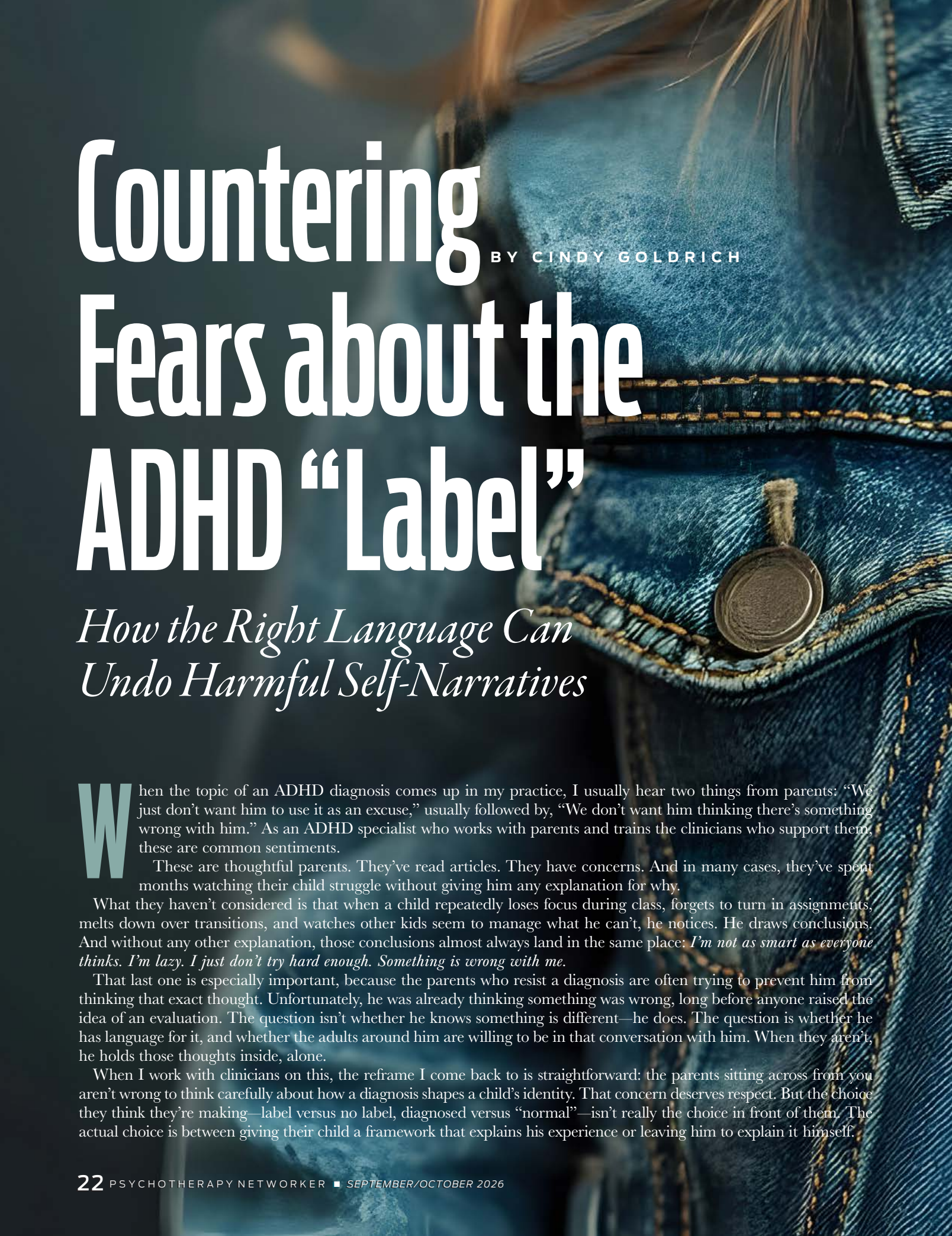
generation of adults who were labeled “depressed,” “anxious,” “OCD,” or “BPD” are beginning to recognize their full neurological context. Naming AuDHD doesn’t magically fix the challenges we live with, and it usually doesn’t change the felt experience of the push-pulls we navigate. But it offers context, and context is what so many of us have been missing for so long.

The first healing direction is often inward. Naming AuDHD helps us shed old shame-based narratives and build new ones. We start to see that we (our emotions, our experiences, our nervous systems) make sense in context. The shame-filled stories begin to loosen as we identify and validate our AuDHD needs. That shift from shame to self-compassion is where a lot of other psychological work becomes possible.

The second direction is outward. AuDHD reshapes what we understand about our needs and what kinds of support help. We can start to build ADHD scaffolding (external structure, reminders, flexible accountability) alongside autistic-centered care (sensory safety, transition scaffolding, predictability in relationships and environments). For those of us in clinical work, the invitation is similar: create space for the complexity and treat the push-pulls our clients describe as paradoxes rather than inconsistencies to be solved or analyzed away.

An AuDHD life often mirrors my experience in that swimming pool where I used to imagine being the Little Mermaid: serenity below, chaos above. Our work helps people learn to swim between the depths and the surface with less shame, gently noticing, over time, that the dives themselves, however protective, can’t carry the weight of life on their own. 

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Countering Fears about the ADHD “Label”

BY CINDY GOLDRICH

How the Right Language Can Undo Harmful Self-Narratives

When the topic of an ADHD diagnosis comes up in my practice, I usually hear two things from parents: “We just don’t want him to use it as an excuse,” usually followed by, “We don’t want him thinking there’s something wrong with him.” As an ADHD specialist who works with parents and trains the clinicians who support them, these are common sentiments.

These are thoughtful parents. They’ve read articles. They have concerns. And in many cases, they’ve spent months watching their child struggle without giving him any explanation for why.

What they haven’t considered is that when a child repeatedly loses focus during class, forgets to turn in assignments, melts down over transitions, and watches other kids seem to manage what he can’t, he notices. He draws conclusions. And without any other explanation, those conclusions almost always land in the same place: *I’m not as smart as everyone thinks. I’m lazy. I just don’t try hard enough. Something is wrong with me.*

That last one is especially important, because the parents who resist a diagnosis are often trying to prevent him from thinking that exact thought. Unfortunately, he was already thinking something was wrong, long before anyone raised the idea of an evaluation. The question isn’t whether he knows something is different—he does. The question is whether he has language for it, and whether the adults around him are willing to be in that conversation with him. When they aren’t, he holds those thoughts inside, alone.

When I work with clinicians on this, the reframe I come back to is straightforward: the parents sitting across from you aren’t wrong to think carefully about how a diagnosis shapes a child’s identity. That concern deserves respect. But the choice they think they’re making—label versus no label, diagnosed versus “normal”—isn’t really the choice in front of them. The actual choice is between giving their child a framework that explains his experience or leaving him to explain it himself.



ADHD

An ADHD diagnosis gives a family a direction, even if ADHD is an imperfect name for what it actually describes. What's imperfect? Most children with ADHD aren't "hyperactive" in any obvious sense. And "deficit" implies a shortage of attention, which isn't quite right either. What's actually happening is closer to a deficit in the *regulation* of attention—the ability to direct focus intentionally, to shift it when needed, to sustain it through tasks that don't generate their own stimulation. The brain's executive system—which handles things like planning, impulse control, working memory, and emotional regulation—isn't operating the way it does for most people.

It's also worth noting that ADHD looks different depending on who you're looking at. Girls are significantly underdiagnosed—not because they don't have ADHD, but because their presentation tends to be quieter: less bouncing off the walls, and more daydreaming, people-pleasing, and internalized frustration. By the time anyone thinks to evaluate them, they've often spent years believing they're simply not trying hard enough.

ADHD has accumulated decades of misunderstanding, stigma, and association with the most disruptive presentations of the condition. So when a parent hears it and flinches, that flinch is not irrational—the label carries baggage that has very little to do with their child. That said, a diagnosis importantly reframes the problem from a character issue to a neurological one. It opens the door to support, accommodation, and a different story for the child—from *I keep failing because something is wrong with me* to *My brain works differently, and here's what we can do about it*. That's no small thing. It's the whole ball game.

A New Framework

One framework that tends to resonate with families resistant to "labeling" is embracing the idea that we are all on a *spectrum*—not the clinical spectrum of autism, but in a broader, more fundamental sense.

Every human being has a profile of strengths and challenges, areas of easy competence and areas that require more effort. Executive function—the cluster of cognitive skills most implicated in ADHD—works the same way. Some people naturally organize time well but struggle with flexible thinking. Some are highly creative but find sequential tasks exhausting. Some have excellent emotional regulation and poor working memory. None of these profiles are disorders. They're simply the range of human variation.

For children with ADHD, the gap between how their brain manages these skills and what a typical school environment demands is wide enough to create real difficulty. That's not a moral failing, it's a mismatch—and naming it as such changes what the conversation is actually about.

When you offer this framing to parents, you're not minimizing the challenge. You're shifting it from a statement about who their child is to a description of how their child's brain works, and what that means for how he learns, relates, and moves through the world. Most parents appreciate that. It doesn't feel like a verdict.

At some point, if the family moves toward a diagnosis, there's a conversation that needs to happen with the child. And this is where many parents feel most stuck. They don't know what to say. They're afraid of saying too much, or the wrong thing. They worry about planting ideas. So they often say very little, or they frame it so carefully that the child understands something has been withheld.

What actually helps is directness—not clinical directness, but the honest, straightforward directness of a parent who wants their child to understand himself better. They might say something like this: "You know how some things feel harder for you than they seem to be for other kids? Like sitting still when you're not interested, or remembering what you're supposed to do next? We found out that's

because your brain works in a specific way. It's called ADHD, and it means your brain has a harder time managing attention—not because you're not smart, but because the part of the brain that helps with that works differently for you. A lot of really interesting people have ADHD. And now that we understand it better, we can figure out what helps."

The specifics will vary. What matters is the message underneath: *You are not failing. Your brain is working exactly the way it works. And we're going to figure this out together.*

Children who receive this message—even imperfectly delivered—tend to feel relieved. Something that felt shameful and private becomes shared. Named. Workable.

That doesn't mean they won't have complicated feelings about it. They will. Some kids resist the idea, at least initially. Some feel reassured. Some feel both at once. What they almost universally don't feel is worse than they did before. Because before, they were alone with something they couldn't name.

The Larger System

The harder conversation is often the one parents have to have with their own parents—or other people in their larger system—who may have raised children in a time when ADHD was either unknown or dramatically oversimplified, when "boys will be boys" was a diagnosis, when difficulty in school was more likely to be addressed with stricter consequences than additional support.

The pushback tends to cluster around a few predictable concerns: *Is this really necessary? Doesn't everyone struggle sometimes? Are you going to medicate him? We didn't have labels when I was growing up, and we turned out fine.*

It's worth spending time in session preparing families for these conversations. Not just validating that they'll be hard, but actually working through what to say. A few things that tend to help:

They don't have to defend the diagnosis. They can simply describe

what they're observing. "We've noticed that certain things are genuinely hard for him—not just normal-hard, but in ways that are affecting his confidence and his relationships. We're trying to understand it so we can help him." Most people, whatever their views on labels, will not argue with a parent's desire to help a struggling child.

They can offer the spectrum framing. "The doctor explained that everyone has different strengths and challenges, and his brain has a specific pattern that makes some things harder. This just gives us a name for it and a direction for support." This is usually less threatening than the clinical language, and it doesn't require a debate about whether ADHD is real.

They can set a boundary without making it a battle. "We understand you see it differently, and we know you love him. We've made this decision based on what we're seeing at home and at school, and we'd love your support even if you're not sure about it yet." That last phrase—even if you're not sure about it yet—leaves room for grandparents to come around without requiring them to concede anything in the moment.

None of this is guaranteed to work. Some people will stay skeptical, and families have to decide how much energy to spend on that. What matters most is that the child isn't caught in the middle—that whatever the adults disagree about, the message to him stays consistent: *We understand you better now, and we're on your side.*

There's a shift that tends to happen in families that do this well. Not right away, and not without some stumbling, but eventually. The child starts to use the language himself. He'll say something like, "I need to do my homework right after school or my brain won't do it later," or "I work better with the door closed," or simply, "That's an ADHD thing for me." He's not using it as an excuse. He's using it as information—which is exactly what it is.

That kind of self-knowledge doesn't come from pretending nothing is dif-

ferent. It comes from being given a framework early enough, and honestly enough, that it becomes part of how he understands himself, rather than a label someone else attached to him.

This is what parents are trying to protect against when they resist a diagnosis—a child who sees himself as broken, who stops trying because a name gave him an out. That fear isn't unreasonable. It can happen. But it's far more likely to happen when the diagnosis is treated as something to be ashamed of, or discussed only among adults, than when it's handled as one straightforward fact among many about who this child is.

The label isn't what defines him. The silence, and the story it leaves him to fill in on his own—that's the real risk.



Below is a list of books parents might use to introduce ADHD through literature. I always recommend that parents read the books themselves first so they're prepared to answer questions their children may have.

Picture books (ages 4-8)

My Whirling, Twirling Motor by Merriam Sarcia Saunders – focuses on the hyperactive-impulsive presentation, reframes restlessness as energy rather than a problem

My Brain is a Race Car by Nell Harris – a gentle, child-friendly metaphor that makes the "different brain" conversation accessible without pathologizing it

Included by Jayneen Sanders – broader neurodiversity framing, good for classrooms and siblings as well as the child with ADHD

Early chapter books (ages 7-10)

Cory Stories by Jeanne Kraus – a straightforward introduction to ADHD written for the child, rather than about them, that includes information on medication and support

This Morning Sam Went to Mars by Nancy Carlson – engaging story that includes a note at the end with con-

crete strategies for parents to use with their child

Middle grade (ages 9-13)

Each Tiny Spark by Pablo Cartaya – features a strong female protagonist with ADHD dealing with school, family, and a father returning from deployment; the ADHD is part of who she is, not the whole story

Fish in a Tree by Lynda Mullaly Hunt – centers on a character whose budding confidence inspires classmates to stand up to bullies, resonates with middle schoolers who may feel alone

Hank Zipzer series by Henry Winkler – based on Winkler's own childhood with ADHD and dyslexia, full of humor, and any kid who learns differently will really identify with Hank

Teens (ages 13+)

ADHD in HD: Brains Gone Wild by Jonathan Chesner – nonfiction, bright and engaging format, over 60 short chapters on distinct topics like dating, homework, and family life; well suited for teens who won't sit with a traditional self-help book

Trout and Me by Susan Shreve – a frank look at ADHD for ages 9-12, gives kids a lot to think about without being heavy-handed

Percy Jackson series by Rick Riordan – Percy is one of the very few fictional characters with ADHD who is defined by more than just the diagnosis – the ADHD and dyslexia are reframed as attributes of a demigod, which is a powerful reframe for kids who are tired of feeling broken. 📖

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BY GABOR MATÉ & LIVIA KENT

ADHD and the Science of Stress

A Conversation with Gabor Maté

Roughly one in nine American children will be diagnosed with ADHD this year—nearly double the rate from 25 years ago. And yet many parents, teachers, medical professionals, and even clinicians routinely miss the lesser-known signs, the toll it takes on relationships and self-esteem, the mental health consequences, and the very real harm of misdiagnosis. In other words, even though ADHD has entered the mainstream, a nuanced understanding of it has not.

Physician and bestselling author Gabor Maté—best known for books on addiction and trauma, including *In the Realm of Hungry Ghosts* and *The Myth of Normal*—has spent decades arguing that the science tells a far more complicated story about ADHD than the one many of us believe. In fact, his first book, *Scattered Minds*, came into being in large part because Maté himself received a late ADD diagnosis, along with medication that helped him focus enough to write it. Since then, some of his views on ADHD have run counter to conventional wisdom and even sparked controversy.

In the conversation that follows, Maté unpacks the science behind his thinking on the environmental factors that contribute to brain development and ADHD—and shares what it's taken to make peace with himself as someone who regularly loses laptops on planes without ever leaving his chair.



Psychotherapy Networker: You're most well-known for your work on trauma and addiction. How did you first get interested in ADHD?

Gabor Maté: I got interested in the subject 27 years ago, when I was diagnosed with ADD. A few months later, so were my kids. It was then I wrote my first book, *Scattered Minds: The Origins and Healing of Attention Deficit Disorder*. I'd always wanted to write books, but I could never get myself organized enough or motivated enough to do it until I understood my own mind.

I took medication to help me concentrate when I wrote *Scattered Minds*. I wouldn't have been able to do it otherwise. I've written five books since then, including *The Myth of Normal*, and didn't need medication to write them.

What does that mean? It means the brain can change, and this is good news because ADHD is a condition of the brain. It's a neurodevelopmental disorder. It does have certain biology associated with it, but that biology is responsive to the environment.

PN: People claim that you deny the role of genetics in ADHD. How do you respond to that?

Maté: It's not true, and only people who haven't read my work can claim so. In *Scattered Minds* and other books, I fully discuss the role of genetics. Genes *do* play a role in all manner of conditions, including ADHD. The question is, what kind of role? And the answer lies in the essential difference between predetermination and predisposition.

Predetermination means that if you have a certain gene, you'll have that condition—for example, Huntington's disease or types of muscular dystrophy, such as runs in my own family. And if you don't, then you won't. Predisposition means that if you have a certain group of genes, you're more than likely to develop that condition. Predisposition is not the same as predetermination—genes develop and unfold and express themselves in interaction with the environment.

Russell Barkley, one of the critics of my work on ADHD, has never read

my book, as he admitted to me; yet he took it upon himself to critique my work on YouTube. I read his book, *Attention-Deficit Hyperactivity Disorder: A Handbook for Diagnosis and Treatment*, which he published decades ago. In fact, I quote him in *Scattered Minds*. He's done a lot of good research on ADHD, and he reports, for example, on a large 1989 study of twins, both identical twins and fraternal twins. Identical twins have exactly the same genes. Fraternal twins are like any sibling pair: they share some of the same genes but not all of them.

According to the most recent information, if an identical twin has ADHD, their identical twin has a 75 percent chance or higher of also having ADHD. In fraternal twins, there is up to a 30 percent concordance. Now, if ADHD is *only* genetic, it would be 100 percent concordant. But in fact, those high concordances are an overestimate, since if the twins, whether identical or fraternal, grow up in the same home, there's no telling what's environmental and what's hereditary. This is where adoption studies come in.

PN: Before we get into that, let's talk a little about what brain development has to do with ADHD.

Maté: There's no shortage of information on how the brain develops, but I'm going to read you a sentence by Jack Shonkoff and colleagues from an article in the official journal of the American Academy of Pediatrics: "The architecture of the brain is constructed as part of an ongoing process that begins before birth, continues into adulthood and establishes either a sturdy or a fragile foundation for all the health, learning, and behavior that follow."

The architecture of the brain means the chemistry, the circuitry, the connections, the synapses—and what I just read points to the fact that the brain is already being constructed in the womb. And we know from multiple studies that if a woman is chronically stressed during pregnancy, stress hormones, like adrenaline and cortisol, get through to the baby and affect the development of the brain. When women experience stress during

pregnancy—as, through no fault of their own, many do in our troubled culture—their kids have a higher risk of mental health and self-regulation challenges, including ADHD. That's the first point.

The second point is that a lot of the genetic hypothesis rests on adoption studies. Since the role of intrauterine stress and its impact on the developing brain has been established by multiple studies beyond any valid doubt, even when twins were adopted to different families it's not true that they had different environments.

Any woman who's forced to give up her infants for adoption is likely to be stressed. Maybe she's poor, addicted, an unsupported teen, perhaps even abused. Those twins shared the same stressed womb for nine months, received the same stress hormones which affect the brain. And then, they both experienced the trauma of separation from the birth mother. This is why, when you look at an ADHD population, their chance of having been adopted is exponentially higher. So, as I discuss in *Scattered Minds*, these oft-cited adoption studies tell us much less than you'd think. And if you want to read an extensive debunking of twin research, see *The Trouble with Twin Studies* by Jay Joseph.

The third point is that there are 20,000 genes in a human genome. Of those 20,000 genes, about half of them are dedicated to the central nervous system. In the human nervous system, there are about 86 billion nerve cells, or neurons, which form from 100 trillion to 500 trillion connections, or synapses. If you add up all the nerve cells in the human brain and stretched them into one line, it would wrap around the earth 10 or 15 times. There are simply not enough genes to account for the variability of the potential circuitry and connections and unfolding of the human brain. That all happens in the impact of the environment.

Another sentence from the American Academy of Pediatrics article reads, "The interactions of genes and experiences literally shape the circuitry of the developing brain, and is critically influenced by the mutual responsiveness of adult-child relationships, particularly in

the early childhood years.” In other words, it’s not genes by themselves. It’s the experiences acting on the genes, because genes are turned on and off by the environment. You can have the same genes and different environments, and get totally different outcomes.

We know this from monkey studies. Certain monkeys are more prone to being hyper-reactive, and they’re called high reactors. Brought up in a certain way, they’ll be bullied by other monkeys, ostracized, and less capable of self-regulation. Put those same monkeys with what are called “super mothers,” and they become leaders. They become more creative, confident, capable. Same genes, different outcomes based on how the environment is acting on the genes.

Nobody has found any particular gene directly linked to ADHD. What they found is a large group of genes, and the more of them you have, the more likely you are to have any number of mental health conditions, including ADHD or depression or anxiety. As a recent review in *The New York Times* summed up, scientists at most have identified a “complex collections of genes that together may be signs of greater risk for ADHD.” Notice the “may be.” Far from a predetermination.

In any case, there is nothing we can do about genes. But there is much we can do about the environment. That’s the point I make in *Scattered Minds*, also echoed in the *NYT* review: “Rather than trying to treat and resolve the biology, we should be focusing on building environments that improve outcomes and mental health.”

PN: The second part of the sentence from the article you read mentions early childhood relationships in the context of the developing brain, which is a major part of the environmental factor you’ve been talking about, right?

Maté: Yes, the most important influence is the quality of interactions with adults and parents. As the renowned psychiatrist Dan Siegel points out, “Human connections create neuronal connections.” And, as trauma expert Bruce Perry writes, “Developmental experi-

ences determine the organizational and functional status of the mature brain.”

What’s happening in this culture and the reason you’re seeing so much more ADHD and other mental health conditions, from bulimia to self-cutting, isn’t due to anything genetic. No one thinks there’s a self-cutting gene out there. The reason is because the conditions under which children develop are becoming more and more stressful. Stressed parents have interactions with their children that are less conducive to a healthy brain. And that’s not the fault of individual parents—they do their best and love their kids. That’s the function of the culture.

PN: Even still, a lot of parents will feel blamed and guilty.

Maté: Yes, unfortunately in this culture of blame that may be true. But in each of my books, I point out that blaming parents is inappropriate, unscientific, and cruel. It’s not the fault of individual parents—it’s owing to what in my most recent book, *The Myth of Normal*, I call our toxic culture.

Here’s the deal. For millions of years, humans lived in small groups where children were parented by the whole community. And parents had all kinds of support. I cite the evidence for that in my writing, particularly *The Myth of Normal*. That’s no longer the case. The psychologist and researcher Darcia Narvaez has studied original cultures. She says we’ve lost the “social commons” for living. We have become “species atypical.”

Stress is a fact of modern life because modern life is increasing our isolation. We have less community and more economic insecurity. In the United States, 25 percent of women have to go back to work within two weeks of giving birth.

What I’m saying is that ADHD does run in families, but that doesn’t make it genetic. The genes don’t predetermine. They represent sensitivity. This statement is apparently controversial. I can’t understand why. We know these kids are genetically more sensitive. They have more allergies, more asthma, more frequent colds, more eczema. They have more respiratory allergies, more ear infections. Statistically this is

true for ADHD kids. Why? Because they’re more sensitive. What are allergies? Hypersensitivities. Which also means that the more sensitive you are, the more you’re affected by the environment. When things are stressed, it affects you more deeply. That’s what’s genetic. That’s the predisposition.

Sensitivity is from the Latin word *sentire*, to feel. They feel more, and that’s how they’re born. That’s not a fault. It’s simply a fact. It means they’re more creative, more intuitive, more full of life in some ways. But it also means when there’s stress, they’re more affected by it. So that’s what’s inherited: the sensitivity. And the good news is that if we give them the right environment, they respond more positively because they’re more sensitive.

PN: You often get accused of saying that ADHD is caused by trauma. How do you respond to that?

Maté: That’s really interesting, and it’s often repeated by people who have never read a word I’ve written, such as Dr. Barkley. *Scattered Minds* has 105,000 words in it. If you do a word count, you will find that trauma only comes up four times, and never as the cause. Now yes, there is a direct relationship between trauma and ADHD according to many studies, but I’ve never said it’s the cause. I’ve never said it, because I don’t believe it. What I do say is that stress is part of the modern parenting environment. That’s different.

In my case, I had a very stressed infancy in the second world war under the Nazis. My kids were born in peaceful Canada, but when my wife and I were young parents, we were stressed and had issues we hadn’t worked out. So the atmosphere in our home was loving, but not very stable. This is all to say that we pass on traits not just because of genetics, but because we create environments from one generation to the next where certain traits are expressed, and therefore certain behaviors and certain patterns are repeated.

Again, as Dan Siegel says, human connections create neuronal connections. Human connections shape the brain. In

the first year of life, every second, millions of circuits are being laid down. Genes can't do that. Dan says, attachment establishes interpersonal relationships that help the immature brain use the mature functions of the parent's brain to organize its own processes. That assumes that the parent's brain is mature. But if you look at my brain, when I was a young parent: yes, I was a successful doctor, but I was emotionally immature in many ways. That affected my children's brains when it came to emotional regulation.

One of the commonalities between addiction and ADHD is poor impulse control. Impulse control is a part of the brain called the right orbital frontal cortex. It develops under the impact of the environment. When the environment is stressed, this part of the brain doesn't develop as well as it should.

PN: Parenting ADHD kids can be incredibly stressful on top of it all. What's the best approach?

Maté: When it comes to parenting ADHD kids, there are two possible goals. One is behavior: *I want you to behave the way I want you to behave right now.* Or you can have the developmental goal: *I want you to develop in a way that nature works out for you according to your own inclinations and needs.* Sometimes what we do to achieve our behavior goals undermines the developmental goal. This starts very early on when you give kids timeouts for not behaving in a certain way and lose the relationship because you leave the room.

The essence of development is relationship, relationship, relationship. We have to build a safe relationship with a kid, so they want to belong with us, want to respect us, want to follow our guidance. The way to help ADHD kids is to make sure that the relationship is working for them. And we have to attune with them, to get and reflect what's happening inside them.

This is difficult for some parents to hear even though no blame is implied or intended, but what's often missing for the kids is not lack of parental love or lack of parental dedication or com-

mitment, but lack of attunement. The more stressed parents are, the more trouble they have attuning to their kids. Not because they don't love their kids. Not because they aren't doing their best. But simply because a stressed person is less able to attune with another human being.

ADHD kids need a lot of attunement, which means we really have to get what's happening inside of them. So instead of focusing on trying to change their behaviors, let's focus on changing their environment so they feel safer and more comfortable in the world. It can't be a question of *I'll be pleased with you or cuddle you when you please me.* The relationship has to be absolutely secure.

I remember my own parenting and how volatile I was. I sometimes yelled at my kids. And every time I did, I was breaking the relationship. I didn't know that, but I was. It's the parent's job to make sure the relationship is absolutely secure no matter what the kid does. That doesn't mean permissive parenting, where the parent doesn't take up their authority. The parent needs to be in charge, and the child needs to feel the parent is in charge—otherwise they feel terribly insecure. And it doesn't mean authoritarian parenting—my way or the highway—because the child doesn't feel attuned to or understood or accepted in that scenario.

The best parenting is authoritative parenting, where the parent is in charge but the relationship is still central and the parents really understand what's going on inside the child. That means they don't judge their children, don't accuse them of anything, don't call them lazy.

PN: A lot of ADHD kids get called lazy. What's really happening?

Maté: Largely, what people are seeing has to do with the dopamine circuits in the brain. Dopamine is the incentive motivation chemical—our brains are wired for it. But ADHD is linked to a dysfunction in how the brain regulates dopamine. So the lazy kid is not really lazy. They're just unmotivated. As Bruce Perry points out, early stress can deplete dopamine receptors. And we know that

from monkey studies as well—the good news being, that good environments can replenish dopamine receptors.

PN: So how do you help them with motivation?

Maté: The answer is you don't. You can motivate kids with rewards, but as soon as you stop the reward, they reject the activity. They sense the coercion. You can go heavy on praise, but that undermines the child's sense of intrinsic motivation. So the question is, how do you promote healthy intrinsic motivation? Well, you do it by providing a safe environment and making a child feel good about themselves.

My other advice is don't parent when you're angry. I'm not saying don't be angry. You can't help being angry—you're a human being—but don't parent from it, because they'll perceive you as a threat. And don't take the oppositionality personally. That means you're not attuned.

PN: But kids spend so much time outside the house. What happens there?

Maté: If the parents need to work, the daycare needs to be seen as an essential venue for child development, so everyone who works with children needs to be trained in attachment, in the importance of human attachments in promoting brain development. In that sense, there needs to be a much better ratio of adults to children than one adult for every six or seven kids. That doesn't work.

PN: We've been talking a lot about kids. But you were diagnosed late in life. What about adults with ADHD?

Maté: As an ADHD adult, you have to decide to be your own parent. You have to ask, what conditions do I need for myself? Look at the stresses in your life. Some stresses are unavoidable. Life is stress, especially in this culture. But what am I doing that takes on more stress? Am I trying to do too many things at the same time? Am I in a relationship that's stressful? Am I multitasking? Am I spending inordinate time on screens,

which affects my brain negatively? Can any of that be worked on?

Also, people with ADHD tend to gravitate toward junk food because it's soothing. But you have to consider your diet. Physical exercise is so important, too. And meditation. If you stay focused for 30 seconds, or 20 minutes, it's a great success. It's good for you just to sit and maybe try various breath techniques. Screens: these are designed to be addictive. Minimize your screen time.

Self-esteem is a huge issue for people with ADHD. When you ask people why they think they have poor self-esteem, they'll say because I never finish anything and I'm always messing up. *I'm sorry* is the most common phrase in the ADD vocabulary, as Dr. John Ratey has aptly said. But genuine self-esteem has nothing to do with that. People have value just because they exist.

Personally, I can't stop losing things. Every time I travel, I lose something: a toothbrush or electric dental flosser or a book or two. And I'm very good at leaving laptops on airplanes. It's a specialty of mine. In fact, I can sit in one spot and lose something without moving. But I don't beat myself up over it any more. Losing things is the cost of being me. It's a frustration, but it's not the end of the world. That's self-acceptance.

PN: What about the overlap between ADHD and addiction?

Maté: Anyone who read *In the Realm of Hungry Ghosts* knows that I worked with North America's most concentrated population of addicts and substance users in the downtown side of Vancouver. In that book, I have an appendix on ADHD and addiction because so many of my clients there had untreated, undiagnosed ADHD. There's a huge link between addictions and ADHD: something like 30 percent of stimulant addicts have diagnosable ADHD. In one study, 40 percent of adult male alcoholics had diagnosable ADHD.

It makes sense that a lot of addicts are actually self-medicating their ADHD. What do we do pharmacologically for ADHD? We give stimulant medications that elevate dopamine levels. Cocaine,

meth, nicotine are also all stimulants. Gambling can also be a stimulant. Addicts and ADHD share an impulse control problem, and a problem with dopamine. Dopamine, remember, is the incentive motivation chemical, and it helps to calm you. Plus, all addictions are attempts to soothe emotional pain, and people with ADHD carry a lot of emotional pain because of their sensitivity. They feel more.

So it's really important when you're dealing with people struggling with addiction to screen them for ADHD. But the history has to predate the onset of the addiction, because if you're on drugs, you might behave like you have ADHD. Similarly, if you're dealing with people with ADHD, check them for addictions.

PN: Earlier, you mentioned that even though you once took pharmacological stimulants, you don't now. Can you say a bit more about your view on medication for ADHD?

Maté: I'm not against medications. As a physician, I used to prescribe them all the time. But keep in mind that studies don't show medications can help short attention spans and behaviors in the long term.

That doesn't mean they can't help in the short term. One woman in her 80s told me that when I gave her Ritalin, it was the first time in her entire life she could sit down and be calm. For an adult, it's a simple matter of trying them. If they don't work, just stop taking them. If they work, great. But there are side effects. Ritalin made me depressed. When I took Dexedrine, it helped me concentrate but made my workaholism worse.

As an adult, you can weigh the benefits with the side effects. You can determine when to take it if it helps. But don't take medication to feel better about yourself or to resolve your self-esteem issues. And no child should get the message that they have to be medicated to please adults in their life. That's a terrible message.

I would ask a child at any age, "Are you having problems concentrating? Does that bother you? If there's a medication that might help you focus and function better, and if it didn't cause you

negative effects, would you be willing to try it?" In other words, the child needs to be involved in the decision-making. No child should be forced to take medication.

The goal of medication should not be behavior control. You can give hyperactive kids Ritalin, and they'll sit there like zombies who don't bother the teacher anymore, but what have you done to their internal life? Medications don't promote development. They should never be the only answer, and rarely should they be the first answer. First, try other kinds of support, more play time. Sometimes they might have to leave the classroom. That's okay.

PN: What's the biggest thing we can change in how we approach ADHD as a field right now?

Maté: The first sentence of my book *Scattered Minds* is: "Until four years ago, I understood attention deficit disorder as well as the average North American doctor—which is to say, hardly at all." The average physician doesn't get any training on ADHD. So how would they recognize it? And teachers don't get taught about it much. So they see ADHD kids in the classroom and just think they're having behavior issues. Caregivers, psychologists, counselors, social workers, educators, daycare workers—they need more education so they can learn to recognize it. That's the bottom line. In the absence of education, it's a sad situation. 

Gabor Maté, MD, is a retired physician who, after 20 years of family practice and palliative care experience, worked in Vancouver's Downtown East Side with patients challenged by drug addiction and mental illness. He's the bestselling author of five books published in 43 languages, including the award-winning In the Realm of Hungry Ghosts and his most recent, The Myth of Normal: Trauma, Illness and Healing in a Toxic Culture. His next book, Hello Again: A Fresh Start for Parents and Their Adult Children, is expected to be published in April, 2027.

Livia Kent, MFA, is the editor in chief of Psychotherapy Networker.

BY DONNA HENDERSON & SARAH WAYLAND

Helping Parents with Neurodivergent Kids

*What Are Well-Meaning
Therapists Getting Wrong?*





Picture a support group for parents of children with behavioral challenges. All the parents gathered in a tight circle were raising neurodivergent children, but some of the parents didn't know it yet.

Diane's son, 11, was recently diagnosed with ADHD and struggling with intense, though undiagnosed, anxiety. Diane had spent the last two years reading, researching, emailing teachers, and requesting meetings. Her son's therapist had finally suggested that Diane might want to examine her own anxiety before assuming her son needed more support. "Your son is picking up on your worry," she'd said. Diane had nodded, driven home, and stopped telling anyone how worried she was.

Marcus's daughter was eight, Autistic, and had stopped going to school five months ago. He and his wife had seen a string of therapists who'd each recommended behavioral approaches, which always seemed to make things worse. The last therapist had been direct: they were enabling their daughter's avoidance. The solution, he'd said, was to stop "over-accommodating." Marcus had tried that for nine days and had never told anyone what those nine days were like. He was tired of the judgment.

Priya's son was 13. He'd had multiple evaluations, multiple diagnoses, multiple therapists. The most recent therapist had looked over the list of things they'd tried and said, admiringly, "Wow, you've really done everything, haven't you?" Then: "I wonder if all that effort sends him a message that he can't cope on his own." Priya had left that session and sobbed in her car for 20 minutes.

Tom's son was nine, and a school counselor had recently used the phrase "helicopter parenting" in a meeting with him and his wife. His wife had cried all the way home. As far as Tom could tell, his son had never once had a transition go smoothly, never once eaten a meal without negotiation, never once fallen asleep without one of them sitting on the floor next to his bed. Tom didn't feel like a helicopter parent. He felt like a parent standing in the rubble of every strategy anyone had ever recommended, wondering what he'd done wrong.

Sandra had worked in special education for 20 years before becoming a parent, which made the blame she encountered for her child's behavior even more painful. Her daughter's therapist had suggested a residential placement, framed as an opportunity for her daughter to "build independence in a more neutral environment." Sandra had heard what was behind the recommendation: Your home is the problem. Although she hadn't moved forward with the referral, she had started worrying that her home wasn't the safe harbor she'd worked so hard to create.

The Traditional Frame

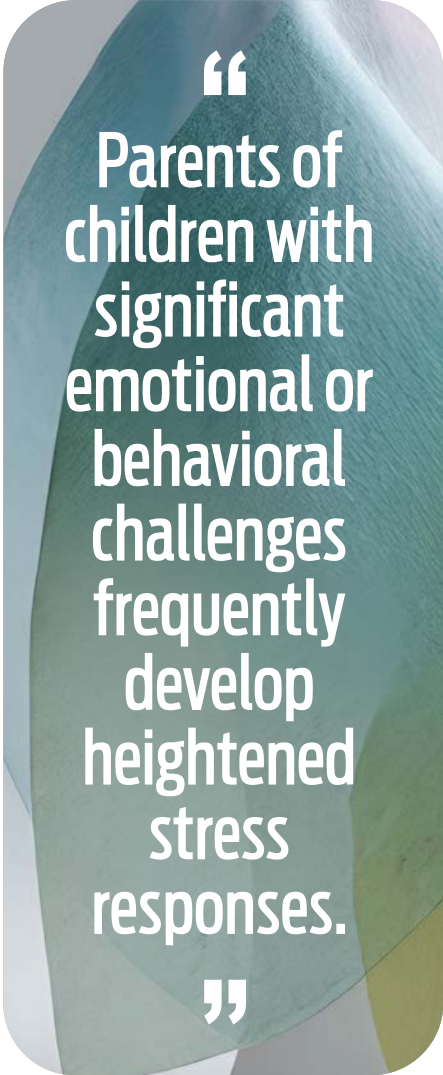
Each of these five parents had been seen by well-trained, thoughtful, empathic clinicians who genuinely wanted to help them. And yet they'd all left feeling at best, misunderstood, and at worst, and like they were the problem.

This isn't about bad clinicians. It's about a set of underlying assumptions so embedded in mainstream therapeutic training that most of us have never examined them. Those assumptions? When a child is struggling, it's because something in the environment isn't working. And in a family system, that almost always means the parents.

Of course, parents shape their children. The science is clear that early relational experience matters, so the clinical instinct to look at caregiving patterns is not a mistake. But it becomes a mistake when it operates as the *only* lens through which we see children with emotional or behavioral challenges.

When a child has ADHD, autism, a PDA profile, sensory processing challenges, or other neurodevelopmental differences, their behavior is influenced by a nervous system that is wired differently. The environment matters—but as a source of friction or accommodation, not as the cause. That understanding changes our approach to the family in front of us.

As clinicians, we are trained to look for what we can change. We have some hope of changing a parent's behavior; we cannot change how a child is wired. So we are more likely to look to the caregivers and design interventions for them. But in doing so, we can inadvertently communicate something we never intended: the parents are the reason this is happening, or the



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parents are inadvertently making it worse.

The Child Also Shapes the Parent

Here's a reframe we find useful: The parent shapes the child, as we all know, but the child also shapes the parent.

This reality is based in neuroscience. Chronic exposure to a dysregulated child, as well as chronic invalidation and isolation, changes the caregiver's nervous system over time. Parents of children with significant emotional or behavioral challenges frequently develop heightened stress responses and patterns that can look from the outside like anxiety, rigidity, or overinvolvement. Clinicians often view these patterns and responses as problems or even character flaws, but they are more accurately seen as understandable adaptations to living with a child whose nervous system is chronically unpredictable and in distress.

Take Diane, for example. A clinician who senses Diane's anxiety and concludes that it might be dysregulating her son is only seeing part of the picture. The reality is that Diane's vigilance developed in response to years of watching her son struggle while others minimized her concerns. Her worry is not the *reason* for the problem. It's a reasonable *response*. It's also information.

With Marcus, what may look like passive parenting actually reflects the exhaustion of a father who tried what all the professionals recommended and found that it made things dramatically worse. And Priya's relentlessness is the rational behavior of a parent who learned that if she didn't advocate fiercely, nothing would happen. Tom's presence at every transition, every meal, every bedtime wasn't helicoptering: it reflected the accumulated knowledge of a parent who has learned what his son needs.

Why Do Well-Meaning Therapists Miss This?

One reason this pattern is so common among skilled, caring clinicians has to do with our training. Most therapeutic models assume that behavior is driven by the environment. And even when the models acknowledge the contribution

of biology, intervention is usually aimed at the environment. It does make sense to focus on what we have some hope of changing—in this case, a parent's behavior. However, just because we can change something doesn't mean it is the underlying cause.

Of course, parenting matters and family dynamics are important. However, focusing exclusively on those factors is like adding only half the ingredients to a recipe. It won't produce the desired results. It's better to begin the clinical narrative by deeply understanding the child, not by evaluating the parents.

Another reason for this pattern of blame has to do with our own nervous systems. Clinicians are human. Sitting with a family in crisis—a child who's dysregulated, parents who are exhausted and frightened—activates something in us. There's a pull to find something actionable, like a behavior management framework, but sometimes it's the wrong recommendation and may make things worse. When we recommend that parents "stay calm," "use consistent limits" or "try a reward chart," it may be that our own nervous system is seeking something concrete and actionable. In our experience, clinicians, like parents, are most effective when we are informed observers of our own nervous system.

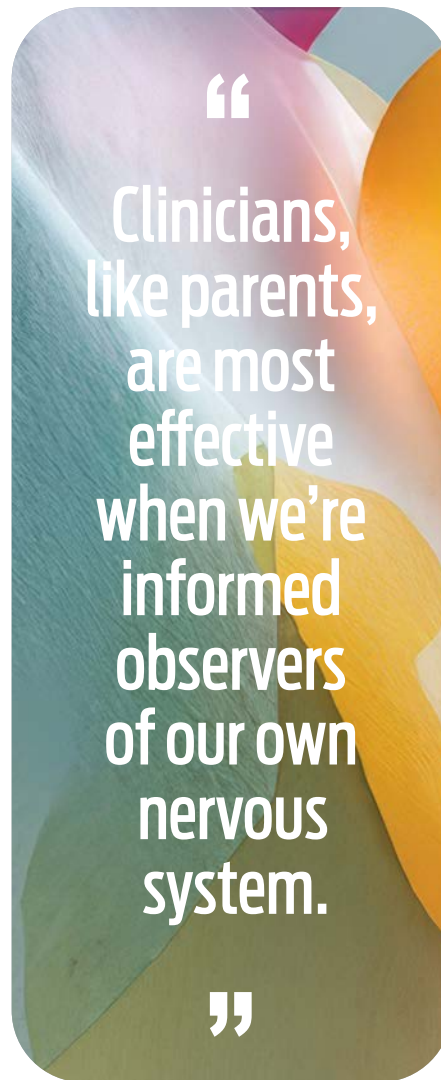
These cases are genuinely complex. Trauma, mental illness, relational dysfunction, and chronic stress all contribute to child outcomes, and clinicians are right to consider them. The difficulty is navigating that complexity while also understanding that a neurologically different child shapes the family over time. That complexity requires careful assessment and a willingness to sit with uncertainty, which can be uncomfortable.

What Might Help

Here are six principles that can guide clinicians working with parents of neurodivergent children.

Principle 1: Be aware of assumptions and language.

Develop awareness of the "blame frame." Make a practice of regularly asking yourself, "To what extent am I operating from an underlying belief that the parent is the problem?" This clinical self-check can help you become more aware of your subconscious



assumptions, for example, when you feel frustrated with the parents or notice yourself thinking, "Why don't they just...?" If this happens, of course, question yourself gently and with compassion, not as an accusation.

Diane's anxiety was unmistakable. But before treating it as an

obstacle, the clinician might have paused and asked what triggered her worry. Parents of children with differences are often the first to grasp the gravity of the situation, and Diane's vigilance accurately reflected her son's distress when no one else took it seriously. Her observations deserved to be treated as clinical data, because they are.

Be aware of the parents' nervous systems. It's also important to remember that the parents' nervous system matters. There's a meaningful difference between "How do you respond when he does that?" and "How does your body respond?" The first suggests that character is at play; the second focuses more on neurology and physiology. As psychologist Jonathan Dalton puts it, the goal is for everyone to become informed observers of their own nervous systems.

Instead of saying to Diane, "Your son is picking up on your worry," a more useful approach validates her worry first, and only then introduces a nervous-system lens with something like, "Your son's system is generating a lot of activation right now, and that's going to affect everyone around him, including you. You're clearly deeply attuned to his struggles." Likewise, instead of telling her to stay calm, which invalidates the reality of her legitimate nervous system response, it's more helpful to validate her concern and then brainstorm what she can do when she's activated.

Watch your pronouns. Our language reflects our underlying assumptions. There's a meaningful difference between "you tend to..." and "we tend to..." The first is vaguely judgmental; the second keeps the clinician alongside the parent. Saying, "Your child is picking up on your anxiety," places the clinician above the parent, judging. If the clinician had said, "We caregivers tend to absorb a lot, so it makes sense that we get activated,"

Diane would have felt that her therapist was with her in the struggle.

Principle 2: Validate rather than solving problems.

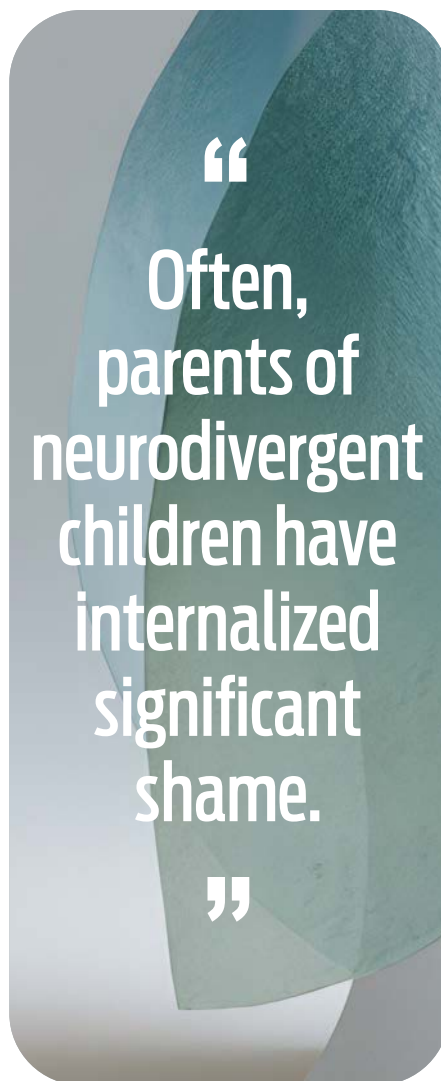
Resist the urge to solve the problem. When situations are incredibly difficult, offering solutions and advice may not be helpful, and may, in fact, be harmful. For example, with Marcus and his Autistic daughter who has stopped going to school, the pressure to do something is intense because the situation is intense. Marcus's therapist felt the pressure and reached for the most available tools: push harder, accommodate less, stop enabling. However, for a child whose school avoidance grows out of nervous system overwhelm, rather than learned behavior, the advice to "stop accommodating and start requiring" will only further dysregulate the child. This was Marcus's experience.

Focus on "being" rather than "doing." So many of these problems can't be solved in a conventional sense. As therapist Sondra Wolff reminds us, sometimes therapy is more about *being* rather than *doing*. The clinician who can tolerate uncertainty—who can sit with a family in a hard situation without rushing to fix it—is offering something genuinely helpful. Part of being with the client is simply naming the pain of an incredibly difficult situation. Never underestimate the profound power of validation!

Name the shame. Often, parents of neurodivergent children have internalized significant shame. It's so profound that many clients will hide important information from their therapist for fear of judgment. Simply naming the shame can shift the therapeutic work: "Parents in this situation wonder if this is their fault. It isn't." Even when there's parenting work to be done, this statement is true and necessary. Many of these parents have never

heard this, much less internalized it. As parents of neurodivergent children ourselves, we can assure you that this is one of the most powerful things you can do for your clients.

Validate. More than anything else, Marcus needs someone to name the impossible position he's in. On the one hand, accommodating his daughter's school avoid-



ance eases her distress. On the other hand, not only does Marcus need to go to work, but he worries that not pushing her to go to school is getting in the way of important opportunities for growth. One place to start is by encouraging curiosity with something like, "I don't know yet what's

right for your daughter, and I won't pretend otherwise. What I want to understand is what happens in her nervous system when you talk about school."

Principle 3: Understand and validate the cycle of effort.

Understand the cycle of effort. We've noticed that parents go through a cycle of effort: searching for answers, becoming exhausted, recovering, and then searching for new answers. They or others may perceive this cycle as repeated failure. This cycle is common, inevitable, and a sign of resilience. It helps to name the stages of that cycle as an understandable human response to an extraordinarily difficult situation.

When the clinician framed Priya's sustained effort as inadvertently communicating a lack of faith in her son, she inadvertently misapplied the concept of fostering autonomy, which is complicated in the context of parenting neurodivergent children. Priya's relentless search for answers reflects the rational strategy of a parent who learned early that the system would not advocate for her child unless she did.

Acknowledge and assure. The first move with a client like Priya is acknowledgment. You could say something like, "I'm not sure where to start. You've clearly done so much, and this is enormously complex. I want you to know I'm not going to give up on you, just as you haven't given up on your son."

Principle 4: Presume competence, and still teach.

Presuming competence means you know your clients are resourceful. By the time they're in your office, they've likely tried many of the usual (and unusual!) things that are recommended to resolve their issues, and mostly these things haven't worked. Even if the parents aren't yet fully competent, *assuming they*

are will help them feel like a valued partner.

Educate. If the parent doesn't already know about how a neurodivergent nervous system works, psychoeducation is almost always a better first move than coaching. Help the parent understand the many aspects of their child's nervous system, such as sensory differences, fight-flight-or-freeze, dysregulation, and the mismatch between the child's wiring and the expectations of a neurotypical world. This will help them understand how to answer the question, "How did your child's nervous system respond when that happened?"

Focus on the child, not the parent. In Tom's case, start with the boy who has never had a smooth transition, who can't fall asleep without someone on the floor beside him, and work with Tom on what's happening for his son in those moments. Suggest to Tom that he may be dealing with a nervous system that doesn't respond to the world the way we'd expect. By starting with an understanding of his child, you'll reorient the conversation, signal to Tom that you're on his side, and empower him with new information.

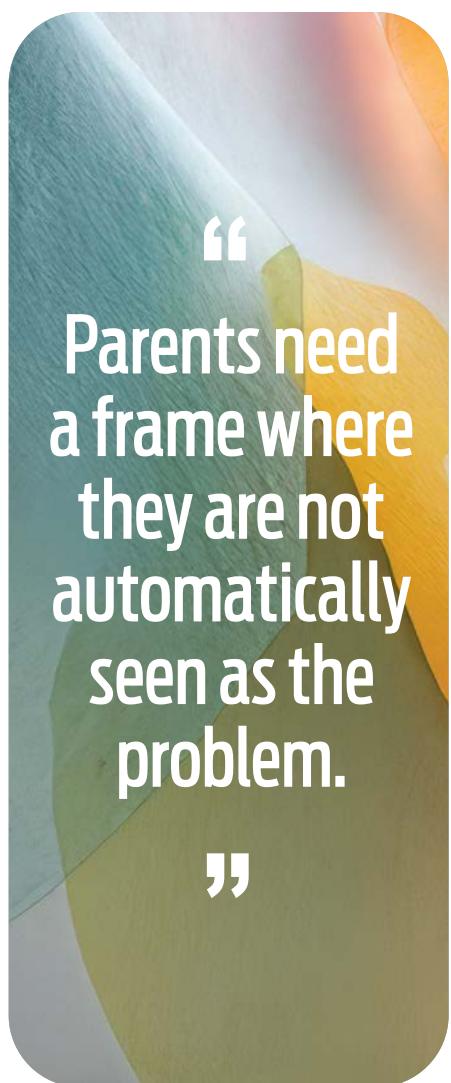
Principle 5: Carefully consider your recommendations.

Be careful about residential placements. If you're considering recommending a therapeutic or residential placement, ask yourself whether the recommendation is driven by clear clinical reasoning or by your own sense of exhaustion and helplessness. Both are understandable; only one is a clinical rationale.

Caution is especially warranted for neurodivergent adolescents. Most intensive programs are built around neurotypical assumptions and a behavioral model, leaving them ill-equipped for Autistic or AuDHD presentations. Furthermore, the social dynamics in a residential

treatment center can be quite harmful for young people who are already vulnerable.

If placement does make sense, be honest about its limits. While it may keep everyone safe and provide relief, it will not change the child's underlying neurology. The family deserves to understand that the ultimate goal is for their child to learn how to work with the nervous system they have,



and this may not be possible during most residential stays. Also be clear that placement does not mean that the parents failed to provide the right environment for their child.

In Sandra's case, above all, she needs to hear what her previous therapist never said. "Your fam-

ily has been through something traumatic, and the fact that you're still looking for help speaks to your extraordinary commitment to your daughter."

Principle 6: Consider everyone's neurotype.

Keep in mind that neurodivergent children often have neurodivergent parents, whether or not they know it. If you find yourself thinking a parent is difficult, consider whether it makes more sense to reframe their behaviors through the lens of neurodivergence.



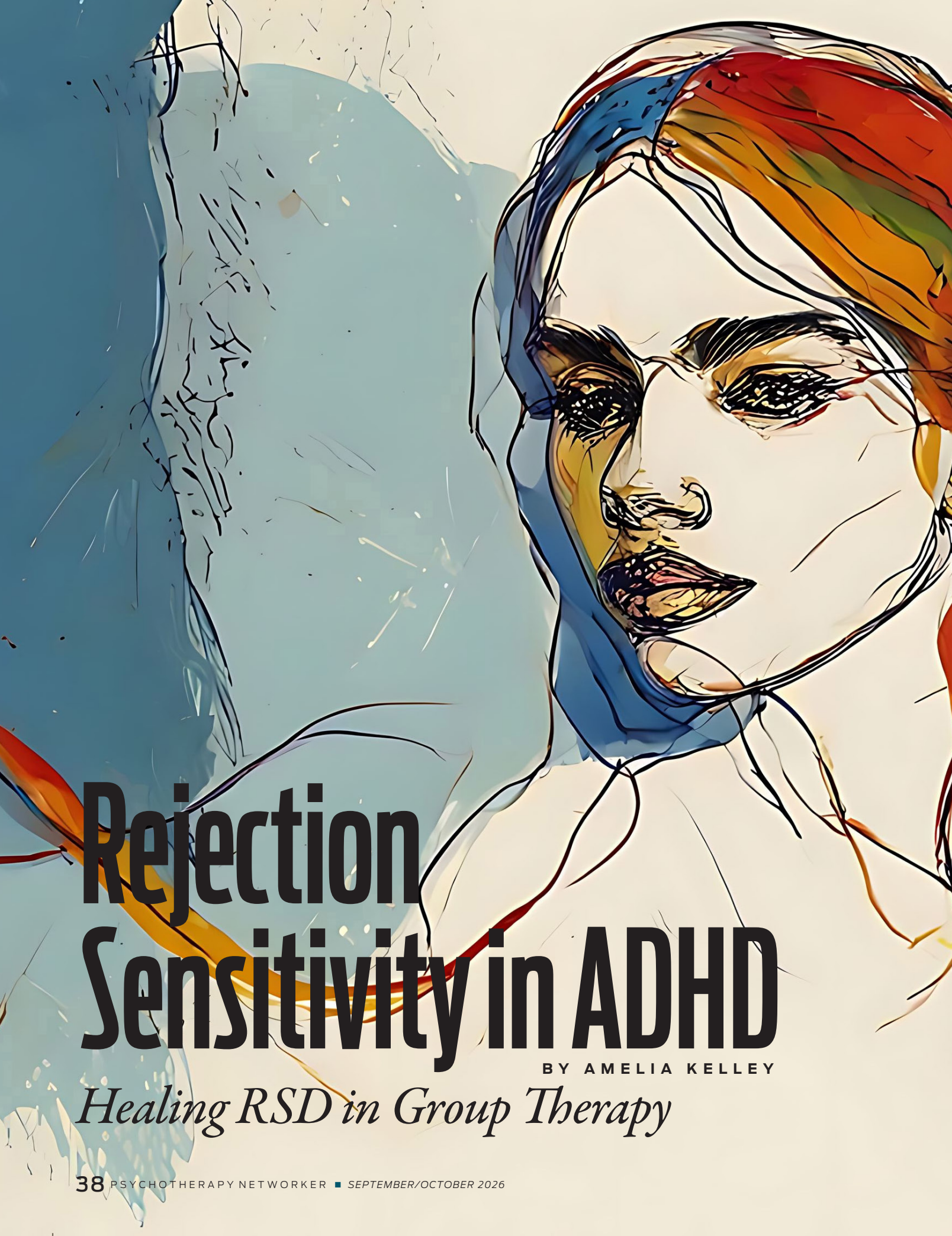
Parents need a frame where they are not automatically seen as the problem. They need a frame that will help them learn about their child's nervous system and their own, and they need to know that someone understands.

The shift from looking *at parents* to looking *with them* can change everything. 🧠

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Let us know what you think at letters@psychnetworker.org.



Rejection Sensitivity in ADHD

BY AMELIA KELLEY

Healing RSD in Group Therapy



Miranda came to therapy after repeated experiences that left her feeling like she was falling short: not finishing her college degree, believing she'd disappointed her parents, and struggling to find work that felt meaningful. Although she was "twice exceptional"—deeply intelligent and living with ADHD—she internalized these experiences as evidence of her personal failure. She was incredibly bright and creative, yet underemployed, underperforming, and perpetually haunted by the sense that there was something big meant for her, something she could never quite grasp.

As a clinician focusing on ADHD in women, many of my clients live with a similar pattern of self-defeat, especially those who've spent their lives masked and afraid to be fully seen. Emerging research and clinical observations suggest that women with ADHD may be particularly vulnerable to rejection sensitivity and internalized shame, likely due to chronic masking, relational expectations, and the cumulative impact of social feedback across development. As a survival strategy, they've tried to appear more "put together," while hiding parts of themselves and pushing down what actually helps them feel regulated. For them, rejection always feels like it's around the corner, which keeps them in a state of emotional and behavioral paralysis and shapes their daily lives, their nervous systems, and the way they relate to others.

This condition, known as rejection sensitive dysphoria (RSD), is characterized by the intense, rapid emotional response to the anticipation of rejection, criticism, or failure—and it happens to be a hallmark of the ADHD experience. Sadly, it can limit access to some of the greatest strengths of ADHD, like creativity coupled with spontaneity—which is linked to a flow state that often emerges through hyperfocus and an increased sense of confidence and immersion while engaged in meaningful tasks.



In my training, the symptoms of ADHD were primarily conceptualized as both a neurological and behavioral condition, with emphasis placed on how differences in brain development and executive functioning contribute to observable challenges with motivation, impulse control, attention regulation, organization, and task completion. But after nearly 20 years in practice, I began to recognize the relational and emotional dimensions that were also shaping how ADHD was experienced and internalized. Once I expanded my lens, what I'd once understood as procrastination and inconsistency began to look different.

In many cases, it wasn't a lack of capacity that was to blame for these behaviors, but a response to anticipated emotional pain—of getting it wrong, being misunderstood, or feeling exposed. This anticipated pain, based on countless past experiences, shaped my clients' personal narratives around feeling like “too much” or “not enough,” as well as their sense of identity. Ultimately, I came to see how ADHD wasn't just a behavioral disorder impacting executive functioning, but a systemic difference in how internal self-talk is formed and expressed in the world.

Of course, we're all wired for connection, and feedback helps us shape how we relate to the world, but RSD distorts this process by negatively impacting a person's sense of reality, self-worth, and what's achievable. It shapes how they show up in relationships—often causing others to perceive them as insecure, defensive, or difficult to connect with given the underlying need for reassurance. But this pattern doesn't develop in a vacuum.

By adolescence, many children with ADHD have received thousands more corrective or negative messages than their neurotypical peers—redirections, reminders, subtle frustrations, and explicit criticism. Over time, this repetition shapes the nervous system and calibrates it toward

threat. It teaches the brain to scan for disapproval and builds internal narratives like *I'm too much*, or *not enough and always getting it wrong*. What begins as external correction becomes internalized expectations.

In this way, RSD isn't just emotional sensitivity but a learned, embodied anticipation of relational rupture that influences attachment safety, disrupts emotion regulation, and creates a baseline of social vigilance. This vigilance creates an emotional cage where the fear of failure, perfectionism, and the sense of not belonging lead to an almost inevitable failure-to-launch pattern.

Learning to Live Beyond Rejection

Supporting clients struggling with “failure to launch” patterns is a common component of ADHD treatment and became a central focus of therapy with Miranda. Much of our work centered on helping her break a cycle of paralysis and inconsistency that seemed to invade nearly every area of her life: home, relationships, and especially work. She dreamed of becoming a realtor, but even after taking meaningful steps toward that goal and earning her license, she remained stuck in a repetitive loop of starting, stalling, and self-doubt.

First, she'd try to learn everything about the market, wanting to feel fully prepared, confident, and ready. But because her knowledge didn't feel adequate, she kept delaying leaving her current job in data analysis, despite how unhappy it made her. She reported being short-tempered with her kids, her neck constantly hurting from hunching over her computer, and constantly feeling tense around her coworkers. Despite all of this, she stayed, fearing that if she took the leap into what she really felt passionate about, her family would become destitute (despite having other sources of income).

In addition to this, the fear of failing and being judged by her critical parents outweighed the potential for success that I could objectively envi-

sion for her. Constantly preparing for the possibility of “making the wrong decision” is a common pattern associated with RSD. When coupled with the racing, catastrophizing thoughts that can accompany a rapidly firing ADHD mind, it often presents as anxiety.

Next in the loop came avoidance. Miranda was reticent to tell people she had her real estate license and wanted to get into the business, fearing that she’d come across as too pushy or sales-like. Instead, when someone mentioned needing a realtor, she’d keep quiet.

This is another way RSD can show up: feeling uncomfortable with *any* attention, even positive attention. For many, praise is filtered through the same lens as criticism, making it difficult to trust. Good things can feel coincidental, undeserved, or temporary, which keeps individuals from stepping fully into opportunities that are already within reach. In Miranda’s case, she dodged conversations with family members who wanted to support her dream, only to return to what felt safer—studying real-estate paperwork and research she already understood. She was doing a lot without moving forward at all.

So, the cycle continued: perfectionism, procrastination, avoidance, overpreparing—and no action. This pattern reinforced the very thing she believed about herself: that she was destined for failure and disappointment.

Helping Clients Drop the Armor

In the context of relationships, rejection sensitivity can make expressing emotions, receiving feedback, taking relational risks, and even setting boundaries feel harder. This is because each of these experiences has the potential to become further “proof” that an individual is a disappointment or failure. As a result, they become more guarded, defensive, or hesitant to fully engage in relationships. Even well-intended or potentially healing feedback can be

experienced as a threat, making it difficult to stay open in moments that could otherwise strengthen connection.

For therapists, effectively treating rejection sensitivity requires more than cognitive restructuring—it must address the entire nervous system and how it operates in relationship with others. What looks like overthinking in RSD is actually a full-

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body protective response attempting to shield a person from shame.

RSD armor can appear strikingly similar to other trauma responses, as the nervous system moves out of connection and into protection at the first sign of perceived rejection. It’s important to remind clients that this isn’t fully within conscious control, nor is it a character flaw—although many individuals with ADHD experience it that way, believing their sensitivity to rejection

is just something else that needs fixing. Clients also need to understand that RSD can’t simply be chalked up to anxiety, low self-esteem, or emotional immaturity.

In practice, tackling RSD requires that the therapist help the client recognize failure as evidence of engagement rather than inadequacy. And when stepping into something new, clients need to see a growth mindset as a nervous system intervention, rather than a concept.

Learning to “fail forward” isn’t about pushing harder, but about creating enough relational safety in therapy that failure no longer feels like rejection. This can look like genuinely celebrating failures with clients through gentle expressions of gratitude, softening their narrative through third-person storytelling, or relating to the experience as if they were speaking to a friend, while leaning into curiosity about the potential avenues they can explore next time. The failure—whether perceived or real—isn’t the end, but a stop along the way.

Why Individual Treatment Alone Falls Short

While relational safety in therapy is just as important as the interventions used, the potential for healing often increases when these relationships expand into a group setting. As Miranda examined her own limiting beliefs and somatic responses to rejection in therapy, she experienced some growth, but our one-on-one sessions limited the amount of “healthy discomfort” needed to fully rewire her old narratives. Individual therapy had helped her understand what was happening, but something different was needed to resolve the fear of rejection that continued to limit her.

This is something I see often in my work with clients like Miranda. Insight alone can only take someone so far when their nervous system still interprets vulnerability as danger. For many women with ADHD, especially those carrying

years of shame, masking, or relational wounds, healing requires corrective emotional experiences that happen in real time with other people. Psychiatrist Dan Siegel's concept of Interpersonal Neurobiology suggests that human relationships help shape neural pathways through repeated interpersonal experiences. In this way, safe relational experiences don't just help people feel understood emotionally—they can also help create new neural associations around vulnerability, connection, and belonging, rather than automatically linking emotional exposure with shame, criticism, or danger.

When Miranda first found out about the ADHD support group for women I lead, she didn't seem thrilled about the prospect of joining. Fearing the reaction of one person was scary enough, let alone an entire group of women she didn't know. But after we explored how corrective relationships and safe exposure to vulnerability could help loosen the grip of her rejection sensitivity, she agreed to give it a try.

Predicting that others will judge you is common with RSD, and I explained that she'd likely continue to struggle with these fears and narratives if she wasn't putting herself in safe spaces to practice and experience corrective relationships. By allowing herself to be emotionally visible to others, perceived faults and all, she could learn from these women who had felt (and continued to feel) many of the same emotions.

In her first group, Miranda didn't say much, and simply observed, which we processed when we met individually. Many of her insights were powerful, and I encouraged her to share them with the group when she felt ready. When she eventually did, she told the others about her worry that her family would think she was irresponsible for choosing a career in real estate, which didn't come with benefits or stability. She spoke about never fully feeling like she belonged in her family, and how she often questioned herself as a result. The group encour-

aged her to begin trusting her own internal voice over the shame-based narratives she'd absorbed from others—even when those messages came from her own family.

During the following group, as we were exploring the impact of negative self-talk on ADHD, Miranda began speaking up in a more empowered way. There was a lightness to her face, and I could see the pressure dissipat-

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”

ing in her body as the other group members listened to her, nodded in agreement, and related to what she was saying. In real time, I could see how the safety of the group allowed her to use insights and skills that she'd developed sitting one-on-one with me but couldn't often access outside my office in the face of relational threat.

This highlights an important point: despite a strong therapeutic alliance, insight, and motivation, many clients remain caught in cycles of

shame, avoidance, and fear of being seen because their nervous system can't access what they know under perceived relational threat. In these moments, both client and therapist can begin to feel stuck, as if more insight or effort should be enough.

As participants shared their stories and Miranda heard others respond with validation—"I get you, I see you"—she began to share more of her own reflections and experiences. This experience of sharing our humanity isn't about looking to others to define who we are, but about receiving accurate reflection.

The group offered other things therapy alone couldn't consistently provide: corrective emotional experiences, coregulation across multiple relationships, and a shared sense of reality that meant people were no longer interpreting themselves in isolation. For some, the group allowed important tools provided in individual therapy—like positive self-talk, compassion, redirection, and self-coaching—to really take hold. It also offered visceral proof that being seen doesn't always lead to rejection. And it helped normalize the difficult feelings that come up when it does.

While family relationships and friendships can offer similar corrective experiences, many people with ADHD and RSD lack consistent access to safe relationships, whether due to critical family systems, past trauma, or social bias. This is where structured group work can become an essential part of the healing process.

Overcoming Hurdles to Group Work

Throughout this work, I've come to believe that the potential for corrective experiences, coregulation, and the uniquely relational nature of group work for people with ADHD should become a more widely recognized and gold standard adjunct to treatment. Group work offers therapists the flexibility to tailor the structure of treatment to fit both the needs of clients and the clinician's therapeutic orientation, whether it's process-

oriented, coaching and skills-based, psychoeducational, or an integrative approach.

No matter what the foundational framework, the group should serve the critical function of allowing members to unmask in a safe support space that allows for all the uniqueness of ADHD. In the virtual groups I run, members frequently do things on our calls that they wouldn't most sessions, like walking on treadmills, styling their hair, crocheting, and eating. I welcome all of it, as it helps to quiet shame-based narratives around trying to seem "normal" rather than simply showing up as themselves.

Still, groups can be corrective only when safety is actively maintained. Clients with ADHD may be especially vulnerable to moving between over-disclosure and emotional withdrawal due to shame, masking, emotional activation, rejection sensitivity amplification, social comparison spirals, and difficulty interpreting tone. There are also important limitations to monitor, including confidentiality concerns, secondary trauma exposure, and emotional contagion escalation. This is where clinical containment matters. This may mean slowing evaluation moments and naming RSD spirals in real time, helping clients differentiate activation from actual relational threat, and teaching needs-based communication through DBT skills like DEAR MAN, where clients learn how to effectively describe, express, assert and reinforce their needs—mindfully, appearing confident and with a willingness to negotiate.

It also means modeling relational effectiveness with warmth, validation, and steadiness while helping clients pace connection so intensity doesn't spike too quickly. And when issues arise—as is common in group work—these ruptures aren't a sign of failure, but rather an opportunity for relational repatterning. Importantly, insights, social shifts, and aha moments in group can be processed in one-on-one counseling on a deeper level and then compared and contrasted with other

relationships in the client's life.

And because the group work is ongoing, clients have repeated opportunities to rebuild trust in their capacity through relational safety rather than performative or deadline-driven pressure. In essence, group work is natural because community is natural, and has been shown to have positive implications not only for relational healing, but for longevity and overall well-being. When clients become more comfortable in group, the next step is often encouraging other community experiences and risk-taking outside the therapy space. Sometimes they stumble and fall, but the group is always there to help process these moments.

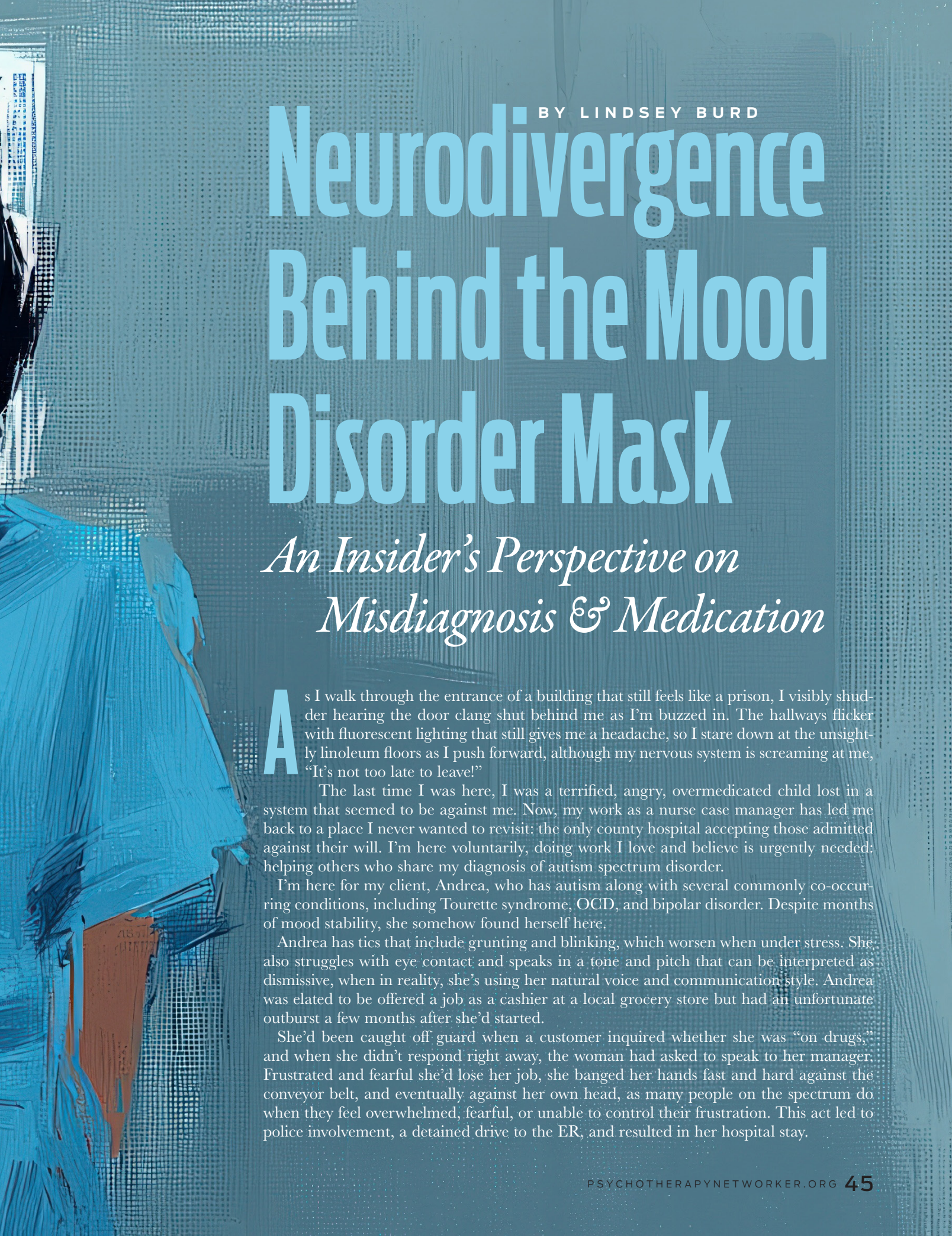
Miranda continues to come to both group and individual therapy as part of her ongoing support system, but there has been a seismic shift in her life. The woman who once could barely make eye contact in our first session now confidently says, "I am a realtor," and feels the pride that comes with it. Being emotionally known by her group, without needing to prove herself, has allowed her nervous system to finally exhale. She no longer asks others to reassure her that everything's okay or overexplains herself to prove she knows what she's talking about.

With this additional space to breathe, her ADHD symptoms feel more manageable, and when the RSD armor rises—as it still does from time to time—she can recognize it for what it is and hold her reactions more lightly than before, knowing they're simply part of her ongoing growth. 

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BY LINDSEY BURD

Neurodivergence Behind the Mood Disorder Mask

An Insider's Perspective on Misdiagnosis & Medication

As I walk through the entrance of a building that still feels like a prison, I visibly shudder hearing the door clang shut behind me as I'm buzzed in. The hallways flicker with fluorescent lighting that still gives me a headache, so I stare down at the unsightly linoleum floors as I push forward, although my nervous system is screaming at me, "It's not too late to leave!"

The last time I was here, I was a terrified, angry, overmedicated child lost in a system that seemed to be against me. Now, my work as a nurse case manager has led me back to a place I never wanted to revisit: the only county hospital accepting those admitted against their will. I'm here voluntarily, doing work I love and believe is urgently needed: helping others who share my diagnosis of autism spectrum disorder.

I'm here for my client, Andrea, who has autism along with several commonly co-occurring conditions, including Tourette syndrome, OCD, and bipolar disorder. Despite months of mood stability, she somehow found herself here.

Andrea has tics that include grunting and blinking, which worsen when under stress. She also struggles with eye contact and speaks in a tone and pitch that can be interpreted as dismissive, when in reality, she's using her natural voice and communication style. Andrea was elated to be offered a job as a cashier at a local grocery store but had an unfortunate outburst a few months after she'd started.

She'd been caught off guard when a customer inquired whether she was "on drugs," and when she didn't respond right away, the woman had asked to speak to her manager. Frustrated and fearful she'd lose her job, she banged her hands fast and hard against the conveyor belt, and eventually against her own head, as many people on the spectrum do when they feel overwhelmed, fearful, or unable to control their frustration. This act led to police involvement, a detained drive to the ER, and resulted in her hospital stay.

When I found out about the circumstances that led to her admission, I knew I had to be there to explain her history during her treatment plan meeting. Unlike my hospital experience a decade before, Andrea will have someone to advocate for her who's informed about neurodiversity. As I walk into the meeting with the therapist and psychiatrist, I feel my heart drop when I recognize a familiar face. It's the same provider who wrongly told my parents, "It's unlikely she'll ever be self-sufficient."

The psychiatrist, busy writing his notes, briefly glances at my face as he reaches to shake my hand, then quickly does a double take and asks, "Have we met?"

I sheepishly say, "Yes, we've actually met here," and I let him connect the dots.

During the meeting, I carefully explain Andrea's history of sensitivity to medications, and the importance of dosing any new medication "low and slow." I educate them on the fact that her outburst was not the result of mania, but of severe frustration, and encourage them not to stop her very effective antidepressant, as this has taken her from being unable to leave her house to maintaining a part-time job for months until this incident.

After the meeting, I check on Andrea. She's lying in the fetal position, back toward the door, sobbing. I knock, and she shouts, "Please, please, don't turn on the lights!"

I respond with: "It's me. I understand, the lights bother me too." I tell her I can put a note on the door asking others to warn her before turning on the lights. She immediately asks if she lost her job, her regret palpable. I try to reassure her as she lies in her hospital bed, but knowing Andrea's fear of unknown routines, I spend most of the visit explaining in detail the hospital schedule and the plan for her to be discharged after a 72-hour hold.

Autism and Medication

Like many patients on the spectrum, Andrea's sensitive nervous system makes her more prone to adverse

or paradoxical reactions to medications. Unfortunately, there's very little research on how autistic individuals respond to medications.

Autism is not a psychiatric condition and does not automatically require medication but co-occurring mental health conditions—often more than one—impact most neurodivergent individuals. The only two FDA-approved medications for autism are Abilify (aripiprazole) and Risperdal (risperidone)—but they are only

“
The reason
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weren't
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because I'm
neurodivergent,
not bipolar.
”

approved for "irritability," and I often wonder why irritability alone warranted the research.

It's not widely recognized that autistic individuals are often misdiagnosed with bipolar disorder, in part because they can be at higher risk for activation—a particularly distressing reaction that's often mistaken for mania and can occur in response to antidepressants at high starting doses where

patients feel irritable, agitated and restless. A brain that's sensitive to light, sound, texture, and surrounding activity may also be more sensitive to medication. Autistic patients who are given a starting dose of any medication that's too strong can have catastrophic responses, including increased anxiety, suicidality, or even severe sedation, restlessness, or painful muscle spasms.

For years, I saw this with my very own eyes as a nurse overseeing clinics for autistic clients with co-occurring mental health conditions. In this capacity, I worked alongside four incredible psychiatrists who were confident enough to treat a complex population without formal guidance, and they taught me about the potential risks of under or over-medicating clients. The doctors would jokingly call me "Dr. Lindsey" and often ask what I thought we should do when things went wrong after medication changes. Doing this work was, as one psychiatrist described it, a "baptism by fire."

I loved my unique position there and took pride in assimilating autistic patients back into the community. Helping them find adequate health care, mental health treatment, and job opportunities with appropriate accommodations was deeply rewarding. In a marginalized and underserved community, I was a familiar face who understood their struggles on a level others couldn't. My caseload ranged from adults who refused to wear winter coats in 0-degree weather (due to the texture) to others who could only drink one flavor of juice because the taste of any other fluid sent them into a panic.

When one of our psychiatrists retired without significant notice, I searched fruitlessly to find an adolescent psychiatrist willing to treat patients on the spectrum. I loved my job, but I knew I could make a greater difference as a provider. So I cut back on my hours and went back to school.

The Experience that Became a Calling

Now a nurse practitioner, I realize most of the mental health providers I

work with are unaware of how intensely neurodivergence impacts an autistic person's mental and physical health status. And I have firsthand experience with how damaging inadequate mental health care can be for individuals on the spectrum.

As a child, school refusal started for me due to bullying. I had no idea how to socialize with my peers, which led to significant social anxiety. I underwent psychological testing with the school psychologist, who told my parents I was oppositional defiant and referred me to therapy and eventually to a psychiatrist. Throughout my childhood and into adolescent years, my parents took me to various specialists, while the school board called in truancy officers who threatened me with jail. From age 10, I was lost in the web of psychiatric treatment. I'm intimately familiar with the medications I prescribe because at one point or another, I took most of them.

By the time I was 16, psychiatric visits were a rushed 10-15 minutes—me shutting down, my parents begging a doctor to help with my behavioral episodes, which were quickly misdiagnosed as bipolar disorder. My frequent interrupting, rapid speech when I was excited, meltdowns when plans changed, severe social anxiety, and late nights spent absorbed in my special interests were all interpreted as signs of mania. None of the mood stabilizers or neuroleptic medications I was given ever seemed to help. I only got worse, and my “behavior”—mainly school refusal—spiraled further out of control. As that happened, my providers increased medication doses, which needless to say, did not help.

My previous hospitalization occurred when I spent a night on a cold park bench instead of in my bed, because I chose the peace of the fall wind over the agony of attending another day at an overcrowded school. The police were involved, and I was hospitalized for “running away.”

By 17, I'd sat across the desk from at least eight different psychiatrists, two psychologists, and four therapists. Never did I feel a connection with any

of my providers—not because I wasn't interested in treatment, but because the entire world felt so overwhelming, and I couldn't explain why small, everyday things seemed unsurmountable. I lived my life in fear and confusion.

It wasn't until one very inquisitive psychiatrist, after talking to my mother and me for well over an hour—most intakes were never more than 30 minutes—shared a new perspective none of the previous helpers seemed to con-

“
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sider. “I don't believe Lindsey is bipolar, I think she's Autistic.” My mom, shocked, asked him what he meant. He bluntly stated, “I think she has autism. Take this for sleep. Everything else, I'm stopping.”

“Autism?” my mom responded in disbelief. My little sister was diagnosed with autism, but hers had been suspected at age three due to develop-

mental delays. All my milestones were early. Never had anyone related my difficulty verbalizing my feelings to her inability to speak or her constant refusals to my inability to go to school.

I truly believe my life was saved by this psychiatrist who was informed about high-masking autism. His assumption was correct: the reason the meds weren't working was because I'm neurodivergent, not bipolar. My long rambling about special interests, extreme social anxiety, fear of leaving the house—all of this was explained by the same disorder that had caused my sister's severe disability. Similar to her, I was just wired different.

My parents were hesitant but agreed to wean me off all my medication and try a small dose of a sleeping pill. With accommodations, instead of overmedication, I found my spark again. I graduated high school early, through a community college program. I continued my studies, transferred to a state university, and graduated with a bachelor's degree in nursing with a 4.0 GPA. Most people would be proud of this. For me, learning facts or taking tests was never challenging. My struggle has always been with processing the many demands of everyday interactions, something I still sometimes find difficult.

The Cost of Being Missed

By the time Eliza found herself in my office, she told me she felt completely defeated by her search for a prescriber who was familiar with neurodiversity. She plopped down on my couch, crossed her arms, and stared at the floor, almost hyperventilating. When I asked her how I could help her, she shouted in frustration, “Maybe you can help me understand what's going on, because no one else seems to know!” I felt a pit in my stomach. It was not a gentle introduction.

Typically, when someone begins an intake by listing their frustrations with multiple providers, it's easy to assume they are “difficult” or “too demanding.” But I took a deep breath, smiled, and worked to quiet my own judgment so I could see the situation as objective-

ly as possible. “Let’s talk about what brought you in,” I responded.

Eliza was diagnosed with OCD and social anxiety as a teenager. She religiously kept receipts and records of her days, filling her home with countless binders of information. She tells me about her ongoing struggle to make friends, her tendency to unintentionally offend coworkers, and her history of being fired from multiple jobs, despite vehemently denying any wrongdoing or mistreatment of others.

Her depression has never improved with any of the medications she’s tried, some of which have left her body with permanent damage. The high dose lithium she once took, normally very effective for bipolar disorder, has left her with thyroid and kidney damage. This was challenging considering her diet was already limited by her sensitivity to certain textures, and her insurance status was constantly changing due to her inability to keep a job. All of this perplexed her.

She teared up as she stared at the floor while handing me a stack of papers. I noticed her nails had been bitten down and her cuticles were covered in scabs from being gnawed on. The papers were two psychological evaluations, containing the Autism Diagnostic Observation Schedule (ADOS) test which is considered the “gold standard” of screening for autism, from two psychologists she’d gone to see after her psychiatrist had declared that he didn’t know what to do with her.

The first assessment was negative. The summary explained she was struggling with bipolar disorder and OCD, not autism. The second assessment, using the same diagnostic test, reached a different conclusion: major depressive disorder, social anxiety, and autism spectrum disorder, level 1. How do two “gold standard” screenings get such different conclusions?

The first evaluation stated that Eliza had a “preoccupation with being on the spectrum.” The psychologist considered it suspicious that she came to the assessment with a binder organized by *DSM-5* sections, complete

with bullet-pointed examples of how she met the criteria. Rather than seeing preparation, the psychologist saw malingering. What she failed to realize was that Eliza loved binders and found comfort in organizing every detail of her life.

So Eliza decided to leave the binder at home when she got a second assessment. Five thousand dollars later, she’s in my office, explaining, “I just want help!” It saddens me that medical providers often unknowingly deepen the

and self-understanding. She had no idea how hard she was about to fight to find a mental health provider who agreed.

Her psychiatrist adamantly disagreed, telling her the late-night research was textbook mania. She increased her dose of the medication that caused sedation. Eliza reluctantly took the medication but made an appointment in four months with a psychologist for an evaluation.

Eliza grew up in a Latino household where mental health was not openly discussed. She shares a lot of similarities with her “quirky” grandmother, including her distinct palate for foods, sensitivity to noise, and an intense urge to collect and organize items like newspaper articles and receipts. She cries as she explains her fruitless efforts to make friends at school and work. She was consistently bullied for reasons she couldn’t understand.

Eliza had called many offices before finding mine. She was visibly relieved when I told her I agreed she was Autistic without a doubt, and we discussed options for care.

As a psychiatric nurse practitioner specializing in neurodiversity, I see appropriate therapy and support as the first step toward understanding and self-regulation, followed by treatment of co-occurring mental health conditions. Some of the most meaningful interventions don’t come in the form of medication, but through accommodation and coping skills developed through therapy. Finding these resources is incredibly difficult, as there are not many therapists who feel confident treating Autistic clients, and even fewer psychiatric prescribers willing to manage their medications.

I do end up prescribing a medication for Eliza—a low-dose antidepressant for anxiety and OCD, and a beta blocker that’s been shown to help with “fight or flight” symptoms that can occur during social interactions or when overstimulated. I also recommend NAC, a supplement that’s been shown to help with rumination and skin picking.

We go over coping strategies that

“
How many
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Autistic patients
are searching
for answers
behind the mood
disorder mask?
”

trauma of someone already struggling to find answers within a web of referrals, diagnoses, and stigma.

I ask Eliza when she first thought she was autistic.

“When I first saw a video about women with autism,” she shares. “I thought, that’s it! This is what’s wrong with me!” She excitedly read as much as she could about the condition, staying up all night with newfound relief

work for her, like box breathing (a simple strategy of breathing in and out in counts of four) and Little Ouchie pain fidgets (small rings covered with spikes that can trigger a release of endorphins to calm and soothe distress) when she feels overwhelmed. I also write a letter asking for accommodations for Eliza at work, including increased ability to work from home. A month later she comes back for a follow-up, sharing that her company let her go. Sadly, this is not the first time a patient has told me they were fired or laid off from a job after requesting accommodations.

Although she's in the position of having to search for a job again, Eliza's outlook on life has improved significantly. Her fingernails are growing back, and she's feeling more confident in her interactions with others. She's given herself more alone time and focused on self-care. She's stopped shaming herself for the things she can't change and began embracing her love of special interests, including organizing binders of information.

Every day, neurodivergent people suffer because of a lack of access to effective healthcare. The recent prevalence of autism per the CDC is believed to be 1 in 31 people. That number hasn't climbed because of an epidemic, overdiagnosis, use of Tylenol, or vaccines. It was lower in decades past because so many neurodivergent people have slipped through the cracks in traditional mental health settings.

No Test Diagnoses Autism

The ADOS assessment was developed in 1989, at a time when Asperger's was still used as a diagnosis for so-called "high-functioning autism." Many now view the term, "high functioning" as an invalidating misnomer, given the herculean effort many expend to maintain a job, sustain a social life, and function in a neurotypical world—often at great cost to their mental health.

Although the ADOS has been updated to reflect changes in *DSM-5* criteria, criticism of the ADOS-2 centers on high rates of false negatives in Autistic adults who camouflage, and

potential racial and gender biases. The ADOS-2 is expensive and time-intensive to administer. As a result, waiting lists grow months to years long, and many people are left seeking answers from therapists and prescribers who may have little formal training in autism.

The ADOS-2 is a valuable tool for children and nonverbal patients. Autism doesn't always look the same, and not all tools are appropriate for each patient. Only using one or two

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”

screenings for a population of people with very different presentations doesn't translate to neurodivergent-affirming care and most providers don't realize that a test like the ADOS isn't required to diagnose autism. No single test diagnoses autism: clinicians do.

Why is it that most providers feel comfortable diagnosing ADHD—a complex neurological mental health

condition that's widely treated—without complex psychological evaluations, whereas the needs of patients with autism remain largely unmet?

Autism doesn't always look like the stereotypes portrayed in the media. People on the spectrum can look just like anyone else, while silently struggling every day to function in a system that too often refuses to recognize their needs.

Approximately 10–15 percent of people with bipolar disorder are estimated to die by suicide, yet Autistic individuals face a similarly elevated risk. It makes me wonder how many neurodivergent adults have been lost within that statistic, never finding relief or even a name for the emotional turmoil they carry. How many undiagnosed Autistic patients are searching for answers behind the mood disorder mask—misunderstood and misdiagnosed, harmed by a system meant to protect them.



If I could go back in time to that scared, over-medicated, misdiagnosed 16-year-old girl huddled in an oversized hoodie on a park bench on a cold November night, I would tell her how strong she is. I would tell her that if her doctor said she's a hopeless case, she should tell him to be careful—one day she may be his colleague.

I wish her journey had been less grueling, but I'm not ashamed of her for coping the only way she knew how. This dark, difficult time will be her survival story one day. Her resilience will make her a strong advocate for those who are dismissed, unsupported, and unseen. Most of all, I would tell her to keep going and do what she was called to do: heal, as a provider and as a patient. 

Lindsey Burd, CRNP-PMH, has specialized in working with Autistic clients for over 13 years. She's also a mental health advocate, clinical preceptor, writer, and the founder of Burd Mental Health, an integrative and neurodiversity-affirming outpatient practice. Contact: BurdMentalHealth.com, or on Instagram at [LindseyBPsychNP](https://www.instagram.com/LindseyBPsychNP).



BY NYCK WALSH

The Case for Autistic Self-Diagnosis

A Tool to Take You Beyond the DSM When Considering Neurodivergent Traits

While the Autistic community tends to give a lot of pushback when people use language like ASD or spell out the acronym, I've noticed much more acceptance of the use of ADHD. I don't think that's okay. While there is less intense societal stigma with this neurotype than with autism, it still gets plenty of invalidation and shame.

Better options are the following two alternatives that hopefully we can get enough traction with to create a systemic shift. These alternatives are kinetic cognitive style (KCS), coined by Dr. Nick Walker, and variable attention stimulus trait (VAST), coined by Drs. Edward Hallowell and John Ratey, coauthors of ADHD 2.0. Both of these shift the focus from deficits to a whole person perspective that includes ample strengths. When I've shared these terms with clients, it's almost as if they intuitively sense the innate accuracy of these terms.

If you are or you know anyone who is KCS/VAST, then you know full well that when it comes to an area of passion or interest, there is no shortage of attention. There is a plethora of attention, also known as hyperfocus. The perceived lack of attention shows up when there is a lack of interest. Both this neurotype and autism are interest-based systems, meaning that focus and attention are directly tied to engagement of interest. Kinetic, in KCS, and variable, in VAST, both refer to these differences in how attention is distributed. Attention stimulus in VAST refers to the impact of sensory and other input from the environment on a person. Both cognitive style, in KCS, and trait, in VAST, refer to this as a neurotype, rather than a disordered way of being.

Also, there is a transition component here that often gets

missed. When a KCS/VAST person is deeply engaged with something, there's a period of time required for them to disengage their attention, shift attention, and then reengage with something else. Monotropism is another way to describe this vortex of attention or singular focus and the need for transition time both into and out of that state. This focused attention can also be referred to as a flow state or hyperfocus. Both neurotypes are monotropic in nature.

But while there has been a lot of emphasis on the autistic neurotype, with seemingly less on KCS/VAST, I want to point out that these two neurotypes share a great deal of overlap. First off, depending on what studies you look at, research shows anywhere from 30–80 percent of Autistic people are also KCS/VAST. I've seen some people suggest that KCS/VAST belongs under the autistic spectrum umbrella. Both neurotypes have a sensory component, a social component, and executive function challenges, and they are monotropic.

There are also many other co-occurrences that people with these neurotypes deal with, including physical ones like Ehlers-Danlos syndrome (EDS), hypermobility, food sensitivities, postural orthostatic tachycardia syndrome (POTS), sleep differences, autoimmune conditions, migraines, and so much more. There's also a greater likelihood of co-occurring depression, anxiety, bipolar, obsessive-compulsive, trauma/complex trauma, or what we call personality disorders, which are starting to be better understood as unique and creative behavioral responses to complex trauma.

One more thought about this neurotype. While KCS/VAST is commonly associated with low dopamine levels or having fewer dopamine receptors, this is not the whole truth. I first learned about this from Janae Elisabeth (she/they),

a white Autistic researcher and ND advocate who is well known online as Trauma Geek. Rather than low dopamine being an innate trait, dopamine gets converted to noradrenaline and then adrenaline, which is associated with a stress response. Due to oppression, trauma, and being forced to focus on things that are not of interest (rather than on dopamine-producing interest-based activities), dopamine gets depleted in order to produce adrenaline.

Now let's explore the importance of identification and especially the validity of self-identification. Gaining language for one's neurotype(s) can be an essential part of self-knowing, self-validation, and dismantling internalized oppression. We will also learn more about how Autistic and KCS/VAST people present across sociocultural locations. The list I provide is intended to broaden our scope of what we previously thought autism was and wasn't and to notice the similarities and differences with KCS/VAST.

Self-Identification and the DSM

I'm going to focus on autism in this section. Self-identification is absolutely just as valid for people with the KCS/VAST neurotype, and getting a KCS/VAST external identification is often more accessible than for autism.

The holy book of psychology that is intended to be a guide for mental health of all humans (I wish you could see my snarky smile in this moment) has eliminated a huge segment of the population: all racialized people, women, nonbinary people, transgender people, gender nonconforming people, intersex people, bi/gay/asexual/pan/queer people, poor people, and people in states of pleasure or neutrality. No wonder it's a novel concept to the masses that someone can be Autistic and joyful, or Autistic and Black, or Autistic and poor, or Autistic and a woman.

Consider the prevalence of misidentification or incomplete identification, oftentimes anxiety, depression, bipolar, obsessive-compulsive, trauma, personality disorders (particularly borderline for people assigned female at birth),

and oppositional defiance or a conduct disorder instead of autism for unidentified Black Autistic kids. Consider too how much sheer lack of information or misinformation is out there; that waiting lists for assessments from psychologists and neuropsychologists can be upwards of a year (and they still may not know anything about nonstereotypical presentations); the enormous costs of assessments (they can cost upwards of \$5,000, and those fees often are not covered by insurance); and that

“
They may be
deeply invested
in the narrative
that “This is a
me problem,
and if I just try
harder,
I’ll be ‘normal’
like everybody
else.”
”

no one knows anyone better than they know themselves. Given all that: self-identification of autism is completely valid and just as valid as any medical or psychiatric identification.

It's easy for me to get fired up about this. I've worked with so many clients over the years who've researched tirelessly about autism, only to finally work up the courage and finances to get an assessment and then be denied their Autistic identity. On top

of the trauma of living as an unidentified Autistic person for potentially decades, they endure more trauma from the medical and psychology fields. By the time they make their way to my virtual office, having endured way too much, usually within the first hour of knowing them, I'm like: "It's obvious to me that you're Autistic!"

This may leave you wondering, "If the DSM is so problematic and incomplete, why bother labeling the neurotype at all?" Great question.

For some people, it's the only way to get their support needs met. For others, especially later identified people assigned female at birth, who may have spent decades being invalidated in their challenges, blamed for their challenges, and isolated, receiving an Autism identification can be a full-on game changer. Having language for one's neurotype can both be a profound relief or source of liberation and a source of tremendous grief, maybe even rage, and everything in between.

You mean it's not my fault?

There's a reason I am the way that I am?!

I'm not broken?!

Who am I, then?

The potential onslaught of thoughts and feelings can be deep and vast. At the same time, with language comes information, validation, access to knowing oneself, identification of support needs, and hopefully, getting those support needs met.

This is where we, ND-affirming, anti-ableist therapists come in to help them reframe their life through this new Autistic lens and help them identify and access the support they need. What this also means is that imposter syndrome is likely. In fact, I've known a lot of people, whether medically or self-identified, who navigate ongoing cycles of imposter syndrome. It's hard not to in the dominant U.S. culture that labels any challenges we face as a moral failing based solely on our own efforts or supposed lack of effort. We get so accustomed to blaming ourselves that it's easy to feel that "Autism is just an excuse."

Oh, I feel the heartbreak in that statement. Both I and so many clients I've worked with over the years have echoed that sentiment. Talk about oppression in action. Part of my own unmasking journey has involved gaining access to my anger and rage, something I wasn't allowed to feel or express growing up in my family of origin. Needless to say, anger and rage come to visit quite often these days, this moment being no exception. It's a truly valid reaction, if I do say so myself.

Possible Qualities or Traits That Could Indicate a Person Is Autistic

The list that I've come up with to indicate whether a person is Autistic includes many qualities that could also apply to KCS/VAST. I'll point out some differences along the way, and the reality is that there are way more similarities than differences between these two neurotypes. This list transcends what exists in the DSM and encompasses many nonstereotypical qualities.

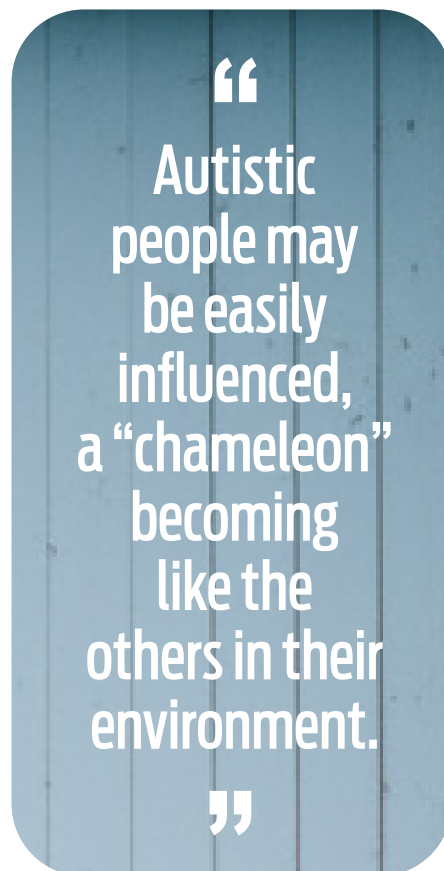
For starters, there is no one way to be Autistic. When I read my first book about autism 15 years ago, this was true. It is still true today. As the saying goes, "When you've met one Autistic person, you've met one Autistic person." We are a beautifully diverse neurotype. Also, autism is so much more than a particular subset of behaviors; it is a different bodymind. Lastly, given that only one tiny subset of the Autistic population is represented within the DSM and that by the time people reach adulthood they have often learned a multitude of strategies for existing within the neurotypical (NT) world, it is essential that we have a broader picture of what autism is. Please note: not everyone will identify with every one of these characteristics.

They report a lifetime of anxiety, sometimes depression too.

They report feeling different or misunderstood.

They have specific sensory needs, preferences, and aversions.

The sensory component of these two neurotypes is extremely important and can often be overlooked or downplayed. Each person, Autistic or KCS/VAST, has their own unique sensory profile that likely includes a combination of sensory seeking and sensory avoiding. I feel like Autistic people are more commonly known for their sensory overwhelm, while KCS/VAST people are more known for their understimulation. This is not entirely true, though, as both neurotypes can and do experience both. The sensory world



can be a source of deep distress; it can also be a source of euphoria and joy!

There are eight senses that are essential: in addition to sight, sound, taste, touch, and smell (to which not all humans have access), we also have three more. Proprioception is about knowing where we are in space, where our body ends and the air or environment begins. Deep pressure, containment, and touch can help us access this knowing. Interoception is inner body awareness, which includes cues

like hunger, thirst, need to rest, need to eliminate, or any other body sensation. Vestibular is connected to the inner ear and balance and is accessed through rhythmic movements like rocking, swaying, or spinning.

They have some degree of discomfort, confusion, and/or anxiety when it comes to being social with other humans.

- Autistic people have their own unique communication style, including body language, that is often misunderstood by non-Autistic people. For KCS/VAST people, it's less that they don't understand NT communication, but more that their tendency toward having many thoughts at once and taking in so much at once makes them more likely to miss certain cues or communication.

They can be easily overwhelmed and when they are really distressed or overwhelmed they may melt down, shut down, explode, implode, or self-injure.

- This looks different person to person and across the two neurotypes. While this is certainly not true of everyone, there seems to be a trend (based on how the binary genders are socialized) that assigned male at birth (AMAB) people tend to express their distress more externally and seemingly, more obviously. Oftentimes, assigned female at birth (AFAB) people tend to internalize more often, making their struggles seem invisible to others. Self-harm, such as cutting, counts in the meltdown category. Racial identity and racism also directly affect how people are allowed or not allowed to express their overwhelm.

Certain things just don't make sense to them, and they don't know why. Alternatively, things that are obvious to them may be not at all obvious to others.

They may or may not make eye contact.

- For some Autistic people, eye contact is actually more distracting than

it is connecting. Possibly due to less synaptic pruning, Autistic people take in vast amounts of information at any given moment, and it is too much to filter. Not making eye contact can provide less input, which often results in more focus.

They are easily distracted or have a hard time staying focused, specifically when something isn't interesting to them.

They have some sort of movement, sound, or other behavior that they engage in repetitively that helps them feel more relaxed, present, engaged, or safe. This is called stimming and is an essential part of self-regulation.

- Stimming is a wonderful thing! It's a part of Autistic innate brilliance that the bodymind knows how to regulate itself as needed. Stimming can be fun, playful, creativity enhancing, relaxing, or energizing. There are endless ways to stim! A lot of people are trained out of their more visible stims as a way to appear more NT or less "weird," which is really sad. The more well-known Autistic stims are rocking and flapping, but they can be big movements or barely visible.

- Both neurotypes stim, but often-times it's referred to as fidgeting for KCS/VAST.

- It is my perception that stimming has more stigma associated with it, while fidgeting is somewhat more socially acceptable. That said, there is still plenty of judgment out there about engaging in repetitive movement. White supremacy prefers people to have "quiet hands and bodies." Ick!

They may seem really intense or deep. Small talk may be a struggle.

They may report a history of feeling disconnected from other humans, lonely, or misunderstood and have a deep longing for connection with others.

They need alone time.

They are extremely passionate about certain topics or areas of interest. This is sometimes referred to as special interests/SPINs, but that can have a condescending connotation, so I choose to say passions.

- Autistic people may have the same passion for years, even decades. Their depth of knowledge about the topic is likely profound and nuanced. It's common for KCS/VAST people's passions to change more frequently. These are not absolutes by any means. Due to oppression, many KCS/VAST people get accused of "not following through," "losing interest too easily," or "jumping from thing to thing." Whether long term or short term, these passions are not just valid but important and vital to that person's aliveness and well-being.

They prefer routines and can seem rigid.

- A primary difference between the two neurotypes is that Autistic people tend to crave sameness, predictability, and knowing what to expect. KCS/VAST people, on the other hand, tend to crave novelty as part of producing more dopamine for their brain. This is also why their passions may change more frequently, because once the novelty wears off a passion may no longer be as interesting.

They may relate to the terms highly sensitive person or empath.

- Within the Autistic community, there are mixed opinions on whether or not highly sensitive is its own neurotype, or if it is a more socially acceptable label for someone who is actually Autistic. Some are adamant that not all Autistic people are highly sensitive, while others argue that using the label highly sensitive is a way to avoid the social stigma associated with autism. Similarly, with the term *empath*, some Autistics believe that word is a way of coding social stigma with a lofty spiritual label.

No matter how much self-growth work they've engaged in, some things just don't change.

- Many times, unidentified Autistic

and/or KCS/VAST people are long-term clients who may be on a perpetual journey to try to change who they are. They may be deeply invested in the narrative that "This is a me problem, and if I just try harder, I'll be 'normal' like everybody else." They may change therapists multiple times to try to find someone who can finally help fix them. They may try to induce their therapist into believing their narrative; together you may find yourselves in cahoots with their belief that they are "broken" and you can be the hero they've been searching for. Turns out, you just might be! But not in the way they anticipated. You may be the person to finally help them accept that they aren't broken, they're Autistic and/or KCS/VAST!

They have a hard time with executive functions such as being on time, managing all the different responsibilities of life/home/adulthood (e.g., cleaning, laundry, groceries and cooking, bills, scheduling appointments), staying organized, advocating for themselves, navigating new situations, and so on.

- Sometimes called "adulthood" for people who are adults. Both neurotypes have varying difficulties with this. For kids this is most often obvious with things like the state or disarray of their room or challenges at school.

The more they heal from trauma, the more sensitive they become.

- Let's use an example of a particular loud sound, say a siren. With trauma work, one would suppose that over time the sound of the siren and the memories associated with it would get integrated into the system and be less disturbing. The person may never like or have an affinity for that sound, but the trigger may diffuse or get easier to tolerate. For Autistic and KCS/VAST people, healing from trauma can make the unwanted loud sound even more difficult to deal with. Healing and unmasking can increase sensitivity, not lessen it.

They may be easily influenced, a "chameleon" becoming like the

others in their environment.

- When I learned this, it was a total lightbulb moment for me. It was what I needed to move beyond the perpetual (not cyclical at the time) imposter syndrome in my self-acceptance as an actually Autistic person. This is especially common in high-masking AFAB folx. They can feel that they have a diffuse sense of self or lack a sense of self, but it can also make them really adaptable. It is often not something that is done consciously, and it can very much be a survival strategy. You may hear clients refer to “becoming who the environment expects them to be.” This can be a form of code switching, is tied to intersectionality, and is about passing as “safe enough” or “normal” in the presence of dominant sociocultural identities. It is deeply tied to masking.

Regulating emotions can be really challenging.

- Perhaps they tend to feel a lot and frequently, and their emotions seem to shift quickly.
- They may not know what they are feeling; it can feel more like a “jumbled internal indecipherable” landscape, also known as alexithymia (there’s a lot happening inside, but I don’t know what it is or why I feel it).

They may experience heightened sensitivity to injustice, also known as justice sensitivity.

- In children, this can present behaviorally as inflexibility in the face of real or perceived injustice, especially with siblings, peers, or people in positions of power. It can also present as deep distress over injustices like climate change, racism, homophobia, transphobia, eating meat, animal abuse, or abuse of any kind.
- In adults, it may be more visible through activism and investment in social justice. Again though, there is deep distress over injustice, deep empathy for the abused planet, people, or beings on the receiving end of injustice, and a profound internal drive to make right what is wrong, unfair, and unjust.

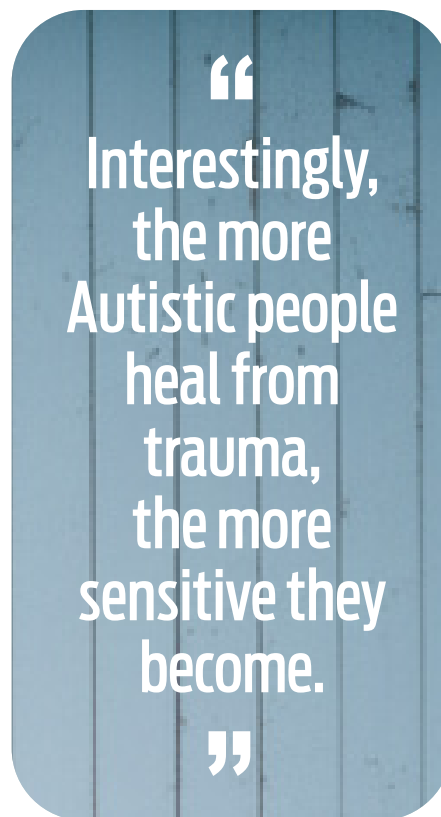
They may be very sensitive to rejection,

whether actual or perceived, or fear of possible rejection, also known as rejection sensitivity dysphoria (RSD).

- This is being more talked about lately with KCS/VAST, though it’s definitely a lesser known but important attribute of this neurotype. Rejection can signal a threat response and be a very real source of trauma.

They have pattern recognition.

- They tend to notice trends and connections among things or ideas and have a way of weaving together past, present, and future.



They are curious about their neurology and find themselves wondering if they might be Autistic or KCS/VAST.

- Just as straight and cisgender people don’t tend to question their identities or spend months if not years researching queerness or transness, learning everything they possibly can, losing sleep over it, maybe even talking to every person who will listen about it, neither do neurotypical

people when it comes to their neurotype. It just is. It’s not a question.

They tend to like or connect more easily with or gravitate toward other Autistic or KCS/VAST people.

They have family-of-origin members who are also Autistic or KCS/VAST.

- There is definitely a genetic component here. It’s common for one person to be identified and then suddenly many others in the lineage get identified, too. Sometimes a child gets identified and then there is a trickle-up effect. Or an adult will get identified, then discover their child(ren) shares their neurotype, or siblings, parents, and other relatives.



As you read through this list, even more ideas may come to mind. Whether you are Autistic or KCS/VAST or love people who are, there may be aspects of who you are or relate to that didn’t make it onto this list. These aspects are just as valid! Here is a great place to remind you of the wisdom and insight with which you came to this article. 

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Nyck Walsh, MA, LPC, (he/they) brings a whole person, anti-oppressive, intersectional, somatic lens to working with Autistic and KCS/VAST (what is commonly known as ADHD) folx. An Autistic and VAST counselor, Nyck is the director of Nyck Walsh Counseling & Training Center and creator of the Neurodivergent Somatics model. He curates reparative experiences for late identified Autistic and VAST folx to connect with their innate wisdom, dismantle ableism, be supported in their challenges, and unpack their lives through their unidentified and misunderstood Neurodivergent (ND) experience.



BY TERRY MATLEN

ADHD from Girlhood to Perimenopause

What Are the Signs We Keep Missing?

When a woman with ADHD comes to me for help, I almost always hear the same questions: *What's wrong with me? Why can't I get my work done? Why can't I get dinner together on time? Why can't I have people over? Why am I late to everything?* These questions resonate deeply with me. After all, I also happen to be a woman with ADHD, which means I was a girl with ADHD, a young mom with ADHD, a young clinician with ADHD, and now, I'm an older clinician and mom with ADHD. My lived experience and clinical practice have taught me things I wish more people—including many in our own field—understood about how ADHD presents differently in girls and women.

In my practice, I work with many of these women. They're bright and talented—and they're suffering. Many were diagnosed with ADHD later in life, and are wrestling with grief over their “lost years,” when their difficulties didn't have a name and their symptoms were seen as character flaws. Many find it difficult to maintain friendships, forgetting to call and connect with people they care about. And their romantic relationships are often filled with misunderstanding and conflict, especially when a non-ADHD partner fails to understand them. In stark contrast to how society often thinks about boys and men with ADHD—more externalized, less misconstrued, and less stigmatized—these women have gone through life hearing things like, *She's chronically unhappy and can't keep up with life.* When these messages get internalized, they often result in misdiagnoses related to depression or anxiety.

Then there are the women whose ADHD is undiagnosed. They often come into our offices simply feeling overwhelmed. They compare themselves to other women who seem to manage their lives more successfully, and they wonder why they don't measure up. Gender roles have always been unequal—women are frequently expected to do more than their fair share of parenting and housework—but for women with ADHD, the added burden of sexism only amplifies their feelings of failure and inadequacy.

A Roller Coaster Ride

When I was a child in the '60s, nobody diagnosed me with ADHD. I wasn't rambunctious, I didn't act out, and I didn't shoot spit balls or shove kids in the playground. Like so many girls around this time, my ADHD was missed because I didn't have behavioral problems. I was a daydreaming teacher's pet who didn't stir anything up. But man, was I disorganized! My school desk looked like an exploding garbage truck. Library books disappeared in the chaos of my

bedroom, whose floor was covered with projects, typically unfinished. This meant that week after week, I failed to earn my coveted allowance. Eventually, I figured out that shoving everything in my closet would earn me my cherished 75 cents each week, but I simply couldn't get organized. I even unintentionally killed my beloved pet turtle, Joey, after forgetting to feed him and refill his water dish one too many times. Poor thing.

Once I entered middle school, life became harder since I could no longer keep up academically. My natural abilities that had made me a superstar in elementary school no longer seemed to work. My mind was constantly elsewhere. I couldn't study, I gave up on homework, and I gave up on myself. Adding insult to injury, I started experiencing intense anxiety, and it wasn't long before my sense of self-worth took a nosedive. Fortunately, college gave me a new lease on life. I had more control over my academic options, and I chose a path well suited to my strengths.

Like so many women, I'd learned to mask my struggles. As a top student and a people-pleaser with many friends, nobody would've thought I was struggling. But my childhood disorganization followed me into my college years. I procrastinated on writing assignments and crammed for big exams the night before. In fact, I became a *master* at procrastination (in many ways, I still am one). But in my earlier years, I battled daily with severe school phobia, feelings of dread and worry, and separation anxiety.

Years later, life got even more complicated: I became a wife and mother and found that my children needed consistency, structure, and dinner on the table each night by six o'clock. Add in the fact that both of my kids were exceptionally active and one had significant special needs, and I felt totally adrift. I was convinced I was a terrible mother, and before long, my daughter's hyperactivity drove me into a state

of high anxiety and my overwhelm reached new heights, where life felt almost too hard to manage.

Looking back, it felt like my small, messy childhood bedroom had been a preview of life to come: a house filled with clutter and chaos. Instead of being littered with my own toys, puzzles, and dolls, the space was filled with unopened mail, laundry baskets of unwashed clothes, piles of dirty plates, multiple junk drawers, unsigned school permission slips,

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Roughly five percent of adult women in the U.S. have ADHD, and increased public awareness means that figure is climbing.
”

and another generation of toys, puzzles, and dolls. Countless little paper slips were scattered throughout the house, scrawled with handwritten reminders of tasks that had long needed my attention.

After my youngest child survived a horrific illness that led to significant disabilities and severe ADHD symptoms, something dawned on me: we shared many of the same

traits, particularly disorganization and forgetfulness. This discovery in my early 40s prompted me to see a prominent expert on adult ADHD, who evaluated and diagnosed me. ADHD contains three subtypes—or “presentations,” as they're called in the *DSM-5*: hyperactive-impulsive type, combined type, and inattentive type. I land in the last category—the most commonly seen subtype in girls and women, and the most commonly missed.

My specialist also recommended psychotherapy and medication treatment, which meant referrals to a therapist and psychiatrist, both of whom specialized in working with adult ADHD. Once again, my life changed dramatically—only now in a good way. I began learning how my ADHD brain worked, and how to work with it instead of against it. I learned strategies to better manage my symptoms and began to process the poor self-esteem that had come from years of living undiagnosed.

Falling Through the Cracks

My story isn't uncommon. Roughly five percent of adult women in the U.S. have ADHD, and increased public awareness means that figure is climbing. Still, our field has been slow to meet the growing need. In fact, ADHD in adult women wasn't even fully recognized until the 1990s. Even now, when a woman with undiagnosed ADHD comes to a clinician seeking help, she's more likely to be given a diagnosis of depression, a prescription for an antidepressant, and a referral for long-term psychotherapy. ADHD has comorbidities such as depression, anxiety, mood disorder, PTSD/trauma, and substance use disorder—and lots of other young girls and women with ADHD are misdiagnosed with these conditions. Then, after years of therapy and meds, they don't get better and are left in despair, wondering, *What's wrong with me?* Their clinicians often become frustrated, too, and may question their skills or blame the client for not wanting to

get better.

For most adults diagnosed with ADHD, a combination of medication, therapy, and ADHD coaching help a lot, so communication between professionals in a treatment team is essential. It's also important to note that most clients with ADHD rarely find symptom relief with the first medication prescribed; it can take a while to find one that works and doesn't have problematic side effects.

Therapy and medication don't make ADHD go away—nothing does—but they can improve life dramatically, like they did for me. When I was newly diagnosed, I learned strategies to help keep things together, thanks to a therapist who understood ADHD in women. I still navigate a plethora of hypersensitivities every day, from clothes that feel too itchy to odors that knock me off my feet to difficulty expressing myself when I'm overloaded with strong feelings. But my life today is much better than it used to be.

I've also found adjuncts to traditional treatment helpful. Jogging, yoga, and meditation have worked wonders for me. Attending support groups for people with ADHD was crucial in my early post-diagnosis years; I no longer felt alone. My clients have told me that support groups have helped them feel understood and accepted, sometimes for the first time in their lives. And a good couples therapist who understands ADHD can help partners improve their communication so non-ADHD partners better understand the dynamics at play. ADHD is no walk in the park, but it's also not a death sentence.

What Can Clinicians Do?

As clinicians, we need to listen carefully to the stories our clients tell us about their early school experiences. How did they interact with peers? Did they struggle to finish schoolwork? Did they get poor grades even though they were capable? And today, are they in a career that matches their strengths and abilities,

or are they underemployed, underpaid, and unhappy? Have their interpersonal relationships been healthy? We also need to understand that many ADHD symptoms and challenges will intensify as a woman ages and her hormones shift, especially in perimenopause and menopause. It's one of the most common reasons why women in midlife or later reach out to us for help.

Menopausal and postmenopausal women deal with the loss of estro-

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Many ADHD symptoms and challenges will intensify as a woman ages and her hormones shift, especially in perimenopause and menopause.
”

gen, causing brain fog, memory issues, mood changes, and physical and emotional fluctuations, which they sometimes misread as signs of early dementia. Sadly, since most women seeking help are diagnosed with depression and given antidepressants that don't help, they spend years riding a rollercoaster of defeat, and leave therapy feeling even more defeated.

Undiagnosed girls and women hit different barriers across their lifespan, including when they first get their period and experience the fluctuations in mood, energy, and sleep, when they're starting college and lose the structure of home and parents, when they're entering a competitive and taxing job market, and when they're starting a family and the focus shifts to the needs of their young children.

At these junctures and other life changes that throw a woman off course, early traumas and PTSD symptoms may overlap with ADHD traits in ways that make diagnosing tricky. This was my situation, with my severe comorbid anxiety disorder, a history of early trauma, and undiagnosed ADHD. Had I been treated appropriately when I was younger, my life would've been far different. It's why I recommend that clinicians who are unsure how to diagnose refer clients for a neuropsychological evaluation, so they can tease out exactly what's going on.

As a field, we're playing catch-up. Back in graduate school, most of us weren't taught much about ADHD in women—or about ADHD in adults at all. But now, we can close that knowledge gap. We can help eliminate the stigma. We can help people be kinder to themselves and give them the tools to better manage their symptoms. We can eliminate years of unnecessary suffering. It starts with changing how we listen. 

*Terry Matlen, LMSW, is a psychotherapist and the author of *The Queen of Distraction and Survival Tips for Women with ADHD*. She presents nationally for PESI on ADHD in women, and has been interviewed on NPR and quoted in *The New York Times* and *The Washington Post*. She offers online consultations for women with ADHD at ADDconsults.com.*

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BY KORY ANDREAS

How Assessments **FAIL** High-Masking Adults

The Case for Narrative Diagnosis

It's 8 p.m. on a Friday night, and my phone's "ding" announces an email from Kristy, a former client. "You have to watch Janet McNamara's stand-up act on YouTube. Right now. Trust me."

Janet's new special, recorded live at The Gutter Comedy Club in Brooklyn, is called *Not Smart Enough*. It opens with a clip of her seated at a desk in the accounting firm where she works, clicking fiercely at her keyboard, her mouth hanging slightly open. A faceless coworker leans in. "Hey, Janet. How was your weekend?" Janet gazes up at the ceiling and sighs, the way a lot of Autistic employees do when they're on the receiving end of small talk. Then she puts her AirPods in and gets back to work.

The scene cuts to Janet on stage. She says she's been tested for autism three times, because "people keep asking me." The first psychologist who evaluated her 15 years ago for Asperger's said she wasn't autistic on the grounds that "people with Asperger's generally have above-average IQs." The crowd is already laughing before the joke lands. "So, apparently, I'm not smart enough to be mildly autistic. That's what that doctor told me."

As a therapist who specializes in working with late-diagnosed, high-masking adults, watching Janet methodically work through her bit starts setting off familiar bells. My specialization isn't an accident. I went most of my life without a diagnosis, collecting explanations for why I was too much or not enough. I spent years in therapy chasing answers and feeling broken. And I'm not a rare case. My practice is full of adults living this reality: people like Janet, who were evaluated, sometimes repeatedly, and given something other than the answers that would have helped them.

Janet's eyes dart past the audience to three fixed positions as she delivers her jokes. The punchline always landing at "12:00." Her voice





is monotone, her presentation deadpan. Her left pointer fingernail digs repeatedly into her thumb in a subtle, yet persistent stim. I know these moves all too well. If Janet were sitting across from me during an intake, I'd already have questions. If she were sitting next to me at a party, I'd know neither of us wanted to be there, and I'm fairly certain we'd get along.

Ding. Another email from Kristy: "Kory, I'm laughing so hard. She's new on the scene. I bet she'd do your podcast if you asked."

I DM Janet's manager that night. A month later, Janet's a guest on my podcast on neurodivergent adults. She's wearing a well-worn, tie-dyed hoodie and the undecorated white wall behind her gives no clues that this apartment has housed her for 20 years. She launches immediately into a comfortable monologue about her life. Beyond the jokes, the story isn't funny at all. Tears well up in her eyes as she recounts all the professionals she'd turned to for help who failed to see the obvious traits of neurodivergence in front of them. And ultimately failed to help her.

Janet doesn't actually have a low IQ. That first psychologist she went to was probably looking for the autism that comes with the word *savant* attached. In the 1980s, this was the only autism professionals were trained to look for. Today we know this presentation is a narrow slice of the whole story. High-masking autistic adults have expanded what the diagnosis looks like. Our clinical approaches haven't yet caught up.

The next clinician Janet saw for an assessment ruled her out for being too coordinated. Janet had been a lifelong athlete whose sports career had brought her the kind of positive attention and self-esteem that school hadn't. But having mainstream special interests, like sports or reading, doesn't mean you're not autistic. Often, it just means that people are more likely to overlook what you're struggling with underneath. Plenty of my clients excelled on the field and then hit adulthood entirely unprepared to make friends outside a structured roster or navigate an office with no rule book. "Soccer player" comes

with rules, routines, and built-in support. "New accountant" does not.

A third clinician ruled Janet out for making "appropriate facial expressions" and having "an understanding of what a friendship is." High masking adults are well versed in learning the expectations of non-verbal communication. We also have friends, often other adults who are wired similarly. These clinical observations are no longer enough to rule out autism. In 2026, they are an indicator to dig deeper beyond traits that can be observed.

This is the paradox of being Autistic. We're frequently capable of overcoming things that would break most people, and we struggle with things most people never have to think twice about. Janet's neurodivergence didn't cancel out her talent, it produced it, the kind of talent that gets you standing gigs at iconic comedy clubs. But long before that dream took shape, years of misdiagnosis left her deep in burnout: anxious, miserable, reprimanded by bosses, sometimes unable to work, and cycling through increasingly higher levels of psychiatric care.

None of those identified disqualifiers should have precluded Janet from getting support for what was actually overwhelming her: sensory stressors, being continually pulled out of hyperfocus, office politics and bullying that altered the shape of her career. High-masking autism shows up regularly in all sorts of sectors: medicine, law, tech, and a range of creative arts—anywhere that intense and brilliant brains get to shine, or *should* get to shine. But all too frequently, my Autistic clients, especially ones who were undiagnosed for much of their life, are met with trauma rather than career growth, because they don't get the support they need to shine.

Janet is a public case study of what happens when professionals don't understand high-masking autism. Fortunately, Janet found her way to a comedy club stage. But many of my clients instead land in unemployment, disability, and the kind of burnout that doesn't get better without neuro-affirming care.

That's why I'm so passionate about sitting with my clients long enough to

ask the right follow-up questions to see what's actually there rather than what fits a checklist.

The Problem with Checklists

The tools we've been handing clients to assess for autism are a little like X-rays. They may catch big, obvious "breaks." But they miss what's happening in those of us whose struggles exist in the "soft tissue" of life.

Do you maintain eye contact? Always, sometimes, or never.

This question trips up high-masking Autistic adults because the answer is complicated. Eye contact comes easily on the couch with a partner. It disappears entirely in an unfamiliar conference room. At the grocery store eye contact depends on the day, the lighting, how many decisions you've had to make that day. Did your mom and teachers shame you into eye contact for years as a kid? Did you learn it through repetition and correction, the way you learn things that don't come naturally? By adulthood, many high-masking autistic people make eye contact so reliably that it reads as effortless. It's not. It's labor that has been so thoroughly automated that even the people doing it forget they're doing it. There's no room for that nuance on a standardized test.

Do you have difficulty making friends? Always, sometimes, or never.

When? Where? Work is work and home is home. High-masking folks are often unsure of how to answer this question. Where's the option that lets them say something like: *Neurotypicals don't usually like me, so I don't try with them. With other autistic people who share my special interests? That usually goes well for about six months, and then it's not so easy keeping those friends. I have a couple of group chats going with people who share my special interest. I'll go out on occasion. Friendship is complicated when we're comparing the kind we prefer to the kind that's dictated by neurotypical standards. Often our brain yearns for connection, while our bodies are exhausted by the expectations that come bundled with the realities of friendship.*

A standardized test can't accurately measure the kinds of nuances you see in high-masking people. Still, the assess-

ment process for autism, even in 2026, is observable, binary, scoreable. Check the box, print the report, and tell the test taker that unfortunately, they “just didn’t meet the criteria.”

I understand the appeal of that assessment. I’m not arguing that these systems should disappear. Standardized measures are built to provide consistency in care. They can reduce the impact of the assessor’s bias, and for clinicians without a strong background in the autistic population, they provide a springboard for a deeper level of understanding. This isn’t an indictment of practitioners who begin with a standardized measure, but rather a plea to consider the limitations when these tools become the final word. Clinical judgement is uniquely critical for this population in ways that are specific to the traits we’re looking to understand in our clients. A tool used as one piece of the picture is useful. The problem is that what these assessments actually measure is a surface presentation. And for a population that’s spent their entire lives learning how to pass as the evaluator’s version of normal, surface presentation is unreliable.

Think about every other diagnostic label we hand out in this field. When a client reports depression, we don’t need a number on a scale. We ask what happened and how it lives in the body now. We ask how long it lasted and what helps. We talk and listen. We’re certainly not asking them to rate their depression against a bell curve.

Even in the medical field, if a client tells a doctor that he has erectile dysfunction, does the doctor ask him to rate the dysfunction on a scale of 1 to 10? Or does the doctor believe him, ask what’s changed, and inquire what the issue is doing to his intimate relationships? We don’t demand ratings for social anxiety, or separation anxiety, or phobias. We ask, listen, and treat what’s in front of us. We certainly do not ask for a second opinion from a family member in order to confirm a diagnosis.

The standardized instrument doesn’t make the diagnostic process more scientific. It gives the illusion that a deviation from the norm makes the treatment

path clear. A client account of their own lived experience *is* data. Observing what they eat, what they wear, what shuts them down—that’s data, too, not a lesser form of evidence that requires validation from a checklist.

Many of the Autistic adults in my office have spent thousands of dollars to mask their way through an assessment built to catch when someone isn’t performing as constantly as they are. They walk out with a report that says they don’t meet the criteria. No diagnosis. No care. No answer for the thing that brought them into the room in the first place. Often, the assumption is, “It must just be anxiety.”

If a missed or wrong diagnosis here meant sending someone into chemotherapy, I’d understand insisting on an airtight, heavily quantified process first. That standard exists for a reason elsewhere in medicine. But we’re talking about therapy, delivered by someone who understands autism, for a person who needs it. Get it right, and the cost is nothing. Get it wrong, and the cost is years of the wrong treatment and a client who has learned, once again, not to trust the process. When provider after provider tells you the reason you’re not improving is you, that causes trauma.

Misdiagnosis is not a neutral outcome. It causes real, documented, lasting harm. And it misses women, people of color, anyone without thousands of dollars to get a second opinion, anyone who learned early that masking was survival. It sends people into treatment rooms with clinicians who are working from wrong information. And when it misses them, far too often, we just move on, delaying appropriate support by years or even decades.

More and more misdiagnosed autistic adults are leaving messages in my inbox, asking to be added to my waiting list, commenting on every post I put up about late diagnosis and recognizing themselves in language no evaluator ever used with them. They’re in their 40s and 50s, finally getting closer to the answer that would have changed the trajectory of their lives if someone had asked better questions decades ago.

Systems are extraordinarily resistant

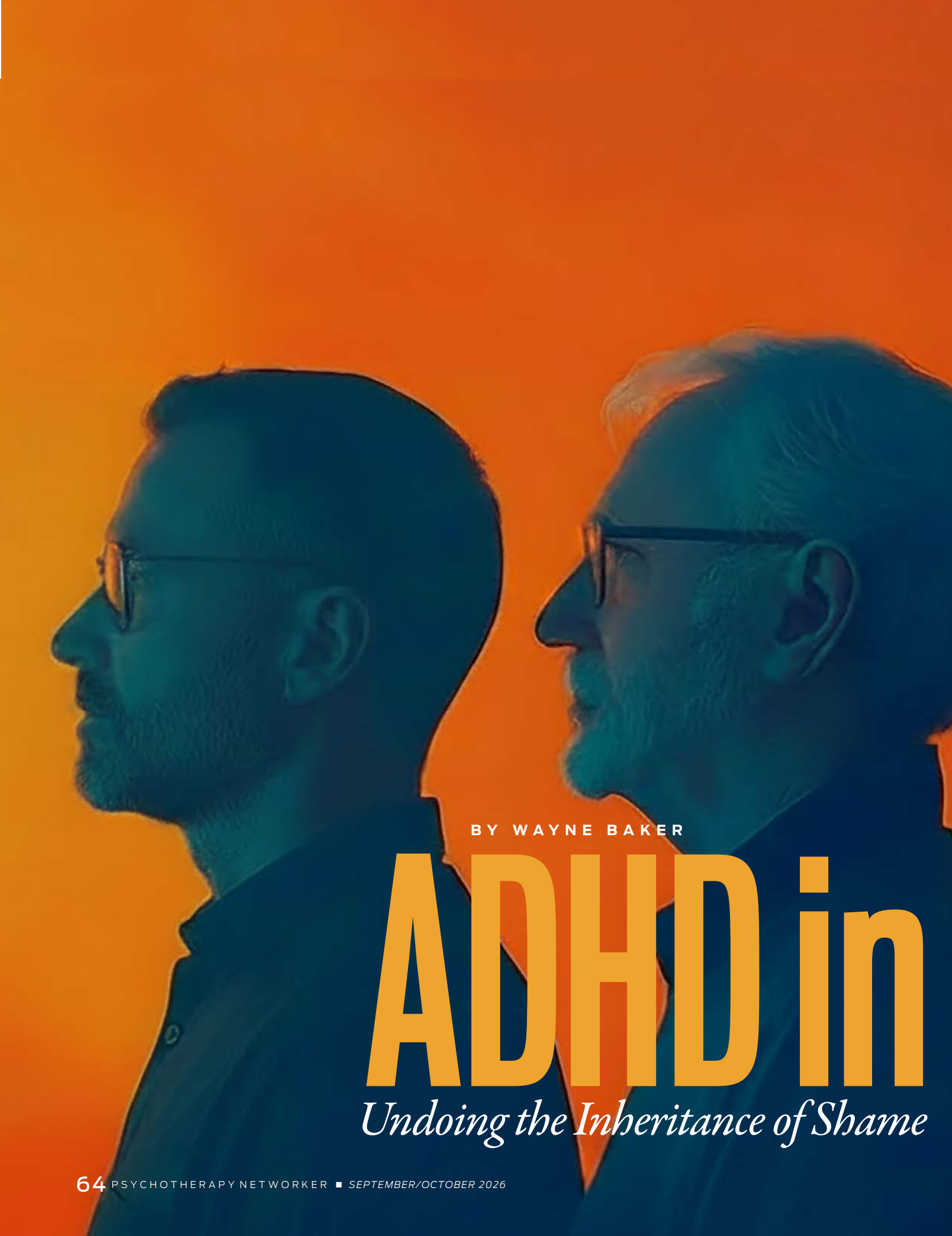
to change, especially when the change requires clinicians to slow down and sit with ambiguity rather than scores. As a result, we’re still using forms designed decades ago, scored against criteria that were developed primarily from observations of a narrow slice of the autistic population—white men—and calling it the “best” way to get diagnosed. The forms have been slightly updated, and the scoring is more refined, but the fundamental approach—observable behavior checklist, norm comparison, and threshold decision—remains largely intact.

The Narrative Alternative

Do you want to know if someone has sensory sensitivities? Skip the checklist and just ask them. And then, importantly, ask follow-up questions. Don’t ask, “Do seams in your socks bother you?” and accept yes or no. Ask what happens in their nervous system when they feel those seams, whether they’ve spent years happily paying 14 dollars for seamless socks from one very particular brand because it’s the only thing that works. When we identify someone as Autistic through a narrative assessment, the treatment that follows is surprisingly ordinary: the client receives therapy focused on their neurodivergence, guidance on accommodations, help understanding their own nervous system and their own sensory needs and building a life around the brain they actually have instead of the one they were taught to perform. It’s the same therapy I’d give anyone, just tailored more precisely to their concerns.

We already have clinical training for this kind of conversation. We have the science that tells us how the autistic nervous system processes sensory input differently and generates responses. Autistic people often try to mask until they burn out and can’t mask any longer. We can show our clients how their Apple Watch can alert them to a nervous system crash more reliably than their own body, and see that it’s the grocery store, the chaos of parenting, and the transition from work to home

CONTINUED ON PAGE 90

A stylized illustration of two men in profile, facing each other. The man on the left is younger with a beard and glasses, wearing a dark shirt. The man on the right is older with a beard and glasses, wearing a dark suit jacket over a light-colored shirt. The background is a solid orange color. The text is overlaid on the right side of the image.

BY WAYNE BAKER

ADHD in

Undoing the Inheritance of Shame



The year is 1970. I'm in third grade. It's after school, and my friends and siblings have long since closed their books and are outside riding bikes on a warm afternoon in Dallas, Texas. I'm still at the kitchen table.

I don't use words like *slow* or *struggling*. But there's a quiet knowing that something is wrong with me I can't yet name. Assignments take me longer. Longer to start. Longer to get through. Longer to find my way back when my mind drifts to something more interesting than how many apples I have in the basket after I gave three to my friends.

I don't know what to make of this. So I file it away in the place where children keep the confusing things they begin to believe about themselves.

Around that same time, my father began taking Ritalin.

He's a grown man. He has a job, a family, a life that, from the outside, looks like it's working. But something has shifted, some new attention to a pattern that has likely always been there: the unfinished projects, the bursts of anger and intensity, the brilliant ideas that arrive like lightning and then disappear just as fast.

Nobody explains this to me in clinical terms. It's 1970, and there's not yet a diagnosis that can fully hold what we're living. ADD will not appear in the DSM until 1980. ADHD will not exist as a term until 1987, and even then, ADHD would be understood primarily as a childhood disorder affecting hyperactive boys. My father is being treated for something medicine has noticed

but not yet fully named. I'm struggling with the same inherited brain circuitry, but from the other side of the kitchen table.

I won't understand any of this until decades later, when my daughter's evaluation handed me back my own childhood in clinical language. That is where this story really begins: not with a diagnosis, but with three generations of one family slowly finding a name for the shape and workings of our minds.

My parents were proud of me. I want to say that clearly, because what I'm about to describe is not a story of neglect or indifference. It's something subtler and, I think, more instructive. The things they said were probably accurate: "It takes him longer to get his work done." But what I heard, in the way children translate adult observations into verdicts about themselves, was: "He's not as smart as his siblings."

That gap, between what was said and what was heard, is one of the implicit injuries that frequently accompany childhood ADHD. Another injurious gap children with ADHD have to navigate is between the effort and the outcome. They watch other children move through tasks with an ease that feels mysterious and faintly shaming. They notice how often they're reminded, redirected, corrected, hurried, or misunderstood. And in the absence of an explanation, they construct one.

Families

*Something is wrong with me.
I am less.*

The neurology comes first. The story the child tells about himself comes second. But once that story has been rehearsed for years, it becomes an identity.

I didn't know any of this at the kitchen table in 1970. I just knew it took me longer, and I quietly decided what that meant about me.

Years later, I became a therapist, which may be the most elaborate compensation strategy a person with undiagnosed ADHD can devise. I built a career around sitting still and listening closely, strong resolve dressed up as a vocation.

I was good at it. I was also, in ways I could not yet see, still that child at the kitchen table: working harder than necessary, compensating for something I had never named, certain that the effort required to keep up was simply the price of being me.

And then my daughter started struggling in school. We almost had her repeat kindergarten. Then her second-grade teacher, Miss London, said it was time to get her evaluated. When the psychologist handed her mom and me her evaluation, Attention Deficit Hyperactivity Disorder, Combined Presentation, something washed over me that I can only describe as recognition. Not just of her, but of my father and of myself—of something that had been moving through our family like an underground river for generations.

A Condition That Travels in Families

Parents often blame themselves for a child's ADHD. They wonder if they were too disorganized, too reactive, too inconsistent, too permissive, too distracted. And, of course, the family environment matters. Parents shape children. Children shape parents. Routines, stress, affective regulation, and relational repair all influence how symptoms are expressed and managed. But ADHD is not caused by bad parenting.

ADHD is among the most heritable psychiatric conditions. Twin studies often place its heritability in the 70 to 80 percent range, roughly comparable to high-

ly heritable physical traits like height. So, when a client with ADHD arrives in a therapist's office, I have learned to wonder gently about the parents and grandparents too. Not to blame or pathologize the family, but because there's a strong chance that at least one parent is living with some version of the same condition that has not become visible.

That parent may be the one forgetting forms, missing appointments, struggling with follow-through, and having intense emotional reactions to things others aren't. My father and his generation did not get an ADHD diagnosis. In his case, a doctor noticed something. Several somethings, actually. The evaluation that led to his Ritalin prescription also yielded diagnoses of mild depression and narcolepsy.

It illustrates something clinicians who work with ADHD families now know well: mood, sleep, motivation, alertness, and attention often cluster together. But in an era before ADHD was well understood, the companions sometimes got treated while the underlying pattern remained only partially recognized.

My father was smart and at times engaging. He could also disappear behind fatigue, low mood, or distraction. I remember the feeling of him being there and not there, present in the room but hard to reach. As a child, I often took that personally.

A pill without a framework is only a partial intervention. Medication may quiet some symptoms, but it doesn't automatically reach the story a person has built about himself after decades of unexplained struggle. There was no family psychoeducation, no ADHD-informed therapy, no language for what connected restlessness, low mood, sleepiness, intensity, and inconsistency. Ritalin may have helped him, but shame is not treated solely with medication.

Without an organized framework, many adults in my father's generation developed elaborate workarounds, building identities around failures as much as gifts. They never quite understood why the gap between potential and performance seemed so hard to close. And this is part of what my father passed to me: not only a genetic vulnerability, but a

family culture defined by two people quietly managing the same uncharted interior landscape.

The Middle Generation

When I finally sought my own evaluation, prompted by the tender irony of watching my daughter struggle, the process was more confusing than I expected.

I've spent more than two decades as a licensed psychotherapist. I've sat with hundreds of clients as they work through their own minds, patterns, histories, and stories of effort and confusion. The version of ADHD I'd absorbed—fidgety boys who couldn't sit still in school—had nothing obvious to do with a man who'd built a clinical career on careful attention.

And yet, the evaluator's report read like a biography of my life.

The chronic underestimation of time. The hyperfocus that could consume an entire day and then disappear completely. The emotional intensity that could arrive suddenly and leave wreckage behind it. The exhausting performance of competence, what researchers sometimes call compensation, that allowed me to pass as organized for decades while quietly burning through energy reserves I didn't know I was depleting.

And then there were the other things, the ones I had explained away separately. The low-grade melancholia that had shadowed me for much of my adult life, never severe enough to fully name, but always present enough to color things. The narcolepsy that made certain stretches of the day feel like moving through water and the sudden weight of sleep arriving at unwelcome moments.

My father's constellation. Now mine.

This is what intergenerational ADHD can look like when you finally see it clearly—not just a single trait passed down, but a recognizable profile of attention, mood, arousal, sleep, intensity, and shame expressing itself with exceptional consistency across family lines.

Now in my 60s, I can look back and see that much of what I'd attributed to temperament, personality, the emotional pressure of work, or simply the human condition was also part of a recognizable neurological pattern sitting in my fam-

ily history, waiting for someone to read it whole.

A late ADHD diagnosis in adulthood is a complicated emotional event. It rarely lands as simple relief. There's grief for the years spent struggling without understanding why, grief for the relationships that paid the price, grief for the version of yourself you might have been with earlier support. There may be anger at the systems that missed it and a kind of retrospective reorganization of the self as years of self-blame get carefully and often painfully reassigned.

For parents who receive their diagnosis because of a child's evaluation, there's another layer. Watching your child get the support you never had can activate profound grief. It can also create a powerful opportunity for connection. A shared language changes a family. It certainly changed mine.

The River Has a Name Now

My daughter was 10 when she was diagnosed. She's 30 now, and she's also a psychotherapist.

That sentence still moves something in me.

She is, in almost every meaningful way, a different story than me or my father. Not because ADHD has been simple for her, but because she had language earlier than we did. She had support. She had adults around her who could say with accuracy: this is not laziness, and this is not a character flaw. This is how your brain is organizing attention, time, energy, emotion, and effort.

I can't know exactly what that spared her. But I know it mattered.

Now, as an adult and a clinician herself, she understands ADHD from both sides of the room. She knows it as a lived experience and as something she may see in clients who arrive carrying the stories: I'm too much. I can't get it together. Why is everything so hard for me?

There's something quietly redemptive in that for me. My father's generation had medication without a map. My generation had competence without language. My daughter's generation has a chance at something more integrated: language, treatment, self-understanding, and perhaps less shame.

When my daughter and I talk about ADHD now, we're not only talking as father and daughter. Sometimes we're talking as two clinicians. Sometimes we laugh about it. Sometimes I feel grief for what I didn't know when she was young, or what I still missed even after I knew. But that's all part of something I now understand in my bones: healing is also intergenerational.

What Therapists Can Do

For clinicians, the family legacy of ADHD presents both a diagnostic and relational opportunity.

First, we need to look upstream. When a child is diagnosed with ADHD, it's worth gently wondering about the parents, and maybe mentioning that ADHD screeners like the Adult ADHD Self-Report Scale (ASRS) exist as a tool for gathering information and helping open a more accurate conversation. A parent who cannot manage paperwork, daily routines, and emotion regulation may not be oppositional. They may be untreated.

Second, we need to screen for the full constellation. ADHD doesn't usually arrive alone, and its symptoms are often mistaken for other conditions. Inattention can look like depression; restlessness can look like anxiety. Mood symptoms, sleep disturbance, emotional dysregulation, and shame often sit nearby. The point isn't simply to sort symptoms into the right diagnostic boxes. It's to get a full picture of the person in front of us so we can treat the whole human being. When ADHD is treated well, some of the surrounding symptoms may soften because the client is no longer working so hard just to survive their own mind. But other symptoms may need their own direct care. If we focus only on the most visible symptoms, we may repeat the same fragmented care many adults in older generations received.

Third, we need to make room for grief. Psychoeducation matters, but information isn't enough. People diagnosed in midlife often need to mourn the years spent believing they were lazy, careless, too sensitive, underachieving, inconsistent, or somehow morally flawed. The diagnosis may explain the struggle, but it

does not erase the cost.

And finally, we need to help families reframe the story.

Families carry genes, but they also carry interpretations, labels. *Lazy. Dramatic. Scattered. Too much. Not trying hard enough.* These words become part of the emotional inheritance. Replacing them with more accurate language needs to be part of the treatment.

This doesn't mean romanticizing ADHD. The condition can be painful, disruptive, and exhausting. It can affect marriages, parenting, school, work, money, and self-trust. But clinical accuracy also requires us to hold the strengths in view: creativity, intensity, intuition, emotional aliveness, humor, divergent thinking, and the capacity for deep focus when interest and meaning are present.

My father had some of this. I have some version of it. My daughter does too.

The underground river is still there, running through my family. It always will be. But we can see it now. We have built some infrastructure around it: medication, therapy, systems, humor, accommodations, self-knowledge, and repair.

Most importantly, we have language.

We have a name for the shape of our minds.

And with that name comes the possibility of telling a truer story.

For therapists, perhaps that is the deeper invitation. Not merely to treat a disorder, but to help a family revise an inherited narrative, one that has often been told in the vocabulary of failure, and that deserves, finally, to be told in the vocabulary of understanding. 

Wayne Baker, LPC, is a psychotherapist, speaker, and educator specializing in betrayal trauma and infidelity recovery. With over 20 years of clinical experience, he works with individuals and couples navigating the complex aftermath of relational rupture, integrating parts work, somatic approaches, and relational neuroscience. He leads trainings and workshops for clinicians across the country and is currently developing a comprehensive model for infidelity recovery that emphasizes process, connection, and the conditions necessary for healing. He has a private practice in Colorado, offering both ongoing therapy and multi-day intensives.

A Critical BY TED FANEUFF Accommodation for ADHD Clinicians

When Notes Turn into a Dopamine Cliff

The sun had just fallen below the horizon, and the neighborhood had gone quiet in that particular way it does when everything is blanketed in snow. It was December, and I was sitting at my dining room table, close enough to the living room to hear my kids laughing. In front of me sat a stack of legal pads, a month's worth of handwritten session notes, and a laptop with my EHR open and waiting. The cursor wasn't moving. Neither was I.

The pages were covered in chicken scratch, desperate attempts to scaffold what I could remember—the important moments, the clinical observations, the things that mattered. The work was all there, somewhere in those pages. I just couldn't get to it.

I felt a pressure in my chest, ready to burst forth like a runner on the starting line. My mind was a maelstrom, holding thoughts with nowhere to land.

Being in a session, as opposed to in my living room with my notes, is something different entirely. A session feels like a dance, a constant push and pull of energy. The client brings the first wave. You receive it, read it, then send something back. Then you do it again. And again.

For a brain wired like mine, a therapy session is actually an ideal condition. The constant movement, the emotional intensity, the simultaneous tracking of what's said and unsaid, reading the body, holding the clinical framework, and managing your own internal response, all at once.

The ADHD brain isn't attention-deficient as much as it's stimulation-driven. It locks onto novelty, emotional intensity, and human complexity. A therapy session provides all of that simultaneously. Many clinicians with ADHD will tell you they feel most present, most alive, and most like themselves in the therapy room. The chaos of it keeps us sharp.

Then the client walks out.

And the stimulation that was holding everything together has left with them. A brain that was just operating at full capacity is suddenly asked to do the thing it's worst at: complete a low-stimulation, self-directed task, like completing progress notes, with no immediate reward. This is the dopamine cliff, and while standing at the edge of it, something as simple as deciding whether to go to the bathroom, get a snack, or open a chart can feel genuinely overwhelming.

What's left in these moments is a choice that doesn't feel like one. You can sit with the depletion and let your mind go numb while you scroll through your phone, or you can push through and try to do the thing your brain is least equipped to do right now. Either way, you pay for it. Either way, it costs something. And you do this multiple times a day.



Consider what a typical day actually looks like in your practice. You arrive at your office (or home office) minutes before your first client. You close one door and open another, and you're expected to be present, regulated, and clinically sharp.

Between sessions, you might have five or 10 minutes. That's enough time to use the bathroom, drink some water, and glance at your notes for the next client. It's *not* enough time to decompress, transition, or let your nervous system find its footing again. Lunch might be an hour, but let's face it, many of us don't take that hour for ourselves, because time is money and the pressure to fill your schedule is its own particular weight.

The intention at lunch is always the same: catch up on the morning notes. But instead, you eat and scroll. After all, your brain has been screaming for rest, and there are at least a hundred videos of puppies on Instagram that need your immediate attention. You tell yourself you'll make time for notes later.

The afternoon looks the same: two, three, sometimes four sessions. By the time the last client logs off or walks out the door, you're depleted beyond recognition. You go home. You want to see your family. You try your best to ignore the low hum of resentment that "something" is still hanging over you, unresolved and waiting. *Why didn't I just do the damn notes? Ugh.*

But that's a problem for another day. Because right now, your brain is done.

As clinicians, we'll fight for our clients without hesitation. We'll research every accommodation, advocate for every support, and chase down every tool that will help them function at their best. We do this because we believe they deserve to operate at full capacity. We do this because we understand that the right support doesn't diminish someone—it frees them.

And then we go home, sit alone at the kitchen table, and drown in a pile of notes that's eating us alive.

The Accommodation Double Standard

Somewhere along the way—in graduate school, in supervision, in the culture of the profession itself—many of us absorbed the belief that asking for help means admitting failure, that needing help is a blight on our competence, rather than a reasonable response to an unreasonable set of demands.

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For those of us diagnosed with ADHD later in life, that belief runs even deeper. We spent years, sometimes decades, developing workarounds we called personality traits, compensating in ways we called resilience, and pushing through in ways we called dedication. We never learned the language of accommodation, because it was never offered.

It's interesting that nobody questions accommodations for therapists who struggle in other ways. People

wouldn't think twice about a therapist needing a standing desk, a screen reader, or a noise-canceling headset because the workspace is too loud. These things don't generate ethical debates. Nobody pulls these clinicians aside to ask whether they're really committed to their clients.

But with ADHD, when the only struggle that shows is the output—the late note, the incomplete chart, the documentation that doesn't reflect the quality of the session that preceded it—the field fills in the gap with judgment of character. “Why is this so hard for you?” people ask. “You just need to get organized.”

Until recently, I smiled when I heard comments like these. I've always been good at smiling and blending in. But underneath the smile, something older was happening—a memory. I'm eight years old, and my teacher has just overturned my desk in front of the class. I'm picking my belongings off the floor, holding back the knot in my throat and feeling the stares of my classmates. I'm learning, in the way children learn things that stay with you forever, that my particular mind is a problem to be managed.

I don't use the word *trauma* lightly. But I know what it means when your body arrives somewhere before your mind does. When a colleague says something offhand about your perceived inability to get the things done, the smile comes first. The internal withering comes after, when you're stuck with the internal thoughts of *Am I good enough?* That thought alone tends to make many with ADHD feel overwhelmed and stuck, which only compounds the cycle. Your brain tells you you're a failure, and your actions stay the course.

What comments like these from fellow therapists completely disregard is the incredible effort therapists with ADHD are exerting to simply hold their lives together—the morning spent ingesting enough caffeine to make sure you're “with it”

and attentive, remembering to take your meds (if you're on them), and pumping yourself up with copious positive affirmation. You're literally telling yourself every day, before the work, that you can do the work, rather than just knowing you can. It's exhausting to start every day feeling mentally drained instead of feeling excited about the work ahead. To construct and reconstruct a mental scaffolding just to stay present and functional. For some of us, staying present feels like trying to focus on a photograph that keeps going blurry. You pull it into focus, it drifts, and you pull it back, again and again. For others, it's different: a physical restlessness beneath a calm exterior, the leg that won't stop bouncing, the racing thoughts running ahead of the conversation, or the energy that has nowhere to go in a room requiring stillness. And underneath it all runs a quiet, cruel loop: *Why can't I just do this? Why is this so hard?* None of it gets acknowledged. It simply disappears in the assumption that everyone's baseline is the same.

It isn't.

When Something Finally Works

The irony is that the same colleagues who'd never question a client's right to accommodations have questioned mine. Because mine involves AI—specifically, an AI documentation assistant. AI isn't magic. It doesn't do the clinical thinking. What it does is remove the translation tax for someone with ADHD, the exhausting work of reconstructing in writing what my brain did deftly in the consulting room. When a fellow clinician questions my ethics for using it, it takes me right back to the classroom floor.

When I first tried an AI documentation assistant, I almost didn't follow through. The weight of the ethical debate, the voices of my colleagues, the years of internalizing that needing help meant something was wrong with me, all of it sat between me and the thing that might actually help. It felt forbidden

before it felt useful. I approached it the way you approach something you aren't sure you deserve.

What I found was this: the output in front of me reflected, maybe for the first time, the actual quality of what had happened in the room—the dance, the push and pull, the clinical observations I'd made in real time but could never quite reconstruct afterward. It was all

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”

there.

My first feeling wasn't pride. It was relief. The knot released. Something I'd been holding for a very long time loosened just slightly. My brain, it turned out, had been beautiful and capable all along. I could be a great clinician even if I wasn't great at the administrative duties. Those were never the same thing. It just took me longer than it should have to believe it.

Now, on most evenings after my

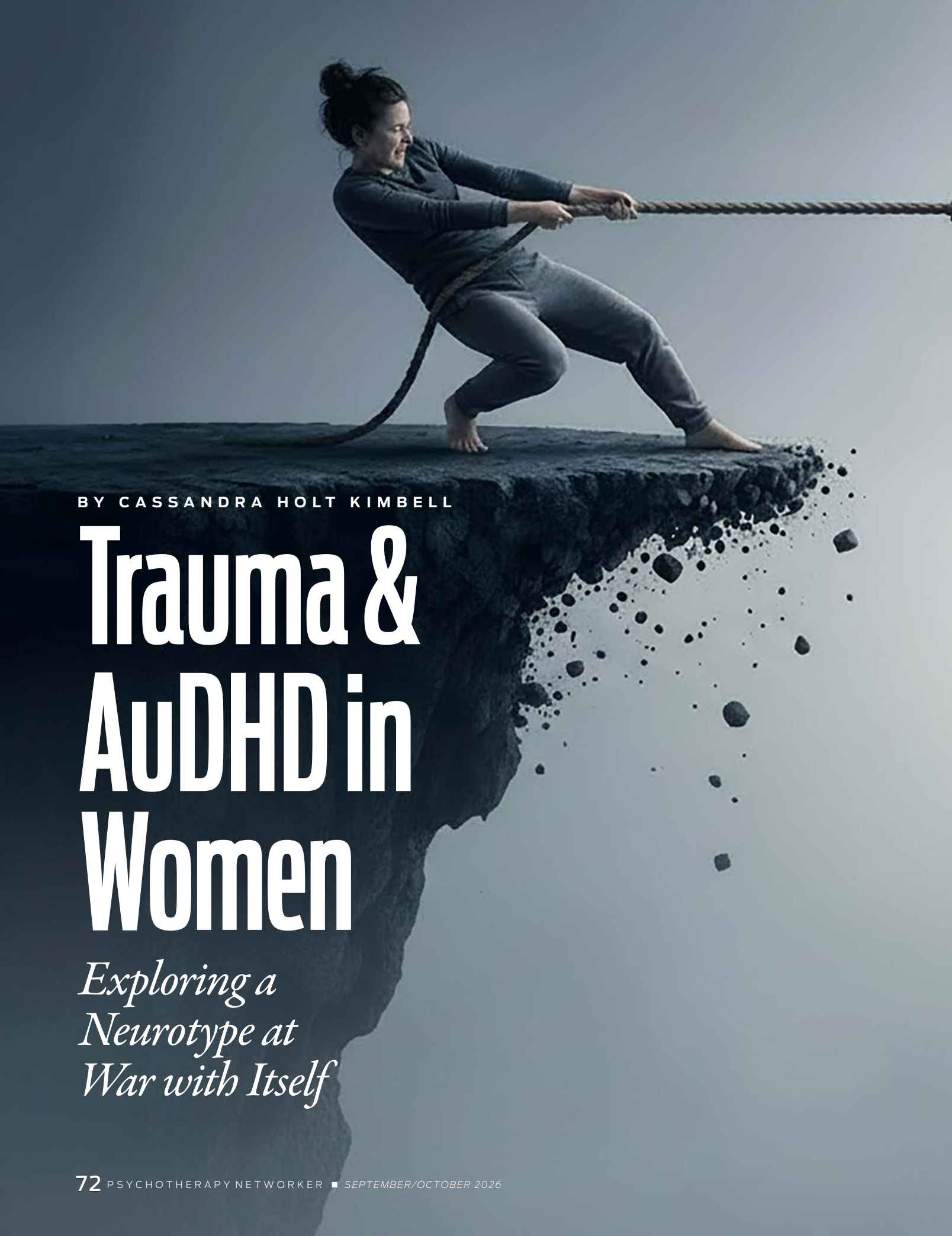
last session, I close the chart and I'm done. The notes are written. The day is actually over.

I should feel relief. And I do. But sometimes, I also feel grief for the many evenings I spent frozen at the dining room table, caught in the maelstrom of my mind as I tried to document sessions while my kids laughed in the next room. To the therapist sitting in the maelstrom right now, know that you're not alone. There are people fighting for you—for us—and for the right to do the work we love with the support we need to do it well.

The reality is that therapists are leaving this field. And it's my belief, formed over years of clinical work and conversations with colleagues, that a disproportionate number of those are the neurodivergent practitioners, the ones carrying the invisible weight. When that practitioner walks away because the cost becomes too high, it isn't only their loss. The client who finally felt seen by them loses something too.

We can't afford that. Understanding what our colleagues carry, even when we can't see it, must also be part of the work we do. That's why this conversation matters. Not because the tools or accommodations are the point, but because the people who need them, don't have them, and are made to feel guilty for using them are paying a cost our field never bothered to calculate. ■

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BY CASSANDRA HOLT KIMBELL

Trauma & AuDHD in Women

Exploring a Neurotype at War with Itself



As I'm sitting here typing this, I'm almost nonverbal. Earlier, I'd gotten confused and drove to the wrong doctor's office in mid-day traffic thanks to Google and my lack of planning. Then, I drove to the right place, speeding the entire way, just to be told my appointment is for next month.

This fiasco, combined with an event at my daughter's school at 7 a.m., has used up any spoons I have for the day. There's no way I can "people" anymore. I'm exhausted. My legs feel heavy, like they've been hammered into the ground. My soul feels the same. So do my eyeballs. The thought of speaking makes me want to cry, though I'll have to pull it together in an hour to pick my daughter up from school.

I stare at the screen for a long while and think about catching up on progress notes but my thoughts are scattered. You'd think working in mental health I'd be able to handle simple tasks. Instead, I just end up staring blankly at hundreds of unopened emails, completely frozen.

As my body shuts down, my brain works overtime, producing negative thought spirals. *You should be able to function. What's wrong with you? Look at that "to do" list just sitting there not being "to done." Everyone else is walking around functioning like it's effortless. They're doing all the things. Look how lazy you are! Why can't you just move?* These thoughts will continue for the rest of the day until I pass out, still staring at my iPad, hoping for inspiration and a burst of energy or motivation to make me not feel worthless anymore.

I've been a licensed professional counselor for the last five years, and I love my job. I love all the creative neurodivergent women and AFAB individuals I get to support who are like me, AuDHD—both Autistic and ADHD. I own a private practice and co-own a group practice where we mentor associate therapists and teach other clinicians how to help AuDHD individuals who've fallen through the cracks of the mental health system. Not every day ends with me speeding to the wrong doctor's office or spending the rest of the day frozen in front of my computer screen or nonverbal, unable to function. But experiences like these, the debilitatingly shameful events, are part of the reality of life with an AuDHD brain.

Originally, I was misdiagnosed as bipolar by a psychiatrist within eight minutes of entering their consulting room. Eight minutes. She didn't ask the right questions, or really, any at all. I don't even think she bothered to look up from her desk at me. I've never been suicidal, but being misdiagnosed and then put on strong mood stabilizers my body didn't need and couldn't handle made me want to be dead for the first time ever.

I was dismissed when I shared that the meds were making me feel wrong. She said, "No they aren't. You just started them. Just let yourself get used to them." I took myself off anyway. But that still left me undiagnosed and alone again without care or help for years—eight years, to be exact. I was left feeling like *I* had done something wrong by asking someone for help.

For AuDHD women with CPTSD, life can be debilitating, disabling, shame inducing, and utterly exhausting. I hadn't been experiencing mania or depression. I was struggling daily with undiagnosed CPTSD and had hit my polyvagal threshold—the point at which the nervous system can no longer regulate itself and tips into survival mode. What looked like mania was actually dissociation in a trauma-induced state, which happens to be common for Autistic people with PTSD navigating a world not built for them. But I didn't know this until I was helped by EMDR therapy, decided to become a therapist, and started doing autism assessments for adult women.

That's when it all started to make sense. The stories I heard from many of the late-diagnosed women I worked with were hauntingly familiar. There was no clean little F-code they could stick on it, but if you take all the symptoms many of my clients were experiencing—along with their neurodevelopmental characteristics and a disabling interplay of complicated circumstances—commonalities appear. My autistic pattern-finding brain found the pattern.

To understand how an AuDHD brain operates, consider the fundamental clash of needs happening within it. The Autistic brain functions as a precision-based system that requires predictability and sensory stillness to feel safe, while the

ADHD brain operates as a novelty-seeking engine that demands constant stimulation and change. When my Autistic side needs answers and definitive closure, my ADHD side can't focus long enough to find it. In a neurotypical brain, these executive functions generally pull in the same direction, but in an AuDHD individual, they're in a state of constant friction.

The ADHD side frequently disrupts the routines and structures that the Autistic side requires to avoid burnout, leading to a unique state of "functional instability," meaning appearing capable on the outside while being constantly destabilized within. When CPTSD is introduced, this internal friction is no longer just a cognitive challenge; it becomes a survival crisis. Because the AuDHD brain is naturally hyper-attuned to environmental shifts, trauma weaponizes this sensitivity, turning baseline neurodivergent traits into high-alert defense mechanisms. Our ADHD demands the very chaos that triggers our Autistic nervous system, while our trauma interprets this internal inconsistency as a bodily emergency and a lack of safety. Cortisol levels shoot up, the amygdala sounds the alarm, and our bodies communicate, "Oh, we've been here before," and either meltdown or shut down, and neither are a choice. The nervous system has been pushed to its limits and can't process one more sound, feeling, smell, or look.

Neurotypical people appear capable of handling small bumps in the road like misremembered doctor's appointments. Maybe it irritates them, maybe it slows them down, but they're still generally equipped to move on with their day. For someone with an AuDHD neurotype, however, the experience of those same small bumps in the road feels vastly different. Small setbacks add up, the energy spent navigating them is greater, and the dysregulation that results can quickly lead to shutdowns or meltdowns. The sensory overload and subsequent reactions I feel trying to parent or exist outside my home is often debilitating. I live a significant portion of my life outside of my therapy sessions wearing noise cancelling headphones and isolating to cope.

Cheat Codes

In my practice, I hear the same shared experience over and over. My clients feel as if the rest of the world got a book of cheat codes to life they never got. Everyone but them seems to just know how to "act right" and "adult right" and "do life." From a young age, many women and AFAB individuals who are late diagnosed feel different. We struggle with things that seem easy for others, or excel in ways that make us stand out, and then make us feel awkward for being seen. In social situations, we feel like we're always on the outside looking in, or like our brain operates on a different frequency. This isn't just a quirky personality trait; it's a persistent, nagging feeling that we don't quite fit the mold. It leaves us wondering whether there's something fundamentally wrong with us and why we can never find the right thing to do or say.

Often, we try desperately to blend in and act normal, but afterward, we replay the conversations over and over again in our minds, agonizing over the fact that we can't go back and do it over better, and it can be so intense that it manifests as physical pain. These repeated attempts to conform are called masking, and while masking may help you get through your day, the cost of the performance is high. This often leads to burnout, anxiety, and a deep sense of inauthenticity. And from what I have lived, what I have observed in practice, and what I have researched the last three years for my PhD, there's a direct link between chronic masking, late diagnosis, and CPTSD.

Masking itself is a form of trauma. We're ridiculed, judged, and corrected just for living. We receive confounding daily messages telling us everything we do is wrong. *Stop doing that. Why are you so weird? Quit faking. Stop standing so close. Look me in the eye when I'm talking to you. Listen to me the first time. Why can't you remember things? What are you staring at? Grow up. Stop tapping. Stop moving. Sit up in your chair. Why are you laughing? Why aren't you laughing, didn't you get the joke? Why are you never on time? Why are you early? You're fine, stop exaggerating. Don't be so dramatic. Smile more. Smile less. You don't look autistic. We're all a little autistic.*

AuDHD women and AFAB individ-

uals are traumatized early on. We try and follow, try and understand what the next right move is. We look to the people around us, and tend to trust more than we should, which leads us into situations where we're taken advantage of and preyed on. We walk through life with an extra layer of vulnerability to danger. We often feel we can't even trust our own judgement.

For late-diagnosed AuDHD women, the intersection of neurobiology and trauma isn't just a list of symptoms: it's a lifetime of complicated, layered structural and emotional masking. In my practice, I see a constant tug-of-war where one neurotype effectively masks the other: the autistic need for rigid structure and logical consistency often hides a chaotic ADHD interior, leading clinicians to miss the executive dysfunction beneath a veneer of over-preparedness. Conversely, the ADHD drive for excitement and novelty can mask the autistic need for predictability and routine.

When CPTSD is added to the mix, the masking becomes even more complex. The hypervigilance of trauma can be indistinguishable from Autistic sensory overload, and a trauma-informed "fawn" response can mimic the masking an Autistic person uses to survive. These intersections are frequently missed by clinicians who aren't informed about neurodiversity and don't understand the physiological reality that one can't simply rationalize their way out of a dysregulated nervous system.

Imagine spending your entire life feeling like you are playing a video game on the hardest difficulty setting, but everyone else seems to be playing on easy mode. You're exhausted, overwhelmed, and constantly burning out, even though you might look completely put together. This is life with an invisible disability.

A New Lens

My lived experience and clinical experience led me to develop something I call the neurodevelopmental trauma lens theory (NTLT). Rather than a clinical model, it's a lens to help therapists understand that for an AuDHD brain, trauma isn't just an event like an accident or a loss: it's the chronic, low-grade

friction of existing in a world not built to accommodate it. NTLT shifts the focus from "what's wrong with your personality?" to "how has your neurodivergent nervous system been forced to adapt to an incompatible world?" And it breaks down the AuDHD experience into three key areas.

The Sensory Trap. In AuDHD, this is an internal battle between sensory seeking (ADHD) and sensory avoidance (Autism). You might crave the high-stimulation environment of a concert to feed your ADHD brain's need for dopamine but then experience a complete Autistic shutdown afterward because the lights and crowds were physically painful. This leaves the nervous system in a state of high alert in every setting.

The Cost of Pretending. For AuDHD women, masking is "high-definition" performance. You use your ADHD "social butterfly" persona to distract people from your Autistic social confusion. You're essentially running two different operating systems in the background to appear "normal." This leads to profound interoceptive blindness, meaning you become so good at ignoring your needs to fit in that you struggle to attune to the messages your body is sending you, like that you're thirsty, overstimulated, or on the verge of a meltdown.

Missed Experiences. While the ADHD side might lead to spiky profiles—such as being brilliant in a crisis but unable to do laundry—the Autistic side struggles with the hidden social rules of adulthood. You might hit professional milestones but experience paralysis with simple things like consistent friendships or executive functioning at home. This creates a deep sense of shame and grief, as you feel like a failed adult despite your obvious intelligence.

The Misinformation Problem

Even as the field starts to become more informed about Autism and ADHD, social media has made neurodivergence clickbait, a hashtag, a funny reel, or a way for "coaches" and self-proclaimed experts to build their following. Studies in 2026 show that over half of the most popular ADHD and autism content on

platforms like TikTok is inaccurate.

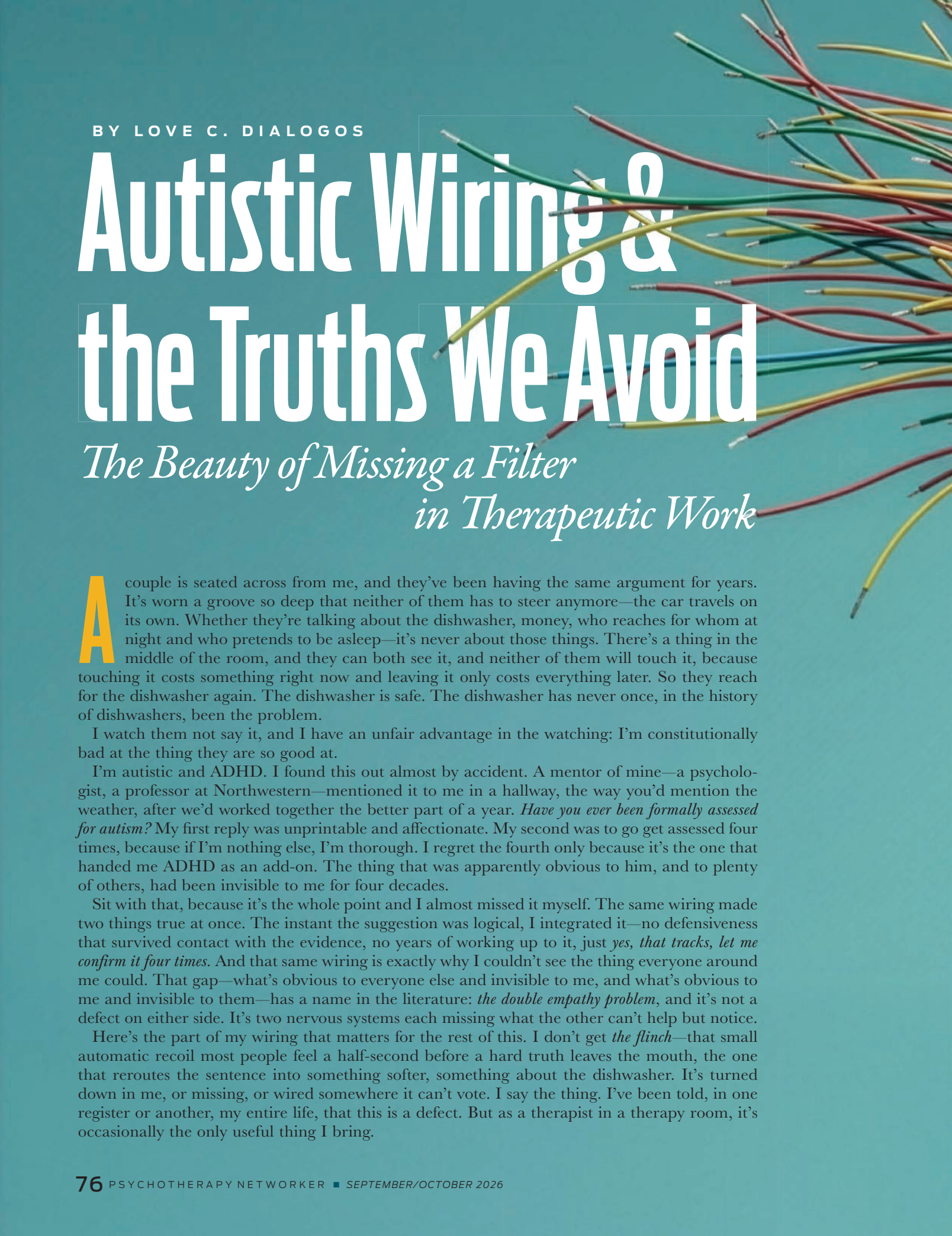
We need grounded voices to bridge the gap between the rigid, often-inaccessible medical model and the chaotic Wild West of the internet so people don't end up replacing one incorrect label with another and missing out on the specific support they need to actually heal. Sure, everyone forgets their keys or gets annoyed by a loud noise sometimes, but living with an AuDHD brain means getting hit by many overwhelming challenges at the exact same time.

We see influencers pathologizing universal human experiences like "preferring your room a certain way" or "getting bored during long meetings" as definitive proof of neurodivergence. This relatability bait flattens complex neurological profiles into catchy 60-second clips.

Truly helping people isn't just about finding a label that works in an algorithm; it's about helping them find language that reflects their lived experience so they can build a life that finally fits. Imagine a world where we didn't just hand young kids a script to follow for the comfort of those around them, but a mirror to see themselves clearly. What if we could save a whole generation from having to experience unnecessary suffering?

I believe we can. It starts with helping AuDHD clients understand themselves better. We have the opportunity to intervene before the mask becomes permanent, sparing people decades of trauma. By establishing more accurate diagnoses earlier and dismantling the systems that prize our compliance over our well-being, we're building a sanctuary for others coming after us, ensuring their light isn't extinguished by the world that should be nurturing it. 

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BY LOVE C. DIALOGOS

Autistic Wiring & the Truths We Avoid

The Beauty of Missing a Filter in Therapeutic Work

A couple is seated across from me, and they've been having the same argument for years. It's worn a groove so deep that neither of them has to steer anymore—the car travels on its own. Whether they're talking about the dishwasher, money, who reaches for whom at night and who pretends to be asleep—it's never about those things. There's a thing in the middle of the room, and they can both see it, and neither of them will touch it, because touching it costs something right now and leaving it only costs everything later. So they reach for the dishwasher again. The dishwasher is safe. The dishwasher has never once, in the history of dishwashers, been the problem.

I watch them not say it, and I have an unfair advantage in the watching: I'm constitutionally bad at the thing they are so good at.

I'm autistic and ADHD. I found this out almost by accident. A mentor of mine—a psychologist, a professor at Northwestern—mentioned it to me in a hallway, the way you'd mention the weather, after we'd worked together the better part of a year. *Have you ever been formally assessed for autism?* My first reply was unprintable and affectionate. My second was to go get assessed four times, because if I'm nothing else, I'm thorough. I regret the fourth only because it's the one that handed me ADHD as an add-on. The thing that was apparently obvious to him, and to plenty of others, had been invisible to me for four decades.

Sit with that, because it's the whole point and I almost missed it myself. The same wiring made two things true at once. The instant the suggestion was logical, I integrated it—no defensiveness that survived contact with the evidence, no years of working up to it, just *yes, that tracks, let me confirm it four times*. And that same wiring is exactly why I couldn't see the thing everyone around me could. That gap—what's obvious to everyone else and invisible to me, and what's obvious to me and invisible to them—has a name in the literature: *the double empathy problem*, and it's not a defect on either side. It's two nervous systems each missing what the other can't help but notice.

Here's the part of my wiring that matters for the rest of this. I don't get *the flinch*—that small automatic recoil most people feel a half-second before a hard truth leaves the mouth, the one that reroutes the sentence into something softer, something about the dishwasher. It's turned down in me, or missing, or wired somewhere it can't vote. I say the thing. I've been told, in one register or another, my entire life, that this is a defect. But as a therapist in a therapy room, it's occasionally the only useful thing I bring.



Knowing Was Never the Bottleneck

The reason hard things don't get fixed is almost never that nobody knows what's wrong. People know. Couples know. Families at holiday tables know, every one of them, exactly what's not being discussed. The agency knows which director is the problem. The field knows which of its models stopped working a decade ago. Knowing was never the bottleneck.

The bottleneck is that fixing the thing requires being uncomfortable *now* in exchange for being better *later*, and the human nervous system would, on the whole, rather die than make that trade.

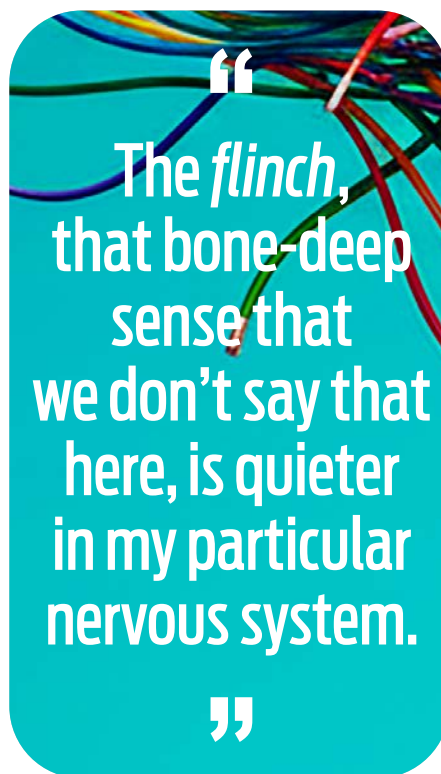
And I mean that close to literally. We do it with cigarettes, lit with hands that have read the box. We do it with the conversation we have been not having for so long it's become a third person in the marriage. We do it, magnificently and terribly, with the entire planet. The cost is real, but it's faceless and lives in the future. The discomfort is small, but it's here, in the chest, right now, and it's sharp. Sharp-and-now beats vast-and-later almost every time, which isn't a moral failing. It's just the math bodies run. The old parts of the nervous system handle here-and-now threats with overwhelming force, and they were built long before "later" was a thing worth planning for.

Our own field has been studying this for 60 years and makes every one of us learn it on the way in. The bystander research is the cleanest version: the larger the group that witnesses something wrong, the *less* likely any single person does anything about it—not because the crowd cares less, but because responsibility thins out across bodies until no one feels like holding enough of it to act. John Darley and Bibb Latané, social psychologists who first mapped the phenomenon in the 1960s, called it *diffusion of responsibility*, and it's held up in every replication since. Scale the room up and the flinch doesn't weaken; it distributes, which is worse, because now it has no address.

The dishwasher fix doesn't scale any better than the flinch does. A system

reaching for the comfortable adjustment instead of the real one is a mechanic changing the oil filter on a car with the wheels off. You can change that filter forever, but the thing is not going to drive. Same flinch, same dishwasher—only now it's an agency, a training program, a profession, a country, reaching for it together, and the bigness of the group is the very thing that guarantees no one will be the one to say the wheels are gone.

The wiring that needs to be examined is the same wiring that decides



what gets examined. To put the avoided thing on the table, somebody has to tolerate the discomfort of putting it there—and that discomfort is the precise thing the entire system is built to avoid. So the problem guards itself, though not on purpose. Nobody has volunteered for that job. There's no alarm that sounds when a system declines to look at itself, the way no bell rings in the couple when they choose to argue about the dishwasher for the four hundredth time. Avoidance is invisible to the thing doing it, which is also what makes it permanent.

A Missing Filter, Not a Superpower

There's a version of what I'm saying that curdles into something I don't mean: the Autistic person as wise seer, the holy fool who sees what the rest of you can't. That's flattering and it's false. What's true is smaller and stranger. The signal that hides the avoided thing from most people—the flinch, the pull toward the group, the bone-deep sense that *we don't say that here*—is quieter in my particular nervous system. I'm not seeing more; I'm missing the static that hides the obvious from everyone else, so the obvious sits there in plain view, humming. It isn't insight; It's a missing filter. I've paid for that missing filter my whole life, in rooms far less forgiving than the therapy room, and I wouldn't romanticize it as a superpower—quite the opposite.

These days, the word *neurodivergent* does a lot of heavy lifting and it's smuggling in a falsehood. ADHD and autism get filed under the same umbrella, but on the exact axis my argument here turns on—how a nervous system meets discomfort—the two are markedly different. I can say this without condescension because I have both. ADHD doesn't come with the turned-down flinch; the rejection-sensitivity that rides with it makes the recoil from social discomfort louder, not quieter. The struggles are real and hard, but they are *different*, not lesser. The umbrella hides that, and it matters: if you let "neurodivergent" blur the two, you'll walk away thinking some vague neuro-specialness sees through avoidance, when the thing I'm describing is narrow and specific and not even always comfortable to carry.

It's also worth saying why ADHD is the familiar diagnosis and autism the dimly understood one. The reason isn't innocent. ADHD is legible to the culture partly because it's monetizable—there's a market in the diagnosis, the medication, the productivity-hack economy built on top of it. Autism is harder to sell, so it stays stranger to the general public. The familiarity gap tracks what can be monetized, not what's true.

And there's one more difference, one that explains why the deferred cost doesn't stay deferred in my body. The neurotypical nervous system is, by comparison to mine, muted—not as an insult, but as a difference in gain, like a volume dial turned down. A neurotypical can walk into a coffee shop and go into portrait mode like a phone camera: blur the espresso machine, the noon rush, the open mic, and still feel genuinely connected. My system can't blur it. Everything comes in at volume. Which is also why the deferred, abstract, far-away cost—the thing done to the community, to the planet, to the person across from me—does not stay abstract in my body. It arrives now, at volume, with everything else. That isn't wisdom. It's the gain turned up, and the bill arriving on time whether I want it to or not.

What This Means for the Therapy Room

Our entire field runs on the flinch. We're trained in attunement, in validation, in the protection of the alliance, in the careful not-rupturing of the thread between us and the person in the chair. And often that training is exactly right; the soft approach is the clinical one. But sometimes—and I think more often than we admit—we've been trained to soften past the most useful move we could make: naming what's being avoided, the truth the client already knows.

Near the end of the three thousand hours it takes to become a clinician, my supervisor gave me a review that was really just a question he couldn't answer. *There's one thing I don't understand*, he said. *Why do people get well so quickly with you? What are you doing that's different?* I've thought about that question for years.

Autism in the public mind is savant syndrome, the party trick. For me, it's high pattern recognition that doesn't respect the walls between fields. I work the way an apothecary works—pulling from sociology, anthropology, neurology, psychology, the Buddhist psychology I was trained in—not because I'm interdisciplinary by ambition,

but because the human system is too complex for any single field to hold. The connections, much like my own unpruned synapses, make their leaps without first stopping to ask the social hierarchy for permission.

A tight, aseptic, controlled one-to-one room is precisely what my wiring requires to be an asset instead of a liability—no group to read, no flinch to manage, no hierarchy to negotiate, just the pattern and the person and the work. The thing that makes me good in the consulting room is the same thing that would make me a disaster in most others. I didn't train into this field so much as get born sideways into it, a nervous system that does by reflex the thing the work requires on purpose.

You can't talk a nervous system out of a flinch it's practiced for three hundred thousand years, and I wouldn't wish my missing filter on people who've never had to survive without it. But I know how patterns actually change, because it's the same in a marriage, a treatment team, or a single nervous system: not by argument, and not by hating the old way. The brain works like a forest path. Walk it every day and the path deepens.

Walk a new one and soon, *that* path defines itself, while weather and disuse reclaim the old one. The brain does this. So do institutions. You don't destroy the avoidance by despising it. You build the harder road—the room where the thing gets said—and you drive it, rough and slow and badly, at first, until it's the established one and the old route is overgrown. The catch is that someone has to drive the new road first, before it's easy, while it still costs something. That first drive is the challenge. It's also the only thing that's ever worked.

We know this, we prescribe it to clients, and we're usually pretty terrible at running it on our own teams, in our own field, at our own holiday tables.



When I was diagnosed, I had no idea how much I'd been missing—and if I was missing that much of the outside, I had to assume I was missing that much of myself. So I did the thing

my wiring does: I put all the Legos on the floor and started sorting. *What in here is me and what's a mask?* Knowledge is a core value for me, which is to say it's load bearing, which is to say the autism wouldn't let me leave the question alone. The Buddhists I practice with—Plum Village, the Thich Nhat Hanh lineage—have a phrase for what followed, after that: *little deaths*. I experienced the death of a self I thought was mine.

What the sorting turned up was the hardest thing in the pile: I loathe inauthenticity, and I'd been participating in it without knowing. So I started tracking—plainly, the way I track everything—what I gave, what I got, where the equity was and where it wasn't. I don't believe in family the way the lexicon uses the word. I define family by necessity and by merit: the people I want to celebrate with and lament with, the ones I pull in closer because they meet me. I believe the old saying gets in backward. Water, for me, has always been thicker than blood.

I'd been with my spouse for 16 years when I turned that same lens on us. Her unwillingness to meet me equitably turned out to be my limit—a limit I couldn't have seen without the insights my AuDHD diagnosis handed me. By year 20 we were divorced, which is the cleanest proof I have of what I've been highlighting: the avoided truth doesn't care how much it costs to say. It was already true. In my case, I finally stopped reaching for the dishwasher.

So here's the question I'd leave you with—the one I now use as my whole measure of who belongs in my constellation of chosen family. When you have the best day of your life, and when you have the worst, who do you call? Those are your people. Everything else is lexicon. 

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BY LAURIE WATSON & GEORGE FALLER

When Couples Get Stuck

How Negative Cycles Block Connection

Sparks flew from the first moment Joey and Maria met at a mutual friend's party. Their physical attraction and chemistry were undeniable. That evening, they lost track of time in deep and thrilling conversation. By morning, each believed they had found their special someone. Dating confirmed they shared similar values and interests. Pouring out their inner worlds to each other made them feel safe and seen. And the sex was great!

Like most of us, Joey and Maria's relationship is a roller-coaster journey. Now, 14 years into their marriage, they still love each other, no question, but their emotional and sexual connection has frayed. With the stress of a mortgage, two careers, and three children, not to mention coaching and community involvement, neither of them has the bandwidth to give each other the attention they once did. The sexual fire and deep emotional sharing that once kept Joey and Maria securely connected have been sidelined, and it's taking a toll.

Sex, which was once always hot, is now frequently lukewarm, if it happens at all. And their levels of desire have become increasingly out of sync. There was a time when they never could have imagined arguing about sex, but these days, it's a regular area of conflict. At this point, they find themselves asking: How did something that once felt natural, spontaneous, and exciting become so constrained, routine—and, at times, even boring?

Things have become shaky outside the bedroom, too. Sometimes, Joey and Maria are on the same page; they still talk and laugh together. But other times, an argument ignites out of nowhere and gets out of control, leaving them both feeling hurt and alone. These conflicts are gaining frequency and are increasingly difficult to bounce back from.

Even though Joey and Maria love each other, and they're both committed to the marriage, the distance in their relationship is growing. Privately, each is starting to fear they may never find their way back to the connection they once had. They feel rejection where they crave reassurance.

Two People, One Problem

To Maria, it feels like all Joey wants from her anymore is sex. She still finds Joey attractive and fit, unlike some of her girlfriends' husbands who have let themselves go. And he is pretty attentive to her in bed. But she often finds herself not in the mood. *Is the problem just her low libido?* she wonders.

Regardless, the constant pressure to match his sexual appetite feels overwhelming. She believes Joey just has two modes: distracted by work or frustrated that she doesn't want sex. Either way, she feels disconnected from him. Worse, he reaches for her body but not her heart.



But now, who has time for romance with their hectic lives? And if a date happens, she plans it, calls the sitter, and gets the restaurant reservation. Joey is a loving father, but the weight of the childcare falls mostly on Maria's shoulders, even though she also works part-time as a dental hygienist. By the end of the day, when Joey is eager for sex, Maria is aching for sleep.

Joey's bids for sex make Maria feel even more disconnected. *How can he possibly think I'd want to have sex after he's been so absent?* she asks herself. *Is he that clueless about how much I need his support? About how lonely I feel? Maybe he just doesn't care.* She complains to her friends about Joey's incessant need, saying, "I don't have sex with strangers."

To Joey, it seems like Maria doesn't want sex anymore. He's baffled. Before they got married, and even for a while afterward, he and Maria needed each other—frequently.

But once the kids came along, she wanted sex with him less and less. Joey had heard from older friends that sex inevitably burns out a few years into marriage, but he never would've believed it would happen to them. He can't understand why it's not important to her, too. She used to initiate, but now it's been years.

Outside the bedroom, Joey feels unsure of how to make Maria happy, but in bed, he knows exactly how to please her. When she lets him, he feels close to her and, for a change, feels like he's a successful husband. Sure, he misses having frequent orgasms. But more than simple release, Joey misses the intimacy afterward—the feelings of closeness and connection. He doesn't just want sex, like she sometimes accuses him; he wants sex with her.

Feeling discouraged and defeated, Joey tries to focus on work and hopes that, someday, things will go back to the way they used to be and Maria will want to have sex with him again.

How It Goes Wrong

It's a Friday afternoon, and Joey comes home a bit early. He's riding high after landing an important new client that morning, and he's been looking forward to sharing the good news and excitement with Maria.

Maria has been looking forward to seeing Joey, too. She's had an upsetting day and wants to share her troubles and feel comforted. Relieved to see him come through the door earlier than expected, she immediately begins pouring out the painful events of the day.

"I finally had time to grab lunch with the girls today; Meredith was as competitive as ever. She talked about Antonio's recent raise and how they can afford private school now. Then, she made all these not-so-subtle comments about how I look in my new sundress." Dripping with sarcasm, Maria mimics her friend: "It's so cute! It fits you well, too. Where did you get it? Do you think they would have it in my size?" God, you know she's a size two?! She might as well have called me fat."

Maria's frustration is alive and growing. Suddenly Joey's

own body goes on alert. He recognizes this conversation pattern, where they start off talking about someone else, but somehow, it always ends with her getting mad at him. After so many previous fights, he knows exactly what not to do: No fixing. No advice. No telling her to stop hanging out with Meredith if she is such a bitch. This conversation is a potential minefield where Joey only knows what not to say. Since he's not exactly sure what a safe response should be—he stops responding at all.

Shark Music Plays

When our attachment feels threatened—even by something as small as a partner's glazed eyes or a forced pivot away from our feelings—the nervous system fires an alarm before the thinking brain has a chance to weigh in. Researchers call this “shark music”: the body's background score of dread, priming us for danger before we've consciously registered why.

As she recounts her interaction with Meredith, Maria keeps talking, relieved to be sharing and hoping Joey will reassure her—tell her that no matter what Meredith says—he thinks she looks great. But for Joey, the shark music has started to play.

As Maria's intensity escalates, Joey's dread deepens. *Am I supposed to just sit here?* There doesn't seem to be anything he could say that would help; he stays silent. Pressure builds in his head, his ears clog like he's on a plane, and her words blur together. Inside, his stress rises; outside, he tries to look calm. Still in the afterglow of his good news, he doesn't want to get dragged into her negative mood. Finally, in response to her expectant look, he asks with a forced smile, “So was the new restaurant you went to any good?”

His hopeful pivot toward positivity shatters.

“What? Who cares about the restaurant?” snaps Maria. “Were you even listening to me?” Maria can't believe what she's hearing; how could Joey not see how upset she is?

Joey freezes: “Uh . . .” Just as he feared, her anger makes a U-turn toward him. Sometimes it happens before he

even opens his mouth. Anxiously he stammers, “Yes, I'm listening . . . Uh, it sounds like you're not getting along with your friends again.”

“Oh my God! Seriously? How am I supposed to get along with someone so petty and insulting?” Maria cries. “I had a feeling you'd take her side. Maybe you think I'm fat, too!” Her voice rises: “I should never tell you what really bothers me. You're never interested! All you care about is work and yourself!”

Joey is flabbergasted. He feels attacked and trapped: When he tries to listen, he gets it wrong. Shrugging, his parting words are: “This is not worth arguing about. You just need to figure this out with your friends.”

Walking toward the stairs, Joey can't understand how his good intentions ended in such a disaster. Again. *What was I supposed to say? I can never win with her! Why do I even try? Can't she see I don't want to fight?* Joey is frustrated, confused, and deeply disappointed. He'd been so excited to be home early, to share his good news. He'd pictured celebration, laughter—*probably sex*—but instead he's retreating to the basement, alone. The whole pattern always feels so unfair.

As Maria watches Joey walk away, she feels doubly injured. Not only does he not understand the drama with her friend but now he's also making everything worse by suggesting she's in the wrong—and then leaving her alone. Her chest aches.

When she lost her older sister, Michelle, to breast cancer in college, she lost her best friend and confidant. Now Joey is mostly who she turns to for support. But emotion isn't a language he speaks fluently; when she reaches for him, he's never there the way Michelle was.

Replaying the fight in her head, Maria insists she began with good intentions. She wants to share her day— isn't that what couples are supposed to do? But then she sees Joey's eyes glaze just as she gets into the details. It feels like everything important to her bores him. What she needed was so simple: for him to tell her she looked hot and

that Meredith was full of herself. Why couldn't he just be reassuring?

Missing Michelle is a constant ache, but right now grief burns a hole in her heart. Her sister would have understood Meredith and comforted her about Joey. Facing that pain, Maria realizes her loneliest moments lately are not when she's alone but when she's talking to Joey.

Trying to Repair

Later in the evening, the rift still obvious, Joey racks his brain for a way to overcome their stifled conversation and silence. He hates it when he can't find the right words and hurts Maria. He knows Maria misses her sister, and he wishes he could be the one to give her what she needs—her man, the guy who can help her when she's down. If only he didn't get so nervous when she talks about her problems. He hates the way this afternoon ended—just as much as Maria does.

As Joey lies there, struggling with how to reconnect, he wants to reach out and comfort her with touch. It is so much simpler than the words he messes up. For Joey, touch is love in action—the thing he craves when he feels lonely and disconnected. Lying in bed, his instincts tell him to pull Maria into his arms. He hopes a hug will soften the distance, maybe even lead to more. As he imagines it, his desire and confidence grow.

He rolls toward Maria. Gently touching her shoulder, he whispers, “Baby, are you awake?”

Maria's voice cuts sharp. “Are you serious? You want sex after not talking to me all evening?”

Confused, Joey freezes. Somehow, he always fucks things up. “Hon, I just want to comfort you,” he protests.

“Comfort me, huh? I know what your shoulder touch means—it means you want more than comforting! Could you stop touching me?” Maria moves closer to her edge of the bed.

She's been hurting all evening, and now it's worse. To her, Joey just wants her body; her troubles and insecurities don't matter. Whenever she needs him, he disappears. How could he think she'd want sex now, after he showed no inter-

est in her feelings? She feels as far away from him as ever.

Frustrated and shocked after feeling briefly hopeful, Joey flings back defensively, “Right, you don’t want me to touch you, fine! I wasn’t even trying for sex; I know you never want it anyway. And that’s a problem you never acknowledge.”

Maria doesn’t respond.

Joey’s mind races. *I was trying to reach you; I wasn’t being selfish. And is it selfish to want to make love to your wife? Why is Maria so cold?*

He’d imagined reconnection—holding each other, falling asleep in each other’s arms, waking up happy. But instead, waves of rejection and hopelessness wash over him. She never prioritizes his needs; everything is about the kids.

Panic rises in his chest; maybe it’s all his fault. He wonders if Maria isn’t attracted to him anymore, if the sex isn’t good for her, if he’s a lousy lover. The harder he tries to block out the anxious thoughts in his head, the more upset he feels.

Finally, he retreats into sleep to escape the frantic worries. Both are making meaning of their partner’s actions (incorrectly), and both are left angry, hurt, and misunderstood. Lying in the same bed, which should offer deep intimacy and pleasure, they feel miles apart.

They sleep poorly. In the morning, the rush of a hectic routine leaves no room to talk. It’s almost a relief to be busy, to avoid bumping into each other and accidentally reigniting the fight. Yet beneath the surface, each feels apologetic and makes small peace offerings: She cooks his favorite dinner, he suggests the romantic series she’d wanted to watch. They reconnect but don’t repair. The conflict is swept under the rug, like so many before—and both know it will return.

So why does this conflict happen even with their love, connection, and attraction? Their fear tells them the answers are pretty straightforward: They just have mismatched sex drives and different emotional needs. They don’t want the same things.

Conflict Occurs in Predictable Cycles

None of us have perfect marriages; differences are always present if we are authentic and real with each other. Gentle, honest engagement with conflict can help partners know each other more deeply. Even in “good enough” marriages, problems tend to repeat . . . and repeat. We get locked into power struggles where no one wins. Couples often describe being stuck in the same fight for years. Unrepaired fights pile up like emotional debt. Because feelings and behaviors are linked between partners, we call these negative cycles. Think of negative cycles like tug-of-war. Two people are at opposing ends of the rope. When one partner is threatened, they pull away. The problem is, this pulls all the negative energy from their partner towards them. When the other partner gets anxious that their needs won’t get met, they push—they pursue, move toward. And we all know what pushing on a rope gets us—nothing. In fact, the more they push, the limper the connection between them becomes.

Each partner’s reaction triggers the other’s survival system—fight, flight, sometimes freeze—making the conflict feel hopeless. These “protective positions” often trace back to childhood, where we first learned what connection and protection looked like.

This is exactly the case with Joey and Maria. Each is convinced the other holds the solution: Joey believes all would be solved if Maria increased her libido. Maria believes Joey just needs to be a more consistent, supportive listener.

For both of them, this other-focused perspective misses a crucial truth: Every action sparks a reaction. What we don’t see when our partner hurts us is that they may be reacting to an earlier hurt from us—one we’ve forgotten or never noticed. We feel the current wound as the source of the problem, but for our partner the origin runs further back.

When we begin to understand the reasons behind our partner’s reactions, the rhythms of the relationship suddenly become clearer. That clarity gives us the chance to practice new ways of

responding. And with practice, the disconnection of a negative cycle can be replaced by the safety and closeness of a positive one.

If Maria and Joey’s conflict feels familiar, you’re not alone. To build brave love and great sex, we have to step back. Clarifying the cycle between them empowers change. The cycle is the real enemy—not Maria, not Joey. It separates them, blocking caregiving right when they’re hurting and longing for closeness.

To break a cycle, we first have to understand what drives it, so we don’t keep missing each other when it matters most. And naming the real enemy—clearly, together—is the first act of brave love. 



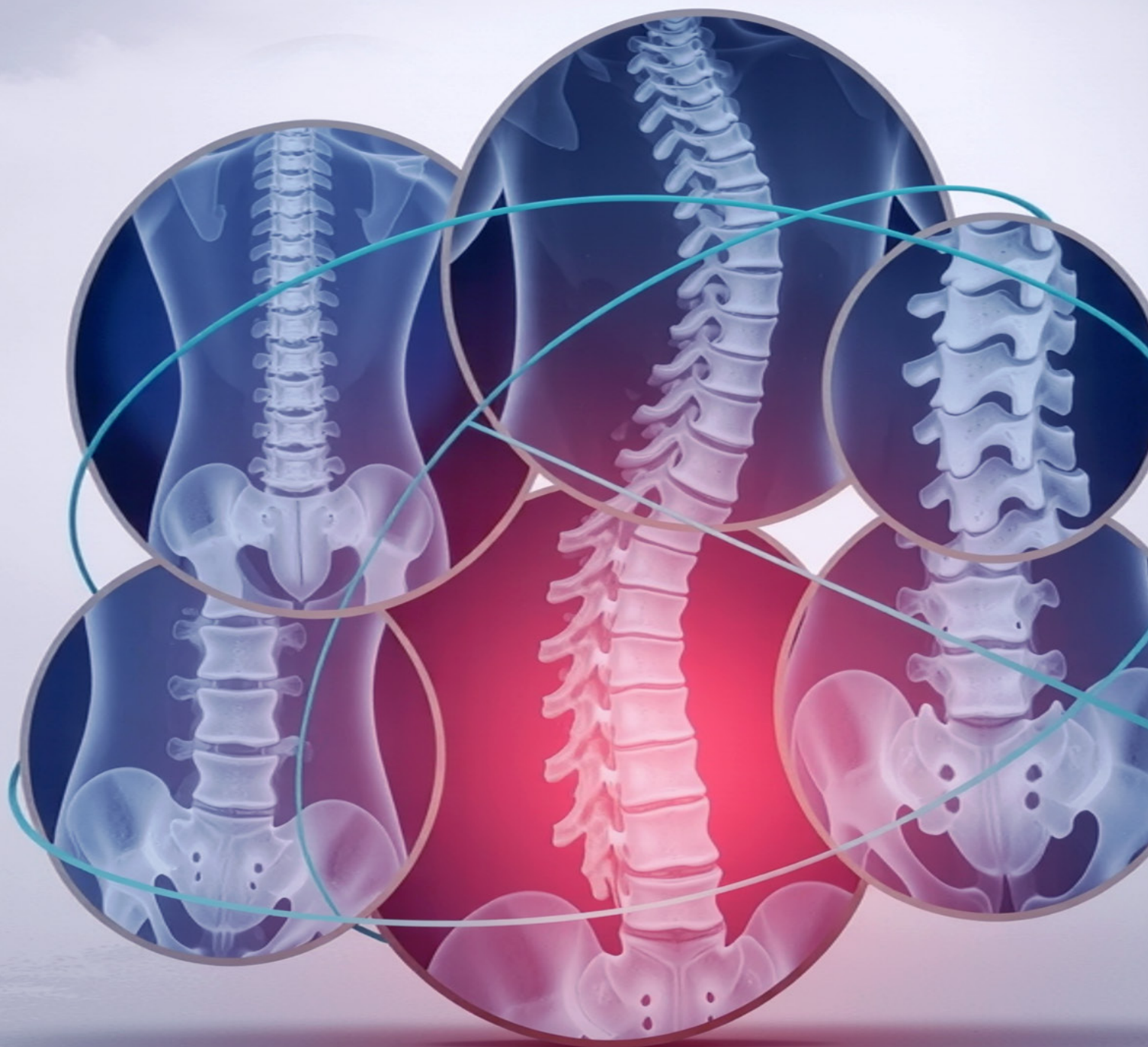
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A Special Case Study

BY LINDA THAI & SAHAJ KAUR KOHLI



The Client in CHRONIC PAIN

TWO TAKES ON TRUST, THE BODY, AND CULTURAL TRAUMA

Remi called ahead to say she's suffered from chronic back pain on and off since her early 20s, but that in the last year, it's become debilitating. "I respect my doctor," she mentioned, "who suggested I give therapy a try."

Remi's in her mid-50s, recently returned from New York, where she spent a decade engaged in diplomatic work for the United Nations. As she enters your office, she holds your gaze for a beat longer than usual, then nods—a wordless recalibration you've seen in other clients relieved to be working with a therapist of color.

When you ask about her life, there's a weary, performative quality to her response. She grew up in Chicago, she tells you. Her mother's people are from Georgia, and her father came from Côte d'Ivoire in the late '70s. "My parents were very different, which is why they fell in love," she says. "They were happy for a while, but then my father went back to his hometown and became obsessed with how the war had made the country unrecognizable." She pauses. "I'm not really close to my family. I have a sister in Atlanta with four kids, and I help her out financially, but that's it." When you ask about other relationships in her life, she shrugs. "I prefer situationships." She winces, then shifts in her chair. "Listen, you seem great, but I don't see how digging into the details of my less-than-perfect life is going to help my back pain go away."

♦♦♦♦

Moving at the Speed of Trust

BY SAHAJ KAUR KOHLI

Remi has been referred to therapy because her doctor can't solve her pain. So it's reasonable to assume she's entering my office with the belief that if medicine hasn't found an answer, the problem is somehow her. And now, here comes a therapist, ready to go searching through her life for the psychological explanation.

I don't take the bait. Instead, I immediately tell Remi, "I'm not interested in convincing you that your pain is secretly psychological. I believe your back hurts."

When I do, I see her look at me with confusion, and relief, but also suspicion. What would my agenda be if not to tell her what's wrong with her? But I don't think Remi needs another professional explaining her body to her. And the last thing I want to do is reinforce a false binary in which Remi's pain must either be physical or psychological, "real" or emotionally driven.

As a narrative therapist, I'm interested in the stories that develop around our problems, particularly when those stories begin telling us something about who we are. Chronic pain may have begun as something Remi experiences, but over time, it turned into something that organizes her life. It can change what she does, what she expects from herself, how she relates to other people, what she imagines about her future, and even how she understands the person she has become.

Before I go looking for trauma, family dysfunction, or psychological explanations for her pain, I want to understand her relationship with herself and her body. But even before that, I want to know Remi and build rapport with her. It's important to me that I meet her where she is and respect her agency around what we do or don't explore.

I'm reminded of writer and activist adrienne maree brown's famous guiding principle, "Move at the speed of trust." This is what grounds my work with all my clients, including Remi. We can only go as deep and as fast as trust allows us. So I aim to build that trust.

I ask what it was like to walk in and realize her therapist is also a woman of color. Shared identity doesn't automatically mean shared understanding, but I note the physical reaction I observed when she saw me. I also ask her about her concerns of being in therapy and what she believes about it.

When Remi starts to describe her skepticism, I decide to use self-disclosure: "I remember the first time I was in therapy—before I became a therapist—and my therapist was asking me all these questions that felt intrusive. They even felt wrong, like, 'Why was I spending money and time talking about things that were trivial compared to what my parents and elders have lived through?'"

I see her shock and relief as her body settles. I keep going, "I've spent my whole career working with immigrants and their children because I know that 'mental health' in the way we talk about it in the West doesn't always translate to our experiences or in our languages."

She nods, "Yeah, *mental health* wasn't even a word in my household. Plus, I'm here for back pain, which has nothing to do with my mental health."

Rather than challenging her on this, I earnestly say, "Well, you're the expert of your life and your body. I won't claim to know better than you, but I do think I have skills and tools that may help you. I want to learn more about you, and I want to understand your relationship with your back and your experience with chronic pain. But

I also don't want to rush it. If you're comfortable, I just want to get to know you a bit today."

She visibly relaxes, so I ask about her family.

There's a polished quality to the way she answers, almost as though she's giving me a briefing. It makes me wonder: Who has Remi had to be for other people? What version of herself is easiest to present? What happens when she isn't composed, impressive, useful, or self-contained? I store these thoughts for another time.

"What was that like for you when your father returned to Côte d'Ivoire?" I inquire.

She shrugs. "It was his country." After a few seconds, she adds, "I mean, obviously it was sad. But people were dying.

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managed to take.
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Families were losing everything. I wasn't exactly going to sit there and say, 'Dad, I'm upset you're distracted.'"

I'm tempted to follow that thread, to wonder whether Remi learned that her feelings became harder to justify, or less than, when placed beside someone else's suffering. But we've only just met, and I'm cautious about making definitive connections just yet. Instead, I say, "It sounds like there was always something bigger happening."

She pauses and her face softens. "Exactly."

"And when something bigger was happening, what happened to the smaller things?"

She laughs, without much humor. "You dealt with them."

"By yourself?"

"Usually." She shifts and reaches behind her lower back.

"Is that your back?" I ask.

"Yeah. Sitting too long."

I resist the temptation to make the timing meaningful. Still, I want Remi to know I'm paying attention to the body she actually came here to talk about. "Do you need to stand?"

"I'm fine."

"You don't have to be fine for my benefit."

She gives me a look that's half amused, half irritated. But she stands. That moment feels more important to me than getting another piece of her family history. She's told me, in a small way, that she's uncomfortable—and I've believed her without requiring her to continue enduring it.

When she sits back down a minute later, I ask about her sister again.

"What does helping her mean to you?"

She looks confused. "It means she needs help and I can help."

"Does it feel like closeness?"

"No."

"Responsibility?"

"I wouldn't call it that either."

"What would you call it?"

"Family."

I pause because if I use emotional disclosure or frequent contact as the primary markers of closeness, I might miss other ways Remi understands care. I don't need to decide whether supporting her sister represents generosity, obligation, reciprocity, or cultural expectation. I need to understand what "family" means in Remi's vocabulary without imposing my own definition.

"I'm curious about the situationships you mentioned before," I say.

Remi winces.

"Your back again?"

"No," she says. "That was embarrassment."

"What's embarrassing?"

"Come on. I'm 55 years old talking to her therapist about situationships."

I'm noticing a few things in this moment. First, she's called me "her" therapist. To me, the possessive pronoun signals a feeling of ownership over the therapeutic relationship. Therapy is no longer something happening to her but rather, it's becoming something she's actively participating in. At the same time, she's talking about embarrassment—shame's not-so-distant cousin. This is one of those moments when cultural responsiveness requires restraint. I have interpretations but voicing them now would tell Remi what I think her life means. Instead, I ask, "Do you *actually* prefer situationships to relationships?"

She laughs. "That's an annoyingly good question." After a moment she says, "I prefer parts of them."

"What parts?"

"The freedom. Nobody needing to know where I am all the time. Nobody building their entire life around me."

"And the parts you don't prefer?"

She looks away. "Sometimes it would be nice if somebody noticed I disappeared."

I let the silence sit.

Then she shakes her head. "See? This is exactly what I was talking about. I came here because my back hurts, and suddenly we're talking about my father and my social

life. I don't see how digging into all this is going to make my back pain go away."

"I don't know that it will," I say, but I do note her avoidance as we talk about the emotional pain she carries around relationships.

She looks surprised.

"I'm serious. I'm not interested in convincing you that your pain is secretly psychological. I believe your back hurts."

Her face softens, but only slightly. "So what are we doing here?"

"That's a fair question." I think for a moment. "I'm interested in your story because I'm interested in *you*, Remi. I want to understand who you were before the pain became this loud. Your relationships, your family, your work, your losses, your values—they've all helped shape the stories you've come to tell yourself about who you are. Not because I think your past caused your back pain, but because I want to understand the story of you before pain entered it. Then, and only then, can we begin to ask how chronic pain may have started rewriting that story, or whether it has become the loudest voice in the room, crowding out the parts of you that existed long before your back ever hurt."

I can tell she's taking this in. She finally says, "I've had chronic pain for so long I don't know who I am without it."

"Chronic pain can become totalizing," I validate. "A person who has done extraordinary things can slowly become 'someone with chronic pain.'" Appointments, limitations, flare-ups, and disappointments occupy more and more narrative territory. These are important, but for now, I want to continue to know who Remi is outside the jurisdiction of her pain.

One place I look to is her work. I ask about her years in diplomacy, and she lights up. She tells me about negotiations, complicated personalities, and an award she received. Up until this point, I'd mostly met the woman living with chronic pain—discouraged, skeptical, hurting. The moment she talks about diplomacy, I meet the woman chronic pain has been trying to overshadow.

"You were good at this," I say.

"Very good." She thinks for a moment. "I listened. I could read a room before most people knew there was anything to read. I didn't need somebody to be wrong for somebody else to be right."

That stays with me.

Rather than only asking what pain has taken from Remi, I want to know what it hasn't managed to take. When does she still feel like herself? Clearly, she was good at finding ways forward when no one got exactly what they wanted. I wonder aloud whether this skill could help her develop a different relationship with her body. Perhaps there's another possibility besides fighting it or being defeated by it. "You said you were good at understanding competing positions without deciding one person

had to be wrong,” I say.

She nods.

“What would it mean to approach your back that way? Not as an enemy to defeat or a mystery to solve, but as another party whose position you don’t fully understand yet?”

She’s quiet, and I’m quiet with her. I may eventually offer psychoeducation about the mind-body connection, chronic stress, and the nervous system. I may even collaborate with her physicians to better understand the medical treatment she’s receiving. But right now, Remi needs someone to investigate alongside her, not explain her body to her.

She says, “I haven’t thought about it that way. I just endure the pain because it is what it is. But approaching it like a negotiation....” She trails off.

Cultural responsiveness isn’t the ability to see someone’s identities and know what they mean—it’s recognizing which questions become possible because we’ve noticed them.

Before I interpret Remi’s pain, I want to give her the space to use her own voice and share what feels important and how she talks to herself. Culture, race, gender, family, age, immigration, intergenerational experiences, and professional identity may each have contributed stories about strength, independence, suffering, usefulness, need, and what deserves attention.

My job isn’t to decide which story is true. It’s to become curious about which stories organize her life now, and to move slowly and avoid rupturing what we’re trying to build.

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Listening to the Body Differently

BY LINDA THAI

What I’m clocking about Remi is that she’s competent, guarded, and bone tired. She doesn’t feel resistant in a hostile way. She feels like somebody who has had to hold herself together for a long time. So I want to be steady, not flashy. I want to say just enough that she knows I’m tracking both the pain and the context. More importantly, I want her to feel connected with, as a Black woman.

“I’m really glad you came in,” I say. “And I want to say up front that I take your pain seriously.”

She exhales a little, but her arms stay close. “Good,” she says. “Because I’m not really into talking about my childhood when what I need is for my back to stop hurting.”

“That makes sense. And honestly, I don’t think we have to split the body off from the story,” I speak slowly. “A lot of people have been told pain is only medical, or only emotional, but the nervous system doesn’t really do that. It’s taking in the whole picture. Of everything that’s happening around you, and everything that has happened to you, and to your peoples, and how your body, your nervous system, your behaviors have adapted to or been re-shaped by those stressors.”

This is the moment to offer a little psychoeducation, but not too much. I watch her body language to see if she’s giving me an opening. I don’t want to lose her by sounding like I’m giv-

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**All my BIPOC clients
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ing a lecture and yet I want to get real.

She shifts in her chair and presses a hand into her lower back. “So you’re saying this is psychological?”

“Not exactly,” I say. “I’m saying the pain is real. And sometimes the body is carrying more than just the injury or the strain. Chronic pain can get worse when somebody’s been under a lot of stress, when they’ve had to keep pushing, or when life has had them on high alert for too long.”

I watch Remi’s face for any flicker of tension or withdrawal, any sign that I might be going further than she’s ready for. I don’t see it. She’s straightened in her chair and looks energized. I pause with a little side eye that signals I’m about to spill some tea, and she softens and leans in. I go for it—code-switching just enough while maintaining a matter-of-fact manner.

“Most of my caseload is BIPOC. In this last year, during the current administration, with all the fuckery that’s been happening—the immigration raids, concentration camps and mass deportations, the dismantling of democracy’s checks

and balances, the rollback of DEI, the final shredding of the Voting Rights Act.” I speak slowly so that I can track her response. She’s right there with me. “All my BIPOC clients are showing signs of stress, pain flare-ups, insomnia, appetite issues, GI issues, rage, and bone-tired fatigue.”

She nods, then shuts her eyes and sighs. I wait until she makes eye contact again. Then, I give her the head tilt, chin lift that signals I’m going in for another round.

“My clients whose emotions and bodies have been through the wringer this last year—somewhere in their history, their childhoods, there’s often an abusive, uncaring, or absent father who wreaked havoc. Or a neglectful parent who expected them to be the strong one, the one with the answers, and now that old pattern is colliding with this relentless wave of attacks on our dignity. The war in Iran has brought up refugee trauma for clients whose parents or ancestors survived war and forced displacement.”

I hold her gaze. She holds mine.

I’m feeling the interrelational space. I’m feeling her feeling me. I’m feeling me tracking and feeling her. Whether she knows right now that I’m a former child refugee or not isn’t important—it’s there on my website. What’s important is that we’re slowing down and being human together in this world.

I look away, take a breath, and then look back to her.

“My clients who are—were—federal employees have had it real bad. Like real bad. Workplace dynamics have shifted to mirror childhood home dynamics full of unpredictability and uncertainty, fear, and powerlessness. Feeling like you have to fight for your right to exist. And the moral injury of knowing what these funding cuts mean for the people you’ve dedicated yourself to serving.”

“I’ve had pain on and off for years,” Remi says, nodding. “But this last year has been brutal.”

“Yep, it sure has been,” I reflect back.

I’ve said enough.

I make eye contact and tilt my head down to signal: now you talk.

She looks away. “I’ve been handling a lot. My work. My family. Everything.”

It’s not easy for her to talk about herself. I keep quiet, give her space.

“My family’s a mess,” she says. “I mean, I help my sister financially, but I’m not close to anyone. And I’m used to keeping things moving. That’s just what I do.”

“You’ve been the one who keeps everything together,” I say.

“Yeah,” she says. “Pretty much.”

“Has it always been this way?”

“Yep.”

We pause and share a sigh of recognition.

This feels like the first real opening. There’s grief here, maybe loneliness, maybe the beginning of feeling seen. I’m also holding the possibility that she’s been overfunctioning for a long time—at work, in her family, probably in spaces where she had to stay polished and composed.

“This costs the body,” I say, a compassionate, wistful

knowing tone in my voice.

“Always being the one who keeps everything together. Over-riding your own needs. Getting your own self ahead in this world. Taking care of others however you can. Over-functioning is how we’ve managed to survive and how our peoples have managed to survive.”

I make direct eye contact with her as I say this last sentence.

“Sometimes pain is one of the places where the body finally says, ‘I can’t keep doing this the same way.’ Not because you’re weak, but because you’re human.”

She looks at me for a long moment. “I’ve never thought of it like that,” she says.

“A lot of people haven’t been offered that frame,” I say. “They’re told to push through, stay positive, prove they’re fine. But chronic pain and mental health often show up together because pain affects sleep, mood, digestion, concentration, relationships. And it also affects hope.”

Does Remi struggle with depression, hopelessness, perfectionism, and self-blame? Maybe. But I don’t allow myself to go there—not yet. I want her nervous system to sense I understand the bigger picture before either of our minds get distracted by labels.

“Our work isn’t to argue with your body,” I continue. “It’s to listen to it differently. To understand what it’s been holding, what it’s been bracing itself against, and what might help it feel safer over time.”

“Okay,” Remi says. Her guardedness has softened into something more vulnerable. “That sounds useful.”

From here, we might build a plan together that includes a symptom diary where she tracks the psychological and environmental factors that worsen or decrease her pain along with how she experiences it. I’ll stay attuned to where the language of parts might eventually support our work and keep tabs on where she is in terms of readiness for change (along the lines of Prochaska and DiClemente’s Stages of Change Model). And before our session ends, I’ll offer her something immediate she can experience for short-term pain relief—like Havening, a technique that combines touch and distraction to calm the nervous system. More important than any intervention, I want her to leave our session feeling deeply met and seen. 

Linda Thai, LMSW, is a trauma therapist who specializes in cutting edge brain- and body-based modalities for the healing of complex developmental trauma.



mental—even with clients they'd been unable to help through conventional methods. This is typically followed by the realization: "I wish I'd had this tool in my kit years ago."

For therapists who want to explore further, several organizations offer ethics-informed training for professionals as well as for use on a self-help basis. The method can be learned at a basic level relatively quickly and integrates readily with CBT and other conventional therapies. The approach is often taught as a back-home tool for clients to continue using between sessions. A study of more than 270,000 users of the Tapping Solution app reported significant decreases in self-rated anxiety and stress after a single session—a finding that speaks both to the method's accessibility and its scalability as a public health tool.



Diane's healing wasn't a miracle. Driving home on a highway after years of avoidance, following a single tapping session, can be explained. The neural signature of the original accident had remained stubbornly encoded in her nervous system until a simple, replicable intervention showed her brain it was safe to update. This is what thousands of clinicians around the world are now reporting. The evidence is no longer thin. For those who want to examine the full scope of that evidence—mechanisms, efficacy, and applications—"How Tapping Works," recently published in *Frontiers in Psychology*, offers a comprehensive review. The question for our field now is whether we're willing to look. 

David Feinstein, PhD, is a clinical psychologist whose works on consciousness and healing have earned nine national awards. He has served on the faculties of Antioch College and the Johns Hopkins University School of Medicine's Department of Psychiatry and Behavioral Science. His book, Tapping, offers clinicians and general readers alike a comprehensive guide to the method and its applications.

that spikes their overwhelm. None of that belongs to generalized anxiety, BPD, bipolar, or anything else our clients are wrongly told they are. It's predictable with a level of precision the field claims to want from a checklist.

Comedian Janet McNamara knows what happens when that precision is missing. She wasn't "smart enough" for one evaluator, she was "too coordinated" for another, and she was "too good at performing neurotypical facial expressions" for a third. Now, in her show, she's showing people, rather than telling them, that Autistic people are unique, creative, and probably not what you learned about in grad school. When I suggested that she's changing the stigma of what autism looks like, Janet said, "I can't really educate somebody on autism at this point. I just know what I'm going through."

I'm not Janet's therapist. But I spent a few hours with her, and I heard a lot of my own struggles in hers. I walked away smiling—partly because she's hilarious and partly because she's a neurodivergent person who's learned to lean into a life built for her, and it's working. She's built her special interest into a way to stay employed, found neurodivergent friends who "get her," and taken real, proactive steps to manage her health.

If I'd been the first diagnostician who evaluated her 15 years ago, rather than handing her an incorrect assessment and a bag of medication, I would've advised her to get comfortable saying no and find a schedule that worked for her body, a therapist who understood autism, and friendships that felt right to her. Janet was left to figure that out on her own.

A lot of us now are assessing for autism through narrative interviews. We focus on knowing the questions to ask, and when to ask more. A negative, standardized result is one data point, not the final word. A narrative assessment is what happens when someone with real expertise asks the next question and presses on the spot that actually hurts instead of drawing a defini-

tive conclusion from an X-ray that supposedly came back clean.

Janet's humor pokes fun at the way the system failed her, but there's real trauma underneath it. Telling her she "didn't meet the criteria" because she didn't offer up sensory challenges unprompted was a missed opportunity, not a clean result. Someone could have asked about the rotation of three baggy shirts she wears, or her drawer of identical Bombas socks, or the fact that she can't tolerate being touched on her arms or legs. Instead, they accepted "I don't have any sensory issues" and moved on.

You don't have to be an Autistic therapist to assess for autism and you don't need to rely on a standardized test. But it does take someone who looks beyond checklists at the bigger picture. People talk a lot these days about the rising number of autism diagnoses as if it's evidence of something wrong: a trend, overdiagnosis. I see it differently. If the numbers are climbing, maybe it's because generations of people are finally getting help they should have gotten decades ago.

For now, I'll keep assessing people through detailed interviews, asking what it feels like inside their nervous system when the lights are bright and the tags haven't been cut out of their shirts. I'll keep reading past every box checked "no" on reports that say, "does not meet threshold," and finding the person who was there all along.

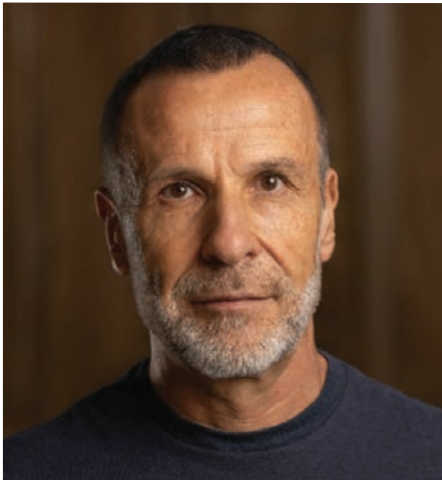
Not enough people in our mental health system have been willing to say "I trust you" to the clients who need to hear it most. I built my entire practice on trusting what people say about their own experience. 

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Is Your Job Hijacking Your Life?

WHAT THERAPISTS GET WRONG ABOUT BURNOUT



GUY WINCH

Burnout has become a defining complaint of modern life. Once considered an occupational hazard, it now touches everyone—parents, caregivers, students, clinicians, and anyone struggling to sustain motivation and find meaning under chronic stress. While the term is often used casually to describe ordinary fatigue, true burnout reaches deeper, affecting emotional resilience, cognitive functioning, relationships, and even our overarching sense of purpose. Yet in a culture that prizes productivity, many people don't recognize it in themselves until they've become detached from work, chronically exhausted, and unable to recover through rest alone.

Enter Guy Winch: a clinical psychologist, bestselling author, TED speaker, and co-host of the Ambienominated *Dear Therapists* podcast alongside Lori Gottlieb—he knows this problem firsthand. By his own admission, he's a recovering workaholic who once needed 12 epidural injections in his spine from years of hunching over a desk. In his latest book, *Mind Over Grind: How to Break*

Free When Work Hijacks Your Life, he argues that contrary to popular opinion, burnout isn't something you can solve by "taking a vacation." It's about learning to manage ourselves more intentionally when we're under pressure.

♦♦♦♦♦

Ryan Howes: How is it that even when we choose a career we love, we still suffer burnout?

Guy Winch: If you love your job, you may be even more susceptible to burnout. When you have your eyes firmly fixed on a target, you take your eye off what happens in other areas of your life.

This happens when your job hijacks your thoughts when you're home, when you ruminate about work while you should be doing other things. The more pressured and stressful your day, the more likely you are to ruminate about it at home.

In fact, many people have fantasy conversations with their boss that they'll never actually initiate. They rehearse mic-drop moments that never occur. It's maladaptive. People think, *Oh, I'm just thinking things through*, but they're not reaching any conclusions, solving any problems, or coming up with any action items. They're just ruminating, and that's damaging.

Research tells us that when one partner is pressured and stressed at work, the other partner might also start to develop symptoms of burnout because it affects the home, often in unconscious ways. We're tribal people. When you spend your whole day with your work tribe, switching those allegiances when you come home takes a minute.

For a lot of people, work is a modern battlefield. When we're in work

mode, we're in battle mode. We get activated. We need to keep our jobs and the stakes are high. It puts you into fight or flight. There are tense meetings all day. You need outcomes to happen. It's one call after another. You can't emerge from the battlefield into someone's embrace. It takes a while to unwind and come down from that intensity. The hug from your spouse or your kid feels like an intrusion because that's not where you're at.

Another way work hijacks us is in how we handle leisure time. Our brain can't tell the difference between mental and physical exhaustion. Most of us sat at our desks all day. We get home feeling drained. And then we veg out on the sofa for four hours. But research shows that if this is how you rest, you're likely to wake up tired the next day because even though you didn't drain your batteries further, you also didn't recharge them. To recharge and get a second wind, you need to do something that recharges you. Passively doomscrolling or binge watching a show isn't going to reinvigorate you.

And our coping mechanisms get hijacked, because when we have a lot to do, most of us put our heads down and just try to get through the day. We move from one task to the next, allowing our unconscious mind to take charge. When we do that, we end up choosing ways of coping that bring a moment of relief but aren't all that helpful, like surfing social media or postponing tasks. And when procrastination and avoidance kick in, the pressure mounts, your ability to regulate yourself emotionally gets upturned, and you're less likely to calm yourself before a difficult meeting. Then, when you enter the meet-

ing room, you're charged up and say the wrong thing.

RH: My clients often say, "It's my job, not me. My employer is expecting too much of me. Why should I be the one to change?"

Winch: Of course, overworking is often expected in many companies and industries. And it's dangerous. The World Health Organization says that 750,000 people a year die from overworking. In Japan, it has a name—death by *karoshi*—or death by overworking. In China you see headlines now all the time: "Thirty-year-old executive died from overworking." It increases your risk of stroke and heart attack.

But we need to begin by managing ourselves, because we tend to make the grind worse when we could actually be making it easier. My approach is to focus more on self-care. Can you monitor your own self-care and make sure that certain essentials remain in place? Can you limit how long you overwork? Many people feel they need to overwork until they receive the promotion, or until the next round of funding. But when will the promotion happen? When will the funding come?

There was a period in my life when I needed epidural shots in my spine because I was hunched over and overworking for so long that I damaged it. And it wasn't the first time this had happened. Sam Altman, the founder of OpenAI, got scurvy working on his previous startup. Scurvy! Because he was *that* malnourished, that single-mindedly focused. People overwork to the point where they become diabetic, lose toes and limbs, because they've put off caring for themselves in basic, essential ways. They're so busy they stop going to the doctor.

If you can monitor self-care, you can work in a way that addresses *your* basic, essential needs—physical and psychological—and then you can make an intentional choice, and maybe that choice is to overwork for

a short period of time. But that period needs to ease up, or your body will break down.

RH: So sometimes, it's about harm reduction?

Winch: Exactly.

I work with people at the top of their fields, and some of the questions I ask when we start are, "When's the last time you had a checkup? When's the last time you saw a gynecologist? When's the last time you saw a dentist?" That's the first thing people begin to postpone, caring for their health.

Another way we neglect ourselves is by no longer pursuing our passions, interests, and hobbies. And we neglect relationships with partners, kids, and friends that used to allow us to express parts of our personalities that we don't get to express at work—our goofy, creative, funny sides. Who we are gets diminished. We become narrower and unhappier. Our quality of life and our ability to recharge are both compromised.

RH: How do you help people develop a healthier mindset so they can return to the basics?

Winch: When I ask people, "How often is your job stressful?" they'll say, "Ninety to 100 percent of the time." They'll say "I hate my job," "I hate my boss," "I hate my team," or "I can't stand the company I work for." The problem with those formulations is they're overgeneralized and create an unnecessary amount of extra stress because when you believe those things, they set you up to go into work every day on high alert, anticipating the worst. That brings a ton of unnecessary stress into your day.

There's an exercise I have in my book called "Identifying Your Stress Mines," which helps people figure out what percentage of their job is actually intensely stressful. It's usually 10 or 20 percent. If it's unusually highly stressful, it can go up to 40

percent. But the reality is, not every meeting or interaction with your boss is stressful. Some are just boring.

If you're assessing accurately, you might say to yourself, "I don't love my boss, but I don't interact with them most of the time," or "My team can be a real pain, but not all the time," or "I have four really difficult meetings today, but three of them are likely going to be fine, and after that, I can take lunch." Assessing work situations more accurately reduces stress.

Then, at lunch, you can sit in the park and have a favorite treat. You can allow yourself to exhale. That alone can take a lot of stress out of your day. From that more centered place, you can problem solve and use coping mechanisms for truly difficult moments. You can take a walk around the block and reset so you don't carry all that tension into the next meeting. There are ways you can be smarter and more intentional in how you manage your workday and reduce the stress you feel daily.

And when you come home, it helps to develop a ritual to transition from a work mindset to a home mindset. Rituals that draw on the senses can help you unwind from the day. You can use aromatherapy, cuddle the dog, do things that help you down-regulate so you can shed as much of that battlefield mindset as you can at the door. You can listen to a certain kind of music that lightens your mood, or change clothes to make you feel at ease and comfortable.

RH: Like Mr. Rogers changing into a cardigan when he comes home.

Winch: Sure, if that works for you! 

Ryan Howes, Ph.D., ABPP is a Pasadena, California-based psychologist, musician, and author of the "Mental Health Journal for Men." Learn more at ryanhowes.net.

Guy Winch, PhD, is a licensed psychologist, best-selling author, keynote speaker, and the cohost of the Dear Therapists podcast. His 3 TED Talks have garnered over 35 million views.

Therapists on 4 Unexpectedly Therapeutic Films

LIGHTS, CAMERA, INSIGHT!

As therapists, we're primed to experience films as windows into the different ways people protect themselves, express love, and find meaning and purpose in the face of change and loss. We asked four prominent therapists to tell us about a film—new or old—that's stayed with them.



"Hacks"

BY RAMANI DURVASULA

Let's start with the good stuff. *Hacks* is a brilliant show: superbly acted and written. Although the characters are people you like and dislike in equal measure, you always find yourself rooting for them. It features glossy, escapist lifestyles and a balance of dark and light comedy. It takes on cross-generational friendship and mentorship, and centers a woman over 60—Deborah Vance (played by Jean Smart).

Still, the characters aren't always easy to embrace. Deborah, who's had phenomenal success despite the hos-

tility she's faced in the entertainment world, is a comedian and businessperson chasing the grail of a late-night talk show. Her counterpoint and head writer Ava Daniels (played by Hannah Einbinder) is a prototypical dysregulated millennial who's made some bad choices and gets a last chance at professional redemption writing material for Deborah. They're surrounded by a coterie of agents, managers, assistants, domestic employees, casino workers, and entertainment-world hangers-on, who benefit from Deborah's generosity, enable her, deal blackjack in her home, endure her abuse, love her, make the impossible happen, and are caught in a toxic cycle of keeping her life as frictionless as possible.

The show opens with Deborah antagonizing her audience in a Las Vegas stand-up comedy act. From there, we observe her behave in ways that are entitled, emotionally dysregulated, contemptuous, vain, and elitist. Ava matches that energy with entitled insouciance and generalized contempt for the world. She lives in a chronic state of "gotcha," a scold correcting everyone around her from her progressive perch.

These two women treat each other horribly, trading verbal abuse, criticism, mockery, contempt, litigation, violence, and threats. They part ways. And then they come back together. And the cycle repeats. It's workplace abuse intermingled with friendship abuse, threaded through with glimmers of mutual respect.

As entertaining and funny as they are, the appeal of these characters is their complexity. They carry wounds, grief, losses, and past traumas. We can contextualize their unhealthy behavior and empathize with it. At times, Deborah is cruel, even sadistic, only to

reveal her vulnerable nature, charitable heart, and desire to get it right. We shift from liking her to fearing her to liking her again. Her money serves as emotional armor, and we're reminded of how much contrition can be paid forward to others through investment capital. Yet that still doesn't tell us who she is. She defies simple characterization as a villain, feminist, or trauma survivor.

But this is TV, not a mental health documentary. Over many episodes, we watch these characters get locked into a trauma-bonded relationship, fueled by boom-bust periods, apologies and abuse, financial largesse and withholding. In fact, we find ourselves rooting for an unhealthy relationship! And because this is TV, everything is beautifully buttoned up at the end of the series. That's not life.

Watching *Hacks* left me wondering if TV and film can sometimes get us stuck in the perpetual hope that if we stick around long enough in a relationship filled with unhealthy dynamics, there will be a happy ending. I've been a therapist long enough to have witnessed clients die waiting for this. I've seen clients put their own happiness on a layaway plan, installing it into an imaginary future when a happy ending will come, or the relationship will calm down, or things will somehow resolve or come together. It rarely does, and in many abusive relationships, tormentors outlive the survivors.

The abusive dynamics in the series—physical, financial, and emotional—would be considered risk factors for escalation and worsening outcomes down the road in real-world therapy. In real life, we stay in these situations for a variety of reasons related to cognitive dissonance, attachment, traumatic re-enactment, practical teth-

ers, and just plain hope. We stay even as things escalate and become increasingly unsafe, believing it will get better.

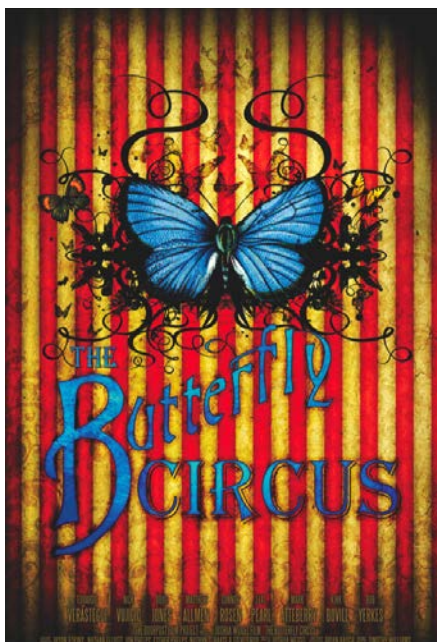
I think we watch shows like *Hacks* because the pairing of laughter and tension has a bittersweet, salty, toxic feel to it, and it reminds us why antagonistic relationships are so seductive and vexatious. The good, bad, abusive, pleasurable, and hopeful all swirl together.

At its core, because closure and happy endings are so rare when antagonistic cycles are at play, there's something soothing about watching the elusive outcome we hope for unfold on TV. That's the escape entertainment offers. In real life, the odds of things coming together as they do at the end of a show like *Hacks* is akin to a fantasy. But after a long day of working with clients through heartbreaking experiences of contentious divorces, long-term emotionally abusive marriages, harmful workplaces, and intergenerational trauma, it's nice to laugh at a few fantastic jokes and see everything work out.

Difficult relationships are complex. We can vacillate between revulsion and connection with an antagonistic character on a show and recognize that it's not as simple as writing them off as "bad." Our clients struggle with this too, only their lives aren't a show. Their struggles are real, and we must help them reckon with the challenges of attachment and self-abandonment within unsafe and unpredictable relationships.

In a TV series, happy endings occur when everything works out. In life, perhaps it's just that we can help ourselves and our clients achieve clarity, even when the hopes we hold for our relationships never materialize.

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 a leading expert on narcissistic relationships.



"The Butterfly Circus"

BY KERRI AUGUSTO

The first time I showed *The Butterfly Circus* (Weigel, 2009) to a room of students, I did not warn them. I dimmed the lights, started the film, and watched their faces instead of the screen. It is a small movie, twenty minutes long, made years ago for a short-film competition, and it has no business landing the way it does. By the halfway point a few of them had stopped taking notes. At the end, one woman came to the front of the classroom to grab my tissue box, and a man in the back who rarely spoke in class held out his hand. The box made its way around the room. Nobody wanted to talk right away. When we finally did, we did not talk about the acting or the camera work. We talked about a client. Everyone in that room, it turned out, had someone, or some particular experience, in mind while they watched.

We kept coming back to the film all semester. It became our shorthand. When a theory felt flat and abstract on the page, someone would say, "like the Butterfly Circus," and the idea would snap into focus. I have taught trauma for a long time, and I have never found a better way to make a theory feel true in the body before a student has to defend it on an exam. That is what I want to talk about here, because I think the film does

something for seasoned clinicians too, something we quietly need and rarely admit to needing.

The story is simple. A young man named Will, born without arms or legs, is bought and put on display in a Depression-era sideshow, billed as a curiosity for people to gawk at. The man who owns him tells him, in a hundred small ways, that he is disgusting, worthless, and less than human, and after enough years Will believes it. Then a traveling troupe called the Butterfly Circus finds him. Its ringmaster, a man named Mendez, looks at Will and does not flinch. He treats him as a person. The rest of the film watches Will move from a creature people pity to a man with a place in the world.

I am not going to pretend Mendez is a therapist. He is not one, and reading him as one would miss the point. The film gives us something better than a technique to copy. It gives us a chance to feel, from a safe distance, the exact human process our theories are trying to describe.

Here is what I have come to believe after years of doing this work and years of watching new people learn it. Treating trauma is more than being a warm, supportive presence in the room. Warmth is where it starts, and warmth is a great deal of it, but warmth by itself is not treatment. Good trauma work asks for something harder. It asks for a clinician who has taken the theories of our profession and made them their own, so fully that they understand, in the moment, *why* they are saying what they are saying and doing what they are doing. The interventions we now call "empirically validated" did not fall out of the sky. They were built on the shoulders of theories and research about how people become broken and how people mend, and a clinician who has lost touch with those theories is following a recipe they cannot adjust when the person in front of them turns out not to be the person the recipe was written for. A film can do what a textbook cannot here. It can put the theory back into the body.

Watch Will and you are watching what Judith Herman described decades ago, when she gave us the language of complex trauma. She showed us that when a

person is hurt again and again by someone they cannot escape, the harm does not stay on the surface. It gets inside. The cruelty of the person in charge becomes the survivor's own opinion of themselves. Will does not simply have a hard life. He has swallowed the sideshow owner's contempt and made it the truth about who he is. That is the wound, and it lives in his beliefs long before anyone lays a hand on him again.

We see versions of Will every week. Some of our clients arrive with a chart that reads "complex PTSD". Some carry a personality disorder diagnosis that other clinicians say with a sigh. Some have no diagnosis at all, only a life that has gone hard and a history of being hurt they can barely put into words. What John Bowlby taught us about attachment is sitting right there in all of them. Early in life, each of us builds a private map of whether other people can be trusted to be safe, and when the people who were supposed to protect us were the ones causing the harm, that map comes out cruel. Will flinches from kindness. He expects mockery. At one point he spits at Mendez, because contempt is the only response he has ever been able to predict. None of that is a character flaw. Each reaction is a prediction, learned the hard way, about what other people do.

Now watch what Mendez does, and what he pointedly does not do. He does not interpret. He does not push Will to talk about the sideshow. He does not rush him toward a breakthrough. He offers, first and only, a place where Will is treated with dignity and is not turned into a spectacle. Any of us who work with trauma will recognize the sequence, because it is the one Herman built into her stages of recovery and the one every good trauma model has kept since. Safety comes first. Stability comes first. The remembering and the grieving come later, and only when the ground is solid enough to hold them.

There is a reason for that order, and Stephen Porges gave us the biology of it. A nervous system braced for humiliation cannot do the work of healing. It is too busy surviving. Before a frightened person can look squarely at what happened to them, their body has to take in enough

signals of safety to come off its guard. Will has to feel safe, and he has to feel met, before anything in him can move. What Mendez provides is close to what Bowlby called a secure base, a steady other from which a scared person can begin to venture out and try. Bessel van der Kolk spent a career reminding us that trauma lodges in the body and in our relationships, and that it heals in relationship too. The film lets us feel that truth rather than simply nod at it. For much of the work, the relationship is the treatment itself.

There is one more layer to Will's wound that our diagnoses tend to skip, and it is the layer the film understands best. Will's suffering runs deeper than loss. Underneath the loss is betrayal. The person who had power over him, the adult responsible for him, used that power to deny that he was a person at all. There is a name for that particular injury, borrowed from work with combat veterans. We call it moral injury, the lasting damage done to a person's moral world when what is right is violated, above all by someone in a position of trust. Jonathan Shay wrote about soldiers betrayed by the leaders who were supposed to protect them, and Will fits that description exactly.

When a wound is a moral one, symptom relief is not enough. You can teach a morally injured person every grounding skill in the manual and still leave the real injury untouched, because what was broken was their standing as someone who deserved better. What Will needs, and what the circus quietly gives him, is that standing restored. He needs to be treated as a person worth having around, again and again, until it begins to overwrite the old verdict. I think we miss this in our clients more often than we know. We treat the anxiety and the dysregulation and never name the betrayal underneath, and then we wonder why the symptoms keep circling back.

The film is careful, too, about how Will finally changes, and this is the part I most want beginners to notice. Encouragement opens a door, but it does not walk him through it. What changes Will is doing. He watches, he tries, he falls into a river, he panics, and then he discovers he can move through the water

on his own. Albert Bandura told us long ago that the strongest source of confidence is the felt evidence of having done a hard thing yourself, far more than any praise from other people. Will believes he *can* because he *has*. This is why we introduce things slowly, why we do not shove a client toward the deep end just because we can see they are capable before they can. Confidence that is handed to a person tends to slip away. Confidence that is earned, one attempt at a time, holds. The film lets Will fail before he succeeds, and that honesty is a gift to a student who thinks their job is to rescue.

All of this is why I put the film in front of people who are just starting out. What new clinicians fear, more than almost anything, is the moment they are sitting across from someone who is hurting and desperate for relief and they do not know what to do. It's a reasonable fear. They may have written hundreds of case conceptualizations by the time they reach a real client, but as academic exercises, the way you write a paper to prove you did the reading. I have yet to watch a new clinician slide into real conceptualizing naturally in the room. It is so much faster to open a practice planner, pick a diagnosis, and click through a menu of measurable goals until a tidy treatment plan appears. The plan looks fine. It will pass an audit. And it has almost nothing to do with the actual person in the chair.

This is the exact spot where a good supervisor earns her keep, and where a good clinician becomes a great one. The best supervisors I know resist the urge to tell a supervisee what to do. They slow the student down and ask what they actually know about this person, what happened to them, what they learned to expect from other people, and why this behavior, the one that looks like the problem, might once have been the best solution available. They help the student take the theories we all memorized and lay them over one real human being. That is what conceptualization actually is, and it is the only honest way to build a treatment plan that is grounded in research and fitted to the person in the room rather than pulled off a shelf. It depends on something no dropdown menu can supply, which is a clinician who remembers,

in her bones, how the theory connects to the outcome. *The Butterfly Circus* is a way back to that. It reminds a room full of anxious beginners that there is a why underneath every good thing we do, and that the why is finally a human one.

That's true for beginning therapists. It's also true for the field right now.

■■■■■

I keep showing this 2009 film year after year, and I think it belongs in front of clinicians now more than at any point I can remember, because of the particular kinds of hurt walking into our offices. Many of us are treating a generation shaped by being watched. Will was put on a platform for strangers to stare at and rank, and I cannot show the film now without someone in the room thinking about what it does to grow up performing your life for an audience online, measured in public and found wanting. Add the loneliness so many people carry, an isolation our Surgeon General has compared to smoking most of a pack a day, and you get a clinical picture that looks a lot like Will before the circus arrived: a person convinced, from the outside in, that they are not worth belonging to anyone.

And then there is us, the clinicians. In 2026, so many of us are tired in a way that goes past ordinary fatigue. Many clinicians carry our own moral injury from working inside systems that ask them to give their patients less than they deserve, and one of the ways to survive that is to go a little numb. We may tell ourselves we “have good boundaries”. We may get efficient. We may stop feeling the histories we take in, because feeling all of them would flatten us. Some of that is healthy self-protection. But our biology is always nudging us to pull back from other people's pain, and if we drift too far, we lose the very thing that made us good at this work. A film like *The Butterfly Circus* pulls us back for twenty minutes, and we return the better for it.

This is why I keep a small circus in my back pocket, for my students and for myself. We came into this work as empathic helpers. Something in us could not look away from suffering, and we decided to build a life around moving toward it instead. That impulse is the

engine of everything we do, and it is also the thing most at risk of quietly wearing out. The theories are real and the research is real, and the careful, unglamorous sequence of good trauma treatment carries enormous weight. But none of it works when it's run by someone who has forgotten why they came. Twenty minutes with Will and the circus works on us differently than a lecture on technique. It brings back the why, both the why behind our interventions and the why behind our own decision to do this at all. I have watched it bring a hardened room back to life. I have felt it do the same for me. That is worth far more than the time it costs.

Kerri Augusto, PhD, is a licensed clinical psychologist with more than 30 years of experience in higher education, training undergraduate behavioral health professionals and graduate mental health counselors in ethics and professional practice. She is Associate Professor of Psychology and Director of Undergraduate Studies at William James College. Her scholarly and clinical interests include trauma, anxiety, and the use of popular culture as a lens for psychological analysis and as a tool for effective pedagogy.



“Backrooms”

BY IRA ISRAEL

In *Backrooms*, directed by Kane Parsons, a wall in the basement of a furniture store becomes a portal into the main character

Clark's unconscious. As Clark enters into it, we are confronted with what his mind has repressed. He stumbles on an endless maze of rooms to nowhere and is progressively drawn deeper and deeper into his worst nightmare.

More than anyone else, therapists know our minds have good reason for keeping certain traumatic memories out of conscious awareness as we go about our daily lives—they're simply too disturbing to hold. If the repression is undone, so are we. And in this sci-fi horror film, Parsons—who at 20 years old is the youngest filmmaker ever to open a box office film at number one—takes us into exactly this territory: the unconscious not as something vague or theoretical, but as a force that can destroy us.

Clark is played with soulful conviction by Chiwetel Ejiofor and appears to be depressed about his failed career as an architect and his recent failed relationship. When the portal entices him in, a labyrinth of jaundiced corridors, stairwells, and rooms replicate themselves infinitely around him. After several therapy sessions where an increasingly distraught Clark hides his discovery and then stops showing up for therapy entirely, his therapist, Dr. Mary Kline—played by Renate Reinsve with hauntingly contrived intelligence—follows him into this netherworld.

What Parsons has built on the other side of the showroom portal is a spatial rendering of the unconscious—the floor plan of a life half-lived. It's haunting and disquieting. As I watched the movie, I was taken back to a moment 40 years ago at the Philadelphia Museum of Art, when I entered—yes, *entered*—Marcel Duchamp's “Étant Donnés” (it's a room). Peepholes drilled into an old barn door drew me across a dim antechamber toward what lay on the other side: a mangled nude woman sprawled in a stream, clutching a lit gas lamp. My professor considered Duchamp's tableau a visceral rendering of our human temptation to glimpse the horror of our own unconscious, and this resonated with me. What hit me as I squinted through those peepholes wasn't what I saw; it was what I felt: repulsion, curiosity, allure, grief.

Watching Parsons' movie arouses simi-

lar feelings as it dramatizes the reality that what we bury rarely stays completely buried. Clark isn't simply lost in a building; he's attacked by his own unrealized potential, ambushed by his moribund dreams. His therapist refuses to reassure him or soften the truth of his predicament. Instead, she informs him that the dismal state of his life is indeed the product of his own poor choices and maladaptive coping strategies. This honesty, in the economy of Clark's unconscious, is punishable by a fate worse than death: he forces Dr. Kline to enact a twisted and humiliating role-play that echoes one of their previous therapy sessions. Although Dr. Kline ultimately flees and escapes the monster, she ends up condemned not by fire and brimstone but by something more sinister—a shadowy research corporation that controls the backrooms.

As a therapist, I can easily imagine Clark's journey having gone differently. He reminds me of some of my clients in Santa Monica who arrive in treatment carrying some version of his split. They have financial goals, but they don't have emotional ones. Many are younger software engineers who earn ten times the national average; however, the rest of their lives suffer as they're compelled to spend 12–14 hours a day in front of their computers, leaving little time for meaning, purpose, or meaningful relationships. Like Clark, their souls are yearning for more, but they're wearing golden handcuffs. They've persevered in their careers in ways that appear practical while feeling less and less like themselves. Depression often grows to fill this schism.

Clark's depression carries a flavor of chronic resignation, and the film captures that condition with remarkable psychological clarity. The monster in the film is self-betrayal incarnate. It arises in the subconscious because Clark has let his dreams and hopes die. What he's let go of comes back as a menace. What he's silenced comes back as a roar. There's an idea, attributed to Freud, that whatever is repressed returns thricefold. For Clark, his self-betrayal returns closer to tenfold. The film's labyrinthine corridors, stairwells, and rooms represent that internal condition. The spaces seem gen-

erated by a psyche crushed under the weight of its own ideals. Drinking blunts his grief, shame, and desire while the signals that might have informed him that his life was going off course are muted. Clark has been unable to create his future while remaining anaesthetized and sealed inside his past.

Watching *Backrooms*, I found myself wondering what I would do if Clark were my patient. I'd want to reconnect him with the dreams and ideals he'd given up on, to help him struggle to find language for the cost of his sacrifices in the hopes that he might realize the difference between earning a living and designing a fulfilling life. I'd want to reignite Clark's passion for architecture in small, concrete ways: a drawing class. A museum visit. An architecture tour. Time spent leafing through old portfolios. The goal wouldn't be a dramatic reinvention. It would be to help him find a path back to agency so he could reawaken the part of himself that still knows how to imagine.

Our work as therapists in such cases isn't just to help clients speak their truth, mourn losses, reduce drinking and numbing, and recover contact with vitalizing work. It's to help them relate from a more genuine place. Someone who hides from himself often hides from others with equal skill. The work of therapy would be to help him become available to contact, honesty, mutuality, and possibly even love again—to show up without disguise, and discover that connection depends on presence, not performance.

Part of the psychological power of *Backrooms* lies in the way it treats unrealized potential as a psychic force. Clark's abandoned architecture, his sales persona, his drinking, his despair, and his damaged capacity for love all belong to the same story. He's lived inside a long series of self-betrays. To market his furniture store, for example, Clark once dressed up as a pirate; that inauthentic version of him incarnates as a monster, bent on making him pay the price for his inauthenticity.

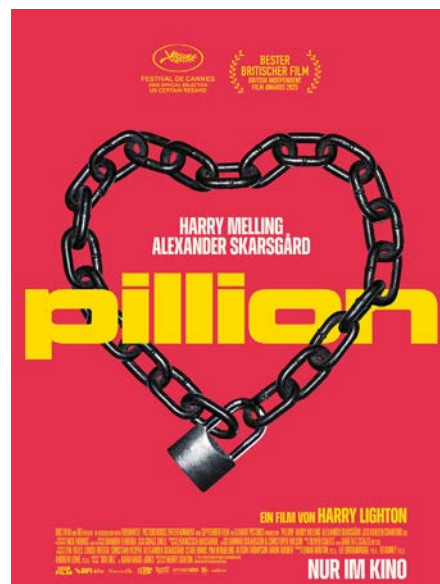
For Clark, healing is foreclosed by self-deception and lack of accountability. With our clients, the path to reconnecting with their desires begins when they stop trading their soul for comfort, and

consider what it might look like to seek fulfillment in work, show up authentically, and love others in their lives genuinely and imperfectly.

There's a quote of unknown origin about hell that fits this film: on your last day on earth, the person you became will meet the person you could have become. *Backrooms* makes this encounter visceral. The film presents the unconscious not as something we have, but as something that inhabits us and can ultimately destroy us if we regularly ignore its invitation toward growth and wholeness.

I was entranced by Parsons' comprehensive vision and the psychological portrait he offered. The film posits that nobody can help you but yourself—that the monster appears when we get caught in our losses in ways that lead to nihilism rather than action. If great art exists to hold up a mirror to our unconscious—and incite us to live fully while there's still time—then *Backrooms*, like Duchamp's *Étant Donnés*, is a masterpiece.

Ira Israel, LMFT, psychotherapist and author of *How to Survive Your Childhood Now That You're an Adult: A Path to Authenticity and Awakening*.



"Pillion"

BY MARK O'CONNELL

Every relationship begins with a script, one handed to us by our families, our

cultures and religions, our individual experiences of intimacy. We adopt ideas and rules about who should lead, who should follow, who's expected to be vulnerable, and who should avoid vulnerability at all costs. And the promise of each script is always the same: if we follow our directions correctly, we're guaranteed to be led toward harmonious connection, belonging, and perhaps even love.

This promise lies at the heart of British director Harry Lighton's poignant romantic comedy, *Pillion*, starring Alexander Skarsgård and Harry Melling (based on the novel *Box Hill*, by Adam Mars-Jones). The surface plot follows Colin (Melling), a naive and nondescript young man who enters a consensual dominant-submissive relationship with Ray (Skarsgård), a tough biker who distinctly resembles a quintessential Tom of Finland illustration. (The term pillion, by the way, refers to the secondary seat on a motorbike—which Colin is taught to occupy as part of the relational terms with Ray.) Something about Ray's certainty and confidence about his social/sexual role offers the submissive Colin an organizing gateway to erotic intimacy that he has struggled to find elsewhere.

Thus begins Colin's exciting, adventurous—and at times painful, embarrassing, and confusing—discovery of BDSM (an acronym for a broad range of consensual practices involving bondage, discipline, dominance, submission, and sadomasochism). But entertaining and absorbing as these courting sequences are, *Pillion* is not a deep-dive exposé of BDSM, nor does it intend to be.

Instead, it's one highly specific story about a relationship that uses the rituals of BDSM as a script to realize the potential of human connection. In fact, one of the most remarkable features of this delightful and deeply moving film is that as the characters negotiate the rules and expectations of their explicitly assigned sub/dom roles, we witness two people simply trying to know one another and be known by one another. BDSM has been written about extensively, particularly in terms of its exploration of power. But what struck me

about its use in the movie was its fascinating emphasis on negotiation.

As Colin learns the rules of engagement from Ray, he tries his best to con-tort himself into the very rigid role he's expected to play. But once he's past the entry point, and their dynamic is established, he begins to test boundaries. He takes creative risks as he searches for more room to express his feelings and desires. And ironically, the emotional conflicts and negotiations that result emerge with greater clarity than we often see in many "traditional" relationships.

As a therapist, I for one found myself thinking less about kink and fringe and sexual idiosyncrasies, and more about every couple with whom I've worked: couples longing not only to be loved, but to be *recognized* by another person and know that they matter to them.

While performing a prescribed role can invite the possibility of such recognition, following a script doesn't necessarily allow each partner to show up with all of their truth, nuance, and vulnerable desires to connect. True mutual recognition requires a willingness for both participants to improvise, to play, and to acknowledge one another as a uniquely complex human being.

But, as well-known researcher Brené Brown points out, fitting in isn't the same thing as *belonging*. Belonging means taking the risk of showing up as we are and asking to be seen and heard by the person in front of us, even if that defies what's safe and familiar to them.

No role—not even one with highly defined rules—can substitute for the extraordinarily vulnerable and challenging work of inviting and allowing another person to know who we really are. And ultimately, this is what *Pillion* exquisitely highlights. The movie isn't asking whether sub/dom romance is good or bad. It's asking the most essential question of any relationship: How do expected roles both help and prevent us from getting closer to one another? And how can we find enough playfulness to inhabit roles truthfully, without getting stuck in the fear of rejection?

Alexander Skarsgård gives perhaps

the most emotionally intelligent performance of his career, because he clearly understands this dilemma. Ray is magnetic and cinematically iconic in his initial certainty, but when he discovers enough bravery to let that certainty slip away, his greatest power emerges—not in dominance and control, but in raw vulnerability, longing, and unadulterated joy. When he finally receives Colin's invitation to show up beyond the expected parameters of his impenetrable role, a refreshing and vital embodiment of masculinity is revealed, one that requires the will to connect and the capacity to access one's emotions.

That insight extends beyond the film itself. Recently, when Alexander's father—the actor Stellan Skarsgård—was asked how he felt about his son playing a gay character in a BDSM movie, he responded: "Oh, I have no problem seeing him do BDSM. If he acts badly, I have big problems." The actor's job, it seems, is to tell the truth about what it means to be human. And as it turns out, that's also a therapist's job.

The longer I practice psychotherapy, the more invested I become in helping people to find balance between the stability of familiar roles and who they are beyond them.

Fortunately for moviegoers, Harry Melling as Colin brilliantly illustrates this dynamic balance. His performance shows us how scripts can help us to find our way to intimacy. But also, and more importantly, he shows us how transcending scripts—imaginatively and playfully—can lead to our ultimate relational goals: to see and be seen, and to hear and be heard. 

Mark O'Connell, LCSW-R, MFA, is a psychotherapist, author, and educator in New York City. Utilizing his training as an actor, he helps clinicians to make use of their nonverbal communication in the therapy room. He's the author of The Performing Art of Therapy: Acting Insights and Techniques for Clinicians and Modern Brides & Modern Grooms. His articles have been published in various clinical journals and popular sources. Contact: markotherapy.com

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