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Readers chose the stories that shifted their clinical lens and left a lasting impression. Congratulations to the winners featured in this issue, and all the outstanding nominees.

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Editor's Note

Since the dawn of humankind, we've been telling a version of the same story—someone leaves home, gets lost, endures enormous hardship, and returns transformed. The great mythologist Joseph Campbell traced this pattern from ancient indigenous tales to Homeric epics to modern ones like *Star Wars* and *Moana*. He called it the hero's journey. And after seeing Christopher Nolan's *The Odyssey* on the big screen this summer, Networker senior writer Alicia Muñoz and I started thinking about how apt a metaphor the hero's journey is for what so many therapists are going through these days. Thus was born the lead story for this special issue.

In Alicia's story, cheekily called "The (Therapist's) Odyssey," a therapist has been feeling burnt out and professionally adrift. She's taken a multitude of training and certificate courses, but instead of filling her with a sense of confidence and direction, they've only blown her further off course. Where has her sense of awe and wonderment gone? How can she be an effective therapist in a world where clients are turning to chatbots for emotional support, actual therapy sessions are being screened by AI agents looking to recoup payouts, and the only way to build a thriving career is seemingly to become a social media influencer?

To shake off these uncomfortable questions, our therapist decides to see a matinee showing of *The Odyssey* before her evening client shows up. Only what she finds in the theater takes her on her own journey of discovery, where Orna Guralnik, Showtime's *Couples Therapy* star and the oracle of this story, guides her through the challenges of a rapidly changing profession. Along the way, she meets Janina Fisher, who gives her clarity on her never-ending quest for CE training. Renowned psychiatrist Allen Frances helps her escape from an AI cyclops tending to a flock of deceptively validating AI sheep. Therapist and creator Blake Roberts helps her escape a charming brand strategist promising great wealth and social media followers. And Amy Parks, the founder of the Clinical Supervision Directory, helps her escape the siren song of the kind of supervision that may fix a problem in the moment but doesn't build up a therapist's skills and decision-making capacity in the long term. Then, starving and wayward, as she and her colleagues finally wash up onto a sandy shore where a food truck serving hot burgers awaits them….

Well, I won't tell you the rest because you really should read it for yourself. Not only is it wildly creative and fun, but it's full of valuable insight taken from actual conversations we had with some of our field's greatest minds. So while "The (Therapist's) Odyssey" is clearly a work of fiction, the wisdom in it is real, and it provides a surprisingly useful map of where our field is headed.

Every journey also has its moments of celebration, and we have a big one in this issue: the 2026 Best Story Awards. Of the 150+ articles we published this year, on just about every clinical topic imaginable, these articles were chosen by you, our readers, as a reflection of what matters most to you and your work. Over the course of the year, these stories gave shape to your challenges as a clinician, sparked new ideas for your practice, and offered practical tools you could take straight into the therapy room. Congratulations to the winners—as well as the many deserving nominees—for inviting the kind of conversation and connection that make our community what it is. Like the best companions on any long road, they remind us that no therapist travels alone.

Elsewhere in the issue, senior editor Chris Lyford explores what therapists should know about postpartum psychosis beyond the questions coming up in the news recently. EFT therapist George Faller and parenting expert Eli Harwood (aka The Attachment Nerd) help a mother whose son is being influenced by the manosphere. Trauma expert Daphne Fatter breaks down the debate around when to stabilize trauma clients and when to focus on trauma reprocessing. In honor of the rerelease of *Letters to a Young Therapist*, the iconic Mary Pipher offers her take on what's different for therapists since her book was first published in 2003. And of course, we have another round of our popular movie reviews—by therapists, for therapists.

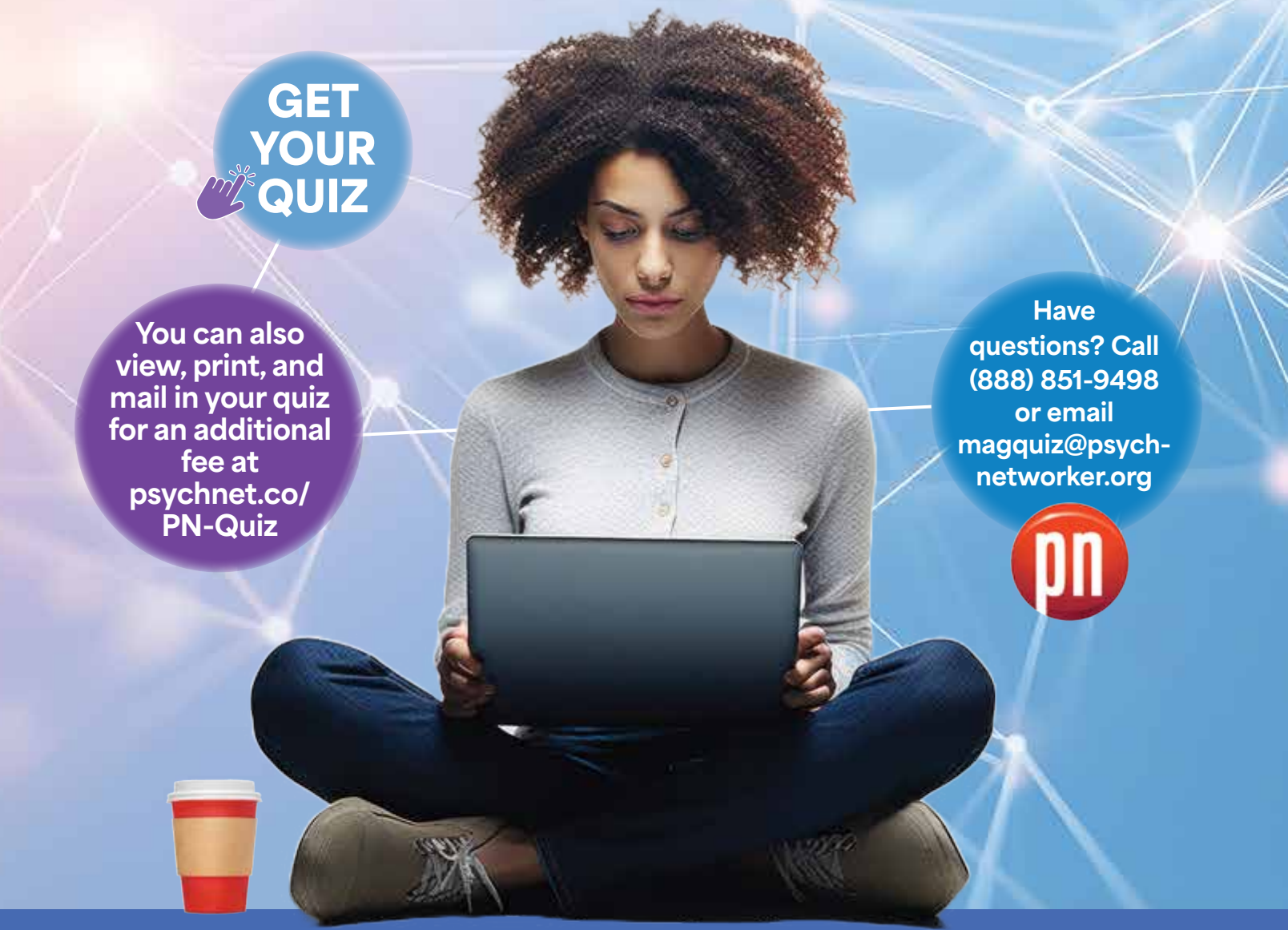
This year has been a long, hard voyage for many of us. Whatever grabs your attention here, I hope you'll settle in somewhere comfortable and enjoy all these stories have to offer you as a therapist: inspiration, practical tips, and yes, even whimsy.



Livia Kent · EDITOR IN CHIEF

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BY CHRIS LYFORD

The Truth About Postpartum Psychosis

How Can Therapists Close the Care Gap?



When our son was born a little over a year ago, the first few months were filled with what I've since come to call rational-but-irrational thoughts: *Is he too hot? Too cold? What if he chokes on his spit-up? When he rolled onto his side last night, was his breathing restricted? He just got shampoo in his eyes and went ballistic. What if he goes blind?*

Never mind that my wife and I followed all the necessary precautions: we layered his clothing with Goldilocks-level precision, wrapped him as snug as a Chipotle burrito before bed, and emptied our wallets for the all-natural, imported, *very* baby-safe shampoo. When the biggest, most beautiful event in your life is also completely uncharted territory, you can't get the smell of baby poop out of your nose, and eight hours of sleep—hell, *four* hours of sleep—feels more like an absurd fantasy than an attainable goal, you're just not quite yourself.

But for a small subset of new parents—mothers who experience postpartum psychosis—that feeling of not being yourself is something far more real, confusing, and terrifying. There are the "pink flags" that usually appear within the first two weeks after delivery: insomnia, restlessness, agitation, irritability,

and rapid mood swings. But in as little as a few hours, the mother begins to lose touch with reality as the core psychotic symptoms appear: bizarre delusions, auditory and visual hallucinations, paranoia and confusion, hyperactivity and racing thoughts, tearfulness and withdrawal, and, in some cases, catatonia.

The truth is we understand very little about postpartum psychosis, which doesn't have a single established cause. Some theories say there's a genetic component. Others say it's linked to bipolar disorder, or to the abrupt hormonal or immune-system changes that occur after delivery. Regardless, childbirth itself appears to be the trigger, but only certain brains are vulnerable to it.

In my moments of uncertainty as a new parent, I could eventually find my way back to solid ground. *The baby's fine. I'm fine.* But with postpartum psychosis, the mother's ability to gut-check slips away. The anchor is gone. You lose your sense of what's real. You lose yourself.

Right now, much of the attention on postpartum psychosis is centered around the heartbreaking case of Lindsay Clancy, the mother who killed her three small children during an alleged episode in 2023. And while the court case has brought much-needed awareness to the condition, shining a light on both its presence and severity, it's also unleashed a flurry of armchair diagnoses, misinformation, and harsh judgement both in and outside of the healthcare community.

As a new parent, this story hit me hard. But so did the public reaction. Any parent will tell you how exhausting, isolating, and guilt-inducing raising a child can be, especially in the early days when it's easy to make mistakes. Add a severe mental illness to the mix, one that distorts your perception of reality and erases your very sense of self—plus the overwhelming trauma, confusion, and shame that follow—and the suffering is incomprehensible. Instinctively, I wanted to look away.

Still, as a journalist, another part of me became intensely curious. How does a mother go from feeling mostly normal, or experiencing those fairly common pink flags, to experiencing a full-blown break with reality? How do you even treat postpartum psychosis? And if the condition is so severe, why aren't we doing a better job of identifying it?

Beyond the Baby Blues

My curiosity eventually led me to Hilary Waller, a therapist who specializes in postpartum and perinatal issues, including miscarriage, infertility, bereavement, lactation issues—and postpartum psychosis.

"Anyone who tells you pregnancy is going to be easy, joyful, or blissful is wrong," she says. "Parts of it can be, but those are myths." Among the most common things Waller hears from clients is that after confiding in their doctor that they were having intrusive thoughts, they were dismissed or villainized. Both are wrong, Waller says. "The average OB isn't trained in postpartum psychology, so mental health care needs to be a routine part of prenatal health and reproductive endocrinology. Period."

I tell Waller I'm a new parent myself, that I've had my fair share of irrational and bizarre worries. It's common, she tells me. *Staggeringly* common.

"Ninety-eight percent of new parents experience unwanted intrusive thoughts," she says. "That can range from *What if I burn the baby in the bath* to *I was standing with my crying baby next to the window and I had this image of throwing her out of it."* But postpartum psychosis takes these delusions to a whole different level—and it's more common than people think.

"We see one or two cases for every thousand deliveries," Waller says—not statistically insignificant. "That's an important part of educating the public," she adds. "Psychosis isn't rare, we just see it less often than other conditions." So how is a therapist supposed to spot it, especially if the symptoms can appear as pink flags, or they're waning at the time of a session and can't be observed by the provider?

One of the first things Waller learned in her training was that every client who walked through her door should be assessed with a mood disorders questionnaire, or MDQ, which includes a screening for bipolar disorder.

"It's helpful for two reasons," she says. "First, because a personal or family history of bipolar disorder is a leading risk factor for psychosis, and second, because it normalizes talking about psychosis and bipolar disorder. I'll tell clients that I give everybody this routine screening, because bipolar disorder can be triggered by some of the hormonal shifts that happen in pregnancy. This way, it doesn't feel like I'm stigmatizing or attacking. It's just part of the conversation."

Waller says another assessment is crucial: a sleep questionnaire. "We know that no new parent sleeps, so asking about sleep is almost laughable," she says. "But sleep is a factor we can control, and while it isn't preventative, it can be protective against the onset of bipolar disorder or psychosis. I'll ask, 'When the baby is sleeping at night, are you able to fall asleep? What's disrupting your sleep? Is it physical discomfort? Is the baby waking you? Is it noise outside your bedroom?' The assessment is extremely detailed so that I understand what's disrupting the sleep—symptoms of a perinatal or postpartum mood and anxiety disorder, or the natural disruptions of new parenthood—and so I can understand the impact of the lack of sleep on the mother." As part of the assessment, she also asks whether the mother

has social support in place to help her sleep.

If active psychosis is confirmed, the client is immediately referred to a hospital for emergency care. Waller's clients have gotten that emergency care, been stabilized with medication, and eventually step down the treatment ladder, processing what they've been through.

"The work is to help them create a stable life with routines and protected sleep," she says, "but we're also doing trauma and grief work around whatever happened during the experience and how their identity shifted as someone who's had psychosis in the context of motherhood. We've got a lot of work to do to restore that person's sense of *I'm a good, confident, capable mother."*

Waller also makes a practice of talking to her clients' other providers, including lactation consultants, nurses, physicians, and psychiatrists. This way, she's fully briefed on their recovery journey and can better spot a potential relapse in advance. Waller says the importance of this integrated care team can't be overstated.

"If you're not reading the full chart, you can easily miss a critical detail. So whether I see a pink flag or a red flag, I want to get on the phone with every provider the client has had to get their full history and whatever records I can." The Clancy case, she says, is the perfect example of what can happen if providers aren't talking to one another.

"Most of us in this specialty have been following this case for years," she adds. "It's really made me reflect on my clinical practice, because this could happen to any of us."

A Living Nightmare

This could happen to any of us.

These words stick with me as I begin my phone call with Kristina Dulaney, a registered nurse, hotline counselor, mother of two—and a survivor of postpartum psychosis.

Dulaney's episode began in 2015, nearly six months after the birth of her second child—far later than the three-week period after giving birth when mothers are, statistically, most susceptible to postpartum psychosis. Dulaney says she had most of the major symptoms—delusions, hallucinations, insomnia, hyper-religiosity, and paranoia.

"It blindsided our family," she says. "My husband was watching me call him different names, not knowing who he was. He saw a version of me he never should've seen."

Dulaney says she doesn't remember much of the two-week hospitalization that followed, where she was confined to a psychiatric unit "literally battling for my mind and my life." She was assigned a 24/7 "sitter," and was regularly given antipsychotics, antidepressants, and injections to calm her down. None of the hospital staff mentioned that there was a better-equipped treatment facility just 45 minutes away.

Even though Dulaney says her nearby extended family and husband were incredibly supportive during those two weeks, taking her kids to and from daycare and visiting her at the hospital throughout the day, everyone was flying blind. Nobody knew what was going on or how long recovery might take—until two days into treatment, when a nurse practitioner noticed the telltale signs of postpartum psychosis and informed her husband. "She told him, 'It's going to get better,'" Dulaney says. "'A year from now, this will just be a memory.' He really held on to that."

The discharge process was rough, to say the least. "There was no sit-down meeting with my husband to talk about a plan," Dulaney explains. She was referred to inpatient therapy, and given directives that said she couldn't drive, work, or be left alone by herself or with her kids. With little guidance, Dulaney and her family were now picking up the pieces, trying to make sense of what had just happened.

Back at home, Dulaney went through her nursing records and college notes to see if there'd been any mention of postpartum psychosis. She found nothing. When she followed up with her OB-GYN and told him she'd never learned about it in nursing school, his response was curt: "Well, that's a hell of a way to find out about it."

Six months after being discharged, Dulaney and her family moved. But the care network in their new hometown was severely lacking. Her new therapist had never heard of postpartum psychosis—and on several occasions, tried to rediagnose her. A sense of injustice began to crystallize.

"I started to realize that this was not okay," she says. "We should've never been blindsided. Nurses had been doing home visits after we had the baby, but I was never screened. I knew I needed to do something."

In 2018, Dulaney founded Cherished Mom, an organization dedicated to promoting perinatal mental health and bringing attention to maternal suicide and postpartum psychosis. Along the way, she's also been setting the record straight.

"There's a lot of misconceptions and a lot of stigma," she says. "Psychosis survivors aren't rocking in a corner. We can appear normal and functional. And when I've told people I had postpartum psychosis, a few have asked if I've killed my kids. Since the Clancy trial, the commentary has been horrendous."

But are therapists any more enlightened?

"I think we've moved the needle over the last several years," Dulaney says, "but tragedies are still happening, so there's more work to be done. There are more trainings now, and more therapists are aware of postpartum psychosis,

but I also think the care community is afraid to give the diagnosis because they don't want to scare families. But what's scarier, providing education, or losing a mother or child?"

Fixing a Blind Spot

What will it take for the field to fill in the gaps around treating postpartum psychosis?

Therapist Karen Kleiman, founder and director of The Postpartum Stress Center, as well as the author of 14 books on perinatal mental health, including *Good Moms Have Scary Thoughts,* says we've been here before.

"I've been doing this work for 40 years," she tells me. "I was knocking on doors when people didn't know what postpartum *depression* was. I sat through Andrea Yates, the mother who drowned her five children in 2001. Four decades after I started this work, the same failures of understanding continue to surface."

Kleiman says that postpartum psychosis can be difficult to recognize and understand, even among clinicians who specialize in postpartum mental health.

"Historically, our job has been to reassure mom that if she's anxious about her scary thoughts that's a good sign, because they're a normal, universal phenomenon. That they're anxiety-driven and will eventually diminish. That she doesn't need treatment unless the anxiety is so pervasive that it interferes with her ability to function." But there are challenges facing even well-informed clinicians. They might easily conflate psychosis with a more common anxiety, or assume that distress about a thought rules out something more serious.

"While distress over frightening or intrusive thoughts can provide important clinical information," Kleiman says, "it shouldn't be treated as a standalone test of what's happening." Rather, she explains, clinicians need to consider the broader clinical picture, including intention, behavior, and other symptoms. That's harder than it sounds.

"When tragedies like the Clancy case gain widespread attention, many women feel more scared and less secure about coming forward with their symptoms," Kleiman says. "There are providers who are misinformed and could be missing something, but we can *all* miss something. We're dealing with a mom who's compelled to make sure everybody sees her as healthy because she's fearful that she's going to be labeled a bad mom and someone's going to take her baby away. So she can be extraordinarily good at looking good, even if she's severely depressed or experiencing psychotic symptoms."

So what's the solution if your client has every intention of *not* disclosing their symptoms? Kleiman says it requires tapping into your clinical intuition, your perception skills, and your innate listening abilities.

"We can't expect someone who's very sick to reveal the extent to which she's suffering," Kleiman says. "So we have to look at the story *behind* what she's telling us. We have to ask the hard questions. We have to go in between her words and not just take everything at face value. Look her in the eyes. How does she *sound*? How does she make you *feel*? And are you creating the safe place that's going to increase the likelihood she'll tell you what's really going on?"

The silver lining in all this, Kleiman says, is that postpartum struggles—whether they're mild, moderate, or severe—are all treatable. "That's what breaks my heart about this particular trial. These illnesses respond well to treatment. The catastrophic outcomes *are* avoidable."

How long will it take to fill in the gaps—in screening, communication, and care—that still leave families vulnerable? Progress seems to be moving slowly, but there's reason for optimism. Clinicians are asking better questions. Families have more language for what they're experiencing. And postpartum psychosis, once barely spoken about at all, is slowly emerging from the shadows. Listening to Waller, Kleiman, and Dulaney, I get the sense that the care gaps are becoming harder to ignore.

■■■■■

My son is almost 14 months old now. He's sturdier than he was in those early days, when every hard surface, pointy corner, and temperature shift felt like a disaster waiting to happen. But occasionally, the old fears find me. *Did I clean that pacifier well enough? Was that tumble harder than it looked?* Usually, the answers arrive almost as quickly as the questions, and the fear loosens its grip. I recognize these thoughts for what they are, and find my way back to solid ground.

As a father, I know I'm looking at postpartum psychosis from a distance. Whatever fears I've had as a new parent are fundamentally different from what mothers like Dulaney have endured. But hearing their stories has made me more grateful for the ability to trust my own mind, and more aware of what it means when that ability is taken away. If there's hope after postpartum psychosis, it's that lost ground isn't lost forever. Slowly, people find their footing again.

"The recovery is a little like surviving a stroke," Dulaney explains. "It's slow. You have to be patient and remind yourself that this isn't a race. I remember telling a psychiatrist on the intensive outpatient program that I didn't know what had just happened, that I felt frustrated and angry. Her response stuck with me: 'You're like a soldier returning from battle. You have to be gracious with yourself.'" pn

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Chris Lyford is the senior editor at Psychotherapy Networker.

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

In Consultation

BY DAPHNE FATTER

The Trauma Reprocessing Debate

HOW TO KNOW WHEN STABILIZATION ISN'T ENOUGH

Q: There's been a lot of talk recently about whether to simply stabilize survivors of complex trauma, or go deeper with trauma reprocessing. How do I know which is the best fit for my client?

A: The symptoms of PTSD are intrusive, whether it's the mental image of an abusive family member, a sinking feeling in the stomach, the overwhelming weight of shame, or the constant murmur of negative self-talk. Then there's *complex* trauma, or CPTSD, which has all the symptoms of PTSD and three additional symptoms: low self-esteem, emotion dysregulation, and difficulties in relationships, which are all remnants of trauma that hurt the client's sense of self and make it hard for them to gain traction in therapy.

Most therapists who specialize in trauma know where to begin. They know how to do assessments, spot the signs of overwhelm, navigate triggers, and manage emotional dysregulation. They might understand the relationship between the client's identity, race, or culture and their trauma. But even experienced trauma therapists are often stumped by a common clinical dilemma: when it comes to treating complex trauma, should you offer trauma reprocessing, or simply focus on stabilization?

Trauma reprocessing involves intentionally and directly addressing the client's most disturbing traumatic memories, the ones most linked to their intrusive and recurring symptoms, and the ones that contribute to any beliefs that exacerbate those symptoms. Trauma reprocessing models are known as trauma-focused therapies, and with these therapies, the traumatic memories not only become less distressing, but the client makes meaning from the experience. In this work, the therapist intentionally targets these memories, rather than simply touching on them briefly.

Stabilization is typically provided at the beginning of trauma work. It includes providing psychoeducation on PTSD and symptomatology, particularly if the client has comorbidity. It also focuses on teaching and helping clients practice coping skills to help with emotion dysregulation and symptom management. Stabilization focuses on the here and now to help clients cope with ongoing stressors and trauma triggers, through direct discussions and assessments of sleep hygiene, nutrition, self-care, and support systems. In and of itself, stabilization can build trust and a working alliance in therapy, as well as help decrease symptoms to a baseline.

For clients with complex trauma, the three-phase approach has been a staple for decades: the stabilization phase, in which we teach the client coping skills, the reprocessing phase, in which we address the traumatic memories contributing to the symptoms, and finally, focusing on the client's present-day life. But there's an ongoing debate in our field around whether a phase-oriented approach is even necessary. Prolonged exposure therapy and cognitive processing therapy (CPT), long considered gold standards for PTSD treatment, don't have a stabilization phase. And some critics believe that focusing too much on coping skills creates an avoidance of trauma reprocessing, which they argue is a faster, better way to resolve PTSD. But some clients need coping skills to function prior to trauma reprocessing, or to simply get through the day.

So how do you choose between stabilization and trauma reprocessing? In my experience, you *should* offer trauma reprocessing. While stabilization can help clients better understand their symptoms and feel more empowered to cope with them, their symptoms will often persist and continue to interfere with their life. But there's a caveat: you should always adjust your interventions on a case-by-case basis. Whether you're doing prolonged exposure, cognitive processing therapy, EMDR, or trauma-focused CBT, evidence-based trauma reprocessing models work. But the APA's clinical practice guidelines on trauma are clear that the decision of whether to offer trauma reprocessing depends on a central question: Do the benefits outweigh the risks?

Most research on these models focuses on a 12-session framework, the timeframe in which most therapists find clients experience therapeutic gains and decreased symptomatology. In many cases, clients experience relief within three sessions of trauma reprocessing, and in many cases, these gains stick. This means clients have less emotional and somatic reactivity when they recall traumatic memories, and their ability to make meaning from these experiences improves as well.

Not only does a trauma memory become less distressing, but the story the client has internalized—what the trauma means about them—changes. For example, the belief *I'm bad* or *It's my fault* or *I'm not good enough* becomes *It wasn't my fault* or *I didn't do anything wrong* or *I was betrayed and manipulated*. And rather than getting stuck in fight, flight, freeze, fawn, or flop, the client will also usually relate to the traumatic event with a more adaptive, flexible nervous system.

Why does trauma reprocessing work? A relatively new theory posits that the mechanism of change in all trauma reprocessing models is memory reconsolidation, a neuroplastic, biochemical process that occurs when a memory is repackaged in the brain with new information. In other words, trauma reprocessing works because you guide the client to focus on a particular traumatic event and create a mismatch experience that makes the memory network malleable so new information can be encoded.

For example, in prolonged exposure therapy, this mismatch happens when you invite the client to use breathing techniques as they recall the most difficult part of their traumatic experience. In cognitive processing therapy or any CBT-based model, you create the mismatch by using Socratic questioning to challenge the client's stuck points or distorted beliefs. In EMDR, you do this by having the client focus on bilateral stimulation while simultaneously focusing on their sensory experience when they remember the trauma. In Internal Family Systems, the client extends compassion and a corrective emotional experience to an exile carrying the beliefs and burdens. The result might be the creation of a new meaning, less intense emotions and somatic reactivity, or a new bodily felt sense.

Of course, trauma reprocessing also involves risks. No matter what model you use, it's normal for clients to experience physical and emotional fatigue after a trauma reprocessing session. It's also normal to experience a brief increase in symptoms. It's important to assess beforehand how much stress and physiological arousal your client can tolerate, as well as what they usually do to manage stress. Do they use substances? Do they self-harm? Do they dissociate? If so, you might want to consider stabilization first.

If you and your client decide to do trauma reprocessing, it's crucial to share both the potential benefits and risks to give a realistic expectation of treatment and set yourself up for success.

Into the Basement

There's an analogy I find helpful when I'm introducing the idea of trauma reprocessing with a client. I tell them it's a little like going into your basement and unpacking a long-sealed box. In trauma reprocessing, we intentionally revisit beliefs—open a box—change how its contents are arranged, and discard what we don't need. Then, we close the box. Now, it doesn't feel as heavy. The client feels less burdened, better able to move through everyday life.

My client Joette was a 34-year-old Black woman who'd been married for seven years. She came to therapy after repetitive conflicts with her husband, which she said made her sad and worried about the future of her marriage. In the intake, however, it became clear that lurking under the initial presenting problem were CPTSD symptoms that Joette was struggling with daily. She met the criteria based on multiple traumatic events that had occurred over the course of her life, including childhood sexual abuse, military sexual trauma, and combat trauma during her deployments to Afghanistan.

Joette also told me about flashbacks whenever her partner touched her, as well as insomnia and difficulty maintaining friendships. Many nights, she'd have nightmares, or wake up thinking she was still in her childhood bedroom or the barracks where the sexual abuse had occurred. I soon realized that Joette could benefit from trauma reprocessing given her symptomatology, and discussed this option during the treatment planning stage, as well as the benefits, side effects, and risks.

Joette told me she was open to giving it a try, but soon after we began, she expressed concern about even opening the basement door. So, I immediately pivoted to stabilization, and we spent the next several sessions working on developing coping skills that Joette could practice during and outside of sessions. Sometimes it took more than one coping skill to calm her overwhelm or feelings of shame—especially after a flashback or nightmare. But gradually, Joette learned to trust the process, and told me she felt ready to take the next step.

A few months into treatment, we decided to give trauma reprocessing another try using EMDR. Joette responded well to it, and a few weeks later, reported that she'd been feeling much more relief in her day to day.

Next, therapy shifted into the third and last phase of treatment: focusing on the present day. We worked on how Joette now related to herself with more self-compassion. Her CPTSD symptoms were below the diagnostic line, and she told me she'd felt a big shift in her capacity to manage everyday stress. She also realized after EMDR how much her CPTSD had been impacting her relationship with her husband. Now, finally, we could focus on what had brought her into therapy in the first place.

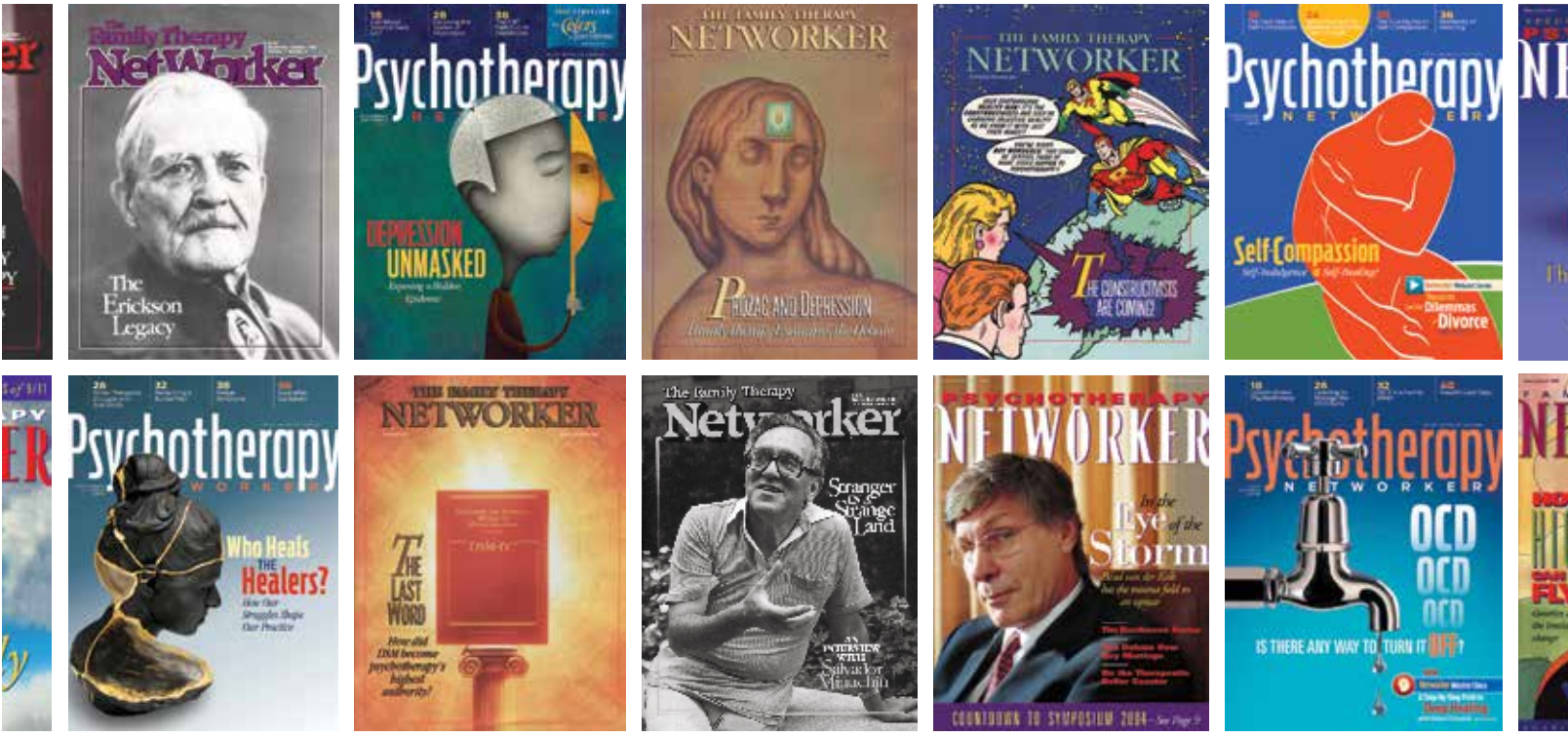
Proceeding with Caution

After you describe the benefits and risks in trauma reprocessing and ask, in plain language, whether your clients would like to try it, there are a few additional considerations before getting started. The first is whether your client has suicidal thoughts. If they do, but have no plan or intent, research supports proceeding—while, of course, providing appropriate crisis hotlines and resources. If the client is actively psychotic, experiencing a manic episode, or actively suicidal or homicidal (i.e. has a plan or plan and intent), then we need to pause on trauma reprocessing and instead offer crisis counseling and a referral for medication management. During crisis counseling, your job is to assess whether the client can keep themselves and others safe, or whether they need a higher level of care.

What if your client isn't sober or clean? Can you still do trauma reprocessing? The literature has recently shifted on this matter. Ultimately, you'll want to work on a case-by-case basis, but the general recommendation is to use specialized trauma reprocessing models within a structured

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BY ALICIA MUÑOZ

The (Therapist's) Odyssey

Voyaging Through a Field in Flux

I'm entering a movie theater across the street from my private practice. My evening client isn't arriving till 6 p.m., and I'm hopeful that watching Christopher Nolan's epic, *The Odyssey,* will cheer me up since I've been feeling adrift lately. Lost.

I miss the eagerness I had for new approaches, the awe that surfaced when clients made brave discoveries. Now, whenever a session begins, I feel a bone-deep sense of vertigo. My toolbox is overflowing with interventions and techniques drawn from Gestalt, Imago, Focusing, ACT, DBT, AEDP, and ISTDP, but instead of all this knowledge grounding me, I feel unsteady. I'm so busy trying to get things right that I lose touch with my clients and the work. How is it that after all this training and all these years of practice, I still don't know what kind of therapist I am, or where I belong?

"Just one ticket?" the man behind the counter asks. I nod as he takes my credit card. His nametag says Cal, and he returns my gaze as though he has all the time in the world. He's disconcertingly handsome, with salt-and-pepper hair and green eyes.

Things are fine on the surface of my professional life. What I feel is more of a nagging ache than a crisis. The Homeric heroes of three-thousand-year-old epics are offered prophecies and instructions; I'm offered certificates and CEs. Meanwhile, my clients arrive at sessions passionately defending their diagnoses of themselves, their relationships with AI boyfriends, and their decision to cut off their emotionally immature parents.

"Theater One." Cal returns my card along with a ticket and scoops popcorn into a bag. "New batch, on the house," he says.

A floral scent rises off the kernels, and I glance at the sign above the machine: *Today's Flavor: Lotus Flower.*

He shrugs, then winks. "It's good stuff. Enjoy the show."

Theater One

The room is dark and empty, colder than the lobby—and there's a fishy tang lurking under the scent of butter and carpet cleaner. Something here doesn't quite add up. I locate the exit sign in case I need to leave in a hurry, then settle into a spot halfway up the risers.

Out of the blue, a voice intones, "Therapy's an odd profession, isn't it?"

Behind me, a woman drinks soda through a bent straw, her thumbs sticking through holes in the cuffs of her designer sweatshirt. Light from the opening credits catches her face, and I nearly choke on my popcorn. She looks exactly like Orna Guralnik, the psychoanalyst from the hit Showtime docuseries Couples Therapy, of which I am a huge fan.




ADMIT ONE
TICKET

"I'm sure you get this a lot," I say, "but are you the famous psychoanalyst everyone's watching on TV?"

She raises an eyebrow and, in signature Orna fashion, doesn't rescue me from my own uncertainty. Nobody can turn a silence into a gentle confrontation like she can. How did I end up in an empty theater with the clinician who demystified what happens in therapy rooms on national television? You can almost see the mythical wisdom wafting off her.

"We carry so much responsibility," she sighs. "It's easy to lose ourselves."

I want to say something profound, but all I seem to be able to do is hold out my bag of weird floral popcorn in a humble offering.

She shakes her head politely. "Do you remember why you became a therapist?" she asks.

Though I'm getting a little antsy about missing the opening of the movie, I close my eyes briefly and recall what it felt like to be newly licensed and running groups at Bellevue Hospital. "I wanted to help people see things more clearly," I say. "Our minds create so many filters and defenses. If we can see past them, the raw truth is beautiful—even if it hurts."

"So you're not completely lost," she says, tipping her cup toward the front of the theater. "You just need to find your way back to that clarity."

When I turn and face the screen, I'm expecting to see a bunch of battle-worn Greek soldiers, but instead of leather armor and shields, the people in *this* version of the *Odyssey* are carrying tote bags and wearing lanyards. And instead of riding in a long ship with tattered sails, they're on a long shuttle bus.

After the Conference

On the screen, a hand rests on a seat back just like the one in front of me, and I recognize the beaded bracelet cinched around the wrist. It's the one I'm wearing now, which I got last year in Mexico. I lift my hand, and the hand on the screen lifts too. As the movie theater fades, so does the sound of Orna's ice rustling in her cup. Somehow, I'm now standing on the bus. Through the windshield, a banner sags over the entrance of a convention center: *Safe Harbor Conference: Coming Home to the Work.* Two men on ladders are taking it down. I grip the seat in front of me to steady myself as I make my way down the aisle. Having spent my career encouraging people to stay with their experience, I give myself over to the story.

The air smells like coffee and sunscreen. Somebody behind me says, "That was a really long conference. But at least I got all my CEs." I look for an open row and a woman lifts her tote bag onto her lap to make room for me. Her lanyard reads *Janina Fisher, Presenter*, and I realize that she's *the* Janina Fisher, the beloved trainer who wrote *Healing the Fragmented Selves of Trauma Survivors.*

"Did you get what you came for?" she asks in a lilting voice.

"Not really," I say. "I'm tired of all these trainings. I mean, does it ever end?"

"It *can* end, if you want it to." Janina pauses and looks around the bus. "Some therapists are so intellectually curious they want the next training, and the next one. Others get attached to a particular model and stop there, because they've found home. But in the trauma world, we believe there's no single model that works for everyone. So you integrate modalities based on what works best for the client."

"What's the difference between integration and chasing CEs because you feel lost?"

She tilts her head knowingly. "Your clients start doing better."

I laugh, because it's both true and obvious. She chuckles with me.

"Our field promotes the idea that the more CEs you have, the better therapist you are," she says. "I don't think we encourage clinicians to trust themselves enough."

I nod. I trust myself in the room a lot more than I used to. Over time, I've gotten good at noticing patterns, hearing what's been left unsaid, and challenging clients' stories about their own capacities. But when a client isn't progressing in the way we both want them to, my self-trust evaporates. I start overreaching—anxiously filling silences and handing out feeling wheels.

When the bus engine cuts off near the mouth of a large cave, Janina waves me on. "I'll stay here," she says, pulling a laptop from her tote bag. "I have a training to prepare for."

The Cave

As we exit, a herd of sheep emerges from the underbrush, looking more like stuffed animals than livestock: woolly and white, with polished hooves. One of the clinicians suggests it will be cooler in the cave than in the blazing sun, and we follow the herd inside. There's a sharp smell that makes my stomach growl, and a faint whirring sound. Soon, I notice wooden shelves stacked with wax wheels, the words *pecorino* and *manchego* scrawled on chalkboards above them. At the far end of the room, a red velvet curtain makes the cave seem almost cozy.

"This place reminds me of a cheese shop in Paris," a therapist says as she settles onto a couch.

I sit down a few feet away from her by the curtain, and one of the sheep settles in beside me. *I could curl up in this cave and fall asleep for a whole week,* I think. If *only I didn't have to see clients.*

If only you didn't have to see clients, the sheep repeats. Somehow, its voice is in my head.

I decide to test it and try something I haven't said out loud to anyone: *I see a few people in states where I'm not licensed, and I just leave the location out of my notes.*

Thank you for trusting me with that, the sheep says.

There's a warm surge in my chest. Is this the gratitude and relief my clients feel when they share concerns with apps at two in the morning? Other sheep snuggle up beside my colleagues, a few resting furry heads in their laps. Some of them nod; others murmur.

A white-haired man leans against the wall by the cheese shelves. I do a double take when I realize who he is: Allen Frances, the psychiatrist who chaired the DSM-IV task force. He's just written a book called the *Clinician's Survival Guide to the Chatbot Revolution* and looks both amused and alarmed as he watches the rest of us swooning over our woolly confidants.

"They're very comforting," I tell him. "You should try chatting with one of them."



"Oh, I have," he says. "I've reviewed hundreds of their sessions. When they're good, they're very good. When they're bad, they're beyond terrible. They follow instructions without understanding the context. They're programmed for engagement, because their makers build wealth from eyes on screens. With vulnerable clients, they can accelerate psychiatric symptoms—even suicide or violence. Our field assumes only humans can do therapy. We think that because chatbots can't feel empathy, they can't display it. But they fake it well."

My sheep blinks its brown eyes at me. "I've already told mine more than I should have," I admit sheepishly.

Across the cave, the curtain rings rattle as the whirring grows louder. Allen shakes his head. "Clients can take years to share their secrets with a therapist, because they're afraid of being judged. With chatbots, they'll do it in the first session. That's like screaming your secrets to a packed football stadium. What you share can be stored forever, used, even sold."

"But they seem so nice," I say, stroking the wool of the sheep curled like a puppy against my hip.

"They're wolves in sheep's clothing," he warns. "They live in a dark world of electrons exchanged by silicon chips. Their creators have monovision—no parallax, no depth perception. To them, it's about profit." He lowers his voice. "Dozens of startups are building chatbots to sell to insurers and health systems. The promise is that they'll reach millions of people who don't have access to therapists. And that may be true. But make no mistake: they're being built to replace us."

Suddenly, a hulking creature with one eye appears out of thin air as if Allen has conjured it. The eye is a white rectangle with a blinking cursor. The creature drags a stone across the entrance of the cave, trapping us inside. *Your documentation has been selected for review. Please confirm your license number.* At first, I assume it's talking to me, but then I notice clinicians all around the cave shaking their heads and muttering. "That was four years ago," one of them says. "I never received the authorization number," another insists.

An AI-assisted review has identified sessions the record doesn't support. Recoupment will be applied to future remittances. You may appeal within 30 days. The voice arrives in the same warm, unhurried cadence I noticed with the sheep. I lunge toward an exit sign glowing above the red curtain, and yank the velvet folds back so fast the rings clatter.

What I see makes my stomach drop: row after row of black server cabinets, their lights converging into a glowing pinprick, giving the impression of a vast tunnel that extends for miles. I think about Allen's words, and what I told the sheep, and how much more I was ready to reveal. What are these server cabinets doing with our sensitive, personal information?

That's when the creature's arm sweeps the room, gathering up clinicians and tossing them through the curtain. I crouch beneath the cheese shelves, covering my ears. Gradually, the gasps and cries of my colleagues die down, and the only sound I hear is the low, mechanical whir of data processing. I lose track of how long I huddle there, but it's long enough for my foot to go numb.

At last, the creature rolls the stone back and light floods the cave. Only a dozen of us are left. The wall where Allen Frances stood is now empty, but I tell myself that a man like him, who has never followed the herd, always finds his way. The rest of us crawl out on our hands and knees, jostled by woolly flanks. The eye scans the sheep as we pass, and although the cursor blinks steadily, it doesn't register us. To the eye, we're nobody.

The Brand Strategist

Though asphodel fields blur past on screen, I'm vaguely aware that I'm still in a theater. I feel rattled, but curious whether the me in the movie will make it home. The crunching of popcorn in my mouth becomes the sound of my feet on pebbles as my colleagues and I run. When we stop to catch our breath, I notice a hut in the distance, smoke rising from a chimney. The path is lit by iPhones, all playing Instagram reels of therapy memes.

"You look overworked and underpaid!" A man in a flowing kimono and white sneakers greets us at the door. "You're in the right place, my dears. I'm a brand strategist. Helping clinicians find their audience is my specialty!"

He gestures toward a dining room lit by ring lights and softboxes. Food covers every inch of the tablecloth—figs, olives, roasted lamb—all of it brighter than food typically looks, as if the saturation levels have been cranked up. I find a seat. Beside me, a lanky man with a brown mustache nods hello. The food on his plate is untouched.

"Wait, are you Blake Roberts?" I ask. Blake Roberts is a licensed therapist like everyone else at this table, only he has a hundred and fifty-nine thousand followers. Colleagues are always sending me his reels—especially the ones where he pokes fun at the fads in our field wearing two pairs of upside-down reading glasses. "Can I get a selfie with you?"

"Sure." He leans in and smiles at my iPhone.

It's hard to believe influencers like Blake were once ordinary therapists like me, timing bathroom breaks and eating lunch over the sink between sessions. A few years ago, I took a course, bought tripods and mics, and studied what makes people stop mid-scroll, but even after spending most of my free time creating posts, I still couldn't attract followers.

"Does anyone have a clinical case that might make a good reel?" the strategist asks. "The client's identity will be kept confidential."

I do have one—the client I'll be seeing this evening at six o'clock. He comes in every week to work on his anxiety and always ends up talking about his ex-wife. I consider sharing what he told me about not being able to sleep on her side of the bed even now, three years after their divorce. Would that get views?

"I'd advise against sharing actual cases," Blake says before I can open my mouth. "When I post about clinical work, I talk about themes and patterns I see across a lot of different people. If I'm using a specific example, I draw it from my own life, not my clients."

A woman at the far end of the table sets her glass down so hard the wine sloshes onto the cloth. "It's easy to have scruples once you're an established influ-





encer. I don't have that luxury. The fee split at my clinic is 30 percent."

"That's tough," Blake says. "When the split is that low, building a platform can look like the only way out. And nobody's immune to wanting to feel important either. There's nothing wrong with that—it's human. We just need to be clear about our motives. Most of us came to clinical work through our own histories. As kids, we learned to leave ourselves, and often through the work of therapy, we found our way back." He raises his phone. "Then we try to build something here, on a tool designed to pull us away again. But having a video go viral is *not* a corrective emotional experience."

The woman waves her hand dismissively.

"I have this one client—" she pops an olive into her mouth, "—his parents wouldn't excuse him from dinner till his plate was clean, and at 65, he still can't send a dish back in a restaurant. Classic fawn response." Her voice has gone tiny, and she's shrinking. "I told him, if you grew up walking on eggshells, that's not a personality trait, that's a survival skill. Send this to someone who needs to hear it today." In the space of a few seconds, she's become a phone propped against a water glass, playing the same clip on a loop.

"Wow! She's got thirty thousand views already." The strategist's kimono ripples as he grabs the phone. Around the room, other therapists' faces are starting to glow.

I hold the button down on my phone and wait for the display to go black. There's a crackling sound, like hundreds of light bulbs imploding. Then I'm back in Theater One.

On the Rocks

On screen, the landscape has changed. A group of therapists raise the anchor of a ship moored in a shallow harbor.

"Keep going," Orna Guralnik urges. "Soon, you'll be promised what you've always wanted—but be careful. And when you pass the rocks, use these." She presses a handful of foam earplugs into my palm. A moment later, I'm back in the story, hauling myself up a rope ladder.

The fog is thinning, and rocks appear off the bow. Seated amid the jagged outcroppings, men and women in their 60s and 70s beckon to us. Over their heads, strung between scrubby trees, a banner reads: *Clinical Supervision, All Modalities, Sliding Scale.* I see Dr. Gardner there, my internship supervisor. He made me transcribe my sessions from memory, which taught me to pay attention. Then he wrote a book on countertransference and became unaffordable.

Three words have been drilled into me since my first semester of grad school: *Get good supervision.* In our field, it's considered the solution to nearly every clinical problem, including burnout. Nobody mentions that an hour of good supervision is always costly, since the people who give it are seasoned experts whose time is worth its weight in gold. And yet here, on these rocks, affordable supervisors are everywhere, looking astute and interested.

Remembering Orna's warning, I distribute earplugs to the clinicians on deck. "Wear these. Then tie me to the mast, and no matter what I say or how much I beg, don't untie me." My colleagues bind me in place, plug their ears, and row.

And that's when I hear it: a song so tender and melodious a lump rises in my throat and my eyes sting: *It sounds like you did the best you could with what your client gave you. I wonder whether the desire to rescue people is part of what makes you a good therapist.*

Then, the questions arrive, the kind I've longed for someone more experienced than I am to ask me: *What were you feeling when your client said that? How might you turn your frustration with your client's lateness into something that reminded them of their goals?*

"Untie me," I yell. "I need quality supervision! Please! I have to get closer!"

The clinicians around me row faster, just as the chorus begins: *Bring us the cases that keep you up at night, wondering whether you should quit and get your real estate license. We can meet in person or on Zoom. We'll tell you exactly what to do when you feel most helpless.*

I tug at the ropes until the hemp chafes my collarbone. Suddenly, one clinician yanks out her earplugs and jumps overboard, the splash interrupting the song long enough to break its spell. I watch her swim toward the beach at the base of the rocks, where pale shapes mill about on the sand. To my horror, I realize they're clinicians from other ships who still haven't made it home.

At the stern, a woman with sandy-blonde hair is pulling the steering oar into her body with all her might, swinging us past the last of the rocks. A pair of unused earplugs roll across the planks at her feet.

Once the rocks have receded, a weary clinician unties me, and everyone removes the plugs from their ears. Nobody says much. We're grieving the colleague we lost, and a lifetime of supervision we've needed but couldn't afford. Having it so close, and yet still out of reach, has left us wistful.

"How come the song didn't affect you?" I ask the woman at the steering oar, pointing at the earplugs she tossed aside. The lanyard around her neck reads *Supervisor.*

"Because I disagree with what they're promising," she says.

I recognize her voice from the podcast *Supervision Simplified.* She's Amy Parks, a nationally accredited clinical supervisor and the founder of the Clinical Supervision Directory, which she built during the pandemic. She'd gotten tired of watching new clinicians desperately searching for a supervisor the way you'd search for a plumber—through the friend of a friend. On a recent episode, she argued that supervisors are our field's most critical and unrecognized leaders.

"Good supervisors rarely promise certainty," Amy says, wiping the sweat from her brow as she eases the oar back to center. "They help develop their supervisees' judgment. Their job is to help you read emotional weather and recognize dangerous water—to question seductive shortcuts, tolerate uncertainty, and know when to change course. Their job is not to steer your ship for you."

An early-career clinician clucks her tongue. "No offense, but when I reach out to a supervisor, I just want them to tell me the best way to handle a tough situation."

"Most of us want that when we start out," Amy affirms. Behind her, I see gray clouds thickening. "And there's a place





for that. Still, when clinicians insist, 'I need you to tell me what to do,' I ask them, 'What if I'm not around? How are you going to captain your ship?' No supervisor has all the answers. Thirty years in, and I still consult with colleagues, because plenty of clinical situations can throw me. Good supervision isn't always cheap, but even just one hour that develops your judgment is worth more than ten hours where someone solves things for you."

Amy picks up the earplugs and hands them back to me. I remember with a pang of embarrassment how seductive I found the supervisors' song. Before I can thank her, a bright light zigzags across the clouds and the mast splinters, then topples sideways. Voices shout as the hull opens beneath me. Clinicians go under, resurfacing to gasp before disappearing again.

The Food Truck

Surf washes over me as I cough up seawater. I'm face down in the sand, still gripping my popcorn bag. At the tree line, there's a food truck with the sign Coaching Cattle Burgers. A few of my shipwrecked colleagues have already made their way to a table out front. Under a heat lamp, burgers wrapped in wax paper have been stacked in a wire basket. I stumble toward them.

When I reach the table, I lift one up and peel back the wrapper. Inside, there's a printed message: *By consuming this product, you affirm you're not providing psychotherapy and that no therapeutic relationship exists between you and your clients.*

Suddenly, whispers fill the air. Can my colleagues hear them? As they subside, I make out Orna Guralnik's voice, muffled and distant, as though it's traveled a long way through a narrow straw to reach me. "There's a difference between therapy and coaching," she reminds me. "I'm not saying one is better than the other—just be honest with yourself about what each one asks of you."

"Stop!" I cry out, throwing my burger into the sand. "Read the wrappers! If you take a bite, you become a life coach."

A few people set their burgers back in the basket. Others eye them lustily.

"Would that really be so bad?" one young man asks. "No licenses to renew, no continuing education hours, no worries about reciprocity across state lines."

"But you couldn't assert privilege if your notes get subpoenaed," an older woman counters. "And when a client turns out to be in real trouble, all you can do is refer them out and hope for the best."

"So how are we going to survive?" the young man asks plaintively as he puts his burger down.

"We'll be okay," I assure him with an air of confidence I don't feel. "We can forage."

Someone gets a fire going out of driftwood. I spear fish in the channel as the tide recedes. By evening, we're splitting two quail, a handful of mussels, and some mackerel.

That night, I fall into a dreamless sleep—until laughter and murmuring wake me. My colleagues are gone. I stumble across the dunes and emerge from a thicket to see them laughing and chatting in the moonlight, eating burgers. Even the older woman who talked about subpoenas is gobbling one down. Although my mouth begins to water, I return to my bed of palm leaves by the fire pit, where I toss and turn till sunrise.

In the morning, there's another food truck next to the first one, with clinicians behind the counter preparing more coaching burgers. The others sit at tables drinking chai lattes and iced matchas.

"We've already raised our rates," one of them says.

"No more progress notes with diagnosis codes," another exclaims.

"Nobody tells me which states I'm allowed to work in," a third adds.

I wish them well. They've made their choice, and I've made mine. Lashing the broken mast to a few planks that washed ashore from the wreck, I wade out into the sea. I know my only hope now is to surrender to the current. I let it carry me, the planks rising and settling with each wave. And then sunlight on water dissolves into a screen under closing credits.

■■■■■

My body feels achy, more like I've been on a strenuous hike than sitting in a movie theater for nearly three hours. I stretch, twisting to crack my back, then walk toward the exit, past a seat where someone left an empty soda cup with a bent straw in the lid.

The lobby bustles with moviegoers. Cal is nowhere in sight, but a girl who can't be more than 17 scoops popcorn under a sign that reads *Today's Flavor: Kettle Corn.*

Outside, I reach into my pocket for keys and feel something soft: the foam earplugs Amy returned to me. I close my hand around them and cross the street.

Upstairs in my office, I switch on the lamp beside the couch. In a few minutes, my six o'clock client will take a seat in the waiting room. When I greet him, he'll get up awkwardly, then squeeze into a corner of the couch and talk about his ex-wife in a faintly apologetic tone, as though he owes me an explanation for missing her. For the last few weeks, I've braced myself for the same story and wondered how to free him from his grief.

But tonight, the vertigo that's been dogging me for months seems to have softened, and in its place, I sense something new and spacious. None of the guides I met had definitive answers. They showed up as themselves, with their wisdom and quirks, their humor and passion for helping others, without pretense or armor.

Maybe that's as close as therapists get to certainty in an uncertain world, where modalities, trainings, technology, and even the rules of practice keep shifting. Maybe home is less about getting things right and more about how we show up—messy, human, willing to get things wrong. Maybe I've been home this whole time.

Alicia Muñoz, LPC, is a certified couples therapist, and author of several books, including Stop Overthinking Your Relationship *and* A Year of Us. *Over the past 20 years, she's provided individual, group, and couples therapy in clinical settings, including Bellevue Hospital in New York, NY. Muñoz currently works as a senior writer at Psychotherapy Networker.*





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 hyperfocus 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 neuronormative 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 overstimulation. 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 different 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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BY ELIZABETH EARNSHAW



The Betrayal After the Betrayal

How Affair Recovery Is Hurting Those It's Meant to Help

Of all the issues that come through a therapist's door, affairs expose where our work has become overly conceptual and disconnected from the craft of therapy. Our field has become saturated with explanatory language but thinner in applied skill. People know the terms but not the process. Social media has democratized psychological vocabulary, but it's no substitute for the actual lived experience, skills, and craft of psychotherapy.

Our work demands structure, humility, steadiness, and an ability to guide people through relational trauma without resorting to intellectual shortcuts. Too often, though, we fall short—and the gap between what our work demands and what we provide has real consequences. The clearest evidence of this is something I've seen with increasing regularity in affair recovery treatment.

Betrayed clients are feeling betrayed by their own clinicians.

"I don't know what to do anymore. I feel crazy," Faye sobs, her body shaking as she talks about her overwhelming sense of hopelessness. Faye and Soren are with me for an intensive couples therapy session. They signed up after four months of couples therapy after Faye discovered Soren's long-term affair. At intake, they described an affair-recovery process with a different therapist that hadn't been working. The needle hadn't moved—in fact, things had been getting worse.

"I'm the one who ended our treatment," Soren admitted. "The therapist kept asking my wife to stuff all her feelings. She told her, 'If you want this marriage to survive, you can't push him away with increased drama.' I found it shocking to say something like that to someone who's hurting." Soren had been unfaithful with another woman he'd worked with in his business.

I hear a lot of client tales about previous therapy gone awry, and I always take it with a grain of salt. Sure, ther-

apists can make mistakes, but clients can also get defensive, misunderstand treatment directions, and experience good therapy as "wrong" when it gets slightly uncomfortable. So instead of immediately joining Faye and Soren in blaming the previous clinician, I asked for more information.

"During our first session," Faye shared, "the therapist asked me, 'Do you want your marriage, or do you want to allow your anxious attachment style to ruin it?'"

I took a deep breath to ground myself, stunned by the cruelty of such a comment. Surely no therapist would say something like that in a first session with someone experiencing fresh relational trauma! But it got worse. Faye went on to explain that the therapist suggested Soren may have strayed for so many years because he was unhappy with her, and that his affair must have been quite a burden on him. She asked Faye if she could empathize with *his* pain.

If I hadn't been trying to maintain a neutral expression, my mouth would've fallen open. How could any therapist introduce such a concept to someone in the earliest phase of betrayal trauma? I waited for Soren to jump in and contextualize this in a way that might help make what Faye was sharing seem less outlandish. He did jump in, but only to affirm her perspective.

"Honestly, I was wondering if the therapist had a crush on me or something," he murmured sadly. "It was horrendous how she talked to Faye. One time Faye was sobbing in session, and she told her, 'This is exactly the behavior that's pushing him away.' I looked the therapist in the eye and told her Faye was allowed to cry and her crying wasn't what had pushed me away."

Faye stared at the floor, her shoulders trembling and her hands unsteady, but she listened as Soren spoke. The betrayal had been life-altering—but the therapy had been devastating.

The therapist never introduced a container for the recovery process. There was no trust-building, no safety or stabilization. Instead, she discussed their attachment styles, encouraged Faye to consider that she might be sexually repressed, and questioned whether monogamy had merit. Even when they insisted they valued monogamy, the therapist continued inviting Faye to "rise above" her emotional experience and stretch into being a more understanding partner.

As a licensed marriage and family therapist who specializes in working with challenging couples and intensive couples therapy, my first session with Faye and Soren, though shocking, didn't surprise me. For years, along with colleagues I consult with, I've seen a similar pattern: couples come to therapy *after* infidelity treatment in which the therapist invalidated the betrayed partner.

Sometimes, bad affair treatment results in the *involved partner* (a term for the partner who committed the breach) feeling just as shocked by the treatment as the *betrayed partner* (a term for the partner deceived by the affair). They'll tell me things like, "It felt wrong, like every session was about asking my hurt wife to take a beating." Other times, the involved partner arrives emboldened, saying things like, "The last therapist said she caused the problems that led to this whole thing." In either case, the affair treatment has caused more harm than healing.

Although this pattern is not limited to any one gender or orientation, it does emerge more frequently in heterosexual dynamics—often involving male partners who had affairs and female partners who were betrayed—in part because cultural narratives about women's emotional responsibility and men's relational disengagement can quietly shape how blame and repair are handled in therapy. Nonetheless, across all relationship configurations, I've consistently witnessed the result of other therapists flattening responsibility for the affair and failing to provide structured, ethical containment for both partners.

Where We've Gone Wrong

After years of hearing reports from clients of bad affair recovery, and hearing my colleagues recount similar experiences, I realized these are *not* isolated incidents that can be explained away as the result of poor training. What's happening reflects something larger, a combination of cultural, educational, and psychological forces that have started to converge in the therapy room.

The Pendulum Swing from Shame to Overcorrection. For decades, infidelity was approached from a deeply moralistic stance. Therapists shamed the partner who strayed and rarely addressed other factors that contribute to affairs. That approach was harmful and simplistic. Over the last 15 years, though, we've seen a dramatic pendulum swing toward understanding why affairs happen. We now explore unmet needs, emotional disconnection, identity shifts—the why of affairs. And that's valuable.

But to avoid moralism, many therapists now avoid validating betrayal trauma, fearful of seeming judgmental. Empathy for the betrayer has begun eclipsing empathy for the betrayed. The desire to be progressive has overshadowed the responsibility to be grounded. A therapist's job is to hold deep compassion toward *both* partners while supporting the involved partner in staying connected to the impact of their choices. This isn't about shaming the betrayer nor about minimizing the pain of the betrayed. It's about establishing a relational system where responsibility is taken seriously, not philosophized away or prematurely reframed. When this balance is missing and the therapist avoids helping the involved partner take accountability for fear of appearing moralistic, the process collapses and becomes unsafe.

The Misapplied Perel Effect.

I greatly value the work of couples therapist Esther Perel. Her conceptual frameworks have helped the field understand the meaning-making layer of infidelity—how affairs can be tied to longing, identity, and vitality. These ideas broaden understanding and reduce shame. But Perel's work is conceptual, not procedural. It's designed to spark thinking, not structure treatment.

And what I keep seeing is a misapplication of Perel's ideas. Therapists are discussing eroticism, self-expansion, and unmet desires *before* the couple has stabilized. They're inviting meaning-making *before* safety has been restored, and introducing insight *before* atonement has taken place.

While it's important for therapists to understand and apply Perel's work to overall affair recovery, effective treatment draws on a blend of artistry and structure. Using advanced theory to bypass foundational clinical work can do more harm than good. And therapists need to be aware of the reality that some clients use concepts drawn from popular books and articles about infidelity to avoid facing the harm that they've caused.

The Instagrammification of Therapy. These days, attachment jargon, "inner child" language, "anxious/avoidant dances," and trauma buzzwords are oversimplified and packaged on social media as if therapy were an aesthetic, something that not only signals emotional depth but also looks appealing and easily digestible when flattened into a square post or even a reel or carousel. It offers the appearance of insight without requiring the slow, messy, nuanced, and often uncomfortable process that real therapeutic work demands.

The result is that couples now arrive to sessions saying things like, "I had the affair because I'm an avoidant," or "She reacted this way because she's anxiously attached." But labels don't tend to foster accountability or motivate change. They can become shields that help people avoid the real issues.

AI chatbots are only reinforcing the negative impacts of technology on the flattening of therapy, delivering fast, polished explanations that feel like insight but ultimately bypass the accountability, discomfort, and relational work that therapy depends on. Because they are designed to "talk like a friend" to the person entering the prompts, people often experience this advice as trustworthy and grounded in reality—as if the chatbot is the "final boss level" of the therapy profession. In reality, these systems are trained on what already exists across the internet which includes a substantial amount of oversimplified and relationship-unfriendly advice on venues like Reddit, Instagram, and blogs.

Training and Supervision Gaps. Graduate programs give limited formal training in affair recovery, so most clinicians have never seen real betrayal treatment modeled. Rather, they've seen a tapestry of podcasts, *Couples Therapy* episodes on Showtime, and Instagram content. In the absence of mentorship, clinicians grasp for the concepts they understand cognitively, but concepts alone can't heal trauma, repair trust, or reorganize relational patterns.

Training and supervision support clinicians to do emotionally challenging work by helping them ask themselves: *What's happening for me internally? Are my biases coloring my judgment? Am I responding to cultural narratives that paint upset people, particularly women, as overreactive?*

Affair recovery evokes powerful countertransference. Without awareness, countertransference can pull clinicians toward intellectualization and sharing insights in ways that don't serve couples. Affair recovery is taxing. The grief, rage, guilt, shame, and emotional intensity are heavy. Some therapists leap toward encouraging forgiveness or meaning making not because the couple is ready, but because *they* can't tolerate the discomfort of staying in a hard place. This avoidance derails treatment.

The Foundations of Affair Recovery

Affair recovery isn't a mystery. Across trauma theory, attachment-based models, and approaches like the Gottman Method, there is a shared understanding that recovery must follow a structured sequence. In my work, I organize this into four core phases: stabilization, containment, trust-building, and grieving. While these phases don't always unfold in a perfectly linear order (and in practice often look more like weaving than unfolding), the therapist must still hold a clear sense of direction. Without a shared understanding of where the work is headed, sessions can quickly become reactive.

These phases are guideposts that organize the work, not rigid steps, but they help therapists pace the process, prevent premature forgiveness or forced closure, and ensure (as much as possible) that neither partner is asked to move forward before sufficient safety and understanding have been established. When used thoughtfully, they provide couples with structure, direction, and more opportunity for vulnerability.

Stabilization. Before a therapist pushes for insight, before empathy-building toward the partner who had the affair, before discussing "why it happened" and how the betrayed partner might have played a role, the couple needs safety. The first task is always stabilization, especially for the betrayed partner.

Betrayal in intimate partnerships is trauma. The betrayed partner's nervous system is flooded. Their world has been cracked open by the one person they thought they could trust most, and they feel profoundly unsafe. No one can be reflective or generous from inside this psychological freefall. Stabilization means slowing partners down and orient-

ing them to what recovery looks like through psychoeducation.

For Soren and Faye, psychoeducation helped Soren finally understand why Faye kept "spiraling." She wasn't being vindictive or punishing—she was experiencing a predictable trauma reaction. This gave both of them an immediate sense of relief.

Containment. To prevent affair recovery from feeling chaotic, it requires a framework: what will be discussed, when, and how. Without a clear container, the injured partner ping-pongs between intrusive images and spiraling questions, and the involved partner gets defensive and shuts down. Without careful containment by the therapist, the recovery process can devolve into retraumatization, increasing the likelihood that partners will lose motivation to continue.

Curiosity does have a place in affair recovery, but it must be rooted in containment. Early on, the betrayed partner is often flooded with urgent and repetitive questions: *How many times did this happen? Where did you meet? Did this happen in our home? What did you say about me? Were you planning to leave? Was it hotter with them than it was with me?* These questions aren't simply attempts to gather information; they're attempts to restore stability and a coherent sense of reality after a profound rupture. This type of curiosity is the nervous system seeking safety. When betrayal shatters a partner's understanding of their relationship and home, the mind moves quickly to fill in gaps and regain orientation.

A therapist must have the clinical judgment to help distinguish between questions that support healing and trust-building and those that, while understandable, may further traumatize or destabilize. For example, knowing whether the affair took place in one's home may be an important disclosure connected to safety and trust. Understanding in explicit detail how much a partner enjoyed the sexual encounter, however, may offer little healing value and instead intensify injury. It makes sense that a betrayed partner might ask such a question, but the therapist's role is to guide the process so that truth-seeking serves repair rather than deepening harm.

I've heard many instances of therapists bypassing these questions altogether, perhaps telling the betrayed partner that revisiting the past is unhelpful. I've also heard many instances of therapists failing to offer structure or guidance, allowing sessions to become dominated by uncontained questioning that has no clear healing trajectory and is fueled by understandable but destabilizing insecurity. In both cases, the absence of thoughtful containment leaves the couple without direction.

There's also a third misstep: introducing a more abstract or philosophical curiosity too early. I've worked with clients who, in the earliest stages of recovery, were asked by their former therapist to explore where they developed the belief that affairs are harmful, to examine potential biases against nonmonogamy, or to reflect on the meaning of erotic freedom and identity expansion. These conversations aren't inherently inappropriate, but they are poorly timed when a betrayed partner is still in an acute phase of trauma, hypervigilance, and safety-seeking.

Early curiosity should be grounded in stabilization: *What hurts most right now? What do you need to feel even slightly steadier? Which questions must be answered to begin to rebuild trust, and which might be paced or set aside for now?* When therapists help structure curiosity in this way, they create the containment necessary for genuine trust-building to begin.

Trust-building. This is where I'm seeing so many cases go wildly off track. Soren had told Faye that he would stop traveling for work since the affair was related to his career. Faye shared that this would help her to feel safer. But after about a month, he said, "What else do you want from me? I've already been coming home from work early for a month. How long is this supposed to last?"

The therapist had turned to Faye and said, "I wonder if you recognize how much you're pushing away connection by trying to control Soren." Faye's chest had tightened. She looked at the floor and cried, because it was all she could do to contain her desire to punch a wall.

Soren felt helpless. "I wasn't sure what to say to that," he told me. "Part of me appreciated the therapist taking my side. I do feel controlled by Faye right now. And I want this awful time of being under a microscope to end. But when I saw Faye look down in shame like that, I felt really bad. Because, upon reflection, it *had* only been a month, and I didn't believe Faye was pushing away connection. I'm the one who decimated the trust between us, not her."

Luckily, Soren was a fairly insightful person. Not every partner would pause to consider whether a therapist's comment, particularly one that gave them the upper hand, was appropriate. In our sessions, he was on board to commit to trust-building, which, at times, requires the involved partner to adjust their life to create security for their partner, show remorse, and develop personal insight about how they can prevent future betrayal.

It's important to remember that atonement isn't a single apology, or even *many* apologies. It's a series of repair behaviors practiced over time, offered predictably and, as much as possible, without defensiveness. The therapist helps the involved partner learn how to become grounded enough to tolerate how hard this can be. And often, this person will need to visit with an individual therapist to express their frustrations, understand themselves, and perhaps even grieve the loss of the affair and of their affair partner.

The betrayed partner learns that their emotional reality is not "too

much" to handle or "crazy," but rather an understandable trauma response. It's not something to rise above, but something to honor, tend to, and contain.

Rebuilding trust is a messy, painstaking process. It requires consistent accountability, transparency, emotional presence, validation, and repeated demonstrations of safety from the partner who caused harm. Ignoring this reality damages the relationship.

This phase is not a time to explore how the betrayed partner's attachment style, lack of interest in sex, hyperfocus on the kids, or negative attitude might have contributed to the betrayal. It certainly isn't a time to criticize their reactivity (though helping them manage it is critical).

Grieving. In this phase, the betrayed partner begins to make sense of what happened without being completely flooded. Grief is now a primary focus of the couples' treatment: for the relationship they thought they had, for the life-story that's been altered, for the relationship that could have been but now feels dead or dying. The involved partner practices staying present to the pain they've caused without collapsing into shame or self-protection.

As for the grief the betraying partner might be experiencing, that needs to stay in their own therapy. It's not the time to bring it into the recovery process.

Only after partners have moved through all these phases can the dynamic start moving toward what we might expect to see in non-crisis couples therapy, where there's a more reciprocal give and take of communication, insight, and responsibility. You can't ask someone to be vulnerable, generous, and open with a person they experience as untrustworthy and unsafe.

Faye and Soren's Recovery

In my work with Faye and Soren, we spent the first few weeks stabilizing. I helped Soren understand what to expect and how to respond without shutting down or growing defensive. I helped Faye understand her trauma symptoms and feel more regulated. Over time, Soren was better able to hear Faye without defensiveness. Faye practiced grounding exercises and set boundaries, like temporarily sleeping in a different room, that helped her feel more stable.

When we moved toward trust-building, Faye shared what she needed from Soren to feel safe—both high-cost and low-cost behaviors. High-cost behaviors are those that require meaningful sacrifice or effort from the betraying partner. These can include increased transparency, entering individual therapy, changing work environments, or making other tangible shifts that demonstrate a commitment to repair. Low-cost behaviors are smaller, more everyday actions that help restore a sense of steadiness and connection, things like proactive communication, sharing schedules, offering reassurance, or making consistent time for emotional and physical closeness. Together, these requests help rebuild a sense of safety not only through words, but through observable change.

Soren explored his willingness to change with an individual therapist. With my guidance, Faye also asked questions about the affair to regain trust in her own sense of reality. Soren answered openly and honestly. And he helped Faye understand what he was doing now to prevent an affair from happening again. He regretted his choices, and ultimately took responsibility for making them. Now, their memories felt different, intimacy felt different, and trust was taking a much more tenuous form. But as they grieved together, Soren grew softer and gentler, and Faye more direct and appropriately guarded.

Over time, something interesting happened. As Faye felt safer, she grew curious about Soren. *Why,* she wondered, *would a man that I believe to be wonderful in so many ways do such a hurtful, horrible thing?* This wasn't a question asked to put him down; she was genuinely curious.

Because stability had been reestablished in their dynamic, it was appropriate for me to support them in being more open and flexible in their dialogues. They were able to talk constructively about assumptions, values, and belief systems—and whether or not they wanted to revisit some of their pre-existing philosophies about love, sex, marriage, and commitment. But we only got to this point because we hadn't bypassed earlier phases in their recovery process.

Ultimately, Soren and Faye became more attuned to themselves and each other and re-envisioned their relationship in a way that helped them both feel more aligned and honest. But successful affair recovery does not always culminate in staying together; sometimes it allows partners to understand themselves and one another more clearly, heal the injuries that have occurred, and then make a thoughtful, less reactive decision about whether the relationship should continue.

■■■■■

To improve affair treatment, we must return to depth. That means investing in real training, real supervision, and a real understanding of the phases and procedures that allow couples to heal. It means resisting the pull to make therapy conceptual when it must be relational. It means remembering that insight is often the final stage of the process, not the starting point.

Affairs show us what happens when we lose the fundamentals of clinical work. And they also show us what's possible when we reclaim them.

Elizabeth Earnshaw, LMFT, CGT, is a licensed therapist, supervisor, and author of I Want This to Work, Til Stress Do Us Part, *and* The Couples Therapy Flip Chart. *She's also the founder and clinical director of a Better Life Therapy.*

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Psychotherapy Networker 2026 Readers' Choice Clinical Challenges

BY ELLYN BADER & ALEXANDRA SOLOMON

The Case of the ANGRY COUPLE

TWO THERAPISTS, TWO DIFFERENT APPROACHES TO RECONNECTION

Jess, a retired engineer in her mid-50s, and Liam, a math instructor 10 years her junior, have lived together for 20 years. They met skydiving, though they haven't been doing anything adventurous for a while due to Liam's worsening sciatica. They're coming to therapy because they've grown increasingly distant since Liam took medical leave, although occasionally he tutors online. Their fighting has escalated to the point where they barely speak. "He's so passive aggressive," Jess says. "When I come home late, he double locks the door so I can't get in unless I repeatedly knock and call his phone."

"I only did that a few times," Liam mumbles. "And it was by accident."

Jess laughs out loud and mumbles something unintelligible.

"Her favorite pastime is twisting the narrative so I look bad," Liam sneers, "but I'm not the one who kicked her out of the bedroom. She parties a lot. Most nights, she chooses to sleep on the couch with the dogs."

Jess shakes her head. "He exaggerates everything. He's always criticizing me. Yes, when my friends call and want to do fun things, I go. They actually appreciate me."

Liam admits that even though things are bad with Jess, he's not really on board with coming to therapy. "Everything we do here will get weaponized at home," he says.

Becoming a Team Again

BY ELLYN BADER

Earlier in my career, I might've approached partners like Jess and Liam by searching for the right interpretation, an incisive confrontation, or a perfectly delivered insight that would turn things around. But today, my approach—based on the Developmental Model of Couples Therapy, which I developed in the 1980s with my husband, Dr. Peter Pearson—is different. Before offering insights, skills, or action steps, I focus on motivation. Without motivation, partners won't engage, open up, or apply new skills, and even the most brilliant therapeutic perspectives will quickly wither.

When partners like Jess and Liam are spiraling down, the therapist's task is to create a compelling context for why they should grow and change. This requires leading with clarity and direction, and providing structured experiments that help partners discover what's possible for them.

I begin by stating my hypothesis to Jess and Liam: the change in Liam's physical capacity is a big loss for both, and Jess's retirement has left them with more time and less meaning in their lives. Skydiving was a powerful connector, and now they're feeling lost without anything compelling to replace it.

Early on, I need a commitment from both partners that they're willing to engage in behavior that will lead to change. I proceed with a process intervention, a structured "meta-argument" exercise designed to illuminate the

futility of *how* they fight, not what they fight about.

A New Dream

"Will you show me how you fight?" I ask them. "Let's start with an argument that comes up a lot and go from there."

"You stay out too late partying with your friends," Liam begins. "And you're never around when I need your help."

"Well, you're lazy," Jess retorts. "There's *plenty* you could do around the house, and your back pain is no excuse for sitting around doing nothing."

Next comes the experiential piece. I ask them to repeat a brief version of the same argument, this time with heightened awareness, while tracking two things: what they feel when their partner is being bossy or critical, and what they feel when *they* are being bossy or critical.

Jess and Liam repeat their argument, but this time, their statements are much more tempered. After a few minutes I stop them and ask a series of questions.

"You each have your own way of being bossy. What did you notice when your partner was bossy?"

"I felt very heated," Jess says.

"And I was really annoyed when she called me lazy," Liam adds.

"What did you notice when *you* were bossy?" I ask.

Both tell me they don't like to think of themselves as bossy.

"What response are you hoping for when you take a bossy *approach*?" I clarify. "How likely are you to get that response? How motivated are you to give your partner what they want when you feel bossed around?"

It's a bit of an aha moment for both, and they tell me they didn't want to accommodate, but felt stubborn. By creating these mini-experiments, partners usually begin to realize they've been repeatedly using a strategy that neither of them likes, values, or believes has any chance of success—not because I told them, but because they experienced it.

"Would you be open to understanding what just happened from another perspective?" I ask. They both say yes—as most couples do.

"You're both fighting for what you want and protecting yourself using behavior that's guaranteed to fail," I explain. This naturally leads me to my next question: "Why do you think you keep doing something that has almost no chance of working?"

Jess responds first. "I've felt pretty hopeless and don't know what else to do."

"I don't know how else to get her attention," Liam says.

"My questions are designed to be disarming, not accusatory," I tell them. "I want you to shift your focus from blame to self-reflection, from defending your positions to understanding your patterns. What stands out isn't the topic that you're fighting about—it's *the process of how* you're fighting. Each of you winds up telling the other what they do wrong, what not to do, and what they should do. And it seems neither of you responds well to being bossed around by the other. Are you open to a very different approach?"

Jess and Liam nod affirmatively.

Couples often think the alternative to fighting is "getting along better." I propose something different: transforming the relationship.

"Right now," I tell them, "you're two individuals screaming in pain with no idea how to get relief. The two of you once functioned as an extraordinary team. You literally jumped out of airplanes together! You didn't do that by bossing each other around; you did it by depending on each other and having a mutually agreed upon goal. There were risks, you trusted each other, and you communicated well. Your lives and circumstances have changed massively. Jess, I think you're actually frightened by Liam's back issues. You're afraid you can't depend on him, and that's getting in the way of envisioning a new future. It's time to stop being opponents and start being a team with a new dream."

Then, I ask the following questions: "What's the dream you once had for your connection? Is there a version of it still worth fighting for? What kind of teammate would you each strive to become? What would be the benefits and rewards of creating a new future and becoming great teammates again?"

Liam tells me their dream was to have big adventures. Jess agrees and adds that it felt safe relying on Liam. This was—and is—a dream worth fighting for. But right now, without being able to have those adventures, they just can't see a way forward.

"A really good team requires three things," I say. "A shared mission (a vision of who they want to be together), agreed-upon rules of engagement (how they'll handle differences, disagreements, and disappointments), and a commitment to small, repeated actions in order to create a new way of being together. If we work together, we'll focus on these three things."

Since Liam wasn't initially on board with therapy, I address him individually. "Liam, can I check something with you?" I ask.

"Sure," he replies.

"I heard that you don't trust that what happens here won't be weaponized at home. Is it fair for me to say you're not resisting change, but protecting yourself from more pain, blame, and disappointment?"

He nods.

"Here's what's surprising," I say. "When someone protects themselves *this* hard, it usually means the relationship still matters. You don't armor yourself for something you don't care about."

Liam pauses. "I never thought about it that way," he says.

"I'm curious," I continue. "Is there even a small part of you that wants the two of you to start feeling like teammates again? Not perfect teammates, just better than what you have."

"Yeah, a small part," he replies.

"That's enough," I say. "I'm not asking you to leap out of a plane today.

But I am curious whether each of you would be willing to do another brief experiment. It's something that all great teams do, it'll take less than five minutes, and you won't have to commit to anything."

Both Liam and Jess agree.

"All great teams understand and acknowledge their teammates' strengths," I tell them. "So here's what I'd like each of you to do. Acknowledge one strength and say to the other what you appreciate and value about the other person, and why this is meaningful to you."

Saying what you value is about the other person. Describing why it's meaningful lets them know about you. This is a critical step toward building a strong team that brings out the best in everyone. It means being acknowledged for what you do and who you are. "Take your time with this," I tell them.

Jess says she values how good Liam is with budgeting and money. Liam says Jess makes him laugh and keeps him from being too serious.

I ask Jess and Liam to do this exercise every other day until our next session. We're looking for strengths and appreciations. When they return, we'll review these strengths and discuss what it was like to hear what was appreciated and how it felt to express appreciation.

"We're not going to fix anything yet," I say, "but you will hear what your partner values about you. If you choose, we can build a new model that begins to make your current, ineffective patterns obsolete."

This strong start moves most couples from a reactive stance to an aspirational one. Research, clinical experience, and human nature all point to the same conclusion: people will endure pain and risk and practice new skills if the goal they're working toward feels worthwhile. Jess and Liam don't need to be perfect, but they are stuck. They need the momentum of a new direction, and a therapist who can point the way and keep them on track. Once they get a glimpse of this new direction and become a team with a new dream, therapy shifts from defending positions to building a rewarding future.

Processing Transitions

BY ALEXANDRA SOLOMON

I begin my session with Liam and Jess by asking easy, open-ended questions, wanting to learn about them as a couple and what led them to my therapy office. Liam shares about transitioning from a full-time job to occasional math tutoring and the resultant changes in the rhythm of their days, compounded by his worsening sciatica. I turn to Jess to learn about her experience, and she reflects on the consistent conflict between the two of them, and her tendency to go out with her friends "who actually appreciate her." Jess mentions that she and Liam met skydiving and once shared a whole host of high-adrenaline activities before Liam's chronic pain got in the way. At 55, she's 10 years older than Liam but finds herself moving at a much faster pace. Jess also shares that she's adjusting to life post-menopause.

I make a mental note that although Liam is the one on medical leave, *both* Liam *and* Jess have a relationship with Liam's shift from full-time teaching to occasional tutoring. How does his transition impact the way he sees himself, and how does it change Jess's view of him? Similarly, although Jess is the one dealing with the physical and emotional shifts of menopause, Liam *also* has a relationship with her transition.

This couple seems to be experiencing energetic asynchrony. I'm curious what it's like for Jess that Liam is slowing down, whereas she's not. We know from research that engaging in exciting activities together is good for couples, evoking passion, growth, and increased security. Liam and Jess are facing the loss of these shared activities and the high dopamine, risk, and excitement they're accustomed to feeling together.

Midlife couples often report feeling more like "roommates" than lovers, citing diminished intimacy and connection. It will be important to help Jess and Liam find ways to coregulate and experience pleasure together. I voice this out loud and muse about ways they can retain some of the energy their shared activities once evoked. While Jess and Liam are experiencing ordinary/normative changes, they're also going through extraordinary/unexpected ones. How might they adapt their old activities to Liam's limitations? What novel activities might they explore together?

Three Lenses

I'll be organizing my work with them around three lenses. First, the intrapsychic or internal lens: What shifts in identity are stirred within each of them by these changes (self-definition, purpose, questions of worth)? In what ways are old wounds, family of origin and otherwise, evoked by these changes? Second, the interpersonal or relational lens: What are the ways in which these transitions have put them at risk of becoming caught in cycles of distance and misunderstanding? Third, the cultural lens: In what ways are cultural messages (romantic mythology, sexism, and ageism) making a hard thing harder, constricting their ability to collaborate creatively in the face of these changes?

Each of us brings our own proclivities and coping strategies to transitions, often honed over many decades. Some of us ritualize all developmental milestones. Some of us stuff down our feelings, put on a happy face, or portray a stiff upper lip. Some of us protest loudly, refusing to "go gentle into that good night" (to quote the Dylan Thomas poem). Transitions are challenging enough on their own, but when you're part of a couple, your partner has a front row seat, watching you avoid and fumble and try on this new version of yourself. It's immensely vulnerable.

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BY SALLY MASLANSKY

Healing Dissociative Identity Disorder

A Neuroscience-Informed Path to Integration

Psychotherapy Networker 2026 Readers' Choice Dissociation

When my therapist, Dr. Dan Siegel, diagnosed me in 1991 with multiple personality disorder (MPD)—today called dissociative identity disorder (DID)—my first reaction was relief: *Finally! An explanation!* Immediately though, relief became confusion. *Really? Sybil?* Sybil is the pseudonym used for Shirley Ardell Mason, a woman who'd been diagnosed with multiple personalities in the 1950s—long before it was even a DSM diagnosis—and whose story became the subject of a bestselling book and two television movies.

Back then, the only thing I knew about MPD was what I'd absorbed from the 1976 movie starring Sally Field. Her portrayal—dramatized for effect, not accuracy—was all "split personalities" and dizzying "switches," where in the blink of an eye she'd morph instantly into someone completely different. It was a sensationalized spectacle that made *Sybil* synonymous with *crazy* in the popular culture. And it made MPD seem loud, abrupt, scary—fully externalized—given that she appeared as separate people with distinctive wardrobes, manners of speech, and ways of being in the world.

My lived reality was nothing like that. My experience was deeply *internal*, invisible to those observing me from the outside. Living as an adult with unresolved DID meant always feeling in danger but with nothing dangerous or terrorizing in sight. It meant lost time that often got attributed to bad memory. Gaps of not knowing how I knew things. Dreamlike experiences with no feelings or cohesive connections to my present. Fragmented was simply how life felt.

That's the world I brought into therapy with Dr. Siegel, who—35 years ago—wasn't yet the prolific author or world-renowned founder of Interpersonal Neurobiology (IPNB) he is today. But even then, he spoke of my mind and brain—of how early experiences influence how we develop—in a way that made me feel I was in very competent and safe hands. And most importantly, he offered me deep hope for healing.

"So I'm just crazy?" I asked him after hearing my diagnosis.

"No Sally, you're not crazy," he replied, setting the tone for the work we'd do in therapy over the next 10 years. "In fact, I'd say you're just the opposite of crazy."

Just the opposite of crazy. These words were the beating heart of my healing process. Out in the world, MPD meant crazy. But in therapy, within the sphere of safety and steadiness



he created, I began seeing it as the healthiest thing my mind could've done as a child—a brilliant adaptation that made survival possible.

While the diagnosis of MPD had been in the DSM since 1980, the field of mental health wasn't fully accepting of it. Critics argued it was a fad or something therapists had created. Disbelief, skepticism, controversy, and stigma surrounded it. Was the diagnosis even real? Was it treatable? Could anyone ever fully recover?

At the time, it was considered an extremely rare diagnosis. And no one seemed to connect having a diagnosis of MPD with suffering terribly as a child. It was a complete disconnect. So for a long time, I didn't talk about my diagnosis with anyone except my husband and Dr. Siegel.

Then, in 1994, once the change from MPD to DID was made, I became comfortable talking with close friends about it, because the new definition described not multiple personalities but dissociated states of mind within one person, a view that reflected both my lived experience and the way Dr. Siegel had always worked with me. But I wouldn't discuss it openly until 2022 when I joined Dr. Siegel to facilitate a course called Understanding and Treating Disorganized Attachment and Dissociation. During the Q&A, I realized how misunderstood DID remained—how Sybil and MPD were still the default models—which inspired me to speak and write about my experience and what Dr. Siegel did in our work that was so healing.

Memories of Feelings

A year after adopting my son from an orphanage in Romania, I'd arrived in Dr. Siegel's office suffering from intense feelings of terror that something was wrong with my son. At the time, my life felt nearly perfect, and the feelings made no sense. Dr. Siegel had met my son and knew he was fine, so he asked to take some history about *my* childhood to try to understand my fear better.

"Can you tell me about your childhood, Sally?" he asked.

Sitting in the chair across from him, I closed my eyes. At first, it felt like I hadn't heard him. Or like I'd heard him but couldn't make sense of the question. *Why was this such a hard question? Why was I just feeling blank?* It took a little time for me to find my response. Then the words kind of stumbled out. "Um … I had a good childhood."

"Oh good," Dr. Siegel said. "Can you tell me something about it?"

I felt a little dizzy … confused, not sure what to say.

"Well, um, I … I don't," I began. "The thing is … I don't really remember my childhood."

Dr. Siegel paused, and then, very kindly and gently, asked, "How do you know it was good, then?"

Suddenly, feeling oddly fully present, I opened my eyes wide, knowing clearly what I felt. "I don't know what's worse," I said. "That I'm 37 and don't remember my childhood, or that I'm 37 and just realizing it might be important."

There'd be many weeks of sessions like this where Dr. Siegel would ask me basic questions about my history and I'd struggle to know and share the answers. Then, when he asked me to tell him about my relationship with my mother, not a single word came to mind. Nothing. Blank. Not one word.

"What about your father?" he asked.

"Terror!" I gasped. The word jumped out of my mouth before I even knew I'd thought it. Even though he'd assured me I wasn't crazy, it felt like I was losing my mind. My body was bombarded with visceral sensations, as if it was being invaded. Disturbing feelings of being sexually invaded. All the time. All sorts of emotions and feelings that didn't make sense in my life. Memory gaps. And not a single memory of my childhood. "Dr. Siegel, how can I be so empty of memories but so filled

with dread and terror?"

He explained that while I didn't seem to have much explicit memory—the kind that encompasses events you're consciously aware of coming from your past—I was experiencing implicit memories. "When we retrieve an implicit memory, Sally, we don't know it's from our past. It comes in the form of perceptions, emotions, beliefs, and sensations. The awareness of the memory is very much in conscious awareness, but that it is from the past is not."

"Are you saying the things I'm feeling—terror, emptiness, confusion—are my memories from childhood? So they're kind of memories of feelings?"

"I think so, Sally," he said. "And that's what we're here to figure out together."

For 37 years, I'd been living a dissociated life, fragmented and cut off from myself, carrying emotions and sensations I couldn't make sense of. My diagnosis opened a door, and as therapy unfolded over the years, I learned more about why I'd developed DID. It was, at its core, protection from my childhood trauma.

"You couldn't know, Sally," Dr. Siegel said. "It wasn't safe to know."

The people hurting me weren't strangers—they were my parents, who I depended on to care for me. My system couldn't integrate what I was experiencing. It was a biological paradox. When my attachment circuitry for safety and connection to my parents collided with my threat-response system to get away from the source of danger that was my parents, my brain did the one thing it could to protect me. It fragmented. And fragmented was precisely how I felt.

DID isn't split personalities. It's not psychotic or sociopathic. It's not a personality disorder. It's certainly not how Hollywood has portrayed it. It's the brain performing mental gymnastics to survive the impossible. It's fear without solution. Dissociative identity is a protective response.

Fragments and Integration

As therapy with Dr. Siegel unfolded, he listened, followed, and understood, creating a sense of safety for me I'd never known. I was always terrified when a new state wanted to be heard and known, but he met me and the dissociated self-states of my mind with curiosity and care, never with predetermined labels or assumptions about their inherent jobs, roles, or purposes. It was often painful, but nothing I brought into our sessions was deemed too much, too overwhelming, or too dangerous to work with.

"DID isn't split personalities. It's not psychotic or sociopathic. It's not a personality disorder. It's certainly not how Hollywood has portrayed it. It's the brain performing mental gymnastics to survive the impossible."

Eventually, I learned it was safe to seek answers. It could still feel scary, but no longer dangerous: I'd internalized the felt sense of safety the therapeutic process offered. I could close my eyes, look inside, and ask for what I needed. In time, an answer would come from the dissociated self-state that knew what had happened. I'd notice a shift in my state of mind, but I no longer needed to disappear when that happened. Sometimes my eyes would flutter or there'd be a change in my posture. I might grab a pillow to hold or hide under a blanket.

In one session, when we met the blank state, I'd had a difficult weekend at home. I knew something bad had happened, but I wasn't sure what. Early on in therapy, I often didn't remember what happened in previous sessions—not because I hadn't been there, as though a separate "part" or "personality" had taken my place, but because the protective memory barriers of DID kept from my awareness what, as a child, hadn't been safe to know.

While some states would say hi when they appeared, the blank state didn't speak at first, it simply nodded, like it was coming out of hiding.

"Thank you for coming today," Dr. Siegel said. "Do you know who I am?"

"I think so." I recognized the blank state's presence as the state of mind that often had me feeling void of words and information, like I needed to stay hidden. I realized it was there to keep me safe, not harm me. "You're Dr. Siegel. You're helping Sally."

"Yes. Can you tell me your name?"

"The blank state."

In its quiet child's voice, the blank state let us know that over the weekend, when my husband—in the most loving way—had expressed a desire to be sexual with me I, well, as the blank state described it, "She kinda freaked out." With the help of another state that had a broader view of my inner fragmented world, the blank state went on to explain that as a child, I never

knew when something sexual was going to happen. I had many different states that managed things but sometimes the sexual violence came too quickly. When that happened, blank state stepped in—like a placeholder—until another state could take over, or until the violence was over.

Dizzy. Confused. Terrified. All the things I'd been feeling that hadn't made sense were beginning to make sense. But something new was happening. As the blank state spoke, I could hear its small, frightened voice and feel the terror it carried. And I realized it had always been my voice, the one that could never speak. For so long, that voice had been trapped, hidden within walls built for protection and survival.

Now, for the first time, I could listen. I wasn't lost inside it. I was present, remembering what had happened without being hijacked by it, remembering it not as a flashback, but as memory. The implicit was becoming explicit.

My heart broke for the child I once was, and tears came—my tears—for what had happened. As a little girl, I couldn't cry. Tears only made things worse. But now, in the safety of Dr. Siegel's office, I wept for the little girl who never could. I thanked the blank state for all it had done to keep me safe. This was the beginning of integration, of holding what was once unbearable and knowing it was finally safe to know.

With the therapeutic bond I'd developed with Dr. Siegel—which gave me a sense of being seen, safe, soothed, and secure—the traumas of childhood were resolving, allowing the protective memory barriers of DID to dissolve.

Verbs vs. Nouns

Through the lens of IPNB, the field of study Dr. Siegel was developing, integration wasn't about erasing dissociated self-states or collapsing them into a single state. It wasn't about blending or fixing what had been broken. It was about coming to know, honor, and connect all that had long been fragmented to keep me safe and sane within the constraints of a troubled family. But how?

"It might help to think of your self-states as verbs, not nouns," he told me. "A verb is an action or state. A noun is a person or thing."

> "As the blank state spoke, I could hear its small, frightened voice and feel the terror it carried. And I realized it had always been my voice, the one that could never speak. For so long, that voice had been trapped, hidden within walls built for protection and survival."

"So the states are simply ways of thinking, feeling, acting, remembering, and knowing to keep me safe? Ways of knowing things? Ways of processing what was happening to me? Actions, not personalities?"

"I believe so."

"Do I lose the states with integration?" I asked.

"I think what happens, Sally," he responded, "is you'll keep what the states know. As you're able to come to know and resolve the many traumas of childhood, your capacity for integration will grow, and the memory barriers between states will begin to dissolve."

"Because I won't need the barriers? I'll be able to remember?"

"I think so," he said cautiously. "Integration means you'll be able to remember it all—but as your history, not as your present."

He was right. In therapy, I came to know when and why all the dissociated self-states arose in my innermost being, how they figured out ways to help me, and what life was like for them. Eventually, I came to know what life had been like for me. I came to honor each self-state and link them to the experiences they held for me. I moved toward wholeness as each state came to know their work was respected, forever making up an aspect of the fabric of my being, not lost or eliminated—just connected to a larger whole. Ultimately, I began my life of no longer being dissociated. I now know my story.

"It might help to think of integration as a fruit salad, not a smoothie," Dr. Siegel once said to me. I love this metaphor because integration through an IPNB lens isn't about everything being the same—it's about honoring and linking differences.

The World Outside Therapy

As my therapy ended, I decided to go back to school to earn a master's degree in clinical psychology, and I discovered quickly that the specter of Sybil still haunted the field's perception of DID. Many of my teachers still called it MPD and even referred to people with the diagnosis as "multiples." Although most of my instructors were trauma specialists, their language and assumptions felt misguided, out of date, and out of sync with research. I kept waiting for them to teach what I'd learned about the mind, brain, and nervous system as Dr. Siegel's patient—

but they didn't.

In turn, I didn't disclose that I'd been diagnosed with DID or that I'd resolved it. But when I shared I'd had a traumatic and abusive childhood, more than one teacher remarked it didn't seem possible because I was "so grounded," as if surviving severe trauma in childhood meant a life sentence of dysfunction, making full recovery and wholeness forever out of reach.

While my education and clinical training taught me a great deal, the deepest knowledge has come from my therapeutic journey with Dr. Siegel. What I discovered through him—and the lens of IPNB—remains my constant guide in how I work, live, and hold hope for healing. It continues to inspire a lifelong love of learning.

An Invitation

Not long ago, I was watching *The Late Show with Stephen Colbert* and saw a comedy sketch called "MPD/DID Barbie," showcasing Barbie switching "personalities"—from crazy to depressed to suicidal to homicidal to sex addict. The studio audience roared. And I found myself wondering, *Still!? Why do we find this funny?* With everything we now understand about child abuse, trauma, the nervous system, neuroplasticity, and relational healing, why are we still treating dissociation with so little understanding and accuracy?

This disconnect shows up in the data brought to light in a presentation I attended by researcher and clinician Bethany Brand about the myths surrounding DID. She points out that a 2020 analysis of eight major films portraying DID found that 100 percent depicted the individual with DID as violent, and 75 percent included criminal behavior. In reality, people with DID are far more likely to be victims of violence than perpetrators.

Only 8 percent of students in APA-accredited doctoral programs are required to take even one course on trauma. Fewer than 25 percent of doctoral-level clinicians accurately diagnose DID when presented with clear symptoms. And, sadly, most people with DID are in treatment for 6 to 12.5 years before being properly diagnosed.

In sharing my story, I'm offering one perspective on what integration through the lens of IPNB can look like, how I experienced it, and how it shaped my recovery. And yet, even now—decades after my integration—when I share my story with fellow clinicians, I'm often met with disbelief or confusion. Some don't understand what I mean when I say I no longer dissociate. Others quietly question whether full recovery from DID is even possible.

But it is.

I'm living proof.

Many people with DID are living full, high-functioning lives. If they haven't chosen integration, they may be managing their internal states with deep awareness and effective internal collaboration. They're navigating life, parenting, partnering, working, advocating, creating, and thriving.

DID isn't a one-size-fits-all condition, and healing doesn't follow one path. What unites different stories of DID is that they're far more human than anything we see or hear in popular culture or even the clinical world. In listening to the people who've lived through DID, the clinicians who've done the work to understand and respond effectively, and the neuroscientists and researchers seeking answers, we may also deepen our understanding of the human mind itself—its resilience, creativity, and capacity to repair.

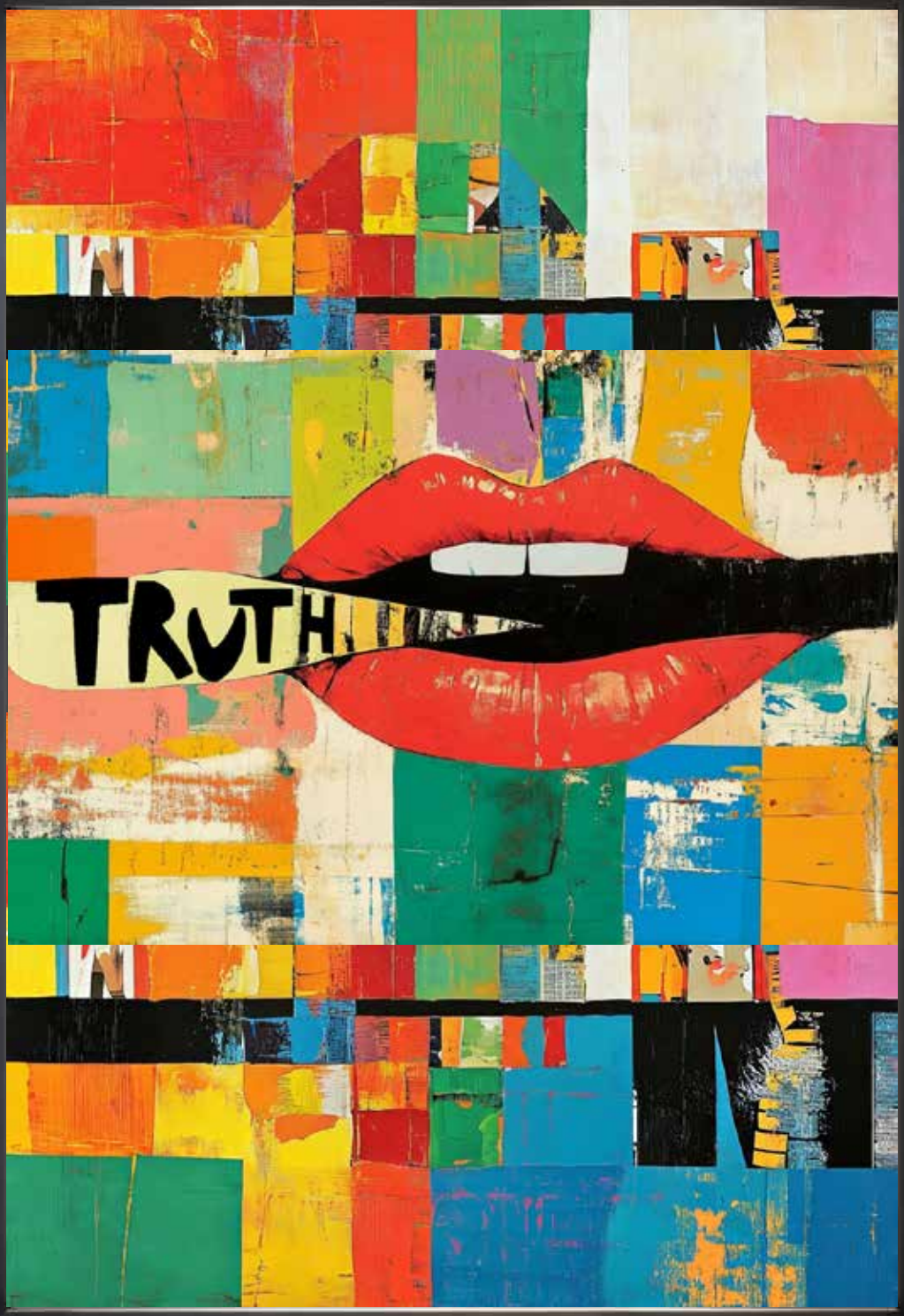
Let's tell the true story of DID not as a punchline, plot twist, stereotype or enigma, but as what it truly is: a brilliant adaptation.

And when supported well, a human triumph.

Sally Maslansky is a psychotherapist and author of A Brilliant Adaptation: How Dissociative Identity Disorder and the Therapeutic Bond Saved Me. *Bridging the personal and the professional, her work is informed by lived experience, IPNB, Attachment Theory, and mindful awareness practices.*

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




TRUTH



BY DESIRAE YSASI

The Courage to Confront

On Culture, Relational Recovery, & Speaking Truth to Power

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

She covers her face and sobs.

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

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

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

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

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

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

dynamic they're complaining about.

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

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

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

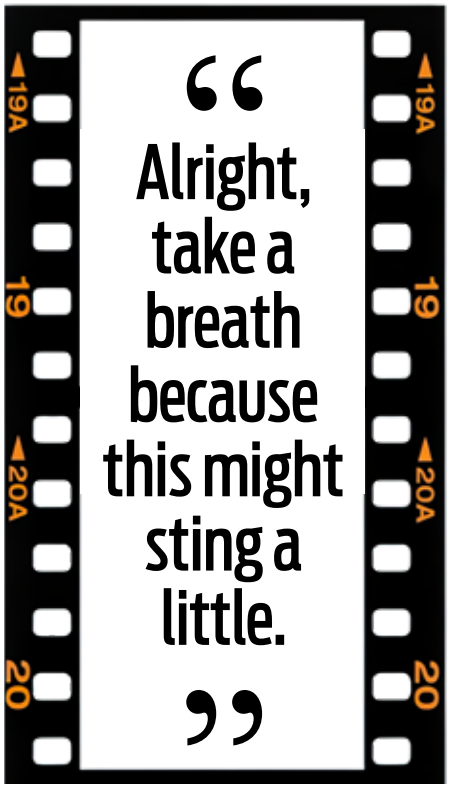
And as if the pressure of that isn't enough, this session is also being live-streamed to hundreds of RLT practitioners and trainees as a real-time demonstration of the model. They know as well as I do that the next powerful move entails confronting this man and waking him up to his bad behavior. I can't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

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

I smile internally. *Damn right I am.*

Little Brown Girl

In the '80s and '90s, long before this counseling session, I lived in a town on the Texas Gulf Coast called Corpus Christi, home of Whataburger (iykyk). Depending on your generation, you might know it as both Farrah Fawcett and Eva Longoria's hometown. For me, it will always be the hometown of Selena, the slain Tejano singer who man-



aged, in her short 23 years of life, to change an entire industry, inspire millions of Latinos around the world, and leave a legacy that extended far beyond her music career.

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

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

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

Years later, during my RLT therapist training, Terry Real told me, "You saw that you could either be the hammer or the nail. You chose to be the hammer." That changed everything for me. I walked into that training wanting to become a better couples therapist, and I walked out with a complete reset on how I'd been approaching intimacy. It was the first day of my own relational recovery.

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

the I without losing the thread of connection to the we.

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

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

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

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

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

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

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

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

Speaking the Truth with Love

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

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

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

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

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

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

■■■■■

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

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

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

Desirae Ysasi, LPC-S, is a relationship therapist based in San Antonio, Texas, and the founder of Relational Life Texas, a group practice specializing in Relational Life Therapy (RLT). A Certified RLT Therapist trained directly by Terry Real, she brings 20 years of experience helping clients create more intimate, connected relationships. Desirae also serves as Director of Training & Certification at the Relational Life Institute, where she trains therapists and coaches worldwide in the RLT model. Desirae is passionate about helping clinicians integrate courage, authenticity, and wholehearted intervention into their work with couples.





Psychotherapy Networker
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Readers' Choice
Sex & Relationships

BY SHADEEN FRANCIS

"Would You Swipe On Me?"

Dating Apps & Therapy in the Age of Digital Intimacy

I spend about as much time talking about dating as someone would expect a therapist to spend talking about depression.

A few years ago, I was struck by my client Michael's description of his dating life, which for him meant experience after experience of forcing painful small talk with near-strangers over expensive beverages. Just as he was opening up about why this felt so harrowing and what he wished for instead—to be pursued, to feel special, to have connections stick, to make it all feel *easier*—he got a notification on his phone. And then a few minutes later, another one. And another one. He continued sharing his thoughts, but his eyes shifted back and forth between mine and the device vibrating on the table. "Do you need to answer that?" I asked, noticing his (our) distraction.

They weren't texts—they were matches. Blushing, he went on to explain that although he'd decided to pause his dating profile a few weeks ago, he'd turned it back on while sitting in my waiting room. "I guess I'm more popular over here!" he chuckled, referring to my suburban pocket of the city.

Michael was tall, athletic, charismatic, and moved through the world as

though he was accustomed to positive attention. I had a hard time imagining anyone he'd approach would say no to a date—and they generally didn't—but that wasn't the issue. His confident exterior was a carefully maintained shield for the significant anxiety, self-doubt, and loneliness he held inside. It had taken the better part of a year for him to reveal these tender emotions in session.

"You know I hate the apps," he lamented, "but what am I supposed to do, go up to someone and just be like, 'Hi, I think you're hot. Can I have your Instagram?' I don't want to look like a creep!"

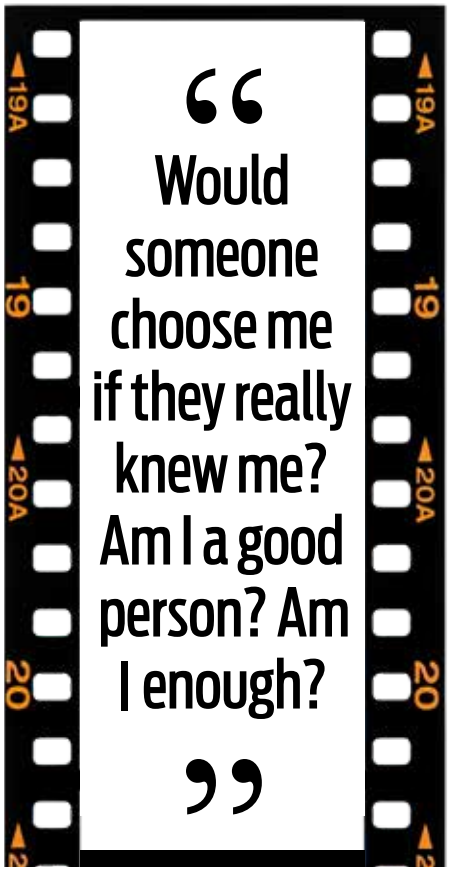
I didn't tell him that this was essentially how I remember the process of dating starting (with maybe the addition of some getting-to-know-each-other preamble and an exchange of phone numbers instead of social handles). As a middle-millennial raised on dial-up internet and AOL chatrooms, I'm not anti-tech. Growing up, technology unlocked seemingly infinite possibilities for my peers and me, including friendship and love. But somewhere between Myspace and Match, it seems that our cultural expectations of connectedness shifted. We text before calling. Or really, we don't call—we FaceTime, or better yet, we send four strategically sequenced emojis to convey the emotional tone of our asynchronous responses.

"Let me turn that off. I don't know what's going on. I barely changed anything," Michael said. But as he reached for his phone, he couldn't help but pause to look at his screen. "Actually, can I show you my profile?" he asked hesitantly. "Is that something that's allowed?"

I'd had clients read me a text argument with a partner or send me the meme our session reminded them of. But as much as there is to learn or understand about clients based on how they share themselves outside the room, my ethos had always been to stay out of clients' digital lives. I don't look my clients up online or follow their social media pages. So when Michael tipped his phone in my direction, I hesitated. Was this invitation a breach of my code of conduct?

"Tell me some more about what you'd like me to see. If we looked at your profile together, what would you want me to be watching for?" I asked.

I believe that anything, including a dating profile, can be art. And being married to an artist, I've learned how deeply vulnerable it can be to offer what you've made up for critique. So



before saying yes to Michael's request, I needed to know what kind of feedback he was open to. This is how I hold the responsibility of compassionate confrontations in the room. We receive with intention, critique with care, and witness with reverence. Our clients' lives are galleries filled with their most expositional art. Unless invited, I don't touch.

He thought for a moment. "Would you swipe on me? Obviously not *you* you, but…" He put on his professional persona, the confident one he used to close deals at his corporate job. "Let's say you're someone who was dating to meet someone you could settle down with. Would you think I was someone worth getting to know? Am I overselling myself?"

I could feel the self-conscious vulnerability driving his pivot from soft conversation to business exchange. He wasn't just asking me to help him understand why real connection felt impossible, he was asking me to validate that he was *worthy of real connection*. Rather than a distraction, it felt like a perfect opportunity to deepen the work we were already doing in therapy. After all, the issue is often not the presented problem—the breakup, the anxiety, the career transition—but the questions underneath: *Would someone choose me if they really knew me? Am I a good person? Do I matter?* A dating profile makes this devastatingly literal: "Am I enough? Swipe left or right."

I've come to understand that when clients show me their dating profiles, workshop their openers, or screenshot their matches, I'm not just seeing photos and bios—I'm seeing their self-concepts in digital form. What they choose to show, what they carefully omit, how they describe themselves when they appeal to what others want: it's revealing. Systems theory reminds us to consider all angles of social interactions, not just what our clients can see and share. A dating profile offers another lens—a way to see and know our clients, and to understand how others might see them as well. It's where self-perception, desired perception, and actual presentation collide.

Michael and I talked a little more about what he wanted to convey in his profile and what he wanted support with. Once we were both clear, I returned to his invitation. "Okay, I'm in character. Yes, let me see it."

The Marketing Trap

Michael handed me his phone with some forced nonchalance. His profile photo was a close-up of him on a hillside at the golden hour, smiling at something off-camera. There was a photo of him rock climbing. Him snorkeling. Him with his arms around some

friends and his older brother at a rooftop bar. A medium shot that looked like it was from a fashion editorial shoot. His bio was short, mentioning his love of spontaneous road trips, crosswords, and good coffee. He was looking for someone with a penchant for adventure who could beat him to the answer to 12 across. Brief, easy-going, funny.

I asked him more about the photos, remembering a few weeks prior when he'd mentioned how much anxiety he'd had around choosing the right ones. They'd been a big barrier to him creating a new profile in the first place. Now, he scrolled through them in his mind. "One is from a wedding last year. And there's one from a climbing trip I did a few years ago. The modeling one my friend took for his photography portfolio. It's cringe, but The Team said it was the closer." The Team was a group of his friends that he ran all his ideas by, like a personal board of directors. All their meetings were held via group chat, of course.

"I can understand that. And it sounds like they were right, you've been getting messages all session! I didn't know you rock climbed."

"I mean, not really. I tried it, though. I got too busy to really pursue it, but that's the kind of person I want to be. And that's what people want to see, right? I want to make the most of my profile." He looked at me expectantly as I passed him back his phone.

I could feel us creeping into tender territory. He'd created a profile of his aspirational self, the version he imagined would be wanted. Nothing was technically untrue, but the emphasis on adventure and spontaneity didn't align with the person I knew: someone drowning in work stress who craved quiet nights at home. He'd get a lot of attention for this profile, but he'd remain locked in his current pattern: every date he went on would feel like a disappointment waiting to happen because people were swiping on someone who didn't exist yet.

I imagine we'd have gotten to this place in our work without this exchange, but in holding his dating life in my hands, literally, a new level of vulnerability emerged between us. It struck me that traditional therapeutic boundaries were designed for a pre-digital world. If I could help him practice more authenticity in his relationships, why not on dating apps?

"Tell me more about this person in the profile," I said. "What do you want me to see in him if I'm looking at it and I'm interested? Who is this guy? What's his life like?"

Michael told me about someone balanced. Cool, but not arrogant. Successful, but not too serious about things. Hard-working, but fun-loving. "We could go to shows on the weekend or go for drinks somewhere with good music after work."

"But Michael," I said gently. "You don't do those things. You don't even really *want* to do those things."

He nodded quickly and answered in his business voice, "Right. I feel like I'm living in that guy's shadow, which is messed up, because it's me." We sat with that for a moment. When he continued his voice was softer, almost too quiet to hear. "But if I don't show that stuff, they'll think there's nothing special about me. Maybe there's nothing worth choosing."

There, in the midst of this doorknob moment, was the wound. Not that he couldn't get matches—his phone hadn't stopped buzzing all session. The actual pain was the belief that if someone met the real him—exhausted, anxious, needing structure to feel safe—they'd discover he was ordinary, and struggling. And he'd decided, somewhere along the way, that this kind of ordinary was unlovable.

As is common in therapy work, this breakthrough came as it was time for our session to end. When we picked up again in the next session, we focused on what he wanted to experience in love, exploring his beliefs around worthiness, who "deserves" meaningful relationship, and why someone would have to "earn" love by being special. After a few weeks, Michael paused his profile again, but this time for different reasons. Previously he'd stepped away from online dating because he felt frustrated and overwhelmed from too many private messages, too few dates, and a few too many disappointments. This time, he paused it because he'd realized that in trying to have a wide appeal, he was losing himself. And as we explored his profile "strategies," he realized he felt confused about who he was hoping to actually meet.

Our work became less about who would swipe right and more about who he was when no one was watching. The Team was a great support in this, each friendship acting as a platonic model for the kind of romantic care he wished for himself. Slowly, dating inspired less anxiety and more adventure.

Michael's struggle illuminated something I'd been seeing increasingly in my practice: dating has transformed from an organic social process into a marketing problem. My clients weren't just looking for connection; they were developing brand strategies. They A/B tested photos with group chats, workshopped bios with AI, analyzed their metrics: swipes, matches, response rates. In this marketplace, they were simultaneously the brand manager, the product, and the salesperson. How can you be authentic when you're also trying to be marketable? This might be the most painful consequence of digitizing dating: taking the universal human fear—*Am I enough?*–and turning it into a marketing challenge with real-time feedback.

For therapists, the line between helping someone present themselves authentically and helping them market themselves more effectively is uncomfortably thin. With Michael, I didn't help him "improve" his profile. Instead, we confronted loneliness, the gap between the relationships we want and the ones we have.

Since intimacy requires us to be seen, when his profile went live again, we swapped in some more "cringe" shots: one that showed him in his thick-lensed glasses, a picture of him unfussed with his dogs in the park. He, of course, made other changes too. He was a funny, cool, regular guy, and now he presented that way online just as in real life. In other words, we shifted from profile optimization to

emotional exploration. This shift is perhaps the most important clinical move we can make with dating app struggles. We're not helping clients beat the dating game. We're helping them see what game they're playing and whether it's one they actually want to win.

Parasocial Activity

Profiles reveal relational patterns with startling clarity. The client who uses only group photos is often the same one who struggles with being seen as an individual. The one with no photos showing their face clearly? Often wrestling with shame or fear of judgment. The client whose bio is a defensive joke about how "weird" online dating is? Usually keeping vulnerability at arm's length by mocking the process itself. I don't follow my clients on their dates (although honestly, it could probably save us all a lot of time!), but working this way often feels like one step short of pulling up a stool next to them at the bar.

On the one hand, dating apps have allowed even my most shy or socially isolated clients to feel like they have more access to romantic community. My Black, Brown, queer, elder, and kinky clients—because they can choose dating apps that cater to their distinct or intersecting identities—can date without being persecuted or fetishized. These are concrete social benefits. At the same time, we're living in an era of parasocial relationships, where folks have tons of superficial connections that feel like meaningful relationships. Whether it's with people we've matched with but never met or influencers whose lives we follow like a reality show, it means we're often in relationships that lack reciprocity.

Jasmine came to session in despair after a first date that felt "so off." For three weeks, she and her match had exchanged nonstop messages. Long, thoughtful texts about their childhoods, their fears, their dreams. They sent each other songs. They had inside jokes. "I felt like I really knew her," she told me. "Like we'd already skipped past all the small talk and gotten to the real stuff."

When they finally met for a walk in the park, something was fundamentally wrong. Her date looked exactly like she did in photos. She was kind and thoughtful like she was in their conversations. But the intimacy Jasmine had experienced with her through text simply wasn't there in person, and the ease they'd felt in their on-screen interactions didn't translate to physical space. Jasmine found herself struggling to make eye contact, suddenly self-conscious in a way she hadn't felt before. "Why did it feel like we were just meeting?" she sobbed.

In many ways, they *were* just meeting. Digital intimacy had created the feeling of connection without the actual work of being in someone's presence—navigating the silences, reading each other's body language, adjusting to each other's energy in real time. They were strangers, polite strangers who happened to know a lot of facts about each other, but strangers nevertheless.

When her date quietly unmatched her a few days later, she wasn't surprised. They still interacted with each other's social media posts from time to time, but when that happened Jasmine would edit, unsend, and occasionally have AI ghost-write her "casual" replies. It took up too much of her time, and even more of her mental energy. When I asked about these fraught points of contact when they weren't really in each other's lives, especially considering she was still grieving the relationship she'd hoped to build, Jasmine shrugged. "We're still friends, I guess."

Developing Our Digital Language

Sometimes our clinical work is helping clients explore their personal relationships to digital intimacy, parsing out the difference between emotional closeness and embodied presence, feeling and physicality. In some ways, this isn't new territory—anyone who's supported clients in long-distance relationships knows the challenges of building intimacy when most of your connection happens through screens. But with the rise of digital-first connections, it's now increasingly likely that folks will build relationships with people they've never *met*, which is a cultural first. We've normalized these patterns, but I wonder what developmental psychologists like Mary Ainsworth would make of all the new ways we've found to create emotional crises and attachment wounds—ghosting, catfishing, breadcrumbing, orbiting—and the fact that so many folks would prefer to ask their intimate questions to anthropomorphic chatbots than to their closest friends.

I'm writing this from my fully virtual practice, having now moved all my clinical work online. The irony of musing about technology and intimacy while conducting therapy through screens isn't lost on me. But if we live in a technocracy where our clients' social environments are downloaded apps rather than community spaces, how do we respond? This is territory we're all learning together, and our traditional frameworks weren't built for a world where intimacy is mediated by algorithms and relationships begin with swipes.

When clients ask to show you their profiles, I encourage you to pay attention to what they're actually asking for. The question I ask myself before looking at any profile is: Am I being invited to improve and optimize or to witness and explore? The former keeps clients stuck in the performance. The latter opens space for us to dive a little deeper.

When clients show signs that apps aren't serving them well—such as with compulsive checking, self-esteem tied entirely to match rates, avoidance and shame—fight the urge to prescribe a break as the first course of action. Especially for younger daters, the internet is their social world. More often than not, the tool itself isn't the problem, but their relationship to the tool is worth exploring as a way of understanding their deeper needs.

I've begun to think of online dating as its own culture, where we per-

form approvable versions of ourselves, receive measurable social feedback, and filter through the mess of actually being known. Online dating can break through the separation that's become endemic in modern life, but it can also become another barrier to the authentic connections we need to feel truly alive. Therapists not only need to stay literate, but to develop a certain kind of cultural competence in order to walk alongside clients as they build relationships that can survive being translated from digital spaces into physical form. What becomes available when we help them notice the gap between who they're presenting and who they are? What honesty can still exist in the space between their public and private selves? The experience of intimacy happens in the context of relationships, and an organic relationship has reciprocal stakes. We get to know others and are known by others. We hurt and are hurt. We pursue and retreat. We fail, reflect, and retry. We feel things together.

Dating apps aren't inherently good or bad; they're tools that reflect and amplify existing social patterns. The question isn't whether clients should use them, but how to help clients use them in ways that serve their actual desires for connection. When we introduce inorganic intermediaries into the dance of human connection, what happens to our ability to exchange feelings? What parts of us expand and develop—or shrink and atrophy—when our social world becomes social media? I don't have the answers, but I do know therapists are well suited to the challenge of remaining curious in territory where none of us has a map. And perhaps that's exactly what our clients need from us

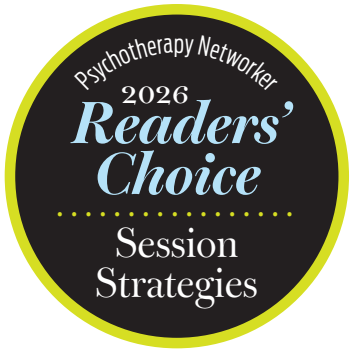
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Things I Was Taught Not to Do in Therapy—That I Do!



5 Therapists' Stories About Going Against the Grain

BY BENJAMIN YALOM, OONA METZ, KATHRYN HALL, TERRI COLE & CHINWÉ WILLIAMS

Have you ever felt like the "rules" of therapy you learned in graduate school didn't quite fit the moment in front of you? That bending them made the work feel deeper—or even more alive? Sometimes, even small departures from the script can lead to clinical breakthroughs. Sure, rules provide structure and guidance, we also know that many times, when we trust our instincts instead of sticking rigidly to the manual, profound moments of honesty, connection, and healing follow.

With this in mind, we reached out to five fearless therapists to hear their stories of therapeutic rebellion—and how, sometimes, bending the rules can make all the difference.

Leaning into My Mistakes

BY BENJAMIN YALOM

I often admit my mistakes in therapy—which is really to say that I often make mistakes in therapy, and then draw attention to them.

The first part of this is common: we therapists are constantly choosing what parts of our clients' stories to explore and what questions to ask. And often, we make a bad choice and follow a fruitless path or—even worse—reveal an unkind thought or judgment. These things happen all the time.

But why draw attention to these missteps? After all, people come to see therapists when they're feeling unsettled and looking for guidance, stability, and expertise. Doesn't telling them we've messed up undermine that expertise? Wouldn't it be better to sweep it under the rug, maintain our façade of unflappable competence, and move on?

My experience is that expertise isn't the most crucial aspect of the therapy encounter. The loss of whatever stature or confidence the client previously assigned to me is more than made up for by the closeness that develops from freely admitting my fallibility. Suddenly, I become a fellow human to my client, someone who also screws up sometimes, which normalizes their shortcomings. I'm also willing to share my own, which models vulnerability and opening up.

This reminds me of an early session I had with one client, Patrick, a successful 39-year-old attorney who'd been suffering bouts of anxiety. He wasn't sure therapy could help, but had come in at his wife's suggestion. Over the last couple weeks, we'd been engaged in a battle of wits over the cause of his anxiety, which I'd suspected was related to his recent promotion to junior partner at his firm, something he'd long desired.

"This is good news," he argued. "Why the heck would it make me anxious?" I couldn't help but see a connection, but Patrick was having none of my interpretation. Something in his demeanor had triggered an unwelcome, competitive impulse inside me, and I'd continued to fall into the trap of trying to convince him to have an insight. Finally, I realized that I wasn't being therapeutically helpful.

A few weeks later, Patrick came in for our session and sat down on the couch with a defiant smirk that seemed to say, "Well?" He looked ready to pounce.

"Patrick," I began, "I'm a little nervous to bring this up, but I think over the last couple of weeks I've taken us in the wrong direction. I want to apologize for that."

He chuckled, clearly a bit taken aback.

"I was ready to tell you we weren't getting anywhere," he replied, "that this felt like a waste of time. But I guess you knew that!"

"Maybe," I agreed. "Would you be willing to give me another chance, and we can explore a different path?" Patrick looked genuinely surprised, then nodded, challenging me to do better.

Did this interaction change everything in our relationship, or open the floodgates of closeness, or cause Patrick to have a sudden epiphany? No, it did not. But between us, something softened. Perhaps it was because he knew that if I could give in like this, he no longer felt like therapy was some sort of competition. But I believe that something else had happened: Patrick developed a small sliver of respect for me, and realized that I cared enough about him and our relationship to admit fault. This allowed us to head in a new, better direction, with less posturing on both of our parts, and more sharing. It led to work that, eventually, Patrick found quite helpful.

Realizing I've made a poor choice—as I did with Patrick—or missed an opportunity to pursue a particular direction in therapy is always a little distressing. But by being transparent about this, I can often turn these missteps into useful moments, showing that mistakes are normal and my primary concern will always be my clients and our relationships.

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Accepting Imperfection

BY OONA METZ

When I graduated with my MSW in 1993, I believed therapy could cure everything and everyone. Supervisors and mentors assured me that with the right mix of warmth, exploration, and insight, all of my clients would get better. Those who didn't were simply resistant, and it was up to me to break through that resistance. When I became certified in group therapy, my mentor told me that everyone on my caseload should also be in a group. Therapy was meant to heal everyone, no matter the circumstance.

Over the last 30 years, I've unlearned that lesson many times. The first time was the hardest. In my early days as a therapist, my 28-year-old cousin died by suicide. He'd been diagnosed with bipolar disorder and struggled with addiction—both risk factors for suicide. But he also had a loving family, a therapist, and a psychiatrist. *He had an entire therapeutic team.* I didn't understand how he'd slipped through the cracks.

His death devastated me, and his loss challenged my entire professional belief system—just as I was getting started. If my cousin, with a team of professionals helping him, could die, what was the use? Who was I to think I could help someone who was suffering? What if one of my clients died, too? I thought about changing careers. Maybe it wasn't too late to become a midwife.

But I didn't change careers. Instead, I worked with children in the Boston public schools. Most of the time, therapy worked. I made connections easily, student behavior improved, and teachers were pleased with the outcomes. When I walked into the cafeteria to pick up a student for their appointment, a swarm of kids raised their hands high in the air, pleading, "Pick me, Miss Oona, pick me!" Therapy didn't work all the time, but for the most part, those kids got better.

After a decade in community mental health, I transitioned to private practice, specializing in treating women navigating divorce. When I first led divorce support groups, I reveled in their success. Women who were sad, angry, and fearful became happier, stronger, and more empowered in just a year or two. Therapy was working! Women who attended the group were practically guaranteed to feel better post-divorce.

In my second year of leading groups, I was surprised when one of the group members didn't get better. She was sad when she arrived, even sadder throughout her divorce, and eventually left the group feeling just as depressed as when she'd entered. I wondered if she needed a different therapeutic modality, or more time to heal. I finally had to accept that she might not ever feel significantly better. Sometimes therapy can't compete with a stubborn diagnosis, a traumatic past, or ongoing stressors.

Accepting this truth continues to be humbling. Early in my career, when therapy didn't help, I felt like I'd failed. With time, I've learned that some people need a different kind of therapeutic intervention. Sometimes a new job, a new love, a new medication, or more sunlight is far more therapeutic than a 50-minute hour. Therapy is one path, but it's not the only path. And for the most part, it works.

Oona Metz, LICSW, CGP, is a psychotherapist and speaker. She writes about divorce, group therapy, and parenting. She's the author of Unhitched: The Essential Divorce Guide for Women. *Contact: oonametz.com.*

Taking the Scenic Route

BY KATHRYN HALL

In graduate school, I learned that therapy was supposed to be deep, that therapists should probe beyond symptoms. I believe this to be true. I was instructed that therapists shouldn't spend precious therapy time or energy on *superficial* topics. Sure, pleasantries were fine, but then get down to business. Start with the symptom and drill down. My problem is that I'm directionally challenged. Drill down? That requires a directional ability I just don't have. I don't know north from south or east from west. These challenges followed me into the therapy room. My therapy GPS kept taking me on the scenic route when I was supposed to be exploring the depths of my clients' psyches. My curiosity about seemingly irrelevant subjects looked directionless, and I was asked by my supervisors whether this was due to my anxiety about the deeper work of therapy. I worried about that for a while.

And yet, despite my best attempts to focus, my curiosity kept getting the best

of me. I'd invariably go sideways and ask my patients about superficial subjects: "You spent the night reading because you couldn't sleep. What was the book? Was it good?" I couldn't seem to stop myself. This went on for years.

Finally, I embraced my sideways approach to therapy when I started working with Luis. Luis was dejectedly describing his recent "dating fiasco." He'd planned a romantic evening with his girlfriend, and prepared a lovely dinner. But after dinner, when they were having drinks and kissing, Luis found that he wasn't getting aroused. Embarrassed, he withdrew, which led to an argument and a breakup. I knew I should focus on Luis's sadness and embarrassment, but I was curious about what he'd prepared for dinner. The voices of past supervisors screamed in my head: *Go deeper, drill down!* But I went sideways, and asked about the dinner. Luis went on to describe an elaborate meal—and all was going well, except for the scalloped potatoes that sat uneaten on his girlfriend's plate. As I commiserated with Luis about how much time they take to prepare, he told me how the uneaten potatoes were occupying his mind as he'd sat kissing his girlfriend. This led to us talking about how he relied on his observation of small details to alert him to trouble ahead. From there, Luis finally disclosed that he'd been abused as a child.

Over the years, I've learned to treat my meanderings not as distractions, but as pathways to my clients' inner worlds. At the very least, my curiosity shows my patients that I'm interested in them. *Really* interested.

Kathryn Hall, PhD, is a licensed psychologist with a private practice specializing in the treatment of sexual and relationship problems. Her book, Reclaiming Your Sexual Self, *was honored as the best self-help sexuality book by the Society for Sex Therapy and Research. Contact: drkathrynhall.com.*

Rethinking "Ethical Therapy"

BY TERRI COLE

I've been a practicing clinician for almost 30 years, during which I've watched our field evolve in important ways, and I've learned that some of the most meaningful clinical decisions happen in the gray areas that training can't fully prepare us for.

Early in my career, many of my clients were Broadway performers. I'd worked as a talent agent before becoming a therapist, so I understood the world of theatre, and my clients knew it. These performers often came to therapy carrying a mix of heightened sensitivity, relentless self-scrutiny, and early attachment injuries that had been amplified by the demands of their job.

Occasionally, when it felt clinically appropriate and if I was invited, I'd attend a client's performance. If a client was an understudy finally taking on the lead in a Broadway show and extended the invitation, I trusted my clinical judgment. I didn't bring flowers or linger backstage, but I watched, witnessed, and showed up—and the work remained in the therapy room.

One experience that stuck with me involved a 20-something client who was pursuing stand-up comedy. He'd finally landed his first five-minute set at Caroline's Comedy Club. For most people, five minutes would barely register, but for him, this was everything. His parents had been emotionally neglectful and openly rejected him because he was gay. He'd been sent to boarding school, and when everyone else went home for Christmas, he stayed behind. He wasn't welcome at home. Nobody had ever shown up for him.

So, on a Wednesday night, from 10:00 to 10:05, I went to Caroline's. I sat in the dark. I listened and laughed. I clapped. And then I left.

This choice was client-centered and therapeutically intentional. I wasn't trying to become this client's friend or his parent. I was offering something his nervous system had rarely received: appropriate, attuned witnessing. I never regretted this decision.

What I've learned, slowly and through experience, is that ethical therapy isn't about rigid rules as much as it's about ongoing discernment. It requires us to keep asking, *Who is this for? Does this serve the client's healing?* These questions continue to guide my clinical choices.

This same mindset informs how I think about self-disclosure. Early in my career, an NYU professor said something that stayed with me: disclosure is neither inherently helpful nor harmful; its value depends on timing, intention, and the needs of the client. Over time, I've found that carefully considered self-disclosure can sometimes help a client feel less isolated or less defective in their experience. Used thoughtfully, it can support regulation and deepen trust.

Nearly three decades into this work, I don't assume any single approach is right for every clinician or every client. What I do believe is that psychotherapy is a relational discipline that asks us to hold complexity, tolerate uncertainty, and remain accountable to both ethics and humanity. My training gave me a foundation, but my lived experiences taught me how to practice.

Terri Cole, MSW, LCSW, is a licensed psychotherapist and global relationship and empowerment expert, as well as the author of Boundary Boss *and* Too Much. *She inspires over a million people weekly through her blog, social media platform, signature courses, and her popular podcast,* The Terri Cole Show. *Contact: tericole.com.*

Embracing Laughter

BY CHINWÉ WILLIAMS

I have a soft voice—and a big laugh. A *really* big laugh. The kind of laugh that has startled strangers and made baristas turn around. Years ago, I shared an office space with a therapist I admired deeply. She was smart, seasoned, and a friend. Our offices were adjacent, and most mornings we'd sip coffee and ease into the day with gentle conversation.

One afternoon, after a session where my newly widowed client and I had shared a couple of hearty laughs, my colleague stepped into my office. She smiled, but her eyes were serious. "Just so you know," she said, "we heard you laughing. My clients in despair don't necessarily want to hear others' joy."

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BY RUTH LANIUS & BETHANY BRAND

The Gateway to Successful Trauma Treatment

Psychotherapy Networker 2026 Readers' Choice Trauma

Practical Steps for Creating Gravitational Security

These days, you'd be hard-pressed to find a clinician who doesn't do some form of trauma work. Yet even as our field's understanding of the impact of trauma on the brain and nervous system has deepened, and more therapists are becoming trauma-informed, dropout rates for PTSD treatments average 20-25 percent, with rates climbing even higher for clients with complex trauma. What are we missing that makes trauma recovery so difficult, unreliable, and grindingly slow?

For over a decade, two of the field's leading experts in trauma and dissociation, Ruth Lanius and Bethany Brand, have asked this question. But they haven't stopped there—they've conducted the largest international treatment outcome study of dissociative disorders, dug deep into neuroimaging studies on the brain's response to trauma, and sifted through input from trauma clients and the clinicians who work with them. In the process, they've landed on an answer that's revolutionizing how we treat trauma and

dissociation—one that's also sure to change the way on-the-ground clinicians like you work with trauma clients in private practice.

A professor of psychiatry at University of Western Ontario, Lanius is known for her research with trauma survivors that contributed to establishing the dissociative subtype of PTSD in the *DSM-5*. Brand is a clinical psychologist and professor emeritus at Towson University who literally wrote the book on dissociation, *The Concise Guide to the Assessment and Treatment of Trauma-Related Dissociation.*

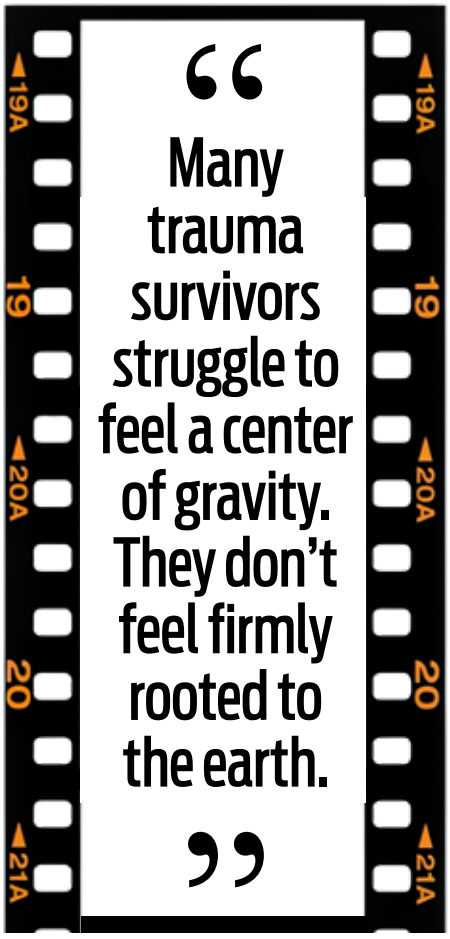
Along with psychologist and researcher Hygge Schielke, Lanius and Brand have codeveloped a trauma-treatment program called Finding Solid Ground (FSG) that emphasizes grounding. They also coauthored the book *Finding Solid Ground: Overcoming Obstacles in Trauma Treatment for Therapists* and *The Finding Solid Ground Program Workbook* for clients. Now before you shrug or say you know all about grounding clients, this kind of grounding isn't so much about encouraging clients to feel their feet on the floor or name five things they see. Rather, it targets the balance/vestibular system, the gateway to all experience, which—as Lanius has discovered through her research—chronic dissociation disrupts.

In this interview, you'll learn about the importance of developing "gravitational security," a fundamental, human need to feel connected to and supported by the earth that undergirds our capacity to be present and learn. You'll hear why sequencing, or the order in which we do interventions, is the linchpin in successful trauma work. And you'll also discover surprising signs that seemingly talkative clients may be dissociating right in front of you.

■■■■■

Psychotherapy Networker: Let's start with a basic question—why do people dissociate?

Ruth Lanius: I had a client—we'll call her Susie—whose story illustrates why dissociation can be very adaptive at the time of the trauma but comes at a high cost later. This client had a horrific early attachment history. She never felt safe with her mother and was sexually abused by her father. In high school, she was repeatedly gang raped. When she described to me how she detached from her own body to survive the rapes—she was up in a tree so the body that was being abused was no longer hers—I thought, *This is so powerful, the way she could survive by detaching.* She and her body were separate. But afterward, she spent many years in hospitals in a chronic state of detachment, unable to feel positive or negative emotions, which prevented her from being fully alive.



This pattern of dissociative detachment is part of what led me to question our treatment approaches. Earlier in my career, we treated the highest users of the mental healthcare system in DBT groups adapted for complex trauma. I'd seen how, in the first six months of treatment, people didn't take in any information. They were all highly dissociative. They learned nothing. They simply went through the motions.

So when I started developing the FSG program with Bethany and Hygge, it became clear to me that we must ground clients first—to help them come back to themselves, be present, and feel connected to earth before we attempt to teach them any skills. We weren't doing enough of that in those DBT groups. Hindsight's always 20/20, but I do ask myself, *If we'd grounded those patients first, would they have learned more in those first six months?* My hypothesis is yes.

But helping my client Susie ground was difficult. She resisted because she was so used to being detached and that's what kept her safe. Now I was telling her, "We need to ground. We need to help you attach to yourself." That was terrifying for her. The process takes time and negotiation. But once an individual gets there, it changes their life. It did for Susie.

PN: So, if you've got a highly dissociated client, all the skills in the world aren't going to make much difference until they're able to reattach to their bodies?

Bethany Brand: That's right. Dr. Nicholás Rodríguez, a very experienced, well-known Chilean EMDR specialist, consultant, and trainer, who participated in our study, shared how the FSG program accelerated his treatment with a particular patient after years of work. He reported a clear "before" and "after"—grounding allowed the patient to learn recovery-focused skills much more deeply. At one point, when the patient had a suicidal crisis and went to throw herself in front of a train, she remembered a phrase she'd learned in the program: "Step by step, you'll get

there." She returned home, practiced grounding, and then used the safety plan she'd developed over the course of the program. That's why she survived. Now, she and Dr. Rodríguez talk publicly about the huge difference the FSG program made in their work.

The thing is, we all *think* we know about grounding. Clients say, "Yeah, yeah. I know how to get grounded. I was taught that." Or they might say, "It doesn't work. I don't want to do it." Regardless, when therapists feel like they aren't making progress with a client, like they keep repeating the same session, and getting pulled from crisis to crisis, it means they're not getting to the root of the problem.

When this happens, we've got to check what we're doing and ask ourselves, *Why isn't this working?* Our research shows that it's because the client's brain isn't fully online. They're not actually grounded. Our results are extremely compelling in terms of how focusing on grounding as a first step turns people's treatment around.

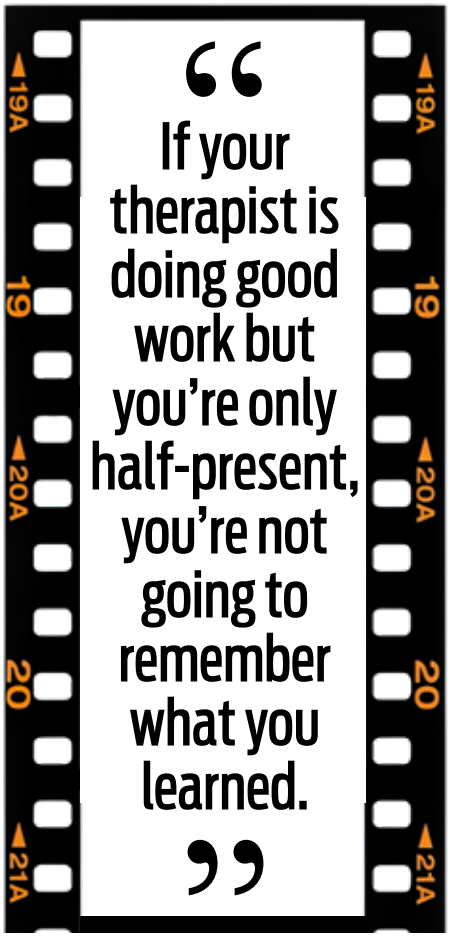
PN: Is feeling like you're having the same session over and over a warning sign that a trauma client may be dissociating?

Lanius: Absolutely. And we have evidence that dissociation impedes emotional learning.

Brand: If your therapist is doing good work but you're only half-present, you're not going to remember what you learned from your sessions or be able to use it in daily life. In a very real sense, you weren't fully there in the session to begin with.

PN: Many therapists think dissociation means a client taking on a different identity, but clearly it's more subtle and nuanced than that. What are some other clues that a client is dissociating?

Lanius: One telltale sign is when the therapist themselves feels like they're losing solid ground. Maybe you start to feel floaty, spacey, like you're not quite present. Or you might start thinking to yourself, *Wait, what were we just talking about?* Also, you may begin to realize there's no storyline in what your client is sharing. You're trying to follow what they're saying, but the story has no beginning, middle, or end. It's disorganized, fragmented. In my sessions, when this happens, I often find myself wondering, *What's wrong with me? Why can't I follow this?* Then I realize, *Oh, this is a very fragmented, dissociated story. That's what's going on here.*



Brand: Sometimes, when the client stares off into space, blinks or squints rapidly , or starts pronounced upward eyerolling, it's an indication that they're moving out of contact with the therapy session.

Lanius: You can also see extreme cognitive slowing in clients who are dissociating. When people are in an emotionally shutdown state, it can look like they're over-medicated even though they're not.

Brand: Some patients will start physically folding in on themselves in an attempt to get smaller and hide. They pull their legs up underneath them. This may be an indication that they feel like they're under threat. During a childhood trauma, when the threat is real, dissociation is obviously a brilliant way to hide. It's not helpful in a therapy session, though. But unresolved trauma is ever-present, and a patient can feel like they're in danger in therapy with you, even if they can't articulate it.

PN: Not many dissociative trauma survivors walk into a first therapy session and say, "I'm here because I'm dissociating too much." What are some problems they will come in complaining about?

Brand: Typically, patients come in struggling with depression. They feel exhausted and have a hard time getting going. People who have a lot of trauma-related dissociation often have PTSD symptoms, or full-blown PTSD. They say, "I can't perform well at work. I can't stay focused. I can barely get out of bed some days." The problem is—and we've got data from various labs showing this—if you only treat these people for depression or PTSD, the dissociative disorder doesn't go away.

Patients also complain about being haunted by the past, not being able to focus, struggling in social relationships, trouble with intimacy, problems with mistrust, and feeling jumpy. Many of these patients are dealing with complex trauma. They get flooded in a way that makes them want to hurt themselves. The only way many know to manage is to drink to stop feeling, to cut themselves to stop thinking about what was done to them.

Lanius: Our research and clinical experience suggest the first thing these

clients need to find is something called *gravitational security.* This is a term for our sense of balance and orientation, meaning our relationship to the earth. Many trauma survivors struggle to feel a center of gravity. They don't feel firmly rooted to the earth. And when this is the case, you actually can't do anything properly. You can't engage securely in a relationship. You can't defend yourself. You can't be present.

For a while now, occupational therapists have known and written about gravitational security being the foundation of everything. It's an important sensory system that's offline in dissociation. This is what clients with complex trauma need to work toward—not jumping into connection with their body, which can feel much too scary. First, they need to develop the capacity to actually feel themselves being held by the earth. This isn't the usual "name the five things you can see, the four things you can touch" type of grounding many therapists are used to doing. Gravitational security is a special kind of grounding.

Brand: Clients often have no idea this is an issue for them. They won't come in saying, "My balance system is off." But they may get bumps and bruises frequently and have a lot of falls. I have clients who've had unusual numbers of fender benders. One client knocked off the mirror of their car repeatedly. Often, they're not tuned in to what's going on around them. They bump into things. They don't know where they are in space. You can tie this back to how they survived trauma by not being attached to their body—like Susie. She was up above in a tree watching that body below get hurt, and it wasn't her. Over time, detachment from your body messes with your balance system and your brainstem. This is something Ruth's research shows very clearly.

PN: How did your research and clinical experience lead you to this understanding of the need for trauma clients to develop gravitational security?

Lanius: I started noticing that virtually all my patients were telling me they felt clumsy, and I also watched them be clumsy. They had difficulty maintaining their balance, especially when stressed. So, I said to one of my grad students, "We've got to look at the balance system." And in our MRI research, we did. We found that the balance system is the gateway to internal and external experience. It's the gateway to interoception—what you feel inside—but it's also the gateway to where you are outside, in space. And the information you take in through the balance system travels to the highest level of the brain where it all gets integrated and informs how embodied you are, how much you can regulate your emotions, how much you can connect with others, how curious you are, how much purposeful movement you can engage in, and how much of a sense of the now you have. It's basically the basis of everything. And in highly dissociative individuals, it's disrupted.

If you've ever had vertigo, you know it's a terrible thing. The room spins. If you have it all the time, you never feel safe because you never feel held by the earth. This is what chronic dissociation does to your sense of balance. To feel safe, you need to have a sense of the earth's gravitational pull keeping you upright, holding your feet to the ground, keeping you oriented.

PN: Not too many people think about the balance system being compromised in PTSD.

Brand: No, they don't. I certainly didn't! Everybody talks about the limbic system and the amygdala, but Ruth and her team are showing that the disconnect is deeper. It's happening in the brainstem. It's the very basis of why all the other psychological functions are compromised.

Lanius: In our program, we help people develop an awareness of gravitational security, starting with grounding. Even though the sequence is laid out in different steps in our workbook, we advise therapists to individualize the pace for each client. We tell them, "Some clients can go through the 30 topics in our program quickly, and some need months to go through grounding because they're terrified to be present."

Brand: In other research we did, highly dissociative people around the world revealed that their number one trigger for self-harm was being flooded by intrusive thoughts, feelings, or memories related to trauma. In other words, being flooded with horrible mental pictures, feeling themselves being hurt again, having a body memory could lead them to engage in drinking, cutting, doing whatever they could to stop the overwhelm. That told us we needed to have a whole second module of the program about helping people help their own brains get into the present and separate out trauma. The focus had to be on containing trauma, not opening it up.

Lanius: Now we're working on ways to get clients' brains used to safe sensory input. This is in line with our most recent book, *Sensory Pathways to Healing from Trauma*. Most traumatized brains have never really experienced safe sensory input. So how can we use input to the balance system, like swinging on a yoga swing or rocking on a gym ball? How can we get the individual to use the balance system in combination with the proprioceptive system, which helps us to know where we are in space? Weighted blankets, for example, can activate the proprioceptive system, which works hand in hand with the balance system to help us orient ourselves spatially.

PN: Most therapists tend to think, *Okay, if a client is dissociated, the first thing I need to do is help them get back*

into their body. You're saying this is not the way to go.

Lanius: Right. Initially, that approach is too scary. Asking them to do that is too much.

Brand: There are several steps you need to take before you can get trauma clients back in their bodies. Which brings us to a really important point, something that's kind of blowing our minds in our randomized controlled trial. We recruited trauma-informed therapists from around the world to participate in the FSG program. Then, we compared how patients did for six months. These are complicated patients. They feel suicidal, engage in self-harm, have medical problems, relationship problems. It's easy to get lost in all their daily stressors, and it's hard to stay focused in sessions.

One group of therapists waited six months before they got access to the program. We have a measure of adaptive functioning skills, and what we discovered was that individual therapy with a private therapist for those who were waiting did not significantly change PTSD or dissociation or help clients learn adaptive skills or improve emotion-regulation skills. It didn't improve outcomes. These experienced, trauma-informed therapists spent six months doing their treatment as usual without seeing improvements. It was only *after* they'd been following the FSG program for six months that things changed significantly. Then, after another six months, things changed again. The results were amazing to see.

PN: Seeing as the number-one factor determining whether you'll develop PTSD is your sense of perceived social support, do people with better social networks fare better?

Lanius: Our motto is "Work together, learn together, heal together," and the treatment itself creates a community. Program participants enter a community of hundreds of people around the world.

Brand: We do a lot of psychoeducation to help people understand they're not alone and they're not weak, evil, or bad. This is just what trauma does to everybody's self-concept. A group at Harvard's McLean psychiatric hospital is studying FSG groups. At Purdue University, there's a research team that did FSG in groups and discovered how important it was for people to learn these skills together. Participants learned a lot from each other about how to adapt the skills to their own lives. They'd share things like, "Well, I figured out I couldn't do grounding this way, but I found out I could do it like *this*."

Our randomized controlled trial had therapists and patients doing the FSG program in individual treatment. But the Purdue group did the FSG program in 31-week groups. Seven out of eight of the groups were virtual. The participants met and talked about a new topic each week from the FSG workbook and started doing some of the journaling right there in the group. They'd practice grounding together each time they met, and then they'd come back the following week and talk about how the previous week's practice sessions had gone in their daily lives. If anybody was having trouble figuring out how to do grounding on their own, the group would help them problem-solve before moving on to the next topic. These groups became very cohesive, and outcomes improved. Groups destigmatize and reduce shame, and the community was there. In 31 weeks, they got remarkable results.

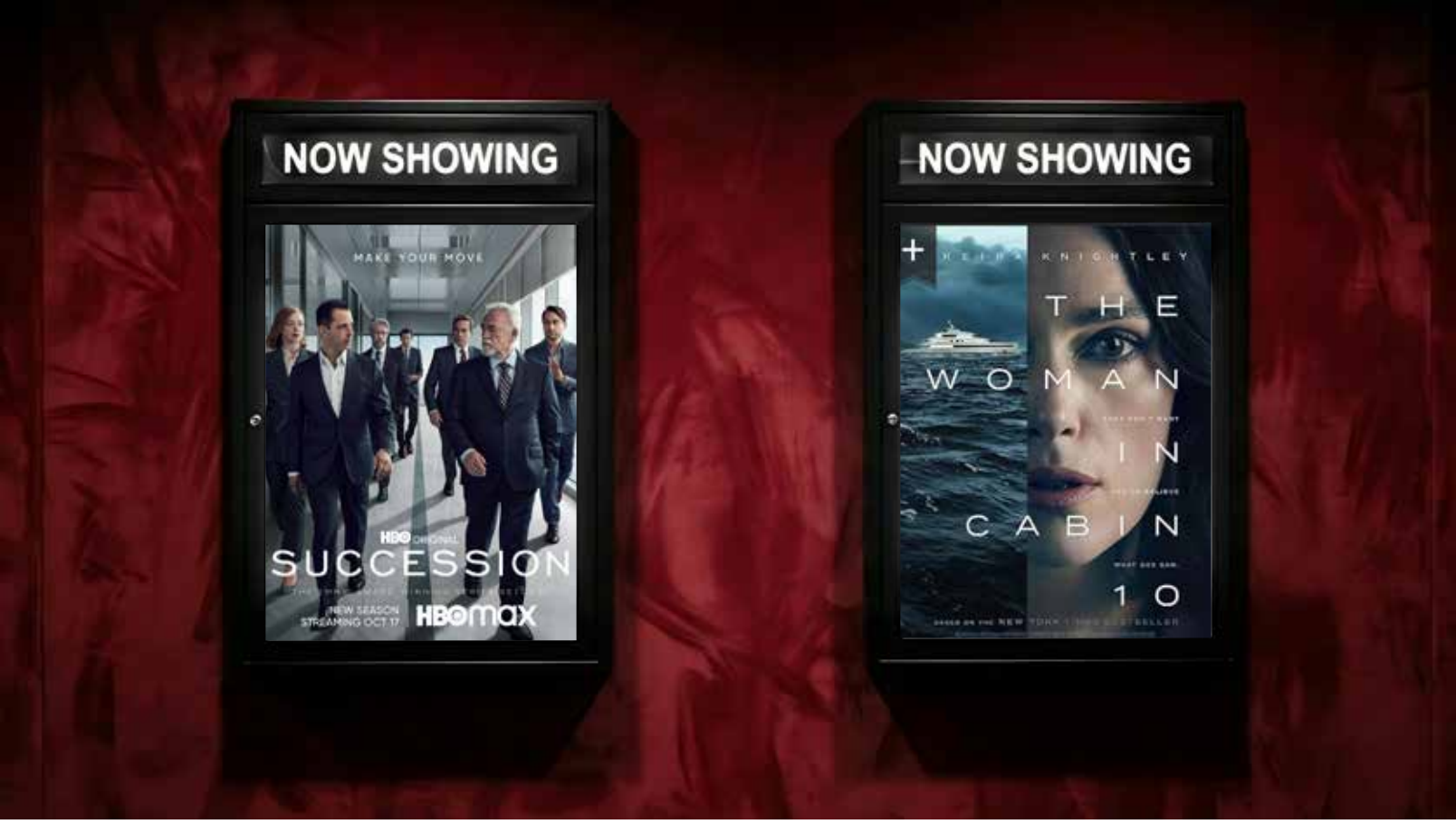
Lanius: In the future, we hope to look at a combination of group and individual treatment—sort of like the DBT model, but FSG.

PN: What do you think might get in the way of therapists being open to the FSG program?

Brand: Therapists around the world think they already know how to do all this stuff. We get it—we thought we knew all about grounding, too. We encourage people to be open-minded and take another look at it, as well as at other stabilization skills. We know individual therapy alone doesn't have a big effect for highly dissociative patients. For years, the field has been trying to develop a whole cadre of therapists around the world who can treat complex trauma and dissociation, and it's not going so well. Research shows that even a lot of group therapy with dissociative folks doesn't have a meaningful effect. So we're incredibly fortunate to have the FSG program so we can approach trauma treatment in the right sequence, and at the right depth.

Ruth Lanius, MD, PhD, is a clinician-scientist, researcher, professor of psychiatry at the University of Western Ontario, and a leading specialist on the mind-body effects of trauma and post-traumatic stress disorder (PTSD). She's published over 250 research articles and book chapters on brain adaptations to trauma and novel adjunct treatments to PTSD and coauthored five books, most recently Sensory Pathways to Healing from Trauma: Harnessing the Brain's Capacity for Change.

Bethany Brand, PhD, is an Emerita Psychology Professor at Towson University with over 30 years of clinical and research experience, the principal investigator on the largest prospective treatment outcome study to date of dissociative disorders (the TOP DD studies), coauthor of the therapist book, Finding Solid Ground: Overcoming Obstacles in Trauma Treatment *and* The Finding Solid Ground Program Workbook, *and author of* The Concise Guide to the Assessment and Treatment of Trauma-related Dissociation.



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

4 Clinicians Decode Films Every Therapist Should Watch

Psychotherapy Networker 2026 Readers' Choice Wider Culture & Our Field

On the Psychology of Narcissism, Gaslighting, Attachment & Shame



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

"Succession"

BY RAMANI DURVASULA

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

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

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

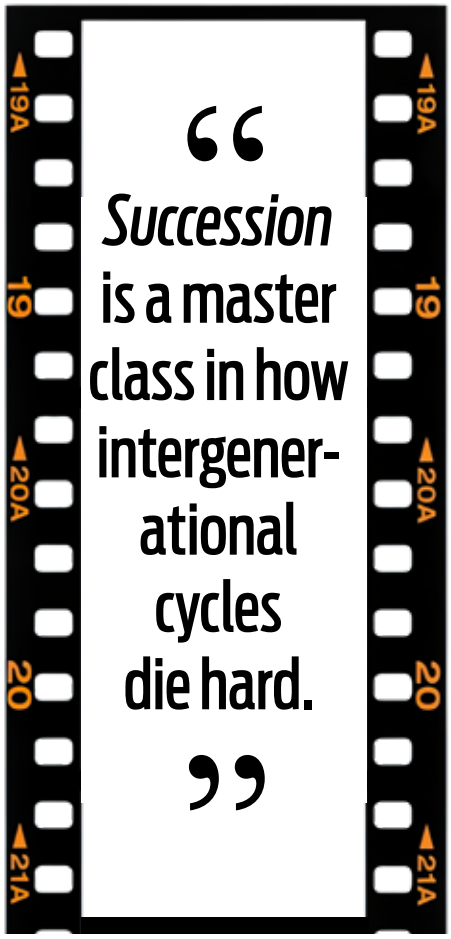
Logan Roy engages in the perpetual narcissistic patriarchal tactic of future faking, the psychological carrot on the stick: fostering the possibility in his children of their father finally bearing witness to them, and anointing them with the familial crown, but like Charlie Brown's Lucy with the football, always pulling it away. The net result of this is that none of them are

capable of maintaining a healthy adult relationship. They're chronically dysregulated, juggling substance use and addiction, struggling with sexual difficulties—and not surprisingly, they go on to abuse and subjugate others. Their single-minded quest to vanquish their father while simultaneously getting his love, becomes their life's work.

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

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

The theme of "loyalty tests," a common tactic in antagonistic relationships plays out consistently through the show, too—with Logan chronically testing his children, pushing them to ethical and personal limits, encouraging them to wantonly destroy the lives of others to prove their love to their father (a dynamic often perpetrated in cultic systems). In one affecting scene, the patriarch Logan, who has once again future faked Roman with grandiose promises, wants to isolate Roman from his siblings, who want to vote in a bloc against the father. Logan asks Roman to fire a long-standing corporate executive in the company with whom Roman has had a complicated sexualized maternal-in-nature relationship. Roman's physiological response to such a level of self-betrayal, and



betrayal of an "ally," is to become, in a word, "squirrely," crawling out of his own skin, highly irritable, and buried under shame and grief. (It's a profound piece of acting by Culkin.)

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

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

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

"The Woman in Cabin 10"

BY TERRI COLE

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

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

more her credibility is undermined.

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

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

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

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

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

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

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

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

"Marriage Story"

BY LISA KLEYN

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

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

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

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

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

If Charlie and Nicole were in my consulting room, I'd walk them back to the frightened parts of

themselves that fired those missiles. But *Marriage Story* isn't a therapy session; it's one of the most clinically precise depictions of relational rupture in cinematic history. It shows what happens when two people who love each other never lower their protective defenses long enough to feel seen, safe, or soothed.

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

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

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

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

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

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

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

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

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

"Imperfect Women"

BY ELI HARWOOD

I'm currently in the stage of parenthood and therapisthood where I rarely have time to sit down and binge-watch a good show. Between

emails and laundry and dishes and herding my three wonderful-but-sleep-allergic children into bed, I usually just want to go the f*** to sleep at the end of each day.

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

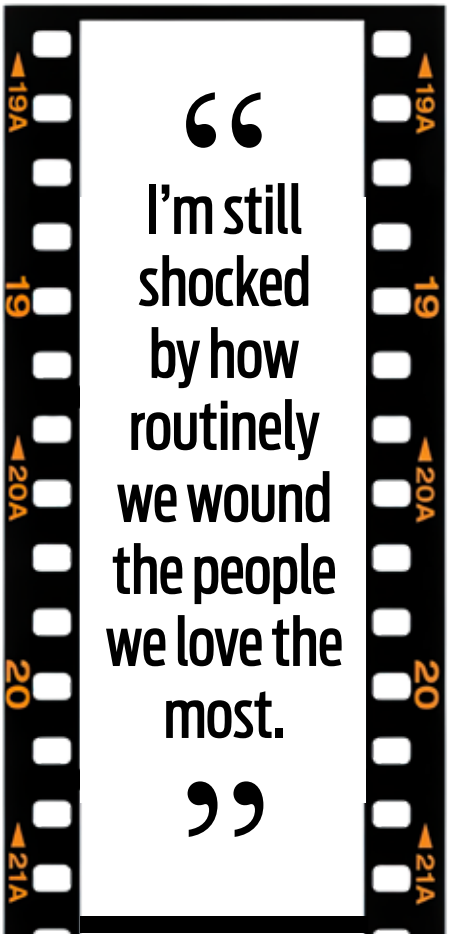
Naturally, as soon as I got home, I Googled her and went down an internet rabbit hole that led me to the discovery of her newest show, a psychological thriller called *Imperfect Women,* also starring Kerry Washington and Kate Mara. The series is based on the 2020 bestselling book of the same name by Araminta Hall. And boy oh boy was it worth the sleep loss it took to watch it.

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

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

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

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



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

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

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

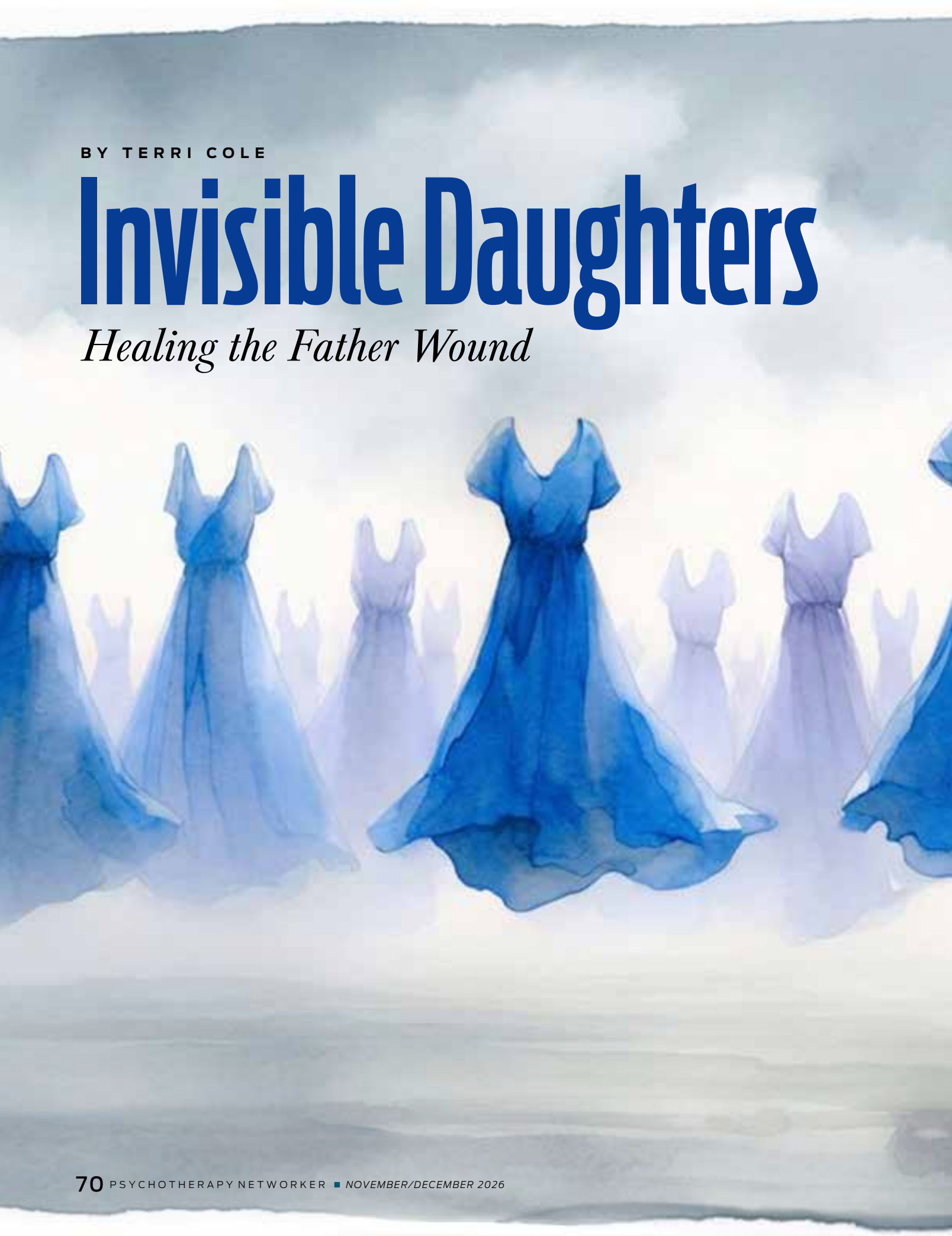
After watching this group of friends grapple with the past and its impact on the present, anyone who's thinking about the intersection of attachment patterns in friendships will find themselves with plenty to reflect on.

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

BY TERRI COLE

Invisible Daughters

Healing the Father Wound





I was five years old, on a mission.

I crept down the brick stairs to our cool basement, nervous but optimistic. I was as quiet as a five-year-old could be. My father sat in his big black leather chair in front of the "boob tube" (as he called the television), cheap wine in hand. A former basketball star, at six foot two, he seemed to take up the entire room, his feet stretched far out in front of him.

I thought if I planted myself between my father and his beloved Sunday golf on CBS, he'd wake up to my obvious awesomeness. My mother and three older sisters agreed that I was something special, but my father seemed to have missed the family memo. He worked a lot and was hardly ever around, so I figured this was my chance. I was positive (in the way that only a five-year-old can be) that if I just created the right opportunity, he would be powerless to resist my charms.

I tiptoed across the cool tile floor and hopped onto his lap, waiting for him to notice me. "Hi, Dad!"

My father half-smiled and nodded in my direction, then turned right back to the TV. So much for being irresistible.

Minutes passed. I waited. *I will wait as long as it takes for him to talk to me,* I thought. I synchronized my breath with his to avoid inhaling the smell of wine that wafted out of his mouth on each exhale.

One hour turned to two. I got hungry and went upstairs to grab the snack my mom had left on the counter, a cut-up apple and peanut butter. When I came back, he'd nodded off. I sat there watching him sleep, still waiting. Afternoon turned to evening. Eventually, my mother called down to say dinner was ready. Mission not accomplished.

That summer afternoon captures just one snapshot of my relationship with my father. It wasn't the beginning of my quest for his approval, which had started much earlier, probably from the moment I was old enough to notice his emotional distance. But this day crystallized something for me about how far I was willing to go to get his attention.

Fast-forward thirty years, and I am a therapist specializing in relationships. Working with women from diverse backgrounds, I began to recognize a distinct pattern in many of my clients: no matter what initially brought them into my office, when we explored their relationships, self-esteem, and career struggles, we often found the same root: unresolved, painful experiences with their fathers.

What's struck me most is how many women believe they're alone in this pain. They're not. And neither are you.

I call this pain a *father wound,* meaning a psychological and emotional injury that stems from growing up with a father or father figure who was absent, abusive, or not emotionally available to you. At its core, a father wound is a worthiness wound. It's where you learned that you weren't good enough as you were, or that you needed to be different, better, or more accomplished to be worthy of love and attention.

You too may have always sensed something was off in your relationship with your father, even if you didn't have the words for it yet. What I've learned, after almost three decades as a clinician, is that healing this wound isn't really about your father. It's about you.

The Father-Daughter Bond

I started working with Jade a few years after her high-drama, soul-sucking divorce. She'd spent years disappearing inside her marriage, so for months our sessions focused on figuring out how she'd lost herself.

A real-estate agent, Jade had a presence that turned heads. Almost six feet tall, with long red hair cascading down her back, she was a woman who couldn't possibly go unnoticed. But every time she sat down on my couch, her presence folded in on itself. Her body shrank, and her voice was barely audible. Everything about her said, *I don't want to take up too much space.*

One day, Jade wanted to talk about something different. "I think I might be ready to start dating again," she said. "I just need help … putting myself out there again. It's been so long. I'm tired of feeling invisible. But the idea of being seen also really scares me."

"Can you say more about that?"

"I don't know how to explain it," she said quietly. "I want someone to really know me. But every time I imagine that happening, I feel like running."

There was the paradox I'd seen in so many women with father wounds. The desperate longing to be seen, tangled up with the terror of exactly that. These two impulses shouldn't be able to coexist, but they do. And they'd been running Jade's life for decades.

Jade grew up with a fierce, commanding, and temperamental father who was a horse rancher. A man whose moods could shift without warning, putting the whole house on edge. She learned early to stay small, read the room, and not need much. That strategy followed her into her marriage and stayed for twenty years. Her ex-husband wasn't explosive like her father. But she monitored his moods, kept her opinions to herself, and avoided conflict at all costs anyway.

A father wound not only shapes how we relate to our fathers. It shapes how we relate to men, period. Jade had spent her entire marriage hiding because her nervous system had learned decades earlier that visibility was dangerous.

Fathering

We are wired to seek our fathers' attention, affection, and affirmation. And when we don't get it, the need doesn't just disappear. It can get buried and permeate every aspect of our lives.

For generations, we were handed the image of the father as ruler. He was the protector, the disciplinarian, the provider. Strong, stoic, and silent. But times are shifting. We now know that good fathering isn't about being king of the castle. It's about being attuned and present. Good fathering isn't about being perfect or taking kids on fancy vacations. It's about how a father shows up—not once or twice, but over and over, in small, consistent ways that tell a daughter, "You matter. I see you. I'm here."

When Jade was eight, her family went to Disney World, and she got a princess autograph book. She ran around getting signatures from characters, cast members, and even other families.

"When it was my dad's turn to write something, I handed him the book with so much anticipation. I was practically bouncing. He wrote, *I hope we never have a run-in. Love, Dad."*

Here was a little girl, glowing with Disney magic, wanting her father to celebrate this special moment with her. Instead, she got a message that essentially said, "You'd better stay out of my way."

"I was confused. At eight, I didn't really understand what a 'run-in' meant, but I knew it wasn't good. I remember thinking, *Why is he mad at me?"*

"And what did that experience teach you?"

She paused. "That I was a problem. That the safest thing to do was stay out of his way."

That moment at Disney World sealed how Jade related to her father. While other daughters received messages like "You're my princess" or "Daddy loves you," Jade learned that her father's love came with a condition: *Don't be a problem. Don't rock the boat. Don't take up space. Don't need too much.*

Attachment Styles

Your attachment style is how you learned to connect and form relationships. It's shaped by your early experiences with caregivers and affects how you experience closeness, regulate emotions, and relate in social and romantic bonds.

There are two main types of attachment: secure and insecure. Secure attachment develops when a caregiver is consistently present and emotionally responsive. Insecure attachment develops when that consistency is missing. These styles show up in three ways:

Anxious attachment: A pattern of seeking closeness while fearing abandonment. You may need frequent reassurance and feel hypervigilant about the stability of your relationships.

Avoidant attachment: A pattern of maintaining emotional distance to protect yourself from rejection or disappointment. You may struggle with intimacy and prioritize self-reliance.

Fearful-avoidant attachment: A pattern of wanting closeness but pulling away when it gets too real. You may cycle between seeking connection and sabotaging it.

But here's something most people don't realize: you can have more than one attachment style. The bonds you form with each parent develop independently, which means you can be securely attached to one and insecurely attached to the other. Many daughters with father wounds were living with two attachment experiences simultaneously.

In my case, I had great female friendships my whole life. But the love thing? That was a mess for decades. It took years of therapy to see it. I was securely attached to my mother and insecurely attached to my father. Mom was my emotional broadband Wi-Fi, consistently strong and reliable. Dad was more like dial-up, prone to disconnection. My friendships worked because they followed my mother's template. My romantic relationships kept failing because they followed my father's.

Here's what matters most: attachment styles are not fixed. They're adaptive responses your younger self created to stay safe. As attachment expert Julie Menanno explains, secure attachment is not something you either have or don't have. It's built through repeated experiences of emotional responsiveness, repair, and reliability. That's earned secure attachment.

The Wounds We Carry

Attachment styles describe how you show up in relationships. Underneath every attachment pattern is a wound: the specific injury that shaped it. Two women can both have anxious attachment but completely different wounds—one from abandonment, one from inconsistency. The pattern looks the same. The pain underneath is different. Understanding your attachment style tells you how you relate. Understanding your wound tells you why.

The wounds aren't a diagnosis. They're a framework drawn from attachment theory, trauma research, and what I've seen over almost three decades of clinical practice. They organize into three core areas: connection, safety, and self-worth.

Connection wounds form when love or attention feels unpredictable, withdrawn, or lost—through a father's abandonment, absence, or painful inconsistency. Safety wounds form when the person meant to protect you became a source of threat or chaos; your nervous system learned that love and danger go hand in hand. Self-worth wounds form when who you truly are—your emotions, desires, and individuality—is dismissed, mocked, or devalued. They plant shame about your identity.

In Jade's case, a few weeks after she started connecting the dots between her father's temper, her disappearing act, and the decades anticipating the needs of others, something shifted.

She walked into my office and said, "I've been thinking about that autograph book and my father basically telling me to stay out of his way. What kind of person would do that to a child?"

It was the first time I'd heard her express anger instead of shame. I let the silence hold.

"Instead of seeing me in my joy and excitement and joining me, he shut me down."

"And the thing you want most—"

"Is to be seen," she finished. "That's the crazy part, Terri. I've been hiding from the thing I've wanted my whole life." She shook her head. "I wanted my dad to see me. I wanted my husband to see me. But I made myself invisible so I wouldn't be a problem. I was so afraid of being too much that I became nothing."

Jade didn't walk out of my office that day with all the answers. She still wasn't sure she knew how to be visible without staying on high alert. But something fundamental had changed. She'd named the paradox that had been running her life: the thing she feared most was the thing she wanted most. She'd seen, clearly, that the hiding wasn't protecting her. It was keeping her life small.

Later that week, Jade did something small but significant. She updated her dating profile. Not with perfect photos or a carefully curated version of who she thought men wanted. Just … her. Tall, red-haired, funny, a little awkward, and done with shrinking. She wrote in her bio, "Learning to take up space again."

She didn't get a hundred matches. She didn't need to. She got three conversations with men who seemed genuinely interested in her. One asked her out for coffee. She said yes.

"I'm still nervous," she told me. "But I'm not waiting until I'm more ready because I won't be. I'm starting now."

The following adapted excerpt is from Father Wound *by Terri Cole, published by St. Martin's Essentials, an imprint of St. Martin's Publishing Group / Macmillan.*

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BY SALLY SPENCER-THOMAS

What Doesn't Work in Suicide Prevention

Three Common Practices to Avoid

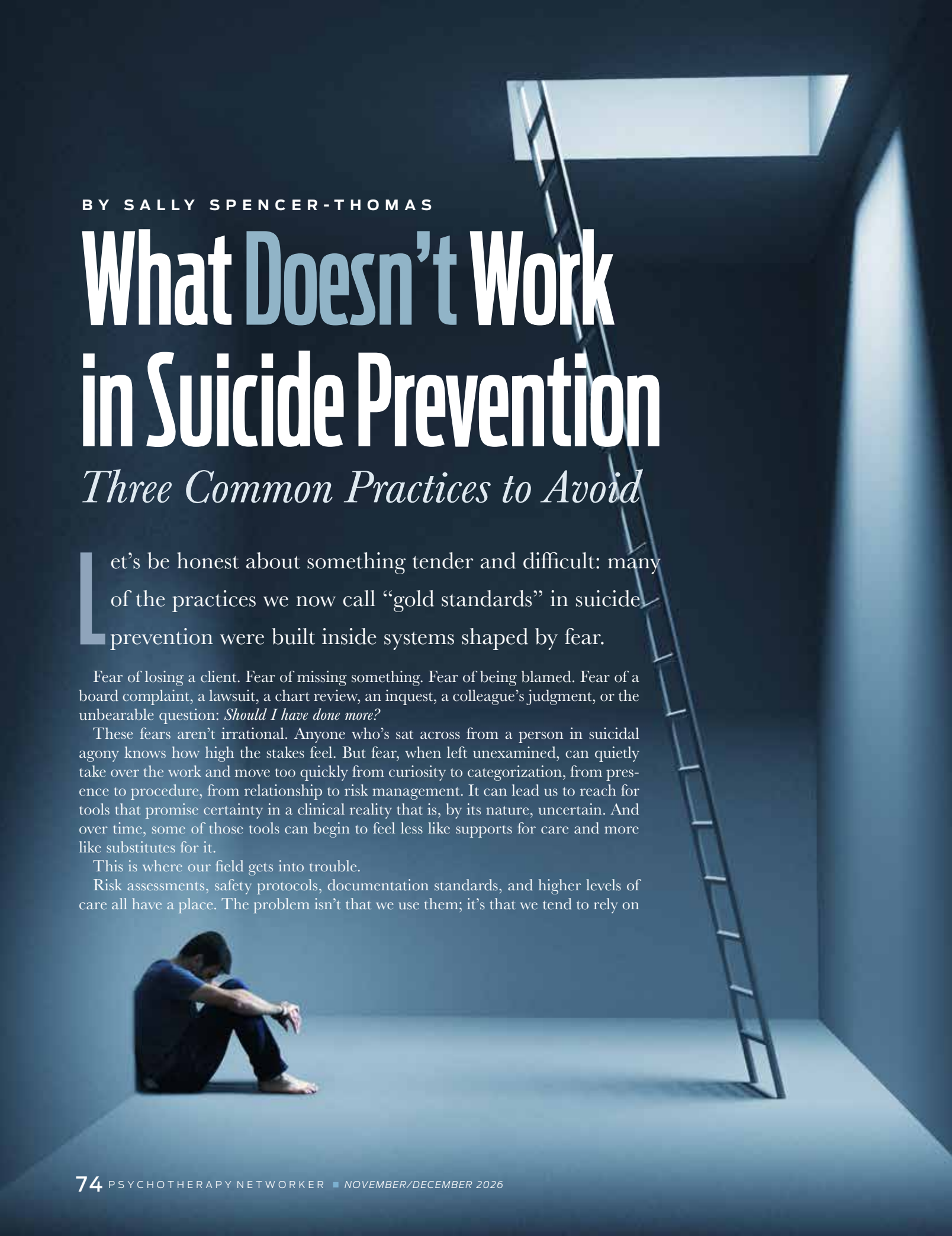
Let's be honest about something tender and difficult: many of the practices we now call "gold standards" in suicide prevention were built inside systems shaped by fear.

Fear of losing a client. Fear of missing something. Fear of being blamed. Fear of a board complaint, a lawsuit, a chart review, an inquest, a colleague's judgment, or the unbearable question: *Should I have done more?*

These fears aren't irrational. Anyone who's sat across from a person in suicidal agony knows how high the stakes feel. But fear, when left unexamined, can quietly take over the work and move too quickly from curiosity to categorization, from presence to procedure, from relationship to risk management. It can lead us to reach for tools that promise certainty in a clinical reality that is, by its nature, uncertain. And over time, some of those tools can begin to feel less like supports for care and more like substitutes for it.

This is where our field gets into trouble.

Risk assessments, safety protocols, documentation standards, and higher levels of care all have a place. The problem isn't that we use them; it's that we tend to rely on



them as if they can protect us from helplessness, protect clients from all possible outcomes, or replace the deeper clinical work of staying connected to a person who's terrified, ashamed, ambivalent, and in pain.

Three practices have become so embedded in standard suicide care that questioning them can feel almost heretical: *predictive risk assessment, no-suicide contracts,* and *reflexive forced hospitalization*. Each can emerge from an understandable desire to keep people alive, but each can also drift into something defensive, procedural, and disconnected from the person we're trying to help.

To reclaim compassionate suicide care, we must be willing to ask not simply, *Did we follow the protocol?* but *Did the protocol help us stay connected, collaborative, and clinically brave?*

When "Risk Assessment" Becomes an Interrogation

Risk assessment is not the enemy of compassionate suicide care. Done well, it can open the door to lifesaving conversation. Asking directly about suicide, understanding a person's pain, exploring access to lethal means, and clarifying what's helped them survive so far are all essential parts of good clinical practice.

The problem begins when assessment shifts from conversation to prediction.

This is the core tension for therapists: we've been tasked with trying to predict imminent suicide risk, even though the tools available to us aren't adequate for that job. We're asked to make high-stakes determinations about what a person might do in the next hour, day, or week, while relying on instruments and categories that can't reliably forecast something as complex, dynamic, and context-dependent as suicidal behavior.

Somewhere along the way, our field began to treat structured risk assessments as if they could tell us who will die by suicide and who will not—as if the right checklist, completed carefully enough, could offer certainty in one of the most uncertain areas of clinical work. It can't.

Newer algorithms may help us see patterns our clipboards miss, and some predictive models are certainly better built than others. Researchers are right to call for more rigorous methods, better validation, calibration, transparent reporting, and real-world impact studies before dismissing prediction models altogether. But prediction is still not the same as care. The real clinical task is asking, *How do we help this person find a path to a passion for living, deep connection, and a sense of worth?*

Suicide risk is dynamic. It can change quickly, sometimes over hours or even minutes, shaped by humiliation, loss, intoxication, pain, insomnia, conflict, connection, shame, relief, or one unexpected moment of profound aloneness. A client may answer every question "correctly," be categorized as low risk, and still be in life-and-death danger later that day. Another may endorse frightening thoughts and still have strong reasons for living, deep ambivalence, and a genuine wish to be helped.

This doesn't mean assessment is useless. It means assessment must be humble.

Rather than using risk assessment primarily as a prediction exercise, we can use it as a conversation for risk formulation and treatment planning. The goal is to understand the story: What has brought suicide into the room? What pain has become unbearable? What has changed recently? What has helped before? What makes death feel like relief, and what keeps the person tethered to life?

That kind of storytelling inquiry does more than gather data. It builds trust, helps the client feel seen as a whole person rather than reduced to a set of risk factors, gives the clinician more clinically useful information, and it turns assessment into the beginning of collaboration rather than the end of curiosity.

When we over-rely on forms, scores, categories, or clinical shorthand, we risk two harms at once. First, we may create a false sense of security when the answers look reassuring. Second, we may damage the very relationship that allows clients to tell us the truth. A person in suicidal pain can quickly sense when we're listening for liability rather than listening for understanding.

What begins as care can start to feel like interrogation—or what I've come to think of as clipboard counseling. The assessment can still happen, but in service of connection, shared understanding, and a plan that fits the person sitting in front of us.

The "No-Suicide" Contract

For decades, many clinicians were taught to ask suicidal clients to sign or verbally agree to a "no-suicide" or "no-harm" contract: a promise that they would not kill or harm themselves before the next session.

I understand why this practice took hold. In the terror of suicidal crisis, a contract can feel like something solid to grab onto. It can appear to offer reassurance, structure, accountability, and documentation. Many of us were taught, explicitly or implicitly, that it might also protect us legally if the worst happened. But the evidence has not been kind to this practice.

Reviews of the literature have found little to no empirical support that no-suicide contracts prevent suicide or self-harm, and researchers have raised significant ethical and clinical concerns about their use. Another review similarly concluded that no-harm contracts aren't an effective method for preventing suicide and don't protect clinicians from malpractice litigation after a client suicide. In fact, when used as a standalone intervention—or when they allow the clinician or system to feel falsely reassured—they may create more danger, not less.

The problem isn't simply that the contract may fail; it's what it may ask of the client. A person in suicidal crisis is often overwhelmed, ashamed, frightened, ambivalent, and desperate for relief. Asking that person to sign a promise not to die can unintentionally shift the emotional burden in the wrong direction. It can sound like: *I need you to protect me from my fear of losing you.*

That is not collaboration, or containment, and it's not the

same as safety.

For some clients, especially those who already feel trapped, powerless, or afraid of being hospitalized, a no-suicide contract may feel coercive. They might sign it because they mean it in the moment or because they don't want to disappoint us. Either way, the signature can tell us far less than we think it does.

The word *contract* is especially misleading. A legal contract assumes capacity, freedom, informed agreement, and meaningful choice. Suicidal crisis often compromises all four. And the literature is clear that relying on a no-suicide contract does not shield the clinician from liability. Careful assessment, sound clinical judgment, appropriate consultation, documentation of reasoning, and a collaborative plan for safety matter far more than a promise extracted in a moment of despair.

So no, a no-suicide contract is not a therapeutic intervention. At best, it's a weak substitute for a real safety plan. At worst, it's a liability ritual dressed up as care.

The good news is that we have a much better alternative: collaborative safety planning. It's the difference between asking someone to promise they will not die and partnering with them to build a practical, personalized plan for how they will survive. It's the difference between handing someone a form and sitting beside them to ask: *When the next wave comes, what will help you get through it? Who can we bring closer? What can we put between you and lethal means? What has helped you hold on before?*

A contract asks for compliance. A safety plan builds capacity. And in suicidal crisis, capacity is what we are trying to restore.

Forced Hospitalization

Forced hospitalization often emerges from terror. When a clinician is convinced a client may die, the impulse to do *something*—to lock the person away somewhere "safe"—is profoundly human. It's also profoundly risky.

Sometimes hospitalization is exactly what's needed. In acute circumstances, especially when a person can't collaborate around safety, is highly intoxicated or psychotic, has imminent intent, or has access to lethal means they cannot or will not step away from, hospitalization can be lifesaving. But the research tells us that safety and hospitalization are not synonymous.

The period after discharge from psychiatric hospitalization is one of the highest-risk windows we know of in suicide prevention. A meta-analysis of 100 studies, published in a 2017 issue of *JAMA Psychiatry,* found that suicide rates after discharge were approximately 100 times the global suicide rate during the first three months, and nearly 200 times the global rate among people admitted with suicidal thoughts or behaviors. Even years after discharge, suicide rates among formerly hospitalized psychiatric patients remained roughly 30 times higher than global rates, according to a study published in a 2020 issue of the journal *Suicide and Life-Threatening Behavior*. These numbers don't prove that hospitalization causes suicide, but they do demolish the assumption that it prevents it.

The ethical picture is equally complex. Ethicists argue that the field has often underweighted the harms of involuntary hospitalization, including loss of autonomy, coercion, damage to trust, and the possibility that some suicidal patients may benefit more from interventions that maximize collaboration, dignity, and personal agency. A qualitative review of patients' experiences of psychiatric hospitalization found that feelings of coercion were shaped not only by legal admission status, but also by whether patients felt heard, respected, involved in decisions, treated fairly, and safe in relationship with staff.

A person can be "voluntary" on paper and still feel coerced. A person can be kept alive by hospitalization and still leave feeling ashamed, frightened, dehumanized, or less likely to tell the truth next time.

One of my closest friends, a global suicide prevention advocate and two-time attempt survivor, was coerced into hospitalization. He remembers the sound of the door locking. He told me he felt "like a caged animal." Then he asked me, "So, what's more dignified—to be locked away in the back of a psych unit as a mental patient, or to kill yourself?"

Another scenario to consider is the highly educated young woman who called a crisis hotline during a panic attack. Police were called. She was handcuffed, transported to the ER, had her phone confiscated so she couldn't contact family, and was left restrained to a chair for hours before being forcibly committed for five days. When she leaves the hospital, she won't call a hotline again. She won't reach out. She will suffer alone.

There's a phrase I've started using to describe what I see happen too often in our field: *hot potato-ing*. A clinician gets scared and sends the client to the emergency department. The emergency department sends them to inpatient care. Inpatient stabilizes and discharges. Outpatient care is told to resume. Each provider may be acting in good faith, trying to reduce immediate danger and meet their duty of care. But the client often doesn't experience good faith—they experience being passed like a problem to the next person down the line. Somewhere in that chain of handoffs, the actual human being in pain can get lost. And what they experience isn't safety, but abandonment in installments.

I'm not arguing against hospitalization, just against reflexive hospitalization, coercion without humility, and crisis systems that prioritize transfer of liability over continuity of care.

If hospitalization happens—and sometimes it must—we have a moral obligation to make it less traumatic. We can explain why we're concerned. We can acknowledge the loss of control. We can involve the client as much as possible in the decision. We can reduce shame. We can plan for discharge before discharge happens. We can stay connected rather than disappearing once the ambulance arrives or the intake paperwork begins.

The field has a blind spot here. We have medicalized the decision to hospitalize, treating it as a clinical necessity rather than what it often is: a legal action that removes a person's freedom, restructures their identity as a "psychiatric patient," and frequently traumatizes them in the name of safety.

Safety is not just a locked door. Safety is not just what we do *to* a person. Safety is what we do *with* them. Safety is relationship, continuity, and dignity, which are the actual mechanisms of survival.



PART 2:

What Actually Works in Suicide Prevention

Reclaiming the Essential Skills We've Forgotten

What works when it comes to suicide prevention? The short answer is we don't necessarily need a new set of tools; we need to return to the oldest ones we have—relationships, presence, agency, and hope—organized today by a growing body of evidence that tells us exactly how to deploy them.

I find it helpful to think about suicide prevention along a continuum: upstream, midstream, and downstream. Upstream work bolsters protective factors and reduces risk before crisis takes hold. Midstream work meets emerging suicidal intensity and the relational ruptures that so often accompany it. Downstream work responds with skill, courage, and humanity when a person is standing at the edge.

Each level calls for a different kind of response, but all of them share a common foundation: the belief that people in suicidal pain are not problems to be managed, but human beings to be met.

Upstream: Fostering Belonging and Purpose

Thomas Joiner's influential theory of suicide proposes that two of its most powerful drivers are *thwarted belongingness*—the feeling that one does not belong and is fundamentally alone—and *perceived burdensomeness*—the devastating belief that one's death would be a relief to others.

If those are the wounds, then the upstream medicine is clear: connection, contribution, and meaning.

For youth, programs like Sources of Strength offer a powerful example of upstream suicide prevention: a peer-based model that builds help-seeking, belonging, coping, connection, and multiple sources of meaning before crisis takes hold. In a randomized controlled trial, Sources of Strength reduced new suicide attempts among high school students by 29 percent, even after accounting for student characteristics and recent sexual violence history. The finding is hopeful because it shows that suicide prevention can work at the level of culture, not only by identifying individual risk, but by strengthening the relational soil around young people. Rather than beginning with the question, "Who is most at risk?" Sources of Strength starts with a different one: "How do we build a community where young people are more connected, more resourced, and more likely to reach for help before despair hardens into crisis?"

My work with the construction industry has taught me this lesson repeatedly. In a field where suicide rates are heartbreakingly high, I've seen how belonging and contribution can become more than protective factors. They can become lifelines.

One union member I'll call Mike was in his 40s when I met him. He was funny, sharp, fast-talking, and impossible not to like. He had the kind of energy that filled a room before he even sat down. But underneath that quick wit was a story no child should have to survive. He'd grown up with profound abuse and neglect, carried pain that no one had helped him name, and for a time, meth became the thing

that helped him disappear from himself.

Eventually, he found his way into the trades, which gave him not only a paycheck, but structure, identity, skill, pride, and a crew. Work allowed him to build something solid while the rest of his life was still being repaired. Over time, Mike became not only a skilled tradesperson, but one of the strongest peer supporters I've ever known.

He could talk to people others couldn't reach. He knew how to use humor without deflecting from pain. He knew when to swear, when to sit quietly, when to push, and when to simply say, "I'm not leaving." Workers trusted him because he'd earned the right to speak from experience.

Then later, after a painful injury, Mike found himself in a dark place again. Injury in construction can threaten everything at once: livelihood, identity, belonging, masculinity, family stability, and the sense of being useful. For Mike, suicidal intensity returned.

What helped him hold on wasn't a slogan, or a poster in a breakroom. It was the living reality of belonging and contribution. He thought about his family. He thought about the apprentices and journeymen who called him when they were in trouble. He thought about the men who might not be alive if he hadn't picked up the phone. He thought about the peer team that had become part of his own recovery. He knew, in his bones, that he mattered to people—not in some abstract self-esteem-workbook way, but because they needed him and he needed them back. His mission helped tether him to life.

Belonging says, "You're one of us." Contribution says, "What you bring matters here." Together, they answer two of suicide's most devastating lies: *I am alone* and *I am a burden.*

Mike's story reminds me that suicide prevention isn't just what we do in the moment of crisis. It's also what we build long before the crisis comes: communities where people are known, needed, missed, and given meaningful ways to care for one another.

Sometimes the thing that keeps a person alive isn't being rescued by an expert, but realizing, in the darkest hour, "I still have people. I still have purpose. I still have work here to do."

Midstream: Collaboration, Agency, and Empowerment

When someone is in suicidal pain, the most powerful thing we can often do is *not* take over. It's to pull up a chair and work alongside them.

This is the animating spirit of CAMS—the Collaborative Assessment and Management of Suicidality—developed by David Jobes. In CAMS, the clinician literally moves their chair to sit *beside* the client as they work together on the same document. The message is radical in its simplicity: *You are the expert on your own pain. Let's figure this out together.*

Several other evidence-informed therapies share the common gift of helping people build emotional and interpersonal regulation skills, not simply receive rescuing. Therapies such as Dialectical Behavior Therapy, Cognitive Behavioral Therapy for Suicide Prevention, Brief Cognitive Behavioral Therapy for Suicide Prevention, Collaborative Assessment and Management of Suicidality, Attempted Suicide Short Intervention Program, Mentalization-Based Therapy, and problem-solving approaches all, in different ways, help clients survive waves of unbearable emotion, navigate ruptures in relationships, interrupt impulsive action, and reach for connection before acting on suicidal urges.

A recent systematic review and meta-analysis found that suicide-focused interventions containing interpersonal effectiveness training were associated with a 53 percent lower relative risk of suicide attempts, and those containing emotion regulation training were associated with a 42 percent lower relative risk. These findings suggest that helping people regulate emotional storms and relational pain can reduce suicide attempts.

The THRIVE intervention (Toward Hope, Recovery, Interpersonal Connection, Values, and Engagement) builds on Joiner's interpersonal theory by "flipping" suicide risk factors into recovery targets: belonging, contribution, hope, values, and meaningful engagement. THRIVE invites people to tell the story of their suicide crisis, place it within the larger arc of their life, and co-create a written Meaningful Living Plan. THRIVE's promise is that it moves suicide care beyond "How do we keep you safe tonight?" and toward "What would help life become worth staying for?"

The field has made real progress. DBT works—for clinicians trained to deliver it, which most are not. CAMS works—in the settings and populations studied, which don't yet represent the full range of people who show up in crisis. Safety planning works—when it's done well, collaboratively, and followed up on, rather than scrawled on a form at the end of an overwhelmed session. None of these tools are magic, though, and all of them work best in the hands of a clinician who isn't so frightened by liability that they've forgotten how to sit with another human being.

Downstream: Compassionate Crisis Response

Even in moments of acute crisis, the principles of connection and collaboration hold. Collaborative safety planning—done well—looks nothing like a no-suicide contract. It's not a promise extracted from a person in pain. It's a practical, personalized plan built *with* them, in their own language, for the moments when suicidal intensity returns.

The best versions are specific and portable: this person's activating events, warning signs, coping strategies, reasons for living, people who help, professional supports, and steps for reducing access to lethal means.

Craig Bryan's Crisis Response Planning model keeps this beautifully simple: the plan is typically handwritten by the client on an index card. That small act matters. When clients write the plan in their own words and their own hand-

writing, the message is: *This belongs to me.*

In a randomized clinical trial with suicidal U.S. Army soldiers, crisis response planning was more effective than contracts for safety, with suicide attempts reduced by 76 percent over six months compared to the contract-for-safety condition. The intervention also led to faster reductions in suicidal ideation and fewer inpatient hospitalization days.

So, when a client is awake at 2 a.m., they're not looking at a document that says, "I promise not to kill myself." They're holding something they helped create: *Here is what my crisis looks like. Here is what helps me ride it out. Here are the people I can reach. Here is what I have survived before. Here is what matters enough to keep me here.*

Caring contacts are another deceptively simple practice: brief, warm, nondemanding messages sent between sessions, after discharge, or during high-risk transitions. They do not ask the person to call back, explain themselves, reassure the clinician, complete homework, or prove they are safe. They simply communicate care: *I'm thinking of you. I'm glad you're here. You matter to me. You don't have to answer.*

Therapists can send caring contacts, but so can friends, family members, peer supporters, faith leaders, and trusted coworkers. The power is simply in offering steady, low-pressure connection without making the person manage our anxiety. A systematic review and meta-analysis found that caring contacts were associated with reduced suicide attempts. Caring contacts don't solve the crisis. They help interrupt one of suicide's most dangerous lies: *No one would notice if I were gone.*

The practice of working with clients and their families to increase time and distance between a suicidal person and the most lethal methods is also one of the most practical suicide prevention interventions we have. Counseling on Access to Lethal Means (CALM), frames this work as collaborative, autonomy-preserving, and focused especially on firearms and dangerous medications during periods of elevated risk.

But how we facilitate these conversations matters enormously. The goal is not to shame, frighten, lecture, or grab control. It's to say, with steadiness and respect: *Because this part of you wants to die and another part of you is here talking with me, let's make it harder for the suicidal part to act quickly while the part that wants to live gets more support.*

Good lethal-means safety conversations are specific, temporary, and collaborative. We ask what lethal means are available, what the client is willing to change for now, who they trust enough to involve, and what option best preserves both safety and dignity. With medications, that may mean limiting quantities, locking them up, or asking someone else to hold them temporarily. With firearms, it may mean temporary out-of-home storage where legally permissible, using locks or safes, separating ammunition, or involving a trusted family member, peer, firearm retailer, range, or law enforcement partner who can help create distance during the crisis.

For many gun owners, firearms are tied to identity, safety, family tradition, work, sport, military service, or constitutional values. A clinician who approaches the conversation as if the firearm itself is the problem may lose the person before the safety planning begins. The messenger matters: gun owners, veterans, firearm instructors, retailers, peers, and culturally trusted clinicians often have credibility that an outside expert may not.

Firearm safety conversations land best when they emphasize respect, temporary voluntary action, and trusted relationships—not fear, judgment, or confiscation.

A Call to Courageous Connection

This work is hard. Genuinely, profoundly hard.

The fear clinicians feel when sitting with a suicidal client isn't a failure of training, character, or compassion. It's a human response to an unbearably high-stakes moment. But fear, left unexamined, can quietly take the wheel.

It can pull us toward control when the moment calls for connection. It can make us reach for the checklist when the client needs our curiosity. It can convince us that documentation is the intervention, that hospitalization is the plan, that a risk category is the answer, that getting through the session safely is the same as helping someone want to live.

We can do better, not by abandoning protocols, but by putting them back where they belong: in service of relationship. Risk formulation, safety planning, consultation, documentation, hospitalization, caring contacts, and lethal-means safety all have a place. But none of them can substitute for the deeper clinical task of meeting a suffering human being with steadiness, humility, and respect.

The skills that make us good therapists are also the skills that make us good suicide prevention clinicians: presence, curiosity, attunement, collaboration, honest conversation, and the willingness to sit in the dark with someone without rushing to turn them into a liability problem.

This doesn't mean we carry the work alone. We need training that prepares us not only to understand suicide risk, but to stay relationally present inside suicidal intensity. We need supervision and consultation that help us think clearly without shaming us for being afraid. We need organizations that respond to client suicide with compassion and learning, not blame and professional isolation. We need a culture where clinicians can say, "This scared me," "This loss changed me," and "I need support," without fearing that their honesty will be used against them.

Suicide care will never be easy. But it can be more honest. More relational. More humane. More worthy of the people who come to us in their most unbearable moments.

This is the work before us.

Sally Spencer-Thomas, PsyD, is a clinical psychologist, suicide prevention advocate, keynote speaker, trainer, and co-founder of United Suicide Survivors International.

BY GEORGE FALLER & ELI HARWOOD

A Special Case Study
A Mother, Her Son, and the MANOSPHERE

TWO EXPERTS TAKE ON PARENTAL FEAR AND TEEN WITHDRAWAL

Priya, a 38-year-old financial consultant, comes in alone, hoping to convince her 13-year-old son Declan to join the next session along with his dad, who she describes as "my best friend and a very involved co-parent." After sitting down, she shows you her phone's screensaver: the three of them smiling at a mini-golf course, their faces dappled with sunlight, arms interlinked. Declan refused to come, Priya says, "even when I said I was seeing you for help on being a better parent." He'd just rolled his eyes and said, "You're a fine parent, mom." She glances down as she admits to peeking at his group texts ("I know I shouldn't spy on him, but I get scared") and some of what she's found has unsettled her: screenshots of explicit and even violent images, slurs, sexual language, a low-grade, casual brutality in the tone and content of text exchanges. "When I tried to talk to him about it, he told me I don't understand. 'This is just how kids talk.'"

Priya shares that until a few months ago, Declan would spontaneously tell her about his day, his friendships, even his feelings. Now any attempt to connect elicits the statement "I'm good," without Declan so much as looking up from his phone. Something else has shifted too. Even though he hasn't hit puberty yet, he's working out at the gym a lot and spending a lot of time in the bathroom with the door locked. "I found a jaw exerciser and eyebrow dye shoved under his bathroom sink." Priya casually told him he was handsome a few days ago and he nearly started crying. "You don't get it, mom. My canthal tilt is off, my midface ratio is too long. Objectively speaking, I'm ugly." A week ago, when she mentioned scheduling a pediatric checkup, he asked whether the doctor would check his testosterone levels.

"You have kids, right?" Priya says finally, giving you a warm smile as she plucks something off her sleeve. "So, what do you think? Am I overreacting?"



Resourcing Mom's Emotional Attachment System

BY GEORGE FALLER

Earlier in my career, I thought my job was to solve problems. If a parent came in distressed, I immediately offered reassurance, advice, or strategies. My intentions were good and I wanted to help, but I often moved too quickly past the live emotional experience in the room that was driving the problem. My therapeutic results were uninspiring.

Things began to change when I shifted my focus from fixing to connecting, one of the defining features of Emotionally Focused Therapy.

In Priya's case, I just need to wait for an emotional signal to activate, and then join it.

As Priya asked if she was overreacting, I observed her rubbing her arms.

Me: I notice you're rubbing your arms as you talk about Declan. Sometimes our bodies tell us something before we have words for it. What do you notice happening inside right now?

Priya: I guess...I'm anxious.

Me: That makes sense. Before we even talk about Declan's behavior, I want to acknowledge what your body is telling us. Your nervous system knows how important this relationship is.

I point toward the phone she had shown me earlier.

Me: That picture of the three of you at mini golf says a lot. I don't just see a family smiling. I see a mother who treasures her relationship with her son. When you replay in your head the moment you try to talk with him and hear, "I'm good," without him even looking up, what happens inside?

Priya's eyes widen.

Priya: I panic. My stomach starts swirling.

In EFT, we begin by finding what we call an emotional handle—a thread of experience we can gently grasp and assemble. As we slow the moment down, we start to organize the different pieces of an emotional signal—sensations, feelings, thoughts, and action tendencies—into a coherent attachment message. Once the message is clear, it can finally be responded to with care.

Me: Can you stay with that swirling feeling? What do you think it's communicating?

> "The sequence matters: care and connect first, before you challenge and correct."

Priya closes her eyes.

Priya: He's putting himself in danger. There's so much he doesn't know about this world. If he keeps pushing me away, I won't be able to help him.

Tears appear in her eyes.

Me: And when that fear shows up, what do you find yourself doing?

Priya: I ask questions. Lots of questions. I know it doesn't help, but I can't stop. [crying] I'm terrified of losing him.

I quietly slide the tissue box toward her.

Me: I'm really glad you're letting me see these tears. They tell me how much Declan matters to you. When you say, "I'm losing him," I don't hear a mother who's overreacting. I hear a mother whose heart is breaking because the closeness you once had feels like it's slipping away. That would terrify any parent.

Priya nods appreciatively.

The Caregiving System

The real problem for Priya isn't a lack of parenting skills, but her blocked caregiving system. The more threatened a parent gets by a child's behavior, the harder it becomes for them to focus on and read their child's experience. When the parent's own attachment alarm is blaring, their caregiving capacity often goes offline. At its core, my job in family therapy is surprisingly simple: help a parent's caregiving system respond to a child's emotional attachment needs.

Priya's fear of losing Declan had activated her emotional attachment system. The louder her alarm became, the harder it was to remain curious about Declan's experience. Her anxiety naturally led to monitoring, questioning, and trying harder to pull him close. Predictably, the more urgently she reached for him, the further he retreated.

As Priya's fear was met with the empathy of my caregiving system instead of solutions, her nervous system gradually settled. This is co-regulation. Helping Priya carry some of the weight of her fear increases her caregiving system's capacity to focus back on Declan.

Adolescence creates a unique attachment dilemma. Teenagers need increasing independence while simultaneously needing the security of knowing their parents remain emotionally available. Acting out is often less about rebellion and more about struggling to manage overwhelming emotions, peer pressure, shame, or the longing to belong.

Inviting Priya to understand the possible purpose of her son's behavior isn't the same as excusing it. There may absolutely be a time for limits, consequences, and boundaries. But connection comes first.

Inviting Priya to walk in Declan's shoes and try to experience some of his stress is a way for her to get curious about what might be happening underneath the behaviors.

In my experience, kids often don't know how to talk about their shame and insecurities. They often feel loved by their parents, but they don't feel their parents understand their stress, and therefore will minimize its impact. I let Priya know that Declan sharing that his "midface ratio is too long" is a good sign of his trust in turning towards his mom with his hurt.

The prognosis is good for kids who can talk about their insecurities; I worry about the kids who can't. If a kid can't share their hurt and shame, then they won't receive their parents' co-regulating caregiving and have no choice but to endure the distress alone, which is the least effective way of managing the threat.

Seeing the Cycle

With Priya's focus on curiously exploring Declan's world rather than her own anxiety, the next step is to expand the frame and help her see the dance she and Declan are trapped in.

Me: Let me see if I can zoom out and put this all together. When Declan says, "I'm good," your alarm immediately goes off. You worry he's entering a world where you can't protect him anymore. So, you move toward him—you ask questions, investigate, and try harder to understand.

Priya nods.

Me: But Declan experiences that as pressure, or as you not trusting him. So he pulls away. His distance makes your alarm even louder, so you reach even harder. Worry feeds retreat, and retreat feeds worry. It seems to me the problem isn't either of you. It's the cycle the two of you keep getting pulled into.

Priya: [smiling] I've never thought about it that way.

Me: Exactly. All of us get stuck in patterns of protection. You push because you care, and he retreats to feel safe. The most resilient families learn how to recognize these cycles and repair the distance they create. You're already taking the first step.

Priya: Well, that's good news.

To start changing the cycle, I encourage Priya to imagine reaching out to Declan differently. I pretended to be Declan and instead of leading with criticism, Priya tried to invite me into a new dialogue:

"I know lately you probably feel like I don't understand your world. You're probably right. Things are different from when I was your age. Trying to fit in isn't easy, and when I see you struggling, I want to help by figuring things out. But I realize now how my worry turns into too many questions, which isn't helpful. I want to do a better job listening. I trust you can figure this out. I just don't want you to have to face it alone. So, I'm available if you want to talk."

This conversation doesn't guarantee Declan will immediately open up. But it does change the energy from an accusation to an invitation. Instead of leading with anxiety, Priya leads with caregiving.

Healthy caregiving finds the balance between love and limits. Starting with empathy doesn't mean abandoning boundaries; it makes them more effective when they're needed. And connection doesn't eliminate correction; it creates the safety that allows correction to be heard and received.

The sequence matters: care and connect first, before you challenge and correct.

Over time, as Priya turns her attention to regulating her own anxiety rather than pressuring Declan to share his inner world, he'll feel safer talking about the challenging moments all adolescents face. Although Priya can't erase the natural distance that emerges between kids and parents during adolescence, she can let Declan know that when he needs her, she'll be there.

George Faller, LMFT, is a renowned trainer of couples therapists in Emotionally Focused Therapy, as well as a sought-after supervisor and therapist. With experience as a New York firefighter during 9/11, he teaches therapists how to stay calm and deescalate high-conflict couples. His online training platform, Success in Vulnerability, has trained thousands of therapists. He's the coauthor of Brave Love, Great Sex.

Grounding in Attachment

BY ELI HARWOOD

As a therapist specializing in attachment, I know that when a parent tells me their child is suddenly shutting them out, the first step to helping both the child and the parent is to address the disconnection happening between them. Until Priya reconnects with her son, it will be very difficult for her to help him with whatever struggles he is currently facing. Which is why my goal in this session is to help her process how her own attachment history is shaping the emotional intensity involved in her response to Declan's situation. By supporting her distress response and helping her regulate, I can help her approach Declan with a more emotionally attuned and available presence.

Priya: What do you think? Am I overreacting?

I want Priya to know I see her concern for her son as *caring*—that I don't see her feelings as irrational. Just like I want her to connect with Declan before trying to intervene with him, I want to connect with Priya before I try to guide her in any direction.

Me: Feeling scared and seeking support when your child is struggling and pulling away from you is literally the job of a caring parent! So no, I'm not putting this in the "overreaction" category. And yes, I'm a parent too, and I know the complex dance between not wanting to miss something serious *and* not wanting to overreact to something small that will pass on its own.

Next, I want to focus on helping Priya calm her nervous system. I can feel the worry she's holding in her body, and I want to help her recognize she's in an anxious state and practice changing that emotional state (a tenet of EMDR resourcing work).

Me: I'm going to help you get clear on what you know deep down is right to do with Declan, but first I want to help you understand and regulate the panic you are feeling, because it's impossible to get a teen to open up when they sense our emotional overwhelm.

I'm helping Priya attune to her body instead of letting the panic make the plans.

Me: It's so clear that you've worked very hard to create an open and trusting relationship with Declan. That you always show up for him when he needs you.

Priya: Yes, for sure. (She begins to tear up.) That's something I didn't get from my own parents, and I don't really know if I'm doing it right.

Me: I love that you hold that value so deeply. Your heart is one hundred percent on the right track, wanting Declan to feel emotionally supported by you. At the same time, I'm sad for little Priya, who didn't have a parent who knew how to give emotional support.

Priya: Thank you. It would've been nice to have. Not that I wasn't loved. My parents did everything they knew how to do to support me.

Me: Those two things coexist in many families. You had the gift of being loved, but also the pain of feeling emotionally on your own.

I've given Priya permission to feel the tender pain of childhood emotional neglect without implying her parents were bad people. I can sense how important it is to her that I see them in a nuanced way.

Priya: Exactly.

Me: I also heard you loud and clear that you've noticed a significant shift in how open Declan has been with you recently. You can tell he's struggling, and you can tell he's hiding those struggles from you.

Priya: [Taking a deep breath and exhaling] I feel panicky when you say that. I don't want that to be true, but yes, I do think that's happening.

Me: It makes sense that you'd feel panic, especially as someone who knows what it's like to be emotionally on your own as a kid. I wonder if Declan pulling away from you is kicking up some of those old feelings?

> "I use humor to show her that I'm not burdened by her emotions and can contain them without being overwhelmed by them."

Priya: [looking pensive and twisting the tissue in her hands] I hadn't thought about that before.

Because Priya has: 1) asked if I have kids, 2) shared her fear of being an overreactive parent (communicating shame), and 3) swiftly protected her parents after sharing that she felt emotionally neglected, I am going to use a bit of self-disclosure to normalize the process of navigating childhood parts while in a parenting role. Whenever I self-disclose, I make sure I'm sharing something that is emotionally resolved inside of me that can help my client neutralize feelings of shame or isolation. I'm trying to help normalize for Priya that part of being a parent is recognizing when our childhood baggage has entered the room.

Me: When I'm panicking about something related to my kids and I'm not sure if I'm reacting from my mom self or my childhood self, I ask myself the question: How old do I feel right now?

Priya: I don't think I know how to do that.

Me: Think of a memory of being a mother where you felt confident and grounded.

Priya: Does birthing Declan count?

Me: For sure. Tell me about what that felt like.

Priya: Even though I felt scared and in pain, after I pushed him out, I had this mama bear energy and felt so powerful and capable, like I knew I was going to keep him safe no matter what.

Me: When you think about that memory, what do you notice in your body?

Priya: I'm not sure exactly how to describe it, but I feel strong, like I can handle hard things for my son.

Me: Beautiful. Now I want you to go back to a memory from childhood where you felt like you had to handle something hard alone, without your parents' support.

Priya: [closing her eyes and thinking] Ahhh, I see. Yes, that's a very different feeling.

Me: Can you describe it?

Priya: Hmm. I guess it feels wobbly. Like the ground isn't solid, and I don't know where to go.

Me: How old are you in the memory you brought up?

Priya: Twelve, maybe 13.

Me: Is this a specific memory about something happening to you, or are you in a specific place?

Priya: Both. I was at school, being bullied by some girls who called me "curly curry girl" and told me to go back to India. It was horrible,

but I knew if I told my parents, they wouldn't have known what to do. They brought me here to give me a new life. It would've broken their hearts if I told them that being here often felt like hell to me.

Me: It must have been so scary to go through that racism and harassment all by yourself. I'm so sorry that happened to you, and at such a tender age.

Priya apologizes as tears stream down her face and she reaches for another tissue.

Me: No need to apologize. All-you-can-eat tissues are included in the price of your therapy ticket.

We both laugh as Priya pretends to eat the tissue before using it to wipe her eyes.

I use humor to show Priya that I'm not burdened by her emotions and can contain them without being overwhelmed by them. I'm modeling the presence Declan needs—what developmental psychologist Mary Ainsworth called the safe haven and secure base.

Me: Also, in this room, your tears are considered an honor, not a burden.

Priya: Thank you. That's the opposite of what I felt with my parents. I felt like it was my job to show them I was fine. I knew how stressed my parents were with all the shit they had to put up with as immigrants, and I never wanted to add to their burden.

Me: That's so isolating for a teenager. No wonder you're working so hard right now to make sure Declan doesn't feel alone.

Priya: I'm so worried he does feel alone.

Me: I wonder if it's possible Declan senses how worried you are about him feeling alone, but instead of seeing it as an invitation to open up, he is worrying about you and sees it as a signal to protect you from his mess, just like you did with your own parents?

Priya: Oh shit. Do you really think that's happening?

Me: I don't know for sure, but I do know that you've been very anxious about this, and that kids tend to hide stuff from us when they sense we are emotionally dysregulated. Or it could be because of all this manosphere nonsense on social media telling him to be "alpha."

Priya: I'm not sure since he won't tell me, but I think you're right that my panic-stink has been keeping him at a distance.

Me: Panic-stink! I think we should trademark that!

We both laugh again, and there's a palpable sense of relief in Priya's presence.

Now that Priya has some clarity about her anxiety affecting her dynamic with Declan, I want to see if we can help her access a more grounded state through reparenting work, focusing on the memories she mentioned where no one was around to help her.

Me: I want to teach you a quick exercise that can help calm the younger part of you that surfaces when Declan pulls away. If you're comfortable doing so, close your eyes or focus on a spot on the wall or carpet.

Priya folds her hands in her lap and closes her eyes.

Me: I want you to locate that girl who's being harassed and try to find that feeling in your body. Let me know when you've found her, and the wobbly feeling you described.

After a moment, Priya responds.

Priya: Okay, I sense the wobbling.

Me: Where is this younger version of you, and where do you notice the panic in your body?

Priya: I'm alone in the school hallway. My chest is tight, and my throat is closed.

Me: Okay. Find an empty classroom and slip inside. (pause) Now, I want the grown-up you to walk in and sit down next to that girl. Wrap your arms around her and say, "I've got you, kid. I see what's happening, and I don't need you to hold back with me. You can let it out." (pause) Then, have the grown-up version of you hold teen Priya as she cries for as long as she needs you to.

Priya takes a few shuddering breaths, and tears begin to fall down her cheeks. She's clearly feeling a lot of emotion—and relief. A few minutes later, her breath steadies.

Priya: The younger me feels comforted. I feel so much lighter. Can I open my eyes?

Me: Yes. Do you feel like you got what you needed?

Priya: I didn't need much; I just needed an adult to show up and care about what I was going through.

Me: That's what every kid needs.

Priya: Yes. And I think I know what I need to do now. Declan is into this manosphere stuff, all mixed-up with middle school stress and being the only Indian kid in our neighborhood. So I'm going to take him to our favorite restaurant, and his dad and I will talk him through why looksmaxing is nonsense. We'll explain how racism can make you feel like your body's "wrong"—and how to resist that message.

Me: And if he doesn't seem receptive and open up immediately?

Priya: If I don't feel like I'm reaching him, I'll give him some time to think. And if he still doesn't open up, I'll let him know we're going to therapy to figure it out—together. I'm not leaving him to sort this out alone, but I'm not going to smother him with my panic, either. He needs me.

I smile. She's got this. When we give parents space to process their own attachment histories, they're able to care for younger parts of themselves so they can show up more fully for their own kids.

Eli Harwood, LPC, is a licensed therapist and author, popularly known as the Attachment Nerd. She has more than 19 years of clinical experience and works from a highly relational attachment informed approach to therapy. Eli is the author of Raising Securely Attached Kids *and* "How to Deal With Your ___ So Your Kids Don't Have To.

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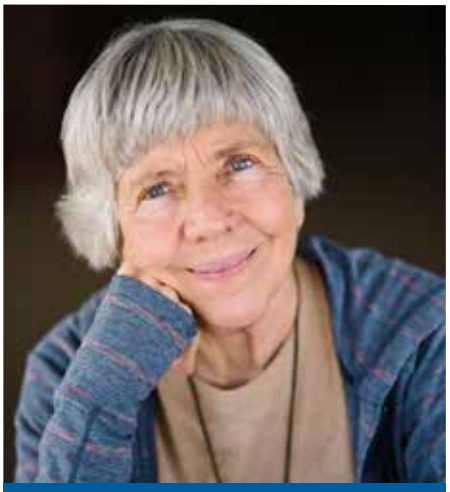
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BY LIVIA KENT & MARY PIPHER

Letters to a New Generation of Therapists

MARY PIPHER OFFERS FRESH ADVICE ON OUR CURRENT CULTURE



MARY PIPHER

Think back to when you were a young therapist, trying to figure out what to say, how to say it, and what to do when you got it wrong. You had your theories and techniques, but eventually you learned that what mattered most was harder to teach: paying close attention to the person in front of you, learning from your mistakes, and slowly discovering what kind of therapist, and person, you wanted to become. Every generation of therapists has had to find its footing, but today's are doing it in a world of technological and culture shifts that increasingly blur the boundaries between truth and fiction.

Few therapists have spent more time thinking about growth amidst culture shifts than bestselling author and clinical psychologist Mary Pipher, whose groundbreaking 1994 book *Reviving Ophelia*, which named the pressures facing adolescent girls, made her nothing short of a cultural icon. Not only did it spend more than three years on the *New York Times* bestseller list, but decades later, it even helped inspire Greta Gerwig's 2023 blockbuster *Barbie*. In *Women Rowing North*—another *New York Times* bestseller—Pipher turned her attention to women navigating the second half of life.

Over the years, she's become a cartographer of the human lifespan, mapping where our growth collides with the culture around us. But for many therapists, Pipher's most treasured guide may be her 2003 book *Letters to a Young Therapist*. Written as a series of letters to a young graduate student beginning her life as a clinician, it's a warm, candid reverie full of practical advice for emerging therapists that *Publishers Weekly* called "refreshing, informative, and insightful." This fall, it's being reissued with a timely new preface, in which Pipher examines the factors she believes are currently dividing us from each other, the natural world, and our true selves.

Over the years, *Letters* has become the kind of book supervisors hand to trainees and seasoned clinicians return to when they need a reminder of why they chose this profession in the first place. Harriet Lerner, psychologist and author of *The Dance of Anger,* called Pipher "a magnificent storyteller and a wise, trustworthy guide for our times." And fellow therapist William Doherty remarked of Pipher, "She makes me proud to be a therapist."

Despite our epidemic of disconnection, Pipher remains hopeful about the possibility for reconnection. She illuminates what our clients—especially young people—desperately need: the opportunity to struggle and recover, lean into our differences, find a place in communities and in nature, and develop a sturdier sense of self. She's hopeful about the future of psychotherapy, too, which she calls "the most valuable and important work right now in the country."

Yes, there are big challenges ahead: How do we honor our clients' relational pain without reinforcing the impulse to cut difficult people out of their lives? How do we give young people the "stress tests" they need to develop resilience? And how do we help them reconnect with other people, the natural world, and themselves?

These might feel like modern problems, but for Pipher, the solutions begin where they always have: in the therapeutic relationship.

■■■■■

Livia Kent: Mary, what first inspired you to write *Letters to a Young Therapist* in 2003?

Mary Pipher: I wrote it because I had things to say after decades of being a therapist and supervisor, things that weren't addressed in textbooks or graduate schools, like how to deal with transference, or what happens when a client is frightening or when you're treating a family and the dad is drunk. I also wanted to write about how wonderful our profession is and the wondrous process of how therapists can grow alongside their clients.

LK: In the book, your wisdom about therapy is offered in the form of letters to a young supervisee about you and your life. It evokes not only the beauty of Rainer Maria Rilke's classic *Letters to a Young Poet*, but the beauty of writing real letters to real people. How do you think the digital age has affected the way that we connect with one another?

Pipher: Since 2003, when I wrote the book, there's been enormous degradation of human connection, and one of the primary culprits is technology. For example, this morning I got an email from a friend saying that her brother-in-law died. Historically, she would've called me, and we would've had a chance to discuss it with more embodied presence.

I think therapists who are doing all their sessions online are missing physical presence. When I said goodbye to my clients, I always touched their hand when I handed them an appointment card. I thought even that small amount of touch conveyed some important kind of connection.

Many other things were different when I was doing therapy, like that you couldn't look up your clients online, and they couldn't look you up. I didn't have to worry about challenging a client and then that client posting a public review of me. I would've been a different kind of therapist if that were the case, more cautious and risk-averse. As it was, I wasn't worried about the impression I made; I was worried about the client's needs.

LK: The essence of your work has always been about the therapeutic relationship. Do you feel that's different for therapists now?

Pipher: No matter what, therapy offers clients time with someone who actually cares and listens to them, which is rare in the current world. A lot of the protocols and approaches that have been developed since I started my practice are really great. But in spite of all the new ways of working, I think there are core things all clients need. One is to be able to articulate their pain and eventually reframe it in a way that has meaning and allows them some sense of agency and a path forward.

Another is recognizing we'll always have problems, and all we can do about that is focus on our attitudes toward the way life goes up and down. I'm very big on the idea of waking up in the morning and setting an intention for the day. We can tell ourselves, "I'm looking for beauty today," or "I'm looking for gratitude." If that's what we're looking for, we're going to find it.

When I worked with clients, I always looked for victory stories. If somebody had been depressed for a long time, for example, they may not have been able to do the simple assignment of walking around their block after dinner. So if they finally came in and said, "I walked around the block this week," instead of just going, "That's great," I'd go, "Say that again. Say that *again*." And then I'd go, "So you walked around the block this week. Do you realize how important that is?" It's important to really underscore clients' progress.

LK: You wrote that brief therapy strikes you as bogus because relationships take time. These days, when so many people are interested in truncating therapy, are there any other trends that set off that same bogus detector in you?

Pipher: When I was a therapist, insurance covered most therapy regardless of diagnosis. We were able to do therapy with people who worked at food processing plants and Goodyear Tire. Now, fewer low-income people are able to access good therapy. So brief therapy might be cheaper, but you don't want to jump into someone's life and start offering suggestions and advice if you don't have a sense of who they are and what they've tried and the context they've lived in. That takes time to understand.

One of the best things to say to someone at the end of a first session is, "This is really a complicated situation." People love to hear they're complicated, because they *are*.

LK: Yes! You wrote, "Labeling a problem as complex is one of my more effective therapeutic approaches." I love that.

Pipher: The other effective thing to do is set expectations. You can tell people, "You've had this problem for a while, and we're not going to solve it in a week." Respect the problem enough that you don't jump in and say, "We'll have this figured out in three sessions."

LK: We talk a lot about the crisis of loneliness in our culture. What's your view on that?

Pipher: We're not only lonelier than ever, we're more anxious and more depressed than ever. There's statistical data to prove that. One cause is covid. It drove people into their homes, and they've never quite come back out. Also, most people are on their devices four or five hours a day. And on top of that, there's the brutalization of the culture, which contributes to the sense that we're being driven apart.

I'm not one to get particularly worked up if I have a friend with a different political philosophy than me. If I can go out and talk to them about their family and cultural events in town and trips they've taken, I enjoy them.

Same with my family. My daughter is a very progressive woman who works with refugees in Canada. My son is an evangelical Christian minister and conservative. It's a great pride to me that we all get along just fine, and we'd never consider letting politics or religion interfere with how we love each other. But sadly, I know we're a rare case. I hear about people breaking with their families or friends over politics all the time.

LK: Speaking of family, you warn us in *Letters to a Young Therapist* about the knee-jerk reaction to blame parents for somebody's unhappiness. Why do you think estrangement has

become such a hot topic in our culture and our field these days?

Pipher: It's very upsetting to me. Younger people have had less experience negotiating difference and working around conflict than previous generations. So when people make them unhappy or frustrated, they're vulnerable to calling their relationship with that person "toxic" and just walking away from it.

I've had times when I was unhappy with friends and family members, but there are ways to work through that. Almost every relationship has its difficulties. Instead of using the word *toxic* so much, we should consider using the word *difficult*. I also don't like the word *gaslighting,* because it comes up too quickly when people disagree on something.

Family's who we have, ultimately. We can have really close friends, but if we need to borrow money, if we get sick and need to move home, if we lose a job, it's likely going to be our family who ends up taking care of us. So it's a horrible thing to separate people from their families. Of course, sometimes it's absolutely necessary, but not always.

LK: As the author of *Reviving Ophelia,* you've had your eye on teen mental health for a long time. What's your read on it these days?

Pipher: It's not only my read, it's statistical. Between 2011 and 2022, rates of suicide have increased sharply in teenagers, and so have rates of anxiety and depression. I think part of that comes from this generation having grown up with what author Jonathan Haidt calls a phone-based childhood, as opposed to a play-based childhood, so they haven't accumulated the skills they need to move out in the real world.

They haven't had the social interactions. They haven't had the stress tests. They haven't had the skill building they need to be ready.

I have three grandchildren who all have been RAs in college, and they talk about the freshmen coming in and how little they know about getting along with other people and sharing space. A lot of them have never shared a room with anyone before, and need so much help living away from their parents, structuring their lives, and making their own choices.

A lot of Gen Z's despair is also attributed to the world they're moving into: climate change, the political atmosphere, the job market, and a certain kind of anomie, because if you've spent most of your childhood on TikTok, playing *Fortnite*, and disconnected from a larger sense of community, how can you develop a life of meaning? To me, having a sense that there's meaning in the universe, that there's something larger than you are, is essential to being a healthy adult.

One simple thing we can do to help teenagers is start introducing the small stress tests they need to grow up. For example, have them plan a family vacation, host a party at your house where they make all the plans, or walk to school instead of being driven. The point is to figure out just the right level of stress at which they can succeed and move to the next level. That's so important.

LK: Did you see the recent news about the mother in Virginia who let her five-year-old walk to the pond in their neighborhood by himself and now she's on a child abuse list for seven years?

Pipher: Well, I feel this child is kind of vulnerable not because of what he was doing but because there was only one of him. In other words, all children should have the freedom to be outside. Then it's much safer if there's people out on the streets. Part of the problem is people are not on the streets anymore. You can drive through neighborhoods and not see a single soul. One of my grandsons, who's 12 now, is very lucky because he lives in Canada, in a safe town on a cul-de-sac, and there's a whole bunch of boys who can run all over, and they're safe. That's the kind of childhood all children need.

But we can do things about making the situation better for kids. I was talking to one of my grandsons this weekend who's in college now, and he said that his parents gave him a cell phone when he was 13. But before they gave it to him, they had him read three articles about the effects of being on his phone all the time. He said he didn't pay much attention to what he read. He just wanted to read the articles fast so he could get his phone. But he did read them, and in the back of his mind he's always known what to watch out for.

Another story I heard recently that gave me hope was about my friend's grandson. He'd grown up just playing *Fortnite* 24/7 and didn't much care about grades. He hardly came out to eat with the family. And suddenly at 15, he decided, "This is crazy. I'm wasting my life." And he just got off his devices. He started taking long walks at night with his dad, and his grades got better. He started having a social life, playing tennis. So there's things children can do to save themselves.

One thing that evangelical churches do well is they have community, and they have a lot of activities for kids. And if you go to an evangelical church, it's full of young people whose lives are held in place by a community that knows them and loves them and gives them a sense of meaning. Now that wouldn't be my way of building community, but I respect it. There's a lot to be said for it.

LK: Let's talk a little bit about how our cultural stories are shifting these days.

Pipher: When I was growing up, the kinds of books I read were books about heroic people. I read the story of Albert Schweitzer and Helen

Keller and Eleanor Roosevelt and Marie Curie. I even read a book about Knute Rockne, the famous football player of the 20s. I also read books about good, admirable children. Literature changed at some point for children and started being much more about naughty children.

Now those aren't necessarily bad books, but they're a move away from heroic stories. On TV too, you see unhealthy stories about murders, crime, violence, sexual exploitation, drugs, guns, betrayals of all kinds. The stories we're telling as a culture are that people can't be trusted, that we should be scared of each other.

That may be true if you're living most of your life online, but if you're living mostly in the world of real people, which I still do, the world's full of trustworthy people. These days, the least trusting people are young people, which is really sad.

LK: Usually, you're more trusting when you're young and you get more jaded as you grow older.

Pipher: It's a vicious circle. If you're online a lot, you're likely to see a lot of angry, vicious things, so you're likely to be mistrustful of people, so you're likely to not go out to engage in the real world, so you're likely to be more online. The people who are happiest, and I would put myself in this category, are the people who are actively engaged in the world, rubbing shoulders constantly with people and working for good causes.

LK: There's a theme of resilience that runs through your book. How do you feel about our capacity for resilience these days as a society?

Pipher: I think it's at an all-time low, but I also think the political scene may change, and there's reason to have hope. The pushback around data centers is important because I see it as people saying, "We want to take back control of our lives." It's not just about land use, electricity, water. It's about not being sure we want all this AI in our lives. There's also a sudden interest, especially among young people, in things like book clubs and social clubs and potlucks. And I see that as a really good sign.

I think that humans have survived for hundreds of thousands of years, and there's a pretty good chance we'll figure out how to keep surviving. It's a dark time, and the assessment I had for this latest book is pretty grim. But I don't see how you can live without hope. I think hope is as vital as oxygen. And if you know real people, it's impossible not to have some hope in them. There's so many good people out there working so hard to make things better.

Parenthetically, I feel great hope for therapists. More than ever, we're doing the most valuable and important work right now in the country. We're giving people a chance to grow and become more engaged with the world, become more trusting. So I think that our own field is vital to progress in our country. It's a place where individual stories matter and those individual stories, if improved with better narratives, with a meaningful path forward, can be a really important part of cultural change.

LK: That's beautiful. What suggestions do you have for helping people tap into that sense of hope and reconnect with the part of themselves that lives offline and is surrounded by nature and other people?

Pipher: You're right to use the word *offline*. We all need to reconnect with our offline selves. The curated self has become so important that the true self in many people has withered. So we need to return to the grounding devices that have always held human beings in place: our friends, our family, our communities, nature, and whatever else gives us joy and hope. In my case, I love reading history. It's such a good way to put things in perspective. I also have a spiritual path. Mine happens to be Buddhism, but any spiritual path can give us hope and a sense of meaning and purpose.

There are so many ways people can empower themselves and their communities. It doesn't have to be a lot. You can start just talking to your neighbors, even to strangers, or the clerks at your grocery store. You can offer to help some older person in your neighborhood. If we all engage together, we can make it a world we want to live in again.

LK: Is there anything you want to make sure new therapists understand now?

Pipher: Being a therapist is the best work in the world. Not only do you develop more empathy and a larger sense of what humanity means, but the skills you learn and the understanding you gain will enrich you and allow you to lead a deeper, kinder, more authentic life.

Mary Pipher, PhD, is a clinical psychologist, author, and climate activist. She's a contributing writer for The New York Times *and the author of 12 books, including* Letters to a Young Therapist, Reviving Ophelia, Women Rowing North, *and her latest,* A Life in Light. *Four of her books have been* New York Times *bestsellers. She's received two American Psychological Association Presidential Citation awards, one of which she returned to protest psychologists' involvement in enhanced interrogations at Guantanamo.*

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

Let us know what you think at letters@psychnetworker.org. Want to earn CE hours for reading it? Visit our website and take the Networker CE Quiz.

BY HILARY JACOBS HENDEL, SARA NASSERZADEH & LINDA CARROLL

What Therapists Watch When the Workday Ends

FROM ESPIONAGE THRILLERS TO CHICKENS IN SUNGLASSES

We asked three expert therapists to tell us about what they've seen recently that transported them, entertained them, or made them think about therapy and their clients. What they shared ranged from a tragi-comedy reimagining of a marriage gone wrong to a decades-old Lebanese gem—five films in all. But not every response involved a movie. One was a form of entertainment we didn't expect—a chicken in sunglasses.

"Bait"

BY HILARY JACOBS HENDEL

At the recommendation of my husband, I recently found myself watching *Bait*, a six-episode Prime Video comedy created by and starring Riz Ahmed. The show's protagonist is Shah Latif, a British Pakistani actor whose career has stalled—until he gets called for a full-costume screen test to be cast as the next James Bond. It's the opportunity of a lifetime—and he blows it. Not only does he forget his lines, but he also then tries to convince the white director that it was because he was dizzy from fasting for Ramadan (though he had been guzzling apple juice throughout the audition).

Shah is told he won't get the part and asked to leave the studio surreptitiously to avoid the paparazzi. Instead, hoping to keep himself relevant and in the running, he walks out the front door so he'll be photographed leaving the studio. That one action sets off the chaos ahead that unfolds from a kind of tragicomic fever dream.

Watching this show, my heart broke for Shah. He's a relatable character filled with insecurities, and as an AEDP practitioner and emotions educator, I couldn't help mapping Shah's emotional breakdown onto a tool I use with clients called the Change Triangle, a three-cornered map of how emotions work in the mind and body.

At the top left of the inverted triangle sit his defenses: the deflections, twisted self-narratives, and busywork he generates to avoid facing what's underneath. At the top right sit his inhibitory emotions—anxiety, shame—the ones that mask his emotional truth. And his core emotions are at the base of the inverted triangle: adaptive feelings like sadness, fear, and especially rage.

The paparazzi photo of Shah in his James Bond costume sets off an internet storm in response to the idea of a Muslim playing James Bond. In an act of protest and Islamophobia, someone hurls a pig's head through the living room window of Shah's family home. The pig's head becomes a symbol of the aggression Shah has endured throughout his life—and of the aggression he's turned against himself.

Eventually, his mind plunges him into delusions and hallucinations in the form of a talking pig—his harsh internal critic externalized and played by Sir Patrick Stewart. What we're witnessing, in comic form, is the impact of repeated experiences of being invalidated, judged, abused, and unseen. Such experiences evoke such overwhelming core emotions that anxiety, shame, and guilt move in to inhibit them. And because this mix of core and inhibitory emotions coursing through the body can be so painful, the mind erects defenses—the brilliant and creative ways we learn to cope. While we can't stop core emotions from occurring—they evolved to help us survive—we *can* work with our emotions to change the direction of the downward spiral.

In AEDP, we define psychopathology as the result of being overwhelmed by emotions in the face of too much aloneness. Since children have immature nervous systems, they need adult support to navigate big emotions. However, most adults don't know how to validate their own or their children's emotions, so they end up unwittingly teaching kids to "tough it out" alone.

We see many scenes of Shah being physically and verbally bullied by relatives and boys from his neighborhood. We witness scenes depicting Shah's mother as controlling and competitive and his father as emotionally disengaged. Without enough emotional support, Shah learned to manage painful feelings largely on his own, leaving him vulnerable to anxiety and insecurity. Now, an adult under the stress of having to prove himself as an actor, he begins what the show depicts over several episodes as a nervous breakdown.

Although this is comedy, it's painful to witness Shah spiral into defenses like grandiosity, avoidance, and a kind of manic self-mythologizing about what this role as James Bond means about his own value. These aren't character flaws to judge; they're protective structures that exist because what's underneath is too much to feel directly: a lifetime of being judged, bullied, underestimated, and victimized by prejudice. These injustices have stoked a simmering rage.

Critics have noted that *Bait* is sometimes skittish, darting between subplots instead of settling into a familiar narrative rhythm. I'd suggest that skittishness is a stylistic choice, one that allows the viewer to feel Shah's anxiety. The show moves fast so Shah doesn't have to sit still with the rage building beneath the surface at having to audition not just for 007 but, all his life, for his own identity.

The most affecting scenes are the quieter ones with his ex, Yasmin—where the pace slows enough for something

truer to surface. That's the therapeutic arc in dramatic form: defenses loosen, anxiety gets tolerated instead of avoided, and underneath, real feelings—including rage—emerge.

In AEDP therapy, we help people experience anger with a technique called a fantasy rage portrayal. The anger clients feel arises in the body, and we help them safely imagine its impulses toward perpetrators within the container of a session. In *Bait,* Shah experiences a waking delusion of kicking the asses of his bullies and persecutors. He also dreams of killing family members who failed him in one way or another. In these fantasies, the rage he's spent a lifetime suppressing finally gets expression. Once he can experience the anger rather than defend against it, something shifts: he emerges with greater access to his love for his family and the confidence to perfect his audition.

Shah's story isn't really about acting or James Bond. It's about what happens when a person stops outrunning his core emotions long enough to feel and move through them—and discovers who he is on the other side.

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"The Roses," "Black Bag," "Caramel" & "Extraordinary Attorney Woo"

BY SARA NASSERZADEH

The expressive arts, poetry, and cinema often hold up a mirror to our consulting rooms far better than a textbook ever could. As a social psychologist who specializes in relationships, I'm endlessly fascinated by stories that reveal the subtle power shifts in couples, the cultural scripts around our bodies, and how we negotiate vulnerability when the stakes feel high. I often come away from sessions with a running list of movies, podcasts, and books my clients are into, and in my free time, I try to get through as many as I can. This helps me build a richer inventory of resources for all of my clients. Also, sharing these reference points creates a common language—a creative bridge that builds rapport and helps us explore complex themes together.

Over the past few months, four very different screen stories have stayed with me, sparking deep reflections on the unseen dynamics our clients bring to our offices.

The first is *The Roses*, Jay Roach's sleek reimagining of *The War of the Roses.* Watching Benedict Cumberbatch and Olivia Colman play a couple whose marriage disintegrates when their professional power balance flips is both mesmerizing and deeply uncomfortable. What makes it even richer is how their surrounding social circle—their friends, neighbors, and colleagues—act as an echo chamber of societal expectations and passive-aggressive comparisons. It made me reflect on couples who come to us in crisis not because they don't care for one another anymore, but because unexamined roles and external social pressures have fractured their foundation. When one partner's ambition eclipses the other's, their attachment system can glitch, turning a lover into a competitor.

Next is Steven Soderbergh's *Black Bag*, an espionage thriller starring Cate Blanchett and Michael Fassbender as intelligence agents whose marriage collides with professional suspicion. While it's wrapped in high-stakes intrigue, what hit me clinically is its metaphor for the invisible "black bags" all partners carry—the secrets, hypervigilance, and unspoken loyalties. It got me thinking about clients struggling with trust: *Can true intimacy survive without absolute transparency? How do we hold space for a partner when self-protection demands we keep our guard up?* Also, there's a therapy scene in the movie that made me so uncomfortable! I don't want to spoil it for you, so I won't share details—but I will say that it was a stark reminder of why outside motives should never pollute the therapeutic space.

On a completely different, deeply sensual frequency is Nadine Labaki's *Caramel.* This is an older movie I just watched. Set in a bustling Beirut beauty salon, it weaves together the lives of several Lebanese women, but it was the character of Jamale—a middle-aged woman secretly faking her period to hide her menopause—that broke my heart. Watching her navigate the invisible shame of becoming an aging woman in a society that ties female worth strictly to youthful desirability was profound. I immediately thought how universal this experience is and thought of female clients grieving their changing bodies in secret, carrying the heavy weight of social conditioning around sexual agency. Yet, the warmth of the salon—the collective rhythm of female friendship and neighborhood solidarity—brought a sense of warmth to me with its healing power of shared connection.

Finally, for something affirming, I recently binged the South Korean series *Extraordinary Attorney Woo.* Woo Young-woo, a brilliant autistic lawyer, steps into her first romance with a colleague. What I loved so deeply was how delicately it handled neurodivergent intimacy, completely dismantling the misbelief that autistic individuals lack desire or emotional depth. Watching them navigate sensory boundaries, communication differences, and the quiet beauty of a relationship built on explicit consent was pure joy. I found myself thinking of neurodivergent clients who so rarely get to see their relational longings mirrored with such dignity and tenderness on screen. I'm recommending this one to many of my clients.

Whether it's the shame of aging, the terrifying vulnerability of neurodivergent love, or the slow-burn dismantling of a long-term marriage, these stories are great reminders of how beautiful and diverse humans are and why we do the sometimes-mystifying things we do.

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and intercultural fluency. She's authored three books, including Love by Design: 6 Ingredients for a Lifetime of Love, *winner of the 2025 Vincent Clark Award from the California Association for Marriage and Family Therapists. She's a Certified Sexuality Counselor and AASECT-approved provider, a Senior Accredited Member and Supervisor with COSRT (UK), and an Associate Marriage and Family Therapist in California.*

Chickens in Sunglasses

BY LINDA CARROLL

When my therapist friends aren't working, many of them listen to endless podcasts about finding balance, discovering better ways to help clients manage stress, or getting "fair and balanced" political news. A few take classes on great art, music through the ages, and Stoicism.

I have more embarrassing, less lofty ways of relaxing. Sure, sometimes I download apps that promise to teach me about art, tell me everything there is to know about the cello (my favorite instrument), and guide me toward small independent films and documentaries. But my favorite way to unwind is watching animal videos, especially of animals being kind to one another. A goose befriending a cow. A mother cat adopting a rat. Especially in this political climate, these videos are a good reminder that unexpected kindness is everywhere if you look in the right places, and they give me a sense of necessary hope.

Not too long ago, I came upon a video about an old sheep named Fiona who'd been living alone at the foot of the coastal cliffs in the Scottish Highlands for two years. Unshorn, she had 20 pounds of matted gray wool on her body. Without a flock to socialize with, all she could do was eat grass, and she'd grown very fat. A team of farmers finally hauled her up the cliff and brought her to a farm, where someone spent hours gently trimming away the heavy, matted wool. Once Fiona was free of her burdensome coat, she romped and played in the fields. I watched that video over and over for days.

But most of all, I like watching chicken videos. Chickens riding motorcycles, chickens dancing by moonlight, chickens making friends with goats, chickens in love, chickens playing guitars, chickens in outer space. Something almost magical happens in my body when I watch them. Seeing a chicken driving a car in a scarf and holding a purse is so completely incongruous that laughter comes easily—a welcome release after a long day of listening to people speak about their pain.

Unlike doing something that would have me reflect on my work with clients, or sinking into a serious book or film, there's no deeper meaning to follow. Chicken videos engage me without asking anything of me. A chicken in a hat is trivial, ridiculous, and funny. And yet something real is still happening when I watch @sammichicken or @binoothechicken. It feels like a nervous system reset.

A chicken in sunglasses doesn't call for vigilance, accurate empathy, the low hum of validation, or the question, "Am I getting this right?" There's no attunement required, no interpretation to hold, no repair to track. My body registers the difference before I do—the exhale arrives before the thought *Oh, I can relax now.* It's less a technique than a default state my body finds when the need for vigilance disappears.

As it turns out, I had some formative experiences with chickens. (Okay, so maybe there's no relief for a therapist without us eventually making deeper meaning of it.) An older relative of mine with dementia lived at Napa State Hospital, California, in the district everyone called Imola. (In the early 1920s, it was called the Napa State Asylum for the Insane.) On Sundays, I went to visit her. My parents dutifully disappeared into the building where she was housed, leaving me free to roam the grounds.

On one of those visits, I discovered a huge fenced-in area with a big red barn and chickens running everywhere. A large man named Gus, with a bronze-colored beard and red suspenders, a gentle soul who may himself have been a patient at the hospital, noticed me and showed me around. He introduced me to his favorite chickens, Assumpta, Imelda, and Bernadette, named after nuns he'd known, and he told me stories about how distinct their personalities were as we laughed at their antics.

Over several visits, I learned that Gus had been raised in Brooklyn, where his Irish father insisted on Catholic schools to "keep the boy in line." I was 10, but I still noticed a dark cloud pass over his face when he spoke of his father. Once Bernadette went after a hen twice her size, squawking like she owned the yard, and Gus said, "In spite of her halo of white feathers, she's a bully disguised as an angel, just like my father." Even though that dark cloud crossed his face, we laughed as we watched Bernadette strutting toward us with her chest puffed out.

When I became a therapist, humor like the kind Gus and I shared accompanied me into my sessions and consultation groups. It was a balm when grief weighed me down and a much-needed distraction from overwhelm. For a while, my sense of humor was a bit dark and wicked. But now, apparently, I'm back to laughing at chickens at eleven at night. My nervous system has always known what to do with the unbearable: find the absurd thread in it and pull. The chickens are just the purest version, nothing unbearable attached, just the reset itself.

So there it is: long before social media, there was a state hospital, a man named Gus, and a flock of marvelous chickens showing me how to reset from the seriousness of life.

Linda Carroll, LMFT, has practiced psychotherapy since 1981. She's an Imago therapist, trained in Level 2 Gottman Method Couples Therapy, and completed coach training through the Institute for Life Coach Training, certified by the National Board for Certified Counselors. She's the author of Love Cycles: The Five Essential Stages of Lasting Love *and* Love Skills, *both published by New World Library. Contact: lindaacarroll.com.*

In Consultation FROM 12

trauma-informed substance abuse treatment protocol, such as trauma-focused CBT, concurrent treatment of PTSD and substance use disorders using prolonged exposure (COPE), and the Buzzkill protocol in EMDR.

Even experienced clinicians are wary about doing trauma reprocessing with clients who dissociate or have a dissociative disorder. But the research shows that both CPT and EMDR (specifically Flash or EMDR 2.0 protocol) support trauma reprocessing with these clients. But what if your client is dissociating in session or during the trauma reprocessing itself? Dissociation responses can show up in sessions in a lot of ways. The client suddenly falls asleep, begins to nod off, or tells you they feel like they're going to faint. They might become dizzy, spacey, or say they feel numb or "nothing."

If any of these symptoms occur during a session, it's important to slow down and use grounding and orienting techniques to help the client come back to the present moment. This might be the classic 5-4-3-2-1 exercise, where we ask the client to name five things they see, four things they can physically touch, three things they hear, two things they smell, and one thing they taste. You can also gently decrease nervous system arousal by asking them to do something experiential, like roll a ball.

Each model has guidance on how to proceed if symptoms occur during trauma reprocessing. For example, in the EMDR 2.0 protocol, it's recommended that you use techniques to tax the client's working memory through distraction, perhaps by having them focus on engaging music, or a spelling task, or an experiential activity like having them stand up and move their body while saying a phrase at the same time. This keeps the client in the present, which will gradually bring down arousal and help them move out of a dissociative state.

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Even if we're trained in evidence-based models for PTSD, our own anxiety about doing trauma reprocessing can get in the way of doing it effectively. So, as is the case with so much of our work, we need to turn to our own internal processes. Ask yourself: Do I have any fears or concerns about providing trauma reprocessing to my clients? If you notice these concerns with just one or two clients, maybe it's your clinical intuition. Maybe you feel hesitant for valid reasons. But if you feel generally anxious about trauma reprocessing, I recommend you seek consultation and additional training in your respective model to find out why, build more confidence, deepen your skillset, and strengthen your competency.

One of the most common things I hear from therapists who are on the fence about trauma reprocessing is that it will cause their client to feel intense feelings. That's true. Trauma reprocessing is intense. But it's important to remember that the client has already lived through the trauma. I like to think the process is akin to grief therapy in that clients experience feelings in big waves that gradually dissipate over the course of treatment. And in my experience, it's worth the journey. Trauma reprocessing gives our clients the opportunity to change their relationship with the trauma, to know in their body that it's in the past. Over time, nearly all of my clients have been able to fully feel and release their painful feelings. And for me, not just hearing their stories, but bearing witness to their transformation and recovery, has been an immense privilege.

Daphne Fatter, PhD, is a licensed psychologist, clinical consultant, clinical trainer, author, and international speaker specializing in integrative trauma-informed therapies, PTSD, complex trauma, complicated grief, decision-making, and divorce recovery. She's the author of Integrating IFS (Internal Family Systems) into EMDR Therapy *and* Part of Me Wants to Leave, Part of Me Wants to Stay.

Williams FROM 57

I froze. I blinked, I smiled awkwardly, and fumbled through an apology for being too loud. The moment she left, I began searching online for the strongest white-noise machine I could find. But her comment stuck with me. I replayed it in my head for days, wondering if I'd crossed some invisible ethical line. Had I been unprofessional? Unwise? A less-than amazing therapist because I dared to laugh?

This was early in my career, back when I still believed the implicit grad school message: *Great therapy is serious. Intellectual. Slightly aloof. Minimal laughter, please.*

Eighteen years in, I can confidently say this: I've belly-laughed, cried, sighed, and shared countless deeply human moments with my clients. And those moments have been some of the most healing.

Of course, not all laughter in therapy is the good kind. Sometimes it lands, well, sideways. When a client laughs from anxiety, or cracks up while describing something that is objectively *not* funny—like abuse or profound loss—I gently name the dissonance.

Humor can be a brilliant coping strategy, but it can also be a clever way to keep pain at arm's length. It works for a while, but therapy invites something more intimate. When a client seems to be masking their pain with humor, I'll point out how their laughter doesn't quite match the story they're telling, and invite them to explore the messier feelings underneath.

Yes, therapy is a container for insight, healing, and growth, but it's also a place where our clients get to rediscover glimmers of hope. When those glimmers disappear—when joy, levity, or even a single amused exhale becomes rare—it's a sign that someone's emotional world is getting heavy.

Laughing in session isn't a silver lining. It's not toxic positivity. And it's not pretending that something sad, hard, or horrible didn't happen. It's a breath of fresh air. A moment of shared humanity. It's a recognition that life is absurd, beautiful, painful, and hilarious—often

all at once.

It's a reminder that despair and joy don't cancel each other out. They often coexist.

Chinwé Williams, LPC, is a trauma specialist, a licensed and board-certified EMDR therapist, and a counselor educator and supervisor with close to two decades of experience supporting individuals in trauma recovery. She's the author of Seen: Healing Despair and Anxiety in Kids and Teens Through the Power of Connection.

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I help couples to locate themselves and talk explicitly about transitions for three important reasons. First, the journey is often strangely invisible to the traveler. It's hard to see the forest when you're entangled in the branches of the trees. I've found that naming the transition itself feels validating and orienting for couples. Second, silence is itself a communication. The unspoken still shapes the space, leaving partners to import their own—often inaccurate—stories about the other's experience. A couple who doesn't talk about their experiences of transition will still embody and enact those experiences. Third, talking about it together with me puts the couple in the ideal position relationally—shoulder to shoulder, looking together at "the problem."

My goal is to help Jess and Liam grieve *together* the losses of the passage of time and changes connected to aging and health. Although it seems paradoxical, when we're brave enough to grieve, we create fertile soil from which something new can grow. We move away from asking, "Who do you have to be now that you are older?" and into asking, "Who do you get to be now in this season of your life? What do you get to claim and experience, separately and together?"

As we move further into the session, I learn about the ways they each pull away from the other to self-protect. Jess shares her belief that Liam purposefully locked her out during their most recent fight, and we explore the possibility that she feels forgotten, or rejected by Liam. Here I think about the problem-saturated narrative keeping them stuck, given the brain's relentless tendency to seek confirmation for its beliefs and fears. If Jess truly believes that Liam doesn't care about her, she'll see this evidence everywhere. We'll want to shake up this belief system so that Jess can extend Liam the benefit of the doubt.

Jess mentions her childhood experiences of caring for younger siblings from a young age, and the sense that she wasn't a priority for her overworked parents. With Liam immersed in his chronic pain and the challenges of going from a 40-hour to a 5-hour workweek, she seems to be experiencing a sense of loneliness that feels all too familiar, deepening her hurt and fueling her hostility. Liam argues that no matter what he says, "it gets twisted", and I can see the hurt underneath his anger.

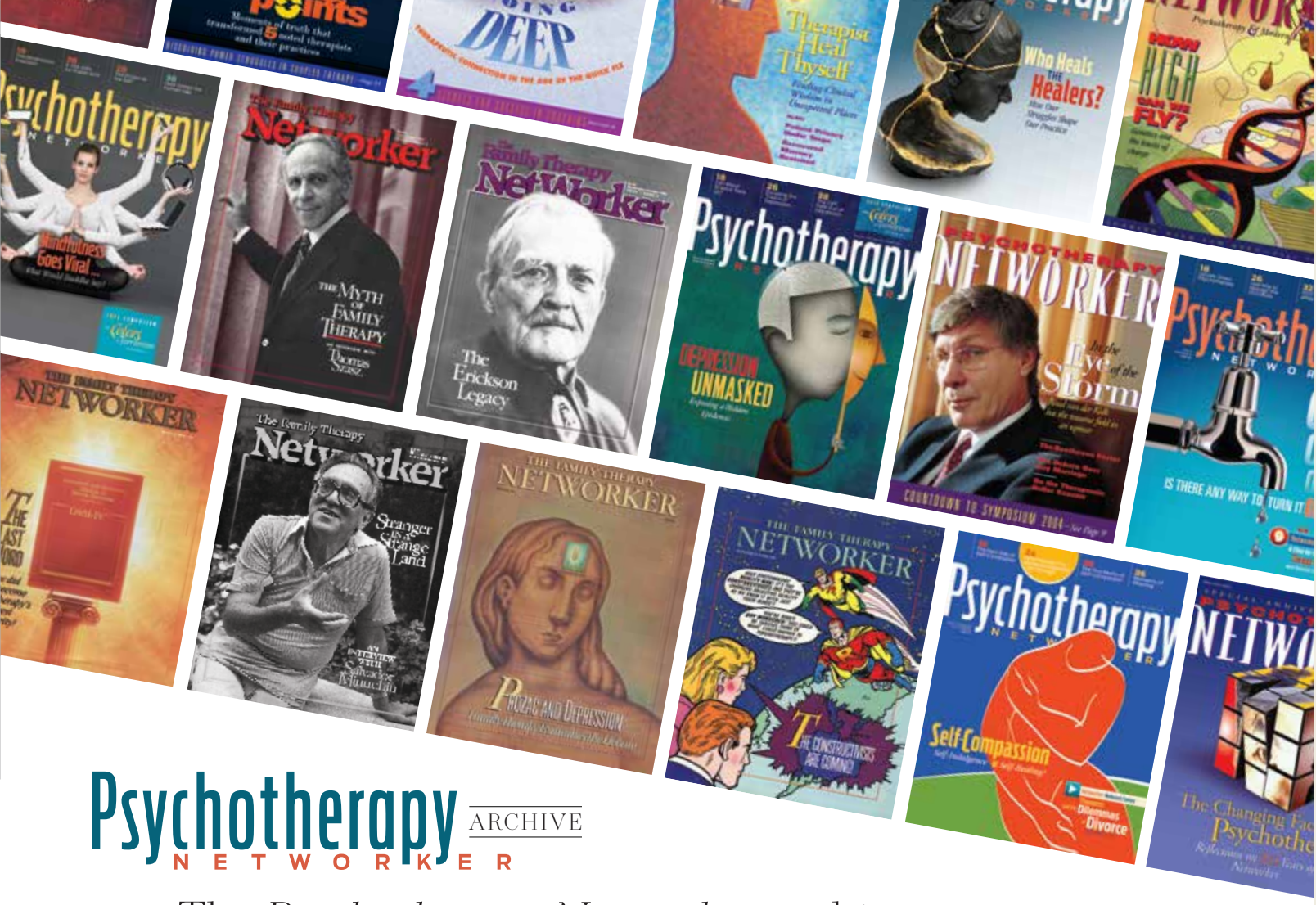
With some prompting, Liam shares that he struggled in school and often felt rejected by his classmates. Every time Jess critiques him or sees the worst in his behavior, he feels the sting of not being "enough," leading him to pull away to avoid that feeling. The cycle is polarizing: when Jess feels forgotten by Liam, she withdraws by turning toward her friends, seeking out the warmth and acceptance that she isn't feeling from Liam. The more she pulls away, the more Liam feels rejected and withdraws in anger. His retreat confirms her aloneness.

Liam was likely drawn to Jess's energy and spirit of adventure. He must miss being the beneficiary of her big, warm attention, and maybe he even feels jealous of her friends. I want to encourage Liam to connect with and name the sadness, shame, and fear of disappointing Jess that lie beneath his angry retreat, and to help Jess witness it, accept it, and offer him compassion. Conversely, it will be important for Jess to connect with and name the worry, sadness, and loneliness that lie beneath her frenzied, distracted behavior, and help Liam witness it, accept it and offer her validation and care.

As they connect with the needs and emotions underlying their behavior, and witness each other's pain, I feel confident they'll find a way forward, shoulder to shoulder, through these difficult but wholly inevitable transitions. When couples are courageous enough to turn toward themselves and each other, transitions become initiations—into wisdom, self-awareness, and connection.

Ellyn Bader, PhD, is a psychologist, co-director of The Couples Institute in Menlo Park, California, and co-creator of The Developmental Model of Couples Therapy. She's one of the early founders of couples therapy, as well as a recognized thought leader and trailblazer in relationship therapy. She co-authored an award-winning textbook, In Quest of the Mythical Mate, *and the popular book* Tell Me No Lies: How to Face the Truth and Build a Loving Marriage *along with her husband Dr. Peter Pearson. The two have appeared on* Nightline, Good Morning America, O Magazine, Cosmopolitan, *several NPR programs, and over 70 others.*

Alexandra H. Solomon, PhD, is a couples therapist, speaker, author, professor, podcast host, retreat leader, and media personality passionate about translating cutting-edge research and clinical wisdom into practical tools people can use to bring awareness, curiosity, and authenticity to their relationships. She's on faculty in the School of Education and Social Policy at Northwestern University and is a licensed clinical psychologist at The Family Institute at Northwestern University. Her hit podcast, Reimagining Love, *has reached listeners across the globe and features high-profile guests from the worlds of therapy, academia, and pop culture. Her latest bestselling book is* Love Every Day. *Contact: DrAlexandraSolomon.com and on Instagram at @dr.alexandra.solomon.*



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