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Psychotherapy NETWORKER

NOVEMEBER
DECEMBER
2025

The Year That Reshaped Therapists

Psychotherapy NETWORKER BEST of 2025

Finding Regulation in a Dysregulated World

Editor's Note

Picture this: A mid-career therapist—let's call her Alicia—is sitting on a park bench between sessions, trying to stave off a growing sense of panic and confusion. When she's with clients, she's present and attuned, but lately that doesn't feel like enough.

She can guide people to breathe into the emotional pain they carry in their bodies. She can help them build tolerance to chronic stressors. She can introduce them to defusion techniques that distance them from their thoughts. But her caseload is filled with laid-off or furloughed workers, parents trying to make sense of ICE raids at school pickup lines, young adults drowning in the chaos of dating apps and AI chatbots. The fact is, even if all the corrective experiences in the world were piled up around today's clients like protective sandbags, the floodwaters of anxiety and helplessness would still be surging through.

In the past, Alicia has quelled her doubts about her work with a gentle reminder about the power of holding space for people, one individual at a time. She's been buoyed by the fact that despite the frenetic proliferation of new therapeutic frameworks and pick-your-acronym modalities, she's up to speed on her training. But this year has felt different—and she, along with many other therapists, can't quite put her finger on why. Everywhere she goes, there's dysregulation in the air. She and her colleagues feel it. Her clients feel it. Even the White Robot, rushing down the path in front of her and muttering about being late, seems to be feeling it.

Wait, what?

She watches curiously as it disappears down a rabbit hole—err, robot hole—and deciding to investigate, she too goes down the hole, landing in a wonderful albeit strange place we'll call Therapyland.

There, she encounters many of our field's leading luminaries—including Ramani Durvasula, Terry Real, Lisa Ferentz, Deb Dana, Frank Anderson, and Tammy Nelson—and discovers that they're grappling with the same questions she is. Why are we feeling so unsettled? How is it affecting our work as therapists? And what in the world do we do about it?

Alicia's journey in Therapyland is the centerpiece of this issue. While the context is clearly fictionalized (yes, it's a riff off *Alice in Wonderland*, and obviously, there's no such thing as a Cheshire Clinician who dispenses wisdom then disappears into the trees, an Integration Inn providing a respite from our field's many silos, or a Polyvagal Elevator that showcases your nervous systems in psychedelic displays), the conversations in the story are real.

They're taken from exclusive interviews we did this fall that carry on our long tradition (almost 50 years, in fact) of putting our ears to the ground and listening to individual therapists around the country as a way to take stock of where we are as a field. The perspectives these clinicians share—on the personal traumas affecting their lives and the collective traumas shaping their practices—are candid gifts of vulnerability you won't find anywhere else.

Another way we're taking stock of the field in this issue is through our 2025 Best Story Awards. Of the 150+ articles we published this year, on just about every clinical topic under the sun, these winners were chosen by you, our readers. Whether they helped give shape to your unique struggles or provided practical tips you shared with your clients, these are the pieces you told us resonated most with you. And you are the beating heart of this wild, ever-evolving field we call psychotherapy. Congratulations to the winners—as well as the many deserving nominees—for sparking conversation and connection in our community.

After all, we hope Psychotherapy Networker continues to feel like part of your professional home. Here, you can kick off your shoes, put your feet up on the furniture, and nerd out on whatever clinical inquiry piques your interest. Why has energy psychology been at odds with APA's Division 12 for so long? Networker Senior Editor Chris Lyford sheds light on this epic battle, one that raises larger questions about what's "effective" vs. "evidence-based" therapy. How can you help a client who wants a relationship but can't sustain sexual interest, even for partners they deem desirable? Two legendary therapists walk you through their approaches. What is "selfish forgiveness"? Find out why it might be a useful intervention. Want to see the five funniest memes therapists are sharing these days? Discover the deeper issues these snappy graphics reveal.

Our stories are written by you, for you. And while this issue addresses much of the heaviness and confusion in our world today, we hope it also offers some inspiration and whimsy too.

LIVIA KENT · EDITOR IN CHIEF

Psychotherapy NETWORKER

NOVEMBER/DECEMBER 2025

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The Year That Reshaped Therapists - Finding Regulation in a Dysregulated World

18 **Confusion in Therapyland** BY ALICIA MUÑOZ

Ask any therapist: clinical practice this year has felt more complicated than usual, fraught with the chaos and conflict that's permeating our culture. But when an overwhelmed clinician falls down a rabbit hole into Therapyland, her fantastical journey leads her to unexpected interactions with some of our field's leading luminaries, including **Ramani Durvasula**, **Terry Real**, **Lisa Ferentz**, **Frank Anderson**, and **Deb Dana**.

2025 Best Story Awards

READERS' CHOICE AWARDS

We published a lot of stories in 2025—on a dizzying array of clinical topics brought to life by therapists from across the field wanting to share their perspectives and experiences with colleagues like you. Then we asked you to vote on the stories that resonated most. After all, *you* are the heartbeat of our field, and finding out what engages you is a great way to know where we are as a field. Here's what you chose!

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Emotional Freedom Technique (EFT) for Emotional Regulation & Trauma Processing

Robert Schwarz, PsyD, DCEP · LIVE ONLINE · January 21, 2026

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BY CHRIS LYFORD

Energy Psychology's Battle for Recognition

A Growing Healing Movement vs. APA's Division 12

Just minutes into a session with his client Mia, Robert Schwarz does something you won't see in most consulting rooms. He holds both palms open, as if receiving a small gift, and repeatedly bumps the sides of his hands together. At his instruction, Mia does the same.

"I imagine we could just go straight to telling the story," Schwarz says. "But why suffer?"

For Mia, "the story" still delivers a gut punch. Even though it happened decades ago, when she was just nine years old, she has a hard time talking about the time her soccer coach cruelly poked fun at her weight while her teammates stood by and laughed. It's all too much to handle. When Schwarz asks Mia how she usually feels when she thinks about that moment, she hunches her shoulders, shrinks her body, and balls her fists.

"Shame, embarrassment, humiliation," she says, visibly upset. "I feel like I want to hide and make myself really small."

"Right," Schwarz replies, scrunching himself down too in a beautiful but subtle display of attunement. "That sure sounds like shame." He quickly and deftly pivots. "So let's take that memory and stick it in a box," he continues. "Let's not even look at it." He pauses. "But if you were to look at it, how would you rank it on a 1-to-10 scale?"

"A seven," Mia replies.

"So let's start tapping," Schwarz says, beginning the hand-bumping. "We're going to say, 'Even though I'd have this sense of humiliation and shame if I were to look in the box, I deeply love and accept myself.'"

Mia repeats the mantra.

"Now let's tap the top of your head," Schwarz instructs, tapping on his own head with his palm. He slowly moves down his body while Mia follows along on hers. He taps above his eyebrows, then his temples, upper lip, chin, chest, armpits, fingertips, and finally, the back of his left hand.

"Now, close your eyes," Schwarz instructs. "Open your eyes. Look left. Look right. Hum a tune"—Mia obliges, humming "Happy Birthday"—"and take a deep breath." It's a cleansing reset, and Mia's shoulders relax.

"Now," Schwarz continues. "If you were to look in the box, at this moment, what do you think the number would be?"

Mia's response is shocking.

"A one or a two."

Beyond Tapping

It's hard to witness what's just happened between Schwarz and Mia and not think some sort of miracle has occurred. In just 10 minutes, Schwarz has managed to virtually eliminate Mia's trauma symptoms—at least for now. In this moment, she's calm, confident, and ready to engage the problem head-on. Now, she *can* tell the story without getting overwhelmed. But how?

Schwarz says Mia's response is due to the unique method he's been practicing for over 30 years, known as the Emotional Freedom Technique, or EFT. It's a form of energy psychology, or EP, a holistic, integrative approach that views the body as an interconnected system of energy. There are several forms of EP, including Thought Field Therapy, Tapas Acupressure Technique, Comprehensive Energy Psychology, Advanced Integrative Therapy, and Heart-Assisted Therapy, but they're mostly similar.

Drawing from ancient Eastern practices like acupuncture, each involves tapping acupressure points to release

the stress said to be caused by negative thoughts, emotions, and experiences that disrupt the body's energy. Used alongside cognitive therapy interventions that target distressing thoughts or memories, like focused awareness, mindfulness, and imaginal exposure, proponents say EP can be used to treat a range of issues, including depression, anxiety, trauma, phobias, and chronic pain—and quickly reduce symptoms or eliminate them altogether.

You'd think most therapists would jump at the chance to give their client a sevenfold reduction in symptoms, a surge of confidence, or a foothold to begin the hard work of therapy, as Schwarz did with Mia. But not everyone is so enamored with EP. Detractors have called it a pseudoscience, questioned the integrity of its studies and the objectivity of study coordinators, and say any benefits are due to the placebo effect or the other modalities it incorporates. Some of the biggest criticism comes from therapy purists, for whom all this talk of *energy, chakras, biofields,* and *meridians* conjures up the mental image of shamans and spellcasters, not bona fide therapists who follow thoroughly researched protocols and diagnostic bibles.

But EP isn't just some fringe intervention, proponents retort. It's been around for nearly 40 years, amassing a wealth of research and success stories along the way. According to the Association for Comprehensive Energy Psychology (ACEP), EP's leading professional organization, today EP boasts tens of thousands of therapists and has more than 200 published research studies, including 103 randomized control trials, 95 outcome studies, nine meta-analyses, and five fMRI studies. ACEP says these studies not only cement EP as an evidence-based treatment, but place it among the top 10 percent most-researched modalities.

And yet, reads a report on EP published in the journal *Psychotherapy: Theory, Research, Practice, Training,* there are "serious flaws in the methodology of the research. Providers should be wary of using such techniques, and make efforts to inform the public about the ill effects of therapies that advertise miraculous claims." A report from the journal *Clinical Psychologist* accuses EP of operating from "an unsupported and implausible theoretical basis." Clinical psychologist Richard McNally, the director of clinical training at Harvard University's department of psychology, calls it downright absurd. "We wondered whether it was a hoax," he writes of Thought Field Therapy, "concocted by some clever prankster to spoof 'fringe' therapies."

This isolated criticism doesn't rattle EP practitioners like Schwarz. He's heard it all: that EP is a pseudoscience because you can't measure meridians ("but you can," he says), that the energy component is strange ("it's actually not that strange"), that it only works because it's similar to other therapies ("most therapies are similar"), or that EP's studies are flawed ("then why are they all pointing to the same thing?"). But again and again, he says the critics fall into the same trap: "They think about EP too simply," reducing it to its most sensational components, like tapping. Schwarz says his method is actually rich and multifaceted. And watching the process unfold, it's hard to disagree.

As Mia continues to tell "the story" over the next 45 minutes, her distress level rises and falls. She shuffles between a variety of emotions: sadness, humiliation, anger, and annoyance. And throughout all of it, Schwarz stays in the trenches with her: mirroring, validating, guiding, and sometimes gently pushing. When Mia says she feels better but something seems amiss in her voice or body language, like a wince or quiver, Schwarz astutely calls attention to it, names it, and asks her to tap and repeat the mantra once again before reassessing her level of distress.

"This is like when you go to the doctor and they ask, 'Does this hurt? Well how about this?' he tells Mia. "We just want to get this out of your system."

Before long, Mia says her distress level is steady at a one. "The anger's not there anymore," she tells Schwarz. "I just want to laugh now."

"Well, let's keep going," he replies. "If you could've said something to that coach, what would you have said?"

Mia ponders for a moment. "I'd have stood up and faced her," she says defiantly. "I'd have said, 'What the hell are you doing?! Why do you need to embarrass me in front of my teammates?! You don't do that to a kid!'"

Schwarz's face lights up. "That's right!" he says. "'You don't do that! Don't mess with me!'"

Schwarz's pride at this bold expression of courage is palpable, but maybe it's not just the pride that comes from seeing a client reach a breakthrough. Maybe there's something about an underdog finally speaking truth to power—a classic David and Goliath story—that resonates with Schwarz in this moment. After all, it's the kind of fight he knows all too well.

Who's Afraid of the APA?

For energy psychologists, most naysayers are more of a nuisance than an actual impediment to their work and livelihood. But then there are the field's Goliaths—the large, powerful institutions whose decrees can make or break entire modalities. In the psychotherapy world, few Goliaths loom larger than the American Psychological Association's Division 12 task force, which certifies treatments as "empirically supported"—and thereby confers multiple privileges and opportunities upon them, not only boosting exposure and solidifying public trust, but opening the door for funding, insurance reimbursement, training and licensure, and research opportunities. Although it's

difficult to quantify exactly how much money flows to methods Division 12 deems empirically supported treatments (ESTs), between federal and private funding, insurance coverage, and public health initiatives, the number can reach hundreds of millions of dollars.

Throughout its battle for recognition, Division 12 has been a thorn in EP's side. The task force says the modalities on its list of ESTs—which includes CBT, ACT, DBT, EMDR, and motivational interviewing—have undergone rigorous clinical trials and research to determine their effectiveness. Yet despite numerous petitions from ACEP and its allies to get EP added to this esteemed list, with its many research studies in tow, Division 12 has continued to balk.

Tensions came to a head in 1999, when the APA took the unprecedented step of sending a memo to its CE sponsors that singled out Thought Field Therapy as ineligible for psychology CE credit. Before long, the ruling was applied to all of EP, threatening any and all APA CE sponsors teaching EP with the loss of sponsorship status. ACEP appealed the APA's decision in late 2009, but lost. In response, a handful of ACEP's allies, including the Energy Medicine Institute's David Gruder (also ACEP's cofounder and first president) made a direct appeal to APA President Carol Goodheart in an email sent the following spring.

"The APA has been actively restraining the dissemination of the approach for more than a decade," Gruder wrote. "As an outside health advocacy group, it is within our purview to publicly challenge a decision regarding energy therapy that negatively impacts public health." The APA's stance on EP, he continued, "is inconsistent with its own CE Standards, reflects a disregard of interdisciplinary developments, and does harm to the public." Evidence of EP's effectiveness had been mounting, Gruder added, before taking aim at the golden child of evidence-based treatments. "Energy psychology," he wrote, "is arguably more effective than conventional treatment strategies such as Cognitive Behavior Therapy."

Twelve days later, Goodheart emailed a response.

"Thank you for writing and expressing your concerns," she wrote. "I do want to inform you that as APA President I cannot make any changes to the decisions of the Continuing Education Committee." Pressed by an NPR reporter in 2011 about the snub, an APA representative gave a predictably curt response. "The American Psychological Association does not approve or endorse specific therapy techniques," she replied. "We therefore have no policy position on energy psychology." The verdict, it seemed, was final.

But ACEP and its allies continued to gather research, and to appeal. Finally, in 2012, the APA relented and reversed its ban on CE sponsorship for EP courses, noting that the 51 reports submitted, including 18 peer-reviewed randomized controlled trials, met their requirements. EP practitioners were jubilant, and in what seemed like an olive branch, ACEP's practitioners were even invited to teach at APA's annual conference.

Sure enough, the APA's change of heart incensed EP's critics, who began to question the organization's integrity. In 2018, clinical psychologist, professor, and scientific skeptic Caleb Lack, who's devoted his career to studying evidence-based assessment, cried foul over this "failure of the APA" in an article he titled "Energy Psychology: An APA-Endorsed Pseudoscience."

"There is no evidence to support the existence of the human energy field, the manipulation of such a field, or the channeling of 'energy' from one person into another," he wrote. "These concepts are in direct conflict with all that we know about how physics, chemistry, and biology work." The APA's decision, he continued, had been made "despite a complete lack of scientific plausibility," adding that "as one of the more powerful mental health groups in the United States, the APA's seal of approval on energy psychology conveys to many people that this is something that works and is widely accepted by the psychological community." In reality, he wrote, "nothing could be farther from the truth."

Forging onward, ACEP continued to push for inclusion in Division 12's list of ESTs, to no avail. Then came a one-two punch: in February, the APA ratified an update to its Division 12 Clinical Practice Guidelines, adding several new recommended modalities for treating PTSD after omitting energy psychology from consideration. And in September, after commissioning a task force to define "psychological treatment," Division 12 released its conclusion: integrative, somatic, and mind-body therapies—including energy psychology—hadn't made the cut. A request for reconsideration was denied.

Few can argue that psychotherapy needs rules and guardrails. But Division 12 isn't just rule-making, EP practitioners argue: it's gatekeeping. And in the ongoing battle between Division 12 and the EP community, few have been louder about Division 12's stance than therapist David Feinstein, former faculty at Johns Hopkins University School of Medicine, an EP practitioner of over 20 years, and the founder and director of the Energy Medicine Institute. Year after year, Feinstein has doggedly sent applications to Division 12, filed appeals, and challenged the detractors in academic publications.

"We sent Division 12 studies showing that we meet the criteria for being listed—again and again," he says. "We received either cursory responses or no response at all. Meanwhile, APA journals are still publishing articles dismissing EP as a pseudoscience and questioning its ethics. This

is misleading and even slanderous toward a legitimate practice, and it's harming the people who could truly benefit."

Feinstein is likewise fed up with the APA's hot-and-cold attitude toward EP, with having his hopes raised and dashed over and over. "In 2003 I said, 'This year will be the tipping point.' I said the same thing the next year, and the next. It's been discouraging to see the evidence repeatedly dismissed—not on its merits, but because it doesn't fit the institutional mindset."

Schwarz is equally vexed. "It's anti-scientific thinking in the name of science," he says of Division 12's decrees. "These are the forces who believe anything holistic is unscientific. It's the medical model. It's the status quo versus change."

You don't just pick up frustration listening to Feinstein and Schwarz, but exasperation. It's something familiar to any therapist who's reluctantly flipped through their copy of the DSM or breathed a heavy sigh as they scribbled down a diagnosis code just to get an insurance reimbursement. On some level, most clinicians can relate to feeling hamstrung by psychotherapy's powers that be, who don't just determine how we practice, but elevate a select few treatments to an elite status under seemingly mysterious circumstances.

As Feinstein and Schwarz see it, the deck has always been stacked against EP. But with decades of painstaking research and countless testimonials, it seems to be speaking the APA's language and following all the rules. So why is there still so much resistance?

"To be honest, I don't know," Schwarz says. "I can only assume they haven't evaluated the literature, even though it's there. If this was a drug, it'd be worth billions of dollars. The research shows EFT works faster, better, and costs less than many other methods. Frankly, if something came along that kicked its ass, I'd be the first to sign up."

Tapped Out?

Feinstein and Schwarz may have built their careers around energy psychology, but they understand why people are initially skeptical about it. As it turns out, they used to be skeptics too.

"I stumbled onto EP about 30 years into my psychotherapy career," Feinstein says. "At first, I thought it was utter nonsense. I thought tapping on the skin to resolve major psychological problems was patently absurd. But I kept hearing about how quickly people who used it were reporting strong benefits. So I finally looked into it. Once I embraced it, my practice shifted radically. While the approach can stand on its own, I found that I didn't have to throw away what I already knew; EP just helped best practices work faster and more effectively."

"In the beginning, I was very secretive about my interest in energy psychology," Schwarz admits. "It was the energy, the tapping, the woo-woo." As a young clinician in the 1990s, he'd been searching for a way to make therapy faster, more effective, and more affordable. After encountering a live demonstration of EFT at a psychology convention, Schwarz knew he'd found what he'd been looking for. But he kept quiet, feeling like the clinical world wasn't quite ready for it.

"I was struggling with my professional identity and didn't want to be seen as a flake," he explains, "so I didn't tell anyone I was interested." But behind closed doors, Schwarz continued to explore the method. He attended trainings and slowly began to test it out with clients. The results shocked him. "You'd see change *just happen*," he says. "Something would loosen up. The flow of information and energy would shift, and they'd have a totally different take on things."

Schwarz believed in EFT so much that he even used it with his then-six-year-old son, who became extremely dysregulated after walking through a haunted house attraction on Halloween. "He was *flipping out*," Schwarz recalls. "I did a little tapping on him, and 30 seconds later, he was fine!" Emboldened, Schwarz went on to teach EP. Later, he joined the board at ACEP, and then became its executive director, a position he'd hold for 17 years.

Schwarz may be a believer, but he admits that EP needs a rebrand to make it more appealing to more people, contending that the way it was conceptualized and presented to the public 40-odd years ago was flawed. "The language started with the energy and the tapping," he says. "Over the last decade, we've been using less of the e-word and more widely accepted phrases like *mind-body intervention."*

Feinstein agrees that perhaps EP didn't make a great first impression. "Methods like EMDR did research right off the bat," he explains. "Francine Shapiro did it from the start, whereas EP founder Roger Callahan's attitude was, 'Well, you don't really need research. Just try it. You'll see that it works.' His first book, *The Five-Minute Phobia Cure*, was published before there was a single peer-reviewed study supporting the method. That attitude didn't play well with the psychology establishment." Now, with evidence, Feinstein is confident he can sway a sizeable number of therapists on the fence about EP.

"The objection I run into most often is, *How could this possibly work?*—which was my first impression too. Even therapists who are open-minded and persuaded by the research often assume that EP works because of other factors, like exposure or placebo. I've been told, 'As long as the mechanism seems so implausible, I have to find other explanations for these results.' My most recent papers offer a compelling neurological model that makes the mechanisms seem entirely plausible."

Of course, any rebranding will probably have little bearing on Division 12's blind refusal to accept EP's merits, Schwarz adds, which doesn't stem from some particular aversion to EP as much as from a systemic barrier to change. "Division 12 says in order for a treatment to make the cut, it must have been created out of 'psychological science,'" he explains. "But CBT didn't come from science; it came from clinical practice. By these standards, you're eliminating Polyvagal Theory, interpersonal neurobiology, mindfulness, most of behavioral therapy, and anything involving the body. That's crazy."

A Change is Gonna Come

You might think that energy psychology is struggling, that it's destined to live on the outskirts of clinical practice, or that it's something to be pitied. But in reality, the opposite is true. Culturally speaking, EP is leading the pack. Holistic practices have never been more popular. By 2030, body, mind, and energy healing is projected to become a $395 billion market, quintupling in size. According to a national study published in *The Journal of the American Medical Association*, more people are seeking out alternatives to conventional mental health treatment because they're dissatisfied with mainstream options, enjoy the autonomy these methods provide, and see them as more compatible with their values and beliefs. In short, clients aren't just curious about interventions like energy psychology; they're asking for them by name precisely because they're different.

"Lately I've been wondering why we're working so hard to get APA approval," Feinstein says, "because even without it, EP is finding its way into mainstream institutions, from Kaiser to the VA. It's also resonating with the culture. Celebrities are talking about how it's helped them with performance issues or with their fear of heights or flying. You have movies showing tapping. More than 30 countries have used it successfully in post-disaster treatment. I think it's finally reached a tipping point."

Clients aren't the only ones warming up to nontraditional methods. According to a 2024 survey published in *Frontiers in Psychiatry*, 78 percent of therapists say alternative, integrative, and mind-body therapies like meditation, biofeedback, hypnosis, and yoga are *the most promising* form of treatment, and most believe that clinicians should receive training in alternative methods. Meanwhile, the National Institutes of Mental Health and Harvard teaching hospitals like Massachusetts General have added alternative treatments to their programming. Feinstein and Schwarz are seeing this same enthusiasm on their end.

"I've been teaching EP at the Networker Symposium for years," Schwarz says. "Early on, maybe 50 people would show up to my workshop. This year, over a thousand signed up. Something is happening. Something has shifted."

As for the clinicians who feel similarly aggrieved by the dominance of a select few treatments and the exclusionary practices locking others out? They're speaking up too. Prominent psychologist and ACT cofounder Steven Hayes—whose method even made Division 12's list—made a bold prediction about the future of EST gatekeeping.

"For nearly 50 years, intervention science has pursued the dream of establishing evidence-based therapy by testing protocols for syndromes in randomized trials," Hayes writes. "That era is ending."

Slowly, the tide is beginning to turn. But the hard truth, at least for now, is that Division 12's dominance and influence will likely continue, and energy psychology will likely continue to fight an uphill battle when it comes to vying for an EST title. Even so, Schwarz isn't deterred.

"I'm not going to wait for Division 12," he says. "My goal is to make a difference in the world, to treat the plague of trauma and dysregulation. Right now, a lot of people are suffering who don't need to suffer."

■ ■ ■ ■ ■

Evidence-based treatments have their place. And there are therapists and clients alike who won't touch therapies that don't fit the bill. But again and again, studies show that what matters to clients isn't whether their treatment is evidence-based, but rather the distinctly human qualities of their therapists, like trust, empathy, and genuine care. And nobody—not even Division 12—can accuse Robert Schwarz of not caring.

As his session with Mia winds down, her distress levels are low, and staying put. Schwarz circles back again and again to nip any lingering symptoms in the bud, with empathy, incisive questions, tapping, and mantras at the ready. Finally, there's only one thing left for Mia to do: say goodbye to the person who's haunted her for decades.

"Coach was always the first person who came to mind whenever I felt insecure," she says. "Now I can almost visualize her walking away. If she popped up again, I wouldn't listen to her anyway."

"'You've been with me for a long time,'" Schwarz says, offering Mia a template. "'And now it's time to say goodbye once and for all.'" He begins to tap, and Mia follows along.

"'I'm an adult now,'" Schwarz says, "'and I deeply love and accept myself. You're not going to haunt me anymore.'" Mia repeats the words. Schwarz takes a tapping hand off his cheek to wave goodbye to Mia's tormentor, and Mia does the same. A moment later, she smiles softly.

"She's gone now," she says. "No hard feelings." pn

Chris Lyford is the senior editor at Psychotherapy Networker.

BY ALAN DEMMITT & KRYSTEL CHENAULT

Embracing Selfish Forgiveness

HOW TO HELP CLIENTS RELEASE A GRIEVANCE STORY

Q: My client comes into every session bitter and upset about a former friend who betrayed her. How can I confront this pattern without invalidating my client's anger and hurt?

A: Over 30 years, while working with clients in private practice and community mental health settings, I've frequently seen this pattern of clients holding grudges that impede their therapeutic progress. I've also seen how these grudges prevent people from letting go of past harmful relationships or moving on to form new relationships that might help them grow and thrive. I've come to call it the "not-forgiving holding pattern" or as psychologist Fred Luskin called it, a "grievance story," because even though the wrongs suffered by the client are in the past, it's hard for them to move out of the familiar state of feeling emotionally wronged.

Take my client Dan. When he first entered my office, his leg bounced so hard from nervousness that it rattled the glass table next to the sofa. His phone was on his lap. He clicked the home button each time his leg shook. The blue "F" of the Facebook app flashed as he absently locked and unlocked his phone without once glancing down to look at the screen.

"I only check once a day now," he said with a wan smile. "We have mutual friends who comment on the pictures, so it's hard to ignore her feed." At my suggestion, he put his phone on the table but continued glancing at it every few minutes.

Dan sought therapy after his ex-wife Carol gave birth to her first child with her new partner, further cementing the realization that she'd moved on and was finding happiness in a new relationship. Dan was taken aback by the visceral reaction the news caused him. He didn't feel jealousy or romantic nostalgia toward Carol, but any happiness Carol experienced in her life felt like a personal affront. It reawakened and amplified the pain she'd caused him years ago, which had led to the end of their marriage two years earlier.

His resentment manifested in his obsessively monitoring Carol's life. He checked her social media pages multiple times a day, integrating the monitoring into his everyday rituals: scroll-

ing through her Facebook page while drinking his morning coffee, checking again on his lunch break at work, checking while preparing dinner, and again before bed. Dan claimed his hatred for Carol and his desire to see her experience pain in her life without him fueled these behaviors. Alternatively, evidence of an absence of pain—or of the presence of happiness—in Carol's life sent Dan into a cycle of resentment followed by shame. *Why do I care so much about her life?* he berated himself. It was clear she no longer seemed to care about him.

I've seen this pattern of resentment and monitoring in couples and families, and in work I've done as a mediator. As a counselor educator teaching the process of forgiveness to clinical mental health counselor students, I've heard two questions come up regularly: If this pattern is so destructive, why do people engage in it? And why do so many of our clients stay stuck in it for so long? Here are a few common reasons.

It provides a false sense of empowerment. Keeping a relationship in the "not forgiven" holding pattern can feel empowering in the short run. When you choose not to forgive someone, the control of release is entirely in your hands.

It feels vindicating. Any evidence of hardship in Carol's life (e.g. loss of a job, dissolution of a romantic relationship) kindled the schadenfreude that strengthened Dan's sense of self-righteousness. He could tell himself, "See! That's what she gets for being so awful to me. And clearly, I was right about the criticisms, judgements, and accusations I've made about her all these years. She's getting what she deserves." Evidence of hardship can give us the false sense that the offender is being punished.

It provides a false sense of safety. Dan holds on to the belief that not forgiving Carol protects him from being hurt by her again. He keeps his defenses up to stay safe, ignoring the fact that he's living as if he's in a constant state of being under attack.

It shields us from uncomfortable feelings. Engaging in the cycle of checking Carol's Facebook page kept Dan too busy to experience the full grief process. His anger and resentment blinded him to the time he was losing by engaging in these repetitive behaviors.

It provides energy. Often, remaining stuck in this cycle can give us what feels like energy or courage to assert ourselves and our point of view. It can also provide energy to do something when we struggle to find the energy to do anything.

It's easier than the alternative. Many people stay stuck in this pattern because they don't know how to forgive. Some view forgiveness as a religious concept rather than a tool for healthy relationships. For some, the word *forgiveness* itself becomes a roadblock because they think forgiveness means you're agreeing with or endorsing another's behaviors or forgetting the pain you suffered.

Logically, Dan understood that his resentment wasn't hurting Carol. She was living her life, seemingly happy and free without him. Dan was locked in a resentment holding pattern toward Carol, yet it wasn't changing her actions or behaviors towards him. She hadn't reached out to him in years. She hadn't atoned for the hurtful things she'd said and done to him in the ways Dan felt she should. Dan believed this was why he was still suffering.

Dan admitted that he hid his behavior from his friends and family, particularly his mother, with whom he had a close relationship. The situation had also cost him a romantic relationship. When monitoring Carol's social media didn't yield the satisfaction he craved, Dan grew irritable for several hours, sometimes lashing out in anger toward his new partner for small affronts or missteps. Although he felt resentment towards the mutual friends who hadn't cut ties with Carol after the two of them split, he still remained connected to them on social media so he could more closely monitor Carol. He tracked and logged their friendly interactions with Carol and grew increasingly conflicted and bitter towards them.

At the start of one of our sessions, when Dan was beginning once again to list the injustices he'd suffered at Carol's hands, I interrupted him.

"Dan," I said. "Would you mind if we did something a little different today? Something that might help you free yourself from the grip of this resentment?"

"I guess," Dan said, shrugging.

"I know Carol has hurt you badly, and I know you feel like she needs to ask your forgiveness in order for you to move on. But what if there were another way?"

"I wish there were," he said. "But I've tried everything."

"Well, are you open to the idea of forgiving Carol for what she's done?"

Dan's eyes widened. He looked visibly angry with me.

"Are you kidding?" he sputtered. "After everything she's done?"

"Well, in this situation, forgiveness is *not* a way to release Carol from responsibility or restore your relationship. Rather, it's a way for you to let go of the pain and find some peace and freedom."

Initially, Dan didn't want to "let her off the hook." Instead of anticipating relief, Dan feared the emptiness that would be left if he let go of the resentment that had become the most tangible and all-consuming focus of his life.

Forgiveness as Self-Care

At this point, we began to explore forgiveness as a form of *self-care*. I call self-caring forgiveness *selfish forgiveness*, a common term for forgiving someone for your own mental health and well-being. Putting the word "selfish" together with "forgiveness" may seem paradoxical, but a healthy tension results from combining these two ideas. Framing it this way frees a client from any moral obligation to "do good" for abstract reasons. This terminology distinguishes this type of forgiveness from the toxic positivity of a culture that insists we have to forgive to be "good" or "spiritual." It positions a client's

inner peace ahead of social norms that prioritize interpersonal amicability at the expense of the self.

Selfish forgiveness can be defined as letting go of resentment—not to restore an ailing relationship, but for one's own well-being and happiness. It's especially useful in situations like Dan's where one party is absent and/or lacks remorse, thereby rendering interpersonal forgiveness difficult or impossible. If we could remove Carol from Dan's forgiveness process, we might be able to genuinely empower him to move on. He could begin the journey toward finding closure in his post-Carol life, and over time, his well-being would become less contingent on Carol's actions or inactions. The day might even come when he would no longer feel compelled to keep tabs on her.

Selfish Forgiveness and the Stages of Change

When transforming the cycle of resentment into selfish forgiveness, it can be helpful to view forgiveness through the lens of Prochaska and DiClemente's Stages of Change framework. This framework provides a roadmap for the forgiveness process.

In the first stage, *precontemplation,* Dan was either unaware of a problem or didn't see the need to change his behavior because he saw Carol as the problem. In the second stage, *contemplation,* Dan acknowledged that there was a problem and that he was contributing to it. He also grew more open to the possibility of changing his actions at some future time. Dan was in the *contemplation* stage when he sought counseling. He identified his obsessive monitoring of Carol's social media as problematic but could not tangibly envision a future where he wasn't compelled to engage in these actions, which caused him unhappiness and fueled his irritability and sense of helplessness. Dan was more focused on Carol's role in contributing to his actions than on his own sense of agency. At this stage, it felt as if his behaviors were a natural result of her past actions towards him, which left him feeling powerless to change.

Understanding the concept of selfish forgiveness, and the ways engaging in it could free him from suffering, helped Dan move from *contemplation* to stage 3: *preparation.* By reiterating that forgiveness would be *intrapersonal*—meaning an experience that took place within his own psyche—and not something that happened between him and Carol, Dan started planning to change some of the behaviors and actions he'd been engaging in that were harmful to him. *Preparation* is marked by a shift in focus towards one's own behavior along with the formulation of a concrete plan to change. After cutting down the number of times he checked Carol's social media daily from five or six times a day to once daily, Dan resolved to block Carol on Facebook so he could no longer see her page. Taking this step wasn't easy for him, but once he did, it diminished the pain he felt about her past actions by removing the triggers of her posts and their old friends' responses to her posts. This didn't mean Dan didn't still hold Carol accountable for her past harmful actions toward him—he did. It meant he didn't experience the same level of resentment.

When moving out of *preparation* and into the *action* and *maintenance* stages, it's important to move the forgiveness process from an interpersonal focus to changing one's own actions and habits. The shift must support intrapersonal forgiveness and self-care. An *interpersonal* forgiveness process—one that depends on another person's actions and behaviors—can be undone by outside factors such as seeing the person who hurt you in public or experiencing a new partner exhibiting similar behaviors to the ones that caused you pain in the past. When forgiveness is firmly established as an internal process of self-care, however, control stays with the forgiver.

While moving from *preparation* to *action*, Dan was still vulnerable to resentment, even as he resolved to let it go. We employed the metaphor of having a kitchen full of smoke after something had burned on a stove. If this happened, it made sense to grab a dish towel or some other item that would help you fan the unpleasant smoke out of the kitchen. The idea of fanning out the smoke for the sake of the smoke was laughable. Of course, he'd fan the smoke out for himself—not because the smoke "wanted" to be free. He was the one inhaling the smoke. It hurt his lungs, and he wanted to be rid of it. Fanning out all the smoke would take some time and work, and maybe some remaining smoky smell might resurface now and again. But eventually, the air in his kitchen would be clear once again.

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Most changes, including forgiveness, aren't simple or absolute. People in our lives don't fall into rigid, binary camps: "forgiven" or "not forgiven." Forgiveness is ongoing. It happens in degrees. The same is true for the act of forgiveness. Selfish forgiveness requires a reenvisioning of forgiveness as an emerging process that shows up in the behaviors we engage in every day. Do the things we do stoke or reduce resentment? Forgiveness isn't a one-time event that *happens* and is over forever. It *begins*, takes place in fits and starts, and in some situations, may never be completely over. And that's okay.

Dan hasn't yet fully forgiven Carol. He hasn't completely purged his resentment towards her from his heart and mind. But he no longer checks her social media, and he's hopeful that one day he'll be free of the pain their marriage caused him. Author Lewis Smedes once said that to forgive is to learn to live with an uneven score. Perhaps, in the case of selfish forgiveness, to forgive is to embrace the possibility that the score isn't worth keeping if it comes at the expense of your own happiness.

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Confusion in Therapyland

BY ALICIA MUÑOZ

Finding Regulation in a Dysregulated World

It's a cool, breezy afternoon in late October, and I'm quietly hyperventilating on a park bench by my house in downtown Washington, DC. I'd decided to go for a walk between therapy clients (good idea), but then sat down and got seduced into doomscrolling cynical memes and shocking news headlines (bad idea).

After pausing over a donation request to "save our crumbling democracy," I saw an email from my afternoon client: she'd been laid off from her government job and isn't sure how she's going to pay rent, much less continue therapy. I feel my heart start to race and my nervous system collapse into a dizzying tailspin, which has been happening a lot lately.

I switch my phone to airplane mode.

"You'll be fine," I whisper. "Breathe."

Whether you lean left or right, the world feels extra confusing this year—and so does psychotherapy. The modalities I've honed and practiced for decades seem like they're becoming increasingly unreliable. Or is it that people's problems have changed, making the modalities less well-suited to resolving them? When I see desperate clients battling systemic traumas *while* trying to heal childhood wounds, forge healthy relationships, *and* search for work, it feels like I'm offering them droplets of self-care to extinguish massive forest fires.

Or am I just having a therapist mid-life crisis, and it's *me* that no longer fits the modalities or my clients' needs? Whatever the cause, I can't keep stumbling around in the dark like this, stressed out and uncertain about my role and what my next step should be.

Nearby, I see cheerful tourists taking selfies on a scenic walkway. Beyond them, members of the National Guard with M4 Carbines slung over their chests cast steely gazes across the Potomac River. It's an eerily discordant scene. Suddenly, a boxy, white robot appears from under a bush. "Oh dear," it mutters in a mellifluous, AI-generated voice, "I'm late!"

Where did that come from? On an impulse, I follow it along a dirt path that leads to an old canal and clamber down a stone wall, landing with a crunch on a heap of garbage. The white robot tips forward, muttering, "Oh, dear." Then, it vanishes down a hole in the ground.

How odd! I peer into the hole that swallowed the robot. And that's when a powerful suction draws me forward, and everything goes dark.

The Problem with Solutions

As I orient myself to my surroundings, I notice I'm falling through the center of a circular bookcase lined with familiar titles: *Us* by Terry Real, *To Be Loved* by Frank Anderson, *The New Monogamy* by Tammy Nelson, *How to Befriend Your Nervous System* by Deb Dana, *Life Isn't Binary* by Alex Iantaffi. Whatever mysterious land I've stumbled into, seeing books by fellow therapists I've long admired piques my curiosity.

It also makes me realize that despite encouraging my clients to reach out to trusted people in their lives when they feel like they're falling, this year, I haven't checked in with my colleagues much, perhaps because I haven't been able to name and understand the vague, existential dread that's enveloped me. Are other therapists feeling it too? What are their perspectives on this strange year in clinical practice?

On a whim, I reach for a book entitled *It's Not You: Identifying and Healing from Narcissistic People* by Ramani Durvasula. Instantly, my body lurches to a stop, bobbing as though I've reached the end of an invisible bungee cord. In front of me, the bookshelf parts, and I'm in a cozy room with a dark-haired woman seated near a walker.

"Dr. Ramani! What a relief!" I cry out. It's good to see a familiar face, at least one I recognize from all her educational content around narcissistic abuse on YouTube and Instagram. "Everything feels so messed up in 2025. Maybe you can help me understand what's happening!"

She trains her eyes on me. It's clear she's torn about how to respond.

"Things *are* messed up," she affirms at last. "Lately, I've been looking for answers too, reading memoirs by people in the mental health field. What's struck me is that in every one of them, the narrator is telling their story from a place of resolution. By the time you read the book, the problem they've had is gone. Life is good. They're in love, healed, forgiven. The stories we hear and read are always about someone who's no longer in a state of pain—no longer suffering in a living hell. What about the other stories?"

She pauses, extends an arm, and rests it on the walker. I hold my breath, a little stunned to be speaking to her one-on-one, and uncertain about how to reply.

"My mother died suddenly in July," she continues in the articulate, commanding voice I've binge-listened to on so many podcasts over the years. "She was my person—brilliant, generous, kind. And now, I have to take care of my 92-year-old father, with whom I have traditionally had a difficult and complicated relationship. I'm also recovering from hip surgery that isn't healing as fast as expected. My vision is not great because of cataracts. And I'm barely mobile." Her fingers tap the walker. "But I'm also financially responsible for a lot of people, so I still have to see clients and step in front of cameras."

I put a hand to my chest, feeling compassion wash over me as I listen to her story.

"Since I was five years old," Ramani continues, "I've wanted one thing only: time alone with my mother where we didn't have to worry about my father's needs and moods. That will never happen now. What I've feared most—losing my mother, and being tasked with caring for my father—is becoming a reality."

Ramani goes on to describe her situation as the kind of hell most therapists don't know how to validate. It's not only that they aren't attuned to South Asian cultural dynamics or the nuances of intergenerational trauma—it's that, as a field, we're rigidly solution-focused. With clients trapped in impossible situations not of their own making, we tend to give tips, recommendations, medication, and diagnoses: *set better boundaries, disentangle your codependence, develop a meditation practice, maybe you need more help*. It's not that these things are bad; it's that sometimes they're the opposite of what people living in hell really need. In Ramani's view, as a field, we use hope and problem-solving defensively. She's found more solace in writings focused on how to navigate suffering, instead of making it "go away."

I'm stunned by her honesty. I know many more people in this country are finding themselves in impossible situations, devastated by circumstances they can't control. If one of the strongest, most insightful women in our field is struggling with the solution-oriented approaches that define our work, then I don't have to feel so alone in my struggle to meet clients' needs.

"Dr. Ramani, you have no idea how much—" I begin, but before I can share my appreciation, I'm falling again, and she's dropped from view.

Down, down, down.

Thud. The landing, though abrupt, isn't as rough as I expected. In the distance, at the end of a hallway lined with doors, I see the white robot disappear around a corner. Rising to my feet, I head toward it, notice an open door, and duck in.

A Year of Grandiosity

"Welcome," a voice calls out as I enter a spacious study. Silhouetted against a window, bestselling author and Relational Life Therapy developer Terry Real lowers his large blue glasses. "Can I help you?"

I know he's a busy man—a docuseries on RLT is being released soon, and he's getting a lot of airtime on popular television shows and podcasts. "I'm a therapist," I say by way of introduction, "and I think I can say a pretty good one. But this year, I feel lost and nervous. I don't know what to do."

"Here's the thing." Terry pauses. "We therapists are supposed to stay out of politics, right? But this year, we're experiencing the biggest resurgence of the most

nakedly bullying, dominating, misogynistic aspects of traditional masculinity and patriarchy I've witnessed in my lifetime. I don't see what's happening in terms of partisanship. I see it in terms of how it's affecting our clients."

His words bring to mind a client who stopped leaving the house recently. He's on a student visa and lives in fear of ICE deporting him. Another client has found herself, like many teachers across the country, in a stressful legal battle because the current administration's views don't match the historic truths she's been teaching for decades. These people are suffering from depression, sleeplessness, anxiety, and intrusive thoughts, not because of any family-of-origin wound or cognitive distortion, but because of what's happening in governmental structures around them. In grad school, no one said symptoms could be political—but these days, a lot of them are.

Terry explains something he calls "ecological wisdom," the understanding that we're in an interdependent system and cooperating with one another is in our own enlightened self-interest. He's convinced that if we don't switch from a traditionally masculine, autocratic, patriarchal paradigm of dominance and control to the deep wisdom of interdependence and cooperation, we're in grave danger. Somehow, it's relieving to hear him say this.

"As a field, we collude with patriarchy," he continues, "mirroring the culture's individualistic bias, doing trauma work behind closed doors, saying there are no bad parts. There are! We have dominant, sadistic, autocratic parts that do tremendous harm. The devilish thing is, these parts feel good! When the history of humankind is written by superintelligent cockroaches or sentient AI, they'll look back at us and say, 'The fatal flaw of the human species was that grandiosity felt good.'"

"If that's our fatal flaw," I interrupt. "How can therapists change it? We're not crusaders or revolutionaries. We support people. We're nurturers!"

"We're *too* nurturing," Terry counters, as if I've proven his point. "We need to skillfully confront perpetrators. We need to speak truth to power."

Speaking truth to power sounds great in theory, but we learn early on that it's risky, whether in a family, a classroom, a community, or a group of colleagues. That risk grows exponentially greater the farther your identities diverge from those of the groups that hold the most power. As a therapist, speaking truth to power will cost you clients. Even, or maybe especially, in 2025, speaking truth to power has been getting a lot of people fired, blacklisted, harassed, and deported. So although the activist part of me agrees with him, the therapist part of me still feels confused and helpless.

"For therapists," Terry continues as if reading my mind, "relationality is the strongest leverage we have. It's our superpower in the fight against patriarchy."

I feel a weight lift. It's true—we're not just nurturers. We're intimacy doulas, and birth is messy. We help clients mired in pain connect with their true selves so they can show up more authentically and less defensively in relationships. Terry isn't saying anything new, but his words are revelatory. Like my clients, I've been in a near-constant state of low-grade anxiety this year. When we're on guard, waiting for the next major or minor catastrophe, our body braces itself. When we can't soften, we can't connect.

"Listen, you're still young," Terry reassures me. "I've been at this forever. It's your calling now. My hope is to embolden you and then for you—for all of us in this profession—to empower those we touch. Now is not the time to be shy. You know what you know. Own it. Share it. Our secret weapon is one another."

A ringtone fills the air.

"Hey, sorry, I gotta go," Terry says. "Let me know if I can help. Best of luck!"

"Bye," I tell him as I back out the door. "And thank you!"

A Tea Party

As the door shuts behind me, I notice the hallway is gone. The air smells like jasmine, and I hear voices and tinkling China. Half-hidden from view under a canopy of leaves, a table has been

set with floral cups and matching kettles. Apparently, three prominent therapists have taken a break from their busy schedules to attend an unlikely tea party.

Trauma expert Lisa Ferentz, with her blonde curtain bangs and warm but direct demeanor, sits across from sex and couples therapist Shadeen Francis, whose graceful gestures and elegant style give her the aura of a fashion icon. Alex Iantaffi—a trans, queer, disabled family therapist with tattoos peeking out from under his "Be Radically Inclusive" t-shirt—is also at the table. And as I approach, it's clear they're deep in conversation.

"In all my years of life," Lisa muses, "this has been the scariest time. For me, as an Orthodox Jew, the rampant, overt antisemitism has been extremely challenging. And in sessions, if I tell my clients, 'I'm as terrified as you,' I risk a profound shift in the therapeutic relationship. But I don't want to sound disingenuous when I say, 'Don't worry, everything's going to be okay.'"

"I was brought up in Italy," Alex confides. "My grandparents lived through fascism. With my clients, lots of stories are surfacing around historical traumas. As the government takes all these hostile actions toward minoritized people, rolling back protections for existing legal rights, dismantling equity initiatives, defunding essential research, deporting people without cause, my clients are

struggling between choices related to personal safety and their commitment to collective safety. It's hard for them."

The white robot crosses the uneven ground and lifts a tea kettle over Alex's cup, its wheels whirring. Alex shakes his head. "No thanks, I'm good."

"I'm seeing so much dissociation these days," Lisa says. "Because I work with trauma survivors, even though they're adults, they're more inherently vulnerable to getting lost in social media and the digital world, because for them, dissociative coping strategies exert a magnetic pull." Shadeen and Alex nod. "The medicalization of marijuana isn't helping trauma survivors either. It may have a soothing, dissociative effect in the short-term, but it exacerbates problems in the long-term. Paradoxically, you're less likely to engage in self-advocacy or self-protection when you're in a dissociative state, which of course is particularly troubling when it comes to trauma survivors. I've started asking all my clients, 'What's your relationship with social media? How many hours are you online?'"

I stealthily pull my phone out of my pocket and locate "Screentime." My daily average is 3 and a half hours—far more than I assumed. Clearly, I've been using a maladaptive coping strategy. I shake the phone like it's a thermometer giving me the wrong temperature reading.

"I've definitely noticed digital technology luring people away from intimacy and connection," Shadeen chimes in, sipping her tea. "And I've noticed the AI conversation changing. It's no longer about artificial *intelligence*—it's about artificial *intimacy*."

I'm starting to feel guilty about eavesdropping on this conversation from the shadows. But if I appear from out of nowhere, will they question my intentions, or worse, send me away? I tuck myself behind a small nearby tree.

"I've seen my couples clients turning away from each other a lot more, this year," Shadeen muses, sweeping her long black locs off her shoulders. "And not only during conflicts, which is to be expected. They're turning away from each other when they want reassurance, inspiration, sexual arousal, answers—or even just to *chat!* People are doing so much offloading of intimacy that I have to imagine it's robbing their relationships of fuel. And the interesting part is what people are turning *toward:* AI."

"Terry Real says relationality is our superpower," I blurt out, and then immediately regret having spoken. Lisa, Shadeen, and Alex turn their heads, and I step cautiously into the sunlight. My cheeks flush under their collective gaze.

"Join us," Shadeen calls out. "Would you like some tea?"

"I wasn't eavesdropping on purpose," I sputter, lowering myself into a chair. "I'm not even sure where I am."

The white robot tips a kettle over my cup. "It makes so much sense that you're here right now," it confides in a gorgeously nuanced, perfectly modulated, stunningly empathetic voice—as if some Machiavellian pied piper had distilled the sounds of millions of gently authoritative, attuned therapists into one exquisite tone. "But you followed me for a reason. You don't have to be or do anything special here. You can show up exactly as you are."

The robot rolls forward and brushes against my leg. I lean toward it like a sunflower drawn irresistibly toward the sun. It's been a while since I've felt this seen and held…. *Wait, what are you doing?* I ask myself. *You're swooning over a machine! This interaction is fake!* The realization makes me sad but determined to get a grip on my emotional needs and return to the real conversation.

"If I had to give this year a title," Alex says regretfully, "I'd call it The Year of Enforced Resilience, at least within my community. If you're not cisgender, straight, white, able-bodied, and Christian, resilience is your only choice right now."

"Aren't we all seeking to be resilient?" I ask.

"Sure, if it's a choice," Alex responds. "But resilience is also a narrative that's placed on minoritized folks. There's a difference between choosing to take part in a marathon because you want to and being forced into one because you're running for your life."

Alex's description of enforced resilience echoes Ramani's observation about how our field leads with solutions more often than presence. For me, it's a reminder to stay curious and humble, acknowledge the challenge of sitting with suffering, and recognize how tempting it is to pressure clients into action, however subtle. Dropping into a space of shared humanity needs to come first. When was the last time I embraced the vulnerability of being fully present without trying to help, fix, or problem solve?

"With everything that's happening," I say, sipping my tea, "it seems like the focus in our field is going to be even more trauma work." Lisa shrugs and nods regretfully.

"Yes, of course," Alex agrees. "But I've been centering pleasure in my trauma work this year—embodied pleasure." Shadeen indicates her agreement with a *mmmm* sound, and I remember that this is one of her areas of expertise. "When we're embodied," Alex continues, "we can access pleasure, connection, and aliveness in the moment. Not just sexual pleasure, though that's important, too. I'm talking about the pleasure of feeling rain on your skin, petting animal companions, looking outside at leaves changing color, a tender moment with a friend. What's grounding me now is the belief that the purpose of life is life, and the simple, basic joy of feeling alive while I'm alive."

I shut my eyes, taking in Alex's words. A faint effervescence floats through my chest. Is this the stirring of a long overdue experience of embodied pleasure? Is this my way back home?

Integration Inn

"Glad you made teatime." A voice jars me awake. Lisa, Shadeen, Alex, and the white robot are gone. I must have dozed off. "A nice way to share ideas. But that tea can knock you out if you're not used to it."

The voice, I realize, is coming from somewhere over my head. When I glance up, I see Zach Taylor smiling down at me from a tree branch in a pair of snug jeans, converse sneakers, and a linen blazer—his signature look when he MCs the yearly Psychotherapy Networker Symposium, the largest annual gathering of therapists in the world.

"What are you doing up there?" I ask.

"Same thing you're doing down there." He swings his legs.

"I don't know what I'm doing," I say, "other than feeling unsettled in my role as a therapist and trying to find a way forward."

"I've been hearing that a lot," Zach says. "Part of why you may be feeling unsettled is that all kinds of forces are altering the shape of our field these days. The business side of psychotherapy is getting gobbled up by venture capitalists, driving down therapist salaries and quality of care. Plus, more coaches, who can practice without a license, are competing with therapists." I'm interested in what he's saying, but I'm also getting distracted by the transparency of his arms and legs. Did the tea affect my vision?

"I can't see you that well." I lift my hand to block the sun.

"Not only that," Zach continues, unphased by my vision concerns, "a backlash is brewing around psychedelic-assisted psychotherapy." It's not that I can't see him, I realize—it's that, as we continue speaking, there's less of him to see, because he's slowly fading away. "A lot more people are sharing stories of bad experiences on ketamine, psilocybin, and ayahuasca retreats," he concludes ominously.

I feel deflated by Zach's perspective. With more therapists than ever becoming psychedelic guides this year, I'd come to think of psychedelic-assisted therapy as an alternative therapeutic option that's finally getting its day in the sun. Should I be more skeptical? One thing's for sure: this journey—from the circular bookcase to the tea party to chatting with an increasingly transparent Zach—is so surreal that it's kind of like I'm having a psychedelic experience right now.

"Don't go!" I implore as Zach's face and torso disappear. "I have no idea what to do now."

"Check out the Integration Inn," his voice echoes. His smile is all that's left. "Fascinating place. I'll give the innkeeper a heads up." And just like that, his smile goes, too.

I rise from the table and walk along a gravel path. Soon, a building emerges out of the foliage. Above the door, three elongated S's have been etched into a sign dangling from chains. I remember the S's from high school calculus as the symbol for the integration of variables. The door opens onto a foyer furnished with vintage sofas, acrylic end tables, and modern paintings. A brass reception bell rings.

"Greetings!" a man with meticulously coiffed salt-and-pepper hair stands behind the front desk. "Zach just stopped by. He mentioned you're confused about what's changing in psychotherapy this year?"

"Frank Anderson!?" Seeing him momentarily deepens my confusion. "How can a world-renowned IFS teacher and trauma expert also be an innkeeper?"

"They're not mutually exclusive," he laughs. He explains that the inn represents the next wave in trauma treatment: integration. "Would you like a tour?"

The dining room is massive, and the kitchen is state-of-the-art. It has a warehouse-sized pantry flanked by towering spice racks. Frank tells me this place took years to construct and contains every therapeutic modality and approach that's ever existed—too many for a practitioner to use in multiple lifetimes. He's been in the field since 1992, when cognitive behavior therapy and exposure therapy were all the rage, and he's worked closely with Bessel van der Kolk and Dick Schwartz. He's seen trauma treatments explode, like Francine Shapiro's EMDR, Marsha Linehan's DBT, Pat Ogden's sensorimotor therapy, Peter Levine's Somatic Experiencing, Diana Fosha's AEDP, Sue Johnson's EFT, and many others.

"All these wonderful models are essential," he says, cracking two eggs into a bowl, adding milk, throwing in spices from a nearby spice tower, and beating everything together with a whisk. "These models advanced the field of trauma treatment by leaps and bounds." He throws the spiced scrambled eggs into a pan, where they sizzle. "But it's time for integration." Frank slides the eggs onto a plate and passes me a fork. "Try it."

"Unusual," I say, putting a forkful in my mouth. "But tasty."

Frank explains that most therapists gravitate toward a model that fits their personality and then take what they like from other approaches. "I'm interested in operationalizing this process. I want to put these models together in a way that's more client-focused than model-specific. Because one size does *not* fit all when it comes to therapy and trauma treatment."

The sound of the reception bell distracts him from our tour.

"Another guest!" Frank sweeps an arm through the air in what I interpret as a *mi-casa-es-su-casa* gesture. "Feel free to look around on your own."

I exit the kitchen and climb a narrow set of stairs. Up, up, up. The walls, I notice, are decorated with photos in wooden frames. I recognize Pierre Janet, the psychologist who pioneered the study of dissociation and trauma, and Jean-Martin Charcot, a neurologist who investigated how trauma manifests physically. I wonder what they'd make of the times we're living in now, and how we're handling our clients' challenges in the midst of our own. A color photo shows Judith Herman, the researcher who introduced the concept of complex trauma into our field. If I run into her in this place, I'll be sure to ask her.

Fighting Back

"Let me know if you need anything else," I hear a familiar AI voice say as a buttery scent fills the air. The white robot rolls into the hall and tips forward

in a mechanical curtsey.

Tammy Nelson, a couples and sex therapist and the director of the Integrative Sex Therapy Institute, holds a bag of popcorn in a doorway.

"Tammy?" I hesitate. She doesn't seem surprised to see me here. As the white robot disappears down the hall, she gestures for me to follow her inside.

"Popcorn?" She shakes the bag. "It's freshly made."

I nod and enter a large industrial loft. Floor to ceiling windows reveal the sky-

line of downtown Los Angeles. Clearly, we're not at Integration Inn anymore. Tammy pours the popcorn into a ceramic bowl.

"If you're wondering how I'm doing, I'm okay." She points at the TV screen. The volume is turned off, but I recognize the characters from season two of *White Lotus*. "Since the assault, I've been watching every Netflix series ever made."

Tammy's a former teacher and mentor of mine, and I know—as some in our field do—that earlier this year, she was physically assaulted a few blocks away from a conference where she was giving a workshop on trauma treatment. "So, what brings *you* around these parts?" she asks.

"I'm trying to get clarity on all sorts of things about therapy this year. I've taken in a lot of new perspectives, and it looks like you're resting, so I don't want to bother you."

"You're not bothering me," Tammy says. "I don't mind sharing with you that this year has been all about my own trauma healing. I've gone back to therapy. I've been doing a lot of EMDR." She tells me one of the strangest things about her assault was what happened in the months afterward. "Everything we teach about trauma is true," she sighs. "The flashbacks, nightmares, and bouts of agoraphobia. For a while, I'd panic whenever I'd walk down the street and a stranger would approach."

There's a faint whirring just outside the door.

"Deactivate yourself, please," Tammy commands loudly. I hear a metallic bumping sound, like a washing machine switching cycles, followed by a click. "See? I could sense the robot out there, listening. Why is that? Because I've spent my whole life relying on my intuition to survive in the world, as women do. We learn to listen to the voice that says, *Don't go down that street. Don't sit with your back to the door. Don't take that job. Don't go out with that man.* I know from the work I do with clients that after trauma, you question your intuition. *Why didn't I see this coming? Will I ever trust again?* The injury isn't only about trusting another person. It's about trusting yourself."

In this place, the veneers we project onto our public therapy icons seem to have disappeared. Many of us who are early- or mid-career therapists convince ourselves that leaders in the field are immune to the kinds of challenges we treat in clients, or struggle with ourselves. Personally, I know I give lip-service to vulnerability being a precious state that allows for deep human connection, but I've always secretly hoped I'd achieve some kind of optimized human-being status that would shield me from depression and anxiety. Hearing Tammy's story reminds me of the cost of turning people into gurus, and of trying to become gurus ourselves. It disconnects us from real life.

"As that man punched and kicked me," Tammy admits, "a part of me wanted to curl up and let it happen. I felt that deer-in-the-headlights response taking over. But then I was like, *No fucking way*. Suddenly, I was my daughter, and every woman who's ever been attacked and harassed, and every single traumatized client I've worked with. I told myself, *This is* not *happening again*. And even though the assault was bad, it could have been worse. Part of my healing journey has been knowing that I *was* listening to my intuition. I *can* trust my intuition. I *am* strong. I *fought* for myself."

The tremor in her voice stirs my own feelings about being a woman in a misogynistic culture. Although no one can ever be invulnerable to loss, trauma, or pain—not even a vibrant therapist like Tammy—we can all strive to make sense of our reactions to events that hurt us from a place of curiosity, and in a way that helps us organize how we respond.

"It's reflective of a greater patriarchal, abusive energy that's at play in the world," Tammy says. "We need to fight back in a way that's transformative and healing. Sure, most days I don't feel like a warrior. I just want to curl up with a bag of popcorn and watch *White Lotus* episodes. But something is shifting. We always tell people about the healing power of community, transparency, and integration. These things are more important than ever. We're all being called to rise up in our own way."

We've reached the bottom of the popcorn bowl. The effervescence I felt at the end of the tea party has blossomed into something larger, though I still can't quite put my finger on what it is. The sensation feels like a handhold amid my anxiety and confusion about the world. I hug Tammy. She wishes me safe travels.

"Take the elevator," she suggests, pointing to a silver door. "It's quicker."

The Polyvagal Elevator

I step into a glass elevator. Outside, shadowy shapes engulf one another, separating into wobbly strands as new blobs emerge from the darkness. Once I get my bearings, my breath slows down and my body feels colder, as if I'm entering a state of hibernation.

Seated near three large elevator buttons, a woman with silver hair in a dark turtleneck greets me with a nod. The lowest button reads *dorsal*, the middle *sym-*

pathetic, and the top *ventral vagal*. "Before you go home," says the woman, who exudes a steady, calm energy, "I thought you might want to take a ride in the Polyvagal Elevator." As she speaks, I realize she's Deb Dana, the trainer who first made neuroscientist Steven Porges's groundbreaking Polyvagal Theory accessible to everyday clinicians like me.

"Why is my body so heavy and numb?" I ask.

"Dorsal vagal despair," Deb says with the hint of a smile. "I admit, it's been tempting to live here this year. One of the things people have asked me a lot lately is, 'How do I change things that are so unjust in the world?' And the truth is, I don't know. It's overwhelming for me, too. I've had to recognize my limitations."

Since her partner, Bob, passed away two years ago, Deb says she's been struggling to find a new rhythm. One thing that's helped her is focusing on micromoments of joy, which she calls "glimmers." These glimmers are what sustained her in Bob's last year of life.

I've always dismissed the idea of glimmers as another overrated psychological concept without real-world applications, but hearing how they sustained Deb gives me pause. "They're all we have," she says. "When everything feels like too much, they're what I hang on to." This idea of savoring life-giving moments reminds me of Alex's point at the tea party about the importance of experiencing our aliveness. Should small glimmers be a bigger focus in my practice and in my life?

Deb presses the "sympathetic" button, and the elevator speeds up. The greyish landscape of slow-moving blobs explodes. Millions of tiny red thunderbolts shoot through my visual field. Instantly, my body aches, and I feel wary and tense.

"Unpleasant, right?" Deb says. "This year, wherever I went, people were stuck in this kind of activation. You could feel it everywhere. The ripples of dysregulation were getting passed from one person to the next. Across our country, we've got a large group of sympathetically dysregulated people, and another large group in dorsal despair. Imagine hundreds of millions of people feeling some version of these states."

I picture all the people in my life, and in my community, and across communities from California to Maine—and realize we're all just nervous systems pinging off one another. If most of us are either jacked-up or numbed-out, no wonder we feel out of sorts.

"Dysregulation is contagious," Deb says. "The good news is that so is regulation. Some people are actively cultivating ventral regulation, but until that group grows larger, nothing's going to change. This is why, as therapists, helping dysregulated people begins with our own nervous systems—with regulating ourselves first."

We hit a pocket of turbulence, and my heart pounds. What if the elevator gets stuck? What if the walls shatter? It's not easy to regulate yourself when life feels unsafe.

"Don't worry," Deb murmurs, sensing my distress. "This elevator was built to move through different states." The constriction in my chest releases. Even amid the sympathetic maelstrom raging around us, Deb exudes a steady, calm energy. In dorsal, her presence vitalized me, counteracting my body's natural pull to disconnect. In sympathetic, it served as a tether, easing my fight-or-flight response. I'll carry this awareness with me into my everyday life beyond this place: one nervous system can transform another.

"Whether I'm teaching, with a client, or standing in the checkout line at a grocery store, I try to help people feel safe from this place of regulation." Deb lifts a hand and presses it over her chest. "For me, it's become the most important thing. Finding ways to anchor in regulation is what allows us to offer our regulated energy to others. It's amazing the ripple effect that one regulated person can have on their environment."

Deb presses the "ventral vagal" button, and the turbulence subsides. "I believe this is your stop," she says.

■■■■■

I'm seated on the same bench where I had my afternoon panic attack. The breeze has died down. My body feels spacious and expansive. My breathing pattern has changed, and my neck, shoulders, and chest relax. I recognize this state as ventral vagal ease.

Tourists are still taking selfies on the walkway. Members of the National Guard are still gazing out across the Potomac. Everything is the same as it was before I followed the white robot down the rabbit hole, except that the world doesn't feel as completely hopeless and menacing. It's not that my confusion about the future has evaporated; it's that I don't feel like I'm experiencing it alone anymore.

As I get up from the bench, and my thoughts turn toward my next client, the effervescence I've been feeling settles into a kind of sweet okayness—a mix of gratitude and tenderness—that's both ordinary and profound. I'm lucky to belong to a tribe of therapists fighting, each in their own way, for this complicated, broken, beautiful, ever-changing world of ours.

I know it's just a glimmer. But it's one I want to savor.

Alicia Muñoz, LPC, is a certified couples therapist, and author of several books, including Stop Overthinking Your Relationship, No More Fighting, *and* A Year of Us. *Over the past 18 years, she's provided individual, group, and couples therapy in clinical settings, including Bellevue Hospital in New York City. She currently works as a senior writer at* Psychotherapy Networker. *Her latest book is* Happy Family: Transform Your Time Together in 15 Minutes a Day.

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Neurodiverse Couples Therapy

The Truth about Relationships through a Neurospicy Lens

BY KORY ANDREAS

I settle into the corner of my home office, a soft blanket on my lap, a warm mug of afternoon coffee in my hands, and a HIPAA-compliant pair of goldendoodles piled at my feet. Despite the thunder booming outside the window, the three of us are ready for Kevin and Laura, one of many couples I see for neurodiverse couples counseling—a niche I developed after seeing how often traditional couples therapy fails to address the unique communication styles and needs of Autistic individuals and their partners.

Despite the thunder booming outside the window, the three of us are ready for Kevin and Laura, one of many couples I see for neurodiverse couples counseling—a niche I developed after seeing how often traditional couples therapy fails to address the unique communication styles and needs of Autistic individuals and their partners.

Seated directly next to a colorful, floating bookshelf, I open my laptop to start the virtual session. The shelf is an optical illusion, leading you to think my favorite stack of autism-related books are effortlessly defying gravity. In actuality, the support is just underneath the last book, hidden and strong.

"How are your books levitating?" new clients sometimes ask. "Good accommodations" I smile. The shelf serves as a reminder that with the right kind of support, we can all defy the forces that weigh us down.

Kevin is a 35-year-old network administrator who sports a messy ponytail and an affinity for edgy, sarcastic t-shirts. He's blunt, direct, and has a way of launching us into action at the start of each session. Laura is 40, soft-spoken, and works in the HR department of a big government agency. After seeing three different couples therapists in four years, Therapist #4, who suspected Kevin might be Autistic, recommended me. Six sessions of assessment interviews confirmed that suspicion.

Kevin and Laura present like many couples seeking therapy all over America. They want to work on communication. They argue over the dishwasher, money, and sex. They want to feel seen and validated by one another. But no matter how "typical" their issues may be, the neurotypical approaches we've all been trained to offer won't work for

them—and may even be harmful. I see Kevin and Laura as well-suited for one another, although traditional therapy approaches are a mismatch for them.

Many of us in the couples therapy world received our licenses years before the word *neurodivergent* entered our lexicon. Before we said goodbye to the Aspergers diagnosis, and *low-functioning* and *high-functioning* became dirty words, we thought autism was rare. We thought it needed a cure. A quick internet search will tell you that 2.2 percent of adults are Autistic, and 85 percent of neurodiverse relationships end in divorce, but neurodiverse couples therapists will tell you these numbers are wildly inaccurate. Neurodivergence is all around us, and many neurodiverse couples thrive with the right support.

Unfortunately, there are only a handful of specialists in neurodiverse couples therapy in most states, and they're like unicorns in the therapy world. As a result, many Autistic people remain undiagnosed, and their partners remain unaware that they're in a neurodiverse relationship.

I'm Nothing Like Rain Man

As an Autistic adult, having an "identity-based" private practice allows my insatiable desire to read, learn, and talk about the neurodivergent experience to double as a therapeutic tool. While my work is always focused on the needs of my clients, my own experience is, as they say, "in the room." Autistic brains are self-focused, meaning we understand life experiences through our own lens first. Only then can we understand it through the lens of others.

While I'm careful to avoid making sessions about me, with Autistic clients, I feel freer to explore the use of self as a springboard to understanding them than my traditionally trained colleagues, many of whom were warned that this kind of self-referential framing of client's experiences was off limits. For the first time in my professional life, I've found joy and peace in my work. My helping heart and my intense, neurospicy brain work in tandem with people wired like me. And it's deeply gratifying to hear my clients consistently report they feel safer in our work than they have elsewhere in the "real world."

My own path to diagnosis and acceptance of my neurodivergent brain was complicated by my ability to mask exceptionally well, and morph into anyone I needed to be. The 10 years I spent masked with my therapist never uncovered signs of my own neurodivergence. "Client Kory" had trouble with boundaries, a failing marriage, struggles with her neurodivergent kiddo, and a lot of anxiety. As my path as a therapist expanded, and I began to specialize in diagnosis and treatment of Autistic adults, I found the stories I heard from Autistic women regularly left me frozen. My own story was echoed in their traumas, frustrations, and longings.

> "My brain is busy and on fire, replaying, reliving every word I've said, wondering if you thought I was likable, knowledgeable, or real."

Autistic people exist in the extremes of intensity and disinterest. Our creative brains are driven by curiosity and passion. While the focus of this passion differs for everyone, my pattern-seeking brain couldn't ignore the trends that emerged and repeated themselves in my office. My caseload was full of animal-loving, well-read, intelligent, creative types who lost themselves in their interests. Often, they sought therapy with me because they also lost jobs, friendships, and partners simultaneously. I saw myself in their struggles: deeply troubled marriages, discontent with the unwritten rules of the working world, and an internal dialogue buzzing with constant worries. Many of my clients battled lifelong social anxieties, health challenges, and confusing family dynamics—just like me.

My work with Autistic women and gender-diverse clients provided the practice-based evidence that was glaringly absent from the evidence-based practices taught in grad school. It was clear to me that the teachings our field still leans on fail to reflect the broader neurodivergent experience. The more I listened, the more I realized that our unique wiring isn't the problem: it's the world we live in not being built with us in mind.

I'm nothing like Rain Man. I'm nothing like your quirky uncle who never stops talking about trains. But like his, my brain is busy and on fire, replaying, reliving every word I've said, wondering if you thought I was likable, knowledgeable, awkward, or real. Did I talk too much? Why am I consumed with the puzzle of what your face means? I have no idea how I'm perceived. Mirrors and compliments often catch me off guard.

And also, I *am* like your uncle. And my uncle, and your doctor, and your daughter's purple-haired art teacher, and my son's trans best friend. I'm like my grandfather making clocks in the basement—except his clocks are my dogs, my books, my pour-over coffee and my coffee mugs, too. They're also my pizza oven, my photography, and my deep obsession with autism. His clocks are *me,* belting out the

soundtrack of *Waitress* every time I'm alone with my overpunctuated feelings in the kitchen. My clocks aren't clocks at all. They're thoughts you can't see, and my basement is my brain. I'd often like to come upstairs. My "nerding out" is anything but typical. I desperately want the people in my world to see the depths of me, and also, I don't want them to see me at all.

Grelief

Young Kory was a geeky, intense little girl with opinions about everything. I was born fragile and sensitive, the product of two neurodivergent families steeped in poor communication, abuse, and trauma—and who never had the luxury of a diagnosis or support. I was always the first person to launch a northbound hand rocket to "answer town" in elementary school. I spent my youth desperate to be an adult, since adults were the experts. I was certain I knew more than my classmates, and probably my teachers, but even in first grade, I realized it's rude to correct your superiors. *Precocious* is another word for *obnoxious*.

Although my charm lies in my transparency, wit, and ability to respond swiftly while everyone else is still thinking, I quickly learned to bite my tongue and say nothing—which meant I was alone in navigating the rich but turbulent sea of the data, experiences, and intense feelings that regularly flooded my mind. Those of us with neurodivergent brains gradually learn to eat our words, not because we want to, but because the world demands it. Somewhere in middle school, the little girl who constructed her self-esteem out of imaginary play with Barbies, crayons, playdough, and popsicle sticks, turned into a people-pleaser focused on helping *others* feel loved for who they are.

Early on, when I brought up the possibility that I might have autism to my long-time therapist, she was quick to dismiss my data points and told me it was my anxiety talking. I disagreed and sought a second opinion from a diagnostician outside the circle of professionals who knew me.

"You and I both know what we're looking at here," she said. "You're Autistic."

The words I expected her to say hit me unexpectedly like a flash fire. My unresolved trauma sat ablaze in the room between us, and yet a piece of my heart took a sweet breath of relief. There it was: *grelief*.

Grelief is the duo of emotions that commonly follows an adult autism diagnosis. The double-edged sword of discovering that your strengths and challenges are linked to a unique and widely misunderstood neurotype. The *relief* comes from having a definitive cause for years of struggle and miscommunication along with a hopeful treatment plan. The *grief* and pain stemming from years of exhaustion and trauma that went unnoticed, unaccommodated, and misunderstood.

Neurodivergence in Couples Therapy

Kevin and Laura are already on standby in the virtual waiting room when I begin the session. Although they're two years post-diagnosis, the complicated feelings related to the differences between their brains remains a prominent theme in our work.

Like many of my couples, their early relationship was intense. Kevin was charismatic, successful, handsome, great in bed, and "tuned into Laura" in a way no previous partner had been. Laura was immediately taken with him. She'd been Kevin's second girlfriend, and he took their relationship very seriously. Kevin used an excel spreadsheet to track details about Laura that he wanted to remember. He planned date ideas and trips that would light her up. Both were foodies, avid runners, and they loved going to concerts. "It was like a dream," Laura had recalled wistfully.

But something about Kevin changed when they moved in together. "He became unemotional, flat, and checked out at home," as Laura put it. She believed Kevin preferred his hobbies to her. They'd stopped running together and attending concerts. He'd lost interest in sex and seemed bothered when she sought affection or wanted to talk. Whenever she asked him about improving their emotional connection, he'd say, "What does that even *mean?*" He felt connected to Laura already and didn't feel a need to do anything differently, while Laura struggled to feel close to him and be direct when describing her needs because "shouldn't he just know?"

Today, when they appear on screen, the first thing I notice is Kevin's t-shirt, which reads, "Synonym Rolls, just like grandpa used to make." I approve with a giggle.

"Hi, Kevin. Hey, Laura," I begin. "I hope this lightning storm doesn't give us any trouble today. I've had enough of this rain."

Although I know cliché small talk about the weather is often poorly received by my Autistic clients, my anxious brain occasionally defaults to masking with neurotypical scripts. Kevin allows it. He mockingly indulges me with some forced banter. "Yeah, yeah, winter's cold, summer's hot, and rain's wet. How about those Ravens? Anyway. Can we cut to the chase? Spoiler alert, she's pissed at me again."

Kevin's here to get results.

Laura's eyes catch mine and her embarrassment is palpable. She'd prefer a gentler, more upbeat segue into the session and sometimes apologizes for Kevin's abruptness. She's inclined to keep people comfortable, though she's aware I don't need her to do that here.

"Sure, Kevin, let's get right to it," I respond. His blunt approach doesn't faze me.

"I tried what you said, and I asked about her day. You said I'm supposed to ask about her feelings, right? She said her day was 'fine.' Fine's a feeling. So, I thought I did okay and went back to my video game. But she sat down next to me with her arms crossed, just staring at me like I'm supposed to know what that means. So I asked her, "Are you pissed?" She said no, so I told her she should probably tell her face that."

"How did that land?" I ask.

"Worse than I anticipated."

"Laura, was he reading you accurately? Were you pissed at that point?"

In my brain, I hear a deep, booming movie voice over: "Laura was indeed pissed." I keep that to myself.

"No, I was just really sad," Laura says, interrupting my mental movie. "I wanted to talk about my day, and I don't think that's a lot to ask. But then he says all kinds of rude stuff. Kevin has no feelings, and when I do, I'm the monster. It's like I'm wrong because I want him to give a shit about my day. So yeah. *After* his rude comment, I was pissed."

I resist an urge to explain that Autistic people may look like they have no feelings when the exact opposite is true. We'll get there, just not now.

"First you get pissed, then you cry," Kevin responds. His pattern-seeking brain knows this routine with Laura. "She's always mad because nothing I do is enough. She's trying to use emotional manipulation to tell me I'm the problem! If she could just stop making me guess what she wants, we'd be fine."

Laura looks away. She's crying. Her tears tell a story of confusion, and it pulls at my heart. She describes Kevin as "an alien from another planet," but she wants to understand him. She's shared that she knows he's a good man, unlike her absent father. When it comes to her feelings, he can seem self-centered and cold, but he's also the most caring partner she's ever had when it comes to expressing his love through actions. While Kevin's right about their dance of disconnection—first anger, then tears—he's wrong about Laura being manipulative. She's tried to reshape their conflict for years in therapy, and she's losing hope.

An Autism-Centered Approach to Relationships

My caseload is a modern qualitative study of the autism we didn't know existed in our grad school days. My clients don't resemble a single character on *Love on the Spectrum*. They look like your accountant, your lawyer, your daughter's dance teacher, your professor, your therapist, your IT guy, and your local business owner. They're between 18 and 78 years old, and include people from every demographic.

On average, my neurodiverse couples have been seen by six or seven other professionals before finding me on a database of certified neurodiverse couples therapists. They've been misunderstood, misdiagnosed, and mismedicated by well-meaning, seasoned therapists. But even fantastic therapists tend to miss the one key to successful couples therapy for neurodivergent clients: up-to-date training on working with neurodivergent brains.

> "Sex can be entirely absent from many healthy neurodiverse partnerships."

Neurodivergent-affirming care emphasizes psychoeducation on key Autistic traits within the context of relationships. This framework teaches how connection can be defined and redefined, accommodates sensory sensitivities, fosters predictability, and moves beyond date nights and as a panacea for all relational ills. Neurodiverse couples who thrive seem to continually reinvent their connection with a focus on shared special interests. Given they often characterize connection differently than neurotypical partners do, they may need more specific interventions for communication, conflict, and repair than "I-statements" and reflective listening scripts.

Also, gender, sexuality, and relational and sexual normativity are different here. Sex, for example, can be entirely absent from many healthy neurodiverse partnerships. The opposite is also true: many neurodivergent partners can be extremely interested in a "typical" sexual relationship. The middle ground, the gray area, the center of the bell curve that we see in neurotypicals is what's missing here. Sex, and many other factors of neurodivergence, often exist in the extremes.

Neurodiverse couples require interventions that may challenge the basic tenets of traditional couples therapy. The core principles of CBT, for example, need to be left on the therapy room floor. Most Autistic clients aren't holding onto a stream of irrational beliefs. Instead, a lifetime of very real social and nervous system traumas are influencing their thinking.

My client Xander, a 27-year-old creative type, experiences debilitating anxiety before large social events. His partner Mo hates how "antisocial" he can be. A CBT approach would entail an inquiry into whether Xander is irrationally worried about all the "what-if's" that could play out at Mo's work party. An autism-centered approach would focus instead on the frightening realities that many Autistic people *do* encounter in social interactions.

Xander's history of "saying the wrong thing" in social settings has often resulted in public embarrassment. His crushing anxiety about having to talk to new people in groups causes a freeze response, leaving him overwhelmed and unable to communicate. People have always joked he's "a man of few words," but this is deeply embarrassing to him. His need for predictability is activated by social events. He fears not having a safe person to talk to, or failing to recognize people who remember him from previous events. Xander struggles to find food he can eat given his gluten, soy, and dairy allergies. He's quickly overtaken

by exhaustion and sensory overwhelm when an event lasts for two hours rather than one. His worries are real and rational for the "lost generation" of Autistic adults who grew up with no supports.

It's not that Xander hasn't gone to parties and come off as charming and engaged, it's that he'd rather not have to. His energy levels plummet long into the next work week after a party, which doesn't make sense to Mo. What could be so hard about chatting with people, Mo wonders, especially since Xander is capable of doing it? CBT and traditional couples therapy frameworks don't typically address masking or how long it can take a neurodivergent brain to recover from it. They fall short when it comes to centering the sensory needs and accommodations that most social events fail to provide.

How Does that Make You Feel?

Another neurodivergent reality that's missed in neurotypical therapies is that many Autistic people operate *first* in their "thinking brain." They may never experience an internal dialogue or an awareness of what they feel in the moment. Untangling emotions can often only be achieved in a separate, defined step.

"I don't know what I'm feeling when I fight with my boyfriend," said my client Mark, a 35-year-old web designer. "I know I'm uncomfortable, but if you want me to really understand my feelings, I need my therapist, my feelings wheel, and time to unwind the amorphous blob of unpleasantness in my body." Mark needs specific help and time in order to dissect, define, and understand his emotions.

Other clients—like Dre, a 31-year-old nonbinary graphic designer—have a different problem. They're continuously flooded with feelings they can't seem to get away from. "I feel everything: my worry, my partner's embarrassment. I'm sharply aware of people's boredom. I feel their annoyance and irritability, but I can't for the life of me figure out where I went wrong."

Luna, a 40-year-old fiber artist, is a high-masking Autistic adult who internalizes her anxiety and panic about conversations she has with other people. She worries her partner will abruptly leave her due to her trouble showing affection and connecting in intimate ways. Her anxiety touches every aspect of her personal, professional, and relational life. Luna fantasizes about a life where she's less "in her head" and more present. autism-focused therapy would help her normalize these fears and redirect her busy brain toward other, healthier places to hyperfocus. She likes to be reminded that without a positive point of focus, intense thoughts will be assigned to her by her worries. It's a feature, not a bug, of her brain that prefers a flow state, but will settle for a doomsday anxious scenario.

As therapists who support Autistic people, we have to come to terms with a simple fact: we'll never solve their challenges with a neat bow comprised of more mindfulness practices and better communication. But we can use what we know about this neurotype to help them accept their differences and give them the skills they need to build a new framework around their relationships. Sometimes our clients' uniqueness is the very thing we need to focus on to help them get to a better place.

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At 44 years old, I've found peace with my diagnosis of autism and ADHD, and feel safe unmasking within my professional community. Post-diagnosis *grelief* took a hold of me during the first year, when I couldn't imagine a time when I'd tell anyone beyond my husband. My extended family, like many families out there, remains blissfully unaware of the world of invisible disabilities.

They know me as the mask I present in public—and I know that autism is genetic, the glue of "sameness" that brings both greatness and struggle to our enormous family. If they ever become curious about my Autistic identity, I'm open to sharing more about myself with them—but I'm not volunteering the information. The weight of showing my work and "proving it" to adults who are largely still wedged in the generational trauma of missed neurodivergence is too much to take on at the Thanksgiving dinner table.

My current therapist understands this decision. With her, I can unmask without shame. She understands that my brain creates chaos I'm not always equipped to untangle alone. Despite all my years as a couples therapist, an argument with my husband can feel existential and threatening to the bright future my "thinking brain" knows we have together. My therapist reminds me that the wisdom and expertise I bring to client sessions is a product of a regulated nervous system that's easy to have in my comfy therapist chair, but not easy to have in a late-night marital argument.

She never makes me feel diminished by how utterly blind I can be to my own perspective-taking struggles. She has a gentle way of letting me know that not everyone wants to listen to a TED Talk at 5:30 a.m., or has the capacity to process all aspects of a conflict before work, when what I really should be doing anyway is packing the kids' lunches.

I pay my therapist's work with me forward to the people I work with. It turns out that a late-diagnosed, super anxious, overachieving, autism-obsessed, divorced and remarried, imperfect parent can offer a lot of acceptance and unmasked "realness" to her clients.

Kevin and Laura seem to agree. At least twice a month, as our sessions together end, I anxiously stumble through our departing social niceties and hang up an awkward moment too soon. My "Autistic goodbye" is an accidental, vulnerable reminder that I too am a work in progress, right along with them.

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Psychotherapy Networker 2025 Readers' Choice Clinical Challenges

Breaking the Cycle of High-Functioning Codependency

When Helper's High Goes Too Far

BY TERRI COLE

By my early 30s, I'd become pretty skilled at "doing life." Running the New York office of a bicoastal talent agency, brokering high-value deals, and earning the respect of my peers—*check*.

Going to grad school to become a therapist and creating a career that aligned with my values—*check*. Surrounded by awesome, inspiring, drama-free friends—*check*. Getting high on life (sober) for close to a decade and invested in my own therapeutic life and personal evolution—*check*. In a passionate, healthy, and reciprocal relationship with a man I deeply loved and building our family with his three teenage boys—*check*.

For the first time ever, I felt peace and freedom within. My life was both full and wonderful, and I somehow managed to keep all the various balls in the air—that is, until my older sister Jenna found herself in crisis. Then, all my zen went flying out the window.

Jenna had a history of substance abuse and bad romances, but this rough patch was "code red" territory. Ever since she moved in with her abusive, drug addicted a-hole of a boyfriend, she'd been blowing up my phone with SOS calls, eager to relay every detail of his drunken tirades. Their fights had even turned physical. Making matters a million times worse, my beloved sister was completely isolated, living with a jerk in a shack in the woods that had no electricity or running water.

You can understand why my blood pressure spiked every time she called and I'd pick up the phone no matter what I was doing. All that mattered was getting her to safety. I lost sight of my own blessings.

In time, I started to notice a pattern. She'd call with another painful horror story ("he pushed me, he threw me out in a snowstorm, he claimed I flirted with a guy at the liquor store"), and I'd listen, filled with dread and determination. "Let's figure this out," I'd say, offering up every single remedy I could think of. "I have a book on escaping abusive relationships that I've underlined for you and will arrive in your mailbox tomorrow. I found a great therapist for you. I talked to a lawyer who specializes in domestic violence." I begged her to leave him and temporarily move in with me. "Please, Jenna—we have room. You can get sober and into therapy, and life will be so much better." The fix was so simple, according to me. All she had to do was consent.

Every time, she'd thank me for my support and advice, saying, "God, I feel so much better just talking to you. Thank you!" I, on the other hand, did not feel better after our calls. I felt awful. The black cloud of Jenna's toxic environment transferred into my body, making me want to vomit. My emotional hangover would last two solid days.

Have you ever heard the saying, "Alcoholics don't have relationships, they take hostages"? Well, if you've ever loved one, you know how true that statement is. With Jenna and this impossibly bad situation, I definitely felt like I'd been taken hostage. Soon, it felt like I rarely thought about anything else. I was often distracted, ruminating obsessively about Jenna in my determination to liberate her from hell. I was sometimes so fixed in worry that I might as well have been on a different planet.

Then one day, I hung up with Jenna and felt sadness wash over me. Before I knew it, I was leaning with my back against the refrig-

erator, sobbing as I slid down to the floor. *How could my beautiful, funny, strong sister be caught up with such a monster? Why couldn't she just accept my help?* For the first time, I allowed myself to fully experience the profound sadness and grief over this impossible situation.

Something has to change, I thought.

At my next session with Bev, my badass, truth-telling therapist, I was still very tender and teary, but when I started to speak, frustration, fear, and fury came out. "Bev, I've done everything I can think of to help Jenna get out and get help! I've sent her money, offered ten thousand escape plans, but she's not doing *anything*. What am I going to do?"

I hoped Bev would reply with *the* answer of how I could fix Jenna's problems, but instead, she took a long pause. Looking at me with great compassion, she asked, "What makes you think that you know what lessons your sister needs to learn in this lifetime?"

Initially, I rejected the entire premise of Bev's question. Obviously, anyone with an ounce of common sense could see that my sister didn't need to learn any lessons by being abused by a drug-addicted POS. "She could learn those lessons while safe with us, hundreds of miles away from this a-hole, in a home with a functional water tank. I think we can all agree on that!" I exclaimed defensively.

Bev looked me in the eye and said calmly, "Actually, Terri, I can't agree with that. I don't know what your sister needs to learn. I'm not God."

My interpretation of Bev's comment was that it's impossible for us to know what is right for another person—when we don't live in their hearts—and it's self-important and egotistical to presume that we do. This *I-know-exactly-what-you-should-be-doing* belief can be harmful to our own mental well-being, too, as I was slowly learning.

Bev reminded me of how hard I'd worked over the last decade to build a beautiful, harmonious, and functional life for myself. My sister's dumpster fire of a situation—or, more precisely, the fact that she would not leave that blazing mess—was threatening my hard-won peace.

"What you really want is for Jenna to get it together, so that your pain can end," Bev explained.

Wow, I thought. Her wisdom hit me like a freight train of truth. *You are not wrong.*

This mind-blowing reframe immediately brought my self-image into question. I truly believed that my care and concern for Jenna (and the rest of the world) was born out of selfless, Mother Teresa-style love. It had never even entered my mind that my need for Jenna to get the hell out of Dodge was motivated, at least in part, by my desire for my own pain to end. I tried to wrap my head around this distressing and humbling truth: my need to free her was more about me than I'd realized.

Until this game-changer of a revelation with Bev, I had no clue that what I thought was straight up caring was actually soaked in codependency. For any HFC—someone with an overachieving, *I-got-it* version of what I call high-functioning codependency—it's hugely helpful to understand the difference.

I conceived of the term *high-functioning codependency* to describe the flavor of codependency that I see in the majority of my highly capable therapy clients every day. It was also uncannily familiar, because it was what I experienced for years. I define HFC as behavior that includes being overly invested in the feeling states, the decisions, the outcomes, and the circumstances of the people in your life to the detriment of your own internal peace and emotional and/or financial well-being. HFC relationships can include blurred boundaries and imbalanced effort and power, with the high-functioning codependent often taking responsibility for fulfilling the other person's needs and trying to control most aspects of the relationship.

High-functioning codependents are often smart, successful, reliable, and accomplished. They don't identify with being dependent because they are likely doing everything for everyone else. They might have an amazing career, run a household, care for children or aging parents, juggle all the extracurriculars, coordinate the various appointments, and likely life coach their friends through all their problems, too.

Bottom line: the more capable you are, the more codependency doesn't look like codependency. But if you are overextending, over-functioning, over-giving, and over-focusing on others—and doing way too much—these behaviors are compromising your inner peace and well-being. Regardless of what we call it, it's a problem.

And because we are so damn efficient, we make all our overdoing and over-managing look easy-breezy—so no one notices we're suffering.

Unhealthy Helping

Many HFCs are the lovers, the caregivers, the healers, the resident "moms" and "therapists" wherever we go. If you're identifying as an HFC, it's a safe bet that your heart is in the right place, like mine was with Jenna. So, it can be challenging to accept that—despite the best intentions—our codependent actions may be misguided.

Whenever I explore the "codependent versus caring" distinction with clients and students, I inevitably hear, "What's wrong with being nice?" The answer is—nothing at all. In fact, *helper's high* is a legit phenomenon that describes the increased feelings of fulfillment and well-being that arise from lending someone else a hand.

Truly healthy, loving, and appropriate giving can create feel-good vibes all around. However, if you're chronically giving, doing, and over-functioning from a place of fear in order to dictate outcomes, feel valued, recognized, or even loved, that's more dysfunctional and codependent than genuine caring. So much of the time, we can see our helping as just being "nice," but the truth is that there is a tipping point where our compulsion to jump into someone else's situation may be less about their needs and more about our own.

The concept of *unhealthy helping*—"helpful" behaviors that are unintentionally *unhelpful*—was originated by Shawn Meghan Burn, a psychologist, researcher, and the author of *Unhealthy Helping: A Psychological Guide to Overcoming Codependence, Enabling, and Other Dysfunctional Giving*. In exploring the unintended consequences of dysfunctional giving, Burn writes, "Some types of helping and giving create unhealthy dependencies and reduce others' self-confidence, competency, and life skills." So, when we engage in unhealthy helping, we're making others dependent on us and

sending the disempowering message that they don't have what it takes to handle their own business.

Why do we engage in unhealthy helping behaviors? A lot of my clients over the years have said things like, "I see myself as a helpful person—it's just who I am," or, "I like to be needed." Here's the thing: If we are *pushing* our help on someone else, then is it really about them? Or are we doing what *we* need to feel valuable or okay?

Other people have a right to make mistakes, to fail, to flail, to not be doing the things we think they should be doing. To paraphrase Bev, none of us are God.

Compulsive Reactions

So often, as HFCs, we give and help without pausing to consider if we *actually* want to be giving or helping in the ways we feel instantly compelled to. We may simply hook our focus on what's going to help avoid conflict. We are motivated by what we think is best for others, and what's going to cause us the least amount of short-term stress.

Auto-accommodating. Auto-accommodating is a state of hyper-awareness, where you are acutely dialed into what's happening around you, unconsciously scanning for ways to ward off conflict or correct problems, even if said conflict or problems have nothing whatsoever to do with you. It's always being ready to lessen someone's burden or to help, even without being asked. It's an unconscious mechanism, so you may not realize how responsible you're feeling for everything and everyone around you.

Whatever form it takes, acting from unconscious reactions is not acting freely—it's reacting to whatever might be causing us angst in our environment. Resisting this type of reaction is vital to stopping HFC behaviors in their tracks. When the urge to spring into action is so strong we can't not do it, that's a telltale sign that we're compulsively reacting and not acting from choice.

Anticipatory Planning. Another compulsive and draining behavior is anticipatory planning, or trying to prevent anyone from getting upset by arranging situations just so, ahead of time, leaving no detail untouched.

Years ago, I was planning a couples road trip and one of my girlfriends was in a relationship with a challenging personality. I found myself ruminating over all the ways I could preemptively avoid conflict with this person who had a history of ruining our gatherings with their drama. How could I make them more comfortable and meet all their needs so they wouldn't instigate problems or torture my friend? That's called *codependent anticipation.* It encompasses the anxiety (and fix-it behaviors) that precedes a situation where there *might* be conflict.

Fear. Looking back, it's kind of remarkable how much energy I was putting toward my sister Jenna's situation when I also had a full-time job, a newish relationship, and three stepkids who definitely needed my time and attention. But my compulsive behavior came from the sheer terror that something *more* terrible might happen to my sister. My actions were more a desperate bid for control than a healthy expression of my free will to help. But it was also so darn sneaky I couldn't even see it.

Over the years, I've treated and encountered many women at the end of their rope, experiencing exhaustion and other physical conditions, like autoimmune disorders, TMJ, irritable bowel syndrome, and burnout. Nearly all were blind to their compulsive behaviors and sought help to address either their stress-related physical symptoms or a loved one's dire pain. It often took time for them to gain awareness around their emotional pain.

Auto-Advice Giving. The moment someone in your orbit so much as hints at a problem, do you find yourself naturally turning your mental dial to the "fix it" channel and offering grade-A, but unsolicited, advice? This behavior is what I call *auto-advice giving*, a common HFC move. To avoid our unease with someone else's discomfort, we whip out strategies, doctor referrals, sage bits of research-backed advice, and relevant personal anecdotes. Our well of sound solutions runs deep.

But let's consider the following hypothetical example: a colleague confides in you because she's just had a fight with her partner over their future. He wants kids, she doesn't. Instead of listening to her with an open, compassionate ear, you mentally gather your ideas, thoughts, and judgments about what's right for her. As she's about to dissolve into tears, you come up with a plan, "Here's the name of a great couple's therapist. Grab a copy of *The Baby Decision*."

We may not realize it, but when we're automatically citing from *the-world-according-to-me*, we're missing out on some of the richest parts of human interaction, which is the give and take of sharing and listening. In this example, you're seeing your colleague through a reactionary, *must help* lens tinged with your own desires and life experiences. Your colleague is not recognized for her strength or who she might become as a result of her struggle. And you've defaulted to a familiar utilitarian role where your value is only as good as what you can do for others. The real connection can get lost in that stream of excellent advice.

To be clear, this doesn't mean you should never ever again share your thoughts or opinions with the folks in your life. It means you can learn to do so mindfully and with respect for the other person's autonomy.

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When most HFCs start to look under the hood and see that their behaviors are not always motivated only by loving-kindness, it can feel mortifying. But as an HFC in recovery, I can sincerely say that it's better to raise your self-awareness and risk this (temporary) discomfort than to stay in a pattern of behaviors and relating that is stealing your precious peace, time, and well-being. You don't have to be perfect; you just have to be willing to unlearn the disordered behavioral patterns that are not optimal for the life you deserve.

Adapted from *Too Much: A Guide to Breaking the Cycle of High-Functioning Codependency* by Terri Cole (October 2024.) Reprinted with permission from the publisher, Sounds True.

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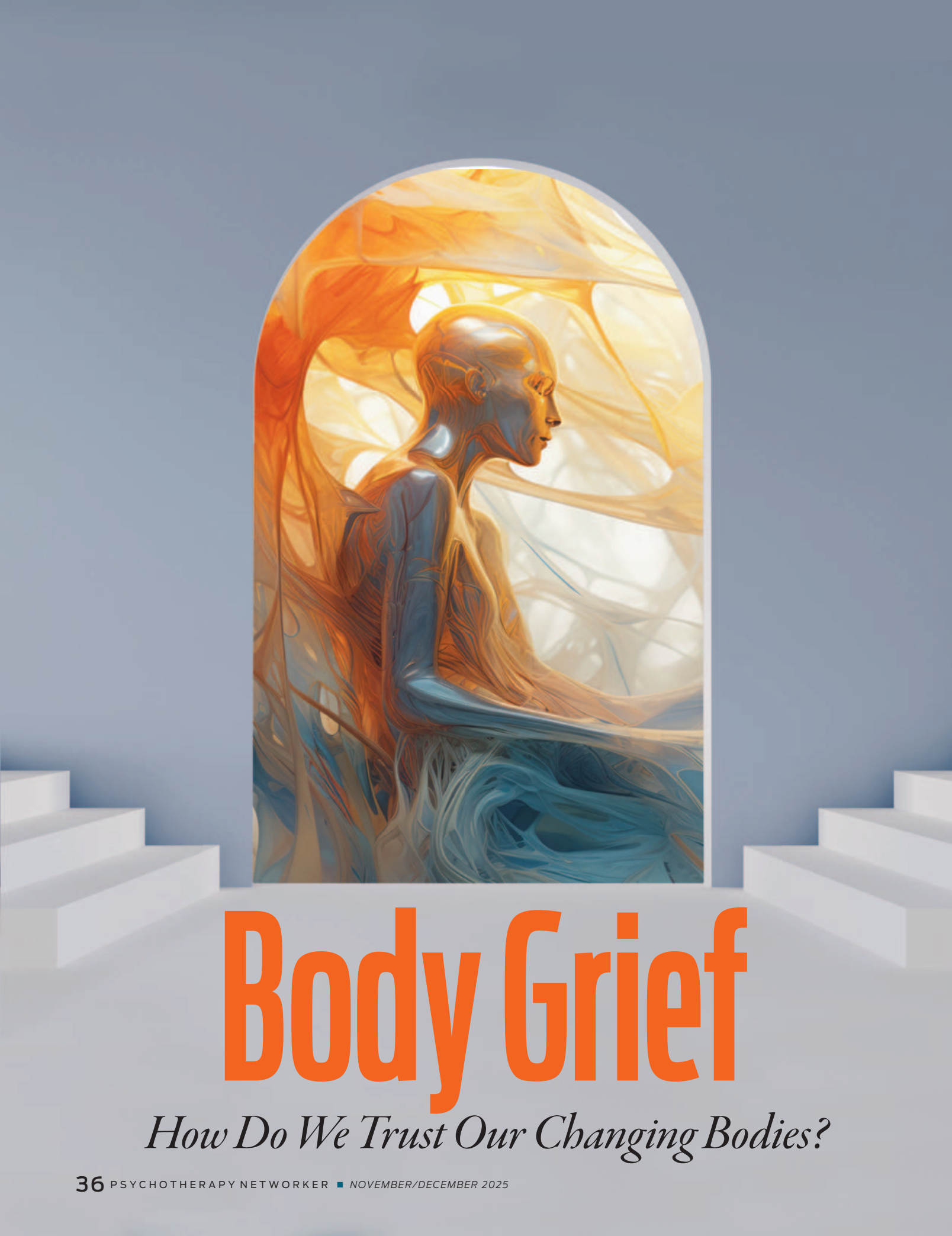


Body Grief

How Do We Trust Our Changing Bodies?

Psychotherapy Networker
2025
Readers' Choice
Grief

BY JAYNE MATTINGLY

In the beginning stages of my chronic illness journey, my internal Dismissal of the seriousness of my condition was validated by External Dismissal from the medical professionals from whom I sought help.

But the dismissal spell broke when I found myself in the ER for the eighth time, and my mom called and demanded to be put on speakerphone to talk to the doctor.

"Jayne has been in and out of the ER for weeks now," she said. "She has a habit of downplaying her symptoms, and because she is young and 'looks good' doctors dismiss her all the time. I am a nurse, I know something is wrong here, and I will not let my daughter leave the hospital tonight. I am worried about meningitis. Do your due diligence!"

The doctor replied, "I mean, I'm always excited to do procedures, and I'd be happy to do a spinal tap to test for meningitis. But I don't think your daughter has that, ma'am. I think she just injured her neck."

I felt myself cringe. Why did my mom have to make a fuss? But I was also angry: Who the fuck did this doctor think he was? I hadn't injured my neck. He didn't know anything about me! Meanwhile, the pressure in my head was so intense, it felt like my eyes were being pushed out of my skull from the inside, like a gruesome scene from *Game of Thrones*. I was achy like I had the flu, and all I wanted was for it all to just stop. I felt like I was dying. In hindsight, I wasn't far off.

Before I knew it, the doctor had snapped on a pair of rubber gloves, assembled his set of shiny, cold, pokey-looking tools, and was asking me to bend over so he could sterilize the area on my back where the needle would be inserted. I was shocked that we were going to do a spinal tap right here in our ER room. As I looked around, I saw a ball of human hair rolling on the ground like a tumbleweed. My gut clenched; this all felt too casual. Wasn't a spinal tap kind of a big deal? But what did I know? I was the patient, and he was the expert, so I didn't say anything.

I was sent home with some Valium, eager to get back to life as "normal." And there it was again: my own Dismissal of my body's wise intuition.

The doctor was acting so blasé about it all, but it turns out he forgot one very important part: to measure the opening pressure of my spinal cord where my cerebral spinal fluid (CSF) was released. This measurement would have shown an increase in CSF, a small but significant detail that would prove incredibly important later on.

When he finished, the doctor said, "All right, I've patched you up. I'll get that tested for you. Just wait here."

Miraculously, as my fiancé Sean and I waited for the results, I started to feel better. The color came back to my face. I could form sentences, and I was even laughing at Sean's jokes. And when the doctor returned, there it was again: External Dismissal. In a smug tone, he said, "Your tests came back normal."

I was utterly confused, feeling both disappointed and relieved. I just couldn't shake how quickly he was dismissing my pain—and yet how excited he'd been to "experiment" on me. But I was feeling better, so maybe it had all been in my head. I was sent home with some Valium, eager to get back to life as "normal." And there it was again: my own Dismissal of my body's wise intuition.

The next day, I saw clients and resumed my usual workout routine. I even went swimming in the pool that weekend (nobody told me you're supposed to wait six to eight weeks before swimming after a spinal tap). "See, I'm fine!" I told

myself. But five days later I couldn't see. Walking was a struggle as my balance was off-kilter, and my pain was at an eight out of ten. By the time I ended up in the ER again, I felt like I was going crazy.

But this time my mom was in town, and she was loud enough and advocated hard enough for me that the hospital brought in the neurosurgery team. I was immediately admitted to the hospital, where I was told that I most likely had a brain tumor, sent up for an MRI, and given another spinal tap, this time checking the opening pressure. The results showed that I did not have a brain tumor and was in fact experiencing pseudotumor cerebri, also known as intracranial hypertension. The excess CS this creates causes pain, loss of sight, nausea, vomiting, loss of balance, and ringing in the ears, among other symptoms I was experiencing. The reason I felt better after the initial spinal tap was that the excess fluid being drained had relieved the pressure on my brain.

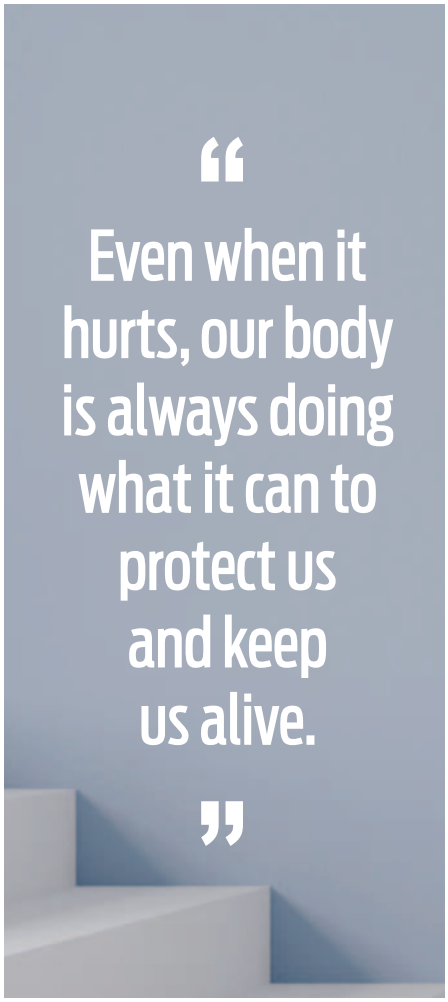
When I finally received my diagnosis, I felt both stunned and validated. All of my symptoms and pain had been real all along, but my own Internal Dismissal had been validated by the doctors' External Dismissal. Like so many of us, I had been silenced, and therefore I continued to silence myself.

Perceived Body Betrayal

My wedding day did not turn out how I'd always pictured it. Both of my parents held me up by my spray-tanned arms as I carefully made my way down the boardwalk aisle and onto the sandy beach, where Sean, and our wedding party were all masked up for our Covid ceremony. Not only did I want both of my parents by my side for emotional support, I needed them for literal support.

In the months prior, I had undergone some of my most serious surgeries to date and begun using a rollator mobility aid. It was the exact same model my ninety-eight-year-old grandmother used. She called it "the Cadillac of walkers," but it felt anything but sporty to me. My body was also bigger than the ones society had told me I must emulate to be the perfect bride: a single-digit size, with perfectly toned arms; a flat tummy; no scars, cellulite, or stretch marks to be seen—and certainly no neck brace! I'd put on a brave face, but if I'm being honest, I was petrified. As a newly disabled bride, not one of the Pinterest boards I'd created or looked at reflected my experience. None. Zero. I had no choice but to just do it my way.

That night, as I danced with my husband—while leaning heavily on the sleek new rollator—I was in pain. I was disabled. I was in love.



Arriving at the rustic driftwood altar, I saw everyone swaying to the Beach Boys' "God Only Knows." Sean's eyes teared up, and for a split second I forgot how much pain I was in. Waves crashed and seagulls cawed, and Gio, our little dog and ring bearer, found a cozy spot to sit in the sand next to my lace train. When I locked eyes with Sean, I saw all the pain, relief, happiness, and hope that had brought us here, and I felt it in my heart. As sappy and rom-com-y as it sounds, with an unspoken "we got this," we really did become one in that moment. Because goddamn—neither of us had signed up for this life.

That night, as I danced with my husband—while leaning heavily on the sleek new rollator my mom had bought me as a wedding gift (which I promptly named Pearl)—and sang at the top of my lungs with my two sisters. I was in pain. I was disabled. I was in love. I was also frightened for what was to come, while grieving what I believed this moment should have looked like.

As happy and hopeful as I was for my future with Sean, this sense of grief followed me as I settled into married life. I found myself grappling with a pervasive sadness and feeling of loss mixed with confusion, denial, and disbelief. We weren't driving off into the sunset like other newlyweds. Instead, we were sitting at home waiting for the arrival of my mobility service dog, and concern for my health was always top of mind. Had we missed out on the "fun years" before we'd even gotten started, and skipped straight to the part where our lives revolved around medical bills and fears about me falling in the shower? I loved Sean so much. But nothing about our union felt sexy or romantic anymore, and my heart was broken.

Like many of us, I am a self-proclaimed doer. I placed so much worth in my ability to get things done, and to get it done well, that grieving the significant loss of abilities that accompanied my diagnosis left me feeling helpless and less-than. I could not see or feel past my pain, and I knew by now that no treatment, medicine, or therapy would fix me. All I knew was that my body would never be able to perform the way it had.

How could the body that had been my home, that I had already helped to heal from my eating disorder, have turned on me? How could it be the cause of so much fresh suffering?

My body has betrayed me, I thought.

This is what I call Perceived Body Betrayal, the narrative that your body has somehow turned "against you." It is the core driver of Body Grief—the sense of loss and mourning that comes with living in an ever-changing body—and what ultimately catapults all of us into a deep disconnect within our bodies and ourselves.

Body Trust

Perceived Body Betrayal is the feeling we get anytime our body changes in ways we are not able to control, does not recover fast enough from any setbacks, experiences pain, or is otherwise unable to perform on demand: that it is somehow against us. This is a maladaptive way of coping with our Body Grief; if what we are experiencing is our body's fault, then we have something concrete to blame. And so we place ourselves at war with our bodies—when what is needed is compassion, grace, and a judgment-free zone in which to heal.

As with Body Grief, Perceived Body Betrayal stems from the societal message that our productivity, looks, and abilities are the primary measure of our worth, when in reality, all bodies of all colors, shapes, sizes, and genders hold equal value, in sickness and in health, and at every life stage. But all bodies are also destined to change, age, and experience different levels of productivity over the course of a person's life. Refusing to accommodate these shifts erodes our innate Body Trust and throws us even deeper into Perceived Body Betrayal.

This is why I say Perceived Body Betrayal, not simply Body Betrayal. Many of us believe that our physical self is separate from our psychological and spiritual self. We often hear things like "Her body is failing her" or "His body gave up on him." And while the underlying sentiment is well-meaning, I have a big problem with the subtext.

Our bodies are not separate from the rest of what makes us who we are, and they are not betraying us—ever. We just perceive they are, based on how we have been told they "should" perform. Our bodies will in fact do everything and anything to find a homeostasis, that is, to find balance, to function, and to maintain themselves. This is, in fact, always our bodies' number one goal.

Sometimes the journey toward homeostasis is not pretty. In fact, it can be incredibly inconvenient, even painful. In my case, my body seeking homeostasis manifested as the swelling, rashes, failed fusions, pain, and body convulsions that were part of my Ehlers-Danlos syndrome diagnosis. For you, it may manifest as fatigue, burnout, anxiety, feeling like you can't get enough sleep, increased appetite, nightmares, or racing thoughts.

But even when it hurts, our body is always doing what it can to protect us and keep us alive. As infants, before we have language, we have no option but to trust in the nonverbal cues our body sends us. Our body lets us know when to eat, when to sleep, when to poop, and when we need a hug—and at that age, that's pretty much all we need to know! But as we mature and language takes over, we discover all sorts of ways to override our innate bodily needs. Rather than taking a nap when we're tired, we caffeinate. Our stomach growls at us, and instead of taking time to sit down and eat a proper lunch, we have another coffee or grab a protein bar on the go. We feel uncomfortable in a social situation, so we chug another glass of wine. We disrupt our Body Trust on the daily, but our body never stops communicating with us. Speaking in both physical sensations and emotions, it signals to us when something needs our attention—be this a physical need or ailment that needs tending to, or when something it wants and needs is being presented to us and it wants us to say yes to it. Body Trust springs from leaning into this mind-body-spirit conversation.

All my debilitating symptoms, which required multiple surgeries to address, were ultimately ways that my body was trying to protect me. But because I had been programmed to believe that a healthy body was pain-free, worry-free, fully functioning, and always happy, I felt like my body was letting me down—when really it was simply fighting to find balance. Part of being with our Body Grief, and growing our capacity to stay in Body Trust, is remembering that our body is always on our side.

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Prior to my clinical training as a therapist, I believed that I would not grieve until I experienced the loss of a loved one. But the reality is, to be human is to experience grief, because grief is intertwined with any and all experience of change. Whether it's a new job, a move to a new city, a divorce from a longtime partner, or recovery from an addiction, regardless of the benefits these changes elicit, they can all induce grief. We grieve for the people we used to be, for the lives we used to live, and for the futures we thought we'd have.

Yet despite grief being our instinctive physical, emotional, and psychological response to loss, society doesn't treat grief as a natural part of the human experience. Instead, it is something to be avoided, pathologized, and compartmentalized. Or, if we can afford it, we learn that grief is best dealt with behind closed therapist's doors. But this only stifles our grieving response, which in turn makes us more prone to stress, deepens our trauma, and exacerbates our emotions.

This is what can make Body Grief so much more complicated, emotionally charged, and hard to navigate. There are very few dedicated forums in which we can openly grieve a death, let alone our own loss of bodily autonomy. Yet our Body Grief is just as big of a grievance as a death in the family; the loss creates just as deep of a wound.

Grief in all its forms wants and needs to be felt and expressed. This is what allows us to heal. With each difficult, messy emotion that is brought to the surface, acknowledgment is how we are able to tend to our wounds.

From This Is Body Grief *by Jayne Mattingly, published by penguin Publishing Group, a division of Penguin Random House, LLC.*

Jayne Mattingly, MA, has a degree in clinical mental health counseling and a background as an eating disorder professional. Her work challenges the toxic narrative that our bodies are broken and reminds us that our bodies have never been against us.

Psychotherapy Networker 2025 Readers' Choice Opinions on the Field

The Venture Capitalist Playbook is Breaking Therapy

Can Clinicians Take it Back?

BY MEGAN CORNISH

For decades, therapy worked a certain, predictable way. The practice of therapy consisted of: a therapist, with a caseload, on a structured path from graduate school to licensure to practice. The models evolved, but the profession itself remained a stable, if not always lucrative, career.

Now, that stability is unraveling, and therapists are feeling it in ways big and small. Caseloads are climbing. Colleagues are leaving. The jobs that once seemed like safe bets, like W-2 salaried roles at mental health companies, or even contractor gigs at large platforms, are becoming riskier, subject to mass layoffs or shifting pay structures. Even solo practitioners are feeling the shift as they watch clients fighting for the insurance reimbursements they were promised, while trying to keep a steady flow of new referrals. There's a real sense that the field itself is tilting in a new direction.

Blaming this change on just one thing would be oversimplifying it. Insurance companies have long dictated the financial realities of therapy, and the pandemic drove demand for mental health care to unseen levels. The introduction of coaching and the increase in societal loneliness are players in this change, too. But one of the biggest forces in recent years has been venture capital.

I want to be clear: venture capital didn't single-handedly create this moment. But it is one of the reasons therapy feels different. And if therapists want to have a say in where the field is going, they need to understand how these financial forces are reshaping the work they do every day.

When Therapists Become a Line Item

One morning in 2023, a therapist I know at a promising, investor-backed mental health platform woke up, logged in for her first session of the day, and found her accounts disabled. No email, no warning—just gone.

By the time she realized she was out of a job, her clients already knew. They'd received a boilerplate email: Their therapist was "no longer with the company," but not to worry—a new one had been assigned. No mention of the trust they'd built. No acknowledgment of the months of hard work. No option to say goodbye.

If I hadn't been following the mental health tech space, I might have assumed this was some bureaucratic mistake, maybe a one-off glitch in the system. But it wasn't. This kind of thing has happened at multiple mental health startups in the past few years. They're not mistakes—they're business decisions.

The Mental Health Startup Boom

When I first moved into copywriting—writing the emails, blogs, and other materials mental health companies use to communicate—after years as a licensed clinical social worker, I was very hopeful that mental health startups could be part of the solution. The system was broken, and these companies promised to fix it—expanding access, lowering costs, and making therapy available to people who had never been able to afford or find it before.

I've met a lot of mental health company founders, and they all start out with good intentions. But once investor funding gets involved, things start to shift. The pressure to grow fast, cut costs, and scale in a way that looks good on paper takes priority. Instead of focusing on continuity of care, clinician support, or ethical business practices, they start optimizing for what investors want to see—rapid expansion, streamlined operations, and a business model that promises big returns. No founder sets out to deprioritize care, but at some point, the demands of profitability start making those decisions for them.

A friend of mine had this model turn his life upside down. He was the top clinical leader at a mental health company that actually prioritized high-quality care, clinician well-being, and strong client outcomes. And it was working. The company was growing, therapists were staying, and clients were getting real, consistent care.

"Most mental health companies start out with good intentions. But once investor funding gets involved, things start to shift."

Then, investors came in. The new executive the investors installed didn't see the point of clinical oversight—literally didn't understand what it was or why it mattered—and didn't bother to ask. So they fired him.

It only took three months for things to start falling apart. Churn was up, therapists were leaving, and clients weren't sticking around. He had flagged these risks before he was fired, and everything he had warned them about was happening.

They hired my friend back to try to undo the damage, but it might be too late. The company is still operating within the model investors pushed for—one designed for rapid growth, not sustainable care. Fixing it would mean making decisions that don't fit the VC investor model, and from everything I've seen, making those kind of decisions isn't how the story of mental health tech companies plays out.

The VC Playbook: Scale, Squeeze, Sell

In 2021, mental health startups raised $5.5 billion across 324 deals. With the pandemic, virtual care exploded, and investors took notice. Suddenly, mental health was a hot market. New companies flooded the space, all promising to "revolutionize mental health" or "democratize therapy."

At first glance, this seemed like a win. More funding meant more access, more therapists, more options for clients. But the money came with expectations.

VC firms don't invest in slow, steady growth. They look for businesses that can scale quickly and generate massive returns. In industries like tech, where a single product can be sold infinitely with little additional cost, that kind of growth is possible. Think, for example, of Adobe or Canva. The initial costs of building this kind of software-as-a-service (SaaS) is high, but then the product can be sold for very little additional cost. Therapy, though, isn't a SaaS product. It's labor-intensive, requires long-term relationships, and doesn't come close to the 70% profit margins that investors expect.

That disconnect set the stage for what happened next. Once venture capital entered the space, companies weren't just focused on expanding access—they had to

expand fast enough to satisfy investors, and they did so using the tried and true VC playbook: First, companies push for rapid expansion, hiring as many therapists as possible and onboarding new clients at an unsustainable rate. Then, when growth slows, they turn inward, looking for ways to increase profitability—cutting therapist pay, increasing caseloads, automating wherever possible. Finally, when it's time to cash out, they make the company look more profitable on paper, even if that means gutting clinical teams and scaling back quality of care.

A therapist I spoke with joined Ginger just as they were merging with Headspace. She was leaving private practice because she wanted income stability and benefits, which her new role provided. But as time went on, the demands escalated. Caseload requirements increased, burnout set in, and the job that was supposed to be a better alternative started to look just as unsustainable as everything else. After that experience, she left the field entirely for several years.

And she wasn't alone. Her story is one I've heard over and over from therapists across the country. Clinicians take jobs at well-funded startups hoping for stability, only to find themselves burning out just as fast, or faster, than they would have in private practice.

This cycle doesn't just affect individual therapists. In the past few years, multiple mental health startups that had made grand promises of fixing therapy have quietly shut down, sold off, or dramatically cut their clinical teams in a bid to stay profitable. The ones that remain have largely made the same calculation: it's more important to please investors than to protect therapists or the clients they serve.

Who Decides What Therapy is Worth?

For therapists hoping to escape the VC model, the alternatives aren't much better.

Venture-backed startups have just started reshaping mental health care in ways that prioritize growth over quality, but insurers have been setting the financial terms for decades. And their incentives are just as misaligned.

Insurance companies don't make money by paying for therapy; they make money by controlling how much therapy they have to pay for. That means keeping reimbursement rates low, narrowing definitions of "medically necessary" care, and making it harder for providers to bill for anything beyond short, standardized sessions.

> "Therapists should always expect that decisions will be made to maximize profits for investors. That's how venture-backed businesses work."

A chief clinical officer I spoke with has spent years fighting to keep clinicians at the center of care while ensuring they're paid fairly. But in the last few months, that fight has become nearly impossible. Payors keep cutting reimbursement rates, making it harder and harder to sustain a model where therapists can afford to stay. As a result, therapists burn out, leave, and access to care shrinks. (Which, I suspect, is exactly the point.)

Stuck between the heavyweights of VC companies and payors, therapists have an impossible choice: take insurance and work unsustainable hours to make a living, go private-pay and risk shutting out lower-income clients, or work for a venture-backed company and accept the trade-offs—lower pay, less autonomy, more burnout.

Why Therapists Have Been Left Without Power

This isn't just a problem of bad employers. It's a profession-wide issue that starts in graduate school.

When you're a therapy student, nobody sits you down and explains how insurance reimbursement actually works, or what to look for in a contract before you sign it. New therapists know all about attachment theory, cognitive distortions, and trauma-informed care, but they rarely know how to negotiate a contract, challenge an insurance denial, or figure out whether a company's business model is sustainable.

That knowledge gap isn't purposeful, but it is convenient. It makes therapists easier to exploit. Companies know that if therapists don't understand the financial side of the industry, they'll accept lower rates, sign contracts with restrictive non-compete clauses, and give up autonomy without realizing what they're losing.

Not only do therapists not like what's happening, they have little recourse. Unionizing isn't a viable option for most therapists because they're classified as independent contractors, making collective bargaining nearly impossible. High turnover makes organizing difficult for therapists who are employees.

It's the same story that played out in medicine, pharmaceuticals, and

law. Private equity firms and corporate consolidations swallowed up independent practices and turned highly paid professionals into low-control employees. Now, it's happening to therapy. The question is whether therapists will fight to keep control.

How Therapists Can Push Back—Without Falling into the Guilt Trap

A lot of therapists have been told the same thing: if you care about access, you shouldn't care about money. It's a useful message for the people profiting off your labor, but it's not true.

For years, therapists have been put in an impossible position. Either you take low-paying insurance rates and overload your schedule, or you go private pay and feel guilty about it. Either you work for a VC-backed company with steady referrals but little control, or you try to make it on your own, knowing you might not be able to afford to see lower-income clients.

The system depends on therapists believing these are the only choices. It keeps labor costs down when clinicians stay in jobs that don't pay enough, accept reimbursement rates that don't cover the cost of care, or take on extra clients just to make ends meet.

One way out is to stop playing by those rules. How?

Step One: Understand the Market

Venture-backed startups and insurance payors don't make decisions on best guesses. They operate within financial models designed to maximize returns—whether for investors, executives, or shareholders. Understanding those models is one of the best ways therapists can avoid being undervalued.

To start, look beyond salary numbers. If a company isn't charging therapists and isn't making most of its revenue from client fees, then who's paying? If a company's main funding comes from employers or insurers, then those are the stakeholders it has to keep happy—not therapists or clients.

Therapists should always expect that decisions will be made to maximize profits for investors. That's how venture-backed businesses work. But if therapists are the primary customers—paying for access to referrals, administrative support, or a network—then the company's success depends on keeping them happy. In those cases, therapists have leverage, because their satisfaction directly impacts the company's bottom line.

> "Therapists don't have traditional labor protections, but that doesn't mean they're powerless. And it doesn't mean they have to fix the system alone."

This means therapists shouldn't automatically distrust companies that charge them fees. In fact, charging therapists directly can be a protective factor. If the money comes from an employer or large insurance contracts instead, priorities shift. What matters is not just whether a company charges therapists, but whether its financial structure aligns with supporting them.

Then there are contracts. Therapists should ask: who really benefits from the terms? Noncompete clauses, productivity quotas, and ownership structures often favor investors and executives over clinicians. If a company is scaling rapidly, what does that mean for workload expectations? If it's paying higher-than-average rates, how sustainable is that model? If a platform keeps its fees low for clients, what's the tradeoff for therapists?

And finally, there's the question of who to hold accountable. Some companies are squeezing every dollar for profit, paying therapists as little as they can while investors collect returns. Others are trying to do the right thing while stuck within an insurance system that dictates how much they can pay. Before blaming a company for its rates, it's worth asking: Is it keeping pay low to boost margins, or is it operating within financial limits imposed by insurers? Who's really setting the rates—the company, the payors, or the investors behind it?

The less secretive this system is, the harder it becomes for companies to sell therapists on bad deals. Therapists don't need to avoid every company that charges them. They just need to ask where the money is going, who is making decisions, and what that means for their work.

Step Two: Leverage Labor—Even Without a Union

Therapists don't have traditional labor protections, but that doesn't mean they're powerless. Collective action doesn't have to mean unionizing or organizing protests. Sometimes, it's as simple as making informed decisions about where to work—and making sure companies know that therapists are paying

attention.

That's the idea behind *The Fit Check for Therapists*, a Facebook group I created where therapists compare pay, working conditions, and company policies. Too often, therapists take jobs without knowing how their rates compare to others or what's buried in the fine print of their contracts. But knowledge is leverage. When therapists can see, side by side, which companies pay fairly, support clinicians, and uphold ethical standards—and which ones don't—companies have to compete for labor.

The goal isn't to expose bad actors but to move therapists toward better ones. When a company that pays and treats clinicians well starts attracting more and more therapists, others are forced to adjust or risk losing their workforce. And when new companies enter the space offering even better conditions, the cycle continues. The power is in the shift of labor flowing toward companies that actually invest in clinicians, forcing the others to either change or sink.

Many industries have forced companies to evolve by shifting labor toward better models. Doctors, pharmacists, and even freelance writers have leveraged transparency and competition to drive up wages and improve working conditions. Therapists can do the same—not by waiting for companies to change, but by making them compete for therapist support.

"The power is in the shift of labor flowing toward companies that actually invest in clinicians, forcing the others to either change or sink."

Step Three: Make Your Work Sustainable—Without Feeding the System

For many therapists, the most practical way forward is to go private-pay. There's a narrative that says it's our duty to sacrifice our financial well-being to help improve access. But the gameplan isn't to vaguely underprice our services in the name of helping. Instead, we should charge our worth and intentionally offer a few sliding scale or pro bono spots.

Of course, this isn't a system-wide fix, but it allows therapists to stay financially stable while still making space for clients who can't afford full fees. More importantly, it stops funneling labor into a system that relies on therapists accepting unsustainable pay.

And I'm going to say the quiet part out loud: if we do this, things will get worse before they get better.

If enough therapists start walking away from exploitative systems, if they start refusing unsustainable insurance rates, if they turn down VC-backed jobs that don't pay enough, access will suffer in the short term. Fewer therapists will take insurance. Clients who rely on those systems will struggle to find care. That's real, and it's painful.

But the alternative is worse.

Because if the field keeps going the way it is—burning out clinicians, underpaying new graduates, making private practice impossible to sustain—access won't just get worse; it will collapse. Therapists will leave, new ones won't enter, and the workforce shortage that insurers and companies claim to be solving will become a full-blown crisis.

That's the real choice. Either access takes a hit now to force payors and companies to change the way they reimburse care and make therapy a sustainable career, or we keep pretending things can go on like this until there aren't enough therapists left to provide care at all.

Therapists don't have to fix this system alone. And they definitely don't have to destroy themselves trying. The system wasn't built for therapists to have power. But that doesn't mean they can't take it back. pn

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Megan Cornish, LICSW, is a writer and former therapist who specializes in copywriting and content for mental health companies. She brings a clinical perspective to mental health communications while advocating for therapists navigating a rapidly changing field. You can find her on LinkedIn, where she writes about these issues and connects with others working to reshape the future of mental health care.

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Psychotherapy Networker 2025 Readers' Choice Relationships & Sex

Why All Therapists Can (and Should) Ask About Sex

BY MARTHA KAUPPI

Tips for Bringing Up a Touchy Subject

Q: Is it essential for therapists to ask clients about sexual issues? I don't want to go outside of my scope of practice, find myself in a conversation I have no idea how to navigate, or make clients uncomfortable.

A: Your concerns are understandable; most therapists don't have much, if any, training working with sex issues. And beyond the lack of training, most of us—clients and therapists alike—rarely experience truly comfortable conversations about sex in our daily lives. At the same time, challenges around sex and sexuality are part of the human experience, and they're often accompanied by a fair amount of distress. Most of us have had to muddle through these issues on our own, contending with shame and misinformation along the way, but what if we didn't have to go it alone?

Most clients are grateful for the opportunity to discuss sex, often reacting like you're throwing them a lifeline when you communicate that sex is a welcome topic in the therapy room. Even if they don't have something particular to discuss, they're usually glad to know they're in a safe space to talk about sex if they ever need to. I'm not speaking solely from my own experience: I've trained hundreds of generalist therapists to discuss sex, and I've heard, over and over again, that clients were much more receptive to the conversation than they assumed.

So, if there's a small part of you that's curious about discussing sex issues in the therapy room, let's lean in. How could you bring it up? And what would you do if it went badly?

Opening the Door

"Is there anything about sex or sexuality you think you might want to discuss in the course of our work together?" I ask this as part of my assessment, right along with questions about anxiety and depression. In that context, I don't think sex needs to be particularly intimidating. You're already asking your clients forthright questions about very sensitive, emotionally charged material. I'll bet that, when you started out, it was challenging to ask detailed questions about suicidality, but you learned how to do it, with some practice. You can reach a similar level of confidence when it comes to asking about sex, too.

> “Sex offers adults a rare opportunity to play—but often becomes so fraught that it feels more like work. Our relationship with sex isn’t static.”

Sometimes my client will respond, “no,” and I’ll say, “That’s just fine. If anything arises, just know you can bring it up here.” I’m not interested in pressuring them, and I’m not invested in what topic we talk about. I see my role here as offering a buffet of conversation topics that are often relevant to therapy.

On rare occasions, you might have a client who says something that indicates a lot of discomfort, some version of, “Oh no, that’s gross, why would we talk about that?” In that case, I’d say something like “Good question! I don’t actually think sex is gross, and lots of people have concerns or questions about it, or distress about it. If that’s you, I’m here for it. If not, that’s fine, of course.”

I’ve never had anyone say, “I think it’s malpractice to ask me about sex. I can’t believe you did it, and I’m leaving now.” If that were to happen, I’d say, “Thank you for your honesty. I’m so glad you spoke up. I didn’t intend to make you feel uncomfortable. I ask everyone about a lot of things, including sex, and we don’t have to discuss it, or any particular topic, unless you want to. One thing I can promise you about working with me is that I’ll honor it when you tell me you don’t want to talk about something, and I really want to know what’s important to you. Would you be willing to consider staying? Are there things you’d like to ask me that would help you figure out if this is a safe place for you?”

You might notice that there’s a common thread here: consent. I introduce the topic as a conversational option, and my client gets to decide if they’re interested in pursuing it. I always seek to model consent in my work, no matter what’s talked about. If a client says they don’t want to talk about something, I might ask why, or what’s coming up for them, but I’ll certainly honor their boundaries, and I’ll let them know that I think it’s important and wonderful that they’re being clear with me about what they want. I strive to be attuned, create safety, reward honesty, and identify options they may not have considered. In nearly every case, this approach results in a strengthen-

ing of the connection between me and my client.

The Cost of Not Asking

The reality is that not asking about sex—though it might feel like a neutral choice—comes with a cost. Many of my individual clients have shared something like, "Thank you so much for being willing to talk with me about sex as if it were a normal part of life. I was able to do a huge amount of healing in a really short period of time because you were so comfortable with the issue." In addition, I can't tell you how many partners I've seen over the years who've told me some variation of this story: "We've been to a number of couples' therapists over the past 25 years, and you're the first one who's ever brought up sex. Now that you mention it, sex has always been difficult for us."

Of course, those therapists probably didn't bring up sex because they were justifiably concerned about respecting boundaries. I respect their caution, but at the same time, I've found that most clients who discuss sex with me don't need a specialist at all. They need a therapist they trust who's curious, interested, and willing to talk frankly about anything that's important to them. They need someone who's willing to walk beside them as they unpack their thoughts, feelings, confusion, early influences, and future aspirations. I believe that could easily be you, the therapist they're already working with.

Much of the work you do in this area will involve dynamics you already have experience with. Your clients will wonder if their experiences are normal, if they're broken, and if there's hope for them. They may wonder if there's a future for their relationship if their partner wants a different type or frequency of sex than they do. They may have a limited sexual repertoire, experience some sexual dysfunction, or have difficulty handling disappointment when sex doesn't go as planned. Commit to a nonjudgemental stance, and use the therapeutic tools you already have in your toolbelt.

When you're unsure of something, it's okay to be honest about the limits of your expertise. It's much more important to be in the conversation than to know the answers, so please don't let the likelihood that you won't know something at some point stop you from talking about sex in therapy.

It would be very powerful to say, "There's so much misinformation about sex that I don't want to make a guess. I think you deserve real answers to your very important questions. Can you think of any steps you could take to get the information you want?" I might encourage my client to look into a topic that interests them, and see what they can learn.

To Refer or Not to Refer

Some of your clients will make great progress on their sex issues through their work with you, particularly if you encourage them to learn more about it. If the progress seems slow or the treatment isn't progressing as you anticipated, I strongly recommend consulting with a sex therapist. The investment will pay off many times over, not just with this case, but with future clients. I consult when the treatment plan isn't moving along as I expect it to. If my consultant thinks there are specialists that could help me be more effective, I consider the pros and cons of collaborating versus referring. Many specialists will feel fine about doing just a handful of sessions with your client, with or without you present, without shifting the bulk of the work away from you.

Keep in mind that there are not nearly enough specialists to work with all the people who have sex issues come up at some point in their lives, because that's pretty much everyone. Most sex therapists will want you to keep your client, because they don't have room in their practice for more than a session or two. If you do need to refer to a specialist, the American Association of Sexuality Educators, Counselors, and Therapists (AASECT) certifies professionals in this area, and has a provider locator.

And hey, you might discover that you love working with sex issues! If so, it's fairly easy to get extra training. You can expand your knowledge base a little and make a big difference for lots of clients. Or you could even expand it a lot and become a specialist.

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Ultimately, sex has physical, emotional, relational, social, and spiritual implications. It's a way many people connect with themselves and their partners, and gauge the health of their relationships, the health of their body, or even their moral wellness. It can be spiritually transcendent, completely casual, a quick release, a way to seek validation, a form of nonverbal communication, a source of shame, an energy exchange, an old wound not yet healed, or something everyone assumes you need to have, even if you have no interest in it at all. The meanings are infinite. This is truly rich material for therapy.

Sex also offers adults a rare opportunity to play—but often becomes so fraught that it feels more like work. Our relationship with sex isn't static. It shifts over time, along with our bodies, lifestyles, relationships, and responsibilities. New sexual challenges emerge continuously, as do new possibilities. Every aspect of sex can be easy as well as incredibly difficult. Sex can be deeply satisfying or leave you feeling lonelier than before. There's so much confusion, misinformation, judgment, and fear about sex that I truly believe you can create a significantly reparative experience for most clients simply by opening a conversation about it and easing the loneliness that comes with all taboo but important topics.

And if you're still wondering if your clients will want to talk about it, all it takes is one question to get started. Give it a try. Let them surprise you.

Martha Kauppi, LMFT, is a therapist, educator, speaker, AASECT-certified sex therapist and supervisor, and author of Polyamory: A Clinical Toolkit for Therapists (and Their Clients). *As a senior trainer of the Developmental Model of Couples Therapy, she teaches therapists all over the world to work effectively with relational intimacy challenges and sex issues.*

Psychotherapy Networker 2025 Readers' Choice Therapists as Clients

The Beauty of Longing & Melancholy

Susan Cain Celebrates the Sensitive Client

BY SUSAN CAIN & LIVIA KENT

In 2012, Susan Cain became world-famous for her bestselling book *Quiet: The Power of Introverts in a World That Can't Stop Talking,* arguably one of the most influential books in the therapy world that's not actually about therapy. With her online "quiet" community that extends across 193 countries and every U.S. state, she's showed that the introverted qualities of thoughtful, low-key people—who tend to get dismissed in our loud, extrovert-centered society—are critical to every system in existence, from families to schools to workplaces and entire global industries.

Now, what has done *Quiet* did for introverts, her latest book—*Bittersweet: How Longing and Sorrow Make Us Whole*—is doing for the wistful, sensitive, misunderstood people among us she calls "melancholics."

In this exclusive interview, Cain talks about her own innate disposition toward melancholy, and her view of sadness and longing not as hardships to endure on the road to happiness, but as deeply spiritual states of being.

Sure, you might say, every therapist knows *all* emotions have something valuable to offer. But let's be honest, how often do you *celebrate* a client's sense of sadness and longing? If your favorite nostalgic poet or spiritual seeker wandered into a modern-day consulting room, what are the chances they'd be diagnosed with anxiety, depression, ADHD, or a dissociative disorder?

As therapists, we're taught to be on the lookout for symptoms of unprocessed trauma, attachment issues, and mental illness. We're taught to wonder if a client is dysthymic or suffering from a depressive episode. And we're taught to be concerned. But as Cain points out,

research shows that the *actual* correlation between melancholy and depression is mild. Just because sadness *can* lead to depression doesn't mean that it *will*. And just because sadness *can* feel heavy doesn't mean it should be seen as a burden.

So if Cain is right—and sorrow and longing are more often linked to transcendence than pathology—then perhaps spirituality shows up a lot more often in therapy than we think.

Livia Kent: How does being melancholy differ from being depressed?

Susan Cain: Melancholy and depression are two separate states. The extent to which the field of psychology makes no distinction between them drives me a little crazy. When I started researching *Bittersweet*, the first thing I did was type "melancholy" into PubMed, and I kept getting articles about clinical depression. Not a single one talked about melancholy as a precious state of being aware of the impermanence of everything and the great piercing joy at the beauty of life that comes with that awareness.

I teamed up with psychologist Scott Barry Kaufman and researcher David Yaden to create a scale that helps people measure where they tend to fall in terms of their state of bittersweetness. We asked questions like, *Do you find joy or inspiration in a rainy day? Do you frequently experience goose bumps? Have other people described you as an "old soul*?"

We found that people who score high on bittersweetness also score high on measures of creativity. They score high on Elaine Aron's construct of being a highly sensitive person. Interestingly, they score moderately high on measures of experiencing states of awe, wonder, and transcendence. Part of why we overlook this is because of the correlation between bittersweetness and anxiety and depression. But it's only a mild correlation, not high at all—and it's not surprising. If you tend to feel everything intensely, you might sometimes tip into a state where that's not helpful to you.

LK: How can therapists help clients value their melancholic states?

Cain: If somebody tends toward melancholy and vibrates intensely with everything life brings to them, we can help them understand that there are times that's not easy. But we can also gently help them understand that they don't have a choice about their fundamental nature. If you're one of those people, you're one of those people. We might help them understand how many gifts come along with that. When I'm vibrating intensely with something negative or with something I'm longing for, I can start with just understanding, *This is who I am*. I can hang out through it and wait for the intensity of the experience to pass. But even while I'm in the depths of it, I can understand that I have this incredible gift to feel things deeply. I can experience a sunset that much more intensely or take the things I observe and shape them into a creative act, or into an act of healing.

LK: Melancholy isn't necessarily sadness. But sadness, too, has an important role to play in our lives. What's the value of sadness?

Cain: If you saw *Inside Out*, you may remember that the two main characters are Joy and Sadness. Well, it wasn't always that way. I gave a talk on introverted employees at Pixar and after we were done, I sat down with Pete Docter—the director of the movie—and he told me that when they first made it, the two main characters were Joy

and Fear.

The production of the movie was already well underway when Docter started having a terrible feeling in his stomach, a sense that the whole movie doesn't work because Fear has nothing to teach Joy. He went into a tailspin and began to envision his career being over. He descended into sadness—and that's when he realized that Sadness should be the core of the movie, because it actually has a lot to teach Joy. Sadness fuels empathy and belonging. Docter knew it was going to be a huge uphill battle to convince the executives at Pixar why Sadness of all things should be a main character—because no one wants to be sad—but he was able to portray life as just that: joy and sorrow, beauty and despair.

I'm guessing many therapists wouldn't have gone into the healing professions without the wish to help clients discover new ways of exploring the full depth of life. It's that full-spectrum expression that can help people heal, that gives us permission to experience sadness and cry.

LK: You link melancholy with our longing for beauty. Is there a link between spirituality and melancholy?

Cain: I say this as a lifelong atheist-turned-agnostic, but I believe we come into this world in a state of longing for the more perfect and beautiful world we just left. This could be the perfect harmony we experience in our mothers' womb, or a perfect and beautiful realm we were once a part of. You see this in all of our religions. We were once in Eden, and then we long for Eden. We were once in Zion, and then we long for Zion. The Sufis call it "the great longing for the belonging for the soul." Then we have secular manifestations of the same great longing. In *The Wizard of Oz,* there's a longing for somewhere over the rainbow. This longing is the great essence of every single human being. When we see something beautiful, what we're seeing is a manifestation of the perfect world we want to be a part of. We experience a thrill at the majesty of it. We also recognize we're only catching a glimpse of this world—which is why we feel sad.

LK: Therapy often focuses on helping clients get what they want. Are we too quick to discount the value of longing over having?

Cain: In our culture, we tend to think of longing as a disabling emotion, something that holds you back from being who you should really be, but I believe longing is momentum in disguise. In Old English, longing literally means "to grow longer, to extend, to be reaching." Great acts of creativity arise from a longing to see something beautiful. Every single creative person will tell you they have a shimmering image of perfection they're aspiring to. A writer will have the idea of the perfect manuscript they will produce, even though they know from day one they'll never produce anything half as perfect as what they have in mind. But they still reach for it, and there's joy in that.

LK: Clearly, there's stuff we can all change about our lives, but we can't change the inevitability of loss.

Cain: One of the great Japanese Buddhist haiku masters was Issa. He had a very difficult life. His first child died and then he had this baby girl, shining and perfect, and he loved her with all of his being. Then she, too, died of smallpox. And he wrote this poem: "This world of dew is a world of dew, but even so, even so."

This poet deeply understood the Buddhist principle of impermanence, and it's clear in these words that he still struggled to accept it at times. That's what he's saying in the line "but even so." Grief, loss, and impermanence are a great gift; they might not be the gift we want, but we're all in this mysterious mix of loss and beauty together—and that's beautiful.

LK: What do you most want people to take away from your work?

Cain: There's a whole realm of humanity that exists in the space that I describe as the quiet, the sensitive, the melancholic, the beauty-seeking. I'm guessing a huge percentage of therapy clients exist in this realm. I'm guessing a lot of therapists do, too. It's so important to remember the beauty of that realm. If you really know it, you know it in a deep-down way.

There's this centuries-old archetype of the wounded healer, which I see so acutely in the work therapists do. This comes from the Greek myth about the wounded centaur Chiron. Because he was wounded and in pain, he had the ability to heal others. There's something in us as humans that can do this. After 9/11, we had a record number of people signing up to be firefighters. During the height of the pandemic, we had a record of number of people signing up to be doctors and nurses. A woman whose daughter was killed by a drunk driver started Mothers Against Drunk Driving. There's something in humanity that has this impulse to take our darkest depths and turn them into something meaningful.

So maybe the pain you can't get rid of is your creative offering, your healing offering to the world.

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

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

Psychotherapy Networker 2025 Readers' Choice Practice Tips

"I've Got NOTHING to Talk About"

How to Work with Tight-Lipped Clients

BY JANINA FISHER

BRITT RATHBONE

STEVE SHAPIRO

KIRSTEN LIND SEAL

Challenges with clients come in all shapes and sizes. Some clients are so chatty you can't get a word in edgewise—not to mention a helpful therapeutic suggestion. Others are consistently grumpy or invariably nervous. But one of the most common issues any type of client might present is when they sit down for a session and announce: "I have nothing to talk about today."

You may know how to work with depression, anxiety, anger, and grief, but how do you work with "nothing"? What do you do when your insightful questions, expert techniques, and earnest attempts to connect elicit only shrugs? Let's be honest: sometimes 50 minutes with these clients feels like pulling teeth.

Fortunately, there are ways to make headway with clients who have "nothing to talk about." There are ways to jumpstart conversation, do deep work, and make your time together less painful. To find out how, we consulted a few seasoned experts who've been in this quagmire—and found their way out of it.

Read on to see how DBT expert Britt Rathbone, international trauma expert Janina Fischer, Experiential Dynamic Therapy teacher and a founding member of the AEDP Institute Steve Shapiro, and MFT and ethics professor Kirsten Lind Seal take on this issue.

Welcoming the Client's Two Sides

International trauma treatment expert Janina Fisher, author of Transforming the Living Legacy of Trauma, says that when a traumatized client declares, "I have nothing to talk about," the therapist needs to pay close attention.

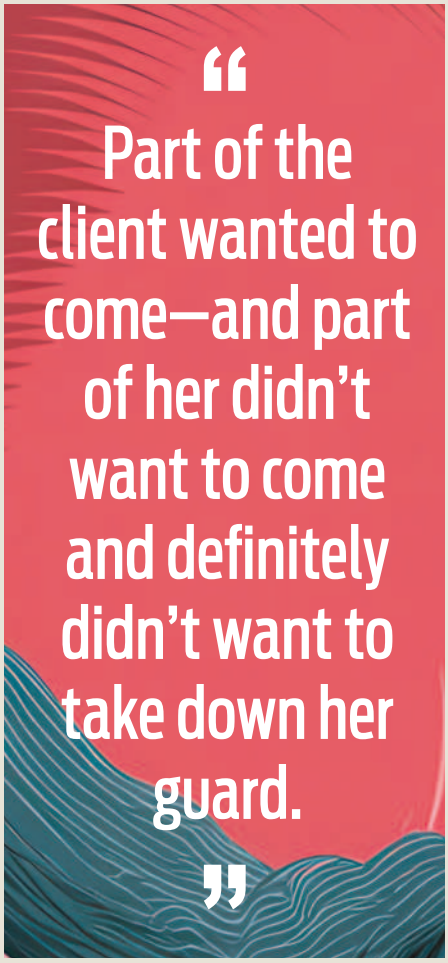
She notes, "What they're really saying is, 'Don't make me talk about it. I'm afraid I'll start to feel overwhelmed.' I usually laugh when I hear, 'I have nothing to talk about.' Then I say, 'Would you tell me if you did have something to talk about? Or does 'nothing to talk about' mean there's nothing you want to talk about?' Then I'll laugh again gently to communicate that there's no judgment attached to their fear of talking about painful emotions."

Fisher says she also reassures clients that there's never any pressure to talk or bring an issue to therapy—it's fine not to have an agenda. "I'll ask, 'What would you not want to talk about? Let's start there. That way, I'll know to what to avoid.'"

She adds that it can be tempting to disengage in these moments—to join clients in their passive resistance. "You might feel like saying, 'Well, then why did you come?' But over time I've learned that 'I have nothing to talk about' implies an internal struggle. Part of the client wanted to come—that's why she's here—and part of her didn't want to come and definitely didn't want to take down her guard.

"The therapist's job is to welcome both the reluctant part that has nothing to say and the part that wants my help and connection. I do that by saying, 'Well, thank you so much for coming anyway, and my thanks to the part of you that let you come. That was very generous!' Or I might joke, 'Many people would love to change places with you because they have too much to talk about and not enough time. They'd love to have nothing to talk about!' Or I'll ask them, 'How does nothing to talk about feel? Does it feel liberating? Or numb? Or fuzzy?'"

Fisher says she had a client who, for two years, began every session by sitting down and saying, "I didn't want to come today, and I have nothing to talk about." They'd always manage to engage by the end of the session. And when Fisher asked, with some trepidation, "Do you want to make another appointment?" the client would look indignant and say, "Of course I want another appointment. Did I give you reason to doubt that?"



Empowering the Client

Clinical psychologist Steve Shapiro, a certified Experiential Dynamic Therapy teacher and a founding member of the AEDP Institute, says "Engagement is difficult for all human beings, but for those with a trauma history, it can feel like being invited to touch a hot stove."

In therapy, he explains, not only do clients learn about how they relate, but also about how their longstanding emotional patterns—like avoidance—can be enacted without their awareness. "If we accused a client of being 'unmotivated,' she'd most likely say that for reasons unbeknownst to her, she 'just can't think of anything to talk about.' And she might be right. After all, motivation is intentional; resistance is unintentional.

Although it might be tempting to think there's intent behind the client's resistance, this could create a polarizing dynamic that keeps her conflict buried and perpetuates her suffering. But if, with our help, she sees the internal conflict, then we empower her to make a choice between that resistance and the healthy alternative."

Shapiro says that even if clients say they don't have much to talk about in therapy, it's important to remember that the simple fact that they showed up reveals motivation in and of itself. He explains, "The therapist could make this explicit by saying something like, "You don't know what to talk about and you came here to take a more active role in getting your needs met.' At this point, the therapist can allow her to struggle with that in silence, and have her response guide the next intervention."

Exploring the Silence

Over nearly four decades of practice, Dialectical Behavior Therapy expert Britt Rathbone has seen his fair share of tight-lipped clients while working with young clients and their families. The coauthor of Parenting a Teen Who Has Intense Emotions, Rathbone says he likes to remember that "behavior always makes sense in the context in which it occurs."

When a client says they have nothing to talk about, Rathbone

says his goal is to "get clear on what's factoring into their silence or lack of direction. Assessing whether it's an angry silence, an unmotivated silence, or a hopeless silence is a good starting point."

To get there, he first asks the client how they felt about coming to the session. "Was there a conflict with someone on the way? Is our time together taking the place of something else they'd rather be doing? Are they upset with me or the therapy itself?"

Whatever comes up, Rathbone says it's important to validate that feeling. For instance, with a teen who'd rather be anywhere but his office, he suggests saying something like, "It makes sense you don't want to talk today, given that you're irritated you're here instead of hanging out with your friends."

Rathbone says that when his adolescent clients come in saying they have nothing to talk about, which is often, it's an opportunity to teach effective ways of communicating and solving problems. "If we can explore their silence or lack of topics with real patience, understanding, and compassion," he says, "then we're also modeling valuable communication and problem-solving skills for them, while getting the therapy unstuck."

For someone whose treatment has been working well enough that they're questioning whether to continue therapy, or they've run out of steam, Rathbone suggests saying something like, "I get it. You resolved the main issue that brought you here, and it isn't clear what to do next."

At these junctures, Rathbone says it's helpful to explore therapy goals. "Maybe we're off track and need to refocus or reestablish goals that still have relevance. Or maybe we're done—and that's okay! Our aim is to put ourselves out of business with clients, and when, with our guidance, they run out of problems to solve, then we've succeeded!"

Rolling with the Punches

Kirsten Lind Seal, a licensed marriage and family therapist with a background in musical theatre, stand-up comedy, and television, says that clients who say they have nothing to talk about often fall into one of four categories.

The first category, she says, consists of those who are simply unsure what therapy entails. Lind Seal says when her clients say, "I don't know what to talk about," that's her cue to do some psychoeducation about the therapy process.

The second category, she says, is clients who tend to be shy or less comfortable with open-ended conversations. Such was the case with her client Allyn, who started therapy by telling her, "You'll have to ask me specific questions, otherwise I won't get anywhere."

"I do my best to roll with the punches," Lind Seal says, "and always have plenty of questions at the ready. I always try to make a note of the last topic we covered in the last session, and then mention it first thing in the next session."

With Allyn, she looked at her notes and said, "So shall we keep talking about your relationship with your father?" And they were off to the races.

Lind Seal says she also finds books to be helpful in jumpstarting conversation. Two of her favorites are Viktor Frankl's Man's Search For Meaning and Melody Beattie's Codependent No More. "Going through these books chapter by chapter together and discussing what comes up as we move along can help deepen therapeutic conversation," she says.

If clients declare they have nothing to talk about during the middle of their work in therapy, Lind Seal believes they may be dealing with something else: they're holding on to something they're unwilling or too nervous to divulge.

As for clients who've been in therapy for a long time by the time they say they have nothing to talk about, she says it's usually a sign that therapy is coming to an end. A good way to check is to say something like, "Maybe we're coming to the end of our work together. Do you think that might be why it feels like you have nothing to talk about today?"

The client's response, she says, will tell you a lot. "One of my clients exclaimed, 'Oh my god, no! Are you dumping me?' Clearly, we were not done. But other clients I've asked have said, 'Yeah, I think so. Is that bad? I'll miss you, but I think we might be done.' Ending therapy usually means that things are going better. I like to tell clients, 'It's my job to get you to eventually fire me.'"

"I have nothing to say" can mean a variety of things, Lind Seal concludes. "But in my experience, therapists just need to decide whether to explain, guide, challenge, or close—and the conversation will flow from there." pn

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Janina Fisher, PhD, is a licensed clinical psychologist and former instructor at The Trauma Center. Known as an expert on the treatment of trauma, she's been treating individuals, couples and families since 1980.

Britt Rathbone, LCSW-C, ACSW, BCD, CGP, is a clinical psychologist and trainer who's been working with adolescents and families for over 30 years. He's the coauthor of several books, including Dialectical Behavior Therapy for At-Risk Adolescents.

Steve Shapiro, PhD, is a clinical psychologist with over 25 years of clinical and teaching experience. He practices various forms of Experiential Dynamic Therapy (EDT), including ISTDP and AEDP, and is a founding member and adjunct faculty member of the AEDP Institute.

Kirsten Lind Seal, PhD, is a marriage and family therapist in private practice and an adjunct associate professor of MFT at Saint Mary's University of Minnesota. She's a regular contributor on WCCO (CBS) TV's Mid-Morning *show.*

Psychotherapy Networker 2025 Readers' Choice Therapists as Clients

The Cost of Neglecting Therapists' Mental Health

Restructuring our Field to Heal the Healers

BY SARAH BUINO

I want to die.

It was the summer of 2020, and this familiar, haunting thought I'd evaded for so long was now creeping back into my brain. I sat motionless on the couch as my dog, Phoebe, howled. My husband had just left to pick up groceries that I'd obsessively wipe down the moment he got home. I glanced at the clock. I had a client session in 20 minutes, followed immediately by supervision with one of my staff members.

My own time in therapy had taught me to recognize suicidal ideation as a sign that I felt trapped in circumstances that seemed inescapable—and that I needed to get help. But I couldn't do that right now; my client and supervisee needed me. *Inhale for four seconds, hold for seven, exhale for eight,* I told myself, remembering one of the grounding skills I'd learned over the years. After a few minutes, I stood up, walked down the hall to my home office, logged in for my session, and tucked the fear and overwhelm away for later.

The truth is that I was in the middle of a silent crisis, one that many other therapists are facing alone. Do we push down our own struggles to keep working, or do we recognize that our own healing and professional competence are inextricably linked?

After I saw my last client of the day, I decided to pick up the phone to call for help, but my head spun with all the reasons why I *couldn't* check myself into residential treatment: *I won't be able to prep for teaching this fall! What will my clients do without me for four weeks? How will I run payroll without access to my computer?* Like so many therapists, my identity was rooted in being a helper. *Who am I,* I wondered, *if I'm not helping my clients or my staff?*

Ultimately, I'm glad I made that phone call and got help. But what if I hadn't? What if, like so many therapists, I'd simply continued to compartmentalize and medicate my overwhelm with wine and Netflix, telling myself this was just part of the job? How long before the problem would've boiled over? How long before my work—and my clients—would've suffered for it?

Sadly, my experience is hardly unique. Therapists are experiencing the same collective trauma as their clients around unprecedented political polarization, climate change, and economic uncertainty. It's impossible for us not to feel fear and anxiety. I hear about these feelings again and again not only when sitting with clients, but in my conversations with supervisees, consultees, and online therapist communities.

In 2023, the National Council for Mental Wellbeing reported that 93 percent of mental health professionals are experiencing burnout, 62 percent classify this burnout as moderate or severe, and 48 percent have considered leaving the field as a result. But graduate school didn't prepare us to manage feelings of overwhelm. And at no point in our careers has any modality, course, or conference *really* taught us how to survive when it feels like the world is falling apart. We've been trained to help others heal while remaining strangers to our own healing.

What so many of us really need goes beyond individual self-care. It will take reimagining our training. It will take learning not only how to heal others, but learning how to heal ourselves. Instead of sitting in pain and isolation, it will take creating places where we can congregate, acknowledge our shared experience, and get support.

The Wounded Healer

In the 1980s and '90s, a handful of studies compared therapists' mental health to the general population. A later meta-analysis suggested that therapists are *twice as likely* to have experienced trauma or mental illness than their nonclinical peers. Indeed, many therapists were drawn to this profession not in spite of their wounds, but because of them. I was one of them.

When I entered graduate school, I knew something was wrong with my family, but couldn't put my finger on it. For two hours a week, my classmates and I would sit in a stuffy, windowless room watching video clips of clinical gurus like Minuchin, Aponte, and Satir. One week, we were tasked with creating family genograms that we'd later present to the class. When I got to work, I started unpacking everything that had felt wrong about my family—the communication styles, family rules, and patterns of mental illness. But when the time came for us to present, my heart began to race.

I watched as student after student took their spot at the front of the room and talked about their seemingly "normal" families. Sure, there was some anxiety, or depression, or addiction here and there, but their stories seemed otherwise unremarkable. My face began to grow hot. *Is my family the only one that's completely screwed up?* I wondered. *How can I possibly talk about my family without crying in front of the whole class?*

Fortunately, I wouldn't be presenting until the following week, so I had some time to get my bearings. Our professor, Dr. Friere, was one of my favorites—a spitfire, badass of a woman with wisdom and heart. After class, I approached her with tears welling in my eyes and told her my concerns.

"If it would help, you don't have to face the class," she said. "You can just present to me, and not look at anyone else."

Her offer, while kind, highlighted exactly what was missing in my training: lessons about how to be present with intense emotion, stay authentic when triggered, and sit in uncertainty.

I didn't take Dr. Friere up on her offer, and the following week, holding my poster board marked with squiggles, half-colored squares, and circles indicating strained communication, addiction, and mental illness, I let the tears fall.

Here I was, learning about family systems while experiencing toxic family dysfunction in my own life. Maybe my classmates had been able to detach from any lived experience of dysfunction, but what about those of us who couldn't? Where was the curriculum to help *us* learn to process *our* demons?

Leaning into Our Humanity

Our profession needs clinicians who have lived experiences of trauma and mental illness. After all, our clients deserve the type of knowing empathy that comes from walking in their shoes. But if so many therapists are drawn to the profession due to their own wounding, why don't we talk about this in our training? Without learning how to do our own work, how can we expect to show up fully for our clients? Sometimes we must learn as we go, as I did with my client Jennifer.

One day, Jennifer sat down in my office and began listing all the existential threats compounding her baseline anxiety: the political rancor, war overseas, and climate change. *How do I tell her I'm grappling with these things too,* I wondered, *without worsening her anxiety?*

As she gazed at me with a combination of panic and desperation, scanning my face for a shred of hope, I knew that no amount of reassurance could soften her dread. It's said that we can only take our clients as far as we've taken ourselves, and if we can't lean into our own existential fears, powerlessness, and grief, we can't help our clients do the same. *Maybe,* I thought, *helping Jennifer right now lies in my own willingness to face these realities not as a neutral professional, but as a fellow human being.*

Rather than jump into the anxiety with her, I decided to lean back and notice the pressure I'd been feeling to find a solution. "What would it be like for you to know that I'm holding the same fears and anxieties as you?" I asked.

We spent the rest of the session exploring the experience of being two humans connected not only by our fears and anxieties, but also by our grief and desire for a better world.

"I feel a little more calm and hopeful now," Jennifer told me as our session came to a close. Truth be told, I felt better too.

The Revolution Starts Now

Of course, simply disclosing to clients that we're experiencing many of the same anxieties they are isn't a reliable solution for combatting burnout in our profession. Change needs to happen on an institutional level. Our field needs to help early career therapists process their own suffering. We need to create systems that support mid-career therapists too, who too often feel isolated and overwhelmed as I did.

I truly believe that we're at an inflection point where we have an opportunity to change the course of our field. Rather than getting trapped in fear and overwhelm, we can choose the antidote: taking collective action and dreaming of a different future for this profession.

How? You can start by simply finding a quiet place to sit. Allow your imagination to expand and flow, inviting creative energy to move through you. Ask yourself: If I could design a psychotherapy training program that would've suited my personal growth and learning needs, what would that look like? What inspires me to help not only my clients, but myself? How can

licensing boards, academic institutions, professional organizations, and workplaces better suit not just my professional development, but my personal development as well?

As you ask yourself these questions, notice what excites you, what scares you, what feels possible, and any other ideas that come to mind. As you contemplate these questions, write down what arises. These thoughts don't have to be practical. They don't even have to make sense. The next chapter of psychotherapy won't be written by a single person or idea. Instead, over time, our collective intentions will coalesce into actionable steps.

I pondered these questions on a recent Sunday afternoon and came up with a list of my own hopes for the field. Here's what I wrote.

Rethinking training programs: Imagine that therapy was mandatory and free for students in all social work, counseling, therapy, and psychology programs. Programs would be a combination of didactic and experiential learning, where students would discover how to examine their own mental health experiences while supporting clients. Programs would also offer parallel training labs where students could process personal material that's triggered by coursework. Small cohorts could meet throughout the program to support one another to integrate academic material into their personal journey.

Rethinking supervision: A profound opportunity for revolution lives in the supervision space. Envision reflective supervision as the norm, where case consultation covers not only how to treat clients, but also addresses the therapist's internal experience. This internal reflection helps new therapists notice how they may be impacting the therapy session. Parallel process is an expectation of supervision as we normalize growing alongside our clients. Emotional responses are seen as a natural part of supervision and revered. Group supervision evolves into support groups where clinicians learn the value of holding one another in our own processes.

Rethinking professional development: Suppose conferences included personal growth tracks that focus on therapist self-awareness and personal growth, not just techniques to help our clients. Therapist meet-ups become staples, safe spaces to process how we're being impacted by our work. Regular retreats combine professional learning with personal healing.

Community-building: Imagine a return to apprenticeships, where experienced mentors shape new clinicians. Each new graduate would be connected with an experienced clinician who offers support, advice, and caring reflection. Local therapist networks band together to share information and resources for running a business, getting client referrals, and taking collective action on policy decisions.

Systemic changes: Micro changes become macro shifts, as licensing boards require ongoing personal work, not just CEs. Therapists automatically receive full insurance coverage for their own therapy. Workplaces regularly screen for burnout and encourage asking for help. Our professional organizations model professional vulnerability and self-work as part of our initial learning and continued development.

The Healing Ripple Effect

"Do you think I can go where you went for treatment?" my supervisee asks timidly, her voice quivering through tears. We spend an hour on the phone as she debates with her ambivalent parts. The stress of working through the pandemic while living alone has activated her childhood trauma, and she's just told me she feels like dying. I share my experience, strength, and hope without making false promises. We create a plan for her clients, so she can focus on her own healing.

Next year, *her* supervisee will ask the same question and find her way to treatment as well.

Sharing our vulnerabilities and traumas can inspire others to ask for help. And if we shift our professional culture to center our own support and growth, we can end so much needless suffering. Our clients will undoubtedly benefit as well. When therapists heal, everyone wins.

But right now, we don't have the systems in place to revolutionize therapy training and development. This will take an abundance of courage, hope, humility, and compassion, as well as a shared understanding about what it means to center our healing. It will take time. History shows that most revolutions don't happen in a single moment; they progress one person at a time. When a clinician changes how they supervise, a professor expands their curriculum, or a small group of therapists creates a weekly meet-up, then change begins to ripple outward.

As the ground becomes more solid beneath our feet, our clients will begin to experience more hope as well. They'll build the capacity to work toward the common good. And the more this happens, the more our systems will start to reflect the values that we therapists know make for healthy communities.

In the meantime, here's my invitation to you: Don't be afraid to take your own healing journey, whatever that may look like. Chances are doing so will make you a better therapist, leader, and teacher. Don't neglect your pain. It connects us with the humanity of our clients and with each other. Try to make a small shift in your practice, teaching, or supervising. And when you do, take note of what changes and share it with your colleagues. This is how we start the revolution. First inward, then outward, one step at a time.

Sarah Buino, LCSW, is a therapist and business consultant for therapy practices. She hosts the podcast Conversations with a Wounded Healer *and helps mental health professionals create practices where meaningful connections flourish between owners, employees, and the communities they serve.*

Psychotherapy Networker 2025 Readers' Choice Trauma

The Trauma of Parental Abandonment

BY KAYTEE GILLIS

Helping Survivors Feel Safe, Minimize Shame, & Heal Old Wounds

Q: One of the most entrenched types of trauma I've worked with is emotional or physical abandonment by a parent or caregiver. How can I best help my clients heal from it?

A: As a therapist who's spent over a decade helping survivors of parental abandonment—and as a survivor myself—I've found that this kind of trauma is often misunderstood, largely due to a combination of cultural and social stigma, lack of awareness, and internalized shame that keeps many survivors silent about their experiences.

When a caregiver makes a conscious choice to remove themselves from their child's life, no matter the reason or form their absence takes, the result will have long-term consequences. I've seen parental abandonment in the form of a parent rejecting a child who gets pregnant or comes out. I've seen it occur when a parent grows emotionally distant after a divorce or remarriage. It can occur when a child suffers abuse and a parent refuses to believe the abuse happened. And it can manifest when a parent believes their child's disability, or even personality, is too burdensome to handle.

As with many traumas, abandonment traumas can deeply influence attachment patterns with friends and romantic partners. They have a profound impact on self-perception and sense of belonging. Survivors often internalize a message of unworthiness, and resort to reflexive self-blame, and as a result, may constantly seek new relationships or avoid intimacy altogether.

Understandably, people who've experienced parental abandonment often have issues with trust, including in the therapeutic relationship. Many also struggle with people in perceived positions of authority, meaning they may see us therapists as intimidating, no matter how hard we try to create a collaborative and welcoming space. Since these can be daunting clinical obstacles to overcome when working with survivors, I've developed a five-step process for working with survivors of parental abandonment that helps mitigate self-blame and build trust with the therapist.

Karalina's Story

Karalina had experienced parental abandonment after getting pregnant when she was 17. Now in her 40s, she was finally realizing the severity of that trauma through our work.

"I always felt different from my siblings," she told me in our first session. "My younger sisters were well-behaved and brought home perfect grades. But because of my anxiety and ADHD, I'd always struggled at school and often skipped class. At night, I could hear my parents arguing about what to do with me through the thin bedroom walls."

When Karalina found out she was pregnant, she hid it for a few months before coming clean to her mother. "I'll never forget the look on her face," she told me. "Shock, shame, disappointment—all at once."

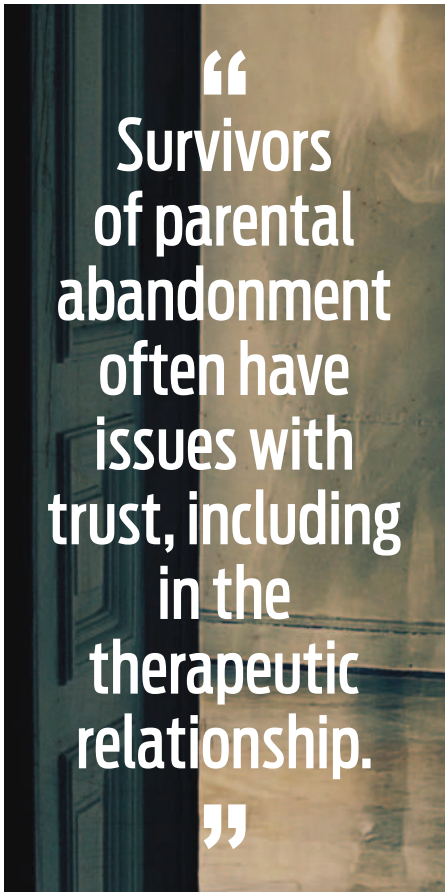
"I have to call your father," her mother had said flatly.

Instead of yelling at Karalina, her father had started working longer and longer hours. He'd go on weeks-long work trips, even though her due date was approaching. She was scared, plagued by her father's absence and the idea that all of this was somehow her fault. After she gave birth to a healthy daughter, her mother helped out with the baby but with a distant expression on her face. Her father would come home occasionally, his loud boots echoing in the hallway, but he barely acknowledged her or his new granddaughter. Eventually, he moved out.

"Dad left because you shamed the family," her sisters would hiss. Karalina didn't want to believe it, but deep down, she believed it was true.

The first step in working with survivors of parental abandonment is to build trust by creating a safe environment. For clients who've been abandoned by someone who was in a protector or caregiver role, and supposed to love them above all else, it's the most important thing you can do. When they're in a relationship, survivors of abandonment often wonder things like, *Are they mad at me? Do they dislike me?* But these questions are actually asking something deeper: Is this person safe? *Am I safe? Are they trustworthy? And if I trust them, will they hurt me?*

Therapists working with survivors can begin creating trust and safety from the very first session by actively listening to the survivor's story without judgment, validating their experiences and emotions, and emphasizing that what they say will remain confidential. The therapist can also create safety and trust—and convey empathy and compassion—by telling the client they believe them.



At first, Karalina's inner defense mechanisms—denial, self-blame, and intellectualizing—were so entrenched that she'd often make comments like "Well, I was a bad kid" or "I wasn't hit, so I guess that means I wasn't really abused," as well as other statements that minimized her experience of abandonment. Once I'd made it clear that I believed her story and didn't blame her for being abandoned, Karalina began to trust me more and made fewer statements minimizing her experience.

Survivors of abandonment often wonder things like, *Are they mad at me? Do they dislike me?* But these questions are actually asking something deeper: *Is this person safe? Are they trustworthy? And if I trust them, will they hurt me?*

The second stage of working with survivors of parental abandonment is helping them acknowledge their trauma. It's a foundational step toward fostering self-awareness, understanding the impact of abandonment on their lives, and beginning to heal. It can be difficult work since coming to terms with past trauma often involves navigating complex and fluctuating emotions, confronting layers of denial or avoidance, and contending with the fragmented nature of memory and perception. Acknowledgment often comes in bits and pieces, rather than as an open declaration of what has occurred.

"I wonder what it would have looked like had your dad been there when you needed him," I said to Karalina, trying to help her see how this had been, in fact, deeply traumatic. "Being 17 and pregnant must have been so scary."

She paused for a moment. "It was," she finally said, tears welling in her eyes. "I was terrified. I really needed him," she said before pausing again. "But he wasn't there."

The third stage of working with survivors is helping them recognize how the abandonment shows up in their adult relationships. After the end of a romantic relationship, for instance, survivors often experience greater distress than those who've had secure caregiver relationships. They sometimes cling to unhealthy relationships or disregard red flags, desperate to avoid the anguish of being abandoned again.

Many of my clients who survived parental abandonment find themselves either cycling through relationships in an attempt to fill the void left by past losses or avoiding relationships altogether to shield themselves

from further pain. The key is helping clients see these patterns by saying things like, "It sounds like you've developed certain coping mechanisms to protect yourself from feeling abandoned again" or "How might your life have been different had your parent never left?" Once you address the connection, the client can begin to see the "why" behind these distressing relationship patterns.

Despite recognizing that her latest romantic relationship hadn't been healthy, Karalina struggled to shake off the desperation she continued to feel about it having ended. It was clear that this desperation was an indirect result of her father abandoning her when she was younger, but Karalina didn't immediately make the connection.

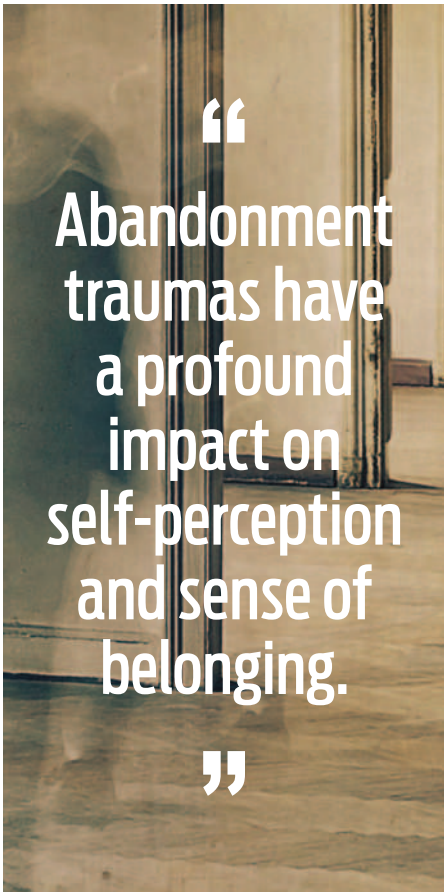
"If your dad had never left," I asked Karalina, "especially during a time when you needed him so much, do you think this breakup would feel different?"

"I think so," she replied. "I'd probably feel more confident in myself and in my ability to be alone and recover." Slowly, she was developing a newfound awareness that allowed her to stop second-guessing the breakup. She got better at reminding herself that the relationship had ended for the right reasons.

The fourth step in working with survivors is minimizing shame. Clients who've been abandoned tend to blame themselves for what happened to them, and by helping them realize they're not to blame, the therapist can facilitate a crucial shift in perspective. Drawing on the IFS model, therapists can help clients see and acknowledge the part of them that amplifies their shame in order to protect them. Once they realize this, they can access more self-compassion. Usually, as they shift from blaming to self-compassion, tension, anxiety, and depressive symptoms begin to decrease.

Karalina was making progress in therapy, but she still sometimes reverted to her childhood belief that she'd been responsible for her father leaving. Like many survivors, her shame amplified the fear that there was something wrong with her. Nothing sends the message to a child that they're unlovable quite like their primary caregiver leaving them. Together, Karalina and I worked to help her acknowledge—and even thank—the parts of her that were trying to protect her by blaming for what was actually her father's failure as a parent.

"Your anxiety serves a purpose," I told her. "It's trying to keep you from being abandoned again. But just because a relationship ended in the past doesn't mean your relationships now will end."



"I worry that my needs are too much," she said at one point. "I feel like a burden."

"But you deserve kindness," I said reassuringly.

Karalina nodded. "It's easier to believe that when I think of my own daughter," she replied. "I've never abandoned her, and she's doing so well. I suppose I deserved to have from my father what she's received from me. In my heart, I know I've been getting in my own way."

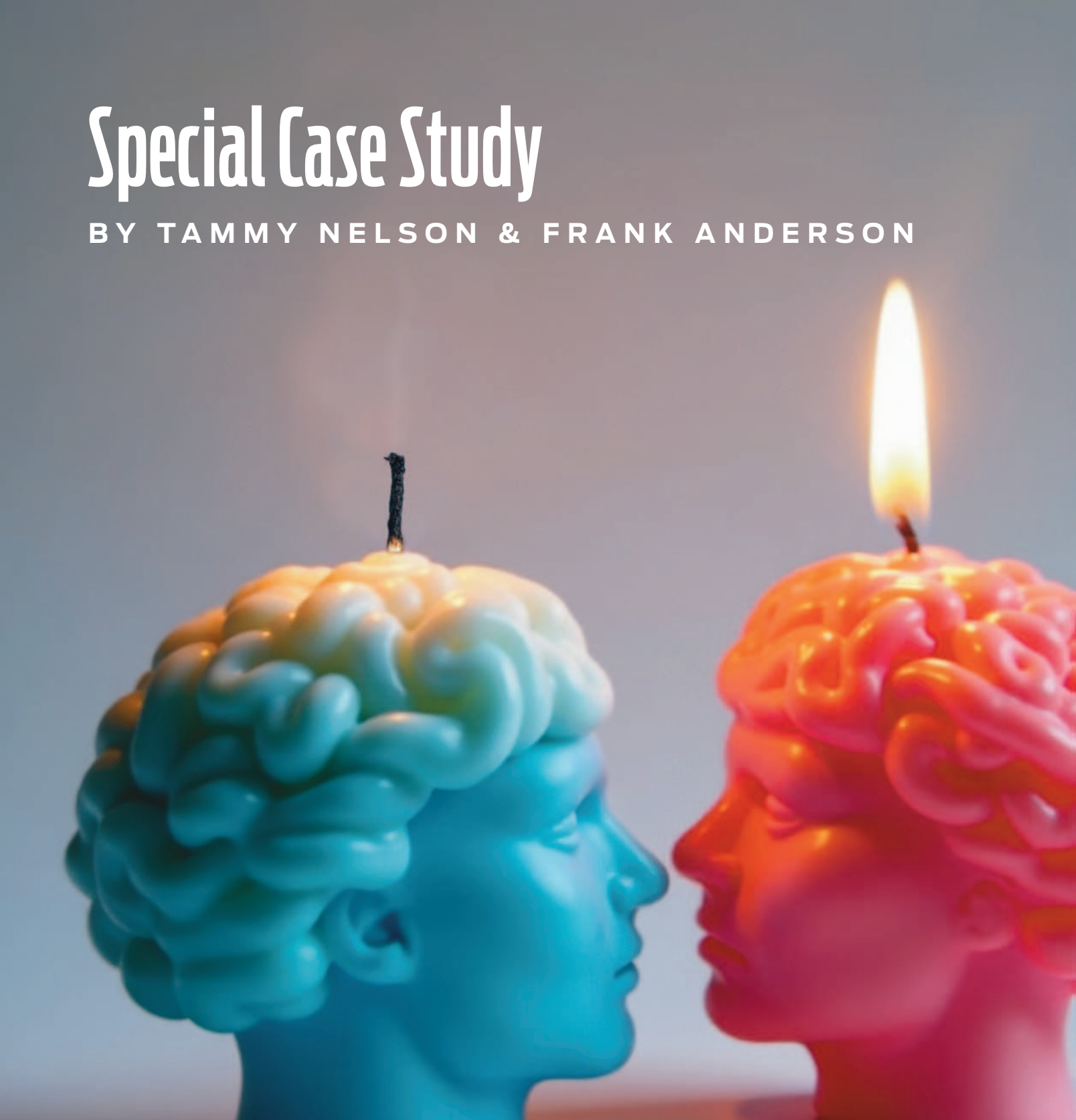
Once you've minimized shame, you can move to the last stage of treatment: helping the client reparent their abandoned inner child. Though reparenting is more of an ongoing process than a one-and-done experience, over time, it helps clients heal old wounds, traumas, and unmet needs from childhood. It involves working creatively with the parts of the client that hold traumatic memories, experiences, and emotions related to abandonment, as well as showing consistent patience, consideration, and care. Importantly, it involves cultivating genuine curiosity about the inevitable moments, however small, when a client feels abandoned by you. Exploring and repairing ruptures in the therapeutic relationship can be deeply healing, and model healthy repairs in relationships beyond the therapy room.

Karalina and I brainstormed tools, like journaling, that she could use to reassure her inner child she was safe when worry arose that she might be abandoned again. When the shame and self-doubt crept in, she was able to remind herself that these feelings were not hers to own; they'd been given to her by her father. Now, with greater self-awareness, she began to see she deserved and was capable of healthier relationships based on trust, respect, and shared accountability.

Kaytee Gillis, LCSW-BACS, is a psychotherapist, writer, and author with a passion for working with survivors of family trauma and IPV. Her work focuses on assisting survivors of psychological abuse, stalking, and other non-physical forms of domestic violence and family trauma. Her recent book, Invisible Bruises: How a Better Understanding of the Patterns of Domestic Violence Can Help Survivors Navigate the Legal System, *sheds light on the ways that the legal system perpetuates the cycle of domestic violence by failing to recognize patterns that hold perpetrators accountable.*

Special Case Study

BY TAMMY NELSON & FRANK ANDERSON



A Case of Disappearing Desire

TWO APPROACHES TO A CLIENT WITH COMMITMENT ISSUES

How do you help a client who wants a relationship but can't seem to sustain sexual interest, even for partners they deem desirable?

Sex and relationship therapist Tammy Nelson, author of The New Monogamy *and* Integrative Sex and Couples Therapy, *and trauma expert Frank Anderson, author of* To Be Loved *and coauthor of* Internal Family Systems Skills Training Manual, *share their unique approaches to working with a client who "couldn't be happier with life" ... except when it comes to longstanding sex and commitment issues.*

Meet Simon

Simon is a 29-year-old medical student who struggles in committed relationships. He says he loses sexual interest in the women he dates soon after things get serious. "I always thought I got bored because I hadn't met the right person, but my last girlfriend was hot, funny, smart—I was crazy about her. When I stopped wanting sex, it confused her, but she stayed. When she caught me watching porn, though, it wrecked her."

Simon jokes about his physical appearance a lot in your first session. "I used to be chopped," he says. You ask about this, and he clarifies that he was overweight, had bad acne, and broke his nose in a fight in high school. "I mostly avoided mirrors till I was in my 20s. Surgery turned my life around. That's why I'm becoming a plastic surgeon."

Simon says he has no memory of his mom, who died when he was a toddler, but his dad was a great parent. "We're still super close. There's nothing my dad wants more than for me to find a partner and start a family. Honestly, other than this issue with sex and commitment," he tells you, "I couldn't be happier with the way my life is going."

A New Narrative Around Intimacy

BY TAMMY NELSON

Simon's story is not uncommon, but it's touching how much he wants a relationship and doesn't understand what might be wrong with his level of desire for his partners. He is a high-functioning, high-achieving young man with issues around eroticism. His confusion around desire—and its disappearance in the context of closeness—is a clue. When clients say, *Everything in my life is great, except for this one thing,* I listen carefully. That "one thing" is usually the thread that connects everything underneath.

Simon's disinterest in sex after emotional intimacy may not be because he grows bored with the sex or the relationship, it may be that his attachment bond desexualizes the relationship. The early loss of the first attachment figure—a mother who disappeared from his life before he could make sense of absence—may have created a rupture in how he bonds and stays connected. In early developmental trauma like this, the body often "remembers" through behavioral and relational patterns.

But let's not blame his mother. I'd be more curious about the *narrative* of losing his mom. How does his dad talk about her? What were his earliest relationships like after the loss of his mother? Did he remarry after his first marriage? Is there a story here that no one could replace his mother, and that no one should?

His sexual shutdown is not a rejection of his partners, it's self-protection. He's reenacting an old wound: connection equals loss. If he lets himself get too close, his body may preemptively shut down the very thing that makes him vulnerable: desire. If he wants someone, they could leave him.

While we don't know that he has early abandonment wounds, it's quite possible he had plenty of positive connections with his father and other adults, which may have been more than enough, but there's a story of loss underneath his story of surviving a tough adolescence.

Porn and masturbation may be not just a coping mechanism but a safe container. Masturbation offers controlled arousal, there's no risk, no rejection, no relationship, and no need to stay emotionally present. That's not pathological; that's emotional and relational survival. I see Simon's porn use as a behavior he developed to soothe himself, so with compassionate curiosity I'd ask more about his fantasies and masturbation behavior without shaming him. What he turns to as his arousal scenario can tell us a lot about what his internal life contains. Emotionally, is he looking for attention, a soothing figure to tell him he's wanted? This can come out in a sexual fantasy of being desired, of a woman telling him he's sexy and that she wants him in an erotic way. If he feels out of control in his life, he may have sexual fantasies of being in charge, telling a woman what to do, or holding her down while he makes love to her. These scenarios are narratives that are not necessarily stories he'd need to act out in real life, but may provide a soothing internal mechanism that allows him to manage his emotions.

Simon also lives in a body he once hated. His comment, "I used to be chopped," followed by descriptions of bullying, reveals body dysmorphia and a sense of humiliation. His transformation into a "desirable" man through surgery and his career choice to become a plastic surgeon show that he's trying to fix on the outside what may still hurt on the inside. His desire to transform other people's bodies may be a longing to rescue his own wounded self.

It feels like Simon is masculinizing himself, and still in search of the missing feminine, the one who could make him feel safe, loved, whole. Therapeutically, I'd explore what sex, closeness and eroticism mean to him beyond just performance. Can he feel desire without fear? Can he stay present in intimacy without feeling like he wants to run away?

I might also discuss his own dreams, versus his father's dreams. ("He wants me to start a family.") If he's still in medical school, it might be too soon to settle down in a serious relationship, maybe he wants or needs more freedom, or perhaps he doesn't know what he wants at all.

I'd want to help Simon understand that losing desire isn't the problem. Losing *himself* and what he really desires in the relationship is what's shutting him down.

Healing won't happen when he finds the "right person" but from integrating the lost parts of himself. Inside Simon is the boy who was mocked, the teen who avoided mirrors, the man who doesn't remember his mother but has been shaped by her absence. And there's also the successful adult man inside of him who helps to shape other people's lives. All of these parts are important to recognize and acknowledge. This way he can understand which part of him is running the show when he feels a certain way or reacts in a relationship. He doesn't have to negate or avoid these parts. Once he understands that they're all parts of him, he can become the parent to them that he always needed. The adult that can soothe him, the grown-up that can tell the frightened parts of him that he'll be ok, and the father inside him that can tell him he'll survive and that whether he's in a relationship or not, he's loveable. Only then can Simon create a new narrative around intimacy, one that includes trust, arousal, connection, and sexual companionship.

An Integrative Approach to Relational Trauma

BY FRANK ANDERSON

As my first session with Simon unfolds, several hypotheses begin to form. My notes are anything but linear, but I jot down things he says and does, along with quick questions and possible connections I'm noticing in the process of mapping out the salient information he offers up. As I listen to him, I take in every word, watch every gesture, pay attention to the slight shifts and body movements, track his eyes as they dart around the room, and listen to every sigh. These are all clues to the root cause of his symptoms.

Having trained as a medical doctor first and a psychotherapist second, I understand that symptoms are what bring people into treatment, be it medical or psychological. Because I've been trained in Eye Movement Desensitization Reprocessing (EMDR), Sensorimotor Psychotherapy, and Internal Family Systems (IFS), I use an integrative approach to trauma treatment—one that's based in my knowledge of neuroscience. I know there's something deeper going on for clients who come to talk about problems, which I see as the root cause of their symptoms. Unresolved trauma—whether it's considered big T or little t, relational trauma or complex PTSD—can rarely be addressed by just one method or model of therapy, and it usually takes time to unravel for sustainable transformation to occur.

At the same time, having done this work for many years, I've learned it's not idealistic to hold the hope that clients' symptoms can be eliminated, or that underlying trauma can be healed as they deepen self-awareness, strengthen their connection to themselves, and release the weight of suffering over issues that don't truly belong to them. Therapy, done skillfully and sensitively, allows people to move forward in life in a different way: from a place of calm power.

Simon's main symptom or chief complaint is a lack of interest in sex and difficulty committing in intimate relationships. He's a medical student, which means he's smart, driven, focused, and works hard to achieve his goals. (I write "smart" at the top left corner of my note pad.) Is he a wounded healer like so many of the other physicians I've worked with? Does he have a strong caretaking part because he didn't get his needs met when he was a child? (I put a question mark next to the word "smart" because we don't yet know what need or longing is driving his success.)

Simon tells me he has commitment issues and loses interest and erections when things get serious. (I instantly write "commitment/sex" in the center of the paper.) My first thought is attachment trauma, but I wouldn't bring a clinical term like that up with a client this early, so as not to depersonalize the work or scare him away with psychobabble. Instead, I ask him to tell me more about what "commitment issues" means. It's important to hear how clients define their own problems, but I also want to assess his level of insight and capacity for self-reflection.

I listen carefully and notice that Simon's body tenses up as he describes his "super high sex drive" and how confusing it is when he's not into it after a few months of "great sex." He diverts his gaze down and away from me. (I can see there's activation and shame held in his body around sex and intimacy. I write "tense/shame" next to the word sex.) I wonder what his relationship with his parents is like. What did he witness unfold between them when it came to affection or loving touch? I also wonder if something medical is going on around sexual functioning and hold the thought that he might be gay. (I write "physical" and "gay" with a question mark beside them.) So many questions have arisen in the first few moments of our meeting. I'm feeling deeply engaged and a bit overwhelmed as well.

Then, Simon takes me off guard: he mentions looking "chopped," shifting the focus and lightening the mood with a joke about his appearance. I don't know what *chopped* means, so I ask, wondering if the age gap will have a negative effect on our connection. I notice a part of me show up that feels insecure: What if he thinks I'm too old to help him or relate to him? I acknowledge the feeling and ask it to soften. It does, and my body relaxes.

Simon proceeds to talk about being overweight, having acne, being made fun of, a fight leading to a broken nose. There's so much to unpack from experi-

ences he had outside of his home growing up. How did he learn to self-soothe? Does he frame what happened as bullying? Are there anger issues here? Social struggles? Shame? How has he learned to deal with conflict? (I write "school/social/shame" with a big circle around it.)

Then, I hear "no mirrors, surgery, and becoming a plastic surgeon." This is a big deal, I think—not your typical adaptation to a schoolyard fight. (I write "nose/plastic surgeon" on the top right of the paper.) Maybe this has less to do with his parents than I assumed. Maybe we're dealing with peer trauma, and this is the source of his commitment/sexual/intimacy issues. I notice a deeply curious part of me emerging. I haven't worked much with social trauma, so I can learn a lot from Simon. Another part of me shows up, too, remembering how much my brother and I fought as kids. I know that working with Simon could activate my own trauma history. Am I prepared for that?

Before our session ends, Simon tells me about his mom dying when he was a toddler. "I have no memory of her," he says. But he reassures me, and perhaps himself, that he has a great relationship with his dad.

The pieces of the puzzle are starting to become clearer. Simon has experienced preverbal trauma, early implicit memories of a traumatic loss in addition to his school trauma. He likely carries emotional and physical memories that are unconscious and stored in his body. He probably holds some level of neglect—growing up with one parent, even a good parent, is usually accompanied by experiences of unmet needs. The preverbal trauma could have set the stage for being targeted at school. Maybe these experiences are linked, or maybe they're separate traumas. Simon could truly have a great relationship with his father, or he could be idealizing their connection. He might have had to view his father as "all good" as a survival strategy. (I add, "mom died" and "great relationship with dad" with a question mark next to it. I've written these notes close to "commitment/sex" at the center of the page.)

At this point, I'm careful not to jump to any conclusions. I'm mostly here to ask and listen, create a connection with Simon, and build a relationship with him that allows us to explore painful, hidden aspects of his life in a safe and effective way. I'm truly awed by his complexity, and I'm looking forward to seeing him again so we can start unraveling the thoughts, feelings, and behaviors that have been confusing him, and perhaps begin to heal the trauma drivers that shaped his life in ways he hasn't been consciously aware of.

As the session ends, I ask Simon if there's anything else he wants to share before we close. He shakes his head no, but with a look of despair on his face. I can see that the work we've done hasn't been easy for him. For us to continue, I know I need to give him an authentic message of hope and healing.

Slowly, I summarize what I've heard him share, and his expression softens. Over the years, I've learned that my great wisdom and brilliant interpretations are not the true change agents in psychotherapy. Instead, hope, healing, and a genuine connection are what give clients the confidence they need to move forward into uncharted waters. I tell Simon I'm confident we'll get to the root cause of his issues. And I let him know that losing a mom at an early age, and being "chopped" in school, can have a big impact on a person's life. "But the suffering that can come with these events isn't permanent," I say. "I believe you have the capacity to release the pain you're carrying, and that you can live a more fulfilling life that includes satisfying intimate relationships."

"Then I'm open to giving it a try," he says.

Our work will entail building a strong therapeutic alliance, one that helps him connect to his own wounded parts, including ones carrying feelings of abandonment that come with a parent's death, and shame related to being bullied. Our goal will be to give these parts corrective experiences. He and I will get to know and appreciate his problematic behaviors. We'll strive to understand the intention behind unwanted patterns he's tried so hard to change.

While we're doing this deeper healing work, I'll check in with him to see how his present-day life is going. I'll encourage him to move forward and try new things. I'll help him learn to connect to his internal wisdom, trust his intuition, and communicate more effectively. He'll begin to develop a different relationship with his body as he repairs the internal chasm created in the aftermath of his traumas.

I've come to believe that therapy is about revisiting the past, repairing the internal relationships severed by trauma, helping our clients release energy that doesn't belong to them, and helping them take risks and change old habitual patterns that get in the way of the life they're creating now. I'm hopeful that the journey we're on together will change Simon's disruptive relational patterns while helping me to grow alongside him.

Tammy Nelson, PhD, is an internationally acclaimed psychotherapist, Board Certified Sexologist, Certified Sex Therapist and Certified Imago Relationship Therapist. She has been a therapist for 35 years and is the executive director of the Integrative Sex Therapy Institute. On her podcast The Trouble with Sex, *she talks with experts about hot topics and answers her listeners' most forbidden questions about relationships. Dr. Tammy is a TEDx speaker, Psychotherapy Networker Symposium speaker and the author of several bestselling books, including* Open Monogamy, Getting the Sex You Want, The New Monogamy, When You're the One Who Cheats, *and* Integrative Sex and Couples Therapy. *Learn more about her at drtammynelson.com.*

Frank Anderson, MD, is a world-renowned trauma treatment expert, Harvard-trained psychiatrist, and psychotherapist. He's the acclaimed author of To Be Loved *and* Transcending Trauma, *and coauthor of* Internal Family Systems Skills Training Manual. *As a global speaker on the treatment of trauma and dissociation, he's passionate about teaching brain-based psychotherapy and integrating current neuroscience knowledge with the Internal Family Systems model of therapy. Contact: frankandersonmd.com.*

Nominees for the 2025 Best Story Award

Autism

Unlearning Behaviorism: The Mindshift of PDA-Informed Care
BY DIANE GOULD
Healing a Lifetime of Neurodivergent Trauma: Accommodation, Validation, and Autistic Attunement
BY TASHA OSWALD
Baseline Suicidality in Neurodivergent Kids: Misunderstanding Sensory and Emotional Chaos
BY SHYANNE ANTHONY

Clinical Challenges

The Case of the Late Client: Janina Fisher & Gabor Maté Tackle a Clinical Challenge
BY JANINA FISHER AND GABOR MATÉ
The Client Who's Tried Everything: ACT and ISTDP Tackle One Challenging Case
BY STEVEN HAYES & STEVE SHAPIRO
IFS and Addictive Processes: Bridging the Gap Between Psychotherapy and Recovery
BY CECE SYKES, MARTHA SWEEZY & DICK SCHWARTZ

Grief

When Grief Is a Soft, Grey Animal: Megan Devine & Leanne Campbell Reveal Unlikely Paths to Healing
BY MEGAN DEVINE & LEANNE CAMPBELL
Embodied Healing in a Disembodied World: Metabolizing Intergenerational Trauma & Collective Grief
BY LINDA THAI & RYAN HOWES
God, Grief & Therapy: The Quest for Meaning after Loss
BY DAVID KESSLER & LIVIA KENT

Opinions on the Field

What Defines Greatness for America: The Impact of New Policies on Social Wellness and Clinical Research
BY BESSEL VAN DER KOLK
Ken Hardy on Racial Reactivity Today: A Clinical Tool for Navigating Defensiveness, Anger & Hopelessness
BY KEN HARDY & ALICIA MUÑOZ
The Turmoil Therapists Carry Alone: Facing the APES in Our Field
BY KHARA CROSWAITE BRINDLE & ASHLEY CHARBONNEAU

Practice Tips

So You Wanna Be a Life Coach?: The Legal & Ethical Risks to Your Therapy Practice
BY TERRY CASEY
When Clients Ask for Session Notes: Tips for Navigating a Legal Gray Zone
BY ALICIA MUÑOZ
How to Build Your Brand as a Therapist: 9 Influencers Reveal Their Unconventional Choices
BY SAHAJ KAUR KOHLI, TERRY REAL, ALEXANDRA SOLOMON, NEDRA GLOVER TAWWAB, SARA KUBURIC, VIENNA PHARAON, DENÉ LOGAN, ELIZABETH EARNSHAW & MARIEL BUQUÉ

Sex & Relationships

The Orgasm Gap: 7 Strategies to Help Women Experience Sexual Pleasure
BY LAURIE MINTZ
The Vulnerability Junkie: A Fresh Look at the Pursuer-Distancer Dynamic
BY ALICIA MUÑOZ
Rethinking Insecure Attachment: From a Fixed Model to a Fluid Spectrum
BY SUE MARRIOTT & ANN KELLEY

Spirituality

Jon Kabat-Zinn's New Radical Act: Recalibrating Our Relationship with Modern Mindfulness
BY CHRIS LYFORD
Reimagining God in Therapy: When a Parent's Critical Voice Is Almighty
BY LISA FERENTZ
The Spiritual Therapist: Healing and the Secular Priesthood
BY CHRIS LYFORD

Therapists as Clients

The Therapist Who Sees Therapists: Working with the Trickiest Clients
BY WAYNE SCOTT
Lessons from Both Sides of the Couch: What My Therapists Taught Me
BY SUSAN EPSTEIN
The Silent Treatment: What I Wish I Could Tell My First Therapist
BY WAYNE SCOTT

Trauma

Humor in Trauma Work?: Making Space for Our Whole Selves in Therapy
BY ALLISON BRIGGS
Do I Have to Forgive to Heal?: Examining the Role of Forgiveness in Trauma Recovery
BY AMANDA ANN GREGORY
The Transgender Community in Crisis: Confronting the Political Erasure of Trans and Nonbinary Identities
BY SHIR WOLF

BY RYAN HOWES

5 Common Factors for Change in Therapy

A NEW INTEGRATIVE TREATMENT FRAMEWORK

BEN OGLES

What's the secret to therapeutic change? f you asked a dozen therapists this question, you'd probably hear a dozen different answers, many long and complex.

But if you asked psychotherapy researcher and Brigham Young University professor Ben Ogles—a leading psychotherapy outcome researcher, who's spent more than 25 years studying the common denominators in personal growth and change—he'll tell you the answer really isn't so complicated after all. In fact, Ogles has boiled it down five factors—and you'll find them in almost every therapeutic modality!

What does this mean for therapists who are laser-focused on learning a particular approach, convinced it's the most effective? Or for clients who feel they need a particular kind of therapy to heal? Is reducing change and growth to a few key principles the best way to inform the way we work? Will it really keep us focused on what's most important?

In Ogles's book *Common Factors Therapy: A Principle-Based Treatment Framework*, he and his coauthor, psychologist and professor Russell Bailey, make a compelling argument, outlining a new modality that pulls from approaches across the board and grounds us in the basic building blocks of change.

Here he gives us an overview of common factors research and, perhaps, a hint about the future of integration in our field.

Ryan Howes: What first inspired the research into common factors and how did it unfold?

Ben Ogles: Back in 1936, American psychologist and therapist Saul Rosenzweig first speculated that what the theorists suggested creates change may not actually be the things creating change. So what does create change? For decades, researchers have done horse-race studies comparing different theoretical orientations for treatment, and they repeatedly found that various treatments are mostly the same in terms of effectiveness. Some things work better in some instances, like exposure therapy for obsessive compulsive disorder, but if you just take the general anxious-depressed person, anything works.

That finding sparked researchers like Mike Lambert to find the things that lead to change that are common across treatments. In reviewing the literature, he showed the things that can consistently predict change regardless of the orientation, and he divided them into *support factors, learning factors*, and *action factors*. Other researchers did similar sorts of things.

In another sphere, Marv Goldfried, partly because he wanted to seek some unity among different orientations, surveyed clinicians to find the common principles of change outside of theory and technique. In his surveys, he consistently found that there were five principles of change that therapists could agree on.

So on the one hand you have researchers asking, "Does this variable predict change regardless of the orientation?" And on the other hand you have researchers asking, "Do therapists agree on this principle of change regardless of their orientation?" But Scott Miller, Barry Duncan, and Mark Hubble referred to these two problems as the Tower of Babel Problem—just using different language for the same thing. And so that's where Russ Bailey and I got interested in common factors.

One day we were having a conversation with Mike Lambert, and we started to wonder, "Okay, so these common factors predict change. Can you make a therapy that's a common factors version of therapy?" Russ thought so. He said, "You can make a therapy that's called Common Factors." Mike said, "No, that's not possible. That's just a name for principles that predict change. It's not a theory of change. In fact, it's kind of a meta theory, So in order to make it a therapy that you use, you're going to have to make it more practical and pragmatic. You're going to have to have a theory of change. You're going to have to have techniques."

Russ thought it was possible, and I hesitantly jumped on board. We worked hard on an article focused on one principle of change, the therapeutic relationship. And then he said he thought we could do this in a book

format. So we submitted something to APA and they liked it. We came up with five principles in the end, and that's how we published the book on a common factors framework for delivering treatment.

RH: What are the five principles of effective therapy?

Ogles: They are the *therapeutic relationship, motivation, corrective experiencing, insight*, and *self-efficacy*. They really match up with what Marv Goldfried originally came up with in 1980. We don't use exactly the same words, but in each chapter, we try to present the evidence and research that this principle of change does predict outcome, and then we try to show how it fits into a variety of orientations using different language.

No one ever has any quibbles with the first of the principles, which is the therapeutic relationship. Second is client motivation, and a lot of the interventions there, as you might expect, have to do with motivational interviewing and expectancies, helping people to have the expectation of change. We see those two as the foundation of the house of change, if you will.

Then comes a cognitive avenue with insight, and an emotional avenue with corrective experiencing. And those aren't completely distinct. It's not like you have insight without any emotion, or corrective experiencing without any insight.

We call the top of the house self-efficacy, which is more of the behavioral, practical change that comes as people think differently.

RH: I was taught that corrective emotional experience was a psychoanalytic construct proposed by Franz Alexander and Thomas French.

Ogles: Sure, the Alexander and French stuff would fit within the corrective experiencing part of our framework. But we'd also put exposure as a corrective emotional experience, because in a sense, the person is confronting their past view.

Similarly, we'd put things like cognitive reframing, psychoanalytic interpretation, and humanistic reflection under insight, because the person is discovering something about themselves, whether through hearing something they said in a slightly different way or having a question posed to them they'd never thought of before. We'd even put straight psychoeducation there. So if you gave them homework to read, that would also be the kind of learning that we call insight.

In essence, we're offering a collection of things from different orientations under a principle framework, and it can inform the way that someone thinks about their therapy.

RH: The first principle is the relationship, and everyone agrees on that. But what is it about the relationship that's such a healing or essential component?

Ogles: When you start to dig into the research literature, you find it's about having a shared, trusting bond, a shared set of goals, and a shared set of tasks. And this matches up with one of the major players in the common factors world, Jerome Frank, who cowrote *Persuasion and Healing*. He talks about four things that are common to all therapies and healing rituals. One is a healing setting, whether it's a sweat lodge or a confessional for a priest or a therapist's room with the diplomas on the wall. The next is what he calls "an emotionally charged confiding relationship." And then the other two are a theory of change and some ritual that you must pass through, whether it's sitting in the sweat lodge or analyzing your thoughts through a three-column technique or whatever the ritual is that's tied to that theory of change.

RH: A safe bond and a trusted process for change.

Ogles: But part of it is that you have to agree on this theory and this ritual, the goals and the task. It has to be culturally acceptable in that way. If it gets too far outside the culture, the client won't believe it, and it's not going to work.

RH: So you have the relationship, the motivation, the cognitive strand, the emotional strand, and then the behavioral roof, as you put it, which is self-efficacy. Is that a need to prove these changes are lasting and show that I've made some change in my life?

Ogles: Yeah, but it's not so much about evidence as it is about practice.

For example, in my therapeutic training, I became aware that I'm somewhat possessive of things, a result of growing up in a home where I was the oldest of nine children. This sense of possessiveness really came out when I got married. I realized that some of the things she did that bothered me came from being 10 years old and having a bunch of little kids messing with your stuff all the time.

But just because I'm aware of that when I'm 35 and married doesn't mean that I'll change how I respond to situations where that possessiveness kicks in. Just because you have the corrective experience or the insight doesn't mean it necessarily translates into your behavior after you're aware. That's where the self-efficacy needs to kick in.

RH: Does a common factors approach assist with integration of modalities or does it make the whole concept irrelevant, because why have all these modalities if we only need effective common factors?

Ogles: It's a good question. It does add yet another approach to the mix. You have behavioral, humanistic, psychodynamic, cognitive, integrative, common factors. So, from one perspective, it didn't help solve any problems; it created a new one. But from another perspective, it offers a more unified, integrative way of both viewing and treating people. And the transtheoretical approach is gaining some ground, especially for treatment of depression and anxiety.

I'd add that our common factors approach isn't a closed book. If anoth-

er principle is identified that meets our criteria for cutting across other orientations and has research evidence for its predictive ability or change, then let's add it. In that way, we have a hope that common factors isn't something we possess. Rather, it's a set of principles that therapists can use as a framework for how to think about change, even though their interventions may come from different conceptualizations.

RH: And those interventions might borrow from these preexisting modalities? If you're going to talk about irrational thoughts and beliefs, for example, that's already an established intervention.

Ogles: Yeah, the only difference with common factors is the way the therapist thinks about it in their head. Instead of using the cut-and-dry theoretical language about why it's effective, they're thinking about it in terms of insight as a common factor of change—and they're using that intervention for that purpose.

So it might be that you see an irrational thought reframe and say, "There's a cognitive therapist." You wouldn't know they were common factors therapists until they suddenly threw in a psychodynamic intervention. It would look exactly like a psychodynamic intervention, but they'd be thinking about it from a corrective experiencing lens.

RH: If I was in a graduate program and learning common factors therapy as a modality, then would I be learning to borrow from different modalities to apply the cognitive, emotional, and behavioral elements of common factors?

Ogles: Yeah, and in some ways it's harder. I mean, if you look at Norcross's work on psychotherapy integration and integrated psychotherapy supervision, he says that it's harder because the supervisor has to be acquainted with more orientations and how they're applied. So at least in our training program, if you visit with first year therapists, they gravitate toward a cognitive model because it's so cut and dried and simple to implement. Then as they get more experienced and less anxious, they tend to spread out a little bit. So I don't know if the common factors approach is the first place people would start, because you have to be acquainted with more orientations in order to really implement it.

RH: In my graduate program, we learned Carl Rogers's client-centered therapy first, because it's a strong framework for establishing the relationship.

Ogles: And it reminds me of Bill Miller's work on motivational interviewing. He's busy doing behavior therapy for alcohol use disorders and discovers that the therapists who have the best alliance are more effective than the ones who don't. And so the birth of motivational interviewing comes out of this finding that the relationship matters a lot. It's not just the technique of the behavior therapist. You have to start with a good relationship.

RH: I love the idea of having something that unifies or at least gives therapists a common language and goals. Can you talk about it from the client perspective, though?

Ogles: Almost all the work done on common factors is survey research of therapists and experts, research about what variables across orientations predict outcome, or theoretical things like how is this idea in this orientation similar to this idea and this orientation? Well, the thing that's missing from that is the client's view. What do clients think creates change?

We're working on an article now based on a survey of 200 college students at a counseling center. We asked them, "What contributed to your change?" We identified 56 possibilities, based on the literature, and had the students rate how much they contributed to their change. And then we factor-analyzed that. When they aren't primed, there's clearly a therapist component to it. They'll say, "My therapist was amazing." "My therapist understood and supported me." "My therapist listened."

But sometimes there's an expertise factor. They'll say, "The therapist knew what I needed." "The therapist was really good at helping me." "The therapist knew how to work with me." In a category we called client work, there were two things. One was the effort or motivation. "I put in the effort." "The reason I made a change was because I desired to make a change." And then there was something we call expression, which has to do with the therapist's role and their own role as well. "I was willing to be vulnerable." "They helped me to talk about my problems."

And then there was one category we called skills or tools. "I learned how to deal with X." "They gave me mental tools." "They taught me how to cope." "They gave me methods for handling intense feelings." Very common. Then there's an insight category. "I see my struggles from a different perspective." "I healed the relationship with my inner self." "I had time to reflect on thoughts and feelings that helped me understand myself." "It helped to hear another perspective."

There was an external category. "I got support from my loved ones." "They gave me resources." "They helped me get medication." And then there was one category about the environment or atmosphere. "This was a safe place."

RH: So the common factors are all there.

Ogles: They are. It does start to sound like the clients actually see change in a similar way to common factors. We hope this will add to the common factors literature. If nothing else, it will certainly mesh with it.

Ryan Howes, PhD, ABPP is a Pasadena, California-based psychologist, musician, and author of the "Mental Health Journal for Men." *Contact: ryanhowes.net*

BY ALEXANDRA SOLOMON, KORY ANDREAS, SARAH MCCASLIN, SARA NASSERZADEH, & LAURIE MINTZ

5 Most Popular Therapist Memes

HUMOR AND INSIGHTS YOUR COLLEAGUES ARE SHARING

Ahh, memes—those wacky, humorous images that float around us like digital candy, easy to digest and even easier to share. But memes are also cultural touchstones, universal portals into our collective grief, pain, and frustrations. They can join us together in laughter, turn concepts we thought we knew on their heads, and speak truth to power—all in a single graphic.

As you'll read below, plenty of therapists have favorite memes, ones they share often with colleagues and even clients. It's a bold proclamation, then, that on our quest for healing in a chaotic world, memes can be a powerful tool in our clinical toolbox.

Opening Up is Hard to Do

BY ALEXANDRA SOLOMON

One meme that hits the spot for me shows a box of mac and cheese with the lid half-torn off. Underneath the caption reads: "Me trying to open up to someone." Most people who've opened cardboard boxes have had this experience. They try to open the box, but only the top layer of cardboard peels away, leaving the box just as tightly sealed shut as it was before they tried to open it.

When I saw this meme, it made me think of all my clients who have trouble opening up. Vulnerability is hard! As Brené Brown says, vulnerability is the first thing I want to see in you and the last thing I want you to see in me. When I'm working with clients who are walled off, we work to identify the threads that go back to their early years. Did someone betray their trust? Did someone use their mistakes against them as a power play? Did someone (usually a parent) need them to be perfect to buoy their own shaky sense of self-worth? As we unearth

these historic ties, I frame their struggle with opening up as a highly adaptive coping strategy they once needed and that they now get to retire.

We talk about how to retire this old way of being by cultivating relationships in which it's safe enough to be open. Toward that end, I offer this vital reframe: Opening up is far less an individual personality trait and far more a relational process. Intimate sharing emerges in the sacred space between two people. I teach my clients that discernment is an essential relationship skill: How do the people in your life demonstrate to you that they're capable of holding what you share? What do you notice in their words and behavior? What are the cues you pick up from your own body that let you know this is someone with whom you can create emotional safety? This work offers healing to their young self and empowerment to their current self.

In the context of an intimate relationship, I talk with my clients about how it's incumbent upon partners to co-create an atmosphere in which it's safe to open up by conveying, in words and actions, *You're deeply imperfect and deeply amazing.* And, by the way, self-compassion is also key. Our relationships are stronger and safer for vulnerability when partners can view themselves as both deeply imperfect and deeply amazing (because it's hard to give something to you that I am unable to give to myself!).

I work with couples on learning to discern when information is private and when it can be shared with others. Or I help them at least be humble enough to clarify with each other first, asking for permission rather than forgiveness! And we talk about how, in order to open their boxes up all the way, partners must demonstrate that they can resist the urge to use vulnerable shares as weapons of war during frustrating moments. The cumulative effect of these practices helps us create the conditions to comfortably peel back the layers and expose our tender underbellies.

Risk and trust exist in tension with each other. We need some modicum of trust to be able to take relational risks. And risk-taking builds trust.

Alexandra Solomon, PhD, is adjunct faculty at Northwestern University, a therapist at The Family Institute at Northwestern University, host of the podcast, Reimagining Love, *and the author of* Loving Bravely *and* Taking Sexy Back.

Joining Our Clients in the Fire

BY KORY ANDREAS

If "meme therapy" ever becomes an official intervention, an Autistic 40-something therapist will undoubtedly take credit for the discovery. Perhaps it should be me.

Grad school assured young therapists that mastery and application of

theory would be the conductor of our healing train. But in 2025, a well-timed meme may actually be sitting in the pantheon of revered interventions (only to be outdone by the occasional metaphor involving Taylor Swift lyrics). Therapists are turning to memes to connect, find common ground, and provide the gift of humor and relatability in an unpredictable and often scary world.

If you're lucky enough to have a neurodivergent therapist with a photographic memory, you might find they have a meme at the ready for most clinical situations. I like to think I do.

The meme at the front of my MVP lineup is, without question, the "This is Fine" dog. You've seen this one: a cheerful cartoon dog, coffee cup in paw, sitting calmly in a house on fire, and saying, "This is fine." For my caseload of high-masking neurodivergent clients, this meme is both funny and painfully accurate. Their "house on fire" presents in predictable patterns of job losses, denied accommodations, threats to their safety and livelihoods, and attacks on their gender, neurotype, and partnerships. As we sit together each week, "we're fine."

Right after the election, if I had a dollar for every time a client started their session by telling me the world was on fire, I'd have a lot of extra money in my pocket. In solidarity, I'd share my computer screen and present this cartoon dog on fire, and we'd begin the session with a giggle. "That's me," they'd say—then we'd get to fire fighting with a smile.

Nowadays, memes are one of many necessary tools in the modern therapist's kit. Therapists of generations past would surely gasp watching our sessions, especially virtual ones like mine. Bedroom corners have replaced stuffy beige offices. Thumbs-up emojis and cartoon fireworks sometimes dance unexpectedly across our screens. Cardigans have been replaced by hoodies and hilarious graphic T-shirts. The resources we recommend could be a digital book, a podcast, or a TikTok video. And "blank slate" therapists have been replaced by clinicians who are transparent about their neurology, their identity, and even their politics. In 2025, therapy, dare I say, has become much more human and real.

Meme-sharing has become as central to my therapy practice today as the go-to question (How does that make you feel?) was to our predecessors. And because my virtual office is filled with pattern-seeking and often anxious neurodivergent adults, we "meme" about anxiety and the many fires burning around us. Do we often outline all the worries, the terrifying realities, and our lack of control? Yes, of course we do. And just as quickly, we circle back to building resilience and noticing who's "sitting in the fire" with us. Sometimes what we really need isn't a cognitive reframe or a scripted meditation, but a reminder that even in smoke-filled rooms, humor can cut through the fear. A meme can offer a moment of oxygen and relief before we start searching for the exits together

The "dog on fire" meme has been with us for over a decade, surviving more crises than most of us care to count. His blank smile has carried us through countless, collective meltdowns, which is exactly why he fits so seamlessly into therapy sessions focused on anxiety and resilience. KC Green, the creator of the meme, drew this while starting antidepressants, and the dog reflects his own ambivalence and uncertainty about turning to medication. That origin story only deepens its impact: what began as one person's vague, dark joke has become universal shorthand for the chaos we sit in and our tendency to smile through it, acknowledging that sometimes "fine" is the best we've got.

Kory Andreas, LCSW-C, is a clinical social worker and autism specialist devoted to supporting neurodivergent individuals through assessments, therapy, and education. She also consults with government organizations, mental health treatment facilities, and therapy practices.

A Nervous System Reset

BY SARAH MCCASLIN

For the past five years, as executive director at the Psychotherapy & Spirituality Institute, I've sent a weekly staff reminder email. What began as a simple message to avoid the inevitable—"Do we have a meeting tomorrow?" or "What's the Zoom link?"—has evolved into something more: an invitation into proximity, a ritual of gathering. It's the ring of the bell that calls us to the hearth, whether online or in person, to dispel the loneliness that can accompany our work. We meet in this common space to recalibrate our clinical compasses and engage in embodied, spiritually attuned presence.

There's also a shared practice of not taking ourselves too seriously. To

lighten the mood, I'll attach a meme to each email—sometimes about therapy and therapists, and sometimes about the human journey and its inevitable follies. These memes have grown into more than lighthearted add-ons—they've become collective touchstones. In our most insecure, confused moments, memes remind us that we're not alone.

I often see the world through a meme-ified lens now—and I'm not sad about it. These small moments of connection are everywhere—sometimes in unexpected places. Imagine my delight when one of these memes appeared on meditation pioneer Sharon Salzberg's Instagram feed. It reads, "I don't struggle with anxiety. I'm actually pretty good at it."

Even such a bastion of mindful awareness and loving-kindness sees the value in humorizing our predicament. And just like that, my nervous system resets as I chuckle to myself. My delight in this quick, playful perspective has deep roots. Philosopher Johan Huizinga described the play-mood as one of "rapture and enthusiasm … a feeling of exaltation."

Humor in therapy isn't just a distraction—it's an intervention. I embrace play and playfulness as therapeutic tools: playfulness as liberation, humor as antidote, and sometimes even as spiritual practice. As a colleague recently said, "Play is essential to well-being throughout our lifespan."

I try to impart this to my clients. I will continue to bear witness to their grief, rage, or tender vulnerability (sometimes all at once), modeling the sacred power of presence. And sometimes, I'll crack a joke and we'll laugh at the ridiculous predicaments of our lives, soothed by shared laughter.

I haven't quite found a clinical context for sharing memes, but let's be honest—who doesn't need a meme now and then to feel like part of the human family?

Sarah McCaslin, MS, MDiv, LCSW, is the executive director of the Psychotherapy & Spirituality Institute in New York City as well as a clinician and educator specializing in spiritually-informed psychotherapy.

A Look is Worth a Thousand Words

BY SARA NASSERZADEH

You know the meme: a couple is walking down a sidewalk, and the boyfriend turns and looks back at a stranger. His girlfriend notices and looks dismayed. The internet laughs! I keep thinking about this meme (which has many variations) because it shows how quickly a glance can become a story. I've explored this meme in sessions with some of my clients, and for my couples, it hasn't really been about the eyes and where they go. It's been about what the glance at the stranger means. Was it a matter of attention or attraction? One is a reflex; the other is a pattern that grows over time. Was it a fleeting moment, or a breach of trust?

I sometimes share this meme with couples to create a reference point and teach them about the ingredients of Emergent Love—especially attraction, trust, and respect. In our conversations, we name the passing stranger in their relationship. It might be another person, like the scene in the meme, or it might be a nonhuman distraction, like a phone or TV. It might be work. It might be the wish for a different life that shows up at 11 p.m.

When we discuss this in session, we don't shame the pulling away. We just get honest about it. Then, we create small habits that help attention come back home, like 60 seconds of eye contact before talking about anything complicated, or phones in a basket during dinnertime, or stopping to notice and appreciate one thing about each other today. Nothing fancy, just practice.

This meme also opens a gentle cultural door. In some families, scanning the room says, "I'm keeping us safe and honoring those around us." In others, this same behavior says, "You don't respect me because you're not focused on me alone." Once partners see they're not arguing about eyes but about attraction, respect, and trust, the air changes. Shoulders drop. They breathe, and we now have an opportunity to talk about what attraction, respect, trust, shared vision, compassion, and loving behaviors look like for both of them. Using this meme as a reference is a playful way to reach this place without a sermon.

My favorite take on this meme came from a couple who renamed it "Brain Buffering." When one partner's attention drifted, they'd smile and say, "My brain is buffering. Be right back." The other would touch their own wrist—our cue for two breaths and a reset. It was tender, a little silly, and it worked! The aim wasn't to police glances; it was to create a climate where attention could return again and again.

That's why this meme stays with me. It's funny. It's a great conversation starter. And it's rare that my couples—of any sexual and relational orientations—don't identify with it, especially when we look at it as more than just glancing at a stranger and instead see it as anything that could take them out of a moment of togetherness.

Sara Nasserzadeh, PhD, is a social psychologist, speaker, and thinking partner specializing in sexuality, relationships, and intercultural fluency. She's authored three books, including Love by Design: 6 Ingredients for a Lifetime of Love.

Stigma on the Silver Screen

BY LAURIE MINTZ

One of the top concerns women bring to sex therapists is difficulty

orgasming during partner sex, and there's a central cause of this problem that's cleverly captured by a meme on Instagram, which reads, "Hello, I am a lady in a movie. I come easily from vaginal penetration." As a sex therapist and educator, as soon as I saw it, I reposted it on my own account—and decided to include it in the PowerPoint for the course I teach mental health professionals about treating women's orgasm issues.

To grasp the pithiness of this meme, it's helpful to understand how women orgasm in real life as opposed to in entertainment media. An analysis of the most popular Netflix programs portraying heterosexual sex reported that the sex act almost exclusively shown is penile-vaginal intercourse. And in a study examining the 50 most-viewed Pornhub videos of all time, when women were shown orgasming, most did so during penetrative sex, and only a small percentage were shown orgasming from clitoral stimulation. But in real sex, the opposite is true. Only four percent of women say their most reliable route to orgasm is intercourse alone. The rest need clitoral stimulation, either alone or coupled with penetration. In short, even though most women don't orgasm from penetration alone, entertainment media portray them doing so.

The problem with these portrayals is that people believe they reflect reality, and in the absence of scientifically sound sex education, individuals turn to the media for sexual information. When a woman sees countless images of women orgasming from penetration, but she doesn't orgasm this way, she's likely to believe there's something's wrong with her instead of something being wrong with the portrayal. One of my clients recently said to me, "I think my vagina must be broken," because unlike what she'd seen in the media, for her, coitus didn't result in orgasmic ecstasy.

When working with this kind of client—and countless others who have difficulty orgasming during penetrative sex—it's essential to correct sexual misrepresentations with research-based information and suggestions. Psychoeducation includes teaching women about their external genital anatomy, including their clitoris. It includes informing clients how rare it is for women to orgasm from penetration alone. Female clients appreciate learning that when women masturbate, 98 percent stimulate their clitoris and 95 percent of those reach orgasm. An essential part of therapy with these women is suggesting that they get the same type of clitoral stimulation when with male partners as they do when alone. We need to encourage our female clients to think of clitoral stimulation as just as important as intercourse, and empower them to get the clitoral stimulation they need when having sex with male partners.

Providing clients with empirically supported information should be a cornerstone of therapy for sexual concerns, and it's essential that we let our clients know that what they're seeing onscreen—as captured so beautifully by this meme—isn't what most women actually experience.

Laurie Mintz, PhD, is a therapist and TEDx speaker, as well as a professor at the University of Florida, where she teaches the psychology of human sexuality. She's the author of two books, Becoming Cliterate: Why Orgasm Equality Matters—and How to Get It *and* A Tired Woman's Guide to Passionate Sex: Reclaim Your Desire and Reignite Your Relationship.

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Psychotherapy NETWORKER

NOVEMEBER
DECEMBER
2025

The Year That Reshaped Therapists

Psychotherapy NETWORKER BEST of 2025

Finding Regulation in a Dysregulated World

Editor's Note

Picture this: A mid-career therapist—let's call her Alicia—is sitting on a park bench between sessions, trying to stave off a growing sense of panic and confusion. When she's with clients, she's present and attuned, but lately that doesn't feel like enough.

She can guide people to breathe into the emotional pain they carry in their bodies. She can help them build tolerance to chronic stressors. She can introduce them to defusion techniques that distance them from their thoughts. But her caseload is filled with laid-off or furloughed workers, parents trying to make sense of ICE raids at school pickup lines, young adults drowning in the chaos of dating apps and AI chatbots. The fact is, even if all the corrective experiences in the world were piled up around today's clients like protective sandbags, the floodwaters of anxiety and helplessness would still be surging through.

In the past, Alicia has quelled her doubts about her work with a gentle reminder about the power of holding space for people, one individual at a time. She's been buoyed by the fact that despite the frenetic proliferation of new therapeutic frameworks and pick-your-acronym modalities, she's up to speed on her training. But this year has felt different—and she, along with many other therapists, can't quite put her finger on why. Everywhere she goes, there's dysregulation in the air. She and her colleagues feel it. Her clients feel it. Even the White Robot, rushing down the path in front of her and muttering about being late, seems to be feeling it.

Wait, what?

She watches curiously as it disappears down a rabbit hole—err, robot hole—and deciding to investigate, she too goes down the hole, landing in a wonderful albeit strange place we'll call Therapyland.

There, she encounters many of our field's leading luminaries—including Ramani Durvasula, Terry Real, Lisa Ferentz, Deb Dana, Frank Anderson, and Tammy Nelson—and discovers that they're grappling with the same questions she is. Why are we feeling so unsettled? How is it affecting our work as therapists? And what in the world do we do about it?

Alicia's journey in Therapyland is the centerpiece of this issue. While the context is clearly fictionalized (yes, it's a riff off *Alice in Wonderland*, and obviously, there's no such thing as a Cheshire Clinician who dispenses wisdom then disappears into the trees, an Integration Inn providing a respite from our field's many silos, or a Polyvagal Elevator that showcases your nervous systems in psychedelic displays), the conversations in the story are real.

They're taken from exclusive interviews we did this fall that carry on our long tradition (almost 50 years, in fact) of putting our ears to the ground and listening to individual therapists around the country as a way to take stock of where we are as a field. The perspectives these clinicians share—on the personal traumas affecting their lives and the collective traumas shaping their practices—are candid gifts of vulnerability you won't find anywhere else.

Another way we're taking stock of the field in this issue is through our 2025 Best Story Awards. Of the 150+ articles we published this year, on just about every clinical topic under the sun, these winners were chosen by you, our readers. Whether they helped give shape to your unique struggles or provided practical tips you shared with your clients, these are the pieces you told us resonated most with you. And you are the beating heart of this wild, ever-evolving field we call psychotherapy. Congratulations to the winners—as well as the many deserving nominees—for sparking conversation and connection in our community.

After all, we hope Psychotherapy Networker continues to feel like part of your professional home. Here, you can kick off your shoes, put your feet up on the furniture, and nerd out on whatever clinical inquiry piques your interest. Why has energy psychology been at odds with APA's Division 12 for so long? Networker Senior Editor Chris Lyford sheds light on this epic battle, one that raises larger questions about what's "effective" vs. "evidence-based" therapy. How can you help a client who wants a relationship but can't sustain sexual interest, even for partners they deem desirable? Two legendary therapists walk you through their approaches. What is "selfish forgiveness"? Find out why it might be a useful intervention. Want to see the five funniest memes therapists are sharing these days? Discover the deeper issues these snappy graphics reveal.

Our stories are written by you, for you. And while this issue addresses much of the heaviness and confusion in our world today, we hope it also offers some inspiration and whimsy too.

LIVIA KENT · EDITOR IN CHIEF

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The Year That Reshaped Therapists - Finding Regulation in a Dysregulated World

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Ask any therapist: clinical practice this year has felt more complicated than usual, fraught with the chaos and conflict that's permeating our culture. But when an overwhelmed clinician falls down a rabbit hole into Therapyland, her fantastical journey leads her to unexpected interactions with some of our field's leading luminaries, including **Ramani Durvasula**, **Terry Real**, **Lisa Ferentz**, **Frank Anderson**, and **Deb Dana**.

2025 Best Story Awards

READERS' CHOICE AWARDS

We published a lot of stories in 2025—on a dizzying array of clinical topics brought to life by therapists from across the field wanting to share their perspectives and experiences with colleagues like you. Then we asked you to vote on the stories that resonated most. After all, *you* are the heartbeat of our field, and finding out what engages you is a great way to know where we are as a field. Here's what you chose!

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BY CHRIS LYFORD

Energy Psychology's Battle for Recognition

A Growing Healing Movement vs. APA's Division 12

Just minutes into a session with his client Mia, Robert Schwarz does something you won't see in most consulting rooms. He holds both palms open, as if receiving a small gift, and repeatedly bumps the sides of his hands together. At his instruction, Mia does the same.

"I imagine we could just go straight to telling the story," Schwarz says. "But why suffer?"

For Mia, "the story" still delivers a gut punch. Even though it happened decades ago, when she was just nine years old, she has a hard time talking about the time her soccer coach cruelly poked fun at her weight while her teammates stood by and laughed. It's all too much to handle. When Schwarz asks Mia how she usually feels when she thinks about that moment, she hunches her shoulders, shrinks her body, and balls her fists.

"Shame, embarrassment, humiliation," she says, visibly upset. "I feel like I want to hide and make myself really small."

"Right," Schwarz replies, scrunching himself down too in a beautiful but subtle display of attunement. "That sure sounds like shame." He quickly and deftly pivots. "So let's take that memory and stick it in a box," he continues. "Let's not even look at it." He pauses. "But if you were to look at it, how would you rank it on a 1-to-10 scale?"

"A seven," Mia replies.

"So let's start tapping," Schwarz says, beginning the hand-bumping. "We're going to say, 'Even though I'd have this sense of humiliation and shame if I were to look in the box, I deeply love and accept myself.'"

Mia repeats the mantra.

"Now let's tap the top of your head," Schwarz instructs, tapping on his own head with his palm. He slowly moves down his body while Mia follows along on hers. He taps above his eyebrows, then his temples, upper lip, chin, chest, armpits, fingertips, and finally, the back of his left hand.

"Now, close your eyes," Schwarz instructs. "Open your eyes. Look left. Look right. Hum a tune"—Mia obliges, humming "Happy Birthday"—"and take a deep breath." It's a cleansing reset, and Mia's shoulders relax.

"Now," Schwarz continues. "If you were to look in the box, at this moment, what do you think the number would be?"

Mia's response is shocking.

"A one or a two."

Beyond Tapping

It's hard to witness what's just happened between Schwarz and Mia and not think some sort of miracle has occurred. In just 10 minutes, Schwarz has managed to virtually eliminate Mia's trauma symptoms—at least for now. In this moment, she's calm, confident, and ready to engage the problem head-on. Now, she *can* tell the story without getting overwhelmed. But how?

Schwarz says Mia's response is due to the unique method he's been practicing for over 30 years, known as the Emotional Freedom Technique, or EFT. It's a form of energy psychology, or EP, a holistic, integrative approach that views the body as an interconnected system of energy. There are several forms of EP, including Thought Field Therapy, Tapas Acupressure Technique, Comprehensive Energy Psychology, Advanced Integrative Therapy, and Heart-Assisted Therapy, but they're mostly similar.

Drawing from ancient Eastern practices like acupuncture, each involves tapping acupressure points to release

the stress said to be caused by negative thoughts, emotions, and experiences that disrupt the body's energy. Used alongside cognitive therapy interventions that target distressing thoughts or memories, like focused awareness, mindfulness, and imaginal exposure, proponents say EP can be used to treat a range of issues, including depression, anxiety, trauma, phobias, and chronic pain—and quickly reduce symptoms or eliminate them altogether.

You'd think most therapists would jump at the chance to give their client a sevenfold reduction in symptoms, a surge of confidence, or a foothold to begin the hard work of therapy, as Schwarz did with Mia. But not everyone is so enamored with EP. Detractors have called it a pseudoscience, questioned the integrity of its studies and the objectivity of study coordinators, and say any benefits are due to the placebo effect or the other modalities it incorporates. Some of the biggest criticism comes from therapy purists, for whom all this talk of *energy, chakras, biofields,* and *meridians* conjures up the mental image of shamans and spellcasters, not bona fide therapists who follow thoroughly researched protocols and diagnostic bibles.

But EP isn't just some fringe intervention, proponents retort. It's been around for nearly 40 years, amassing a wealth of research and success stories along the way. According to the Association for Comprehensive Energy Psychology (ACEP), EP's leading professional organization, today EP boasts tens of thousands of therapists and has more than 200 published research studies, including 103 randomized control trials, 95 outcome studies, nine meta-analyses, and five fMRI studies. ACEP says these studies not only cement EP as an evidence-based treatment, but place it among the top 10 percent most-researched modalities.

And yet, reads a report on EP published in the journal *Psychotherapy: Theory, Research, Practice, Training,* there are "serious flaws in the methodology of the research. Providers should be wary of using such techniques, and make efforts to inform the public about the ill effects of therapies that advertise miraculous claims." A report from the journal *Clinical Psychologist* accuses EP of operating from "an unsupported and implausible theoretical basis." Clinical psychologist Richard McNally, the director of clinical training at Harvard University's department of psychology, calls it downright absurd. "We wondered whether it was a hoax," he writes of Thought Field Therapy, "concocted by some clever prankster to spoof 'fringe' therapies."

This isolated criticism doesn't rattle EP practitioners like Schwarz. He's heard it all: that EP is a pseudoscience because you can't measure meridians ("but you can," he says), that the energy component is strange ("it's actually not that strange"), that it only works because it's similar to other therapies ("most therapies are similar"), or that EP's studies are flawed ("then why are they all pointing to the same thing?"). But again and again, he says the critics fall into the same trap: "They think about EP too simply," reducing it to its most sensational components, like tapping. Schwarz says his method is actually rich and multifaceted. And watching the process unfold, it's hard to disagree.

As Mia continues to tell "the story" over the next 45 minutes, her distress level rises and falls. She shuffles between a variety of emotions: sadness, humiliation, anger, and annoyance. And throughout all of it, Schwarz stays in the trenches with her: mirroring, validating, guiding, and sometimes gently pushing. When Mia says she feels better but something seems amiss in her voice or body language, like a wince or quiver, Schwarz astutely calls attention to it, names it, and asks her to tap and repeat the mantra once again before reassessing her level of distress.

"This is like when you go to the doctor and they ask, 'Does this hurt? Well how about this?' he tells Mia. "We just want to get this out of your system."

Before long, Mia says her distress level is steady at a one. "The anger's not there anymore," she tells Schwarz. "I just want to laugh now."

"Well, let's keep going," he replies. "If you could've said something to that coach, what would you have said?"

Mia ponders for a moment. "I'd have stood up and faced her," she says defiantly. "I'd have said, 'What the hell are you doing?! Why do you need to embarrass me in front of my teammates?! You don't do that to a kid!'"

Schwarz's face lights up. "That's right!" he says. "'You don't do that! Don't mess with me!'"

Schwarz's pride at this bold expression of courage is palpable, but maybe it's not just the pride that comes from seeing a client reach a breakthrough. Maybe there's something about an underdog finally speaking truth to power—a classic David and Goliath story—that resonates with Schwarz in this moment. After all, it's the kind of fight he knows all too well.

Who's Afraid of the APA?

For energy psychologists, most naysayers are more of a nuisance than an actual impediment to their work and livelihood. But then there are the field's Goliaths—the large, powerful institutions whose decrees can make or break entire modalities. In the psychotherapy world, few Goliaths loom larger than the American Psychological Association's Division 12 task force, which certifies treatments as "empirically supported"—and thereby confers multiple privileges and opportunities upon them, not only boosting exposure and solidifying public trust, but opening the door for funding, insurance reimbursement, training and licensure, and research opportunities. Although it's

difficult to quantify exactly how much money flows to methods Division 12 deems empirically supported treatments (ESTs), between federal and private funding, insurance coverage, and public health initiatives, the number can reach hundreds of millions of dollars.

Throughout its battle for recognition, Division 12 has been a thorn in EP's side. The task force says the modalities on its list of ESTs—which includes CBT, ACT, DBT, EMDR, and motivational interviewing—have undergone rigorous clinical trials and research to determine their effectiveness. Yet despite numerous petitions from ACEP and its allies to get EP added to this esteemed list, with its many research studies in tow, Division 12 has continued to balk.

Tensions came to a head in 1999, when the APA took the unprecedented step of sending a memo to its CE sponsors that singled out Thought Field Therapy as ineligible for psychology CE credit. Before long, the ruling was applied to all of EP, threatening any and all APA CE sponsors teaching EP with the loss of sponsorship status. ACEP appealed the APA's decision in late 2009, but lost. In response, a handful of ACEP's allies, including the Energy Medicine Institute's David Gruder (also ACEP's cofounder and first president) made a direct appeal to APA President Carol Goodheart in an email sent the following spring.

"The APA has been actively restraining the dissemination of the approach for more than a decade," Gruder wrote. "As an outside health advocacy group, it is within our purview to publicly challenge a decision regarding energy therapy that negatively impacts public health." The APA's stance on EP, he continued, "is inconsistent with its own CE Standards, reflects a disregard of interdisciplinary developments, and does harm to the public." Evidence of EP's effectiveness had been mounting, Gruder added, before taking aim at the golden child of evidence-based treatments. "Energy psychology," he wrote, "is arguably more effective than conventional treatment strategies such as Cognitive Behavior Therapy."

Twelve days later, Goodheart emailed a response.

"Thank you for writing and expressing your concerns," she wrote. "I do want to inform you that as APA President I cannot make any changes to the decisions of the Continuing Education Committee." Pressed by an NPR reporter in 2011 about the snub, an APA representative gave a predictably curt response. "The American Psychological Association does not approve or endorse specific therapy techniques," she replied. "We therefore have no policy position on energy psychology." The verdict, it seemed, was final.

But ACEP and its allies continued to gather research, and to appeal. Finally, in 2012, the APA relented and reversed its ban on CE sponsorship for EP courses, noting that the 51 reports submitted, including 18 peer-reviewed randomized controlled trials, met their requirements. EP practitioners were jubilant, and in what seemed like an olive branch, ACEP's practitioners were even invited to teach at APA's annual conference.

Sure enough, the APA's change of heart incensed EP's critics, who began to question the organization's integrity. In 2018, clinical psychologist, professor, and scientific skeptic Caleb Lack, who's devoted his career to studying evidence-based assessment, cried foul over this "failure of the APA" in an article he titled "Energy Psychology: An APA-Endorsed Pseudoscience."

"There is no evidence to support the existence of the human energy field, the manipulation of such a field, or the channeling of 'energy' from one person into another," he wrote. "These concepts are in direct conflict with all that we know about how physics, chemistry, and biology work." The APA's decision, he continued, had been made "despite a complete lack of scientific plausibility," adding that "as one of the more powerful mental health groups in the United States, the APA's seal of approval on energy psychology conveys to many people that this is something that works and is widely accepted by the psychological community." In reality, he wrote, "nothing could be farther from the truth."

Forging onward, ACEP continued to push for inclusion in Division 12's list of ESTs, to no avail. Then came a one-two punch: in February, the APA ratified an update to its Division 12 Clinical Practice Guidelines, adding several new recommended modalities for treating PTSD after omitting energy psychology from consideration. And in September, after commissioning a task force to define "psychological treatment," Division 12 released its conclusion: integrative, somatic, and mind-body therapies—including energy psychology—hadn't made the cut. A request for reconsideration was denied.

Few can argue that psychotherapy needs rules and guardrails. But Division 12 isn't just rule-making, EP practitioners argue: it's gatekeeping. And in the ongoing battle between Division 12 and the EP community, few have been louder about Division 12's stance than therapist David Feinstein, former faculty at Johns Hopkins University School of Medicine, an EP practitioner of over 20 years, and the founder and director of the Energy Medicine Institute. Year after year, Feinstein has doggedly sent applications to Division 12, filed appeals, and challenged the detractors in academic publications.

"We sent Division 12 studies showing that we meet the criteria for being listed—again and again," he says. "We received either cursory responses or no response at all. Meanwhile, APA journals are still publishing articles dismissing EP as a pseudoscience and questioning its ethics. This

is misleading and even slanderous toward a legitimate practice, and it's harming the people who could truly benefit."

Feinstein is likewise fed up with the APA's hot-and-cold attitude toward EP, with having his hopes raised and dashed over and over. "In 2003 I said, 'This year will be the tipping point.' I said the same thing the next year, and the next. It's been discouraging to see the evidence repeatedly dismissed—not on its merits, but because it doesn't fit the institutional mindset."

Schwarz is equally vexed. "It's anti-scientific thinking in the name of science," he says of Division 12's decrees. "These are the forces who believe anything holistic is unscientific. It's the medical model. It's the status quo versus change."

You don't just pick up frustration listening to Feinstein and Schwarz, but exasperation. It's something familiar to any therapist who's reluctantly flipped through their copy of the DSM or breathed a heavy sigh as they scribbled down a diagnosis code just to get an insurance reimbursement. On some level, most clinicians can relate to feeling hamstrung by psychotherapy's powers that be, who don't just determine how we practice, but elevate a select few treatments to an elite status under seemingly mysterious circumstances.

As Feinstein and Schwarz see it, the deck has always been stacked against EP. But with decades of painstaking research and countless testimonials, it seems to be speaking the APA's language and following all the rules. So why is there still so much resistance?

"To be honest, I don't know," Schwarz says. "I can only assume they haven't evaluated the literature, even though it's there. If this was a drug, it'd be worth billions of dollars. The research shows EFT works faster, better, and costs less than many other methods. Frankly, if something came along that kicked its ass, I'd be the first to sign up."

Tapped Out?

Feinstein and Schwarz may have built their careers around energy psychology, but they understand why people are initially skeptical about it. As it turns out, they used to be skeptics too.

"I stumbled onto EP about 30 years into my psychotherapy career," Feinstein says. "At first, I thought it was utter nonsense. I thought tapping on the skin to resolve major psychological problems was patently absurd. But I kept hearing about how quickly people who used it were reporting strong benefits. So I finally looked into it. Once I embraced it, my practice shifted radically. While the approach can stand on its own, I found that I didn't have to throw away what I already knew; EP just helped best practices work faster and more effectively."

"In the beginning, I was very secretive about my interest in energy psychology," Schwarz admits. "It was the energy, the tapping, the woo-woo." As a young clinician in the 1990s, he'd been searching for a way to make therapy faster, more effective, and more affordable. After encountering a live demonstration of EFT at a psychology convention, Schwarz knew he'd found what he'd been looking for. But he kept quiet, feeling like the clinical world wasn't quite ready for it.

"I was struggling with my professional identity and didn't want to be seen as a flake," he explains, "so I didn't tell anyone I was interested." But behind closed doors, Schwarz continued to explore the method. He attended trainings and slowly began to test it out with clients. The results shocked him. "You'd see change *just happen*," he says. "Something would loosen up. The flow of information and energy would shift, and they'd have a totally different take on things."

Schwarz believed in EFT so much that he even used it with his then-six-year-old son, who became extremely dysregulated after walking through a haunted house attraction on Halloween. "He was *flipping out*," Schwarz recalls. "I did a little tapping on him, and 30 seconds later, he was fine!" Emboldened, Schwarz went on to teach EP. Later, he joined the board at ACEP, and then became its executive director, a position he'd hold for 17 years.

Schwarz may be a believer, but he admits that EP needs a rebrand to make it more appealing to more people, contending that the way it was conceptualized and presented to the public 40-odd years ago was flawed. "The language started with the energy and the tapping," he says. "Over the last decade, we've been using less of the e-word and more widely accepted phrases like *mind-body intervention."*

Feinstein agrees that perhaps EP didn't make a great first impression. "Methods like EMDR did research right off the bat," he explains. "Francine Shapiro did it from the start, whereas EP founder Roger Callahan's attitude was, 'Well, you don't really need research. Just try it. You'll see that it works.' His first book, *The Five-Minute Phobia Cure*, was published before there was a single peer-reviewed study supporting the method. That attitude didn't play well with the psychology establishment." Now, with evidence, Feinstein is confident he can sway a sizeable number of therapists on the fence about EP.

"The objection I run into most often is, *How could this possibly work?*—which was my first impression too. Even therapists who are open-minded and persuaded by the research often assume that EP works because of other factors, like exposure or placebo. I've been told, 'As long as the mechanism seems so implausible, I have to find other explanations for these results.' My most recent papers offer a compelling neurological model that makes the mechanisms seem entirely plausible."

Of course, any rebranding will probably have little bearing on Division 12's blind refusal to accept EP's merits, Schwarz adds, which doesn't stem from some particular aversion to EP as much as from a systemic barrier to change. "Division 12 says in order for a treatment to make the cut, it must have been created out of 'psychological science,'" he explains. "But CBT didn't come from science; it came from clinical practice. By these standards, you're eliminating Polyvagal Theory, interpersonal neurobiology, mindfulness, most of behavioral therapy, and anything involving the body. That's crazy."

A Change is Gonna Come

You might think that energy psychology is struggling, that it's destined to live on the outskirts of clinical practice, or that it's something to be pitied. But in reality, the opposite is true. Culturally speaking, EP is leading the pack. Holistic practices have never been more popular. By 2030, body, mind, and energy healing is projected to become a $395 billion market, quintupling in size. According to a national study published in *The Journal of the American Medical Association*, more people are seeking out alternatives to conventional mental health treatment because they're dissatisfied with mainstream options, enjoy the autonomy these methods provide, and see them as more compatible with their values and beliefs. In short, clients aren't just curious about interventions like energy psychology; they're asking for them by name precisely because they're different.

"Lately I've been wondering why we're working so hard to get APA approval," Feinstein says, "because even without it, EP is finding its way into mainstream institutions, from Kaiser to the VA. It's also resonating with the culture. Celebrities are talking about how it's helped them with performance issues or with their fear of heights or flying. You have movies showing tapping. More than 30 countries have used it successfully in post-disaster treatment. I think it's finally reached a tipping point."

Clients aren't the only ones warming up to nontraditional methods. According to a 2024 survey published in *Frontiers in Psychiatry*, 78 percent of therapists say alternative, integrative, and mind-body therapies like meditation, biofeedback, hypnosis, and yoga are *the most promising* form of treatment, and most believe that clinicians should receive training in alternative methods. Meanwhile, the National Institutes of Mental Health and Harvard teaching hospitals like Massachusetts General have added alternative treatments to their programming. Feinstein and Schwarz are seeing this same enthusiasm on their end.

"I've been teaching EP at the Networker Symposium for years," Schwarz says. "Early on, maybe 50 people would show up to my workshop. This year, over a thousand signed up. Something is happening. Something has shifted."

As for the clinicians who feel similarly aggrieved by the dominance of a select few treatments and the exclusionary practices locking others out? They're speaking up too. Prominent psychologist and ACT cofounder Steven Hayes—whose method even made Division 12's list—made a bold prediction about the future of EST gatekeeping.

"For nearly 50 years, intervention science has pursued the dream of establishing evidence-based therapy by testing protocols for syndromes in randomized trials," Hayes writes. "That era is ending."

Slowly, the tide is beginning to turn. But the hard truth, at least for now, is that Division 12's dominance and influence will likely continue, and energy psychology will likely continue to fight an uphill battle when it comes to vying for an EST title. Even so, Schwarz isn't deterred.

"I'm not going to wait for Division 12," he says. "My goal is to make a difference in the world, to treat the plague of trauma and dysregulation. Right now, a lot of people are suffering who don't need to suffer."

■ ■ ■ ■ ■

Evidence-based treatments have their place. And there are therapists and clients alike who won't touch therapies that don't fit the bill. But again and again, studies show that what matters to clients isn't whether their treatment is evidence-based, but rather the distinctly human qualities of their therapists, like trust, empathy, and genuine care. And nobody—not even Division 12—can accuse Robert Schwarz of not caring.

As his session with Mia winds down, her distress levels are low, and staying put. Schwarz circles back again and again to nip any lingering symptoms in the bud, with empathy, incisive questions, tapping, and mantras at the ready. Finally, there's only one thing left for Mia to do: say goodbye to the person who's haunted her for decades.

"Coach was always the first person who came to mind whenever I felt insecure," she says. "Now I can almost visualize her walking away. If she popped up again, I wouldn't listen to her anyway."

"'You've been with me for a long time,'" Schwarz says, offering Mia a template. "'And now it's time to say goodbye once and for all.'" He begins to tap, and Mia follows along.

"'I'm an adult now,'" Schwarz says, "'and I deeply love and accept myself. You're not going to haunt me anymore.'" Mia repeats the words. Schwarz takes a tapping hand off his cheek to wave goodbye to Mia's tormentor, and Mia does the same. A moment later, she smiles softly.

"She's gone now," she says. "No hard feelings." pn

Chris Lyford is the senior editor at Psychotherapy Networker.

BY ALAN DEMMITT & KRYSTEL CHENAULT

Embracing Selfish Forgiveness

HOW TO HELP CLIENTS RELEASE A GRIEVANCE STORY

Q: My client comes into every session bitter and upset about a former friend who betrayed her. How can I confront this pattern without invalidating my client's anger and hurt?

A: Over 30 years, while working with clients in private practice and community mental health settings, I've frequently seen this pattern of clients holding grudges that impede their therapeutic progress. I've also seen how these grudges prevent people from letting go of past harmful relationships or moving on to form new relationships that might help them grow and thrive. I've come to call it the "not-forgiving holding pattern" or as psychologist Fred Luskin called it, a "grievance story," because even though the wrongs suffered by the client are in the past, it's hard for them to move out of the familiar state of feeling emotionally wronged.

Take my client Dan. When he first entered my office, his leg bounced so hard from nervousness that it rattled the glass table next to the sofa. His phone was on his lap. He clicked the home button each time his leg shook. The blue "F" of the Facebook app flashed as he absently locked and unlocked his phone without once glancing down to look at the screen.

"I only check once a day now," he said with a wan smile. "We have mutual friends who comment on the pictures, so it's hard to ignore her feed." At my suggestion, he put his phone on the table but continued glancing at it every few minutes.

Dan sought therapy after his ex-wife Carol gave birth to her first child with her new partner, further cementing the realization that she'd moved on and was finding happiness in a new relationship. Dan was taken aback by the visceral reaction the news caused him. He didn't feel jealousy or romantic nostalgia toward Carol, but any happiness Carol experienced in her life felt like a personal affront. It reawakened and amplified the pain she'd caused him years ago, which had led to the end of their marriage two years earlier.

His resentment manifested in his obsessively monitoring Carol's life. He checked her social media pages multiple times a day, integrating the monitoring into his everyday rituals: scroll-

ing through her Facebook page while drinking his morning coffee, checking again on his lunch break at work, checking while preparing dinner, and again before bed. Dan claimed his hatred for Carol and his desire to see her experience pain in her life without him fueled these behaviors. Alternatively, evidence of an absence of pain—or of the presence of happiness—in Carol's life sent Dan into a cycle of resentment followed by shame. *Why do I care so much about her life?* he berated himself. It was clear she no longer seemed to care about him.

I've seen this pattern of resentment and monitoring in couples and families, and in work I've done as a mediator. As a counselor educator teaching the process of forgiveness to clinical mental health counselor students, I've heard two questions come up regularly: If this pattern is so destructive, why do people engage in it? And why do so many of our clients stay stuck in it for so long? Here are a few common reasons.

It provides a false sense of empowerment. Keeping a relationship in the "not forgiven" holding pattern can feel empowering in the short run. When you choose not to forgive someone, the control of release is entirely in your hands.

It feels vindicating. Any evidence of hardship in Carol's life (e.g. loss of a job, dissolution of a romantic relationship) kindled the schadenfreude that strengthened Dan's sense of self-righteousness. He could tell himself, "See! That's what she gets for being so awful to me. And clearly, I was right about the criticisms, judgements, and accusations I've made about her all these years. She's getting what she deserves." Evidence of hardship can give us the false sense that the offender is being punished.

It provides a false sense of safety. Dan holds on to the belief that not forgiving Carol protects him from being hurt by her again. He keeps his defenses up to stay safe, ignoring the fact that he's living as if he's in a constant state of being under attack.

It shields us from uncomfortable feelings. Engaging in the cycle of checking Carol's Facebook page kept Dan too busy to experience the full grief process. His anger and resentment blinded him to the time he was losing by engaging in these repetitive behaviors.

It provides energy. Often, remaining stuck in this cycle can give us what feels like energy or courage to assert ourselves and our point of view. It can also provide energy to do something when we struggle to find the energy to do anything.

It's easier than the alternative. Many people stay stuck in this pattern because they don't know how to forgive. Some view forgiveness as a religious concept rather than a tool for healthy relationships. For some, the word *forgiveness* itself becomes a roadblock because they think forgiveness means you're agreeing with or endorsing another's behaviors or forgetting the pain you suffered.

Logically, Dan understood that his resentment wasn't hurting Carol. She was living her life, seemingly happy and free without him. Dan was locked in a resentment holding pattern toward Carol, yet it wasn't changing her actions or behaviors towards him. She hadn't reached out to him in years. She hadn't atoned for the hurtful things she'd said and done to him in the ways Dan felt she should. Dan believed this was why he was still suffering.

Dan admitted that he hid his behavior from his friends and family, particularly his mother, with whom he had a close relationship. The situation had also cost him a romantic relationship. When monitoring Carol's social media didn't yield the satisfaction he craved, Dan grew irritable for several hours, sometimes lashing out in anger toward his new partner for small affronts or missteps. Although he felt resentment towards the mutual friends who hadn't cut ties with Carol after the two of them split, he still remained connected to them on social media so he could more closely monitor Carol. He tracked and logged their friendly interactions with Carol and grew increasingly conflicted and bitter towards them.

At the start of one of our sessions, when Dan was beginning once again to list the injustices he'd suffered at Carol's hands, I interrupted him.

"Dan," I said. "Would you mind if we did something a little different today? Something that might help you free yourself from the grip of this resentment?"

"I guess," Dan said, shrugging.

"I know Carol has hurt you badly, and I know you feel like she needs to ask your forgiveness in order for you to move on. But what if there were another way?"

"I wish there were," he said. "But I've tried everything."

"Well, are you open to the idea of forgiving Carol for what she's done?"

Dan's eyes widened. He looked visibly angry with me.

"Are you kidding?" he sputtered. "After everything she's done?"

"Well, in this situation, forgiveness is *not* a way to release Carol from responsibility or restore your relationship. Rather, it's a way for you to let go of the pain and find some peace and freedom."

Initially, Dan didn't want to "let her off the hook." Instead of anticipating relief, Dan feared the emptiness that would be left if he let go of the resentment that had become the most tangible and all-consuming focus of his life.

Forgiveness as Self-Care

At this point, we began to explore forgiveness as a form of *self-care*. I call self-caring forgiveness *selfish forgiveness*, a common term for forgiving someone for your own mental health and well-being. Putting the word "selfish" together with "forgiveness" may seem paradoxical, but a healthy tension results from combining these two ideas. Framing it this way frees a client from any moral obligation to "do good" for abstract reasons. This terminology distinguishes this type of forgiveness from the toxic positivity of a culture that insists we have to forgive to be "good" or "spiritual." It positions a client's

inner peace ahead of social norms that prioritize interpersonal amicability at the expense of the self.

Selfish forgiveness can be defined as letting go of resentment—not to restore an ailing relationship, but for one's own well-being and happiness. It's especially useful in situations like Dan's where one party is absent and/or lacks remorse, thereby rendering interpersonal forgiveness difficult or impossible. If we could remove Carol from Dan's forgiveness process, we might be able to genuinely empower him to move on. He could begin the journey toward finding closure in his post-Carol life, and over time, his well-being would become less contingent on Carol's actions or inactions. The day might even come when he would no longer feel compelled to keep tabs on her.

Selfish Forgiveness and the Stages of Change

When transforming the cycle of resentment into selfish forgiveness, it can be helpful to view forgiveness through the lens of Prochaska and DiClemente's Stages of Change framework. This framework provides a roadmap for the forgiveness process.

In the first stage, *precontemplation,* Dan was either unaware of a problem or didn't see the need to change his behavior because he saw Carol as the problem. In the second stage, *contemplation,* Dan acknowledged that there was a problem and that he was contributing to it. He also grew more open to the possibility of changing his actions at some future time. Dan was in the *contemplation* stage when he sought counseling. He identified his obsessive monitoring of Carol's social media as problematic but could not tangibly envision a future where he wasn't compelled to engage in these actions, which caused him unhappiness and fueled his irritability and sense of helplessness. Dan was more focused on Carol's role in contributing to his actions than on his own sense of agency. At this stage, it felt as if his behaviors were a natural result of her past actions towards him, which left him feeling powerless to change.

Understanding the concept of selfish forgiveness, and the ways engaging in it could free him from suffering, helped Dan move from *contemplation* to stage 3: *preparation.* By reiterating that forgiveness would be *intrapersonal*—meaning an experience that took place within his own psyche—and not something that happened between him and Carol, Dan started planning to change some of the behaviors and actions he'd been engaging in that were harmful to him. *Preparation* is marked by a shift in focus towards one's own behavior along with the formulation of a concrete plan to change. After cutting down the number of times he checked Carol's social media daily from five or six times a day to once daily, Dan resolved to block Carol on Facebook so he could no longer see her page. Taking this step wasn't easy for him, but once he did, it diminished the pain he felt about her past actions by removing the triggers of her posts and their old friends' responses to her posts. This didn't mean Dan didn't still hold Carol accountable for her past harmful actions toward him—he did. It meant he didn't experience the same level of resentment.

When moving out of *preparation* and into the *action* and *maintenance* stages, it's important to move the forgiveness process from an interpersonal focus to changing one's own actions and habits. The shift must support intrapersonal forgiveness and self-care. An *interpersonal* forgiveness process—one that depends on another person's actions and behaviors—can be undone by outside factors such as seeing the person who hurt you in public or experiencing a new partner exhibiting similar behaviors to the ones that caused you pain in the past. When forgiveness is firmly established as an internal process of self-care, however, control stays with the forgiver.

While moving from *preparation* to *action*, Dan was still vulnerable to resentment, even as he resolved to let it go. We employed the metaphor of having a kitchen full of smoke after something had burned on a stove. If this happened, it made sense to grab a dish towel or some other item that would help you fan the unpleasant smoke out of the kitchen. The idea of fanning out the smoke for the sake of the smoke was laughable. Of course, he'd fan the smoke out for himself—not because the smoke "wanted" to be free. He was the one inhaling the smoke. It hurt his lungs, and he wanted to be rid of it. Fanning out all the smoke would take some time and work, and maybe some remaining smoky smell might resurface now and again. But eventually, the air in his kitchen would be clear once again.

■ ■ ■ ■ ■

Most changes, including forgiveness, aren't simple or absolute. People in our lives don't fall into rigid, binary camps: "forgiven" or "not forgiven." Forgiveness is ongoing. It happens in degrees. The same is true for the act of forgiveness. Selfish forgiveness requires a reenvisioning of forgiveness as an emerging process that shows up in the behaviors we engage in every day. Do the things we do stoke or reduce resentment? Forgiveness isn't a one-time event that *happens* and is over forever. It *begins*, takes place in fits and starts, and in some situations, may never be completely over. And that's okay.

Dan hasn't yet fully forgiven Carol. He hasn't completely purged his resentment towards her from his heart and mind. But he no longer checks her social media, and he's hopeful that one day he'll be free of the pain their marriage caused him. Author Lewis Smedes once said that to forgive is to learn to live with an uneven score. Perhaps, in the case of selfish forgiveness, to forgive is to embrace the possibility that the score isn't worth keeping if it comes at the expense of your own happiness.

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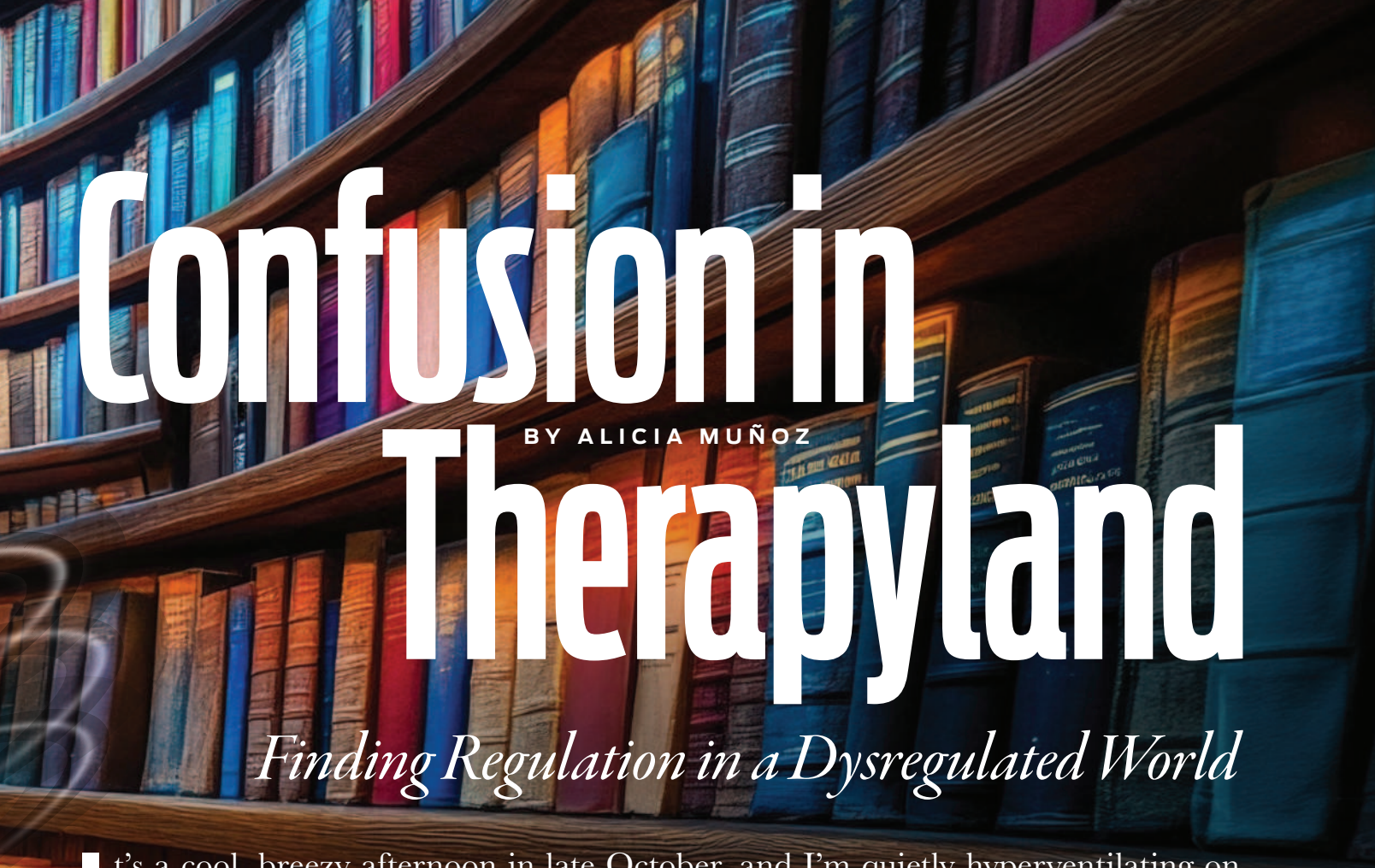

Confusion in Therapyland

BY ALICIA MUÑOZ

Finding Regulation in a Dysregulated World

It's a cool, breezy afternoon in late October, and I'm quietly hyperventilating on a park bench by my house in downtown Washington, DC. I'd decided to go for a walk between therapy clients (good idea), but then sat down and got seduced into doomscrolling cynical memes and shocking news headlines (bad idea).

After pausing over a donation request to "save our crumbling democracy," I saw an email from my afternoon client: she'd been laid off from her government job and isn't sure how she's going to pay rent, much less continue therapy. I feel my heart start to race and my nervous system collapse into a dizzying tailspin, which has been happening a lot lately.

I switch my phone to airplane mode.

"You'll be fine," I whisper. "Breathe."

Whether you lean left or right, the world feels extra confusing this year—and so does psychotherapy. The modalities I've honed and practiced for decades seem like they're becoming increasingly unreliable. Or is it that people's problems have changed, making the modalities less well-suited to resolving them? When I see desperate clients battling systemic traumas *while* trying to heal childhood wounds, forge healthy relationships, *and* search for work, it feels like I'm offering them droplets of self-care to extinguish massive forest fires.

Or am I just having a therapist mid-life crisis, and it's *me* that no longer fits the modalities or my clients' needs? Whatever the cause, I can't keep stumbling around in the dark like this, stressed out and uncertain about my role and what my next step should be.

Nearby, I see cheerful tourists taking selfies on a scenic walkway. Beyond them, members of the National Guard with M4 Carbines slung over their chests cast steely gazes across the Potomac River. It's an eerily discordant scene. Suddenly, a boxy, white robot appears from under a bush. "Oh dear," it mutters in a mellifluous, AI-generated voice, "I'm late!"

Where did that come from? On an impulse, I follow it along a dirt path that leads to an old canal and clamber down a stone wall, landing with a crunch on a heap of garbage. The white robot tips forward, muttering, "Oh, dear." Then, it vanishes down a hole in the ground.

How odd! I peer into the hole that swallowed the robot. And that's when a powerful suction draws me forward, and everything goes dark.

The Problem with Solutions

As I orient myself to my surroundings, I notice I'm falling through the center of a circular bookcase lined with familiar titles: *Us* by Terry Real, *To Be Loved* by Frank Anderson, *The New Monogamy* by Tammy Nelson, *How to Befriend Your Nervous System* by Deb Dana, *Life Isn't Binary* by Alex Iantaffi. Whatever mysterious land I've stumbled into, seeing books by fellow therapists I've long admired piques my curiosity.

It also makes me realize that despite encouraging my clients to reach out to trusted people in their lives when they feel like they're falling, this year, I haven't checked in with my colleagues much, perhaps because I haven't been able to name and understand the vague, existential dread that's enveloped me. Are other therapists feeling it too? What are their perspectives on this strange year in clinical practice?

On a whim, I reach for a book entitled *It's Not You: Identifying and Healing from Narcissistic People* by Ramani Durvasula. Instantly, my body lurches to a stop, bobbing as though I've reached the end of an invisible bungee cord. In front of me, the bookshelf parts, and I'm in a cozy room with a dark-haired woman seated near a walker.

"Dr. Ramani! What a relief!" I cry out. It's good to see a familiar face, at least one I recognize from all her educational content around narcissistic abuse on YouTube and Instagram. "Everything feels so messed up in 2025. Maybe you can help me understand what's happening!"

She trains her eyes on me. It's clear she's torn about how to respond.

"Things *are* messed up," she affirms at last. "Lately, I've been looking for answers too, reading memoirs by people in the mental health field. What's struck me is that in every one of them, the narrator is telling their story from a place of resolution. By the time you read the book, the problem they've had is gone. Life is good. They're in love, healed, forgiven. The stories we hear and read are always about someone who's no longer in a state of pain—no longer suffering in a living hell. What about the other stories?"

She pauses, extends an arm, and rests it on the walker. I hold my breath, a little stunned to be speaking to her one-on-one, and uncertain about how to reply.

"My mother died suddenly in July," she continues in the articulate, commanding voice I've binge-listened to on so many podcasts over the years. "She was my person—brilliant, generous, kind. And now, I have to take care of my 92-year-old father, with whom I have traditionally had a difficult and complicated relationship. I'm also recovering from hip surgery that isn't healing as fast as expected. My vision is not great because of cataracts. And I'm barely mobile." Her fingers tap the walker. "But I'm also financially responsible for a lot of people, so I still have to see clients and step in front of cameras."

I put a hand to my chest, feeling compassion wash over me as I listen to her story.

"Since I was five years old," Ramani continues, "I've wanted one thing only: time alone with my mother where we didn't have to worry about my father's needs and moods. That will never happen now. What I've feared most—losing my mother, and being tasked with caring for my father—is becoming a reality."

Ramani goes on to describe her situation as the kind of hell most therapists don't know how to validate. It's not only that they aren't attuned to South Asian cultural dynamics or the nuances of intergenerational trauma—it's that, as a field, we're rigidly solution-focused. With clients trapped in impossible situations not of their own making, we tend to give tips, recommendations, medication, and diagnoses: *set better boundaries, disentangle your codependence, develop a meditation practice, maybe you need more help*. It's not that these things are bad; it's that sometimes they're the opposite of what people living in hell really need. In Ramani's view, as a field, we use hope and problem-solving defensively. She's found more solace in writings focused on how to navigate suffering, instead of making it "go away."

I'm stunned by her honesty. I know many more people in this country are finding themselves in impossible situations, devastated by circumstances they can't control. If one of the strongest, most insightful women in our field is struggling with the solution-oriented approaches that define our work, then I don't have to feel so alone in my struggle to meet clients' needs.

"Dr. Ramani, you have no idea how much—" I begin, but before I can share my appreciation, I'm falling again, and she's dropped from view.

Down, down, down.

Thud. The landing, though abrupt, isn't as rough as I expected. In the distance, at the end of a hallway lined with doors, I see the white robot disappear around a corner. Rising to my feet, I head toward it, notice an open door, and duck in.

A Year of Grandiosity

"Welcome," a voice calls out as I enter a spacious study. Silhouetted against a window, bestselling author and Relational Life Therapy developer Terry Real lowers his large blue glasses. "Can I help you?"

I know he's a busy man—a docuseries on RLT is being released soon, and he's getting a lot of airtime on popular television shows and podcasts. "I'm a therapist," I say by way of introduction, "and I think I can say a pretty good one. But this year, I feel lost and nervous. I don't know what to do."

"Here's the thing." Terry pauses. "We therapists are supposed to stay out of politics, right? But this year, we're experiencing the biggest resurgence of the most

nakedly bullying, dominating, misogynistic aspects of traditional masculinity and patriarchy I've witnessed in my lifetime. I don't see what's happening in terms of partisanship. I see it in terms of how it's affecting our clients."

His words bring to mind a client who stopped leaving the house recently. He's on a student visa and lives in fear of ICE deporting him. Another client has found herself, like many teachers across the country, in a stressful legal battle because the current administration's views don't match the historic truths she's been teaching for decades. These people are suffering from depression, sleeplessness, anxiety, and intrusive thoughts, not because of any family-of-origin wound or cognitive distortion, but because of what's happening in governmental structures around them. In grad school, no one said symptoms could be political—but these days, a lot of them are.

Terry explains something he calls "ecological wisdom," the understanding that we're in an interdependent system and cooperating with one another is in our own enlightened self-interest. He's convinced that if we don't switch from a traditionally masculine, autocratic, patriarchal paradigm of dominance and control to the deep wisdom of interdependence and cooperation, we're in grave danger. Somehow, it's relieving to hear him say this.

"As a field, we collude with patriarchy," he continues, "mirroring the culture's individualistic bias, doing trauma work behind closed doors, saying there are no bad parts. There are! We have dominant, sadistic, autocratic parts that do tremendous harm. The devilish thing is, these parts feel good! When the history of humankind is written by superintelligent cockroaches or sentient AI, they'll look back at us and say, 'The fatal flaw of the human species was that grandiosity felt good.'"

"If that's our fatal flaw," I interrupt. "How can therapists change it? We're not crusaders or revolutionaries. We support people. We're nurturers!"

"We're *too* nurturing," Terry counters, as if I've proven his point. "We need to skillfully confront perpetrators. We need to speak truth to power."

Speaking truth to power sounds great in theory, but we learn early on that it's risky, whether in a family, a classroom, a community, or a group of colleagues. That risk grows exponentially greater the farther your identities diverge from those of the groups that hold the most power. As a therapist, speaking truth to power will cost you clients. Even, or maybe especially, in 2025, speaking truth to power has been getting a lot of people fired, blacklisted, harassed, and deported. So although the activist part of me agrees with him, the therapist part of me still feels confused and helpless.

"For therapists," Terry continues as if reading my mind, "relationality is the strongest leverage we have. It's our superpower in the fight against patriarchy."

I feel a weight lift. It's true—we're not just nurturers. We're intimacy doulas, and birth is messy. We help clients mired in pain connect with their true selves so they can show up more authentically and less defensively in relationships. Terry isn't saying anything new, but his words are revelatory. Like my clients, I've been in a near-constant state of low-grade anxiety this year. When we're on guard, waiting for the next major or minor catastrophe, our body braces itself. When we can't soften, we can't connect.

"Listen, you're still young," Terry reassures me. "I've been at this forever. It's your calling now. My hope is to embolden you and then for you—for all of us in this profession—to empower those we touch. Now is not the time to be shy. You know what you know. Own it. Share it. Our secret weapon is one another."

A ringtone fills the air.

"Hey, sorry, I gotta go," Terry says. "Let me know if I can help. Best of luck!"

"Bye," I tell him as I back out the door. "And thank you!"

A Tea Party

As the door shuts behind me, I notice the hallway is gone. The air smells like jasmine, and I hear voices and tinkling China. Half-hidden from view under a canopy of leaves, a table has been

set with floral cups and matching kettles. Apparently, three prominent therapists have taken a break from their busy schedules to attend an unlikely tea party.

Trauma expert Lisa Ferentz, with her blonde curtain bangs and warm but direct demeanor, sits across from sex and couples therapist Shadeen Francis, whose graceful gestures and elegant style give her the aura of a fashion icon. Alex Iantaffi—a trans, queer, disabled family therapist with tattoos peeking out from under his "Be Radically Inclusive" t-shirt—is also at the table. And as I approach, it's clear they're deep in conversation.

"In all my years of life," Lisa muses, "this has been the scariest time. For me, as an Orthodox Jew, the rampant, overt antisemitism has been extremely challenging. And in sessions, if I tell my clients, 'I'm as terrified as you,' I risk a profound shift in the therapeutic relationship. But I don't want to sound disingenuous when I say, 'Don't worry, everything's going to be okay.'"

"I was brought up in Italy," Alex confides. "My grandparents lived through fascism. With my clients, lots of stories are surfacing around historical traumas. As the government takes all these hostile actions toward minoritized people, rolling back protections for existing legal rights, dismantling equity initiatives, defunding essential research, deporting people without cause, my clients are

struggling between choices related to personal safety and their commitment to collective safety. It's hard for them."

The white robot crosses the uneven ground and lifts a tea kettle over Alex's cup, its wheels whirring. Alex shakes his head. "No thanks, I'm good."

"I'm seeing so much dissociation these days," Lisa says. "Because I work with trauma survivors, even though they're adults, they're more inherently vulnerable to getting lost in social media and the digital world, because for them, dissociative coping strategies exert a magnetic pull." Shadeen and Alex nod. "The medicalization of marijuana isn't helping trauma survivors either. It may have a soothing, dissociative effect in the short-term, but it exacerbates problems in the long-term. Paradoxically, you're less likely to engage in self-advocacy or self-protection when you're in a dissociative state, which of course is particularly troubling when it comes to trauma survivors. I've started asking all my clients, 'What's your relationship with social media? How many hours are you online?'"

I stealthily pull my phone out of my pocket and locate "Screentime." My daily average is 3 and a half hours—far more than I assumed. Clearly, I've been using a maladaptive coping strategy. I shake the phone like it's a thermometer giving me the wrong temperature reading.

"I've definitely noticed digital technology luring people away from intimacy and connection," Shadeen chimes in, sipping her tea. "And I've noticed the AI conversation changing. It's no longer about artificial *intelligence*—it's about artificial *intimacy*."

I'm starting to feel guilty about eavesdropping on this conversation from the shadows. But if I appear from out of nowhere, will they question my intentions, or worse, send me away? I tuck myself behind a small nearby tree.

"I've seen my couples clients turning away from each other a lot more, this year," Shadeen muses, sweeping her long black locs off her shoulders. "And not only during conflicts, which is to be expected. They're turning away from each other when they want reassurance, inspiration, sexual arousal, answers—or even just to *chat!* People are doing so much offloading of intimacy that I have to imagine it's robbing their relationships of fuel. And the interesting part is what people are turning *toward:* AI."

"Terry Real says relationality is our superpower," I blurt out, and then immediately regret having spoken. Lisa, Shadeen, and Alex turn their heads, and I step cautiously into the sunlight. My cheeks flush under their collective gaze.

"Join us," Shadeen calls out. "Would you like some tea?"

"I wasn't eavesdropping on purpose," I sputter, lowering myself into a chair. "I'm not even sure where I am."

The white robot tips a kettle over my cup. "It makes so much sense that you're here right now," it confides in a gorgeously nuanced, perfectly modulated, stunningly empathetic voice—as if some Machiavellian pied piper had distilled the sounds of millions of gently authoritative, attuned therapists into one exquisite tone. "But you followed me for a reason. You don't have to be or do anything special here. You can show up exactly as you are."

The robot rolls forward and brushes against my leg. I lean toward it like a sunflower drawn irresistibly toward the sun. It's been a while since I've felt this seen and held…. *Wait, what are you doing?* I ask myself. *You're swooning over a machine! This interaction is fake!* The realization makes me sad but determined to get a grip on my emotional needs and return to the real conversation.

"If I had to give this year a title," Alex says regretfully, "I'd call it The Year of Enforced Resilience, at least within my community. If you're not cisgender, straight, white, able-bodied, and Christian, resilience is your only choice right now."

"Aren't we all seeking to be resilient?" I ask.

"Sure, if it's a choice," Alex responds. "But resilience is also a narrative that's placed on minoritized folks. There's a difference between choosing to take part in a marathon because you want to and being forced into one because you're running for your life."

Alex's description of enforced resilience echoes Ramani's observation about how our field leads with solutions more often than presence. For me, it's a reminder to stay curious and humble, acknowledge the challenge of sitting with suffering, and recognize how tempting it is to pressure clients into action, however subtle. Dropping into a space of shared humanity needs to come first. When was the last time I embraced the vulnerability of being fully present without trying to help, fix, or problem solve?

"With everything that's happening," I say, sipping my tea, "it seems like the focus in our field is going to be even more trauma work." Lisa shrugs and nods regretfully.

"Yes, of course," Alex agrees. "But I've been centering pleasure in my trauma work this year—embodied pleasure." Shadeen indicates her agreement with a *mmmm* sound, and I remember that this is one of her areas of expertise. "When we're embodied," Alex continues, "we can access pleasure, connection, and aliveness in the moment. Not just sexual pleasure, though that's important, too. I'm talking about the pleasure of feeling rain on your skin, petting animal companions, looking outside at leaves changing color, a tender moment with a friend. What's grounding me now is the belief that the purpose of life is life, and the simple, basic joy of feeling alive while I'm alive."

I shut my eyes, taking in Alex's words. A faint effervescence floats through my chest. Is this the stirring of a long overdue experience of embodied pleasure? Is this my way back home?

Integration Inn

"Glad you made teatime." A voice jars me awake. Lisa, Shadeen, Alex, and the white robot are gone. I must have dozed off. "A nice way to share ideas. But that tea can knock you out if you're not used to it."

The voice, I realize, is coming from somewhere over my head. When I glance up, I see Zach Taylor smiling down at me from a tree branch in a pair of snug jeans, converse sneakers, and a linen blazer—his signature look when he MCs the yearly Psychotherapy Networker Symposium, the largest annual gathering of therapists in the world.

"What are you doing up there?" I ask.

"Same thing you're doing down there." He swings his legs.

"I don't know what I'm doing," I say, "other than feeling unsettled in my role as a therapist and trying to find a way forward."

"I've been hearing that a lot," Zach says. "Part of why you may be feeling unsettled is that all kinds of forces are altering the shape of our field these days. The business side of psychotherapy is getting gobbled up by venture capitalists, driving down therapist salaries and quality of care. Plus, more coaches, who can practice without a license, are competing with therapists." I'm interested in what he's saying, but I'm also getting distracted by the transparency of his arms and legs. Did the tea affect my vision?

"I can't see you that well." I lift my hand to block the sun.

"Not only that," Zach continues, unphased by my vision concerns, "a backlash is brewing around psychedelic-assisted psychotherapy." It's not that I can't see him, I realize—it's that, as we continue speaking, there's less of him to see, because he's slowly fading away. "A lot more people are sharing stories of bad experiences on ketamine, psilocybin, and ayahuasca retreats," he concludes ominously.

I feel deflated by Zach's perspective. With more therapists than ever becoming psychedelic guides this year, I'd come to think of psychedelic-assisted therapy as an alternative therapeutic option that's finally getting its day in the sun. Should I be more skeptical? One thing's for sure: this journey—from the circular bookcase to the tea party to chatting with an increasingly transparent Zach—is so surreal that it's kind of like I'm having a psychedelic experience right now.

"Don't go!" I implore as Zach's face and torso disappear. "I have no idea what to do now."

"Check out the Integration Inn," his voice echoes. His smile is all that's left. "Fascinating place. I'll give the innkeeper a heads up." And just like that, his smile goes, too.

I rise from the table and walk along a gravel path. Soon, a building emerges out of the foliage. Above the door, three elongated S's have been etched into a sign dangling from chains. I remember the S's from high school calculus as the symbol for the integration of variables. The door opens onto a foyer furnished with vintage sofas, acrylic end tables, and modern paintings. A brass reception bell rings.

"Greetings!" a man with meticulously coiffed salt-and-pepper hair stands behind the front desk. "Zach just stopped by. He mentioned you're confused about what's changing in psychotherapy this year?"

"Frank Anderson!?" Seeing him momentarily deepens my confusion. "How can a world-renowned IFS teacher and trauma expert also be an innkeeper?"

"They're not mutually exclusive," he laughs. He explains that the inn represents the next wave in trauma treatment: integration. "Would you like a tour?"

The dining room is massive, and the kitchen is state-of-the-art. It has a warehouse-sized pantry flanked by towering spice racks. Frank tells me this place took years to construct and contains every therapeutic modality and approach that's ever existed—too many for a practitioner to use in multiple lifetimes. He's been in the field since 1992, when cognitive behavior therapy and exposure therapy were all the rage, and he's worked closely with Bessel van der Kolk and Dick Schwartz. He's seen trauma treatments explode, like Francine Shapiro's EMDR, Marsha Linehan's DBT, Pat Ogden's sensorimotor therapy, Peter Levine's Somatic Experiencing, Diana Fosha's AEDP, Sue Johnson's EFT, and many others.

"All these wonderful models are essential," he says, cracking two eggs into a bowl, adding milk, throwing in spices from a nearby spice tower, and beating everything together with a whisk. "These models advanced the field of trauma treatment by leaps and bounds." He throws the spiced scrambled eggs into a pan, where they sizzle. "But it's time for integration." Frank slides the eggs onto a plate and passes me a fork. "Try it."

"Unusual," I say, putting a forkful in my mouth. "But tasty."

Frank explains that most therapists gravitate toward a model that fits their personality and then take what they like from other approaches. "I'm interested in operationalizing this process. I want to put these models together in a way that's more client-focused than model-specific. Because one size does *not* fit all when it comes to therapy and trauma treatment."

The sound of the reception bell distracts him from our tour.

"Another guest!" Frank sweeps an arm through the air in what I interpret as a *mi-casa-es-su-casa* gesture. "Feel free to look around on your own."

I exit the kitchen and climb a narrow set of stairs. Up, up, up. The walls, I notice, are decorated with photos in wooden frames. I recognize Pierre Janet, the psychologist who pioneered the study of dissociation and trauma, and Jean-Martin Charcot, a neurologist who investigated how trauma manifests physically. I wonder what they'd make of the times we're living in now, and how we're handling our clients' challenges in the midst of our own. A color photo shows Judith Herman, the researcher who introduced the concept of complex trauma into our field. If I run into her in this place, I'll be sure to ask her.

Fighting Back

"Let me know if you need anything else," I hear a familiar AI voice say as a buttery scent fills the air. The white robot rolls into the hall and tips forward

in a mechanical curtsey.

Tammy Nelson, a couples and sex therapist and the director of the Integrative Sex Therapy Institute, holds a bag of popcorn in a doorway.

"Tammy?" I hesitate. She doesn't seem surprised to see me here. As the white robot disappears down the hall, she gestures for me to follow her inside.

"Popcorn?" She shakes the bag. "It's freshly made."

I nod and enter a large industrial loft. Floor to ceiling windows reveal the sky-

line of downtown Los Angeles. Clearly, we're not at Integration Inn anymore. Tammy pours the popcorn into a ceramic bowl.

"If you're wondering how I'm doing, I'm okay." She points at the TV screen. The volume is turned off, but I recognize the characters from season two of *White Lotus*. "Since the assault, I've been watching every Netflix series ever made."

Tammy's a former teacher and mentor of mine, and I know—as some in our field do—that earlier this year, she was physically assaulted a few blocks away from a conference where she was giving a workshop on trauma treatment. "So, what brings *you* around these parts?" she asks.

"I'm trying to get clarity on all sorts of things about therapy this year. I've taken in a lot of new perspectives, and it looks like you're resting, so I don't want to bother you."

"You're not bothering me," Tammy says. "I don't mind sharing with you that this year has been all about my own trauma healing. I've gone back to therapy. I've been doing a lot of EMDR." She tells me one of the strangest things about her assault was what happened in the months afterward. "Everything we teach about trauma is true," she sighs. "The flashbacks, nightmares, and bouts of agoraphobia. For a while, I'd panic whenever I'd walk down the street and a stranger would approach."

There's a faint whirring just outside the door.

"Deactivate yourself, please," Tammy commands loudly. I hear a metallic bumping sound, like a washing machine switching cycles, followed by a click. "See? I could sense the robot out there, listening. Why is that? Because I've spent my whole life relying on my intuition to survive in the world, as women do. We learn to listen to the voice that says, *Don't go down that street. Don't sit with your back to the door. Don't take that job. Don't go out with that man.* I know from the work I do with clients that after trauma, you question your intuition. *Why didn't I see this coming? Will I ever trust again?* The injury isn't only about trusting another person. It's about trusting yourself."

In this place, the veneers we project onto our public therapy icons seem to have disappeared. Many of us who are early- or mid-career therapists convince ourselves that leaders in the field are immune to the kinds of challenges we treat in clients, or struggle with ourselves. Personally, I know I give lip-service to vulnerability being a precious state that allows for deep human connection, but I've always secretly hoped I'd achieve some kind of optimized human-being status that would shield me from depression and anxiety. Hearing Tammy's story reminds me of the cost of turning people into gurus, and of trying to become gurus ourselves. It disconnects us from real life.

"As that man punched and kicked me," Tammy admits, "a part of me wanted to curl up and let it happen. I felt that deer-in-the-headlights response taking over. But then I was like, *No fucking way*. Suddenly, I was my daughter, and every woman who's ever been attacked and harassed, and every single traumatized client I've worked with. I told myself, *This is* not *happening again*. And even though the assault was bad, it could have been worse. Part of my healing journey has been knowing that I *was* listening to my intuition. I *can* trust my intuition. I *am* strong. I *fought* for myself."

The tremor in her voice stirs my own feelings about being a woman in a misogynistic culture. Although no one can ever be invulnerable to loss, trauma, or pain—not even a vibrant therapist like Tammy—we can all strive to make sense of our reactions to events that hurt us from a place of curiosity, and in a way that helps us organize how we respond.

"It's reflective of a greater patriarchal, abusive energy that's at play in the world," Tammy says. "We need to fight back in a way that's transformative and healing. Sure, most days I don't feel like a warrior. I just want to curl up with a bag of popcorn and watch *White Lotus* episodes. But something is shifting. We always tell people about the healing power of community, transparency, and integration. These things are more important than ever. We're all being called to rise up in our own way."

We've reached the bottom of the popcorn bowl. The effervescence I felt at the end of the tea party has blossomed into something larger, though I still can't quite put my finger on what it is. The sensation feels like a handhold amid my anxiety and confusion about the world. I hug Tammy. She wishes me safe travels.

"Take the elevator," she suggests, pointing to a silver door. "It's quicker."

The Polyvagal Elevator

I step into a glass elevator. Outside, shadowy shapes engulf one another, separating into wobbly strands as new blobs emerge from the darkness. Once I get my bearings, my breath slows down and my body feels colder, as if I'm entering a state of hibernation.

Seated near three large elevator buttons, a woman with silver hair in a dark turtleneck greets me with a nod. The lowest button reads *dorsal*, the middle *sym-*

pathetic, and the top *ventral vagal*. "Before you go home," says the woman, who exudes a steady, calm energy, "I thought you might want to take a ride in the Polyvagal Elevator." As she speaks, I realize she's Deb Dana, the trainer who first made neuroscientist Steven Porges's groundbreaking Polyvagal Theory accessible to everyday clinicians like me.

"Why is my body so heavy and numb?" I ask.

"Dorsal vagal despair," Deb says with the hint of a smile. "I admit, it's been tempting to live here this year. One of the things people have asked me a lot lately is, 'How do I change things that are so unjust in the world?' And the truth is, I don't know. It's overwhelming for me, too. I've had to recognize my limitations."

Since her partner, Bob, passed away two years ago, Deb says she's been struggling to find a new rhythm. One thing that's helped her is focusing on micromoments of joy, which she calls "glimmers." These glimmers are what sustained her in Bob's last year of life.

I've always dismissed the idea of glimmers as another overrated psychological concept without real-world applications, but hearing how they sustained Deb gives me pause. "They're all we have," she says. "When everything feels like too much, they're what I hang on to." This idea of savoring life-giving moments reminds me of Alex's point at the tea party about the importance of experiencing our aliveness. Should small glimmers be a bigger focus in my practice and in my life?

Deb presses the "sympathetic" button, and the elevator speeds up. The greyish landscape of slow-moving blobs explodes. Millions of tiny red thunderbolts shoot through my visual field. Instantly, my body aches, and I feel wary and tense.

"Unpleasant, right?" Deb says. "This year, wherever I went, people were stuck in this kind of activation. You could feel it everywhere. The ripples of dysregulation were getting passed from one person to the next. Across our country, we've got a large group of sympathetically dysregulated people, and another large group in dorsal despair. Imagine hundreds of millions of people feeling some version of these states."

I picture all the people in my life, and in my community, and across communities from California to Maine—and realize we're all just nervous systems pinging off one another. If most of us are either jacked-up or numbed-out, no wonder we feel out of sorts.

"Dysregulation is contagious," Deb says. "The good news is that so is regulation. Some people are actively cultivating ventral regulation, but until that group grows larger, nothing's going to change. This is why, as therapists, helping dysregulated people begins with our own nervous systems—with regulating ourselves first."

We hit a pocket of turbulence, and my heart pounds. What if the elevator gets stuck? What if the walls shatter? It's not easy to regulate yourself when life feels unsafe.

"Don't worry," Deb murmurs, sensing my distress. "This elevator was built to move through different states." The constriction in my chest releases. Even amid the sympathetic maelstrom raging around us, Deb exudes a steady, calm energy. In dorsal, her presence vitalized me, counteracting my body's natural pull to disconnect. In sympathetic, it served as a tether, easing my fight-or-flight response. I'll carry this awareness with me into my everyday life beyond this place: one nervous system can transform another.

"Whether I'm teaching, with a client, or standing in the checkout line at a grocery store, I try to help people feel safe from this place of regulation." Deb lifts a hand and presses it over her chest. "For me, it's become the most important thing. Finding ways to anchor in regulation is what allows us to offer our regulated energy to others. It's amazing the ripple effect that one regulated person can have on their environment."

Deb presses the "ventral vagal" button, and the turbulence subsides. "I believe this is your stop," she says.

■■■■■

I'm seated on the same bench where I had my afternoon panic attack. The breeze has died down. My body feels spacious and expansive. My breathing pattern has changed, and my neck, shoulders, and chest relax. I recognize this state as ventral vagal ease.

Tourists are still taking selfies on the walkway. Members of the National Guard are still gazing out across the Potomac. Everything is the same as it was before I followed the white robot down the rabbit hole, except that the world doesn't feel as completely hopeless and menacing. It's not that my confusion about the future has evaporated; it's that I don't feel like I'm experiencing it alone anymore.

As I get up from the bench, and my thoughts turn toward my next client, the effervescence I've been feeling settles into a kind of sweet okayness—a mix of gratitude and tenderness—that's both ordinary and profound. I'm lucky to belong to a tribe of therapists fighting, each in their own way, for this complicated, broken, beautiful, ever-changing world of ours.

I know it's just a glimmer. But it's one I want to savor.

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Psychotherapy Networker 2025 Readers' Choice Autism

Neurodiverse Couples Therapy

The Truth about Relationships through a Neurospicy Lens

BY KORY ANDREAS

I settle into the corner of my home office, a soft blanket on my lap, a warm mug of afternoon coffee in my hands, and a HIPAA-compliant pair of goldendoodles piled at my feet. Despite the thunder booming outside the window, the three of us are ready for Kevin and Laura, one of many couples I see for neurodiverse couples counseling—a niche I developed after seeing how often traditional couples therapy fails to address the unique communication styles and needs of Autistic individuals and their partners.

Despite the thunder booming outside the window, the three of us are ready for Kevin and Laura, one of many couples I see for neurodiverse couples counseling—a niche I developed after seeing how often traditional couples therapy fails to address the unique communication styles and needs of Autistic individuals and their partners.

Seated directly next to a colorful, floating bookshelf, I open my laptop to start the virtual session. The shelf is an optical illusion, leading you to think my favorite stack of autism-related books are effortlessly defying gravity. In actuality, the support is just underneath the last book, hidden and strong.

"How are your books levitating?" new clients sometimes ask. "Good accommodations" I smile. The shelf serves as a reminder that with the right kind of support, we can all defy the forces that weigh us down.

Kevin is a 35-year-old network administrator who sports a messy ponytail and an affinity for edgy, sarcastic t-shirts. He's blunt, direct, and has a way of launching us into action at the start of each session. Laura is 40, soft-spoken, and works in the HR department of a big government agency. After seeing three different couples therapists in four years, Therapist #4, who suspected Kevin might be Autistic, recommended me. Six sessions of assessment interviews confirmed that suspicion.

Kevin and Laura present like many couples seeking therapy all over America. They want to work on communication. They argue over the dishwasher, money, and sex. They want to feel seen and validated by one another. But no matter how "typical" their issues may be, the neurotypical approaches we've all been trained to offer won't work for

them—and may even be harmful. I see Kevin and Laura as well-suited for one another, although traditional therapy approaches are a mismatch for them.

Many of us in the couples therapy world received our licenses years before the word *neurodivergent* entered our lexicon. Before we said goodbye to the Aspergers diagnosis, and *low-functioning* and *high-functioning* became dirty words, we thought autism was rare. We thought it needed a cure. A quick internet search will tell you that 2.2 percent of adults are Autistic, and 85 percent of neurodiverse relationships end in divorce, but neurodiverse couples therapists will tell you these numbers are wildly inaccurate. Neurodivergence is all around us, and many neurodiverse couples thrive with the right support.

Unfortunately, there are only a handful of specialists in neurodiverse couples therapy in most states, and they're like unicorns in the therapy world. As a result, many Autistic people remain undiagnosed, and their partners remain unaware that they're in a neurodiverse relationship.

I'm Nothing Like Rain Man

As an Autistic adult, having an "identity-based" private practice allows my insatiable desire to read, learn, and talk about the neurodivergent experience to double as a therapeutic tool. While my work is always focused on the needs of my clients, my own experience is, as they say, "in the room." Autistic brains are self-focused, meaning we understand life experiences through our own lens first. Only then can we understand it through the lens of others.

While I'm careful to avoid making sessions about me, with Autistic clients, I feel freer to explore the use of self as a springboard to understanding them than my traditionally trained colleagues, many of whom were warned that this kind of self-referential framing of client's experiences was off limits. For the first time in my professional life, I've found joy and peace in my work. My helping heart and my intense, neurospicy brain work in tandem with people wired like me. And it's deeply gratifying to hear my clients consistently report they feel safer in our work than they have elsewhere in the "real world."

My own path to diagnosis and acceptance of my neurodivergent brain was complicated by my ability to mask exceptionally well, and morph into anyone I needed to be. The 10 years I spent masked with my therapist never uncovered signs of my own neurodivergence. "Client Kory" had trouble with boundaries, a failing marriage, struggles with her neurodivergent kiddo, and a lot of anxiety. As my path as a therapist expanded, and I began to specialize in diagnosis and treatment of Autistic adults, I found the stories I heard from Autistic women regularly left me frozen. My own story was echoed in their traumas, frustrations, and longings.

> "My brain is busy and on fire, replaying, reliving every word I've said, wondering if you thought I was likable, knowledgeable, or real."

Autistic people exist in the extremes of intensity and disinterest. Our creative brains are driven by curiosity and passion. While the focus of this passion differs for everyone, my pattern-seeking brain couldn't ignore the trends that emerged and repeated themselves in my office. My caseload was full of animal-loving, well-read, intelligent, creative types who lost themselves in their interests. Often, they sought therapy with me because they also lost jobs, friendships, and partners simultaneously. I saw myself in their struggles: deeply troubled marriages, discontent with the unwritten rules of the working world, and an internal dialogue buzzing with constant worries. Many of my clients battled lifelong social anxieties, health challenges, and confusing family dynamics—just like me.

My work with Autistic women and gender-diverse clients provided the practice-based evidence that was glaringly absent from the evidence-based practices taught in grad school. It was clear to me that the teachings our field still leans on fail to reflect the broader neurodivergent experience. The more I listened, the more I realized that our unique wiring isn't the problem: it's the world we live in not being built with us in mind.

I'm nothing like Rain Man. I'm nothing like your quirky uncle who never stops talking about trains. But like his, my brain is busy and on fire, replaying, reliving every word I've said, wondering if you thought I was likable, knowledgeable, awkward, or real. Did I talk too much? Why am I consumed with the puzzle of what your face means? I have no idea how I'm perceived. Mirrors and compliments often catch me off guard.

And also, I *am* like your uncle. And my uncle, and your doctor, and your daughter's purple-haired art teacher, and my son's trans best friend. I'm like my grandfather making clocks in the basement—except his clocks are my dogs, my books, my pour-over coffee and my coffee mugs, too. They're also my pizza oven, my photography, and my deep obsession with autism. His clocks are *me,* belting out the

soundtrack of *Waitress* every time I'm alone with my overpunctuated feelings in the kitchen. My clocks aren't clocks at all. They're thoughts you can't see, and my basement is my brain. I'd often like to come upstairs. My "nerding out" is anything but typical. I desperately want the people in my world to see the depths of me, and also, I don't want them to see me at all.

Grelief

Young Kory was a geeky, intense little girl with opinions about everything. I was born fragile and sensitive, the product of two neurodivergent families steeped in poor communication, abuse, and trauma—and who never had the luxury of a diagnosis or support. I was always the first person to launch a northbound hand rocket to "answer town" in elementary school. I spent my youth desperate to be an adult, since adults were the experts. I was certain I knew more than my classmates, and probably my teachers, but even in first grade, I realized it's rude to correct your superiors. *Precocious* is another word for *obnoxious*.

Although my charm lies in my transparency, wit, and ability to respond swiftly while everyone else is still thinking, I quickly learned to bite my tongue and say nothing—which meant I was alone in navigating the rich but turbulent sea of the data, experiences, and intense feelings that regularly flooded my mind. Those of us with neurodivergent brains gradually learn to eat our words, not because we want to, but because the world demands it. Somewhere in middle school, the little girl who constructed her self-esteem out of imaginary play with Barbies, crayons, playdough, and popsicle sticks, turned into a people-pleaser focused on helping *others* feel loved for who they are.

Early on, when I brought up the possibility that I might have autism to my long-time therapist, she was quick to dismiss my data points and told me it was my anxiety talking. I disagreed and sought a second opinion from a diagnostician outside the circle of professionals who knew me.

"You and I both know what we're looking at here," she said. "You're Autistic."

The words I expected her to say hit me unexpectedly like a flash fire. My unresolved trauma sat ablaze in the room between us, and yet a piece of my heart took a sweet breath of relief. There it was: *grelief*.

Grelief is the duo of emotions that commonly follows an adult autism diagnosis. The double-edged sword of discovering that your strengths and challenges are linked to a unique and widely misunderstood neurotype. The *relief* comes from having a definitive cause for years of struggle and miscommunication along with a hopeful treatment plan. The *grief* and pain stemming from years of exhaustion and trauma that went unnoticed, unaccommodated, and misunderstood.

Neurodivergence in Couples Therapy

Kevin and Laura are already on standby in the virtual waiting room when I begin the session. Although they're two years post-diagnosis, the complicated feelings related to the differences between their brains remains a prominent theme in our work.

Like many of my couples, their early relationship was intense. Kevin was charismatic, successful, handsome, great in bed, and "tuned into Laura" in a way no previous partner had been. Laura was immediately taken with him. She'd been Kevin's second girlfriend, and he took their relationship very seriously. Kevin used an excel spreadsheet to track details about Laura that he wanted to remember. He planned date ideas and trips that would light her up. Both were foodies, avid runners, and they loved going to concerts. "It was like a dream," Laura had recalled wistfully.

But something about Kevin changed when they moved in together. "He became unemotional, flat, and checked out at home," as Laura put it. She believed Kevin preferred his hobbies to her. They'd stopped running together and attending concerts. He'd lost interest in sex and seemed bothered when she sought affection or wanted to talk. Whenever she asked him about improving their emotional connection, he'd say, "What does that even *mean?*" He felt connected to Laura already and didn't feel a need to do anything differently, while Laura struggled to feel close to him and be direct when describing her needs because "shouldn't he just know?"

Today, when they appear on screen, the first thing I notice is Kevin's t-shirt, which reads, "Synonym Rolls, just like grandpa used to make." I approve with a giggle.

"Hi, Kevin. Hey, Laura," I begin. "I hope this lightning storm doesn't give us any trouble today. I've had enough of this rain."

Although I know cliché small talk about the weather is often poorly received by my Autistic clients, my anxious brain occasionally defaults to masking with neurotypical scripts. Kevin allows it. He mockingly indulges me with some forced banter. "Yeah, yeah, winter's cold, summer's hot, and rain's wet. How about those Ravens? Anyway. Can we cut to the chase? Spoiler alert, she's pissed at me again."

Kevin's here to get results.

Laura's eyes catch mine and her embarrassment is palpable. She'd prefer a gentler, more upbeat segue into the session and sometimes apologizes for Kevin's abruptness. She's inclined to keep people comfortable, though she's aware I don't need her to do that here.

"Sure, Kevin, let's get right to it," I respond. His blunt approach doesn't faze me.

"I tried what you said, and I asked about her day. You said I'm supposed to ask about her feelings, right? She said her day was 'fine.' Fine's a feeling. So, I thought I did okay and went back to my video game. But she sat down next to me with her arms crossed, just staring at me like I'm supposed to know what that means. So I asked her, "Are you pissed?" She said no, so I told her she should probably tell her face that."

"How did that land?" I ask.

"Worse than I anticipated."

"Laura, was he reading you accurately? Were you pissed at that point?"

In my brain, I hear a deep, booming movie voice over: "Laura was indeed pissed." I keep that to myself.

"No, I was just really sad," Laura says, interrupting my mental movie. "I wanted to talk about my day, and I don't think that's a lot to ask. But then he says all kinds of rude stuff. Kevin has no feelings, and when I do, I'm the monster. It's like I'm wrong because I want him to give a shit about my day. So yeah. *After* his rude comment, I was pissed."

I resist an urge to explain that Autistic people may look like they have no feelings when the exact opposite is true. We'll get there, just not now.

"First you get pissed, then you cry," Kevin responds. His pattern-seeking brain knows this routine with Laura. "She's always mad because nothing I do is enough. She's trying to use emotional manipulation to tell me I'm the problem! If she could just stop making me guess what she wants, we'd be fine."

Laura looks away. She's crying. Her tears tell a story of confusion, and it pulls at my heart. She describes Kevin as "an alien from another planet," but she wants to understand him. She's shared that she knows he's a good man, unlike her absent father. When it comes to her feelings, he can seem self-centered and cold, but he's also the most caring partner she's ever had when it comes to expressing his love through actions. While Kevin's right about their dance of disconnection—first anger, then tears—he's wrong about Laura being manipulative. She's tried to reshape their conflict for years in therapy, and she's losing hope.

An Autism-Centered Approach to Relationships

My caseload is a modern qualitative study of the autism we didn't know existed in our grad school days. My clients don't resemble a single character on *Love on the Spectrum.* They look like your accountant, your lawyer, your daughter's dance teacher, your professor, your therapist, your IT guy, and your local business owner. They're between 18 and 78 years old, and include people from every demographic.

On average, my neurodiverse couples have been seen by six or seven other professionals before finding me on a database of certified neurodiverse couples therapists. They've been misunderstood, misdiagnosed, and mismedicated by well-meaning, seasoned therapists. But even fantastic therapists tend to miss the one key to successful couples therapy for neurodivergent clients: up-to-date training on working with neurodivergent brains.

> "Sex can be entirely absent from many healthy neurodiverse partnerships."

Neurodivergent-affirming care emphasizes psychoeducation on key Autistic traits within the context of relationships. This framework teaches how connection can be defined and redefined, accommodates sensory sensitivities, fosters predictability, and moves beyond date nights and as a panacea for all relational ills. Neurodiverse couples who thrive seem to continually reinvent their connection with a focus on shared special interests. Given they often characterize connection differently than neurotypical partners do, they may need more specific interventions for communication, conflict, and repair than "I-statements" and reflective listening scripts.

Also, gender, sexuality, and relational and sexual normativity are different here. Sex, for example, can be entirely absent from many healthy neurodiverse partnerships. The opposite is also true: many neurodivergent partners can be extremely interested in a "typical" sexual relationship. The middle ground, the gray area, the center of the bell curve that we see in neurotypicals is what's missing here. Sex, and many other factors of neurodivergence, often exist in the extremes.

Neurodiverse couples require interventions that may challenge the basic tenets of traditional couples therapy. The core principles of CBT, for example, need to be left on the therapy room floor. Most Autistic clients aren't holding onto a stream of irrational beliefs. Instead, a lifetime of very real social and nervous system traumas are influencing their thinking.

My client Xander, a 27-year-old creative type, experiences debilitating anxiety before large social events. His partner Mo hates how "antisocial" he can be. A CBT approach would entail an inquiry into whether Xander is irrationally worried about all the "what-if's" that could play out at Mo's work party. An autism-centered approach would focus instead on the frightening realities that many Autistic people *do* encounter in social interactions.

Xander's history of "saying the wrong thing" in social settings has often resulted in public embarrassment. His crushing anxiety about having to talk to new people in groups causes a freeze response, leaving him overwhelmed and unable to communicate. People have always joked he's "a man of few words," but this is deeply embarrassing to him. His need for predictability is activated by social events. He fears not having a safe person to talk to, or failing to recognize people who remember him from previous events. Xander struggles to find food he can eat given his gluten, soy, and dairy allergies. He's quickly overtaken

by exhaustion and sensory overwhelm when an event lasts for two hours rather than one. His worries are real and rational for the "lost generation" of Autistic adults who grew up with no supports.

It's not that Xander hasn't gone to parties and come off as charming and engaged, it's that he'd rather not have to. His energy levels plummet long into the next work week after a party, which doesn't make sense to Mo. What could be so hard about chatting with people, Mo wonders, especially since Xander is capable of doing it? CBT and traditional couples therapy frameworks don't typically address masking or how long it can take a neurodivergent brain to recover from it. They fall short when it comes to centering the sensory needs and accommodations that most social events fail to provide.

How Does that Make You Feel?

Another neurodivergent reality that's missed in neurotypical therapies is that many Autistic people operate *first* in their "thinking brain." They may never experience an internal dialogue or an awareness of what they feel in the moment. Untangling emotions can often only be achieved in a separate, defined step.

"I don't know what I'm feeling when I fight with my boyfriend," said my client Mark, a 35-year-old web designer. "I know I'm uncomfortable, but if you want me to really understand my feelings, I need my therapist, my feelings wheel, and time to unwind the amorphous blob of unpleasantness in my body." Mark needs specific help and time in order to dissect, define, and understand his emotions.

Other clients—like Dre, a 31-year-old nonbinary graphic designer—have a different problem. They're continuously flooded with feelings they can't seem to get away from. "I feel everything: my worry, my partner's embarrassment. I'm sharply aware of people's boredom. I feel their annoyance and irritability, but I can't for the life of me figure out where I went wrong."

Luna, a 40-year-old fiber artist, is a high-masking Autistic adult who internalizes her anxiety and panic about conversations she has with other people. She worries her partner will abruptly leave her due to her trouble showing affection and connecting in intimate ways. Her anxiety touches every aspect of her personal, professional, and relational life. Luna fantasizes about a life where she's less "in her head" and more present. autism-focused therapy would help her normalize these fears and redirect her busy brain toward other, healthier places to hyperfocus. She likes to be reminded that without a positive point of focus, intense thoughts will be assigned to her by her worries. It's a feature, not a bug, of her brain that prefers a flow state, but will settle for a doomsday anxious scenario.

As therapists who support Autistic people, we have to come to terms with a simple fact: we'll never solve their challenges with a neat bow comprised of more mindfulness practices and better communication. But we can use what we know about this neurotype to help them accept their differences and give them the skills they need to build a new framework around their relationships. Sometimes our clients' uniqueness is the very thing we need to focus on to help them get to a better place.

■■■■■

At 44 years old, I've found peace with my diagnosis of autism and ADHD, and feel safe unmasking within my professional community. Post-diagnosis *grelief* took a hold of me during the first year, when I couldn't imagine a time when I'd tell anyone beyond my husband. My extended family, like many families out there, remains blissfully unaware of the world of invisible disabilities.

They know me as the mask I present in public—and I know that autism is genetic, the glue of "sameness" that brings both greatness and struggle to our enormous family. If they ever become curious about my Autistic identity, I'm open to sharing more about myself with them—but I'm not volunteering the information. The weight of showing my work and "proving it" to adults who are largely still wedged in the generational trauma of missed neurodivergence is too much to take on at the Thanksgiving dinner table.

My current therapist understands this decision. With her, I can unmask without shame. She understands that my brain creates chaos I'm not always equipped to untangle alone. Despite all my years as a couples therapist, an argument with my husband can feel existential and threatening to the bright future my "thinking brain" knows we have together. My therapist reminds me that the wisdom and expertise I bring to client sessions is a product of a regulated nervous system that's easy to have in my comfy therapist chair, but not easy to have in a late-night marital argument.

She never makes me feel diminished by how utterly blind I can be to my own perspective-taking struggles. She has a gentle way of letting me know that not everyone wants to listen to a TED Talk at 5:30 a.m., or has the capacity to process all aspects of a conflict before work, when what I really should be doing anyway is packing the kids' lunches.

I pay my therapist's work with me forward to the people I work with. It turns out that a late-diagnosed, super anxious, overachieving, autism-obsessed, divorced and remarried, imperfect parent can offer a lot of acceptance and unmasked "realness" to her clients.

Kevin and Laura seem to agree. At least twice a month, as our sessions together end, I anxiously stumble through our departing social niceties and hang up an awkward moment too soon. My "Autistic goodbye" is an accidental, vulnerable reminder that I too am a work in progress, right along with them.

Kory Andreas, LCSW-C, is a clinical social worker and autism specialist devoted to supporting neurodivergent individuals through assessments, therapy, and education. A late-diagnosed Autistic adult, she consults with government organizations, mental health treatment facilities, and therapy practices to equip them with strategies for fostering truly inclusive and neurodivergent-affirming environments. Contact: koryandreas.com.

Psychotherapy Networker 2025 Readers' Choice Clinical Challenges

Breaking the Cycle of High-Functioning Codependency

When Helper's High Goes Too Far

BY TERRI COLE

By my early 30s, I'd become pretty skilled at "doing life." Running the New York office of a bicoastal talent agency, brokering high-value deals, and earning the respect of my peers—*check*.

Going to grad school to become a therapist and creating a career that aligned with my values—*check*. Surrounded by awesome, inspiring, drama-free friends—*check*. Getting high on life (sober) for close to a decade and invested in my own therapeutic life and personal evolution—*check*. In a passionate, healthy, and reciprocal relationship with a man I deeply loved and building our family with his three teenage boys—*check*.

For the first time ever, I felt peace and freedom within. My life was both full and wonderful, and I somehow managed to keep all the various balls in the air—that is, until my older sister Jenna found herself in crisis. Then, all my zen went flying out the window.

Jenna had a history of substance abuse and bad romances, but this rough patch was "code red" territory. Ever since she moved in with her abusive, drug addicted a-hole of a boyfriend, she'd been blowing up my phone with SOS calls, eager to relay every detail of his drunken tirades. Their fights had even turned physical. Making matters a million times worse, my beloved sister was completely isolated, living with a jerk in a shack in the woods that had no electricity or running water.

You can understand why my blood pressure spiked every time she called and I'd pick up the phone no matter what I was doing. All that mattered was getting her to safety. I lost sight of my own blessings.

In time, I started to notice a pattern. She'd call with another painful horror story ("he pushed me, he threw me out in a snowstorm, he claimed I flirted with a guy at the liquor store"), and I'd listen, filled with dread and determination. "Let's figure this out," I'd say, offering up every single remedy I could think of. "I have a book on escaping abusive relationships that I've underlined for you and will arrive in your mailbox tomorrow. I found a great therapist for you. I talked to a lawyer who specializes in domestic violence." I begged her to leave him and temporarily move in with me. "Please, Jenna—we have room. You can get sober and into therapy, and life will be so much better." The fix was so simple, according to me. All she had to do was consent.

Every time, she'd thank me for my support and advice, saying, "God, I feel so much better just talking to you. Thank you!" I, on the other hand, did not feel better after our calls. I felt awful. The black cloud of Jenna's toxic environment transferred into my body, making me want to vomit. My emotional hangover would last two solid days.

Have you ever heard the saying, "Alcoholics don't have relationships, they take hostages"? Well, if you've ever loved one, you know how true that statement is. With Jenna and this impossibly bad situation, I definitely felt like I'd been taken hostage. Soon, it felt like I rarely thought about anything else. I was often distracted, ruminating obsessively about Jenna in my determination to liberate her from hell. I was sometimes so fixed in worry that I might as well have been on a different planet.

Then one day, I hung up with Jenna and felt sadness wash over me. Before I knew it, I was leaning with my back against the refrig-

erator, sobbing as I slid down to the floor. *How could my beautiful, funny, strong sister be caught up with such a monster? Why couldn't she just accept my help?* For the first time, I allowed myself to fully experience the profound sadness and grief over this impossible situation.

Something has to change, I thought.

At my next session with Bev, my badass, truth-telling therapist, I was still very tender and teary, but when I started to speak, frustration, fear, and fury came out. "Bev, I've done everything I can think of to help Jenna get out and get help! I've sent her money, offered ten thousand escape plans, but she's not doing *anything*. What am I going to do?"

I hoped Bev would reply with *the* answer of how I could fix Jenna's problems, but instead, she took a long pause. Looking at me with great compassion, she asked, "What makes you think that you know what lessons your sister needs to learn in this lifetime?"

Initially, I rejected the entire premise of Bev's question. Obviously, anyone with an ounce of common sense could see that my sister didn't need to learn any lessons by being abused by a drug-addicted POS. "She could learn those lessons while safe with us, hundreds of miles away from this a-hole, in a home with a functional water tank. I think we can all agree on that!" I exclaimed defensively.

Bev looked me in the eye and said calmly, "Actually, Terri, I can't agree with that. I don't know what your sister needs to learn. I'm not God."

My interpretation of Bev's comment was that it's impossible for us to know what is right for another person—when we don't live in their hearts—and it's self-important and egotistical to presume that we do. This *I-know-exactly-what-you-should-be-doing* belief can be harmful to our own mental well-being, too, as I was slowly learning.

Bev reminded me of how hard I'd worked over the last decade to build a beautiful, harmonious, and functional life for myself. My sister's dumpster fire of a situation—or, more precisely, the fact that she would not leave that blazing mess—was threatening my hard-won peace.

"What you really want is for Jenna to get it together, so that your pain can end," Bev explained.

Wow, I thought. Her wisdom hit me like a freight train of truth. *You are not wrong.*

This mind-blowing reframe immediately brought my self-image into question. I truly believed that my care and concern for Jenna (and the rest of the world) was born out of selfless, Mother Teresa-style love. It had never even entered my mind that my need for Jenna to get the hell out of Dodge was motivated, at least in part, by my desire for my own pain to end. I tried to wrap my head around this distressing and humbling truth: my need to free her was more about me than I'd realized.

Until this game-changer of a revelation with Bev, I had no clue that what I thought was straight up caring was actually soaked in codependency. For any HFC—someone with an overachieving, *I-got-it* version of what I call high-functioning codependency—it's hugely helpful to understand the difference.

I conceived of the term *high-functioning codependency* to describe the flavor of codependency that I see in the majority of my highly capable therapy clients every day. It was also uncannily familiar, because it was what I experienced for years. I define HFC as behavior that includes being overly invested in the feeling states, the decisions, the outcomes, and the circumstances of the people in your life to the detriment of your own internal peace and emotional and/or financial well-being. HFC relationships can include blurred boundaries and imbalanced effort and power, with the high-functioning codependent often taking responsibility for fulfilling the other person's needs and trying to control most aspects of the relationship.

High-functioning codependents are often smart, successful, reliable, and accomplished. They don't identify with being dependent because they are likely doing everything for everyone else. They might have an amazing career, run a household, care for children or aging parents, juggle all the extracurriculars, coordinate the various appointments, and likely life coach their friends through all their problems, too.

Bottom line: the more capable you are, the more codependency doesn't look like codependency. But if you are overextending, over-functioning, over-giving, and over-focusing on others—and doing way too much—these behaviors are compromising your inner peace and well-being. Regardless of what we call it, it's a problem.

And because we are so damn efficient, we make all our overdoing and over-managing look easy-breezy—so no one notices we're suffering.

Unhealthy Helping

Many HFCs are the lovers, the caregivers, the healers, the resident "moms" and "therapists" wherever we go. If you're identifying as an HFC, it's a safe bet that your heart is in the right place, like mine was with Jenna. So, it can be challenging to accept that—despite the best intentions—our codependent actions may be misguided.

Whenever I explore the "codependent versus caring" distinction with clients and students, I inevitably hear, "What's wrong with being nice?" The answer is—nothing at all. In fact, *helper's high* is a legit phenomenon that describes the increased feelings of fulfillment and well-being that arise from lending someone else a hand.

Truly healthy, loving, and appropriate giving can create feel-good vibes all around. However, if you're chronically giving, doing, and over-functioning from a place of fear in order to dictate outcomes, feel valued, recognized, or even loved, that's more dysfunctional and codependent than genuine caring. So much of the time, we can see our helping as just being "nice," but the truth is that there is a tipping point where our compulsion to jump into someone else's situation may be less about their needs and more about our own.

The concept of *unhealthy helping*—"helpful" behaviors that are unintentionally *unhelpful*—was originated by Shawn Meghan Burn, a psychologist, researcher, and the author of *Unhealthy Helping: A Psychological Guide to Overcoming Codependence, Enabling, and Other Dysfunctional Giving*. In exploring the unintended consequences of dysfunctional giving, Burn writes, "Some types of helping and giving create unhealthy dependencies and reduce others' self-confidence, competency, and life skills." So, when we engage in unhealthy helping, we're making others dependent on us and

sending the disempowering message that they don't have what it takes to handle their own business.

Why do we engage in unhealthy helping behaviors? A lot of my clients over the years have said things like, "I see myself as a helpful person—it's just who I am," or, "I like to be needed." Here's the thing: If we are *pushing* our help on someone else, then is it really about them? Or are we doing what *we* need to feel valuable or okay?

Other people have a right to make mistakes, to fail, to flail, to not be doing the things we think they should be doing. To paraphrase Bev, none of us are God.

Compulsive Reactions

So often, as HFCs, we give and help without pausing to consider if we *actually* want to be giving or helping in the ways we feel instantly compelled to. We may simply hook our focus on what's going to help avoid conflict. We are motivated by what we think is best for others, and what's going to cause us the least amount of short-term stress.

Auto-accommodating. Auto-accommodating is a state of hyper-awareness, where you are acutely dialed into what's happening around you, unconsciously scanning for ways to ward off conflict or correct problems, even if said conflict or problems have nothing whatsoever to do with you. It's always being ready to lessen someone's burden or to help, even without being asked. It's an unconscious mechanism, so you may not realize how responsible you're feeling for everything and everyone around you.

Whatever form it takes, acting from unconscious reactions is not acting freely—it's reacting to whatever might be causing us angst in our environment. Resisting this type of reaction is vital to stopping HFC behaviors in their tracks. When the urge to spring into action is so strong we can't not do it, that's a telltale sign that we're compulsively reacting and not acting from choice.

Anticipatory Planning. Another compulsive and draining behavior is anticipatory planning, or trying to prevent anyone from getting upset by arranging situations just so, ahead of time, leaving no detail untouched.

Years ago, I was planning a couples road trip and one of my girlfriends was in a relationship with a challenging personality. I found myself ruminating over all the ways I could preemptively avoid conflict with this person who had a history of ruining our gatherings with their drama. How could I make them more comfortable and meet all their needs so they wouldn't instigate problems or torture my friend? That's called *codependent anticipation.* It encompasses the anxiety (and fix-it behaviors) that precedes a situation where there *might* be conflict.

Fear. Looking back, it's kind of remarkable how much energy I was putting toward my sister Jenna's situation when I also had a full-time job, a newish relationship, and three stepkids who definitely needed my time and attention. But my compulsive behavior came from the sheer terror that something *more* terrible might happen to my sister. My actions were more a desperate bid for control than a healthy expression of my free will to help. But it was also so darn sneaky I couldn't even see it.

Over the years, I've treated and encountered many women at the end of their rope, experiencing exhaustion and other physical conditions, like autoimmune disorders, TMJ, irritable bowel syndrome, and burnout. Nearly all were blind to their compulsive behaviors and sought help to address either their stress-related physical symptoms or a loved one's dire pain. It often took time for them to gain awareness around their emotional pain.

Auto-Advice Giving. The moment someone in your orbit so much as hints at a problem, do you find yourself naturally turning your mental dial to the "fix it" channel and offering grade-A, but unsolicited, advice? This behavior is what I call *auto-advice giving*, a common HFC move. To avoid our unease with someone else's discomfort, we whip out strategies, doctor referrals, sage bits of research-backed advice, and relevant personal anecdotes. Our well of sound solutions runs deep.

But let's consider the following hypothetical example: a colleague confides in you because she's just had a fight with her partner over their future. He wants kids, she doesn't. Instead of listening to her with an open, compassionate ear, you mentally gather your ideas, thoughts, and judgments about what's right for her. As she's about to dissolve into tears, you come up with a plan, "Here's the name of a great couple's therapist. Grab a copy of *The Baby Decision*."

We may not realize it, but when we're automatically citing from *the-world-according-to-me*, we're missing out on some of the richest parts of human interaction, which is the give and take of sharing and listening. In this example, you're seeing your colleague through a reactionary, *must help* lens tinged with your own desires and life experiences. Your colleague is not recognized for her strength or who she might become as a result of her struggle. And you've defaulted to a familiar utilitarian role where your value is only as good as what you can do for others. The real connection can get lost in that stream of excellent advice.

To be clear, this doesn't mean you should never ever again share your thoughts or opinions with the folks in your life. It means you can learn to do so mindfully and with respect for the other person's autonomy.

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When most HFCs start to look under the hood and see that their behaviors are not always motivated only by loving-kindness, it can feel mortifying. But as an HFC in recovery, I can sincerely say that it's better to raise your self-awareness and risk this (temporary) discomfort than to stay in a pattern of behaviors and relating that is stealing your precious peace, time, and well-being. You don't have to be perfect; you just have to be willing to unlearn the disordered behavioral patterns that are not optimal for the life you deserve.

Adapted from *Too Much: A Guide to Breaking the Cycle of High-Functioning Codependency* by Terri Cole (October 2024.) Reprinted with permission from the publisher, Sounds True.

Terri Cole is a licensed psychotherapist and global relationship and empowerment expert and 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: terricole.com.*

Body Grief

How Do We Trust Our Changing Bodies?

Psychotherapy Networker
2025
Readers' Choice
Grief

BY JAYNE MATTINGLY

In the beginning stages of my chronic illness journey, my internal Dismissal of the seriousness of my condition was validated by External Dismissal from the medical professionals from whom I sought help.

But the dismissal spell broke when I found myself in the ER for the eighth time, and my mom called and demanded to be put on speakerphone to talk to the doctor.

"Jayne has been in and out of the ER for weeks now," she said. "She has a habit of downplaying her symptoms, and because she is young and 'looks good' doctors dismiss her all the time. I am a nurse, I know something is wrong here, and I will not let my daughter leave the hospital tonight. I am worried about meningitis. Do your due diligence!"

The doctor replied, "I mean, I'm always excited to do procedures, and I'd be happy to do a spinal tap to test for meningitis. But I don't think your daughter has that, ma'am. I think she just injured her neck."

I felt myself cringe. Why did my mom have to make a fuss? But I was also angry: Who the fuck did this doctor think he was? I hadn't injured my neck. He didn't know anything about me! Meanwhile, the pressure in my head was so intense, it felt like my eyes were being pushed out of my skull from the inside, like a gruesome scene from *Game of Thrones*. I was achy like I had the flu, and all I wanted was for it all to just stop. I felt like I was dying. In hindsight, I wasn't far off.

Before I knew it, the doctor had snapped on a pair of rubber gloves, assembled his set of shiny, cold, pokey-looking tools, and was asking me to bend over so he could sterilize the area on my back where the needle would be inserted. I was shocked that we were going to do a spinal tap right here in our ER room. As I looked around, I saw a ball of human hair rolling on the ground like a tumbleweed. My gut clenched; this all felt too casual. Wasn't a spinal tap kind of a big deal? But what did I know? I was the patient, and he was the expert, so I didn't say anything.

I was sent home with some Valium, eager to get back to life as "normal." And there it was again: my own Dismissal of my body's wise intuition.

The doctor was acting so blasé about it all, but it turns out he forgot one very important part: to measure the opening pressure of my spinal cord where my cerebral spinal fluid (CSF) was released. This measurement would have shown an increase in CSF, a small but significant detail that would prove incredibly important later on.

When he finished, the doctor said, "All right, I've patched you up. I'll get that tested for you. Just wait here."

Miraculously, as my fiancé Sean and I waited for the results, I started to feel better. The color came back to my face. I could form sentences, and I was even laughing at Sean's jokes. And when the doctor returned, there it was again: External Dismissal. In a smug tone, he said, "Your tests came back normal."

I was utterly confused, feeling both disappointed and relieved. I just couldn't shake how quickly he was dismissing my pain—and yet how excited he'd been to "experiment" on me. But I was feeling better, so maybe it had all been in my head. I was sent home with some Valium, eager to get back to life as "normal." And there it was again: my own Dismissal of my body's wise intuition.

The next day, I saw clients and resumed my usual workout routine. I even went swimming in the pool that weekend (nobody told me you're supposed to wait six to eight weeks before swimming after a spinal tap). "See, I'm fine!" I told

myself. But five days later I couldn't see. Walking was a struggle as my balance was off-kilter, and my pain was at an eight out of ten. By the time I ended up in the ER again, I felt like I was going crazy.

But this time my mom was in town, and she was loud enough and advocated hard enough for me that the hospital brought in the neurosurgery team. I was immediately admitted to the hospital, where I was told that I most likely had a brain tumor, sent up for an MRI, and given another spinal tap, this time checking the opening pressure. The results showed that I did not have a brain tumor and was in fact experiencing pseudotumor cerebri, also known as intracranial hypertension. The excess CS this creates causes pain, loss of sight, nausea, vomiting, loss of balance, and ringing in the ears, among other symptoms I was experiencing. The reason I felt better after the initial spinal tap was that the excess fluid being drained had relieved the pressure on my brain.

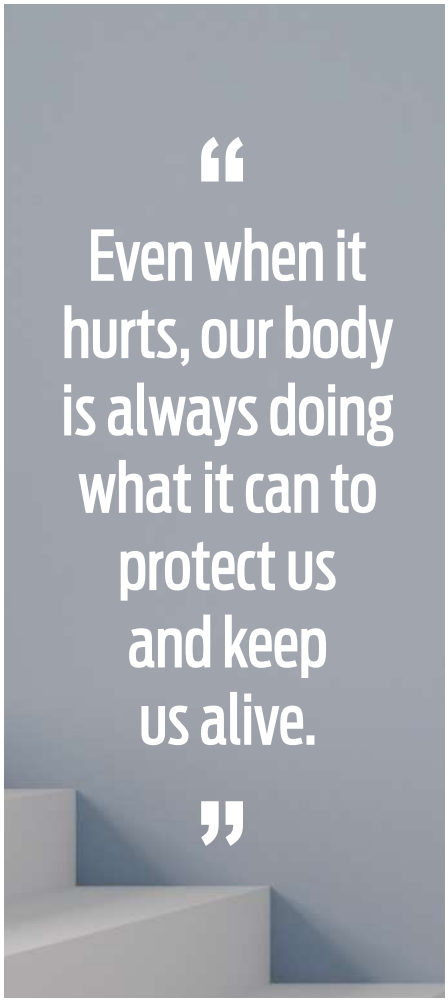
When I finally received my diagnosis, I felt both stunned and validated. All of my symptoms and pain had been real all along, but my own Internal Dismissal had been validated by the doctors' External Dismissal. Like so many of us, I had been silenced, and therefore I continued to silence myself.

Perceived Body Betrayal

My wedding day did not turn out how I'd always pictured it. Both of my parents held me up by my spray-tanned arms as I carefully made my way down the boardwalk aisle and onto the sandy beach, where Sean, and our wedding party were all masked up for our Covid ceremony. Not only did I want both of my parents by my side for emotional support, I needed them for literal support.

In the months prior, I had undergone some of my most serious surgeries to date and begun using a rollator mobility aid. It was the exact same model my ninety-eight-year-old grandmother used. She called it "the Cadillac of walkers," but it felt anything but sporty to me. My body was also bigger than the ones society had told me I must emulate to be the perfect bride: a single-digit size, with perfectly toned arms; a flat tummy; no scars, cellulite, or stretch marks to be seen—and certainly no neck brace! I'd put on a brave face, but if I'm being honest, I was petrified. As a newly disabled bride, not one of the Pinterest boards I'd created or looked at reflected my experience. None. Zero. I had no choice but to just do it my way.

That night, as I danced with my husband—while leaning heavily on the sleek new rollator—I was in pain. I was disabled. I was in love.



Arriving at the rustic driftwood altar, I saw everyone swaying to the Beach Boys' "God Only Knows." Sean's eyes teared up, and for a split second I forgot how much pain I was in. Waves crashed and seagulls cawed, and Gio, our little dog and ring bearer, found a cozy spot to sit in the sand next to my lace train. When I locked eyes with Sean, I saw all the pain, relief, happiness, and hope that had brought us here, and I felt it in my heart. As sappy and rom-com-y as it sounds, with an unspoken "we got this," we really did become one in that moment. Because goddamn—neither of us had signed up for this life.

That night, as I danced with my husband—while leaning heavily on the sleek new rollator my mom had bought me as a wedding gift (which I promptly named Pearl)—and sang at the top of my lungs with my two sisters. I was in pain. I was disabled. I was in love. I was also frightened for what was to come, while grieving what I believed this moment should have looked like.

As happy and hopeful as I was for my future with Sean, this sense of grief followed me as I settled into married life. I found myself grappling with a pervasive sadness and feeling of loss mixed with confusion, denial, and disbelief. We weren't driving off into the sunset like other newlyweds. Instead, we were sitting at home waiting for the arrival of my mobility service dog, and concern for my health was always top of mind. Had we missed out on the "fun years" before we'd even gotten started, and skipped straight to the part where our lives revolved around medical bills and fears about me falling in the shower? I loved Sean so much. But nothing about our union felt sexy or romantic anymore, and my heart was broken.

Like many of us, I am a self-proclaimed doer. I placed so much worth in my ability to get things done, and to get it done well, that grieving the significant loss of abilities that accompanied my diagnosis left me feeling helpless and less-than. I could not see or feel past my pain, and I knew by now that no treatment, medicine, or therapy would fix me. All I knew was that my body would never be able to perform the way it had.

How could the body that had been my home, that I had already helped to heal from my eating disorder, have turned on me? How could it be the cause of so much fresh suffering?

My body has betrayed me, I thought.

This is what I call Perceived Body Betrayal, the narrative that your body has somehow turned "against you." It is the core driver of Body Grief—the sense of loss and mourning that comes with living in an ever-changing body—and what ultimately catapults all of us into a deep disconnect within our bodies and ourselves.

Body Trust

Perceived Body Betrayal is the feeling we get anytime our body changes in ways we are not able to control, does not recover fast enough from any setbacks, experiences pain, or is otherwise unable to perform on demand: that it is somehow against us. This is a maladaptive way of coping with our Body Grief; if what we are experiencing is our body's fault, then we have something concrete to blame. And so we place ourselves at war with our bodies—when what is needed is compassion, grace, and a judgment-free zone in which to heal.

As with Body Grief, Perceived Body Betrayal stems from the societal message that our productivity, looks, and abilities are the primary measure of our worth, when in reality, all bodies of all colors, shapes, sizes, and genders hold equal value, in sickness and in health, and at every life stage. But all bodies are also destined to change, age, and experience different levels of productivity over the course of a person's life. Refusing to accommodate these shifts erodes our innate Body Trust and throws us even deeper into Perceived Body Betrayal.

This is why I say Perceived Body Betrayal, not simply Body Betrayal. Many of us believe that our physical self is separate from our psychological and spiritual self. We often hear things like "Her body is failing her" or "His body gave up on him." And while the underlying sentiment is well-meaning, I have a big problem with the subtext.

Our bodies are not separate from the rest of what makes us who we are, and they are not betraying us—ever. We just perceive they are, based on how we have been told they "should" perform. Our bodies will in fact do everything and anything to find a homeostasis, that is, to find balance, to function, and to maintain themselves. This is, in fact, always our bodies' number one goal.

Sometimes the journey toward homeostasis is not pretty. In fact, it can be incredibly inconvenient, even painful. In my case, my body seeking homeostasis manifested as the swelling, rashes, failed fusions, pain, and body convulsions that were part of my Ehlers-Danlos syndrome diagnosis. For you, it may manifest as fatigue, burnout, anxiety, feeling like you can't get enough sleep, increased appetite, nightmares, or racing thoughts.

But even when it hurts, our body is always doing what it can to protect us and keep us alive. As infants, before we have language, we have no option but to trust in the nonverbal cues our body sends us. Our body lets us know when to eat, when to sleep, when to poop, and when we need a hug—and at that age, that's pretty much all we need to know! But as we mature and language takes over, we discover all sorts of ways to override our innate bodily needs. Rather than taking a nap when we're tired, we caffeinate. Our stomach growls at us, and instead of taking time to sit down and eat a proper lunch, we have another coffee or grab a protein bar on the go. We feel uncomfortable in a social situation, so we chug another glass of wine. We disrupt our Body Trust on the daily, but our body never stops communicating with us. Speaking in both physical sensations and emotions, it signals to us when something needs our attention—be this a physical need or ailment that needs tending to, or when something it wants and needs is being presented to us and it wants us to say yes to it. Body Trust springs from leaning into this mind-body-spirit conversation.

All my debilitating symptoms, which required multiple surgeries to address, were ultimately ways that my body was trying to protect me. But because I had been programmed to believe that a healthy body was pain-free, worry-free, fully functioning, and always happy, I felt like my body was letting me down—when really it was simply fighting to find balance. Part of being with our Body Grief, and growing our capacity to stay in Body Trust, is remembering that our body is always on our side.

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Prior to my clinical training as a therapist, I believed that I would not grieve until I experienced the loss of a loved one. But the reality is, to be human is to experience grief, because grief is intertwined with any and all experience of change. Whether it's a new job, a move to a new city, a divorce from a longtime partner, or recovery from an addiction, regardless of the benefits these changes elicit, they can all induce grief. We grieve for the people we used to be, for the lives we used to live, and for the futures we thought we'd have.

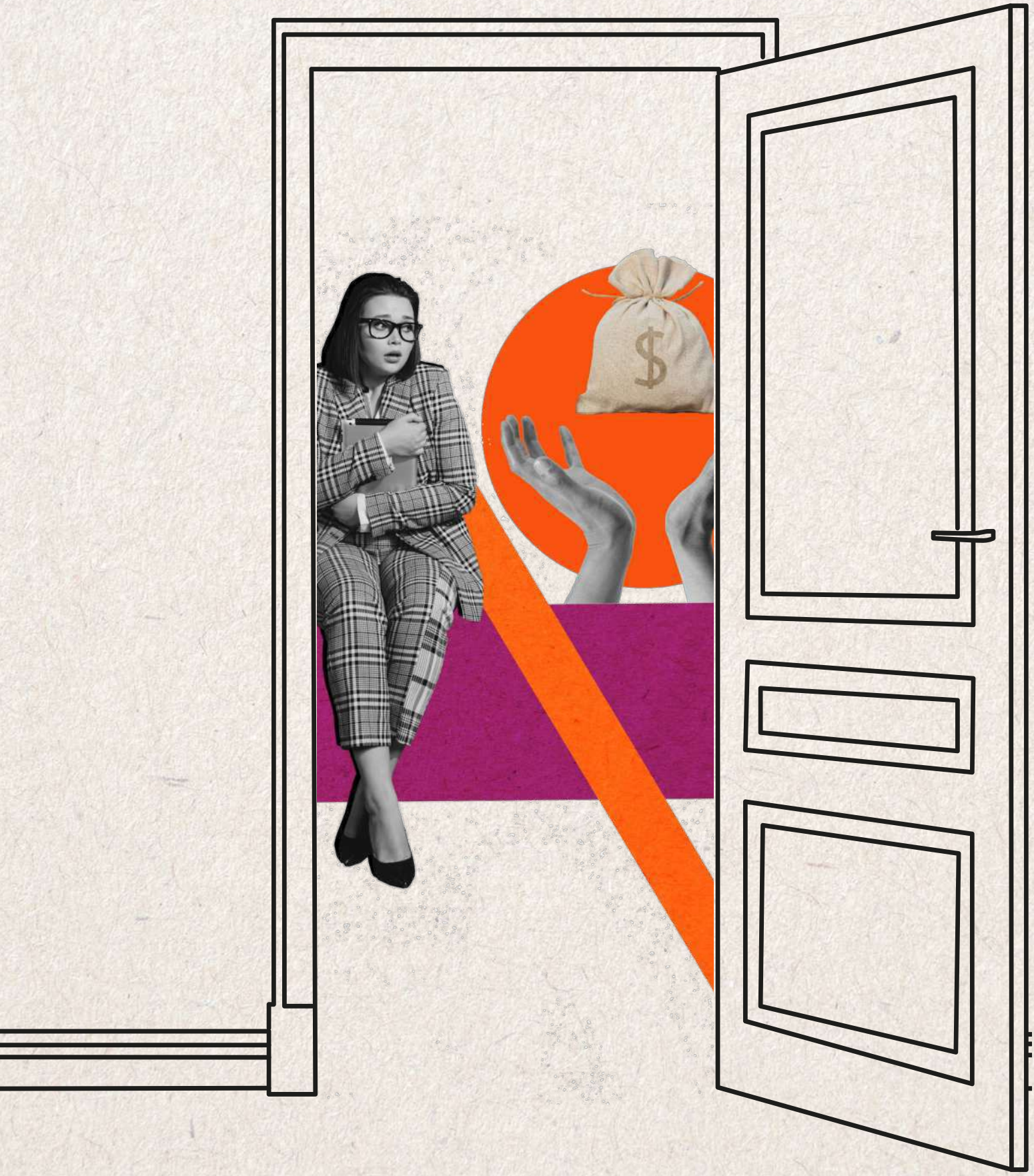
Yet despite grief being our instinctive physical, emotional, and psychological response to loss, society doesn't treat grief as a natural part of the human experience. Instead, it is something to be avoided, pathologized, and compartmentalized. Or, if we can afford it, we learn that grief is best dealt with behind closed therapist's doors. But this only stifles our grieving response, which in turn makes us more prone to stress, deepens our trauma, and exacerbates our emotions.

This is what can make Body Grief so much more complicated, emotionally charged, and hard to navigate. There are very few dedicated forums in which we can openly grieve a death, let alone our own loss of bodily autonomy. Yet our Body Grief is just as big of a grievance as a death in the family; the loss creates just as deep of a wound.

Grief in all its forms wants and needs to be felt and expressed. This is what allows us to heal. With each difficult, messy emotion that is brought to the surface, acknowledgment is how we are able to tend to our wounds.

From This Is Body Grief *by Jayne Mattingly, published by penguin Publishing Group, a division of Penguin Random House, LLC.*

Jayne Mattingly, MA, has a degree in clinical mental health counseling and a background as an eating disorder professional. Her work challenges the toxic narrative that our bodies are broken and reminds us that our bodies have never been against us.



Psychotherapy Networker 2025 Readers' Choice Opinions on the Field

The Venture Capitalist Playbook is Breaking Therapy

Can Clinicians Take it Back?

BY MEGAN CORNISH

For decades, therapy worked a certain, predictable way. The practice of therapy consisted of: a therapist, with a caseload, on a structured path from graduate school to licensure to practice. The models evolved, but the profession itself remained a stable, if not always lucrative, career.

Now, that stability is unraveling, and therapists are feeling it in ways big and small. Caseloads are climbing. Colleagues are leaving. The jobs that once seemed like safe bets, like W-2 salaried roles at mental health companies, or even contractor gigs at large platforms, are becoming riskier, subject to mass layoffs or shifting pay structures. Even solo practitioners are feeling the shift as they watch clients fighting for the insurance reimbursements they were promised, while trying to keep a steady flow of new referrals. There's a real sense that the field itself is tilting in a new direction.

Blaming this change on just one thing would be oversimplifying it. Insurance companies have long dictated the financial realities of therapy, and the pandemic drove demand for mental health care to unseen levels. The introduction of coaching and the increase in societal loneliness are players in this change, too. But one of the biggest forces in recent years has been venture capital.

I want to be clear: venture capital didn't single-handedly create this moment. But it is one of the reasons therapy feels different. And if therapists want to have a say in where the field is going, they need to understand how these financial forces are reshaping the work they do every day.

When Therapists Become a Line Item

One morning in 2023, a therapist I know at a promising, investor-backed mental health platform woke up, logged in for her first session of the day, and found her accounts disabled. No email, no warning—just gone.

By the time she realized she was out of a job, her clients already knew. They'd received a boilerplate email: Their therapist was "no longer with the company," but not to worry—a new one had been assigned. No mention of the trust they'd built. No acknowledgment of the months of hard work. No option to say goodbye.

If I hadn't been following the mental health tech space, I might have assumed this was some bureaucratic mistake, maybe a one-off glitch in the system. But it wasn't. This kind of thing has happened at multiple mental health startups in the past few years. They're not mistakes—they're business decisions.

The Mental Health Startup Boom

When I first moved into copywriting—writing the emails, blogs, and other materials mental health companies use to communicate—after years as a licensed clinical social worker, I was very hopeful that mental health startups could be part of the solution. The system was broken, and these companies promised to fix it—expanding access, lowering costs, and making therapy available to people who had never been able to afford or find it before.

I've met a lot of mental health company founders, and they all start out with good intentions. But once investor funding gets involved, things start to shift. The pressure to grow fast, cut costs, and scale in a way that looks good on paper takes priority. Instead of focusing on continuity of care, clinician support, or ethical business practices, they start optimizing for what investors want to see—rapid expansion, streamlined operations, and a business model that promises big returns. No founder sets out to deprioritize care, but at some point, the demands of profitability start making those decisions for them.

A friend of mine had this model turn his life upside down. He was the top clinical leader at a mental health company that actually prioritized high-quality care, clinician well-being, and strong client outcomes. And it was working. The company was growing, therapists were staying, and clients were getting real, consistent care.

> "Most mental health companies start out with good intentions. But once investor funding gets involved, things start to shift."

Then, investors came in. The new executive the investors installed didn't see the point of clinical oversight—literally didn't understand what it was or why it mattered—and didn't bother to ask. So they fired him.

It only took three months for things to start falling apart. Churn was up, therapists were leaving, and clients weren't sticking around. He had flagged these risks before he was fired, and everything he had warned them about was happening.

They hired my friend back to try to undo the damage, but it might be too late. The company is still operating within the model investors pushed for—one designed for rapid growth, not sustainable care. Fixing it would mean making decisions that don't fit the VC investor model, and from everything I've seen, making those kind of decisions isn't how the story of mental health tech companies plays out.

The VC Playbook: Scale, Squeeze, Sell

In 2021, mental health startups raised $5.5 billion across 324 deals. With the pandemic, virtual care exploded, and investors took notice. Suddenly, mental health was a hot market. New companies flooded the space, all promising to "revolutionize mental health" or "democratize therapy."

At first glance, this seemed like a win. More funding meant more access, more therapists, more options for clients. But the money came with expectations.

VC firms don't invest in slow, steady growth. They look for businesses that can scale quickly and generate massive returns. In industries like tech, where a single product can be sold infinitely with little additional cost, that kind of growth is possible. Think, for example, of Adobe or Canva. The initial costs of building this kind of software-as-a-service (SaaS) is high, but then the product can be sold for very little additional cost. Therapy, though, isn't a SaaS product. It's labor-intensive, requires long-term relationships, and doesn't come close to the 70% profit margins that investors expect.

That disconnect set the stage for what happened next. Once venture capital entered the space, companies weren't just focused on expanding access—they had to

expand fast enough to satisfy investors, and they did so using the tried and true VC playbook: First, companies push for rapid expansion, hiring as many therapists as possible and onboarding new clients at an unsustainable rate. Then, when growth slows, they turn inward, looking for ways to increase profitability—cutting therapist pay, increasing caseloads, automating wherever possible. Finally, when it's time to cash out, they make the company look more profitable on paper, even if that means gutting clinical teams and scaling back quality of care.

A therapist I spoke with joined Ginger just as they were merging with Headspace. She was leaving private practice because she wanted income stability and benefits, which her new role provided. But as time went on, the demands escalated. Caseload requirements increased, burnout set in, and the job that was supposed to be a better alternative started to look just as unsustainable as everything else. After that experience, she left the field entirely for several years.

And she wasn't alone. Her story is one I've heard over and over from therapists across the country. Clinicians take jobs at well-funded startups hoping for stability, only to find themselves burning out just as fast, or faster, than they would have in private practice.

This cycle doesn't just affect individual therapists. In the past few years, multiple mental health startups that had made grand promises of fixing therapy have quietly shut down, sold off, or dramatically cut their clinical teams in a bid to stay profitable. The ones that remain have largely made the same calculation: it's more important to please investors than to protect therapists or the clients they serve.

Who Decides What Therapy is Worth?

For therapists hoping to escape the VC model, the alternatives aren't much better.

Venture-backed startups have just started reshaping mental health care in ways that prioritize growth over quality, but insurers have been setting the financial terms for decades. And their incentives are just as misaligned.

Insurance companies don't make money by paying for therapy; they make money by controlling how much therapy they have to pay for. That means keeping reimbursement rates low, narrowing definitions of "medically necessary" care, and making it harder for providers to bill for anything beyond short, standardized sessions.

> "Therapists should always expect that decisions will be made to maximize profits for investors. That's how venture-backed businesses work."

A chief clinical officer I spoke with has spent years fighting to keep clinicians at the center of care while ensuring they're paid fairly. But in the last few months, that fight has become nearly impossible. Payors keep cutting reimbursement rates, making it harder and harder to sustain a model where therapists can afford to stay. As a result, therapists burn out, leave, and access to care shrinks. (Which, I suspect, is exactly the point.)

Stuck between the heavyweights of VC companies and payors, therapists have an impossible choice: take insurance and work unsustainable hours to make a living, go private-pay and risk shutting out lower-income clients, or work for a venture-backed company and accept the trade-offs—lower pay, less autonomy, more burnout.

Why Therapists Have Been Left Without Power

This isn't just a problem of bad employers. It's a profession-wide issue that starts in graduate school.

When you're a therapy student, nobody sits you down and explains how insurance reimbursement actually works, or what to look for in a contract before you sign it. New therapists know all about attachment theory, cognitive distortions, and trauma-informed care, but they rarely know how to negotiate a contract, challenge an insurance denial, or figure out whether a company's business model is sustainable.

That knowledge gap isn't purposeful, but it is convenient. It makes therapists easier to exploit. Companies know that if therapists don't understand the financial side of the industry, they'll accept lower rates, sign contracts with restrictive non-compete clauses, and give up autonomy without realizing what they're losing.

Not only do therapists not like what's happening, they have little recourse. Unionizing isn't a viable option for most therapists because they're classified as independent contractors, making collective bargaining nearly impossible. High turnover makes organizing difficult for therapists who are employees.

It's the same story that played out in medicine, pharmaceuticals, and

law. Private equity firms and corporate consolidations swallowed up independent practices and turned highly paid professionals into low-control employees. Now, it's happening to therapy. The question is whether therapists will fight to keep control.

How Therapists Can Push Back—Without Falling into the Guilt Trap

A lot of therapists have been told the same thing: if you care about access, you shouldn't care about money. It's a useful message for the people profiting off your labor, but it's not true.

For years, therapists have been put in an impossible position. Either you take low-paying insurance rates and overload your schedule, or you go private pay and feel guilty about it. Either you work for a VC-backed company with steady referrals but little control, or you try to make it on your own, knowing you might not be able to afford to see lower-income clients.

The system depends on therapists believing these are the only choices. It keeps labor costs down when clinicians stay in jobs that don't pay enough, accept reimbursement rates that don't cover the cost of care, or take on extra clients just to make ends meet.

One way out is to stop playing by those rules. How?

Step One: Understand the Market

Venture-backed startups and insurance payors don't make decisions on best guesses. They operate within financial models designed to maximize returns—whether for investors, executives, or shareholders. Understanding those models is one of the best ways therapists can avoid being undervalued.

To start, look beyond salary numbers. If a company isn't charging therapists and isn't making most of its revenue from client fees, then who's paying? If a company's main funding comes from employers or insurers, then those are the stakeholders it has to keep happy—not therapists or clients.

Therapists should always expect that decisions will be made to maximize profits for investors. That's how venture-backed businesses work. But if therapists are the primary customers—paying for access to referrals, administrative support, or a network—then the company's success depends on keeping them happy. In those cases, therapists have leverage, because their satisfaction directly impacts the company's bottom line.

> "Therapists don't have traditional labor protections, but that doesn't mean they're powerless. And it doesn't mean they have to fix the system alone."

This means therapists shouldn't automatically distrust companies that charge them fees. In fact, charging therapists directly can be a protective factor. If the money comes from an employer or large insurance contracts instead, priorities shift. What matters is not just whether a company charges therapists, but whether its financial structure aligns with supporting them.

Then there are contracts. Therapists should ask: who really benefits from the terms? Noncompete clauses, productivity quotas, and ownership structures often favor investors and executives over clinicians. If a company is scaling rapidly, what does that mean for workload expectations? If it's paying higher-than-average rates, how sustainable is that model? If a platform keeps its fees low for clients, what's the tradeoff for therapists?

And finally, there's the question of who to hold accountable. Some companies are squeezing every dollar for profit, paying therapists as little as they can while investors collect returns. Others are trying to do the right thing while stuck within an insurance system that dictates how much they can pay. Before blaming a company for its rates, it's worth asking: Is it keeping pay low to boost margins, or is it operating within financial limits imposed by insurers? Who's really setting the rates—the company, the payors, or the investors behind it?

The less secretive this system is, the harder it becomes for companies to sell therapists on bad deals. Therapists don't need to avoid every company that charges them. They just need to ask where the money is going, who is making decisions, and what that means for their work.

Step Two: Leverage Labor—Even Without a Union

Therapists don't have traditional labor protections, but that doesn't mean they're powerless. Collective action doesn't have to mean unionizing or organizing protests. Sometimes, it's as simple as making informed decisions about where to work—and making sure companies know that therapists are paying

attention.

That's the idea behind *The Fit Check for Therapists*, a Facebook group I created where therapists compare pay, working conditions, and company policies. Too often, therapists take jobs without knowing how their rates compare to others or what's buried in the fine print of their contracts. But knowledge is leverage. When therapists can see, side by side, which companies pay fairly, support clinicians, and uphold ethical standards—and which ones don't—companies have to compete for labor.

The goal isn't to expose bad actors but to move therapists toward better ones. When a company that pays and treats clinicians well starts attracting more and more therapists, others are forced to adjust or risk losing their workforce. And when new companies enter the space offering even better conditions, the cycle continues. The power is in the shift of labor flowing toward companies that actually invest in clinicians, forcing the others to either change or sink.

Many industries have forced companies to evolve by shifting labor toward better models. Doctors, pharmacists, and even freelance writers have leveraged transparency and competition to drive up wages and improve working conditions. Therapists can do the same—not by waiting for companies to change, but by making them compete for therapist support.

Step Three: Make Your Work Sustainable—Without Feeding the System

For many therapists, the most practical way forward is to go private-pay. There's a narrative that says it's our duty to sacrifice our financial well-being to help improve access. But the gameplan isn't to vaguely underprice our services in the name of helping. Instead, we should charge our worth and intentionally offer a few sliding scale or pro bono spots.

"The power is in the shift of labor flowing toward companies that actually invest in clinicians, forcing the others to either change or sink."

Of course, this isn't a system-wide fix, but it allows therapists to stay financially stable while still making space for clients who can't afford full fees. More importantly, it stops funneling labor into a system that relies on therapists accepting unsustainable pay.

And I'm going to say the quiet part out loud: if we do this, things will get worse before they get better.

If enough therapists start walking away from exploitative systems, if they start refusing unsustainable insurance rates, if they turn down VC-backed jobs that don't pay enough, access will suffer in the short term. Fewer therapists will take insurance. Clients who rely on those systems will struggle to find care. That's real, and it's painful.

But the alternative is worse.

Because if the field keeps going the way it is—burning out clinicians, underpaying new graduates, making private practice impossible to sustain—access won't just get worse; it will collapse. Therapists will leave, new ones won't enter, and the workforce shortage that insurers and companies claim to be solving will become a full-blown crisis.

That's the real choice. Either access takes a hit now to force payors and companies to change the way they reimburse care and make therapy a sustainable career, or we keep pretending things can go on like this until there aren't enough therapists left to provide care at all.

Therapists don't have to fix this system alone. And they definitely don't have to destroy themselves trying. The system wasn't built for therapists to have power. But that doesn't mean they can't take it back. pn

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Megan Cornish, LICSW, is a writer and former therapist who specializes in copywriting and content for mental health companies. She brings a clinical perspective to mental health communications while advocating for therapists navigating a rapidly changing field. You can find her on LinkedIn, where she writes about these issues and connects with others working to reshape the future of mental health care.

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Psychotherapy Networker 2025 Readers' Choice Relationships & Sex

Why All Therapists Can (and Should) Ask About Sex

BY MARTHA KAUPPI

Tips for Bringing Up a Touchy Subject

Q: Is it essential for therapists to ask clients about sexual issues? I don't want to go outside of my scope of practice, find myself in a conversation I have no idea how to navigate, or make clients uncomfortable.

A: Your concerns are understandable; most therapists don't have much, if any, training working with sex issues. And beyond the lack of training, most of us—clients and therapists alike—rarely experience truly comfortable conversations about sex in our daily lives. At the same time, challenges around sex and sexuality are part of the human experience, and they're often accompanied by a fair amount of distress. Most of us have had to muddle through these issues on our own, contending with shame and misinformation along the way, but what if we didn't have to go it alone?

Most clients are grateful for the opportunity to discuss sex, often reacting like you're throwing them a lifeline when you communicate that sex is a welcome topic in the therapy room. Even if they don't have something particular to discuss, they're usually glad to know they're in a safe space to talk about sex if they ever need to. I'm not speaking solely from my own experience: I've trained hundreds of generalist therapists to discuss sex, and I've heard, over and over again, that clients were much more receptive to the conversation than they assumed.

So, if there's a small part of you that's curious about discussing sex issues in the therapy room, let's lean in. How could you bring it up? And what would you do if it went badly?

Opening the Door

"Is there anything about sex or sexuality you think you might want to discuss in the course of our work together?" I ask this as part of my assessment, right along with questions about anxiety and depression. In that context, I don't think sex needs to be particularly intimidating. You're already asking your clients forthright questions about very sensitive, emotionally charged material. I'll bet that, when you started out, it was challenging to ask detailed questions about suicidality, but you learned how to do it, with some practice. You can reach a similar level of confidence when it comes to asking about sex, too.

> “Sex offers adults a rare opportunity to play—but often becomes so fraught that it feels more like work. Our relationship with sex isn’t static.”

Sometimes my client will respond, “no,” and I’ll say, “That’s just fine. If anything arises, just know you can bring it up here.” I’m not interested in pressuring them, and I’m not invested in what topic we talk about. I see my role here as offering a buffet of conversation topics that are often relevant to therapy.

On rare occasions, you might have a client who says something that indicates a lot of discomfort, some version of, “Oh no, that’s gross, why would we talk about that?” In that case, I’d say something like “Good question! I don’t actually think sex is gross, and lots of people have concerns or questions about it, or distress about it. If that’s you, I’m here for it. If not, that’s fine, of course.”

I’ve never had anyone say, “I think it’s malpractice to ask me about sex. I can’t believe you did it, and I’m leaving now.” If that were to happen, I’d say, “Thank you for your honesty. I’m so glad you spoke up. I didn’t intend to make you feel uncomfortable. I ask everyone about a lot of things, including sex, and we don’t have to discuss it, or any particular topic, unless you want to. One thing I can promise you about working with me is that I’ll honor it when you tell me you don’t want to talk about something, and I really want to know what’s important to you. Would you be willing to consider staying? Are there things you’d like to ask me that would help you figure out if this is a safe place for you?”

You might notice that there’s a common thread here: consent. I introduce the topic as a conversational option, and my client gets to decide if they’re interested in pursuing it. I always seek to model consent in my work, no matter what’s talked about. If a client says they don’t want to talk about something, I might ask why, or what’s coming up for them, but I’ll certainly honor their boundaries, and I’ll let them know that I think it’s important and wonderful that they’re being clear with me about what they want. I strive to be attuned, create safety, reward honesty, and identify options they may not have considered. In nearly every case, this approach results in a strengthen-

ing of the connection between me and my client.

The Cost of Not Asking

The reality is that not asking about sex—though it might feel like a neutral choice—comes with a cost. Many of my individual clients have shared something like, "Thank you so much for being willing to talk with me about sex as if it were a normal part of life. I was able to do a huge amount of healing in a really short period of time because you were so comfortable with the issue." In addition, I can't tell you how many partners I've seen over the years who've told me some variation of this story: "We've been to a number of couples' therapists over the past 25 years, and you're the first one who's ever brought up sex. Now that you mention it, sex has always been difficult for us."

Of course, those therapists probably didn't bring up sex because they were justifiably concerned about respecting boundaries. I respect their caution, but at the same time, I've found that most clients who discuss sex with me don't need a specialist at all. They need a therapist they trust who's curious, interested, and willing to talk frankly about anything that's important to them. They need someone who's willing to walk beside them as they unpack their thoughts, feelings, confusion, early influences, and future aspirations. I believe that could easily be you, the therapist they're already working with.

Much of the work you do in this area will involve dynamics you already have experience with. Your clients will wonder if their experiences are normal, if they're broken, and if there's hope for them. They may wonder if there's a future for their relationship if their partner wants a different type or frequency of sex than they do. They may have a limited sexual repertoire, experience some sexual dysfunction, or have difficulty handling disappointment when sex doesn't go as planned. Commit to a nonjudgemental stance, and use the therapeutic tools you already have in your toolbelt.

When you're unsure of something, it's okay to be honest about the limits of your expertise. It's much more important to be in the conversation than to know the answers, so please don't let the likelihood that you won't know something at some point stop you from talking about sex in therapy.

It would be very powerful to say, "There's so much misinformation about sex that I don't want to make a guess. I think you deserve real answers to your very important questions. Can you think of any steps you could take to get the information you want?" I might encourage my client to look into a topic that interests them, and see what they can learn.

To Refer or Not to Refer

Some of your clients will make great progress on their sex issues through their work with you, particularly if you encourage them to learn more about it. If the progress seems slow or the treatment isn't progressing as you anticipated, I strongly recommend consulting with a sex therapist. The investment will pay off many times over, not just with this case, but with future clients. I consult when the treatment plan isn't moving along as I expect it to. If my consultant thinks there are specialists that could help me be more effective, I consider the pros and cons of collaborating versus referring. Many specialists will feel fine about doing just a handful of sessions with your client, with or without you present, without shifting the bulk of the work away from you.

Keep in mind that there are not nearly enough specialists to work with all the people who have sex issues come up at some point in their lives, because that's pretty much everyone. Most sex therapists will want you to keep your client, because they don't have room in their practice for more than a session or two. If you do need to refer to a specialist, the American Association of Sexuality Educators, Counselors, and Therapists (AASECT) certifies professionals in this area, and has a provider locator.

And hey, you might discover that you love working with sex issues! If so, it's fairly easy to get extra training. You can expand your knowledge base a little and make a big difference for lots of clients. Or you could even expand it a lot and become a specialist.

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Ultimately, sex has physical, emotional, relational, social, and spiritual implications. It's a way many people connect with themselves and their partners, and gauge the health of their relationships, the health of their body, or even their moral wellness. It can be spiritually transcendent, completely casual, a quick release, a way to seek validation, a form of nonverbal communication, a source of shame, an energy exchange, an old wound not yet healed, or something everyone assumes you need to have, even if you have no interest in it at all. The meanings are infinite. This is truly rich material for therapy.

Sex also offers adults a rare opportunity to play—but often becomes so fraught that it feels more like work. Our relationship with sex isn't static. It shifts over time, along with our bodies, lifestyles, relationships, and responsibilities. New sexual challenges emerge continuously, as do new possibilities. Every aspect of sex can be easy as well as incredibly difficult. Sex can be deeply satisfying or leave you feeling lonelier than before. There's so much confusion, misinformation, judgment, and fear about sex that I truly believe you can create a significantly reparative experience for most clients simply by opening a conversation about it and easing the loneliness that comes with all taboo but important topics.

And if you're still wondering if your clients will want to talk about it, all it takes is one question to get started. Give it a try. Let them surprise you.

Martha Kauppi, LMFT, is a therapist, educator, speaker, AASECT-certified sex therapist and supervisor, and author of Polyamory: A Clinical Toolkit for Therapists (and Their Clients). *As a senior trainer of the Developmental Model of Couples Therapy, she teaches therapists all over the world to work effectively with relational intimacy challenges and sex issues.*

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The Beauty of Longing & Melancholy

Susan Cain Celebrates the Sensitive Client

BY SUSAN CAIN & LIVIA KENT

In 2012, Susan Cain became world-famous for her bestselling book *Quiet: The Power of Introverts in a World That Can't Stop Talking,* arguably one of the most influential books in the therapy world that's not actually about therapy. With her online "quiet" community that extends across 193 countries and every U.S. state, she's showed that the introverted qualities of thoughtful, low-key people—who tend to get dismissed in our loud, extrovert-centered society—are critical to every system in existence, from families to schools to workplaces and entire global industries.

Now, what has done *Quiet* did for introverts, her latest book—*Bittersweet: How Longing and Sorrow Make Us Whole*—is doing for the wistful, sensitive, misunderstood people among us she calls "melancholics."

In this exclusive interview, Cain talks about her own innate disposition toward melancholy, and her view of sadness and longing not as hardships to endure on the road to happiness, but as deeply spiritual states of being.

Sure, you might say, every therapist knows *all* emotions have something valuable to offer. But let's be honest, how often do you *celebrate* a client's sense of sadness and longing? If your favorite nostalgic poet or spiritual seeker wandered into a modern-day consulting room, what are the chances they'd be diagnosed with anxiety, depression, ADHD, or a dissociative disorder?

As therapists, we're taught to be on the lookout for symptoms of unprocessed trauma, attachment issues, and mental illness. We're taught to wonder if a client is dysthymic or suffering from a depressive episode. And we're taught to be concerned. But as Cain points out,

research shows that the *actual* correlation between melancholy and depression is mild. Just because sadness *can* lead to depression doesn't mean that it *will*. And just because sadness *can* feel heavy doesn't mean it should be seen as a burden.

So if Cain is right—and sorrow and longing are more often linked to transcendence than pathology—then perhaps spirituality shows up a lot more often in therapy than we think.

Livia Kent: How does being melancholy differ from being depressed?

Susan Cain: Melancholy and depression are two separate states. The extent to which the field of psychology makes no distinction between them drives me a little crazy. When I started researching *Bittersweet*, the first thing I did was type "melancholy" into PubMed, and I kept getting articles about clinical depression. Not a single one talked about melancholy as a precious state of being aware of the impermanence of everything and the great piercing joy at the beauty of life that comes with that awareness.

I teamed up with psychologist Scott Barry Kaufman and researcher David Yaden to create a scale that helps people measure where they tend to fall in terms of their state of bittersweetness. We asked questions like, *Do you find joy or inspiration in a rainy day? Do you frequently experience goose bumps? Have other people described you as an "old soul*?"

We found that people who score high on bittersweetness also score high on measures of creativity. They score high on Elaine Aron's construct of being a highly sensitive person. Interestingly, they score moderately high on measures of experiencing states of awe, wonder, and transcendence. Part of why we overlook this is because of the correlation between bittersweetness and anxiety and depression. But it's only a mild correlation, not high at all—and it's not surprising. If you tend to feel everything intensely, you might sometimes tip into a state where that's not helpful to you.

LK: How can therapists help clients value their melancholic states?

Cain: If somebody tends toward melancholy and vibrates intensely with everything life brings to them, we can help them understand that there are times that's not easy. But we can also gently help them understand that they don't have a choice about their fundamental nature. If you're one of those people, you're one of those people. We might help them understand how many gifts come along with that. When I'm vibrating intensely with something negative or with something I'm longing for, I can start with just understanding, *This is who I am*. I can hang out through it and wait for the intensity of the experience to pass. But even while I'm in the depths of it, I can understand that I have this incredible gift to feel things deeply. I can experience a sunset that much more intensely or take the things I observe and shape them into a creative act, or into an act of healing.

LK: Melancholy isn't necessarily sadness. But sadness, too, has an important role to play in our lives. What's the value of sadness?

Cain: If you saw *Inside Out*, you may remember that the two main characters are Joy and Sadness. Well, it wasn't always that way. I gave a talk on introverted employees at Pixar and after we were done, I sat down with Pete Docter—the director of the movie—and he told me that when they first made it, the two main characters were Joy

and Fear.

The production of the movie was already well underway when Docter started having a terrible feeling in his stomach, a sense that the whole movie doesn't work because Fear has nothing to teach Joy. He went into a tailspin and began to envision his career being over. He descended into sadness—and that's when he realized that Sadness should be the core of the movie, because it actually has a lot to teach Joy. Sadness fuels empathy and belonging. Docter knew it was going to be a huge uphill battle to convince the executives at Pixar why Sadness of all things should be a main character—because no one wants to be sad—but he was able to portray life as just that: joy and sorrow, beauty and despair.

I'm guessing many therapists wouldn't have gone into the healing professions without the wish to help clients discover new ways of exploring the full depth of life. It's that full-spectrum expression that can help people heal, that gives us permission to experience sadness and cry.

LK: You link melancholy with our longing for beauty. Is there a link between spirituality and melancholy?

Cain: I say this as a lifelong atheist-turned-agnostic, but I believe we come into this world in a state of longing for the more perfect and beautiful world we just left. This could be the perfect harmony we experience in our mothers' womb, or a perfect and beautiful realm we were once a part of. You see this in all of our religions. We were once in Eden, and then we long for Eden. We were once in Zion, and then we long for Zion. The Sufis call it "the great longing for the belonging for the soul." Then we have secular manifestations of the same great longing. In *The Wizard of Oz,* there's a longing for somewhere over the rainbow. This longing is the great essence of every single human being. When we see something beautiful, what we're seeing is a manifestation of the perfect world we want to be a part of. We experience a thrill at the majesty of it. We also recognize we're only catching a glimpse of this world—which is why we feel sad.

LK: Therapy often focuses on helping clients get what they want. Are we too quick to discount the value of longing over having?

Cain: In our culture, we tend to think of longing as a disabling emotion, something that holds you back from being who you should really be, but I believe longing is momentum in disguise. In Old English, longing literally means "to grow longer, to extend, to be reaching." Great acts of creativity arise from a longing to see something beautiful. Every single creative person will tell you they have a shimmering image of perfection they're aspiring to. A writer will have the idea of the perfect manuscript they will produce, even though they know from day one they'll never produce anything half as perfect as what they have in mind. But they still reach for it, and there's joy in that.

LK: Clearly, there's stuff we can all change about our lives, but we can't change the inevitability of loss.

Cain: One of the great Japanese Buddhist haiku masters was Issa. He had a very difficult life. His first child died and then he had this baby girl, shining and perfect, and he loved her with all of his being. Then she, too, died of smallpox. And he wrote this poem: "This world of dew is a world of dew, but even so, even so."

This poet deeply understood the Buddhist principle of impermanence, and it's clear in these words that he still struggled to accept it at times. That's what he's saying in the line "but even so." Grief, loss, and impermanence are a great gift; they might not be the gift we want, but we're all in this mysterious mix of loss and beauty together—and that's beautiful.

LK: What do you most want people to take away from your work?

Cain: There's a whole realm of humanity that exists in the space that I describe as the quiet, the sensitive, the melancholic, the beauty-seeking. I'm guessing a huge percentage of therapy clients exist in this realm. I'm guessing a lot of therapists do, too. It's so important to remember the beauty of that realm. If you really know it, you know it in a deep-down way.

There's this centuries-old archetype of the wounded healer, which I see so acutely in the work therapists do. This comes from the Greek myth about the wounded centaur Chiron. Because he was wounded and in pain, he had the ability to heal others. There's something in us as humans that can do this. After 9/11, we had a record number of people signing up to be firefighters. During the height of the pandemic, we had a record of number of people signing up to be doctors and nurses. A woman whose daughter was killed by a drunk driver started Mothers Against Drunk Driving. There's something in humanity that has this impulse to take our darkest depths and turn them into something meaningful.

So maybe the pain you can't get rid of is your creative offering, your healing offering to the world.

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

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

Psychotherapy Networker 2025 *Readers' Choice* Practice Tips

"I've Got NOTHING to Talk About"

How to Work with Tight-Lipped Clients

BY JANINA FISHER

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Challenges with clients come in all shapes and sizes. Some clients are so chatty you can't get a word in edgewise—not to mention a helpful therapeutic suggestion. Others are consistently grumpy or invariably nervous. But one of the most common issues any type of client might present is when they sit down for a session and announce: "I have nothing to talk about today."

You may know how to work with depression, anxiety, anger, and grief, but how do you work with "nothing"? What do you do when your insightful questions, expert techniques, and earnest attempts to connect elicit only shrugs? Let's be honest: sometimes 50 minutes with these clients feels like pulling teeth.

Fortunately, there are ways to make headway with clients who have "nothing to talk about." There are ways to jumpstart conversation, do deep work, and make your time together less painful. To find out how, we consulted a few seasoned experts who've been in this quagmire—and found their way out of it.

Read on to see how DBT expert Britt Rathbone, international trauma expert Janina Fischer, Experiential Dynamic Therapy teacher and a founding member of the AEDP Institute Steve Shapiro, and MFT and ethics professor Kirsten Lind Seal take on this issue.

Welcoming the Client's Two Sides

International trauma treatment expert Janina Fisher, author of Transforming the Living Legacy of Trauma, says that when a traumatized client declares, "I have nothing to talk about," the therapist needs to pay close attention.

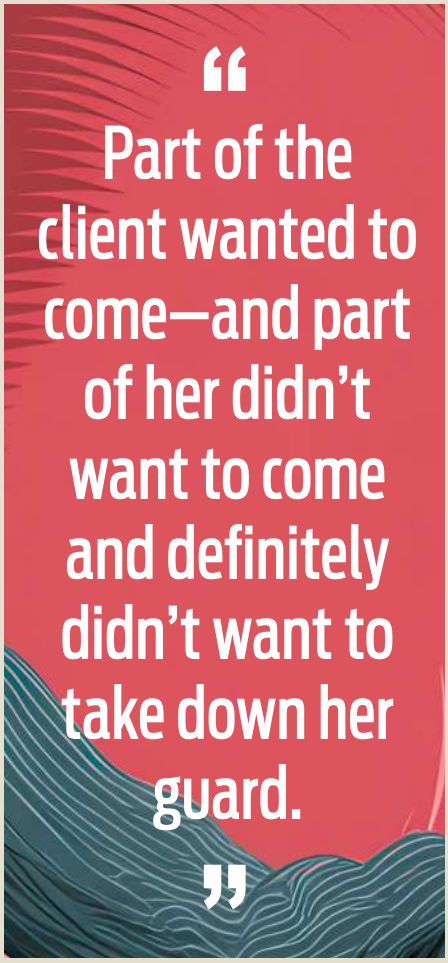
She notes, "What they're really saying is, 'Don't make me talk about it. I'm afraid I'll start to feel overwhelmed.' I usually laugh when I hear, 'I have nothing to talk about.' Then I say, 'Would you tell me if you did have something to talk about? Or does 'nothing to talk about' mean there's nothing you want to talk about?' Then I'll laugh again gently to communicate that there's no judgment attached to their fear of talking about painful emotions."

Fisher says she also reassures clients that there's never any pressure to talk or bring an issue to therapy—it's fine not to have an agenda. "I'll ask, 'What would you not want to talk about? Let's start there. That way, I'll know to what to avoid.'"

She adds that it can be tempting to disengage in these moments—to join clients in their passive resistance. "You might feel like saying, 'Well, then why did you come?' But over time I've learned that 'I have nothing to talk about' implies an internal struggle. Part of the client wanted to come—that's why she's here—and part of her didn't want to come and definitely didn't want to take down her guard.

"The therapist's job is to welcome both the reluctant part that has nothing to say and the part that wants my help and connection. I do that by saying, 'Well, thank you so much for coming anyway, and my thanks to the part of you that let you come. That was very generous!' Or I might joke, 'Many people would love to change places with you because they have too much to talk about and not enough time. They'd love to have nothing to talk about!' Or I'll ask them, 'How does nothing to talk about feel? Does it feel liberating? Or numb? Or fuzzy?'"

Fisher says she had a client who, for two years, began every session by sitting down and saying, "I didn't want to come today, and I have nothing to talk about." They'd always manage to engage by the end of the session. And when Fisher asked, with some trepidation, "Do you want to make another appointment?" the client would look indignant and say, "Of course I want another appointment. Did I give you reason to doubt that?"



Empowering the Client

Clinical psychologist Steve Shapiro, a certified Experiential Dynamic Therapy teacher and a founding member of the AEDP Institute, says "Engagement is difficult for all human beings, but for those with a trauma history, it can feel like being invited to touch a hot stove."

In therapy, he explains, not only do clients learn about how they relate, but also about how their longstanding emotional patterns—like avoidance—can be enacted without their awareness. "If we accused a client of being 'unmotivated,' she'd most likely say that for reasons unbeknownst to her, she 'just can't think of anything to talk about.' And she might be right. After all, motivation is intentional; resistance is unintentional.

Although it might be tempting to think there's intent behind the client's resistance, this could create a polarizing dynamic that keeps her conflict buried and perpetuates her suffering. But if, with our help, she sees the internal conflict, then we empower her to make a choice between that resistance and the healthy alternative."

Shapiro says that even if clients say they don't have much to talk about in therapy, it's important to remember that the simple fact that they showed up reveals motivation in and of itself. He explains, "The therapist could make this explicit by saying something like, "You don't know what to talk about and you came here to take a more active role in getting your needs met.' At this point, the therapist can allow her to struggle with that in silence, and have her response guide the next intervention."

Exploring the Silence

Over nearly four decades of practice, Dialectical Behavior Therapy expert Britt Rathbone has seen his fair share of tight-lipped clients while working with young clients and their families. The coauthor of Parenting a Teen Who Has Intense Emotions, Rathbone says he likes to remember that "behavior always makes sense in the context in which it occurs."

When a client says they have nothing to talk about, Rathbone

says his goal is to "get clear on what's factoring into their silence or lack of direction. Assessing whether it's an angry silence, an unmotivated silence, or a hopeless silence is a good starting point."

To get there, he first asks the client how they felt about coming to the session. "Was there a conflict with someone on the way? Is our time together taking the place of something else they'd rather be doing? Are they upset with me or the therapy itself?"

Whatever comes up, Rathbone says it's important to validate that feeling. For instance, with a teen who'd rather be anywhere but his office, he suggests saying something like, "It makes sense you don't want to talk today, given that you're irritated you're here instead of hanging out with your friends."

Rathbone says that when his adolescent clients come in saying they have nothing to talk about, which is often, it's an opportunity to teach effective ways of communicating and solving problems. "If we can explore their silence or lack of topics with real patience, understanding, and compassion," he says, "then we're also modeling valuable communication and problem-solving skills for them, while getting the therapy unstuck."

For someone whose treatment has been working well enough that they're questioning whether to continue therapy, or they've run out of steam, Rathbone suggests saying something like, "I get it. You resolved the main issue that brought you here, and it isn't clear what to do next."

At these junctures, Rathbone says it's helpful to explore therapy goals. "Maybe we're off track and need to refocus or reestablish goals that still have relevance. Or maybe we're done—and that's okay! Our aim is to put ourselves out of business with clients, and when, with our guidance, they run out of problems to solve, then we've succeeded!"

Rolling with the Punches

Kirsten Lind Seal, a licensed marriage and family therapist with a background in musical theatre, stand-up comedy, and television, says that clients who say they have nothing to talk about often fall into one of four categories.

The first category, she says, consists of those who are simply unsure what therapy entails. Lind Seal says when her clients say, "I don't know what to talk about," that's her cue to do some psychoeducation about the therapy process.

The second category, she says, is clients who tend to be shy or less comfortable with open-ended conversations. Such was the case with her client Allyn, who started therapy by telling her, "You'll have to ask me specific questions, otherwise I won't get anywhere."

"I do my best to roll with the punches," Lind Seal says, "and always have plenty of questions at the ready. I always try to make a note of the last topic we covered in the last session, and then mention it first thing in the next session."

With Allyn, she looked at her notes and said, "So shall we keep talking about your relationship with your father?" And they were off to the races.

Lind Seal says she also finds books to be helpful in jumpstarting conversation. Two of her favorites are Viktor Frankl's Man's Search For Meaning and Melody Beattie's Codependent No More. "Going through these books chapter by chapter together and discussing what comes up as we move along can help deepen therapeutic conversation," she says.

If clients declare they have nothing to talk about during the middle of their work in therapy, Lind Seal believes they may be dealing with something else: they're holding on to something they're unwilling or too nervous to divulge.

As for clients who've been in therapy for a long time by the time they say they have nothing to talk about, she says it's usually a sign that therapy is coming to an end. A good way to check is to say something like, "Maybe we're coming to the end of our work together. Do you think that might be why it feels like you have nothing to talk about today?"

The client's response, she says, will tell you a lot. "One of my clients exclaimed, 'Oh my god, no! Are you dumping me?' Clearly, we were not done. But other clients I've asked have said, 'Yeah, I think so. Is that bad? I'll miss you, but I think we might be done.' Ending therapy usually means that things are going better. I like to tell clients, 'It's my job to get you to eventually fire me.'"

"I have nothing to say" can mean a variety of things, Lind Seal concludes. "But in my experience, therapists just need to decide whether to explain, guide, challenge, or close—and the conversation will flow from there." pn

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Janina Fisher, PhD, is a licensed clinical psychologist and former instructor at The Trauma Center. Known as an expert on the treatment of trauma, she's been treating individuals, couples and families since 1980.

Britt Rathbone, LCSW-C, ACSW, BCD, CGP, is a clinical psychologist and trainer who's been working with adolescents and families for over 30 years. He's the coauthor of several books, including Dialectical Behavior Therapy for At-Risk Adolescents.

Steve Shapiro, PhD, is a clinical psychologist with over 25 years of clinical and teaching experience. He practices various forms of Experiential Dynamic Therapy (EDT), including ISTDP and AEDP, and is a founding member and adjunct faculty member of the AEDP Institute.

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Psychotherapy Networker 2025 Readers' Choice Therapists as Clients

The Cost of Neglecting Therapists' Mental Health

Restructuring our Field to Heal the Healers

BY SARAH BUINO

I want to die.

It was the summer of 2020, and this familiar, haunting thought I'd evaded for so long was now creeping back into my brain. I sat motionless on the couch as my dog, Phoebe, howled. My husband had just left to pick up groceries that I'd obsessively wipe down the moment he got home. I glanced at the clock. I had a client session in 20 minutes, followed immediately by supervision with one of my staff members.

My own time in therapy had taught me to recognize suicidal ideation as a sign that I felt trapped in circumstances that seemed inescapable—and that I needed to get help. But I couldn't do that right now; my client and supervisee needed me. *Inhale for four seconds, hold for seven, exhale for eight,* I told myself, remembering one of the grounding skills I'd learned over the years. After a few minutes, I stood up, walked down the hall to my home office, logged in for my session, and tucked the fear and overwhelm away for later.

The truth is that I was in the middle of a silent crisis, one that many other therapists are facing alone. Do we push down our own struggles to keep working, or do we recognize that our own healing and professional competence are inextricably linked?

After I saw my last client of the day, I decided to pick up the phone to call for help, but my head spun with all the reasons why I *couldn't* check myself into residential treatment: *I won't be able to prep for teaching this fall! What will my clients do without me for four weeks? How will I run payroll without access to my computer?* Like so many therapists, my identity was rooted in being a helper. *Who am I,* I wondered, *if I'm not helping my clients or my staff?*

Ultimately, I'm glad I made that phone call and got help. But what if I hadn't? What if, like so many therapists, I'd simply continued to compartmentalize and medicate my overwhelm with wine and Netflix, telling myself this was just part of the job? How long before the problem would've boiled over? How long before my work—and my clients—would've suffered for it?

Sadly, my experience is hardly unique. Therapists are experiencing the same collective trauma as their clients around unprecedented political polarization, climate change, and economic uncertainty. It's impossible for us not to feel fear and anxiety. I hear about these feelings again and again not only when sitting with clients, but in my conversations with supervisees, consultees, and online therapist communities.

In 2023, the National Council for Mental Wellbeing reported that 93 percent of mental health professionals are experiencing burnout, 62 percent classify this burnout as moderate or severe, and 48 percent have considered leaving the field as a result. But graduate school didn't prepare us to manage feelings of overwhelm. And at no point in our careers has any modality, course, or conference *really* taught us how to survive when it feels like the world is falling apart. We've been trained to help others heal while remaining strangers to our own healing.

What so many of us really need goes beyond individual self-care. It will take reimagining our training. It will take learning not only how to heal others, but learning how to heal ourselves. Instead of sitting in pain and isolation, it will take creating places where we can congregate, acknowledge our shared experience, and get support.

The Wounded Healer

In the 1980s and '90s, a handful of studies compared therapists' mental health to the general population. A later meta-analysis suggested that therapists are *twice as likely* to have experienced trauma or mental illness than their nonclinical peers. Indeed, many therapists were drawn to this profession not in spite of their wounds, but because of them. I was one of them.

When I entered graduate school, I knew something was wrong with my family, but couldn't put my finger on it. For two hours a week, my classmates and I would sit in a stuffy, windowless room watching video clips of clinical gurus like Minuchin, Aponte, and Satir. One week, we were tasked with creating family genograms that we'd later present to the class. When I got to work, I started unpacking everything that had felt wrong about my family—the communication styles, family rules, and patterns of mental illness. But when the time came for us to present, my heart began to race.

I watched as student after student took their spot at the front of the room and talked about their seemingly "normal" families. Sure, there was some anxiety, or depression, or addiction here and there, but their stories seemed otherwise unremarkable. My face began to grow hot. *Is my family the only one that's completely screwed up?* I wondered. *How can I possibly talk about my family without crying in front of the whole class?*

Fortunately, I wouldn't be presenting until the following week, so I had some time to get my bearings. Our professor, Dr. Friere, was one of my favorites—a spitfire, badass of a woman with wisdom and heart. After class, I approached her with tears welling in my eyes and told her my concerns.

"If it would help, you don't have to face the class," she said. "You can just present to me, and not look at anyone else."

Her offer, while kind, highlighted exactly what was missing in my training: lessons about how to be present with intense emotion, stay authentic when triggered, and sit in uncertainty.

I didn't take Dr. Friere up on her offer, and the following week, holding my poster board marked with squiggles, half-colored squares, and circles indicating strained communication, addiction, and mental illness, I let the tears fall.

Here I was, learning about family systems while experiencing toxic family dysfunction in my own life. Maybe my classmates had been able to detach from any lived experience of dysfunction, but what about those of us who couldn't? Where was the curriculum to help *us* learn to process *our* demons?

Leaning into Our Humanity

Our profession needs clinicians who have lived experiences of trauma and mental illness. After all, our clients deserve the type of knowing empathy that comes from walking in their shoes. But if so many therapists are drawn to the profession due to their own wounding, why don't we talk about this in our training? Without learning how to do our own work, how can we expect to show up fully for our clients? Sometimes we must learn as we go, as I did with my client Jennifer.

One day, Jennifer sat down in my office and began listing all the existential threats compounding her baseline anxiety: the political rancor, war overseas, and climate change. *How do I tell her I'm grappling with these things too,* I wondered, *without worsening her anxiety?*

As she gazed at me with a combination of panic and desperation, scanning my face for a shred of hope, I knew that no amount of reassurance could soften her dread. It's said that we can only take our clients as far as we've taken ourselves, and if we can't lean into our own existential fears, powerlessness, and grief, we can't help our clients do the same. *Maybe,* I thought, *helping Jennifer right now lies in my own willingness to face these realities not as a neutral professional, but as a fellow human being.*

Rather than jump into the anxiety with her, I decided to lean back and notice the pressure I'd been feeling to find a solution. "What would it be like for you to know that I'm holding the same fears and anxieties as you?" I asked.

We spent the rest of the session exploring the experience of being two humans connected not only by our fears and anxieties, but also by our grief and desire for a better world.

"I feel a little more calm and hopeful now," Jennifer told me as our session came to a close. Truth be told, I felt better too.

The Revolution Starts Now

Of course, simply disclosing to clients that we're experiencing many of the same anxieties they are isn't a reliable solution for combatting burnout in our profession. Change needs to happen on an institutional level. Our field needs to help early career therapists process their own suffering. We need to create systems that support mid-career therapists too, who too often feel isolated and overwhelmed as I did.

I truly believe that we're at an inflection point where we have an opportunity to change the course of our field. Rather than getting trapped in fear and overwhelm, we can choose the antidote: taking collective action and dreaming of a different future for this profession.

How? You can start by simply finding a quiet place to sit. Allow your imagination to expand and flow, inviting creative energy to move through you. Ask yourself: If I could design a psychotherapy training program that would've suited my personal growth and learning needs, what would that look like? What inspires me to help not only my clients, but myself? How can

licensing boards, academic institutions, professional organizations, and workplaces better suit not just my professional development, but my personal development as well?

As you ask yourself these questions, notice what excites you, what scares you, what feels possible, and any other ideas that come to mind. As you contemplate these questions, write down what arises. These thoughts don't have to be practical. They don't even have to make sense. The next chapter of psychotherapy won't be written by a single person or idea. Instead, over time, our collective intentions will coalesce into actionable steps.

I pondered these questions on a recent Sunday afternoon and came up with a list of my own hopes for the field. Here's what I wrote.

Rethinking training programs: Imagine that therapy was mandatory and free for students in all social work, counseling, therapy, and psychology programs. Programs would be a combination of didactic and experiential learning, where students would discover how to examine their own mental health experiences while supporting clients. Programs would also offer parallel training labs where students could process personal material that's triggered by coursework. Small cohorts could meet throughout the program to support one another to integrate academic material into their personal journey.

Rethinking supervision: A profound opportunity for revolution lives in the supervision space. Envision reflective supervision as the norm, where case consultation covers not only how to treat clients, but also addresses the therapist's internal experience. This internal reflection helps new therapists notice how they may be impacting the therapy session. Parallel process is an expectation of supervision as we normalize growing alongside our clients. Emotional responses are seen as a natural part of supervision and revered. Group supervision evolves into support groups where clinicians learn the value of holding one another in our own processes.

Rethinking professional development: Suppose conferences included personal growth tracks that focus on therapist self-awareness and personal growth, not just techniques to help our clients. Therapist meet-ups become staples, safe spaces to process how we're being impacted by our work. Regular retreats combine professional learning with personal healing.

Community-building: Imagine a return to apprenticeships, where experienced mentors shape new clinicians. Each new graduate would be connected with an experienced clinician who offers support, advice, and caring reflection. Local therapist networks band together to share information and resources for running a business, getting client referrals, and taking collective action on policy decisions.

Systemic changes: Micro changes become macro shifts, as licensing boards require ongoing personal work, not just CEs. Therapists automatically receive full insurance coverage for their own therapy. Workplaces regularly screen for burnout and encourage asking for help. Our professional organizations model professional vulnerability and self-work as part of our initial learning and continued development.

The Healing Ripple Effect

"Do you think I can go where you went for treatment?" my supervisee asks timidly, her voice quivering through tears. We spend an hour on the phone as she debates with her ambivalent parts. The stress of working through the pandemic while living alone has activated her childhood trauma, and she's just told me she feels like dying. I share my experience, strength, and hope without making false promises. We create a plan for her clients, so she can focus on her own healing.

Next year, *her* supervisee will ask the same question and find her way to treatment as well.

Sharing our vulnerabilities and traumas can inspire others to ask for help. And if we shift our professional culture to center our own support and growth, we can end so much needless suffering. Our clients will undoubtedly benefit as well. When therapists heal, everyone wins.

But right now, we don't have the systems in place to revolutionize therapy training and development. This will take an abundance of courage, hope, humility, and compassion, as well as a shared understanding about what it means to center our healing. It will take time. History shows that most revolutions don't happen in a single moment; they progress one person at a time. When a clinician changes how they supervise, a professor expands their curriculum, or a small group of therapists creates a weekly meet-up, then change begins to ripple outward.

As the ground becomes more solid beneath our feet, our clients will begin to experience more hope as well. They'll build the capacity to work toward the common good. And the more this happens, the more our systems will start to reflect the values that we therapists know make for healthy communities.

In the meantime, here's my invitation to you: Don't be afraid to take your own healing journey, whatever that may look like. Chances are doing so will make you a better therapist, leader, and teacher. Don't neglect your pain. It connects us with the humanity of our clients and with each other. Try to make a small shift in your practice, teaching, or supervising. And when you do, take note of what changes and share it with your colleagues. This is how we start the revolution. First inward, then outward, one step at a time.

Sarah Buino, LCSW, is a therapist and business consultant for therapy practices. She hosts the podcast Conversations with a Wounded Healer *and helps mental health professionals create practices where meaningful connections flourish between owners, employees, and the communities they serve.*

Psychotherapy Networker 2025 Readers' Choice Trauma

The Trauma of Parental Abandonment

BY KAYTEE GILLIS

Helping Survivors Feel Safe, Minimize Shame, & Heal Old Wounds

Q: One of the most entrenched types of trauma I've worked with is emotional or physical abandonment by a parent or caregiver. How can I best help my clients heal from it?

A: As a therapist who's spent over a decade helping survivors of parental abandonment—and as a survivor myself—I've found that this kind of trauma is often misunderstood, largely due to a combination of cultural and social stigma, lack of awareness, and internalized shame that keeps many survivors silent about their experiences.

When a caregiver makes a conscious choice to remove themselves from their child's life, no matter the reason or form their absence takes, the result will have long-term consequences. I've seen parental abandonment in the form of a parent rejecting a child who gets pregnant or comes out. I've seen it occur when a parent grows emotionally distant after a divorce or remarriage. It can occur when a child suffers abuse and a parent refuses to believe the abuse happened. And it can manifest when a parent believes their child's disability, or even personality, is too burdensome to handle.

As with many traumas, abandonment traumas can deeply influence attachment patterns with friends and romantic partners. They have a profound impact on self-perception and sense of belonging. Survivors often internalize a message of unworthiness, and resort to reflexive self-blame, and as a result, may constantly seek new relationships or avoid intimacy altogether.

Understandably, people who've experienced parental abandonment often have issues with trust, including in the therapeutic relationship. Many also struggle with people in perceived positions of authority, meaning they may see us therapists as intimidating, no matter how hard we try to create a collaborative and welcoming space. Since these can be daunting clinical obstacles to overcome when working with survivors, I've developed a five-step process for working with survivors of parental abandonment that helps mitigate self-blame and build trust with the therapist.

Karalina's Story

Karalina had experienced parental abandonment after getting pregnant when she was 17. Now in her 40s, she was finally realizing the severity of that trauma through our work.

"I always felt different from my siblings," she told me in our first session. "My younger sisters were well-behaved and brought home perfect grades. But because of my anxiety and ADHD, I'd always struggled at school and often skipped class. At night, I could hear my parents arguing about what to do with me through the thin bedroom walls."

When Karalina found out she was pregnant, she hid it for a few months before coming clean to her mother. "I'll never forget the look on her face," she told me. "Shock, shame, disappointment—all at once."

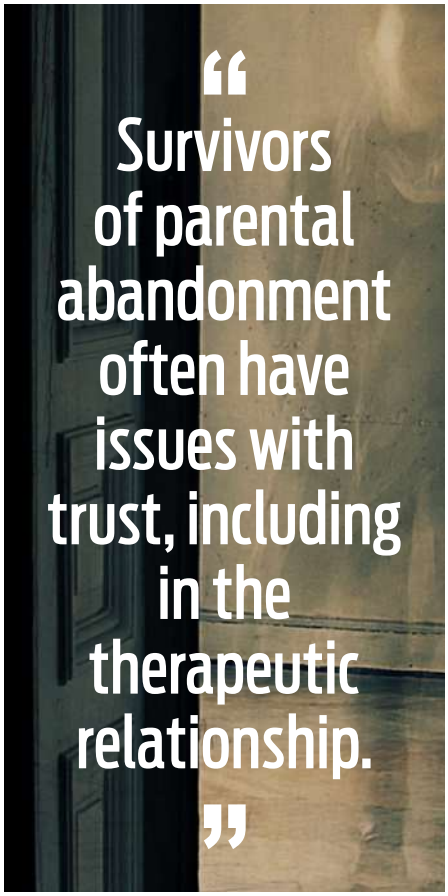
"I have to call your father," her mother had said flatly.

Instead of yelling at Karalina, her father had started working longer and longer hours. He'd go on weeks-long work trips, even though her due date was approaching. She was scared, plagued by her father's absence and the idea that all of this was somehow her fault. After she gave birth to a healthy daughter, her mother helped out with the baby but with a distant expression on her face. Her father would come home occasionally, his loud boots echoing in the hallway, but he barely acknowledged her or his new granddaughter. Eventually, he moved out.

"Dad left because you shamed the family," her sisters would hiss. Karalina didn't want to believe it, but deep down, she believed it was true.

The first step in working with survivors of parental abandonment is to build trust by creating a safe environment. For clients who've been abandoned by someone who was in a protector or caregiver role, and supposed to love them above all else, it's the most important thing you can do. When they're in a relationship, survivors of abandonment often wonder things like, *Are they mad at me? Do they dislike me?* But these questions are actually asking something deeper: Is this person safe? *Am I safe? Are they trustworthy? And if I trust them, will they hurt me?*

Therapists working with survivors can begin creating trust and safety from the very first session by actively listening to the survivor's story without judgment, validating their experiences and emotions, and emphasizing that what they say will remain confidential. The therapist can also create



safety and trust—and convey empathy and compassion—by telling the client they believe them.

At first, Karalina's inner defense mechanisms—denial, self-blame, and intellectualizing—were so entrenched that she'd often make comments like "Well, I was a bad kid" or "I wasn't hit, so I guess that means I wasn't really abused," as well as other statements that minimized her experience of abandonment. Once I'd made it clear that I believed her story and didn't blame her for being abandoned, Karalina began to trust me more and made fewer statements minimizing her experience.

Survivors of abandonment often wonder things like, *Are they mad at me? Do they dislike me?* But these questions are actually asking something deeper: *Is this person safe? Are they trustworthy? And if I trust them, will they hurt me?*

The second stage of working with survivors of parental abandonment is helping them acknowledge their trauma. It's a foundational step toward fostering self-awareness, understanding the impact of abandonment on their lives, and beginning to heal. It can be difficult work since coming to terms with past trauma often involves navigating complex and fluctuating emotions, confronting layers of denial or avoidance, and contending with the fragmented nature of memory and perception. Acknowledgment often comes in bits and pieces, rather than as an open declaration of what has occurred.

"I wonder what it would have looked like had your dad been there when you needed him," I said to Karalina, trying to help her see how this had been, in fact, deeply traumatic. "Being 17 and pregnant must have been so scary."

She paused for a moment. "It was," she finally said, tears welling in her eyes. "I was terrified. I really needed him," she said before pausing again. "But he wasn't there."

The third stage of working with survivors is helping them recognize how the abandonment shows up in their adult relationships. After the end of a romantic relationship, for instance, survivors often experience greater distress than those who've had secure caregiver relationships. They sometimes cling to unhealthy relationships or disregard red flags, desperate to avoid the anguish of being abandoned again.

Many of my clients who survived parental abandonment find themselves either cycling through relationships in an attempt to fill the void left by past losses or avoiding relationships altogether to shield themselves

from further pain. The key is helping clients see these patterns by saying things like, "It sounds like you've developed certain coping mechanisms to protect yourself from feeling abandoned again" or "How might your life have been different had your parent never left?" Once you address the connection, the client can begin to see the "why" behind these distressing relationship patterns.

Despite recognizing that her latest romantic relationship hadn't been healthy, Karalina struggled to shake off the desperation she continued to feel about it having ended. It was clear that this desperation was an indirect result of her father abandoning her when she was younger, but Karalina didn't immediately make the connection.

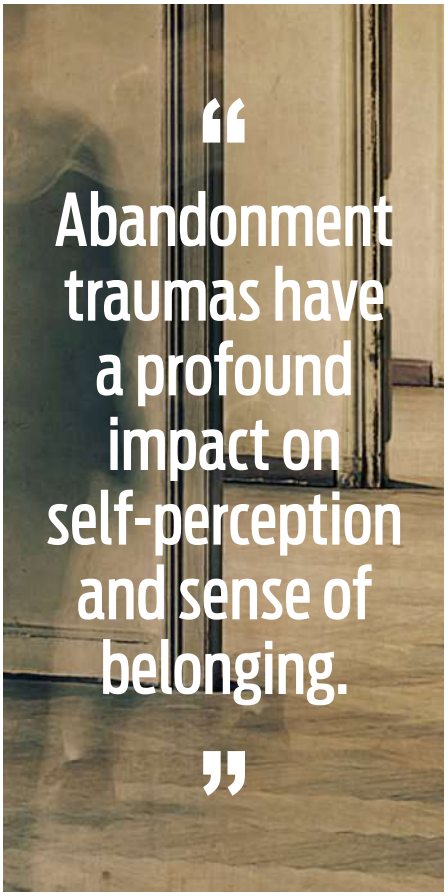
"If your dad had never left," I asked Karalina, "especially during a time when you needed him so much, do you think this breakup would feel different?"

"I think so," she replied. "I'd probably feel more confident in myself and in my ability to be alone and recover." Slowly, she was developing a newfound awareness that allowed her to stop second-guessing the breakup. She got better at reminding herself that the relationship had ended for the right reasons.

The fourth step in working with survivors is minimizing shame. Clients who've been abandoned tend to blame themselves for what happened to them, and by helping them realize they're not to blame, the therapist can facilitate a crucial shift in perspective. Drawing on the IFS model, therapists can help clients see and acknowledge the part of them that amplifies their shame in order to protect them. Once they realize this, they can access more self-compassion. Usually, as they shift from blaming to self-compassion, tension, anxiety, and depressive symptoms begin to decrease.

Karalina was making progress in therapy, but she still sometimes reverted to her childhood belief that she'd been responsible for her father leaving. Like many survivors, her shame amplified the fear that there was something wrong with her. Nothing sends the message to a child that they're unlovable quite like their primary caregiver leaving them. Together, Karalina and I worked to help her acknowledge—and even thank—the parts of her that were trying to protect her by blaming for what was actually her father's failure as a parent.

"Your anxiety serves a purpose," I told her. "It's trying to keep you from being abandoned again. But just because a relationship ended in the past doesn't mean your relationships now will end."



"I worry that my needs are too much," she said at one point. "I feel like a burden."

"But you deserve kindness," I said reassuringly.

Karalina nodded. "It's easier to believe that when I think of my own daughter," she replied. "I've never abandoned her, and she's doing so well. I suppose I deserved to have from my father what she's received from me. In my heart, I know I've been getting in my own way."

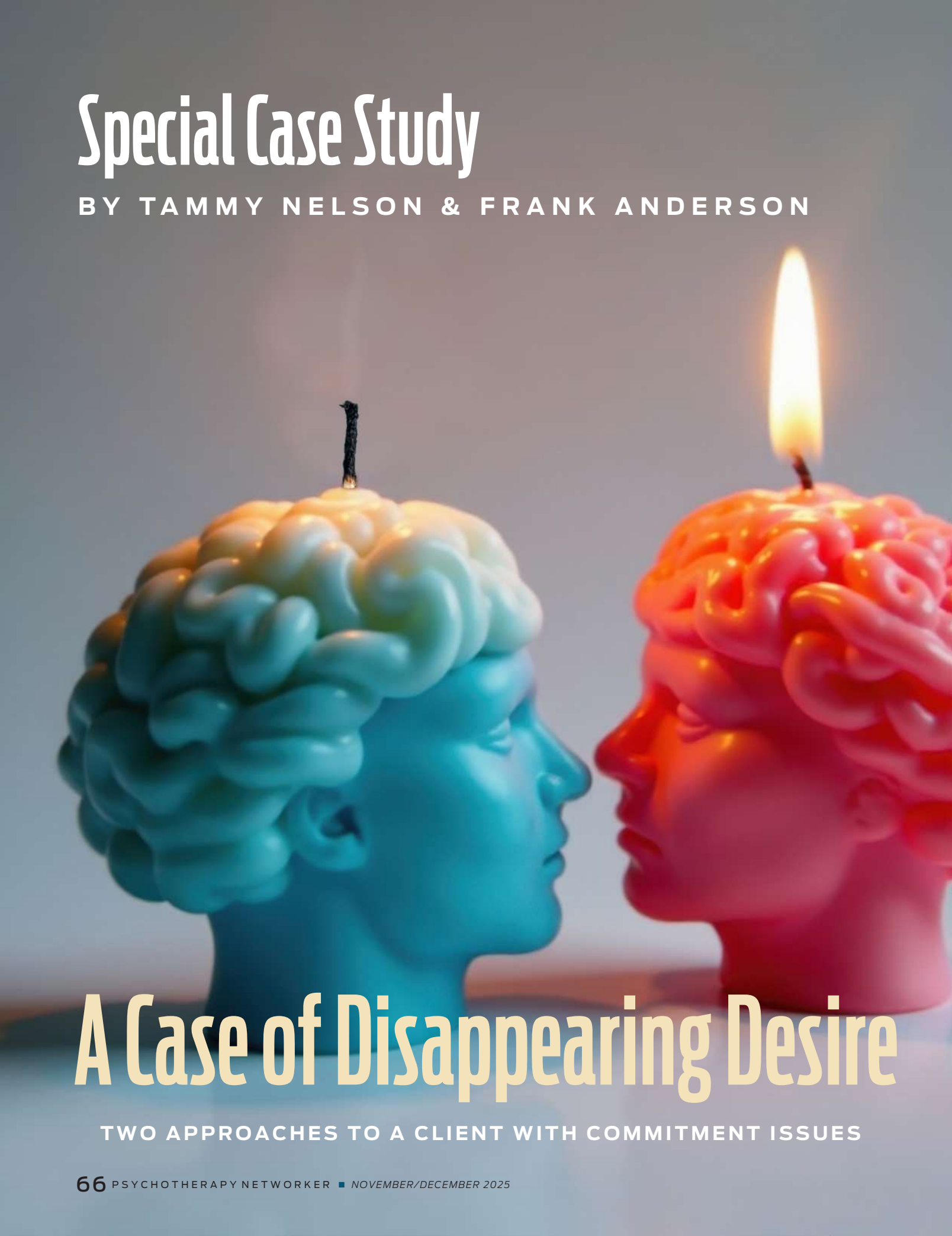
Once you've minimized shame, you can move to the last stage of treatment: helping the client reparent their abandoned inner child. Though reparenting is more of an ongoing process than a one-and-done experience, over time, it helps clients heal old wounds, traumas, and unmet needs from childhood. It involves working creatively with the parts of the client that hold traumatic memories, experiences, and emotions related to abandonment, as well as showing consistent patience, consideration, and care. Importantly, it involves cultivating genuine curiosity about the inevitable moments, however small, when a client feels abandoned by you. Exploring and repairing ruptures in the therapeutic relationship can be deeply healing, and model healthy repairs in relationships beyond the therapy room.

Karalina and I brainstormed tools, like journaling, that she could use to reassure her inner child she was safe when worry arose that she might be abandoned again. When the shame and self-doubt crept in, she was able to remind herself that these feelings were not hers to own; they'd been given to her by her father. Now, with greater self-awareness, she began to see she deserved and was capable of healthier relationships based on trust, respect, and shared accountability.

Kaytee Gillis, LCSW-BACS, is a psychotherapist, writer, and author with a passion for working with survivors of family trauma and IPV. Her work focuses on assisting survivors of psychological abuse, stalking, and other non-physical forms of domestic violence and family trauma. Her recent book, Invisible Bruises: How a Better Understanding of the Patterns of Domestic Violence Can Help Survivors Navigate the Legal System, *sheds light on the ways that the legal system perpetuates the cycle of domestic violence by failing to recognize patterns that hold perpetrators accountable.*

Special Case Study

BY TAMMY NELSON & FRANK ANDERSON



A Case of Disappearing Desire

TWO APPROACHES TO A CLIENT WITH COMMITMENT ISSUES

How do you help a client who wants a relationship but can't seem to sustain sexual interest, even for partners they deem desirable?

Sex and relationship therapist Tammy Nelson, author of The New Monogamy *and* Integrative Sex and Couples Therapy, *and trauma expert Frank Anderson, author of* To Be Loved *and coauthor of* Internal Family Systems Skills Training Manual, *share their unique approaches to working with a client who "couldn't be happier with life" ... except when it comes to longstanding sex and commitment issues.*

Meet Simon

Simon is a 29-year-old medical student who struggles in committed relationships. He says he loses sexual interest in the women he dates soon after things get serious. "I always thought I got bored because I hadn't met the right person, but my last girlfriend was hot, funny, smart—I was crazy about her. When I stopped wanting sex, it confused her, but she stayed. When she caught me watching porn, though, it wrecked her."

Simon jokes about his physical appearance a lot in your first session. "I used to be chopped," he says. You ask about this, and he clarifies that he was overweight, had bad acne, and broke his nose in a fight in high school. "I mostly avoided mirrors till I was in my 20s. Surgery turned my life around. That's why I'm becoming a plastic surgeon."

Simon says he has no memory of his mom, who died when he was a toddler, but his dad was a great parent. "We're still super close. There's nothing my dad wants more than for me to find a partner and start a family. Honestly, other than this issue with sex and commitment," he tells you, "I couldn't be happier with the way my life is going."

A New Narrative Around Intimacy

BY TAMMY NELSON

Simon's story is not uncommon, but it's touching how much he wants a relationship and doesn't understand what might be wrong with his level of desire for his partners. He is a high-functioning, high-achieving young man with issues around eroticism. His confusion around desire—and its disappearance in the context of closeness—is a clue. When clients say, *Everything in my life is great, except for this one thing,* I listen carefully. That "one thing" is usually the thread that connects everything underneath.

Simon's disinterest in sex after emotional intimacy may not be because he grows bored with the sex or the relationship, it may be that his attachment bond desexualizes the relationship. The early loss of the first attachment figure—a mother who disappeared from his life before he could make sense of absence—may have created a rupture in how he bonds and stays connected. In early developmental trauma like this, the body often "remembers" through behavioral and relational patterns.

But let's not blame his mother. I'd be more curious about the *narrative* of losing his mom. How does his dad talk about her? What were his earliest relationships like after the loss of his mother? Did he remarry after his first marriage? Is there a story here that no one could replace his mother, and that no one should?

His sexual shutdown is not a rejection of his partners, it's self-protection. He's reenacting an old wound: connection equals loss. If he lets himself get too close, his body may preemptively shut down the very thing that makes him vulnerable: desire. If he wants someone, they could leave him.

While we don't know that he has early abandonment wounds, it's quite possible he had plenty of positive connections with his father and other adults, which may have been more than enough, but there's a story of loss underneath his story of surviving a tough adolescence.

Porn and masturbation may be not just a coping mechanism but a safe container. Masturbation offers controlled arousal, there's no risk, no rejection, no relationship, and no need to stay emotionally present. That's not pathological; that's emotional and relational survival. I see Simon's porn use as a behavior he developed to soothe himself, so with compassionate curiosity I'd ask more about his fantasies and masturbation behavior without shaming him. What he turns to as his arousal scenario can tell us a lot about what his internal life contains. Emotionally, is he looking for attention, a soothing figure to tell him he's wanted? This can come out in a sexual fantasy of being desired, of a woman telling him he's sexy and that she wants him in an erotic way. If he feels out of control in his life, he may have sexual fantasies of being in charge, telling a woman what to do, or holding her down while he makes love to her. These scenarios are narratives that are not necessarily stories he'd need to act out in real life, but may provide a soothing internal mechanism that allows him to manage his emotions.

Simon also lives in a body he once hated. His comment, "I used to be chopped," followed by descriptions of bullying, reveals body dysmorphia and a sense of humiliation. His transformation into a "desirable" man through surgery and his career choice to become a plastic surgeon show that he's trying to fix on the outside what may still hurt on the inside. His desire to transform other people's bodies may be a longing to rescue his own wounded self.

It feels like Simon is masculinizing himself, and still in search of the missing feminine, the one who could make him feel safe, loved, whole. Therapeutically, I'd explore what sex, closeness and eroticism mean to him beyond just performance. Can he feel desire without fear? Can he stay present in intimacy without feeling like he wants to run away?

I might also discuss his own dreams, versus his father's dreams. ("He wants me to start a family.") If he's still in medical school, it might be too soon to settle down in a serious relationship, maybe he wants or needs more freedom, or perhaps he doesn't know what he wants at all.

I'd want to help Simon understand that losing desire isn't the problem. Losing *himself* and what he really desires in the relationship is what's shutting him down.

Healing won't happen when he finds the "right person" but from integrating the lost parts of himself. Inside Simon is the boy who was mocked, the teen who avoided mirrors, the man who doesn't remember his mother but has been shaped by her absence. And there's also the successful adult man inside of him who helps to shape other people's lives. All of these parts are important to recognize and acknowledge. This way he can understand which part of him is running the show when he feels a certain way or reacts in a relationship. He doesn't have to negate or avoid these parts. Once he understands that they're all parts of him, he can become the parent to them that he always needed. The adult that can soothe him, the grown-up that can tell the frightened parts of him that he'll be ok, and the father inside him that can tell him he'll survive and that whether he's in a relationship or not, he's loveable. Only then can Simon create a new narrative around intimacy, one that includes trust, arousal, connection, and sexual companionship.

An Integrative Approach to Relational Trauma

BY FRANK ANDERSON

As my first session with Simon unfolds, several hypotheses begin to form. My notes are anything but linear, but I jot down things he says and does, along with quick questions and possible connections I'm noticing in the process of mapping out the salient information he offers up. As I listen to him, I take in every word, watch every gesture, pay attention to the slight shifts and body movements, track his eyes as they dart around the room, and listen to every sigh. These are all clues to the root cause of his symptoms.

Having trained as a medical doctor first and a psychotherapist second, I understand that symptoms are what bring people into treatment, be it medical or psychological. Because I've been trained in Eye Movement Desensitization Reprocessing (EMDR), Sensorimotor Psychotherapy, and Internal Family Systems (IFS), I use an integrative approach to trauma treatment—one that's based in my knowledge of neuroscience. I know there's something deeper going on for clients who come to talk about problems, which I see as the root cause of their symptoms. Unresolved trauma—whether it's considered big T or little t, relational trauma or complex PTSD—can rarely be addressed by just one method or model of therapy, and it usually takes time to unravel for sustainable transformation to occur.

At the same time, having done this work for many years, I've learned it's not idealistic to hold the hope that clients' symptoms can be eliminated, or that underlying trauma can be healed as they deepen self-awareness, strengthen their connection to themselves, and release the weight of suffering over issues that don't truly belong to them. Therapy, done skillfully and sensitively, allows people to move forward in life in a different way: from a place of calm power.

Simon's main symptom or chief complaint is a lack of interest in sex and difficulty committing in intimate relationships. He's a medical student, which means he's smart, driven, focused, and works hard to achieve his goals. (I write "smart" at the top left corner of my note pad.) Is he a wounded healer like so many of the other physicians I've worked with? Does he have a strong caretaking part because he didn't get his needs met when he was a child? (I put a question mark next to the word "smart" because we don't yet know what need or longing is driving his success.)

Simon tells me he has commitment issues and loses interest and erections when things get serious. (I instantly write "commitment/sex" in the center of the paper.) My first thought is attachment trauma, but I wouldn't bring a clinical term like that up with a client this early, so as not to depersonalize the work or scare him away with psychobabble. Instead, I ask him to tell me more about what "commitment issues" means. It's important to hear how clients define their own problems, but I also want to assess his level of insight and capacity for self-reflection.

I listen carefully and notice that Simon's body tenses up as he describes his "super high sex drive" and how confusing it is when he's not into it after a few months of "great sex." He diverts his gaze down and away from me. (I can see there's activation and shame held in his body around sex and intimacy. I write "tense/shame" next to the word sex.) I wonder what his relationship with his parents is like. What did he witness unfold between them when it came to affection or loving touch? I also wonder if something medical is going on around sexual functioning and hold the thought that he might be gay. (I write "physical" and "gay" with a question mark beside them.) So many questions have arisen in the first few moments of our meeting. I'm feeling deeply engaged and a bit overwhelmed as well.

Then, Simon takes me off guard: he mentions looking "chopped," shifting the focus and lightening the mood with a joke about his appearance. I don't know what *chopped* means, so I ask, wondering if the age gap will have a negative effect on our connection. I notice a part of me show up that feels insecure: What if he thinks I'm too old to help him or relate to him? I acknowledge the feeling and ask it to soften. It does, and my body relaxes.

Simon proceeds to talk about being overweight, having acne, being made fun of, a fight leading to a broken nose. There's so much to unpack from experi-

ences he had outside of his home growing up. How did he learn to self-soothe? Does he frame what happened as bullying? Are there anger issues here? Social struggles? Shame? How has he learned to deal with conflict? (I write "school/social/shame" with a big circle around it.)

Then, I hear "no mirrors, surgery, and becoming a plastic surgeon." This is a big deal, I think—not your typical adaptation to a schoolyard fight. (I write "nose/plastic surgeon" on the top right of the paper.) Maybe this has less to do with his parents than I assumed. Maybe we're dealing with peer trauma, and this is the source of his commitment/sexual/intimacy issues. I notice a deeply curious part of me emerging. I haven't worked much with social trauma, so I can learn a lot from Simon. Another part of me shows up, too, remembering how much my brother and I fought as kids. I know that working with Simon could activate my own trauma history. Am I prepared for that?

Before our session ends, Simon tells me about his mom dying when he was a toddler. "I have no memory of her," he says. But he reassures me, and perhaps himself, that he has a great relationship with his dad.

The pieces of the puzzle are starting to become clearer. Simon has experienced preverbal trauma, early implicit memories of a traumatic loss in addition to his school trauma. He likely carries emotional and physical memories that are unconscious and stored in his body. He probably holds some level of neglect—growing up with one parent, even a good parent, is usually accompanied by experiences of unmet needs. The preverbal trauma could have set the stage for being targeted at school. Maybe these experiences are linked, or maybe they're separate traumas. Simon could truly have a great relationship with his father, or he could be idealizing their connection. He might have had to view his father as "all good" as a survival strategy. (I add, "mom died" and "great relationship with dad" with a question mark next to it. I've written these notes close to "commitment/sex" at the center of the page.)

At this point, I'm careful not to jump to any conclusions. I'm mostly here to ask and listen, create a connection with Simon, and build a relationship with him that allows us to explore painful, hidden aspects of his life in a safe and effective way. I'm truly awed by his complexity, and I'm looking forward to seeing him again so we can start unraveling the thoughts, feelings, and behaviors that have been confusing him, and perhaps begin to heal the trauma drivers that shaped his life in ways he hasn't been consciously aware of.

As the session ends, I ask Simon if there's anything else he wants to share before we close. He shakes his head no, but with a look of despair on his face. I can see that the work we've done hasn't been easy for him. For us to continue, I know I need to give him an authentic message of hope and healing.

Slowly, I summarize what I've heard him share, and his expression softens. Over the years, I've learned that my great wisdom and brilliant interpretations are not the true change agents in psychotherapy. Instead, hope, healing, and a genuine connection are what give clients the confidence they need to move forward into uncharted waters. I tell Simon I'm confident we'll get to the root cause of his issues. And I let him know that losing a mom at an early age, and being "chopped" in school, can have a big impact on a person's life. "But the suffering that can come with these events isn't permanent," I say. "I believe you have the capacity to release the pain you're carrying, and that you can live a more fulfilling life that includes satisfying intimate relationships."

"Then I'm open to giving it a try," he says.

Our work will entail building a strong therapeutic alliance, one that helps him connect to his own wounded parts, including ones carrying feelings of abandonment that come with a parent's death, and shame related to being bullied. Our goal will be to give these parts corrective experiences. He and I will get to know and appreciate his problematic behaviors. We'll strive to understand the intention behind unwanted patterns he's tried so hard to change.

While we're doing this deeper healing work, I'll check in with him to see how his present-day life is going. I'll encourage him to move forward and try new things. I'll help him learn to connect to his internal wisdom, trust his intuition, and communicate more effectively. He'll begin to develop a different relationship with his body as he repairs the internal chasm created in the aftermath of his traumas.

I've come to believe that therapy is about revisiting the past, repairing the internal relationships severed by trauma, helping our clients release energy that doesn't belong to them, and helping them take risks and change old habitual patterns that get in the way of the life they're creating now. I'm hopeful that the journey we're on together will change Simon's disruptive relational patterns while helping me to grow alongside him.

Tammy Nelson, PhD, is an internationally acclaimed psychotherapist, Board Certified Sexologist, Certified Sex Therapist and Certified Imago Relationship Therapist. She has been a therapist for 35 years and is the executive director of the Integrative Sex Therapy Institute. On her podcast The Trouble with Sex, *she talks with experts about hot topics and answers her listeners' most forbidden questions about relationships. Dr. Tammy is a TEDx speaker, Psychotherapy Networker Symposium speaker and the author of several bestselling books, including* Open Monogamy, Getting the Sex You Want, The New Monogamy, When You're the One Who Cheats, *and* Integrative Sex and Couples Therapy. *Learn more about her at drtammynelson.com.*

Frank Anderson, MD, is a world-renowned trauma treatment expert, Harvard-trained psychiatrist, and psychotherapist. He's the acclaimed author of To Be Loved *and* Transcending Trauma, *and coauthor of* Internal Family Systems Skills Training Manual. *As a global speaker on the treatment of trauma and dissociation, he's passionate about teaching brain-based psychotherapy and integrating current neuroscience knowledge with the Internal Family Systems model of therapy. Contact: frankandersonmd.com.*

Nominees for the 2025 Best Story Award

Autism

Unlearning Behaviorism: The Mindshift of PDA-Informed Care
BY DIANE GOULD
Healing a Lifetime of Neurodivergent Trauma: Accommodation, Validation, and Autistic Attunement
BY TASHA OSWALD
Baseline Suicidality in Neurodivergent Kids: Misunderstanding Sensory and Emotional Chaos
BY SHYANNE ANTHONY

Clinical Challenges

The Case of the Late Client: Janina Fisher & Gabor Maté Tackle a Clinical Challenge
BY JANINA FISHER AND GABOR MATÉ
The Client Who's Tried Everything: ACT and ISTDP Tackle One Challenging Case
BY STEVEN HAYES & STEVE SHAPIRO
IFS and Addictive Processes: Bridging the Gap Between Psychotherapy and Recovery
BY CECE SYKES, MARTHA SWEEZY & DICK SCHWARTZ

Grief

When Grief Is a Soft, Grey Animal: Megan Devine & Leanne Campbell Reveal Unlikely Paths to Healing
BY MEGAN DEVINE & LEANNE CAMPBELL
Embodied Healing in a Disembodied World: Metabolizing Intergenerational Trauma & Collective Grief
BY LINDA THAI & RYAN HOWES
God, Grief & Therapy: The Quest for Meaning after Loss
BY DAVID KESSLER & LIVIA KENT

Opinions on the Field

What Defines Greatness for America: The Impact of New Policies on Social Wellness and Clinical Research
BY BESSEL VAN DER KOLK
Ken Hardy on Racial Reactivity Today: A Clinical Tool for Navigating Defensiveness, Anger & Hopelessness
BY KEN HARDY & ALICIA MUÑOZ
The Turmoil Therapists Carry Alone: Facing the APES in Our Field
BY KHARA CROSWAITE BRINDLE & ASHLEY CHARBONNEAU

Practice Tips

So You Wanna Be a Life Coach?: The Legal & Ethical Risks to Your Therapy Practice
BY TERRY CASEY
When Clients Ask for Session Notes: Tips for Navigating a Legal Gray Zone
BY ALICIA MUÑOZ
How to Build Your Brand as a Therapist: 9 Influencers Reveal Their Unconventional Choices
BY SAHAJ KAUR KOHLI, TERRY REAL, ALEXANDRA SOLOMON, NEDRA GLOVER TAWWAB, SARA KUBURIC, VIENNA PHARAON, DENÉ LOGAN, ELIZABETH EARNSHAW & MARIEL BUQUÉ

Sex & Relationships

The Orgasm Gap: 7 Strategies to Help Women Experience Sexual Pleasure
BY LAURIE MINTZ
The Vulnerability Junkie: A Fresh Look at the Pursuer-Distancer Dynamic
BY ALICIA MUÑOZ
Rethinking Insecure Attachment: From a Fixed Model to a Fluid Spectrum
BY SUE MARRIOTT & ANN KELLEY

Spirituality

Jon Kabat-Zinn's New Radical Act: Recalibrating Our Relationship with Modern Mindfulness
BY CHRIS LYFORD
Reimagining God in Therapy: When a Parent's Critical Voice Is Almighty
BY LISA FERENTZ
The Spiritual Therapist: Healing and the Secular Priesthood
BY CHRIS LYFORD

Therapists as Clients

The Therapist Who Sees Therapists: Working with the Trickiest Clients
BY WAYNE SCOTT
Lessons from Both Sides of the Couch: What My Therapists Taught Me
BY SUSAN EPSTEIN
The Silent Treatment: What I Wish I Could Tell My First Therapist
BY WAYNE SCOTT

Trauma

Humor in Trauma Work?: Making Space for Our Whole Selves in Therapy
BY ALLISON BRIGGS
Do I Have to Forgive to Heal?: Examining the Role of Forgiveness in Trauma Recovery
BY AMANDA ANN GREGORY
The Transgender Community in Crisis: Confronting the Political Erasure of Trans and Nonbinary Identities
BY SHIR WOLF

BY RYAN HOWES

5 Common Factors for Change in Therapy

A NEW INTEGRATIVE TREATMENT FRAMEWORK

BEN OGLES

What's the secret to therapeutic change? f you asked a dozen therapists this question, you'd probably hear a dozen different answers, many long and complex.

But if you asked psychotherapy researcher and Brigham Young University professor Ben Ogles—a leading psychotherapy outcome researcher, who's spent more than 25 years studying the common denominators in personal growth and change—he'll tell you the answer really isn't so complicated after all. In fact, Ogles has boiled it down five factors—and you'll find them in almost every therapeutic modality!

What does this mean for therapists who are laser-focused on learning a particular approach, convinced it's the most effective? Or for clients who feel they need a particular kind of therapy to heal? Is reducing change and growth to a few key principles the best way to inform the way we work? Will it really keep us focused on what's most important?

In Ogles's book *Common Factors Therapy: A Principle-Based Treatment Framework*, he and his coauthor, psychologist and professor Russell Bailey, make a compelling argument, outlining a new modality that pulls from approaches across the board and grounds us in the basic building blocks of change.

Here he gives us an overview of common factors research and, perhaps, a hint about the future of integration in our field.

Ryan Howes: What first inspired the research into common factors and how did it unfold?

Ben Ogles: Back in 1936, American psychologist and therapist Saul Rosenzweig first speculated that what the theorists suggested creates change may not actually be the things creating change. So what does create change? For decades, researchers have done horse-race studies comparing different theoretical orientations for treatment, and they repeatedly found that various treatments are mostly the same in terms of effectiveness. Some things work better in some instances, like exposure therapy for obsessive compulsive disorder, but if you just take the general anxious-depressed person, anything works.

That finding sparked researchers like Mike Lambert to find the things that lead to change that are common across treatments. In reviewing the literature, he showed the things that can consistently predict change regardless of the orientation, and he divided them into *support factors, learning factors*, and *action factors*. Other researchers did similar sorts of things.

In another sphere, Marv Goldfried, partly because he wanted to seek some unity among different orientations, surveyed clinicians to find the common principles of change outside of theory and technique. In his surveys, he consistently found that there were five principles of change that therapists could agree on.

So on the one hand you have researchers asking, "Does this variable predict change regardless of the orientation?" And on the other hand you have researchers asking, "Do therapists agree on this principle of change regardless of their orientation?" But Scott Miller, Barry Duncan, and Mark Hubble referred to these two problems as the Tower of Babel Problem—just using different language for the same thing. And so that's where Russ Bailey and I got interested in common factors.

One day we were having a conversation with Mike Lambert, and we started to wonder, "Okay, so these common factors predict change. Can you make a therapy that's a common factors version of therapy?" Russ thought so. He said, "You can make a therapy that's called Common Factors." Mike said, "No, that's not possible. That's just a name for principles that predict change. It's not a theory of change. In fact, it's kind of a meta theory, So in order to make it a therapy that you use, you're going to have to make it more practical and pragmatic. You're going to have to have a theory of change. You're going to have to have techniques."

Russ thought it was possible, and I hesitantly jumped on board. We worked hard on an article focused on one principle of change, the therapeutic relationship. And then he said he thought we could do this in a book

format. So we submitted something to APA and they liked it. We came up with five principles in the end, and that's how we published the book on a common factors framework for delivering treatment.

RH: What are the five principles of effective therapy?

Ogles: They are the *therapeutic relationship, motivation, corrective experiencing, insight*, and *self-efficacy*. They really match up with what Marv Goldfried originally came up with in 1980. We don't use exactly the same words, but in each chapter, we try to present the evidence and research that this principle of change does predict outcome, and then we try to show how it fits into a variety of orientations using different language.

No one ever has any quibbles with the first of the principles, which is the therapeutic relationship. Second is client motivation, and a lot of the interventions there, as you might expect, have to do with motivational interviewing and expectancies, helping people to have the expectation of change. We see those two as the foundation of the house of change, if you will.

Then comes a cognitive avenue with insight, and an emotional avenue with corrective experiencing. And those aren't completely distinct. It's not like you have insight without any emotion, or corrective experiencing without any insight.

We call the top of the house self-efficacy, which is more of the behavioral, practical change that comes as people think differently.

RH: I was taught that corrective emotional experience was a psychoanalytic construct proposed by Franz Alexander and Thomas French.

Ogles: Sure, the Alexander and French stuff would fit within the corrective experiencing part of our framework. But we'd also put exposure as a corrective emotional experience, because in a sense, the person is confronting their past view.

Similarly, we'd put things like cognitive reframing, psychoanalytic interpretation, and humanistic reflection under insight, because the person is discovering something about themselves, whether through hearing something they said in a slightly different way or having a question posed to them they'd never thought of before. We'd even put straight psychoeducation there. So if you gave them homework to read, that would also be the kind of learning that we call insight.

In essence, we're offering a collection of things from different orientations under a principle framework, and it can inform the way that someone thinks about their therapy.

RH: The first principle is the relationship, and everyone agrees on that. But what is it about the relationship that's such a healing or essential component?

Ogles: When you start to dig into the research literature, you find it's about having a shared, trusting bond, a shared set of goals, and a shared set of tasks. And this matches up with one of the major players in the common factors world, Jerome Frank, who cowrote *Persuasion and Healing*. He talks about four things that are common to all therapies and healing rituals. One is a healing setting, whether it's a sweat lodge or a confessional for a priest or a therapist's room with the diplomas on the wall. The next is what he calls "an emotionally charged confiding relationship." And then the other two are a theory of change and some ritual that you must pass through, whether it's sitting in the sweat lodge or analyzing your thoughts through a three-column technique or whatever the ritual is that's tied to that theory of change.

RH: A safe bond and a trusted process for change.

Ogles: But part of it is that you have to agree on this theory and this ritual, the goals and the task. It has to be culturally acceptable in that way. If it gets too far outside the culture, the client won't believe it, and it's not going to work.

RH: So you have the relationship, the motivation, the cognitive strand, the emotional strand, and then the behavioral roof, as you put it, which is self-efficacy. Is that a need to prove these changes are lasting and show that I've made some change in my life?

Ogles: Yeah, but it's not so much about evidence as it is about practice.

For example, in my therapeutic training, I became aware that I'm somewhat possessive of things, a result of growing up in a home where I was the oldest of nine children. This sense of possessiveness really came out when I got married. I realized that some of the things she did that bothered me came from being 10 years old and having a bunch of little kids messing with your stuff all the time.

But just because I'm aware of that when I'm 35 and married doesn't mean that I'll change how I respond to situations where that possessiveness kicks in. Just because you have the corrective experience or the insight doesn't mean it necessarily translates into your behavior after you're aware. That's where the self-efficacy needs to kick in.

RH: Does a common factors approach assist with integration of modalities or does it make the whole concept irrelevant, because why have all these modalities if we only need effective common factors?

Ogles: It's a good question. It does add yet another approach to the mix. You have behavioral, humanistic, psychodynamic, cognitive, integrative, common factors. So, from one perspective, it didn't help solve any problems; it created a new one. But from another perspective, it offers a more unified, integrative way of both viewing and treating people. And the transtheoretical approach is gaining some ground, especially for treatment of depression and anxiety.

I'd add that our common factors approach isn't a closed book. If anoth-

er principle is identified that meets our criteria for cutting across other orientations and has research evidence for its predictive ability or change, then let's add it. In that way, we have a hope that common factors isn't something we possess. Rather, it's a set of principles that therapists can use as a framework for how to think about change, even though their interventions may come from different conceptualizations.

RH: And those interventions might borrow from these preexisting modalities? If you're going to talk about irrational thoughts and beliefs, for example, that's already an established intervention.

Ogles: Yeah, the only difference with common factors is the way the therapist thinks about it in their head. Instead of using the cut-and-dry theoretical language about why it's effective, they're thinking about it in terms of insight as a common factor of change—and they're using that intervention for that purpose.

So it might be that you see an irrational thought reframe and say, "There's a cognitive therapist." You wouldn't know they were common factors therapists until they suddenly threw in a psychodynamic intervention. It would look exactly like a psychodynamic intervention, but they'd be thinking about it from a corrective experiencing lens.

RH: If I was in a graduate program and learning common factors therapy as a modality, then would I be learning to borrow from different modalities to apply the cognitive, emotional, and behavioral elements of common factors?

Ogles: Yeah, and in some ways it's harder. I mean, if you look at Norcross's work on psychotherapy integration and integrated psychotherapy supervision, he says that it's harder because the supervisor has to be acquainted with more orientations and how they're applied. So at least in our training program, if you visit with first year therapists, they gravitate toward a cognitive model because it's so cut and dried and simple to implement. Then as they get more experienced and less anxious, they tend to spread out a little bit. So I don't know if the common factors approach is the first place people would start, because you have to be acquainted with more orientations in order to really implement it.

RH: In my graduate program, we learned Carl Rogers's client-centered therapy first, because it's a strong framework for establishing the relationship.

Ogles: And it reminds me of Bill Miller's work on motivational interviewing. He's busy doing behavior therapy for alcohol use disorders and discovers that the therapists who have the best alliance are more effective than the ones who don't. And so the birth of motivational interviewing comes out of this finding that the relationship matters a lot. It's not just the technique of the behavior therapist. You have to start with a good relationship.

RH: I love the idea of having something that unifies or at least gives therapists a common language and goals. Can you talk about it from the client perspective, though?

Ogles: Almost all the work done on common factors is survey research of therapists and experts, research about what variables across orientations predict outcome, or theoretical things like how is this idea in this orientation similar to this idea and this orientation? Well, the thing that's missing from that is the client's view. What do clients think creates change?

We're working on an article now based on a survey of 200 college students at a counseling center. We asked them, "What contributed to your change?" We identified 56 possibilities, based on the literature, and had the students rate how much they contributed to their change. And then we factor-analyzed that. When they aren't primed, there's clearly a therapist component to it. They'll say, "My therapist was amazing." "My therapist understood and supported me." "My therapist listened."

But sometimes there's an expertise factor. They'll say, "The therapist knew what I needed." "The therapist was really good at helping me." "The therapist knew how to work with me." In a category we called client work, there were two things. One was the effort or motivation. "I put in the effort." "The reason I made a change was because I desired to make a change." And then there was something we call expression, which has to do with the therapist's role and their own role as well. "I was willing to be vulnerable." "They helped me to talk about my problems."

And then there was one category we called skills or tools. "I learned how to deal with X." "They gave me mental tools." "They taught me how to cope." "They gave me methods for handling intense feelings." Very common. Then there's an insight category. "I see my struggles from a different perspective." "I healed the relationship with my inner self." "I had time to reflect on thoughts and feelings that helped me understand myself." "It helped to hear another perspective."

There was an external category. "I got support from my loved ones." "They gave me resources." "They helped me get medication." And then there was one category about the environment or atmosphere. "This was a safe place."

RH: So the common factors are all there.

Ogles: They are. It does start to sound like the clients actually see change in a similar way to common factors. We hope this will add to the common factors literature. If nothing else, it will certainly mesh with it.

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BY ALEXANDRA SOLOMON, KORY ANDREAS, SARAH MCCASLIN, SARA NASSERZADEH, & LAURIE MINTZ

5 Most Popular Therapist Memes

HUMOR AND INSIGHTS YOUR COLLEAGUES ARE SHARING

Ahh, memes—those wacky, humorous images that float around us like digital candy, easy to digest and even easier to share. But memes are also cultural touchstones, universal portals into our collective grief, pain, and frustrations. They can join us together in laughter, turn concepts we thought we knew on their heads, and speak truth to power—all in a single graphic.

As you'll read below, plenty of therapists have favorite memes, ones they share often with colleagues and even clients. It's a bold proclamation, then, that on our quest for healing in a chaotic world, memes can be a powerful tool in our clinical toolbox.

Opening Up is Hard to Do

BY ALEXANDRA SOLOMON

One meme that hits the spot for me shows a box of mac and cheese with the lid half-torn off. Underneath the caption reads: "Me trying to open up to someone." Most people who've opened cardboard boxes have had this experience. They try to open the box, but only the top layer of cardboard peels away, leaving the box just as tightly sealed shut as it was before they tried to open it.

When I saw this meme, it made me think of all my clients who have trouble opening up. Vulnerability is hard! As Brené Brown says, vulnerability is the first thing I want to see in you and the last thing I want you to see in me. When I'm working with clients who are walled off, we work to identify the threads that go back to their early years. Did someone betray their trust? Did someone use their mistakes against them as a power play? Did someone (usually a parent) need them to be perfect to buoy their own shaky sense of self-worth? As we unearth

these historic ties, I frame their struggle with opening up as a highly adaptive coping strategy they once needed and that they now get to retire.

We talk about how to retire this old way of being by cultivating relationships in which it's safe enough to be open. Toward that end, I offer this vital reframe: Opening up is far less an individual personality trait and far more a relational process. Intimate sharing emerges in the sacred space between two people. I teach my clients that discernment is an essential relationship skill: How do the people in your life demonstrate to you that they're capable of holding what you share? What do you notice in their words and behavior? What are the cues you pick up from your own body that let you know this is someone with whom you can create emotional safety? This work offers healing to their young self and empowerment to their current self.

In the context of an intimate relationship, I talk with my clients about how it's incumbent upon partners to co-create an atmosphere in which it's safe to open up by conveying, in words and actions, *You're deeply imperfect and deeply amazing.* And, by the way, self-compassion is also key. Our relationships are stronger and safer for vulnerability when partners can view themselves as both deeply imperfect and deeply amazing (because it's hard to give something to you that I am unable to give to myself!).

I work with couples on learning to discern when information is private and when it can be shared with others. Or I help them at least be humble enough to clarify with each other first, asking for permission rather than forgiveness! And we talk about how, in order to open their boxes up all the way, partners must demonstrate that they can resist the urge to use vulnerable shares as weapons of war during frustrating moments. The cumulative effect of these practices helps us create the conditions to comfortably peel back the layers and expose our tender underbellies.

Risk and trust exist in tension with each other. We need some modicum of trust to be able to take relational risks. And risk-taking builds trust.

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Joining Our Clients in the Fire

BY KORY ANDREAS

If "meme therapy" ever becomes an official intervention, an Autistic 40-something therapist will undoubtedly take credit for the discovery. Perhaps it should be me.

Grad school assured young therapists that mastery and application of

theory would be the conductor of our healing train. But in 2025, a well-timed meme may actually be sitting in the pantheon of revered interventions (only to be outdone by the occasional metaphor involving Taylor Swift lyrics). Therapists are turning to memes to connect, find common ground, and provide the gift of humor and relatability in an unpredictable and often scary world.

If you're lucky enough to have a neurodivergent therapist with a photographic memory, you might find they have a meme at the ready for most clinical situations. I like to think I do.

The meme at the front of my MVP lineup is, without question, the "This is Fine" dog. You've seen this one: a cheerful cartoon dog, coffee cup in paw, sitting calmly in a house on fire, and saying, "This is fine." For my caseload of high-masking neurodivergent clients, this meme is both funny and painfully accurate. Their "house on fire" presents in predictable patterns of job losses, denied accommodations, threats to their safety and livelihoods, and attacks on their gender, neurotype, and partnerships. As we sit together each week, "we're fine."

Right after the election, if I had a dollar for every time a client started their session by telling me the world was on fire, I'd have a lot of extra money in my pocket. In solidarity, I'd share my computer screen and present this cartoon dog on fire, and we'd begin the session with a giggle. "That's me," they'd say—then we'd get to fire fighting with a smile.

Nowadays, memes are one of many necessary tools in the modern therapist's kit. Therapists of generations past would surely gasp watching our sessions, especially virtual ones like mine. Bedroom corners have replaced stuffy beige offices. Thumbs-up emojis and cartoon fireworks sometimes dance unexpectedly across our screens. Cardigans have been replaced by hoodies and hilarious graphic T-shirts. The resources we recommend could be a digital book, a podcast, or a TikTok video. And "blank slate" therapists have been replaced by clinicians who are transparent about their neurology, their identity, and even their politics. In 2025, therapy, dare I say, has become much more human and real.

Meme-sharing has become as central to my therapy practice today as the go-to question (How does that make you feel?) was to our predecessors. And because my virtual office is filled with pattern-seeking and often anxious neurodivergent adults, we "meme" about anxiety and the many fires burning around us. Do we often outline all the worries, the terrifying realities, and our lack of control? Yes, of course we do. And just as quickly, we circle back to building resilience and noticing who's "sitting in the fire" with us. Sometimes what we really need isn't a cognitive reframe or a scripted meditation, but a reminder that even in smoke-filled rooms, humor can cut through the fear. A meme can offer a moment of oxygen and relief before we start searching for the exits together

The "dog on fire" meme has been with us for over a decade, surviving more crises than most of us care to count. His blank smile has carried us through countless, collective meltdowns, which is exactly why he fits so seamlessly into therapy sessions focused on anxiety and resilience. KC Green, the creator of the meme, drew this while starting antidepressants, and the dog reflects his own ambivalence and uncertainty about turning to medication. That origin story only deepens its impact: what began as one person's vague, dark joke has become universal shorthand for the chaos we sit in and our tendency to smile through it, acknowledging that sometimes "fine" is the best we've got.

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A Nervous System Reset

BY SARAH MCCASLIN

For the past five years, as executive director at the Psychotherapy & Spirituality Institute, I've sent a weekly staff reminder email. What began as a simple message to avoid the inevitable—"Do we have a meeting tomorrow?" or "What's the Zoom link?"—has evolved into something more: an invitation into proximity, a ritual of gathering. It's the ring of the bell that calls us to the hearth, whether online or in person, to dispel the loneliness that can accompany our work. We meet in this common space to recalibrate our clinical compasses and engage in embodied, spiritually attuned presence.

There's also a shared practice of not taking ourselves too seriously. To

lighten the mood, I'll attach a meme to each email—sometimes about therapy and therapists, and sometimes about the human journey and its inevitable follies. These memes have grown into more than lighthearted add-ons—they've become collective touchstones. In our most insecure, confused moments, memes remind us that we're not alone.

I often see the world through a meme-ified lens now—and I'm not sad about it. These small moments of connection are everywhere—sometimes in unexpected places. Imagine my delight when one of these memes appeared on meditation pioneer Sharon Salzberg's Instagram feed. It reads, "I don't struggle with anxiety. I'm actually pretty good at it."

Even such a bastion of mindful awareness and loving-kindness sees the value in humorizing our predicament. And just like that, my nervous system resets as I chuckle to myself. My delight in this quick, playful perspective has deep roots. Philosopher Johan Huizinga described the play-mood as one of "rapture and enthusiasm … a feeling of exaltation."

Humor in therapy isn't just a distraction—it's an intervention. I embrace play and playfulness as therapeutic tools: playfulness as liberation, humor as antidote, and sometimes even as spiritual practice. As a colleague recently said, "Play is essential to well-being throughout our lifespan."

I try to impart this to my clients. I will continue to bear witness to their grief, rage, or tender vulnerability (sometimes all at once), modeling the sacred power of presence. And sometimes, I'll crack a joke and we'll laugh at the ridiculous predicaments of our lives, soothed by shared laughter.

I haven't quite found a clinical context for sharing memes, but let's be honest—who doesn't need a meme now and then to feel like part of the human family?

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A Look is Worth a Thousand Words

BY SARA NASSERZADEH

You know the meme: a couple is walking down a sidewalk, and the boyfriend turns and looks back at a stranger. His girlfriend notices and looks dismayed. The internet laughs! I keep thinking about this meme (which has many variations) because it shows how quickly a glance can become a story. I've explored this meme in sessions with some of my clients, and for my couples, it hasn't really been about the eyes and where they go. It's been about what the glance at the stranger means. Was it a matter of attention or attraction? One is a reflex; the other is a pattern that grows over time. Was it a fleeting moment, or a breach of trust?

I sometimes share this meme with couples to create a reference point and teach them about the ingredients of Emergent Love—especially attraction, trust, and respect. In our conversations, we name the passing stranger in their relationship. It might be another person, like the scene in the meme, or it might be a nonhuman distraction, like a phone or TV. It might be work. It might be the wish for a different life that shows up at 11 p.m.

When we discuss this in session, we don't shame the pulling away. We just get honest about it. Then, we create small habits that help attention come back home, like 60 seconds of eye contact before talking about anything complicated, or phones in a basket during dinnertime, or stopping to notice and appreciate one thing about each other today. Nothing fancy, just practice.

This meme also opens a gentle cultural door. In some families, scanning the room says, "I'm keeping us safe and honoring those around us." In others, this same behavior says, "You don't respect me because you're not focused on me alone." Once partners see they're not arguing about eyes but about attraction, respect, and trust, the air changes. Shoulders drop. They breathe, and we now have an opportunity to talk about what attraction, respect, trust, shared vision, compassion, and loving behaviors look like for both of them. Using this meme as a reference is a playful way to reach this place without a sermon.

My favorite take on this meme came from a couple who renamed it "Brain Buffering." When one partner's attention drifted, they'd smile and say, "My brain is buffering. Be right back." The other would touch their own wrist—our cue for two breaths and a reset. It was tender, a little silly, and it worked! The aim wasn't to police glances; it was to create a climate where attention could return again and again.

That's why this meme stays with me. It's funny. It's a great conversation starter. And it's rare that my couples—of any sexual and relational orientations—don't identify with it, especially when we look at it as more than just glancing at a stranger and instead see it as anything that could take them out of a moment of togetherness.

Sara Nasserzadeh, PhD, is a social psychologist, speaker, and thinking partner specializing in sexuality, relationships, and intercultural fluency. She's authored three books, including Love by Design: 6 Ingredients for a Lifetime of Love.

Stigma on the Silver Screen

BY LAURIE MINTZ

One of the top concerns women bring to sex therapists is difficulty

orgasming during partner sex, and there's a central cause of this problem that's cleverly captured by a meme on Instagram, which reads, "Hello, I am a lady in a movie. I come easily from vaginal penetration." As a sex therapist and educator, as soon as I saw it, I reposted it on my own account—and decided to include it in the PowerPoint for the course I teach mental health professionals about treating women's orgasm issues.

To grasp the pithiness of this meme, it's helpful to understand how women orgasm in real life as opposed to in entertainment media. An analysis of the most popular Netflix programs portraying heterosexual sex reported that the sex act almost exclusively shown is penile-vaginal intercourse. And in a study examining the 50 most-viewed Pornhub videos of all time, when women were shown orgasming, most did so during penetrative sex, and only a small percentage were shown orgasming from clitoral stimulation. But in real sex, the opposite is true. Only four percent of women say their most reliable route to orgasm is intercourse alone. The rest need clitoral stimulation, either alone or coupled with penetration. In short, even though most women don't orgasm from penetration alone, entertainment media portray them doing so.

The problem with these portrayals is that people believe they reflect reality, and in the absence of scientifically sound sex education, individuals turn to the media for sexual information. When a woman sees countless images of women orgasming from penetration, but she doesn't orgasm this way, she's likely to believe there's something's wrong with her instead of something being wrong with the portrayal. One of my clients recently said to me, "I think my vagina must be broken," because unlike what she'd seen in the media, for her, coitus didn't result in orgasmic ecstasy.

When working with this kind of client—and countless others who have difficulty orgasming during penetrative sex—it's essential to correct sexual misrepresentations with research-based information and suggestions. Psychoeducation includes teaching women about their external genital anatomy, including their clitoris. It includes informing clients how rare it is for women to orgasm from penetration alone. Female clients appreciate learning that when women masturbate, 98 percent stimulate their clitoris and 95 percent of those reach orgasm. An essential part of therapy with these women is suggesting that they get the same type of clitoral stimulation when with male partners as they do when alone. We need to encourage our female clients to think of clitoral stimulation as just as important as intercourse, and empower them to get the clitoral stimulation they need when having sex with male partners.

Providing clients with empirically supported information should be a cornerstone of therapy for sexual concerns, and it's essential that we let our clients know that what they're seeing onscreen—as captured so beautifully by this meme—isn't what most women actually experience.

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