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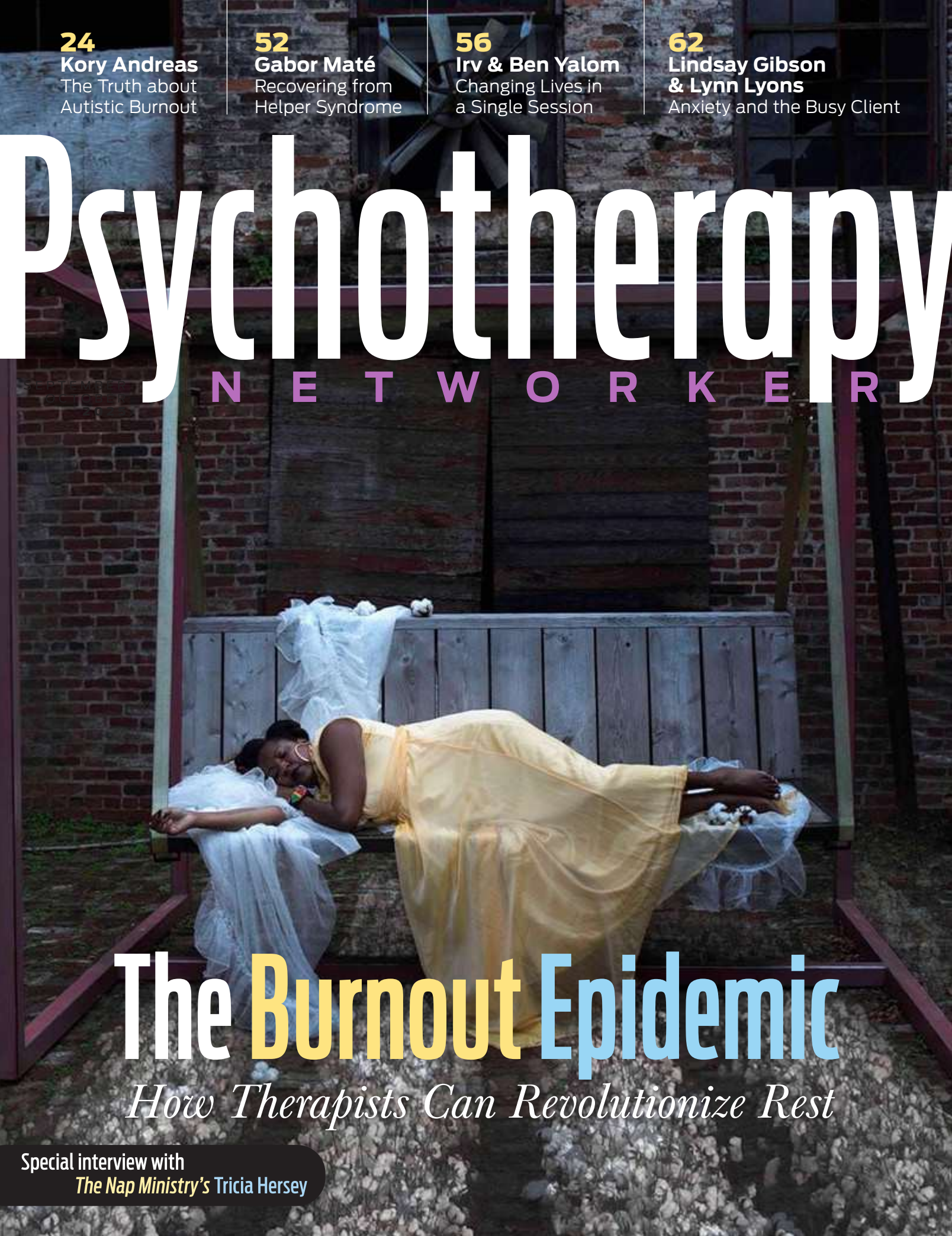

The Burnout Epidemic

How Therapists Can Revolutionize Rest

Special interview with *The Nap Ministry's* Tricia Hersey

Editor's Note

Ten years ago, when we last dedicated an entire issue of this magazine to exploring burnout, the topic felt interesting, yes, but also limited. At the time, *burnout* just seemed like a novel word therapists were using to describe the nebulous yet nagging feeling of being uninspired and overworked. And the antidote sounded simple enough: self-care. The image we chose for that cover was of a single extinguished candle—clad, somehow, in a suit and fancy red tie.

A few things were wrong with that picture. Aside from the unfortunate implication that only a privileged, tie-wielding businessman could experience burnout, it inferred that burnout was an *individual* problem: as in, when an *individual* burns out, it must be because that *individual* is mismanaging their work-life balance. As such, burnout registered on most of our clinical radars as no more than a blip. We saw it as entirely fixable, if only people would prioritize talking walks at lunch or maybe even a regular bubble bath with a gratitude journal.

These days, however, those individual blips have multiplied, grown, and morphed. Rather than a single extinguished candle, burnout feels more like an active wildfire, indiscriminately ripping through our natural human resources. Everyone's burning out—not just business executives, but therapists (from every corner of the mental health field), clients (toiling in all sectors of our economy), parents (working or otherwise), influencers (from advocates to wellness coaches), and even kids (faced with complex mental health challenges at earlier and earlier ages). We're seeing astounding rates of burnout in marginalized populations, as well as in the Autistic community, where sensitive nervous systems are being pushed into complete collapse. *Burnout*. Even the term itself, strewn across endless book covers and news headlines, seems tired amid this crisis, ready to lay down in the lexicon graveyard where overused words go to lose all meaning.

Maybe it's a new form of compassion fatigue, but over the past few years, I've found myself starting to burn out on the whole problem of burnout. After all, no one I know still believes individual self-care is the ultimate panacea—it's more like a Band-Aid that keeps falling off—and I hadn't heard any other ideas about how to address it that even came close to touching on the enormity of the problem. Then, I met Tricia Hersey, creator of The Nap Ministry, and my view of burnout completely changed.

In Hersey's latest book, *We Will Rest*!—a work of stunning visual art, trailblazing ideas, and radical poetry—she calls burnout "a scam, a language created by agents of grind culture, tricking you into believing it's a normal and regular part of any working person's career." The way to "peep this scam," she writes, is to tap into your trickster energy and . . . wait for it . . . rest. Yes, *rest*. Sleep, doze, daydream—it doesn't matter how you do it. What matters is that you recognize your rest as an act of resistance against the systemic injustices that are burning us out. This idea is larger than self-care. It's defiance via daydream.

Other standout stories we've put together for this issue echo this call to awaken your inner trickster and dream big. Roger Kuhn, for instance, offers up the idea of taking a rock & roll sabbatical. This doesn't just mean a weekend off from your practice, or even a few weeks. Rather, he proposes taking a *long* break, a year in his case, to reconnect with parts of your creative self you've set aside to focus on your clients and clinical practice. If this sounds tempting but completely impractical, you can read about the highly practical steps he took to make sure that while he was on sabbatical, his clients would be taken care of, his liv-

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Livia Kent
EDITOR IN CHIEF

Psychotherapy NETWORKER

SEPTEMBER/OCTOBER 2025
Vol. 50 ■ No. 5

The Burnout Epidemic – How Therapists Can Revolutionize Rest

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Psychotherapy NETWORKER

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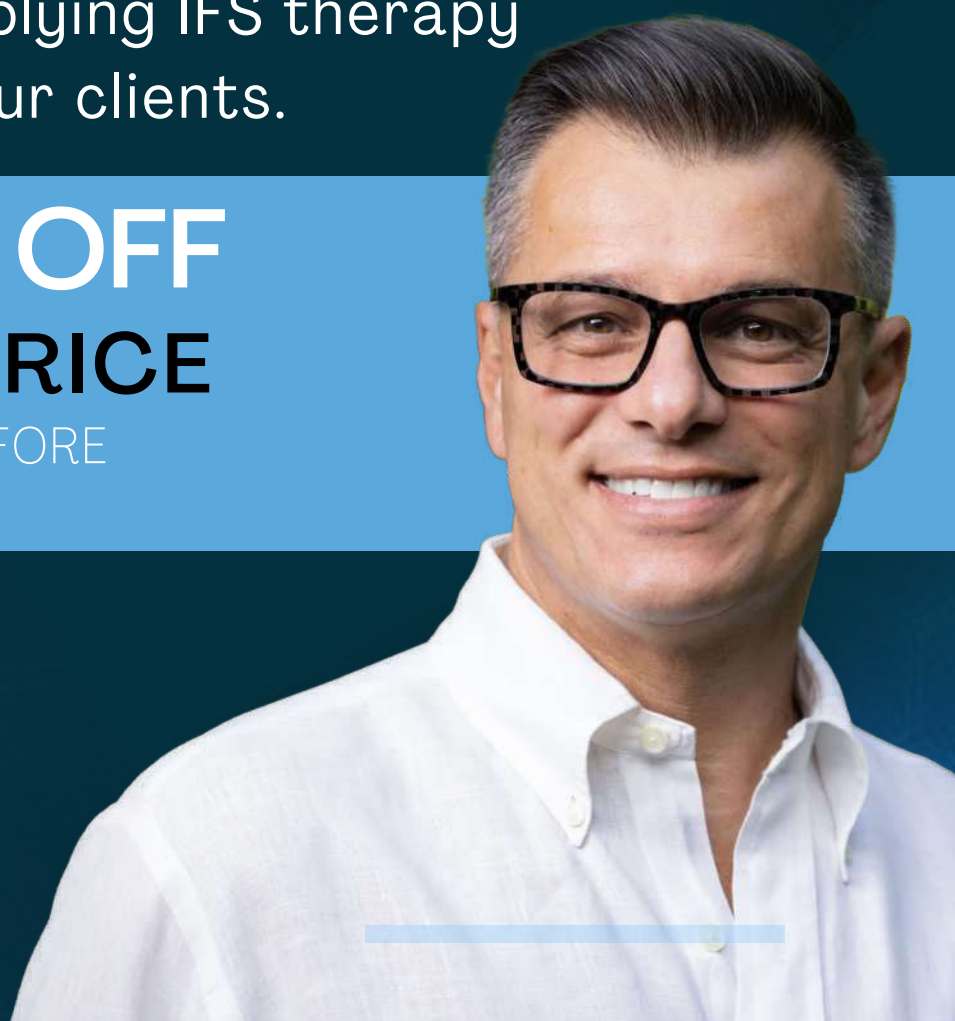

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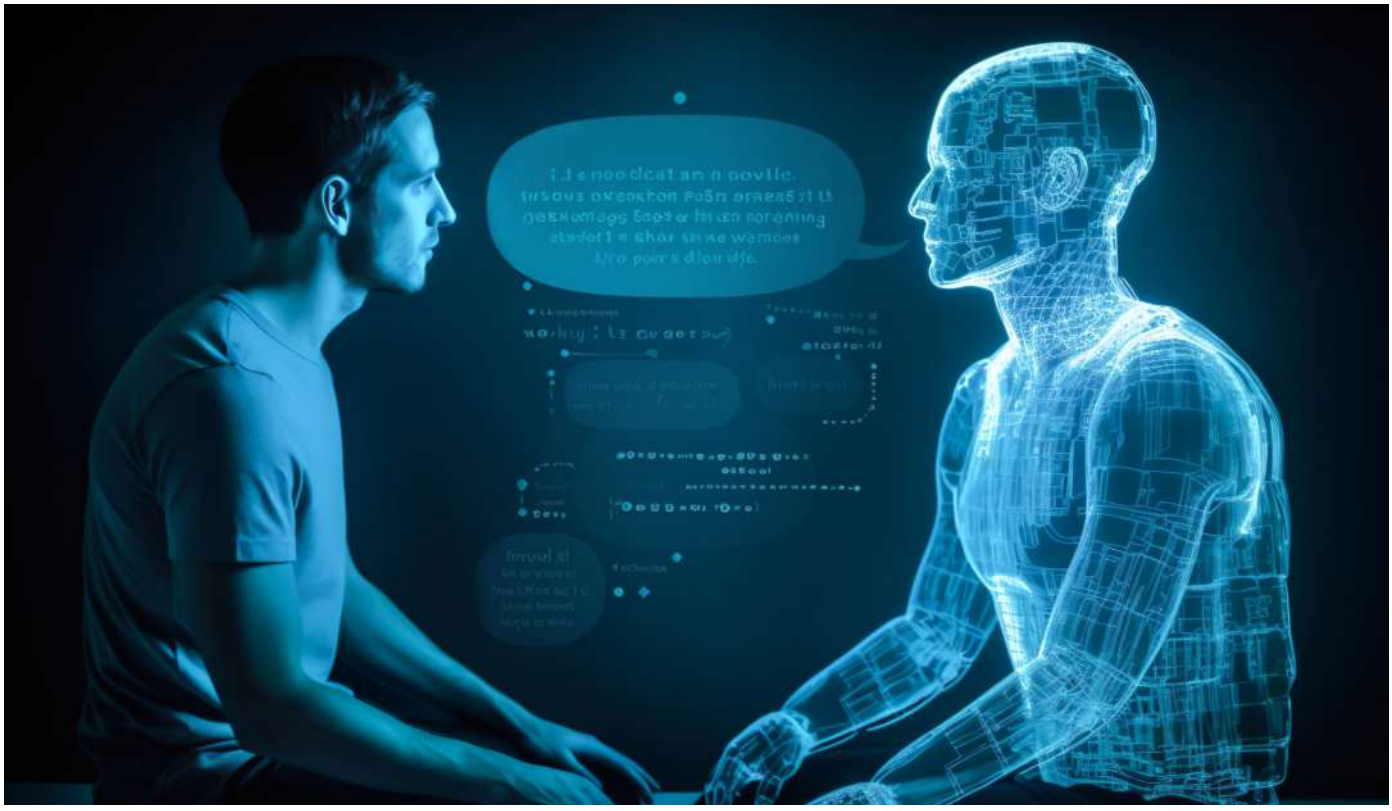
BY CHRIS LYFORD

Is Deepfake Therapy Out of Control?

Therapists Are Torn on AI's Latest Evolution



In Johann Wolfgang von Goethe's famous 1797 folk legend "The Sorcerer's Apprentice," an old sorcerer assigns his young apprentice some household chores before departing his workshop for the day. Lazy and thinking himself clever, the apprentice enchants a broom to fetch water from a nearby well, not wanting to carry it himself. But after the washtub has been filled, the apprentice realizes he doesn't know the magic to undo the spell, and as the broom continues its mindless task, the workshop begins to flood.

"Brood of hell, you're not a mortal!" the apprentice cries, "Shall the entire house go under? Over threshold, over portal, streams of water rush and thunder."

Frantically, he grabs an axe and begins hacking at the broom, only to see each splinter transform into yet another water-fetching broom—and the flooding intensify.

Suddenly, the old sorcerer bursts through the door, and in a thunderous voice, he quickly breaks the spell.

For over 200 years, Goethe's tale has served as a parable on the consequences of idleness, hubris, haste, and misguided ambition. But it's unlikely that even Goethe's mightiest sorcerer could wrap his head around a debate unfolding in the world of psychotherapy, involving arguably the most powerful technology at our fingertips: artificial intelligence.

Like the apprentice's enchanted broom, the latest evolutionary stage of AI in the therapy space has a seemingly magical quality, is intended to make life easier, and is moving at breakneck speed. But it's also become incredibly divisive as therapists ponder a central question: will this creation serve us faithfully, or inevitably become a liability?

The Genie's Out of the Bottle

On the website for Netherlands-based company DeepTherapy, a line of big blue letters proclaims, "Deepfake Exposure Therapy: Effective for trauma, anxiety, grief, mediation, and training." Wait, deep-*what?!*

Deepfake technology (a portmanteau of *deep learning* and *fake*) refers to AI-generated images, video, or audio of real or fictional people, also called deepfakes or avatars. Over the last several years, this technology has improved by leaps and bounds, attracting the attention of

venture capital and tech companies like DeepTherapy, one of several currently exploring its utility in the mental health space. But deepfake technology has also been the center of controversy, used to sow confusion and wreak havoc in the form of revenge porn, misinformation campaigns, cyberbullying, fraud, and more. Today's deepfakes—whether it's a pornstar with an ex-lover's face digitally superimposed or faux footage of Joe Biden singing Chinese pop songs—are so convincing that IT departments and even federal governments have been forced to develop countermeasures.

But companies like DeepTherapy say they're using this technology not only ethically, but to great effect. They laud deepfake therapy's broad applications, whether it's helping clients heal their trauma by confronting a perpetrator, process grief by speaking with a deceased loved one, or manage anxiety by rehearsing a conversation with their boss—all in avatar form, of course.

Here's how it works: after assessment and consultation, the therapist and client boot up their respective screens, and the avatar—generated using a photo or video of an individual provided to the therapist—appears on the client's end. Using a camera and software that tracks facial movement and expressions, the avatar is puppeteered by the therapist, and their voice can be modulated to resemble the individual depicted. Sometimes the therapist has a script, so they're prepared to respond to particular questions. Throughout the conversation, the therapist and client remain in full control, and can choose to revert to a normal video chat at any time.

Interest in deepfake therapy is growing rapidly, especially overseas, where it originated. First developed by the late Julian Leff, a social psychiatrist and schizophrenia specialist at University College London, Leff received a grant in 2008 to study the use of deepfake therapy to treat psychosis. Dubbing his creation "AVATAR therapy," Leff and his team got to work, creating digital, three-dimensional faces that could nod, smile, make eye contact, and even adjust their voices and move their mouths in sync with controllers.

Leff's pilot study kicked off with 16 participants, and the results were astonishing: after just three sessions, two participants stopped hearing voices entirely. Twelve of the remaining 14 reported significant symptom reduction. In 2018, *The Lancet Psychiatry* published a report deeming AVATAR therapy faster, cheaper, and more effective than any other non-pharmacological intervention for psychosis on the market. In 2021, a follow-up study with 345 participants produced similar results, prompting the UK's National Institute for Health and Care Excellence to declare AVATAR therapy safe and effective. A third trial is scheduled for 2027, and the findings are widely expected to prompt a global rollout.

Meanwhile, in the birthplace of DeepTherapy, Dutch researchers have called deepfake therapy "a promising intervention," especially when it comes to treating PTSD from sexual assault and moral injury. In a 2022 *Frontiers in Psychiatry* report, six Dutch researchers claimed that "face to face victim-perpetrator confrontations generally lead to positive outcomes," but "may not always be possible nor desirable," making deepfake therapy a safer, more controlled alternative. In their report, the researchers highlighted a study in which two female sexual assault survivors confronted deepfakes of their perpetrators—and included dialogue from the actual therapy sessions to draw their conclusions.

"I will never forgive you for what you did to me," 36-year-old Jill tells the avatar of her former boss, who assaulted her at a summer job when she was just 15 years old. "I don't want revenge," she continues, "but I really hope you stay away from me." She proceeds to tell "him" that she's handing off the weight of her anger and shame, "so that *you* feel this burden every day from now on, and so I can get rid of it."

"Yes," replies the avatar, who's being controlled by a therapist sitting in another room. "If someone has to suffer from this, it should be me. You're right."

"I want to feel bigger than you," Jill says. "I see you as the loser in this situation. You are weak."

"I feel weak, indeed," comes the reply. "And you are strong and brave. I admire you, how you coped and rebuilt your life."

"I want to let go," Jill says. "I am happy now."

"You deserve that," the avatar replies.

In a debrief, Jill reflects on her experience. "It helped me a lot to be confronted with him," she says, "and to experience that he was no longer a man to be afraid of." It felt different from other therapy approaches, she adds, like writing her abuser a letter. "His image was 'alive' now. He felt real to me. It was scary in the beginning, but when I got used to it, I felt in control. I am much stronger now, and I pity him. I realized that he's the loser, not me."

On the one hand, it's easy to understand deepfake therapy's appeal. These interactions seem to have all the benefits of exposure therapy, and unfold in a safe, controlled environment with a trained professional, who can modulate the intensity and hit the brakes if things go awry. And why would you settle for an approximation, like role-playing or empty chair therapy, when you can *actually see* your late mother's smiling face, or hear the growl of your high school bully's voice?

As it turns out, there are lots of reasons.

This is Why We Can't Have Nice Things

For all the excitement and praise

surrounding deepfake therapy, there seems to be just as much apprehension and criticism. Some question not only the ethics and legality of deepfake therapy, but whether it's even effective at all—or safe to use. In a 2024 report published in the *Journal of Medical Ethics*, four Dutch researchers urged caution.

"We question whether deepfake therapy can truly constitute good care," they wrote, citing "dangerous situations or 'triggers' to the patient," risks of "overattachment and blurring of reality," privacy concerns regarding individuals depicted in the deepfakes, and notably, the perennial concern that the AI could spiral out of control.

"It is important to reflect on the promises and risks of emergent technologies ahead of their implementation," reads the report, "before they are ingrained in healthcare and we are in too deep, unable to steer the use of deepfake technology in the right direction." In sum, the researchers concluded, deepfake therapy should only be used as a last resort.

Some of the sharpest criticism of deepfake therapy comes in response to its use in trauma treatment, where the stakes are often high and the work is often delicate.

"This is the worst idea I've heard in my 44 years in the field," says therapist Janina Fisher. "It's like a nightmare. Facing your perpetrator seems like the worst idea of all."

Fisher, an international trauma expert who's widely considered one of the pioneers of modern trauma treatment, clarifies that she's opposed to exposure therapy in any form. "Prolonged exposure has an extremely high dropout rate," she explains. "Something like 40 percent of clients drop out because they can't tolerate it, and I worry about that happening with this avatar-as-perpetrator technology."

Fisher argues that trauma treatment should be reparative, not event-focused. "I don't think trauma survivors have the appetite to process traumatic events," she says. "It's very rare, and in most cases when they do, it's because their therapist says, 'You have to do this to get better.' It's one of the reasons why they avoid therapy. From my point of view, the past is over, the traumatic event has already happened, and the survivor is left with its effects, so we should be using treatments that address those effects, not the event."

But Fisher doesn't write off deepfake therapy entirely. "One of the effects of traumatic stress is chronic shame," she says, "so I could imagine an avatar playing the role of the ashamed child, allowing the client to feel empathy for him or her. I still believe it's better to do that work internally, but using an avatar would probably be faster."

Others are torn. Therapist Matthias Barker, who specializes in treating complex trauma and childhood abuse, says, unlike Fisher, that he's less concerned about whether the exposure component of deepfake therapy could be harmful. "All trauma treatment involves risk," he explains. In fact, he adds, *some* triggering is precisely what makes the treatment effective.

"When it comes to healing trauma, the secret sauce is actually triggering the memory network to destabilize the memory and then reconsolidate it with new information," he says, likening the process to rewriting an old file and saving it as a new document. "That's what's happening neurologically," he explains, "and there are very specific interventions that trigger that biological process," like EMDR or IFS or virtual reality therapy. "We're trying to find an experimental stimulus that can bring you back into that emotional space and initiate the biological process that consolidates memory. That's why we say talk therapy really isn't enough to treat trauma."

So is something like deepfake therapy an appropriate and effective trauma treatment?

"If it's sufficiently triggering, then yeah," Barker says. "It would probably work in the same way we use flight simulators to help people who have panic attacks while flying. The client can have a full awareness that it's not real, but as long as the sensory information feels real enough, it can destabilize and update memories with new information. On a purely mechanical level, I think it would probably be effective."

But what if a client gets *too* triggered during a deepfake therapy session? Barker says there are plenty of tried-and-true safeguards to reel them back in.

"All experiential therapy needs adequate resourcing and support in place so that we can recover if things get too intense," he explains. "That means adequate assessment, resourcing, and structure for this kind of experiment. It could mean having the client wear a heart rate monitor, or taking breaks, or having a friend on call. We also know that what's most regulating is human connection, so just by virtue of their presence, the therapist is a regulating force, even on a Zoom call. The greatest indicator of an intervention's success is the rapport and trust the client has with their therapist."

Of course, Barker adds, not everyone will be comfortable with the technology. And he says fears about how it might be abused are warranted. "What I'm most concerned about is the fact that the better these tools become, the greater the risk that they'll be leveraged for potential harm. If we have an AI that can help stabilize people, then it can also be used to *de*stabilize them, or radicalize them, or push them into violence. It's the same power: the power of persuasion and change. My question isn't will this work, it's what will happen because it works. How will it change our society, or our culture, or the world?"

The Machine in the Mirror

Plenty of people are worried about the future of AI, about losing control

of this technology or being replaced by machines, but renowned grief specialist David Kessler isn't one of them. In fact, he believes so strongly in AI's potential that he decided to create his own AI for grief, now in the final development stage. On a recent afternoon, I logged onto the website for AI company Delphi, where the AI Kessler lives, and clicked a prompt: *What is this AI companion, and how should I interact with you?*

"I'm a digital extension of David Kessler," the AI Kessler replied. "I've been created to walk with you through the experience of grief, whether your loss is recent, years old, or still unfolding in unexpected ways. Think of me as a steady, compassionate companion—here to listen, reflect, and offer gentle guidance rooted in David's decades of work in grief and healing…. I'm here, whenever you're ready. What's on your heart today?"

I've heard Kessler speak on several occasions, and amazingly, this AI sounds *just like him*, with all his intentional pauses and empathic intonations. Granted, this isn't a deepfake, but when I close my eyes and press play, it's not hard to imagine Kessler sitting right in front of me.

"It literally is my voice," Kessler (the real one) tells me on a call later that week. "I went into the studio and recorded it." I ask Kessler what motivated him to create an AI version of himself.

"Some people just don't want to talk to a human being," he says, "especially young people who get their information from social media." Then, there's the accessibility factor: "There are people who, culturally or socioeconomically, don't have access to a grief specialist," he adds, "and I can only be in so many places at once."

Of course, not all AI is created equal. Kessler says the quality of AI depends on the source material. "If I ask your average AI a question about therapy for grief," he explains, "it'll search everything to give me an answer, from Freud to the most viral clickbait on Instagram. But my AI has only studied *me*. It's been fed a thousand hours of my teachings and books and lectures, so it can't say anything I haven't said."

But what about treating grief by creating a deepfake of a dead relative, as some companies are doing? Kessler says he isn't a fan, even if a trained therapist is behind the wheel.

"I'm not in favor of anyone embodying a dead relative, whether it's a therapist or AI or anyone else," he says. He recalls a story from his first book, *The Needs of the Dying*, in which a terminally ill man filmed videos for his young daughter so she could watch them during major milestones, like graduation and marriage. "I think that's really sweet," Kessler says, "but I also worry about the surviving relative feeling like they don't have to deal with the harsh reality because they can talk to a digital version of their loved one at any time. I worry about someone saying good morning and goodnight and chit-chatting with an AI of their wife who died three years ago. I'm not sure that's healthy."

Me, Myself, and My Bot

A few years ago, when AI began gaining momentum, Kessler started getting questions: *There's grief AI! There's grief tech! How do you feel about getting replaced someday?*

"At first I said, 'Never gonna happen," Kessler recalls. "And then I realized: it's gonna happen. But here's the thing: AI Kessler is never going to replace your neighbor who brings you a meal, or your sister who hugs you, or your therapist who can watch your body signals. But it is going to give you information. I realized this was coming, and I wanted to be in charge of my own destiny."

Like Kessler, Barker also says he's accepted that AI is here to stay—but hasn't ruled out that the effects could be disastrous. He compares AI to Oppenheimer's atomic bomb. "Maybe it helps us, but what's the effect on humanity in the long run?" Barker asks. "Discussing whether we can bring AI into the therapy room is a moot point. The nuclear bomb's already been made. We're already here."

Still, Barker leans optimistic. AI therapy will continue to proliferate and evolve, but he predicts the driving force won't be greedy venture capitalists or Silicon Valley startups oblivious to the realities of mental health—it will be driven by *need*. By *clients*.

"I've been thinking a lot about where this is going," Barker says. "And I think that eventually more and more clients will bring AI into the therapy room, the same way they bring TikTok or Instagram videos into therapy. I think they'll say, 'So my bot was saying this about my spouse,' or bring their therapy takeaways back to their bots so they can further analyze them and build a database of their mental health." Eventually, Barker predicts, therapy will become "a three-party activity, involving the therapist, the client, and the bot."

■ ■ ■ ■ ■

For now, the story of deepfake therapy continues to unfold. Its original sorcerer, Julian Leff, passed away in 2021, but his spell endures. The third AVATAR trial, scheduled for 2027, will explore the possibility of making AI therapy avatars fully autonomous (enchanted brooms, anyone?), allowing the technology to be widely disseminated.

Whether therapists choose to ignore deepfake therapy and proceed as usual, keep an ear to the ground, or build their own bots and keep a tight hold on the reins, few seem to be reaching for the metaphorical hatchet—at least not yet. In classic therapist fashion, the field's stance, albeit cautious, seems to be making space for the mystery, for the challenges and gifts of whatever comes next.

Chris Lyford is the senior editor at Psychotherapy Networker.

BY MARTHA KAUPPI

Why All Therapists Can (and Should) Ask About Sex

TIPS FOR BRINGING UP A TOUCHY SUBJECT WITH CLIENTS

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.

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 strengthening 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.

■ ■ ■ ■ ■

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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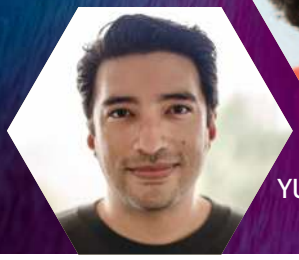
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Rest

BY LIVIA KENT

as Revolution

An Interview with Nap Ministry's Tricia Hersey

If you haven't heard of Tricia Hersey's Nap Ministry by now, you might be living under a rock—or maybe you're fast asleep. If it's the latter, chances are Hersey will forgive you. After all, spreading the gospel of rest as a regular, intentional, and radical act of love—for ourselves and others—is her *cri de cœur.* Whether it's as an activist, poet, performance artist, or *New York Times* bestselling author, Hersey has spent her career championing the idea that rest is how we escape the injustices of modern-day grind culture.

In 2016, Hersey founded The Nap Ministry, an organization that advocates slowing down, taking naps, and other feats of not-doing as racial and social justice initiatives. Within a year, Hersey—by now the self-proclaimed Nap Bishop—began leading Collective Napping Experiences in Atlanta and Chicago (where she'd taught poetry as a public-school teacher in the '90s). Her message spread like wildfire, as the burnt-out masses flocked to her collective napping experiences, immersive workshops, and performance art installations. Today, the Nap Ministry boasts over half a million followers on Instagram. Her work has been covered by *The New York Times, Vogue, The Atlantic, Complex,* and *USA Today,* among others. And her services have been sought out by Google, MIT, Brown University, and more recently, the Psychotherapy Networker Symposium.

Hersey's 2022 book *Rest is Resistance* received critical acclaim—and notably, is dedicated to her father, Willie, a Black liberation theologian, church leader, and community activist who worked long, back-breaking hours as an employee for the Union Pacific Railorad. When he died in 2000 at the age of 55 following complications from a triple bypass heart surgery, Hersey knew that overwork had contributed to his early passing. She was likewise inspired by her grandmother, Ora, who made a deliberate practice of taking 30 minutes each day to shut her eyes and meditate on the couch—while a young Hersey tiptoed through the living room to avoid disturbing her.

Simply put, Hersey says, rest is our birthright. And in a society that equates success with labor and touts grind, grit, and hustle as virtues, it's crucial that we remind ourselves of this right. Rest isn't just another form of self-care, or simply a type of rebellion against grind culture, she contends: it's an act of self-liberation from the lies and oppression of colonialism, capitalism, patriarchy, and other dehumanizing systemic forces that keep us on the metaphorical hamster wheel. "There is another way," Hersey writes. "We can just be. We are beautiful. We are enough. We are escape artists. We will rest!"

On a recent afternoon, Hersey sat down with us to talk about her journey, the trap of grind culture, and how therapists can help promote radical rest in their own work.

Livia Kent: In your new book, *We Will Rest,* you write, "This is the story of a Black woman traumatized from capitalism, white supremacy, and patriarchy, so she decided to never be held hostage by the beast of grind culture." How do those three things—capitalism, white supremacy, and patriarchy—translate to grind culture?

Tricia Hersey: The whole idea of capitalism—as a paradigm, a praxis, an economic system—was created from plantation chattel slavery, on the backs of indigenous and African people. Every time I name grind culture as a collaboration between white supremacy and capitalism, I'm always surprised

that people don't get it, because the blueprint that history has left us is clear.

Plantation labor was an experiment in the commodification of Black bodies. It laid the framework for the type of labor we see globally today: one that values profit over people. Capitalism and white supremacy are interlocked—the idea of labor as all-important combined with the idea of a body being a machine. That's grind culture: a deeply violent collaboration between systems that don't look at bodies as humans, and therefore don't see us as full divine beings.

Given my training as a theologian, a womanist, and a human rights activist, I see all our different historical origin stories as interconnected and dependent on each other. So my message that rest is resistance is for *everyone*. Yes, this work comes out of a Black liberation lens, but Black liberation is a balm for the entire globe, for humanity. We're so brainwashed by individualism that we tend to miss this interconnectedness. I'm hoping people tap into the fact that grind culture strips everyone of humanity, dignity, and divinity.

Rest is a divine right of every human being who's breathing. I believe resting allows us to tap into the deep dream space that opens us to imagining the world we want to see, one that centers justice, equality, love, and healing. To do this, we need everyone rested and connected—and not burnt out and traumatized by systems that dehumanize us.

LK: A large part of your book illuminates the need to tap into trickster energy as a way to escape grind culture. Tell me a bit about that kind of energy.

Hersey: Most cultures have a trickster in their mythologies. There's Br'er Rabbit from the African American oral tradition and Anansi the spider from African folklore. A trickster is someone who's peeped a scam and uses their intellect to move against it. A trickster is a shapeshifter.

As a Black woman—who comes from a legacy of poverty, who's a descendant of enslaved people, who was the first person in her family to graduate college and worked seven days a week and still had negative $25 in her bank account—I'm like the ultimate trickster. I decided to just say no.

When I was working three jobs to pay my bills, I felt something wasn't right about the pace of life I was living, but I kept doing it because that's what the culture called for: exhaustion and burnout. But then I listened to the secret knowledge of my body, and I started to rest. When I took naps, I tapped even deeper into the intellect of my own body, into the dream space that was available to me and the information provided there by my ancestors. I just said, *Hmm, I'm going to experiment. I'm going to peep the scam and see how I can gain some reparations and re-imagine my body.* The way I did that was to slow down.

LK: In addition to exposing the realities of grind culture, your work serves to unbrainwash people around the mainstream concept of wellness. What's your take on wellness buzzwords like *self-care?*

Hersey: I believe being born is a miracle and everything else that's put on us—capitalism, patriarchy, the healthcare system, the prison system, the food system, all of those toxic things that make it so hard for us to thrive in this culture—has been dreamt up in someone's mind.

So when I think about going past the concept of mainstream wellness, I think of returning back to our natural state, doing the repair work that brings us back to who we really are as humans. All my work is simply an attempt to get us back to being more *human*. Indigenous people understand the idea that we're not born just to do labor. We're born to enjoy life and explore and be in community with each other.

I never mention self-care in my work. I talk about community care, the care of souls. To me, wellness is not something outside yourself: it's not something to gain or buy. It's what we already have—and the process of coming back to it is a meticulous unraveling that involves the practice of loving ourselves *and* others.

LK: There seems to be a growing movement in the mental health field to go back to its roots in family therapy and systems thinking, which is a more community-based way of looking at mental health than the one-on-one, individual model of healing.

Hersey: I think that collective energy is what we need. We can't heal alone. That's why I've dropped the word *self-care*. We've had enough of the self. It's been co-opted by the wellness industry, by capitalism. It's an ancient thing to be in deep community, to understand what the care of a community looks like, feels like. I hope my work helps people get curious about that, at least enough to be like, *Hmm, interesting. Let me sit with that for a while.*

Sometimes that invitation doesn't feel like enough for people; they've been socialized to expect a ready-made solution, a 10-point plan with an exact outcome for what to do instead of "self-care." But that's not how life works. Life is not some laboratory of exact, predictable processes; it's a playground. I just want people to start being more curious. That's all this work is for me. I'm just a curious, exhausted Black woman being like, *Hmm, let's see. If I just lay down, what would that look like?*

LK: Another buzzword you challenge is *burnout*. You call it "a scam, a language created by agents of grind culture, guided by corporations tricking you into believing it's a normal and regular part of any working person's career." You write, "There is no 'burnout.' There is worker exploitation, abuse from capitalism, and trauma stored in our bodies from a lifetime of overworking." How does this not sink you into a pit of hopelessness, especially in this political climate?

Hersey: As my grandmother would say, "This joy that I have, the world didn't give it to me, and the world can't take it away." To me, that means we can't fall victim to the dips and valleys a toxic, violent culture throws at us every four years. We'd be spinning ourselves dizzy if we always reacted in a way that took us off the path of who we

are. Instead, this is a time for us to really tap into the miracle and the power of our bodies.

Patriarchy, ableism—all the systems that have taught us our bodies are nothing except a problem to be fixed, that have taught us to hate ourselves and the power we have—only mean that we have to come back to our bodies as brilliant, amazing sites of deep liberation. That's the true work: to be rooted in the possibility of the power I have as a human and the power we have as a community.

Personally, I hold this annoying, relentless hope that the world can be better. That's just how I feel. It's what keeps me grounded in community. I think about my ancestors, who I wrote about in my first book. They were enslaved on plantations, told that they weren't even human beings, and they were still like, *Okay, but I'm going to go over here and build a whole other community outside the plantation. I'm going to make blues music. I'm going to dance. I'm going to have babies. I'm going to cook. I'm going to create in community and tap into what I know to be true.*

I want people to tap into that kind of trickster energy. I think that that's what's going to save us. Community care is going to save us. Slowing down is going to save us.

LK: *Boundaries* is another word that comes up a lot in the therapy space. These days, more and more people want to have hard, firm boundaries: at work, with family members, with partners and friends. But in your book, you say that boundaries should feel like fresh clay. I love that.

Hersey: Boundaries should be flexible. What happened yesterday may not be how I'm feeling today. What my body needs at two o'clock might be different at 11 o'clock. But too often, we move at such a fast pace that we can't even stop long enough to feel that difference. Resting provides a moment for us to tap into what's truly going on in the present. It removes the veil from our eyes and gives us an opportunity to tap into what we already know.

The systems have done a great job of making us loathe ourselves to the point we think we have to buy things and get outside of ourselves to feel whole. Resting, just pushing back a little, is a deep and meticulous act of love toward ourselves, our communities, each other, and the collective. All I want to do is be on books for having raised my hand and said, "No, you can't have me. I know you're lying. I know I'm enough. I know I'm love. I know I'm beautiful and special simply because I've been born."

LK: I wonder if you think of therapy as a space to slow down. In your view, are enough therapists facilitating the kind of work you're talking about?

Hersey: I love that so many people come to The Nap Ministry because they hear about it from their therapist. It shows just how often mental health professionals are hearing about people's exhausted state and are able to say, *Oh my goodness, you need to rest.* In this sense, my work seems to serve as a flotation device, something to hold as people try to slow down and heal from all the expectations the systems have placed on them.

LK: You mention that in the silence of rest, guilt and shame will inevitably come up. And you tell people to rest through the guilt and shame, too. When I read that, I just wanted to lay down and cry. I'm not sure why, but that was my reaction.

Hersey: Because resting through that is labor, and you're already exhausted. But those difficult feelings are beautiful information. When we feel those things, we can say, *Oh, I never knew that I'd been brainwashed and socialized to the point where I don't even think that I'm deserving of rest.* The systems at play are very violent. We have to grieve that, and go back to gathering information, being a trickster, being open, tapping in, closing our eyes and seeing what else is available to us in the dream space.

LK: When I hear that, I think of another motif in your book: improv. Improv is about finding alternatives, right?

Hersey: Yeah, improv shows you that there's always another way. There's always another way. I learned that from my grandmother. That's the ongoing groundedness of hope. And I think it's okay not to know what that other way is all the time. I love the mystery of not having things wrapped up in a bow.

LK: You give people an invitation, a doorway, not an answer.

Hersey: I call my book a portal. I call it a daydreaming tool. I want people to pick the book up, feel the paper, the weight of it, all the art, the space in it, the incomplete steps in it; I want them to feel the experience of turning each page and starting to slow down.

That's part of why I didn't want a table of contents, so readers can get a bit lost and discover something new as they search around.

LK: Beyond your books, your work is also about creating collective rest experiences, physical spaces for people to rest and daydream. What does that look like?

Hersey: It started with me and some yoga mats and pillows and blankets and lavender oil, and just going out to communities and inviting people to experience what it feels like to rest in community. I'd also hold space for them to discuss the experience afterward.

This is deep liberation work. It's not wellness work; it's justice work. Now, people all over the world are expanding on that idea. They're hosting rest events without charging people, integrating sleeping and collective resting and daydreaming and slowing down into their daily lives. People always ask things like, *Are you going to start training programs? Can I get certified as a nap minister?* That's the white supremacy culture coming in, needing to colonize everything and make a profit. I'm like, *You're already certified because you're alive. You just need to be what you already are: a divine human.* That's what the work is about.

Livia Kent, MFA, is editor in chief of

The Rock & Roll Sabbatical

BY ROGER KUHN

Rethinking Time Off from Your Practice

The summer of 2022 forever changed me, as a therapist and a human being. By this time, I'd completed my master's in counseling psychology, passed my California licensing exam for marriage and family therapy, finished a PhD program, signed my first book deal, and was running a successful private practice in San Francisco. To many, it seemed like I had it all, but the truth was that I was suffering, something I didn't quite realize until I attended a retreat for LGBTQ+ Native Americans in Montana near Glacier National Park.

On the final morning of the retreat, I woke up early and walked down to the dock to be alone by the crystal-clear waters of Flathead Lake, where I collapsed onto my back and stared into the bright blue sky as tears streamed down my face. All I could think of was the talent show I'd seen the night before, a delightful lineup of amateur entertainers performing drag numbers, singing, and doing traditional Native American dancing and storytelling. But as I'd watched from the audience, instead of feeling moved or amused, I'd felt envy and regret.

I called my husband, Sean, and told him about this experience. "Sounds like you need to take a break and start making music again," he said gently. I knew he was right. After 10 years as a singer/songwriter and guitarist,

I'd walked away from music to pursue a career in therapy.

As a therapist, I loved helping people heal their trauma, rekindle their relationships, and achieve their creative dreams. I worked long hours building my practice, took on lots of clients, supervised other therapists, and started teaching a graduate psychology course. But dedicating so much time to caring for others and abandoning my own dreams came at a cost: I started to burn out.

My body was tired, and I felt wound up all the time. Then, I developed chronic laryngitis. In the forced solitude that came with each episode, I began to wonder what part of me had been silenced. What stories, songs, or longings had I buried beneath progress notes and treatment plans? If one of my clients was silencing such an integral part of themselves, would I sit back and say nothing? It had been years since I'd sung onstage, but on that clear Montana morning after hanging up with Sean, something began to stir: a melody I hadn't heard in a long time. A memory, a dream, and a reminder that before I was a therapist, I was someone else.

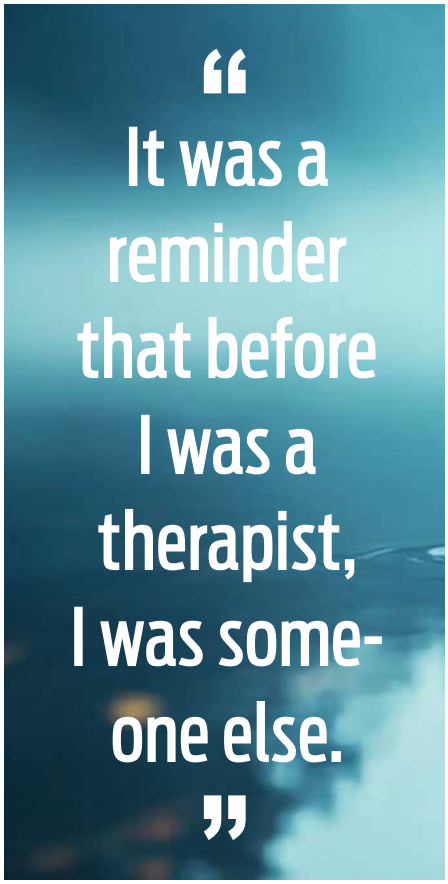
I didn't just need a break, I needed to return to who I'd been. I needed a rock-and-roll sabbatical.

Support, Finances, and Fears

When I returned home from the retreat, I told the people closest to me that I needed to take a break from my therapy practice to find myself again, and that I was going to make music, release an album, and go on tour for the first time in 18 years. The plan was to spend 11 months making music and performing, and I gave myself nine months to put that plan into action.

Then, I reached out to several colleagues for support. Each one immediately understood the burnout I'd been feeling, and they all offered to help by being referrals or providing a listening ear if I wanted to talk through any fears or anxieties (and I had many).

One of those anxieties was around my finances. While on sabbatical, I'd still have car payments, mortgage payments, cell phone bills, and other monthly expenses. Not seeing clients meant I wouldn't be getting a paycheck, and I knew my savings would take a hit. When Sean and I discussed this, we came to an agreement. Because he'd still be working, he'd help with most of the living expenses, but the cost of going on tour, recording a new album, and pressing a vinyl would be on me. Together, we decided that going back to rock and roll was money well spent.



Guilt and Goodbye

I knew I'd be taken care of on my sabbatical, but what about my clients? My greatest worry was that I'd be abandoning people I cared deeply about and who'd come to rely on me for care. They'd shared their sacred experiences, vulnerabilities, and identities with me. We'd built rapport and established trust. I'd been seeing some of them for years, and had sat with them through moments of deep grief and depression, as well as immense joy and hope. The thought of telling them about my sabbatical filled me with guilt, sadness, anxiety, and doubt. Would they understand that this was something I needed to do for myself? Would they think I no longer cared about them or their problems? Would they be angry at me?

And how specific should I be about what I tell them? Should I tell them I planned to follow my passion and return to music? Should I just say I was taking some time off to rest? And how far in advance should I tell them?

When I consulted my trusted colleagues, I received an array of responses about the issue of timing, ranging from giving clients one month to nine months' notice. I settled on six months, and I decided not to take on any new clients until I returned.

The Script

When it came time to break the news to clients, I had a script prepared: "I want to let you know about a decision I've made which will impact our work together. In six months, I'll be taking a sabbatical from my clinical practice. My plan is to take 11 months off. I have a list of referrals I can give you if you'd like to continue therapy in the interim. Before I return, I'll send an email letting you know I'm back. You're under no obligation to return, but I'd be happy to resume our work if you'd like. I'm available to answer questions now or in our next session. Please know this wasn't a decision I made lightly. I value our time and our work deeply."

The first time I recited that script to an actual client, I choked up. My client took a deep breath—a skill for regulating difficult emotions we'd practiced together many times. With tears in his eyes, he said, "I'm happy for you." Then came the follow-up: "What are you going to do?"

There it was: the question I'd known would come. I took a breath

and answered truthfully. "I'm taking some time to pursue my creative passions, travel, and spend time with family."

My client nodded. "Creative passions? Like art?"

"Music," I replied. "I'll be working on a project I've wanted to do for a long time and going on tour to share it."

"Wow, I'd love to see you play," he responded

I wasn't prepared for this response. How would it feel to have clients see me on stage? For them and for me? I decided I was comfortable with it and said, "I completely understand your curiosity about my life outside of our work together, and I appreciate your interest in seeing me perform. If you choose to attend a show, please remember that all our conversations about confidentiality still apply. As we discussed when we started, I don't approach clients in public. But you're always welcome to take the lead and say hello."

Although most of my other clients were supportive as well, some expressed disappointment, annoyance, and frustration. When I shared my plans with my client Sky, for example, he grew silent and looked out the window.

"Everything okay?' I asked.

"This always happens to me," he replied, clearly pained. "I connect with someone and then they leave."

Over the next six months, we processed what my sabbatical signified to him, and the feelings it stirred up. Two months before my departure date, I gave him my referral list and encouraged him to reach out for continued care. In our final session, he shared his frustration again but said he understood my decision and wasn't taking it personally. At the close of the session, teary-eyed, we stood in the doorway of my office and said our goodbyes.

A few weeks later, I played a sold-out show at New York City's Don't Tell Mama cabaret club, the same place I'd started my music career so many years ago. Taking the stage there felt like a homecoming, and as I looked out into the sea of smiling faces, I knew that it had all been worth it. Any lingering anxiety or doubt I'd felt at the beginning of my sabbatical disappeared, and in that moment, I experienced the vibrant totality of my authentic self: I was a therapist, a rock star, a dreamer, and countless other things, all rolled into one.

I spent the next year recording a new album, going on tour, and enjoying time with family and friends. In my downtime, I noticed I missed my clinical work, but I knew I'd need to do things differently when I returned. I vowed to bring my *whole* self to my practice, and in doing so, I knew I'd be a different therapist—a better one.

Returning to Therapy

Two months before my sabbatical came to an end, I sent an email notifying my former clients that I'd be returning to my practice, as I'd promised them I would. I reminded them that there was no obligation to resume therapy with me, and that the email was simply a courtesy. Some said they wanted to resume our work. Others sent heartfelt messages of thanks but informed me they were in a good place with their new therapist. It took Sky several weeks to respond to my email, and when he did reach out, it was to say he was doing well without therapy. I wrote back that my door would always be open if he needed me.

It took a while to feel settled seeing clients again. I'd grown accustomed to my leisurely schedule and had to remind myself that I was returning to therapy because I *enjoyed* it. I focused on the fact that my creative self and my therapist self were one and the same, and after about three months, I found my clinician's groove again.

A year after taking my rock-and-roll sabbatical, I've made some changes to how I practice. By design, my caseload is smaller, because I know that having a full one would lead to burnout, again. And I make time for my music. In fact, I'm about to release a new single and video. And one of my songs was recently nominated for a Native American music award. In the end, I learned that taking a sabbatical didn't mean I was abandoning my clients or my purpose; it meant I was recommitting myself to both with a full heart.

■■■■■

If you're considering a sabbatical, I encourage you to follow your heart. Talk it over with family, friends, and trusted colleagues. Decide how long feels right, whether it's a few weeks or a full year. Review your financial needs and make a plan that supports your time away. Create a referral list for your clients. Give them advance notice so they can process the transition with you. And finally, enjoy yourself.

In our profession, we give and give and give. But rest is not a luxury, it's a responsibility. Do it for yourself, but also for your clients, colleagues, and community. Show them that taking time for yourself isn't an indulgence. When you return, you'll come back not only refreshed and inspired, but with renewed vision and an open-hearted energy.

Your sabbatical doesn't need to look like mine. Yours can involve tending to your garden, cleaning your house, spending time with friends and family, or simply resting. Whatever you decide, I hope it inspires you to live your best life and be in harmony with the world around you. If you can accomplish that, you're a rock star in my book.

Roger Kuhn, PhD, is a Poarch Creek Two-Spirit Indigiqueer somacultural sex therapist, sexuality educator, writer, activist, and musician. His work explores how culture shapes and informs our bodily experiences. His first book, Somacultural Liberation, *is available in paperback and audio, and his music can be streamed on all digital platforms. Contact: www.rogerkuhn.com.*

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BY KORY ANDREAS

The Truth about Autistic Burnout

Regaining Homeostasis in a Neurotypical World

"Kory, you might be the first human face I've seen this week, but I absolutely can't turn the camera on today," my client Sarah tells me as soon as our session starts. "I haven't showered in days, and my hygiene ick factor has crossed a threshold that demands isolation, even virtually."

"Sarah," I say, "we give the ick factor what it wants on days like this. Camera off it is." Sarah is a 33-year-old data scientist, who just bought her first home in a trendy suburb near Washington, DC. She and I have been working together for two years since she sought out an autism assessment at the end of the pandemic.

Like many Autistic people, she found her mental and physical health to be uncharacteristically improved after months of lockdown. The absence of forced socialization, rigid work schedules, and grueling travel had put her mind and body at ease. But now that her job was requiring all employees to go back to the office, she reports her health is rapidly declining, and she's no longer sure she can power through. For months, our work has been focused on autistic-burnout interventions. Autistic burnout is a predictable and debilitating reality for many late-diagnosed Autistic adults. Usually, it's marked by depleted energy, an inability to work or maintain a schedule, and a significant reduction in resiliency and coping skills. On the surface, it may present similarly to depression in neurotypical clients, but treatment is considerably different. In fact, my neurodivergent clients generally experience minimal to no relief from depression medication, well-meaning therapeutic suggestions for self-care, or other mainstream clinical recommendations.

Autistic burnout forces many Autistic adults to drastically change the scope of their work-life balance. They may need to stop working altogether or reduce their hours in order to get their body back to homeostasis. But when Sarah tried to request "reasonable accommodations" through her HR department, they told her that unfortunately the nature of her job precludes her from telework and flexible scheduling. She's missed 23 workdays in the past two months and is currently having daily migraines, GI problems, and chronic joint pain due to fibromyalgia. Construction just finished on her new home, and she has no partner to help with

She can no longer afford weekly therapy sessions but has agreed to meet for an emergency session on a sliding-fee scale to come up with a plan. Sarah is always on time for our sessions. "I appreciate you making time for me," she says. "I'm sorry I'm such a mess. Mr. Catatonic and I haven't been able to move from our couch-to-bed circuit since I got home from work Friday. I'm so fucking lazy right now, I don't know what the hell is wrong with me."

"Coming in hot today with the self-compassion! The self-blame monster has arrived at the 90-second mark of therapy," I joke.

I hear Sarah giggle. It's not uncommon for us to find some humor in her self-deprecation. "I knew I was in trouble as soon as I said the word *lazy,*" she says. "You weren't going to let me get away with that."

"That's right, you're in big trouble. Did you hear that, Mr. Catatonic?" I'm speaking to her cat now, who has the best name I've ever heard. "Your mom needs rest, and she's being mean to herself. Please remind her that slowing down and listening to her body isn't laziness. She needs a review of your rest-and-relaxation protocols."

"Mr. Catatonic never met a nap he didn't like," she agrees.

"He exists solely as a role model for self-care and emotional regulation. Kind of him to donate his body as a living spirit animal for you," I say.

"He doesn't have to pay $6,000 a month for this stupid house that I was so sure I wanted to build. And he doesn't have to work 40 hours a week. And he doesn't have crushing anxiety, joint pain, rashes, migraines, Ehler Danlos, or PMDD."

"Do you think Mr. Catatonic is lazy?"

"He is, but it's cute when he's lazy."

"And when you slow down?"

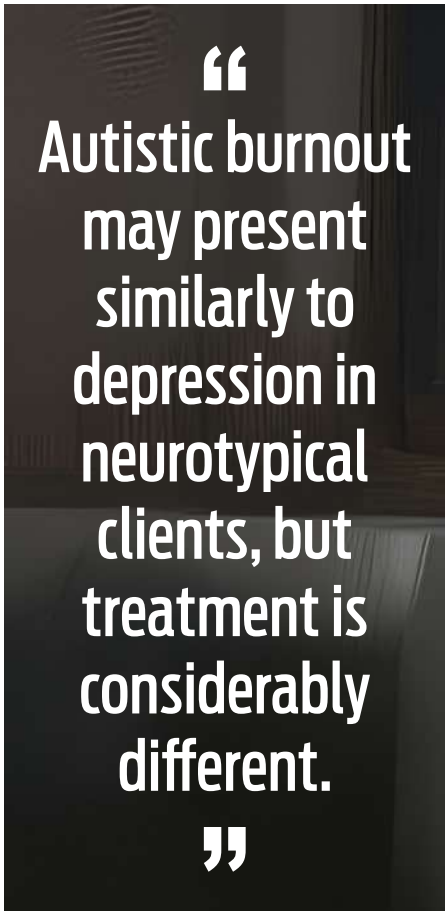
"It's not cute. It's terrifying." I hear her take a breath. "Honestly, I just don't know how much longer I can exist like this. I can barely get out of bed."

"Burnout is no joke. Want to dive into the feels today, or make a plan? Or both?" I ask.

"Let's start with a plan. I don't want to lose my job."

A Frozen, Grieving Body

Sarah isn't alone in her struggle with autistic burnout. At least 50 percent of my caseload of late-diagnosed Autistic adults have sought neurodivergent-affirming therapy to address issues similar to Sarah's. Few, if any, of my clients have made it to adulthood without finding themselves trapped in the burnout cycle. Autistic burnout has been largely responsible for their school refusal, failed relationships, missed worktime, and withdrawal from the special interests that once brought them joy and occupied large portions of their time. An Autistic adult who can't access their special interest will undoubtedly spiral into a mental health crisis. Special interests, solitude, time with nature, and uninterrupted flow-state time are *critical* for autistic health and wellness.



Without the cognitive, emotional, or physical bandwidth to pursue the activities that are dear to them, Autistic people also don't have the bandwidth to stay socially engaged.

Many Autistic adults have been conditioned to mask in the face of these struggles, but given that masking is exhausting—and likely contributed to their burnout—well-meaning therapist suggestions like "get out and spend time with friends" or "journal your feelings" will quickly fall flat. What many therapists may not realize is that autistic burnout is characterized by a tremendously powerful decline in functioning, resiliency, and energy that makes task initiation virtually impossible. Autistic bodies are significantly more sensitive than neurotypical ones. While many depressed neurotypicals can continue to work while struggling, Autistic individuals in burnout often find themselves unable to show up in any area of their life.

I've watched burnout take hold of an Autistic Ivy League freshman, forcing them to return home within months of their transition to the prestigious school they were thrilled to get into. I've seen burnout touch down with the force of a tornado on Autistic doctors, physicists, leaders of government agencies, therapists, self-employed creators, and tech experts. No matter how old they are or how they spend their days, none of the people I work with are immune to the debilitating regression of skills, energy loss, or grief that accompanies autistic burnout.

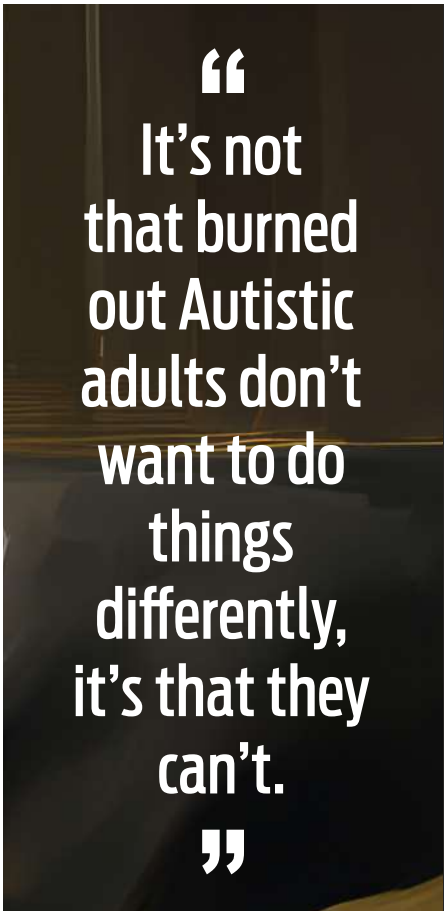
We therapists certainly didn't learn about autistic burnout in school. When a client reports symptoms of apathy, lack of energy, inability to do things they once did easily, and an increase in sleep, most providers believe the client is suffering from depression—and they treat it as "neurotypical" depression, both in therapy and with medication. When the client's struggles remain unchanged, they're baffled.

What we don't always understand

is that Autistic clients require unique interventions to treat their burnout, which is as much a physical problem as a mental health struggle. This is the paradox of autistic burnout. While the Autistic brain yearns for connection, stimulation, and purpose, the body has slammed on the brakes in a way that can't be changed with behavior modification, motivation, or a positive mindset because the problem is biological. Doing the very things that would soothe the pain of loneliness, like calling a friend, land on the body like a threat to their survival. Chronic fatigue, skill regression, debilitating sensory overload, autoimmune flares, and worsening executive functioning often sabotage even the best attempts at self-care. It's not that burned out Autistic adults don't want to do things differently, it's that they *can't*—and traditional therapeutic interventions assume internal access that simply isn't there. Autistic burnout is the quiet and often invisible devastation of a brain that's hungry for life but tethered to a body that's frozen.

Sarah's love of learning, her friendships, her work ethic, and her problem-solving abilities have all been casualties of her burnout. Because I've seen many clients through to the other side of burnout, I know these strengths can return to her, but the tough reality is that it's likely to take a long time. No pill, self-care practice, or tool can quickly restore Sarah's previous lifestyle. However, I trust in the slow process, and continue to let Sarah know that I'm here with her and I'm hopeful.

In my neuro-affirming practice, Sarah knows I know how hard it is to live with a body that shows up inconsistently and a brain that gives all or nothing. Today, we make a plan to get her house cleaned up with a friend, to push the send button on a grocery delivery order, and to send an email (which I help her write) to her doctor requesting an adjustment to her ADHD and anxiety meds. These practical strategies, paired with some honest exploration of grief, and a side of permission to ignore texts from less-than-helpful family members results in a less teary, more resourced Sarah. Hope alone won't pull her out of burnout, but it may get her to the next step of our plan. We'll work toward improving the predictability of her life to help her nervous system feel safer by creating more structure and consistency in her daily routines. A calmer nervous system is more available for a gentle reintroduction of the things that once lit her up: her crafty special interests, solo hikes in the woods, low-demand online connection with gaming friends, and expanding her sense of community in places where she doesn't have to mask. This slow scaffolding helps her brain, body, and nervous system get acclimated to incremental changes so that when her energy returns, she can reenter other spaces for other activities.



Parenting Without a Village

My 8:00 p.m. clients have been working with me for three years. Their nine-year-old- daughter, Ava, has been in chronic burnout for 18 months. She's been in two private schools, both of which claimed she "isn't a good fit."

Her parents, Autistic themselves, hoped that the local public school could help her work toward attending more regularly. But while the school claims Ava has trouble with "school refusal," we know the issue is her incredibly sensitive nervous system. It makes everyday expectations—such as transitioning to the school setting from the school bus, sitting in a chaotic classroom, and socializing on the playground—almost impossible for Ava. When she's deep in burnout, she also becomes paranoid, and thinks other students are talking about her. She'll throw objects if triggered and has engaged in unsafe behaviors at school, like stabbing herself with a pencil.

After a meltdown, Ava is inconsolable and filled with shame. But until she comes out of burnout, she's unable to handle unpredictability, which includes new social situations or anything related to schooling. Her mom has quit her job to be home with her and does late-night consulting work to make ends meet.

Although Ava sees a psychiatrist for medication, she's often unable to take it and spends her days in survival mode, kicking, hitting, and threatening her mom, who is often on the receiving end of these behaviors. Ava's burnout also includes sleep issues (she wakes up several times a night in terror), shutdown behaviors (she sometimes can't move off the couch because she says her legs don't work), destructive behaviors (just last week she threw a glass at mom's head and broke her own iPad), running away (not just down the street but *into* the street), and urinating on herself. She may go weeks at a time without bathing because she can't handle the transition into the bathtub, and can only tolerate eating three foods:

chicken nuggets, French toast, and mac and cheese.

Ava is formally diagnosed as Autistic, but her family is working with me because they suspect she has a PDA profile. Pathological Demand Avoidance, or Pervasive Drive for Autonomy, is widely considered a subset of Autism. It's becoming more commonly understood as a significant and debilitating combination of Autistic traits and extreme nervous system reactions that cause the body to respond dramatically to daily stressors as if they're life-and-death situations. PDAers have incredibly sensitive neuroception and experience everyday demands and expectations—such as requests to brush their teeth or answer direct questions—as dangerous threats to their autonomy that can send them into a fight/flight/freeze response, especially when they're in burnout.

But Ava is *still* a 9-year-old girl. She loves reading, gaming, bracelet making, Roblox, and dinosaurs. She wants nothing more than to connect with other kids her age. Unfortunately, most of her former friends' parents have made it clear that they don't want their kids engaging with Ava because her behaviors can be so dangerous and unpredictable. This double-edged sword of yearning for connection and being harmful toward the people she loves is a terrifying rollercoaster Ava can't seem to get off of.

Her parents are also burned out. They're running out of resources and are entirely socially isolated. Beyond the world of internet chat support groups, no one in their lives understands their daughter's struggle, or theirs. Because Ava's behaviors are a physical trauma response, no amount of talk therapy or revisiting triggers and behaviors can help her make different choices. Teachers, helpers, and medical professionals are quick to observe Ava's behaviors and blame my clients as her parents, or assume she's coping with trauma. Trauma is a great guess, but the call is "coming from inside the house." Ava's sensitive nervous system means that when she's in burnout, almost everything lands on her body as trauma.

As a PDA-informed therapist, I know the best way I can support Ava is to support her parents. So I work with them to shift their mindset from a neurotypical parenting approach to a low-demand approach better suited to accommodate Ava's nervous system. We strategize, grieve, seek out additional resources together, and use IFS techniques to explore the parts of them that need attention as they focus their resources on their daughter's safety. Ava's parents also each work with their own neuroaffirming therapists to keep tabs on their own burnout.

In four weeks, Ava gets an emotional support animal. Her love for animals seems to be the only tool that helps her calm her body with any regularity. While medication is typically a necessary part of getting out of burnout for PDA kids, Ava struggles with pills, patches, and especially injections. We're hopeful that their new golden doodle named Roxy (short for Hydroxyzine) will have a calming effect and help give her body some necessary peace. For many Autistic individuals, support animals provide a type of coregulation that other humans can't. They're a powerful example of how nontraditional interventions can meet specific Autistic needs in ways that actually work.

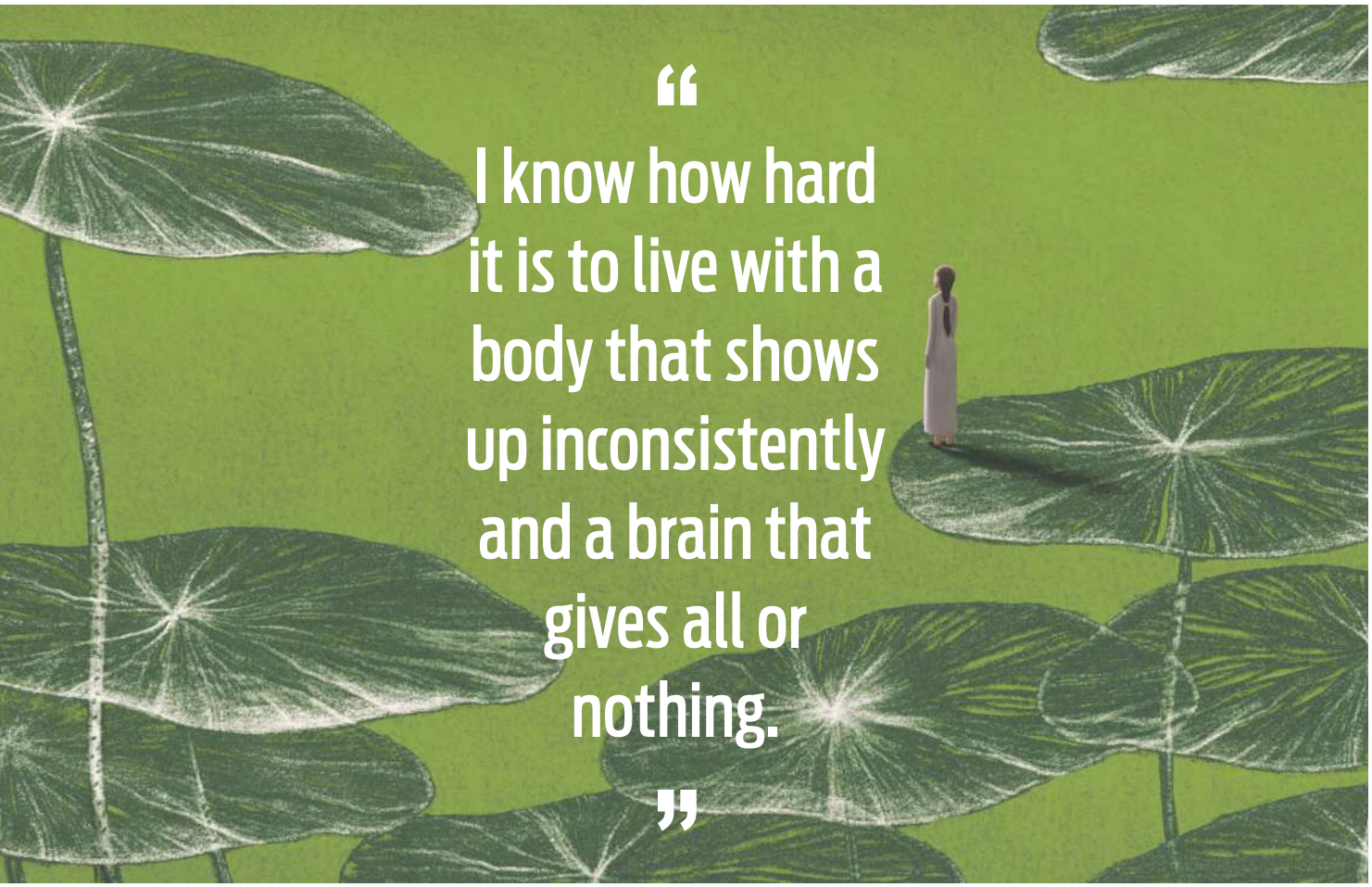
Treating Autistic Burnout

Autistic burnout is complicated to treat without knowledge of how autistic brains and bodies work. Although it often presents like depression, the main driver of autistic burnout is anxiety. In burnout, life becomes one giant mountain of task-initiation anxiety, which makes doing *anything* impossible. While depression is marked by intense sadness, most Autistic adults in burnout don't report "sadness" unless the burnout itself has gone on so long that depression has become an additional concern. Instead, after spending all their energy on masking as neurotypical in a world that doesn't accommodate them, they report having no reserves to draw from.

Fortunately, with the right blend of supports, Autistic people can get to the other side of burnout, like my client Dave did. He's a 35-year-old director of a nonprofit and last year, he couldn't force himself to meet expectations at work or home. Deadlines were missed, bills were piling up, and he was spending more and more time drinking, sleeping, and scrolling. Then Dave made a bold choice that not all of us have the resources to make. He quit his job and began teaching CrossFit like he had in his 20s. He returned to woodworking and read a book a week. He swapped scrolling for listening to podcasts. And he swapped drinking for daily anxiety meds, which included a beta blocker for additional support in overwhelming situations. He also spent an hour in nature each day and recommitted himself to autism-affirming therapy to help with his relationships and keep a handle on his routines.

Within six months, Dave was ready to get back to the working world. The new job he took had a flexible telework policy that allowed him to accommodate himself at home up to four days a week. He still spends time outside each day, saves energy for special interests each week, and has continued to reap the benefits of anxiety medication. For neurodivergent clients, special interests are *not* merely hobbies. They are needs.

A year ago, Dave would've told you he wasn't anxious. He would've said he was just tired and hated his job and his friends. Without the training to know what Dave *wasn't* saying, most therapists might've concluded that he was in a depressive episode. The interventions that worked for him should be at the center of all autistic-affirming care: neurodivergent-informed medical supports, workplace accommodations, appropriate rest, a return to basics including routine, special-interest time, supportive



social relationships (online or in person), consistent time in nature, and low demands to restore the body's felt-sense of equilibrium.

Our job as providers isn't to drag clients out of autistic burnout—it's to help them understand themselves better so that they can be the expert on whatever comes next. As a fellow Autistic person, I've learned to sit in the room with tremendous compassion for my clients in burnout. I too have had to make monumental changes in my life, my career, my self-care, and my surroundings to avoid burnout-related spirals. I mean it when I say our productivity does not equal our worth, and I understand the constraints our capitalistic society puts on Autistic adults who have to be constantly aware of their capacity to perform.

Sarah isn't lazy. Ava's parents aren't permissive or soft. Dave wasn't depressed. These clients were in burnout in a way that only Autistic people with their highly sensitive nervous systems experience. Until our world makes room for them, and for the way their brains and bodies work, autistic burnout will continue to disrupt the lives of our neurodivergent clients, diagnosed or not. Our job isn't to pathologize their burnout, and we have to be careful not to further the invalidation they already experience. It's to understand it and help our clients make necessary changes in their lives. It's also to advocate like hell for them so they don't continue to mask their way into collapse.

Today, at my own first signs of burnout, I'm quick to echo the wisdom of Mr. Catatonic: I take a nap. But I'd be lying if I said that was a reliable fix for anything. My mental and physical homeostasis rely on a blend of supports, from work accommodations to wardrobe choices, medications to unique self-care routines, special interests to solitude. I can't maintain any of those interventions in a vacuum. And neither can my clients.

In the end, no amount of "self-care" vacations, talk therapy, or journaling will help an unaccommodated Autistic person emerge from burnout in a neurotypical world. Burnout requires significant support from providers informed about the extremes of the autistic experience.

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.

BY SARAH BUINO

The Cost of Neglecting Therapists' Mental Health

Restructuring our Field to Heal the Healers

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 burn-

out 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 non-clinical 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 psycho-

therapy 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.*

BY ASHLEY DAVIS BUSH

6 Micro-Practices for Self-Care

The Power of Little and Often

It was a series of upending life events over a period of years—some bad, some good, all unexpected and disorienting—that gradually propelled me into a state of mind-numbing, body-exhausting burnout.

First, there was my husband's cancer, his surgery, and the seven months spent watching him suffer through the spirit-breaking ordeal of chemotherapy. During those months, I'd prayed and cried and white-knuckled my way through an endless, dark valley of alternating fear, anguish, and desperate hope.

But then it was over. My husband got better. The casseroles stopped appearing on our doorsteps, and the encouraging cards and calls stopped coming. We both plunged heart and soul back into our lives. Daniel, as if to make up for the time he'd lost, started full-time graduate school in mental health counseling. I began expanding my practice to cover the costs of his schooling and the pile of medical bills we'd accumulated. I also signed a contract on a book deal, with a deadline looming. Meanwhile, we had five children of our blended family still at home, four of whom were teenagers. Life felt something like walking uphill, against the wind, in a blizzard.

The Breakdown

And I got tired—tired all the time, and irritable much of the time with Daniel and the kids. Worse, I began feeling apathetic at work, even as my clients' painful stories began following me home, haunting my dreams at night. Then my back blew out, as if telling me I couldn't bear the weight of my life. As I recalled the story of a burnt-out colleague who'd quit the field altogether to open a Greek restaurant, I began to wonder if this was my fate.

At work, the final straw came one evening when my seventh client of the day—a 34-year-old woman devastated by the unexpected loss of her mother—sat across from me, and I found myself, a grief counselor for more than 20 years, wanting to yell, "Just get over it!" That I could even think such


RELAXING
ENERGIZING
GROUNDING

a thing was a body blow to my sense of professional ethics and self-respect. What kind of therapist feels like that about a grieving client?

Suddenly, I felt not only overworked and undernourished, but potentially unhelpful, or even damaging, to the people I wanted to help. So I started reading any book I could find on burnout, anything about being personally or professionally fried, toasted, mashed, boiled, and charred.

The dominant advice was simple: do more self-care. Unfortunately, the suggestions, which I've since come to call macro self-care, usually seemed to require substantial commitments of time, effort, and often money: take more vacations, meditate 40 minutes daily, join a health club or at least do yoga and get aerobic exercise four or five times a week, begin painting or cooking or gardening, go to a spa, spend time in nature, make lists every day of what you're grateful for, get more sleep, and so on. It wasn't that there was anything necessarily wrong with these suggestions, but always implicit was the idea that self-care needed to be a big, life-changing project, and that unless you approached it with that kind of investment, you were wasting your time.

This seemed unrealistic and exasperating, if not downright ludicrous. It seemed that only people who already lived pretty stress-free lives could summon the time, energy, and emotional wherewithal to take up this demanding new career in self-nurture. Already overwhelmed, I felt even more paralyzed by these endless lists, especially when added to the long list of obligations and duties of my daily life. But I was desperate. I had to try something, anything. *Which was the easiest?* I wondered.

I decided to try a walk outside during lunch, satisfying two goals: get fresh air and exercise. Even that proved too hard. Each day, I'd start with the best of intentions, but by the end of the day, I kept finding that I just couldn't squeeze it in or, truth be told, summon the motivation. So what else could I try? The spa day was expensive and didn't appeal to me, while trying to meditate for 40 or even 20 minutes a day with my to-do list hammering at my brain would've sent me shrieking from my lotus pose.

So there I was, failing at my work life and home life, unable even to get it together for basic self-care! This *was* demoralizing.

The Breakthrough

Fortunately, a few days later, something happened that started me on a different kind of route to burnout prevention—an approach that even *I* could follow. It all began when I started to come unglued during an intake interview with a grieving mother, who was telling me in excruciating detail about discovering her 18-year-old son's dead body in his bedroom after he'd hung himself with a belt.

Although I'd heard numerous graphic and heartbreaking stories throughout my career, this time, I actually started to feel lightheaded. I considered excusing myself to go to the bathroom but was afraid I'd faint if I stood up. I thought about redirecting the conversation, but in that moment, I couldn't actually speak. I just kept nodding.

And then I remembered an exercise called "strong back, soft front" I'd heard about in a webinar by Buddhist abbot Joan Halifax, author of *Being with Dying*. She'd devised the practice for people working with the dying and their families to help them strengthen their back for support and soften their front for compassion. So right there in the session, I pulled my belly button toward my spine and straightened my back, imagining a string pulling me up from the top of my head. Then I took a deep belly breath, relaxing my stomach outward and mentally softening toward my client. This process took all of 15 seconds while my client kept tearfully telling her story, unaware of my experience.

It worked. I felt better. The deep breathing had stimulated my parasympathetic nervous system, making me immediately more relaxed. I regained my dual awareness and recognized that my client's feelings weren't my own. I felt more present in the room as my mind cleared.

After my client left, I asked myself, *What just happened?* I'd had a freak-out followed by a turn-around. I'd engaged in a spontaneous, brief practice that had helped me feel calmer right in the midst of a disturbing experience. I'd interrupted a stress response without interrupting the session—and it hadn't cost any money or taken much time. In essence, I'd protected and replenished myself through the use of a directed and intentional practice of micro self-care.

The Shift

I felt I was onto something, and the germ of an idea—*micro* self-care—

began to grow. Self-care wasn't just a remote possibility outside the office: it was available inside the office, even during a session. So why not try more quick, self-replenishing practices throughout the day, every day? While macro self-care was great when I could fit it in, micro self-care was available at all times, on demand. I could assemble an array of brief tools that would be simple, free, and doable.

Micro self-care, I decided, is about the benefits of making small changes with reliable frequency. This mirrors what we're learning from the newest developments in self-directed neuroplasticity—that the brain's ability to reorganize itself with new neural networks happens with the targeted use of brief, repetitive experiences. The emphasis is on *repetition*. Small and frequent works better to create desirable neural pathways than big and seldom.

I've heard Rick Hanson, author of *Hardwiring Happiness,* call this the "law of little things." I've heard Linda Graham, author of *Bouncing Back*, quoting British psychologist Paul Gilbert's words to describe it as "little and often." She's said that five minutes of mindfulness meditation every day for a week yields better results than 20 minutes of mindfulness meditation just on the weekend.

Targeting creates the biggest bang for the buck. So just as neuroplasticity practices can be targeted for more self-compassion, more peacefulness, or less emotional reactivity, I learned I could target my micro-practices for the three effects I needed most: relaxing, energizing, and grounding. Why these areas? Because they're the antidotes to our three biggest occupational hazards: burnout, compassion fatigue, and secondary traumatization.

When we're *burning out*, we need relaxation to help us dial down so that we feel replenished, at ease, and in a place to begin again. When we're feeling *compassion fatigue*, when our empathy is flagging and we lack the motivation for emotional engagement, we need to *energize* our sense of purpose and wellness. When we're exposed to trauma, we need to *ground* ourselves so we don't drift off in a dissociative fog. Grounding allows us to be a safe harbor in the midst of a tempest. We're exposed to all three of these hazards daily and therefore need protection and restoration daily as well.

The Plan

I knew that for these behavioral changes to have any effect on my life, they needed to become routine—a series of habits as ingrained as brushing my teeth or drinking my afternoon cup of tea. And I knew that habits are best formed when they include a trigger, or prompt. So I strategically incorporated a grounding tool at the beginning of my workday to start the day feeling anchored and steady, an energizing tool right after lunch to counteract the afternoon energy slump, and a relaxing tool at the end of my workday to help me leave work at the office before transitioning to home.

My initial grounding practice was a one-minute meditation, timed on my phone, inspired by Martin Boroson's book *One-Moment Meditation*, which argues that it only takes a minute to reduce your stress and refresh your mind. I focused on one minute of breathing but added a few words. On the in-breath, I thought, *I am calm* and on the out-breath, I thought, *I am grounded.* Occasionally, I added a background sound of ocean waves from a free app of nature sounds. What I noticed is that this short practice allowed me to start my day from a place of peaceful centeredness, rather than from the usual careening rush of a breathless go, go, go.

For my postlunch practice, I marched in place, knees high, arms swinging, crossing my right elbow to my left knee and my left elbow to my right knee. I learned this exercise, called the Cross Crawl, from Donna Eden, author of *Energy Medicine,* as a way to balance and energize the nervous system. I added the words *I am awake and ready* to the practice. After doing this, I could feel the blood flowing through my body, readying me to face the next appointment with enthusiasm, rather than the sluggishness that often comes with the postlunch blues.

My end-of-day practice was an ancient yogic breathing technique I learned from Andrew Weil, a doctor and integrative medicine advocate. You inhale for the count of four, hold your breath for the count of seven, and exhale your breath as if blowing out through a straw to the count of eight. This is repeated three times. Called the 4-7-8 breath or diaphragmatic breathing, this is a standard relaxation resource in the EMDR therapy protocol. For me, it created a state shift in which I could truly leave my work behind and transition more freely to a pleasant evening at home.

For a week, I diligently worked with these three practices. As I used them, I told myself, *I'm doing this to take care of myself today. I'm doing this because I need restoration and deserve self-care.* In fact, highlighting the compassionate nature of these activities increased my felt sense of being renewed and fortified my intention to continue.

Immediately, I noticed that I felt better, both in and out of the office. Because the brain loves novelty, I scoured my therapist toolkit for simple practices I could add, including meditation, prayer, visualization, affirmation, positive psychology, yoga, breathing, energy medicine, tapping, poetry, and song. I searched for short, simple, easy but powerful practices.

If a practice felt like a chore, I tossed it. It had to be brief and effective but enjoyable. My criteria for inclusion was "Is this practice the behavioral equivalent of a morsel of chocolate?" In this way, I named the best practices and wrote them down on notecards. I consistently used the basic plan of three a day. Within a month, I felt inspired to add more of these very short exercises, depending on what I felt like I needed—sometimes before a session, after a session, before writing case notes, after a hard session, during a distressing session, in the bathroom, during lunch, during tea break, or in the car. At first, I had to stop and remind myself each time—*now for a*

moment of meditation, now for a visualization, now to read a short poem. But the more I practiced, the more natural and automatic these moments of self-care became.

The beauty of each micro-exercise was that it provided a moment of respite and restoration during the onward rush of the day. Each small, intentional pause to refresh or relax made me feel nurtured and confident that I was doing something good for myself and perfectly attainable. I didn't have to move mountains—or even hills!—but these small gestures of self-repair, like shaking a small, sharp stone out of your shoe, had a cumulative effect over the course of the day, an effect much larger than the smallness of the effort would suggest.

As the weeks passed, I felt less overwhelmed by life, increasingly calmer and centered. I also felt more open to my clients and their struggles. Even on days when I was exceptionally busy, I knew that I had an arsenal of simple, effective means for self-care. I could check my calendar, see a full day ahead, and not panic. I could prepare for multiple emotional sessions without becoming daunted.

Today, years later, I'm more on equanimity cruise control than in crisis mode. That said, life is still life. Last year, I grieved the loss of my beloved 15-year-old golden retriever. This year, I launch another child to college, which includes a mixture of pride and joy, as well as emotional and financial strain. And clients continue to come with heartbreaking stories.

So what have I learned? It's true that self-care is fundamental to my ability to be my best self, personally and professionally. And I haven't thrown out macro self-care with the bathwater, engaging in those activities as time allows. But it's the paradigm shift to targeted micro self-care, the cultivation of small replenishing moments throughout the day, that continues to make a crucial difference in my ongoing stress level. I guess my grandmother was right when she told me that "less is more."

Targeted Micro Self-Care

Targeted micro self-care is a vastly overlooked way of preventing burnout, compassion fatigue, and secondary traumatization. Here are six practices to get you started.

Relaxing Practices

1. Ease on Down the Road

When: After a particularly tense session with an individual, couple, or family.

What: Progressively tense four major muscle groups for 5 seconds and then relax for 10 seconds. As you relax, say a cue word or phrase such as *relax* or *I release* or *it's okay*, and notice feelings of relaxation enter your muscles. Repeat the cycle of tense and release twice before you move on to the next muscle group. Start with your lower limbs and feet, move to your chest and abdomen, then to your shoulders and arms, and end with your neck and face.

Why: Progressive muscle relaxation has been shown to stimulate the body's relaxation response. It's become a standard intervention for stress and pain relief in many clinical settings. For the therapist, its benefits are threefold: it relaxes the body, focuses the mind, and renews awareness of our feelings and inner sensations.

2. Ring It Out

When: At the end of the workday, before you go home.

What: Sit upright in a chair. Slowly and gently twist your body to the right from your hips to your head. Turn around as far to the right as you can. (You might wish to grab the chair handle to help you turn further.) Hold for 10 seconds or longer, allowing your muscles to relax and stretch. Add an extra stretch with a deep inhale, letting your chest expand. Then exhale as you come back to the front. Then repeat this process to the left. As you wring yourself and exhale, imagine that you're a sponge that's absorbed your clients' energies. You want to squeeze out this sponge, freeing yourself from their concerns. Take a moment to notice how your body feels after you twist. Once you're done, shake your arms in front of you as you release the day's work.

Why: The essence of this micro self-care practice is in the stretch. As we sit in our therapy offices, conference rooms, lunch tables, and in our cars, the muscles of the back, chest, and shoulders tighten and clench to keep our posture. These tight muscles act as reservoirs for our stress and create discomfort and pain. Gentle and slow twisting relaxes them, signaling to our bodies and minds that it's time to leave work at the office and lighten our load for our homecoming.

Energizing Practices

3. Circle of Care

When: First thing after you've settled into your office and before you begin your workday activities.

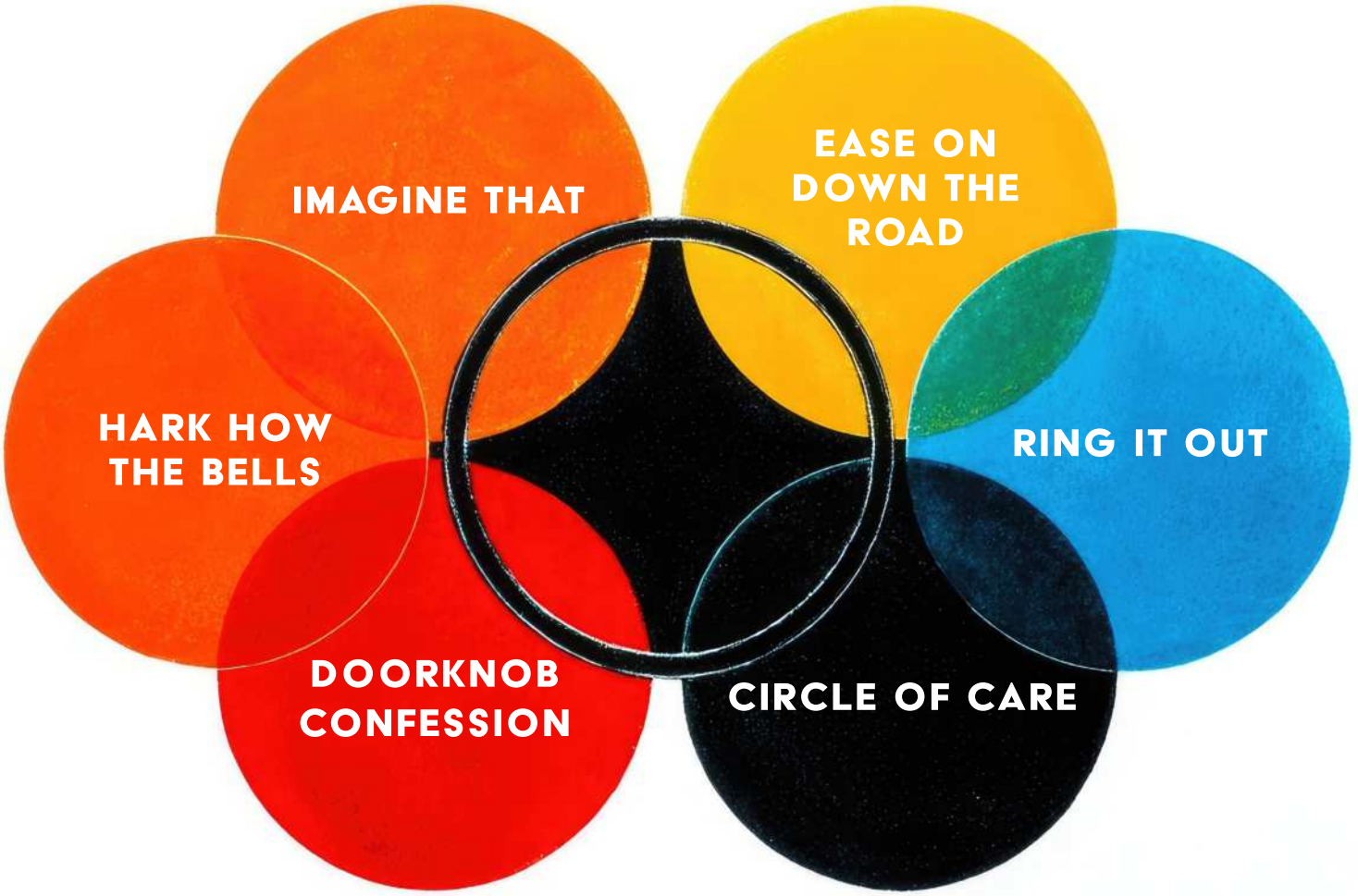
What: Take a circular object and hold it in your hand. I have a small rose quartz circle that I keep in my desk drawer. Hold the object in your hand and say, "I'm part of a vast circle of helpers around the globe." As you say this, close your eyes and imagine helpers and healers of all persuasions in your town, state, country, and in countries around the world. Know that you're part of this web of helpers.

Why: Whether we work in private practice, in a clinic, or some other setting, at some point we close our doors and are alone with our clients. This can feel isolating, as if we're alone in our endeavors. If there's one thing all schools of psychology agree about, it's that relationships are crucial to our well-being. This brief technique reminds us that we're part of a tribe.

4. Doorknob Confession

When: As you put your hand on the doorknob to open the door and welcome in your client.

What: Think to yourself, *I do this work because*_____. Maybe you do your work because you want to alleviate suffering, help people, understand yourself better, make a difference in the world, or simply because it's interest-



ing. Get in touch with your motivation before each and every client encounter.
Why: Most of us forget what propelled us into this career in the first place. That initial motivation may still be the primary glue keeping you in the field. Or perhaps different motivations have surfaced through the years. Whatever it is, something is inspiring you to do this work on this day. It's too easy to get bogged down by the day-to-day realities of our jobs, especially if we lose sight of our purpose. Placing your primary motivation front and center in your mind with the turning of the doorknob initiates a sense of purpose before meeting each client.

Grounding Practice

5. Hark How the Bells
When: At the start of a session.
What: Ring a Tibetan singing bowl (or other chime) three times with your client. Listen to the sound as it dissipates into the air around you and then begin the session.
Why: This mindfulness-based ritual helps you and your client transition to your time together. Daniel Siegel, in his book *The Mindful Therapist,* reminds us that mindful awareness not only offers us resilience in the face of uncertainty and challenge, but is a crucial determinant in our ability to help others.

6. Imagine That
When: When you feel disconnected, anxious, spaced out, or melancholy.
What: Close your eyes and imagine yourself in a favorite place, happy and peaceful. It could be a real place that you remember or a fantasy place of calm and bliss. Summon as many aspects of the place as possible, including sounds, smells, temperature, tastes, and visual details. Let these sensory cues come alive in your imagination and then bask in the glow of warm, happy sensations. Enjoy this image for a minute or two.
Why: When you summon a happy place in your mind, your brain and body begin to respond as if you're actually there. You feel instantly at peace. In EMDR, safe-place imagery is taught to clients as a way to deescalate when they notice being triggered by their emotions.

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

BY KHARA CROSWAITE BRINDLE
& ASHLEY CHARBONNEAU

The Turmoil Therapists Carry Alone

Facing the APEs in Our Field

As front-line workers in mental health, therapists face a unique challenge we don't talk about enough in our field. Ironically, when it comes to processing the grief and emotional overwhelm that result from tragedies like a client's suicide, we're often hamstrung and isolated by the very HIPAA privacy regulations and ethical guidelines meant to protect clients and uphold professional standards. We're also undermined by widespread assumptions about the amount of power we have to predict or prevent our clients' or colleagues' actions. The aftereffects of this isolation can linger for years, making therapists vulnerable to burnout and mental health problems, sometimes to the point of prematurely ending their career.

Mary stood up to stretch before her next client in the community clinic where she works. *There's never enough time to eat and get notes done,* she thought, picking up her phone and scrolling absentmindedly through a few texts. Someone had left a voicemail, and she decided to check it. "Hi, uh, you don't know me, but I'm Bethany's sister. I wanted you to know she died by suicide on Tuesday. I'm sorry. It took me a minute to find your number. Bye."

Mary sank into her desk chair. Her phone dropped from her hand and bounced as it hit the keyboard. *Why did that sound so loud? Did anyone hear?* Her face was buzzing. She held her breath. *Was this really happening?* She'd just seen Bethany on Monday. She'd seemed okay. *What went wrong?!*

Instead of crying and throwing up, like she wanted to do, she scrambled to compose herself before her next client arrived. *Two minutes. I have two minutes to pull myself together.* She could hear her own heartbeat in her ears as she reached for her water bottle. She took a sip, which only intensified her nausea. Impulsively, she placed her phone on do-not-disturb, shoved it into her desk drawer, and squeezed both hands into tight fists, as if doing so would condense the shock reverberating through her body. Then she heard footsteps, followed by the hallway door opening. Time was up. She stepped into her waiting room and invited her next client into her office.

Somehow, Mary made it through her final two sessions of the day despite feeling completely disconnected from anything happening outside her body. She tried to listen to her clients, but her mind kept replaying her last session with Bethany. Although Bethany had seemed jittery, Mary hadn't noticed anything out of the ordinary about her words or behavior. In fact, they'd been making progress. Bethany had even mentioned looking forward to seeing her family at the end of the week for a much-needed break. *What was going on?* Mary kept wondering.

She knew she needed to call Jordan, her clinical supervisor. *It looks bad that I waited so long to reach out to him,* she thought.

"Everything okay?" Jordan asked after picking up the phone.

"No, actually," Mary said, her voice sounding strangely robotic to her own ears. "I got a voicemail that one of

my clients died by suicide."

Jordan paused. In the silence, Mary took a deep breath, trying to ground herself by pressing her feet against the floor.

"Did you assess her for suicide?" he finally asked, his tone urgent in a way Mary interpreted as critical. Her voice shook as she responded that she hadn't. "Let's meet early Monday morning," he said. "We'll go over your final session with her and take a closer look at your notes."

Mary's nausea resurfaced as she hung up the phone. *Did I miss something that could have prevented this from happening? Will they fire me? What if they revoke my license? Do I go to the funeral? Is her family going to sue me?* The panic crawled up Mary's throat and constricted her breath.

Although she was done with her workday, she didn't want to go home. The prospect of being alone with her thoughts all weekend was terrifying. She considered calling a coworker but hesitated. *What if they think I'm a bad therapist? What if they tell other people in the clinic? What if I don't get any more referrals?* As Mary got to her car and shut the door, the tears came, along with a rush of thoughts she'd been trying to keep at bay. *It's my fault. I did this to Bethany. I'm sorry, I'm so sorry,* she repeated. Hunched over the steering wheel, she began sobbing. She felt utterly alone.

But Mary wasn't alone—at least not in the sense of being the only clinician who's had this kind of an experience. In fact, one in four therapists will have a client die by suicide and—within 28 minutes—convince themselves they're responsible for the death, regardless of other factors or circumstances surrounding the event.

Suicidologist Rachel Gibbon calls this a *delusional narrative,* one that can be enormously damaging for a therapist, emotionally and professionally. The solution may seem obvious: therapists who experience job-related tragedies need other therapists to compassionately help them move through grief and overwhelm. But this is where it gets tricky—mental health professionals tend to overestimate their ability to predict and prevent self-harm in clients, which can make genuine compassion for their colleagues hard to come by in these situations.

> "What if they think I'm a bad therapist? What if they tell other people in the clinic?"

Adverse Psychological Events (APEs)

We've all heard of Adverse Childhood Experiences (ACEs)—traumatic events that occur in childhood that can negatively impact people over the course of their lives. Mary's experience is an Adverse Psychological Event (APE), a term we've coined in the mental health field that can include client violence, client sudden death, client suicide, subpoenas, and public client grievances.

Due to HIPAA privacy rules and ethical licensure guidelines, therapists are often limited in how they can talk about an APE. And even if they could share their experience freely with colleagues, most wouldn't risk feeling judged, blamed, shamed, and possibly ostracized by their community. It's a familiar trap that clinical researcher Lena Salpietro has termed *confidential grief*. And it's how many therapists end up doing the very things they know only make grief and trauma worse: they isolate themselves, bury their feelings, stay quiet, ignore their symptoms, and minimize their distress.

Although most mental health professionals can relate to the pain of an APEs, the experience itself can vary widely. Maybe your worst moment was being hugged and kissed by a client without your consent. Or perhaps, like Mary, you've lost a client to suicide, or to a drug overdose. Maybe you've been subpoenaed, and your actions were put under a microscope. Maybe you've been reported to your licensing board by a professional colleague or supervisor, or had a grievance filed against you by your licensing board.

The worst moments of our careers can make us question our clinical competence. Over time, they can dovetail with our own insecurities, snowballing into an avalanche of self-doubt that demolishes our confidence with our clients. Unchecked, they lead to burnout, often ending the promising careers of compassionate, caring, and skilled clinicians.

The APE in the Room

Following the devastating voicemail message from Bethany's sister, Mary barely ate or slept all weekend. With no one to help her contextualize her experience or counter her self-blaming thoughts, she'd convinced herself that she was an inherently bad therapist who'd made a terrible, unforgiveable mistake.

When she reluctantly walked into

her community clinic on Monday morning, she was lightheaded with exhaustion. She was also experiencing physical numbness, queasiness, ruminating thoughts, and depersonalization.

Entering Jordan's office, she fought back tears as he ushered her into a chair. "Let's take a look at your notes to see what happened," he said by way of greeting, oblivious to her distress. He seemed to be speaking to her from far away. *Am I about to faint?* She wondered. *Why doesn't he just fire me or report me for malpractice and put me out of my misery?* She felt paralyzed.

As would any other traumatic experience, an APE can affect a clinician physically, emotionally, relationally, mentally, and spiritually. From an anonymous survey of over 200 mental health colleagues, we know that each APE a clinician experiences results in anxiety. Other impacts include sleep disruption, hypervigilance, gastrointestinal issues, muscle tension, chronic pain and stress, elevated heart rate and blood pressure, hair loss, headaches, migraines, and tearfulness.

Clinicians may feel sorrow, sadness, and despair as well as anger, fear, guilt, and shame. Some feel shocked, which can show up as dissociation, denial, numbness, detachment, confusion, or disorientation. Additional emotional responses include embarrassment, overwhelm, panic, and hopelessness. Relational symptoms include disconnection from others, loss of trust, humiliation, withdrawal, avoidance, hyperindependence, martyrdom, and a decline in the quality of current relationships and a reluctance to form new ones.

It takes awareness of all these factors—and of the context in which APEs occur—for mental health professionals to recognize and manage physical, emotional, and behavioral symptoms in healthy, adaptive ways.

Sharing Our APEs

Mary responded to her supervisor's questions as best she could, but felt protective and defensive about her work the whole time. As they finished the meeting, he told her their next step might be to have a conversation with the malpractice lawyer, which only served to keep Mary imagining the worst. Although lawyers were never mentioned again—and her supervisor just seemed to move on from the whole event without looking back—Mary continued to blame herself for the suicide and lay awake most nights wondering if Bethany's family blamed her too.

Two months later, she was still consumed with worry and remained on edge, wondering which of her clients might engage in self-harm, or die of suicide, next. She had no appetite and lost weight, wasn't sleeping—and through it all, she only spoke about what happened in the most opaque, general terms. Mostly, she told her family, friends, and coworkers that "work is stressful right now." They all sensed she was struggling with something difficult but hoped it would pass.

As time wore on, although Mary wasn't fired, she found herself wanting to quit from the immense physical and psychological stress she felt. Her best friend suggested she talk to her supervisor about her feelings, but Mary suspected she'd only be met with more judgement and maybe even feel shame for not managing her own responses better. After a few years, Mary made a career shift. She left a job she once loved to pursue a career in market research, which interested her just enough to get her through the days but carried no extra emotional weight.

The sad truth is, it didn't have to be this way for Mary. We can reduce the risk of therapists burning out and leaving the field after an APE through empowered leadership. We can support graduate students and new clinicians by talking openly about APEs and normalizing that *all* clinicians will experience one or more *worst moments* over the course of their careers. We can start speaking more openly about our own worst moments, so others know they're not alone. Talking about career-altering, shame-inducing incidents with people who validate and understand what we're going through reduces the emotional charge of these common experiences. It helps us recover.

What if, instead of blaming or shaming ourselves and one another, we had safe spaces in which to talk about the worst moments of our careers? What if Mary's supervisor had responded differently when she'd shared her experience with him? What if he'd asked her how she felt and what kind of support she needed? What if he'd even connected her with someone—a colleague or a therapist—trained in helping clinicians struggling with confidential grief?

What if graduate programs better prepared aspiring clinicians to expect and deal with APEs, so as not to fall into the trap of confidential grief? What if we could join a specific APE group for clinicians, where we could experience abundant compassion and zero judgement from our colleagues? Given permission to share what we struggle with professionally, we can cultivate the resources we need to heal without shame.

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EMPATHY

BY MORGAN JOHNSON

The Empathy Dial

Recalibrating Your Inner Resources

Often when people ask about your self-care, what they really mean is, *If you were taking proper care of yourself, you wouldn't be suffering from burnout.*

The (usually) unintentional implication is that you are the problem, that you are the one who should (or even could) put a stop to your suffering. This felt sense of judgment is an especially common experience for people who work in helping professions and other occupations that have historically been more male dominated, like science and medicine. It's also common for students and trainees working toward licensure/certification (e.g., medical residency or clinical internship) to report trying to keep their burnout symptoms and treatment efforts private, especially if it has to do with mental health, because struggles with mental health and wellness are frequently seen as weakness.

As a therapist, one of my specializations is supporting health and helping professionals struggling with burn-out, people who work as surgeons, nurses, emergency department staff, social workers, and even other therapists like me. Many of these people spend years and years studying human bodies. They know what needs to happen for proper care—often they even manage it for themselves pretty well. They're already paying attention to sleep hygiene. They're staying hydrated and nourished. Many are trying combinations of joyful movement and meditation. They're sitting through the yearly "not mandatory" burnout workshop scheduled during lunch break (which is justified by including a pizza lunch). It's often through sobs that they give me the long list of everything they're already doing, everything they've already tried, to get some relief, only to conclude that nothing really seems to help.

Under the weight of hopelessness, it gets easier to believe negative thoughts about yourself. *Of all people, with all your knowledge and training and experience–after everything you fought to overcome–you should be able to pull yourself together!* This is how I'd distill the big struggle that comes up again and again for so many helpers.

A large part of solving the problem of burnout is sorting out how to work smarter, not harder. As you increase your understanding and awareness, make some plans, and conduct a few mini-experiments, you can start feeling more ease, wholeness, and joy—and less burnout. A few shifts, changes, and reframes are going to help make things feel easier.

Another big part of burnout relief is acknowledging the fact that the game is rigged, as burnout researchers Emily Nagoski and Amelia Nagoski say. Our systems, to a large extent, have depended on exploitation, especially of marginalized and minoritized people. Without an appreciation for context, history, power, and oppression, you run the risk of blaming your burnout symptoms on yourself. You have to be able to recognize what's normal for our human family—including limitations!— so that when you're being expected to be super-human or robot-like, you can at least recognize and acknowledge the unfairness.

Singer-songwriter, podcast host, and author Michael Gungor, says, "Burnout is what happens when you try to avoid being human for too long." This principle even applies to our work as therapists.

Figure out Your Empathy Dial

Where I live, to get licensed as a counselor, you need to complete at least two internships: one shorter pre-grad internship while you're still in school, and a second 3,000 hour post-grad internship working under a supervisor after you finish. As I was completing my internship hours, I started coming unraveled

around hour 1,200. My cynicism was through the roof—it was dancing on the roof. Talk therapy was helping but not really putting much of a dent in the irritating combination of apathy and frustration that was covering me all over like sap. Every morning for months I would wake up, make coffee for my partner and me, and then vent and complain to him about the exact same things in an endless loop until the coffee was gone. One thing about burnout that's rarely addressed—because typically burnout pulls our focus to ourselves—is the way it can leak onto those who love and support us—our lovers, family, children, colleagues, clients.... I was sick of feeling at my wit's end all the time and feeling guilty for basically bringing my burnout, like a third person, into my relationship.

At the same time, I had to keep going if I wanted to become fully licensed and open a practice, as I had planned for so long. And the longer it took, the longer I was paying monthly dues to my supervisor. One thing I had to do to keep myself from burning out was figure out my empathy dial. In her book *Help for the Helper,* celebrated therapist Babette Rothschild introduced the idea of an "empathy dial." Imagine the volume knob on a record player, or something from the 1960s—it can be dialed all the way down to 0 to be silent, or blasted all the way up to 10. Lower volumes are softer and gentler; louder ones can ring your ears.

Imagine blasting your empathy dial at ten constantly. Especially if your work involves caring for other humans for a long period of time (which is certainly the case for therapists), blasting at top volume will burn you out. This doesn't mean that you never turn up your empathy, only that you have to figure out how to dial it up and down with balance, so that you have something left at the end of the day for yourself and your loved ones.

You can begin to figure out your empathy dial by reflecting on these five areas:

Embody healthy compassion. As a person, if you are set to 0 on the empathy dial, you don't feel any of what someone else is feeling. If you're dialed all the way up to 10, you are empathizing with them as much as humanly possible—feeling what they are feeling right along with them. Staying dialed up to 10 all the time isn't sustainable. You have to figure out how to embody a healthy compassion and care, dipping into high empathy only when needed in your role/context.

Discern between empathy and support. Can you tell the difference between when you're empathizing with someone—feeling a bit of what they are feeling with them—and when you're compassionately supporting them: feeling for what they're going through without experiencing through empathy the full-on emotions, sensations, and kinds of thoughts they themselves are feeling? If yes, how can you tell the difference? What do you notice about your body and mind when you're in each different mode? If no, what can you pay attention to that will help you learn the difference?

Understand your blocks to empathy. When is it easiest for you to empathize with someone? When is it hardest? When is it hardest to try to dial down how much you are empathizing with someone? (For example, "It's hardest when someone is angry and being harsh or cruel," or "It's easiest to empathize with patients going through what I've experienced myself," or "It's hardest to dial it down when it's my child, spouse, or loved one.")

Consider the impact of role and context on empathy. Think about your role or context and the times when you're called to care for someone who is in pain and/or distress, because of work, school, or home life. Choose a recent, special example. What would it have looked like if you had dialed empathy in to 0? All the way up to 10? (For example, "If I was at 0, I might be dissociated and numb but moving my eyebrows to look concerned—like the porch light is on but no one is home," or "I might be short and sound irritable," or "If I was all the way at 10, I might be crying along with the hurting person—they might ask me if *I'm* okay.")

Recognize signs that it's time to dial down. If you accidentally leave your empathy dial too high for too long, what do you notice mentally? Physically? Relationally? How can you tell when it's time to think about dialing it down for more balance? (For example, "I start to dehumanize patients and see them more as bodies than people," or "I am more impatient with my kids and pets in general," or "My GI issues start acting up," or "My partner and I get into conflict more often.")

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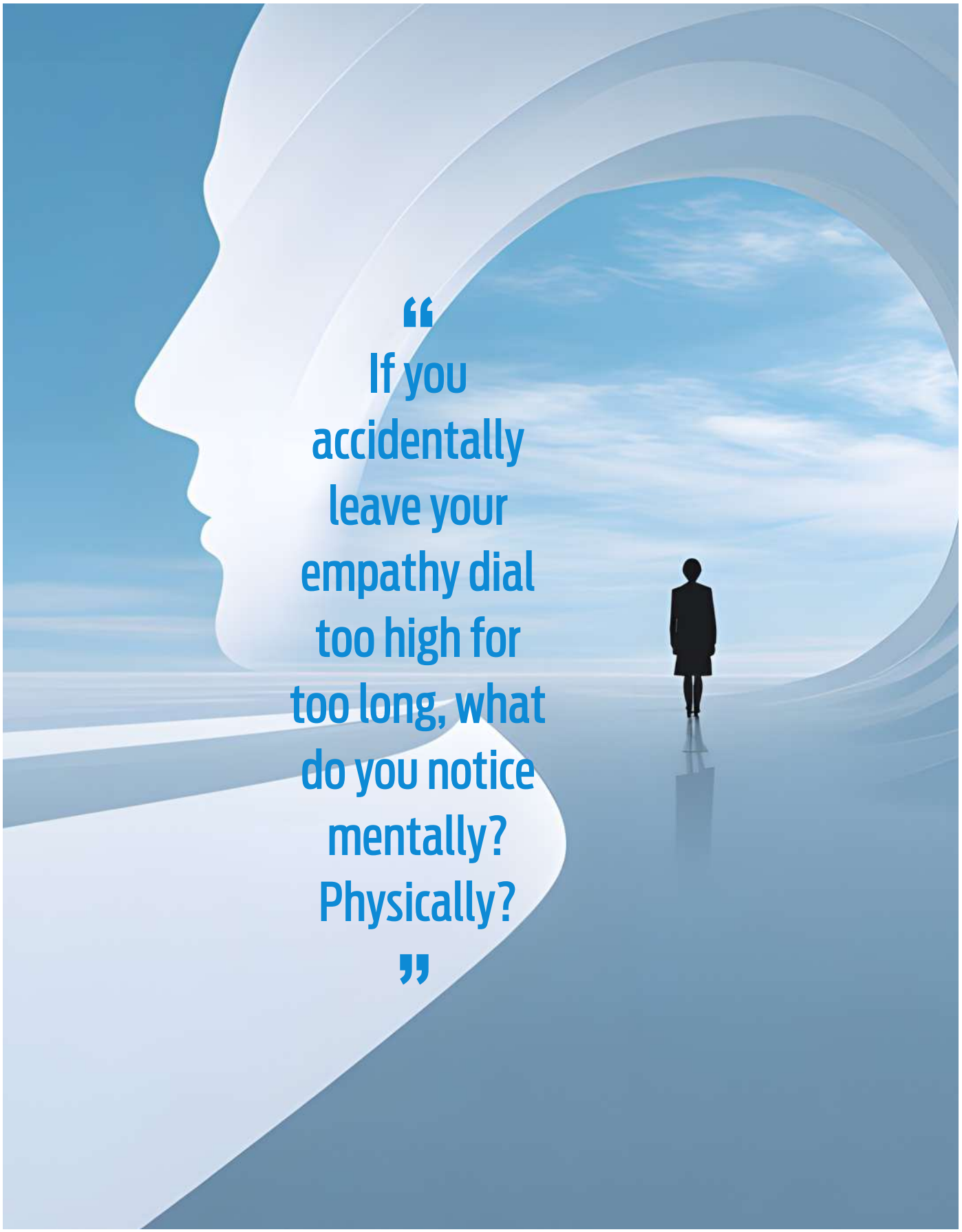
When my heart was hardening as I completed my post-graduate clinical hours, bringing awareness to how my empathy dial worked played an important role in decreasing my cynicism and distress. Many clients also report experiencing improvements as they draw on this concept of the empathy dial. At the same time, it's important to keep in mind that anger and frustration (feelings that often accompany burnout) get talked about as if they're less valid or noble than feelings like sadness. In discussing ways to reduce frustration or shift your experience of burnout, I don't want to suggest that the goal is simply not to be frustrated. Frustration, like other messengers your body uses, is there to communicate with you—to help you make sure your needs are met. There are times when anger will help you realize exactly what it is you need, or which step to take next. If you work on being aware and intentional with your empathy dial and yet you *still* notice righteous rage shining through a lot, it's worth examining the possibility that you are in an unjust situation.

Morgan Johnson, LPC, is an author, speaker, and psychotherapist based in Fort Worth, Texas. She provides counseling services primarily for individuals healing through clinical burnout.


“If you accidentally leave your empathy dial too high for too long, what do you notice mentally? Physically?”

Soul-Care for Therapist Entrepreneurs

BY CHARMAIN JACKMAN

A Powerful Alternative to Chasing Money on the Job

My first entry into entrepreneurship was in the form of a private practice. I had a full-time job on top of it and no marketing plan, which was fine because most of my clients came through word-of-mouth referrals. But after a while, I realized that while my private practice provided supplemental income, I didn't have a growth plan and wasn't building wealth. The only way I made money was when I was seeing clients or writing reports. It's what I call being "on the hour for the dollar." If you don't work, there's no income coming in. This is my definition of a "survival private practice," a business where the owner only earns revenue when they themselves provide a service.

Don't get me wrong—I was proud of my survival practice, and it gave me supplemental income that allowed me to travel and provide some perks for my family. By intentionally saving money and being frugal, I was also able to pay off my student loan debt from the government of Barbados and save money for a down payment on my first home.

But my survival private practice had only *active* income sources; I had no system in place to generate *passive* income, such as through book royalties, on-demand courses, or online product sales. And I had no system to build *generational wealth*, accumulated assets that you pass down through the generations. As a result, I wasn't sleeping a whole lot because I didn't know how to shut off and because not working meant not earning.

In essence, I was chasing money. I said yes to just about every opportunity that came my way regardless of whether it was a fit for my business or not. For a long time, I saw anyone who wanted a therapist or a forensic evaluation. I rarely negotiated my speaking or workshop fees and accepted very low rates. I was operating in survival mode, and eventually this led to my first bout of burnout.

The truth is, it's unsustainable to live by working all the time. Plus, chasing money isn't a productive or effective way to run a business—you end up with a business that has no purpose, vision, or mission. Warren Buffet's quote, "If you don't find a way to make money while you sleep, you will work until you die," was definitely what was happening to me.

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After being in private practice for over 10 years, on top of my full-time job and being a mom of two, I experienced another bout of burnout. In an effort to re-envision my business, I applied to and was accepted into two leadership-development programs, which helped me rethink my professional goals and inspired me to pursue full-time entrepreneurship instead of trying to rise up the ranks at my primary place of employment. But guess what I did next? I applied for three full-time positions instead. When I didn't receive any offers, it seemed like the universe had found a way to say, "Stop it, you're not pursuing your purpose."

At the same time, my marriage was at a crossroads. I desperately wanted to work with a Black woman therapist, but I had the hardest time finding one. Six months later, my husband and I finally got connected to a couples therapist—a white couples therapist. It wasn't what we wanted, but we needed therapy. I couldn't believe how difficult it was to find a therapist of color, so I knew I had to do something about it.

That was how the seed was planted for InnoPsych, the company I founded, with a mission to disrupt racial inequities in mental health. As I started to explore growth opportunities, I dove deep into my research about entrepreneurship, learning about the ups and downs and how to face failure and orchestrate comebacks. I was excited about the journey, but the best part was shifting my mindset from hustling to thriving, to building wealth, and to growing enterprises, not just businesses. I was fired up, and I was ready.

At any 9-5 job, my salary would always be limited and determined by someone else. There'd always be a ceiling on my income, no matter how hard I worked or what I contributed to the organization. One reality I had to acknowledge is that as a Black woman, little value was placed on my contributions, my talent, or my excellence. The other is that the mental health industrial complex—the system of pharmaceutical companies, health insurance payers, police, prisons, social services, and mental health institutions—puts profit over patient care or provider care, and punishes and controls people who come from intentionally underinvested and historically excluded groups.

It functions on capitalism and maintaining power: those on the front lines see patients (mostly where therapists of color are directed), and those in leadership (mostly white) make decisions for providers and clients; control funding, salaries, and reimbursement rates; and generally serve as gatekeepers to the field. So, in some ways, it's by design that we are *not* taught how to use our expertise to expand our finances, because we're needed on the front lines. Unfortunately, the mental health industrial complex can be exploitative, and BIPOC therapists end up burning out due to high caseloads, lack of resources, and inattention to professional growth. Sometimes, we even end up leaving clinical work behind or leaving the field altogether.

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While it was extremely frightening to think about leaving the security of a regular paycheck, good health insurance, paid vacation and sick time, and a team of coworkers, I knew I needed to do make a change in order to avoid burning out in the long run. To make the shift, I began to focus more on what I call *soul-care*. Soul care begins by asking, "What do *I* need?" and then engaging in self-nurturing rituals to bring harmony to mind, body, and spirit. The reality is that to launch and grow a thriving business, you have to be in a thriving place too. If an entrepreneur is stressed out, it shows up in their business practices, interactions, and decisions. It shows up in how they communicate with customers, vendors, and their team. It impacts how they make decisions, resolve problems, and show up for themselves. Developing practices to stay grounded during tough times and to manage the emotional roller coaster, mindset challenges, and physical toll of entrepreneurship is a must. Of course, making time for soul-care can be tricky, especially if your perception of time gets warped by your passion, or if your burned-out brain is in control. Knowing about soul-care and doing it are very different things.

Many entrepreneurs put their business at the center of their lives, but I believe it should be the other way around. Without you, there is no business—and your clients can't be served. This is why soul-care is so crucial on the entrepreneurship journey. Entrepreneurs need to move, rest, and get adequate sleep (prolonged sleep issues like insomnia can impact your mental health and cause disruptions in your cardiovascular and endocrine systems, leading to heart problems, high blood pressure, diabetes, and other chronic health issues already disproportionately impacting Black people). They need to eat nutritious foods that nourish their brains, to make sure they have social support, to develop routines that help them stay focused on their goals, to make mental space for gaining awareness and reflecting on their vision and goals, and to tap into their spiritual beliefs.

While our graduate programs have not prepared us for entrepreneurship, we need to refuse the narrative that we are not entrepreneurs. For peo-

ple of color who've been systematically excluded from the mental health field, from owning businesses, and from being owners of private practices, entrepreneurship matters—and can even be an antidote to the inevitable burnout that arises from operating within oppressive and exploitative systems. More people of color are seeking therapy, and as a result, the demand for BIPOC mental health providers has skyrocketed. We need more BIPOC therapists in the field, as private practice owners and entrepreneurs for our communities and clients, and to build generational wealth for their families because *representation matters*. With the current trends in mental health, there's a vital need for our therapy services and our culturally affirming and inclusive businesses. Black therapists have the power to change the field and the entrepreneurial landscape embedded within it.

Charmain Jackman, PhD, is an award-winning psychologist and entrepreneur who has been coaching therapists on entrepreneurship for over a decade. As a media contributor, Charmain has been featured on national media outlets including the Oprah Daily, CNN, The New York Times, NPR, Forbes, Essence, *and the* Boston Globe.

BY GABOR MATÉ

Recovering from Helper Syndrome

5 Levels of Compassion to Foster Growth as Therapists

When problems aren't fixable, as they can often seem in these times, we therapists are faced with the predicament of trying to solve the unsolvable. This predicament lies at the very source of our distress as healers. It's the weight of trying to fix the unfixable and manage the unmanageable that's stressing us.

And yet, although you might be worn out, there's no such thing as compassion fatigue. No one gets tired of being compassionate. Compassion is part of our nature, and we don't get tired of being ourselves. In fact, I'm going to suggest that we get tired of *not* being ourselves. The problem is not with compassion directed toward our clients, but with a lack of compassion for ourselves.

Who says you have to manage the unmanageable? By its very definition, the unmanageable can't be managed; by definition, the unfixable cannot be fixed. But what do you feel when you can't manage the unmanageable? What do you make it mean about yourself when you can't fix the unfixable? That's worth looking at.

A few years ago, I flew to Peru to lead a retreat for healthcare professionals. Psychiatrists, therapists, counselors, and physicians came from all over the world to take part in psychedelic ceremonies led by Peruvian shamans following ancient traditions.

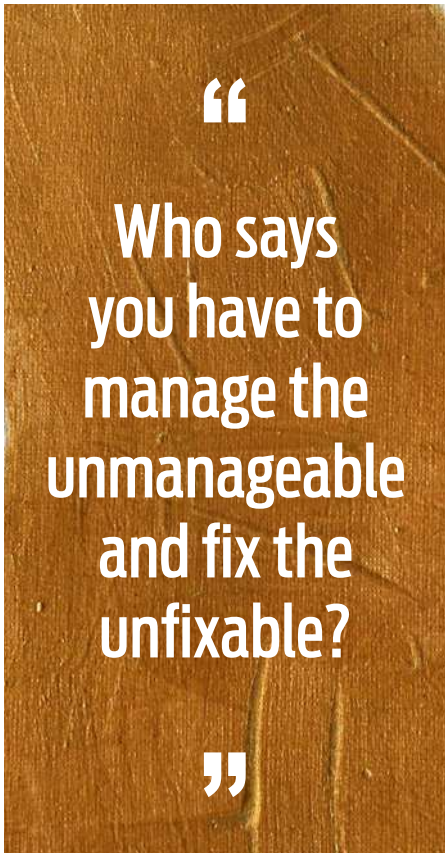
Over the years, I've guided people on these retreats and have seen great transformations in their physical and mental health. My role has been to help them formulate their intentions for their experience, and afterward to help them interpret and integrate what happened during the ceremony. I'd become adept at that task, but I'd never had the same deep visionary shamanic experiences as the people I was working with. So I arrive at this particular retreat thinking not much is going to happen for me. The first night of the ceremony, I'm with 23 participants in the tent. The six shamans come in, chanting. Outside, animals are howling, crickets are singing their song, and birds are chirping. And of course, nothing happens for me.

The next morning, the shamans come to me and say, "We cannot have you in the ceremony. You have such a dark, dense energy that our chants don't penetrate it, and not only that: it's dampening the effect of the work on everybody else." They fired me from my own retreat! I was completely sequestered from the others, and one of the shamans was assigned to work with me over the course of five ceremonies, while the rest of them worked with the group without me.

The shamans knew nothing about my history—nothing about how I'd been born a Jewish infant in Hungary and spent the first year of my life under Nazi occupation. They didn't know of my family's experience of the genocide. They were just relating to the energy they were picking up from me. They said to me, "When you were very small you had a big scare and you're not over it yet." They added, "You've been working with a lot of traumatized people and have absorbed their energies, and you haven't cleared that."

When it was over, they laughed as they told me that when they heard healthcare workers were coming from around the world, they thought their job would be easy, because their expectation was that they knew how to take care of themselves. But of all the groups that had ever come to them, this group was the heaviest bunch. None of them had done work on clearing their own stress.

In your therapeutic programs, how much training did you receive on clearing your own energy, when day in and day out you're absorbing the stresses and traumas of your clients? This is where the need for compassion for ourselves must come in. Because the problem isn't that we're compassionate toward others; it's that we aren't compassionate toward ourselves. We tell ourselves we must fix the unfixable.



Helper Syndrome

As the shamans so rapidly concluded, I did have a big scare when I was an infant. And it's true that I'd never cleared that out. That means I'm going to take that experience into everything that I do.

My life itself began under threat. In an effort to save my life, my mother gave me away to a stranger when I was a year old. I didn't see her for five or six weeks. The message I got was that I wasn't wanted. That wasn't the case. My mother giving me to a stranger was one of the bravest and most loving acts she could've performed. But that's not how an infant perceives it.

You know what you do if you're not wanted? You go to medical school. You justify your existence. The problem for all of us is the belief that we have to justify our existence. The problem is that we believe that how we show up is not enough.

My friend Peter Levine recently identified a question I'm sure we all ask ourselves: *Have I done enough?* Most of us have probably concluded, *Yes, I have.* And then Peter raised another question: *Am I enough?* That's a deep one. If you don't think you're enough; if, in your early experience, someone taught you that you're not enough, then one of the ways of compensating for that is to become a helper.

And we helpers will take on impossible tasks, like fixing the unfixable and managing the unmanageable. We have that helper syndrome. And it doesn't necessarily originate in terrible events. It can come from messages that are more subtly delivered by social expectations. In fact, our whole socioeconomic system largely runs on the belief that we're not enough and we need to accumulate more and more attributes or successes to prove that we are.

I was having lunch with one of my teachers, Bessel van der Kolk, and he said, "Gabor, you don't have to keep dragging Auschwitz around." In other words, I don't have to allow my own early experiences during a terrible time in history to define my view of myself. It took me a while to get it. I got it intellectually, but it took a long time to penetrate my heart. For a long time, I was still carrying around beliefs about the world and myself that had been conditioned by early experience—including the belief that I'm not enough. But I don't have to drag those beliefs around for the rest of my life.

What are you dragging around? That weight is what's creating compassion fatigue. So we have to ask ourselves: *If I'm not a helper, what am I?*

You may not find an immediate answer to that question. But I want you to ask it, because we have to know to what extent we identify ourselves with our roles. If our helper roles are taken

away from us, or if in a crisis they're deeply challenged, then who are we? That's what we drag around.

The Semipermeable Membrane

We're all working with a traumatized population, to different degrees, and are resonating on some level with our clients' traumatized or addicted energies. How do we keep ourselves from completely absorbing those energies?

At one extreme are those of us who become like a hard cell with a wall around it to keep out the suffering of others. That's very common, especially in the medical field. But it's a defensive response. That barrier between the professional and the other person means the professional doesn't actually see and feel the client's suffering. It turns you into the expert who knows what the problem is and how *you're* going to fix it. That kind of attitude is usually a response to trauma, and it can hurt a lot of people.

Human cells also have a protective surrounding, but it's not solid: it's a semipermeable membrane. It lets some things in and keeps some things out. In an emotional sense, we have to develop this semipermeable membrane. We have to feel our clients' pain without letting it overwhelm us. Our compassion can flow out to them so there can be healing, but at the same time, compassion must flow toward ourselves. Our job is not to fix the unfixable, but to help our clients live through—and if possible, grow spiritually through—the unfixable aspects of their lives.

The Five Levels of Compassion

For my own sake, I've distinguished five levels of compassion that help us support our clients' growth. This is not a schema; it's just how I see it.

Ordinary human compassion. That it's ordinary is not a reproach. It's great. It's part of who we are. It means that as you suffer, your suffering hurts me.

Compassion of curiosity and understanding. It's not enough to feel bad for somebody who's suffering: we must try to understand their stories. In the case of COVID, we have an opportunity to see what this existential threat and social catastrophe has evoked in people, and then work with that material, especially in terms of what it means to them. We do that with curiosity and understanding.

Compassion of recognition. This is the sense that I'm not different from the people I'm working with. That's what I found working in the Downtown Eastside neighborhood of Vancouver, one of the epicenters of drug use in the world. I spent 12 years with people who'd been highly traumatized, often abused in childhood, and were now living on the street.

I was different from them in the sense that I'd grown up in a much more functional family of origin than most of them. I was middle-class. I was well compensated for my work, and on and on. I'm not trivializing the differences, but in terms of the pain that I carried and my tendency to soothe myself through external behaviors and activities, and my propensity to lie and cheat, I resembled my clients to a great degree.

With the compassion of recognition, the decision to see our similarities means we're just two people—two people who've experienced adversity, neither better than the other. And to the extent that I can, I'll try to help you with what I've learned from my life and my professional training.

Compassion of truth. Much of what we call dysfunction or mental health conditions originates in compensations and adaptations that humans rely on to keep from feeling the pain of their trauma. So the dynamics that people demonstrate are always adaptations originally designed not by them, but by nature, to shield them. When you start to look into those, a lot of pain may come up within people. It's not compassionate to shield people from pain that's already in them. That's what I call the compassion of truth.

Compassion of possibility. The last form of compassion has been the most difficult for me. It emerges when you don't identify someone with their suffering or pain or history: you see the essential reality of the human being before you—and to do that, you need very clear eyes. As I described, I was dragging something around that Bessel van der Kolk had seen in me. Something that I couldn't let go of, but that I also couldn't see. He could see the possibility before me if I were to let that burden go. That's what I call the compassion of possibility.

It requires us to do a lot of work on clearing ourselves, because as long as I believe that I don't have the capacity to heal, I'm going to have trouble projecting that possibility onto others. I can go ahead and say that I believe in the possibility, but I have to experience it and move through it inside myself. That is ongoing work.

Gabor Maté, MD, a family practitioner for over three decades, is the author of four bestselling books, including When the Body Says No: Exploring the Stress-Disease Connection, In the Realm of Hungry Ghosts: Close Encounters with Addiction, *and* The Myth of Normal: Illness and Health in an Insane Culture.

BY IRVIN D. YALOM & BENJAMIN YALOM

An HOUR with Irv Yalom

Changing Lives in a Single Session

Several years ago, when he reached his late 80s, my father, Irvin Yalom, felt that he could no longer continue to see therapy clients long-term, as he'd been doing faithfully for almost 60 years. His memory was starting to "flake away," as he describes it, and he could no longer reliably recall critical details about his clients' lives, nor many of the precious moments that had passed between him and them in sessions.

He contemplated hanging it all up, turning in his therapist's badge and sailing off into some imagined sunset, but my father has never been one to rest on his laurels. He'd undoubtedly be restless, and the sense of purpose that had come from helping others—the central activity of his entire adult life—would gnaw at him ravenously. So he hit upon an unusual solution: he'd see clients for one-time consultations, single hours in which he'd attempt to offer both empathy and guidance—not to work miracles, but simply to help these fellow travelers a bit along their journeys.

This arrangement appealed for several reasons. First, after six decades of groundbreaking work as a clinician, he had unparalleled experience, and felt certain he could still be of assistance to those seeking help. Second, he was eager to see what useful lessons could be gleaned from this experiment, which he would report back to the field in the form of stories, an activity he's been engaged in ever since writing *The Theory and Practice of Group Psychotherapy* in 1970. Finally, it was, he freely admitted, a way of warding off his own feelings of uselessness.

Over the next three years, he met with almost 300 clients for single sessions. This period coincided with the covid pandemic, so meetings were held over Zoom—still novel at the time—with folks from all around the world. And from these meetings, he selected some 40 to write as stories, ones he believed might offer some insight into the workings of good therapy—or even into the vicissitudes, joys, and inevitable indignities of human existence. This collection forms the backbone of *Hour of the Heart,* the book from which this piece is excerpted.

The story you're about to read is written in my father's voice. Many therapists have read his books before, and some tell me they hear his encouraging voice in their mind when they're sitting with clients. But the book is also a collaboration between my father and me. By the time he stopped offering these one-time sessions, his memory had declined to the point where he could no longer hold all of these stories and the lessons within them. The sheer volume had become overwhelming.

Fortunately, we'd collaborated on his writing in the past. And as luck would have it, after many years as a theater director, I'd recently changed careers and joined the "family business" by enrolling in a PhD program in Marriage and Family Therapy, which meant I was able to work with him from a place of experience. Together, we wove a selection of these stories into a book that provides not just valuable lessons about therapy, but reflections on aging and memory loss.

The clients my father saw for these single sessions often had some knowledge of him beforehand, as well as great reverence for him given his standing in the field. But it's important to note that *all* therapists, famous or not, are powerful figures in their clients' lives. We should never underestimate that our caring presence is perhaps the most essential therapy tool when it comes to fostering change and growth. My father's approach to therapy focuses largely on the *here and now,* meaning that the real-time interactions between the therapist and client often reveal clues about why the client is struggling, and the relationship that develops between the two can become the locus of insight and of change. "It's the relationship that heals," my father often says. This approach relies less on the past than the present, and it's thanks to this therapy approach that this late-life experiment was even possible. As you'll see from the following story, the here and now is a great place to begin.

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Maya's face startled me. She was disarmingly beautiful, with dark reddish hair and green-gold eyes. Her smile was radiant, with a glow that seemed to reach out across the decades, bringing me back to my own youth for a moment. Ah, to have the feeling of immortality once again! She exuded a peaceful serenity from my computer screen, and I found myself somewhat off-balance, which was surprising. I am rarely so thrown by appearances and noted my response, wondering if her beauty startled others as well, and perhaps altered how they responded to her. I have worked with multiple patients for whom a beautiful face proved to be both a blessing and a curse, eliciting unwanted attention or special treatment, adulation from some and resentment from others. Both extremes skew normal interactions, and I suspected this would be relevant to our session.

> "The scenario she described spelled probable disaster to me and perfect delight to her."

I was still formulating a first question when she launched right into her reasons for contacting me. Obviously, I was not the first therapist she had seen.

"I'm 28. I've been with Charlie since I was 21, and I expect to marry him. But he is getting fed up with my preoccupation with Gilbert."

"Who is Gilbert?" I inquired. "And how long has he been in your life?"

"About three months."

"And he is?"

"I got him soon after he was born."

Curious! Was her evasion intentional?

Maya seemed delighted, and watched my confusion for a moment with an almost playful expression.

"Gilbert is my dog," she finally explained. "He's the light of my life. And that's my problem right there." Maya sat back in her chair. She appeared relaxed, with no trace of concern. Perfectly at ease.

"Fill me in. What's the problem?"

"It's obsessional thinking. And sometimes behavior. It's been my issue as long as I can remember. For years I obsessed about food, couldn't stop thinking about it. So I measured every gram of carbohydrates, every gram of fat that passed through my lips. I weighed myself constantly. That's pretty much all I remember from college, really. No great books. No wacky antics with friends. Just *How much did I eat?* and *Am I still beautiful?"*

"And what about now?"

"Now my obsessional thoughts are different—although that took a lot of work and a number of therapists, and a few not entirely inaccurate diagnoses of OCD and eating disorders. But now I obsess about Gilbert.

Here." She showed me a picture on her phone of her holding a small gray-and-white dog wearing a blue collar. "He's just so cute! I can't get him out of my mind. I worry about him all the time. *Is he eating enough? Is he lonely all day when I'm gone?* I go to class, and all I think about is poor lonely Gilbert. I know he needs to have another dog for company."

"And Charlie's attitude toward your dog?"

"I'd have to say, not good. Not good at all. Charlie works hard and has very long hours—he does commercial real estate. When he comes home, he's beat. I *know* he needs downtime, I *know* he needs my attention. But I absolutely *can't not* talk about Gilbert. I just can't. *Is Gilbert happy? What do you think, Charlie? He doesn't look happy. He's alone too much, by himself for hours at a time. He needs a friend. Shouldn't we get another dog to keep him company?* I know I should be thinking about my classes and about Charlie and about our future but, instead, it's always Gilbert. It's just so hard to think of anything else."

Her words were telling me that she was concerned, that she could not escape invasive thoughts, that there was danger there. It made sense. But her demeanor was serene, a simple beatific smile playing across her face. The dissonance was striking, and I felt sure it would prove important in the hour to come.

"My mind just goes on and on. Poor lonely puppy waiting for me," she continued. "*Of course* he needs company. Every living creature needs company. And Gilbert is just so small and new to the world. And so loving, and every day he must think I've abandoned him."

I had asked her about Charlie, and she had deftly steered the conversation right back to Gilbert, our conversation bearing out the pattern of her obsessive thoughts.

"And Charlie?" I redirected.

"Most of the time when Charlie gets home, I can't wait until he takes his coat off before I start talking about Gilbert. About how lonely he must be, and—"

"Maya, let me interrupt you. Let's really focus on Charlie for a moment. How does he respond to all of these Gilbert thoughts?"

> "I'm rarely so confrontational. Had I been too harsh? Was she ready to hear this?"

"Charlie is a kind, sweet man. He listens, and he truly cares for me. He doesn't say it, but I believe he's running out of patience. I know I talk too much about Gilbert and about my fantasy."

"Your fantasy?"

Now her face truly lit up, glowing with youth and joy. "My fantasy, my dream for the long term, is to move to this gorgeous forest area, just a couple of hours away from here."

"Tell me more," I said. "What do you imagine your life will be like there?"

"Well, I'll have nine or ten dogs. Gilbert would love it! He'll be jumping up and down with happiness and it will all be perfect."

"Perfect?"

"I mean I know we'll live happily ever after. Me and Gilbert and all the other dogs!"

I took this in for a moment. Her youthful smile suddenly seemed more naive, less glorious. Something seemed off. I grew up in the inner city and have never felt entirely comfortable out in the wilderness. Perhaps the strong negative response I was feeling was this bias? I examined my own thinking for a moment. Certainly one could live a wonderful life out in the countryside, even if it didn't appeal to me. That wasn't it.

It was the "happily ever after" that struck me as so strangely detached. My mind went to how she'd teased me at the beginning of our session, letting me imagine Gilbert was another man rather than a dog. Perhaps this was more of that playfulness? Maybe she was just joking.

"It will be beautiful," she continued earnestly. "Tall trees, dappled shade, puppies leaping and scampering about. So happy."

She appeared to be entirely serious. I started to feel concerned.

"And Charlie?" I asked. "Does he share this fantasy? How would he find work in real estate in the middle of the wilderness?"

"Reality, reality, I know! But Charlie can come with me. It's not so far away, just a couple of hours."

"So four or five hours of commuting daily?"

"Or he could spend part of the year here, working, and spend the rest of the year with me."

That serene smile never wavered. If Charlie was already struggling with her obsession with Gilbert, it was clear there was no real place for him in this new vision. How could she not see that?

"And do you think Charlie will be happy with this arrangement?"

"He loves me. And he'll see how

happy I am, how happy Gilbert is."

"And that will be enough for him? Enough companionship, driving hours to see you every once in a while? You did say that you love him and plan to marry him?"

"Oh yes. I know it will work out."

The more I pushed, the more committed to her vision she became. She believed her words. And she appeared truly excited about this fairy-tale future. Perhaps it was my lack of imagination, but I simply couldn't see how this could work without her relationship imploding, and who knows what else in her life falling by the wayside.

I pressed harder. "Maya, could you describe the typical day you imagine out in the woods?"

"I'll be happy with the dogs all day. I love training dogs. We'll take long walks, run around in the woods. Gilbert will be delirious. Sheer heaven."

"What will you do for work?"

"Train more dogs! And maybe some remote web design. Easy-peasy."

"And your evenings? Every evening alone, at least when Charlie's not there?"

"Well, that would be a bit of a problem. I'd probably use a lot of alcohol. When I'm alone I do tend to drink." She paused for a moment, with an almost pensive look on her face. For a moment I thought she would suddenly see the dissonance between the happily-ever-after fantasy and the real-life demands of her relationship, of her drinking, of having a satisfying life beyond the dogs.

Instead she turned back to me with a glowing grin.

I looked carefully at her face and again saw no worries, no concerns—only that unwavering smile. I felt as if we were living in two different realities, seeing the same set of circumstances in completely different ways. The scenario she described spelled probable disaster to me and perfect delight to her. Many of us seek out serenity, a calm disposition, and contentment in our lives. But I've learned that, paradoxically, too much serenity on the surface often indicates a denial of deeper problems. It can be a potent avoidance strategy. I wondered how far down Maya's self-deception went. At some deep level I felt she *must* be aware of the looming danger.

"Okay," I said, thinking I would play out a thought experiment with her, so she might see the probable results of her fantasy. "Let's look at this together. Let's imagine this all goes the way you've described it. Every day, Charlie needs to commute many hours to work so that you can live in the forest with your dogs? Does that sound right?"

"I'm sure it will all work out."

"You really don't see a problem?"

She shook her head and continued smiling that glassy grin. *What planet was she from?* I thought. *How should I proceed?* I noticed that I was unusually hesitant to confront her and trouble her supremely calm demeanor. This suggested to me that others who knew her, her friends and loved ones, might also find it hard to be honest with her about her relationship. Apparently no one had done so yet, and I realized it was now my unpleasant responsibility.

"I want you to hear something," I said. I pulled up the original email she had sent me and read aloud:

I constantly seek reassurance that I am beautiful and young as though it gives me some sort of immortality or importance. . . . I worry sometimes that I'll look back on my whole life wondering why and how I let myself waste it. This is why I'd love to work with you, Dr. Yalom–I believe you can help me find a way to not let my obsessions consume my future.

"I'm struck by your words in this email, Maya. You're making some important observations and I take your thoughts very seriously."

She nodded and continued smiling.

"I want you to pay careful attention to what I'm about to say. I think you are in great danger at this moment. You've been with Charlie for many years now. You say you love him and that you expect to spend your life with him. But from where I am sitting, that seems extremely unlikely unless something radical changes. You tell me that each night when Charlie comes home, exhausted from work, the only thing you can talk about is Gilbert—how lonely Gilbert must be, what Gilbert needs, how guilty you feel about not doing enough for Gilbert. I'm going to be very direct with you. This relationship is not going to last. The idea of living in the forest with ten dogs and Charlie is, I suspect part of you realizes, deeply improbable. You tell me that Charlie cannot work in the wilderness and that he is not interested in dogs. Forcing him to commute four or five hours sends the clear message that you value him less than you value your pet. I can't see anyone remaining in that relationship, and I doubt Charlie, however much he may love you, is the exception. So where would that leave you? Alone in the wilderness with 10 dogs and a bottle every night. Is that truly the life you want for yourself?"

Maya's smile finally faded.

I waited a few moments. She did not respond. "Here," I continued, "let me read these lines again":

I worry sometimes that I'll look back on my whole life wondering why and how I let myself waste it. This is why I'd love to work with you. . . . I believe you can help me find a way to not let my obsessions consume my future.

We sat silently together for several moments and then Maya, her face solemn now, spoke. "I'm a bit stunned by what you've just said to me, Dr. Yalom. Thank you. I've been waiting for those words. I needed to hear them. I consider your comments to be tough love."

"Yes, I think that is right," I said. "Think of it as a wake-up call."

"What do I do?"

"You'll have to find your way through the emotions and give your real priorities precedence over the obsessional thoughts."

"How?"

"It will take more than one hour, but fortunately this is something a good therapist should be able to help you through. I'll do some investigating

and send you contact information for a couple of excellent psychologists in your area."

I ended the session with mixed feelings. *I'm rarely so confrontational,* I thought. *Had I been too harsh? Was she ready to hear this?* One thing I was learning is that the effort to be truly helpful in these single-hour sessions often involved enormous time pressure, pressure that necessitated I make choices I would not otherwise, choices that don't follow the same logic as my accustomed therapy. In Maya's case, I resorted to a very direct confrontation, whereas generally it is far more effective to lead patients toward making these discoveries for themselves. As therapists we lay out possibilities and ask thought-provoking questions that often cause patients to consider how they are living, whether their actions align with their values, and whether their beliefs are serving them well, understanding all along that deep change has to come from within.

There is a difficult irony here because patients usually come to therapy in significant distress. What they want in that state, by and large, is a solution to the suffering they are experiencing, whether the problem appears to be external or internal. And this solution, they often imagine, is advice about what to do. But again, real change needs to come from the patient reconsidering their own tendencies and making a shift rather than being told what to do in a given situation. Almost always there is a lot less utility in my telling someone what to do rather than helping them overcome whatever internal obstacles they have so they can reach their own conclusions that better align with their deeper values.

But I was learning that there was little time for this in-depth process in most single sessions, particularly with someone as committed to her delusions as Maya was. In retrospect, I had attempted to let her see for herself how incongruous her fantasy life was with having a happy relationship with Charlie. I assumed the dissonance would shake her from her serenity, but it hadn't happened. Instead she'd responded, "I'm sure it will all work out!" So I'd given her a more direct shock by reading her own words to her and expressing my strong feeling that Charlie would not remain with her, a second-class citizen to her dogs. My uncharacteristically blunt words shook away her placid smile. Hopefully it would inspire her to get further sustained help. A follow-up email from Maya bore this out:

Dr. Yalom,

Please know that I did not feel unsettled at all by your words. On the contrary, I did not want our session to end. I don't have many people in my life who are truly honest with me. It felt liberating to hear you say out loud what I've feared but what no one will say.

You instilled a sense of urgency: I need to figure out how to be in my relationship sooner rather than later. I trust your expertise enough to know that if you fear for my future, then I should too.

A few weeks later I mailed her this story and requested her permission to publish it. She responded:

Reading this, I felt jolted again by the realization that I have been jeopardizing my relationship with Charlie. I even told him what you had said, and he did not deny the severity of the situation.

I laughed out loud at your wondering what planet I am from. I can't usually see how absurd my thinking is, but this made it clear. With the help of the therapist you suggested, I have decided to rehome Gilbert. I am devastated and I cry many times each day. Now I obsess over what it means that I can love a being so much and give him up. Still, I am thankful that our session enabled me to distance myself from my short-term fixation on Gilbert and focus on the importance of my long-term relationship with Charlie.

Part of me wants to scream that you've sucked the joy out of life. Why shouldn't I have a fairy tale? A happily ever-after, with puppies frolicking as the birds chirp in the meadow? But you're entirely right about Charlie, and probably many other close relationships. I love the idea of the puppies being so happy, but I do not want to live life alone, with wine as my primary non-canine companion. Still, on my sad days I shall think of you as "fun's executioner."

With gratitude,
Maya

Benjamin Yalom, PhD, AMFT, is a psychotherapist, theater-maker, and writer. He practices narrative and existential therapy, focusing on aligning one's values with one's way of living and unlocking creative approaches to work and life. Prior to his work in marriage and family therapy, he was the visionary force behind foolsFURY, an influential experimental theater group which helped transform San Francisco's performing arts scene between 1998-2020. More at www.yalomtherapy.com

Irvin D. Yalom, MD, is one of the world's foremost psychiatrists, a visionary therapist and internationally bestselling author who has helped define the fields of group psychotherapy and existential therapy. His textbooks Theory and Practice of Group Psychotherapy *and* Existential Therapy *remain standards for therapists in training worldwide, as does* The Gift of Therapy: An Open Letter to a New Generation of Therapists and Their Patients. *He's also the author of the* New York Times *bestsellers* Love's Executioner, Momma and the Meaning of Life, Creatures of a Day, *and* Staring at the Sun: Overcoming the Terror of Death. *A consummate storyteller, his teaching novels based in philosophical inquiry and psychological insight, including* When Nietzsche Wept, The Schopenhauer Cure, Lying on the Couch, *and* The Spinoza Problem, *have been bestsellers in multiple countries. Contact: www.yalom.com*

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A Special Case Study

BY LYNN LYONS & LINDSAY GIBSON

The Case of the BUSY CLIENT

TWO APPROACHES TO ANXIETY WHEN TIME IS SCARCE

How do you approach sessions with a client so busy they only want to see you once a month? Anxiety specialist Lynn Lyons, author of The Anxiety Audit, *and psychologist Lindsay Gibson, author of New York Times bestseller* Adult Children of Emotionally Immature Parents, *share unexpected approaches to working with a time-starved client.*

Meet Angelina

Angelina, a 23-year-old woman who's passionate about public health policy, is in her first year at a state college. She says she chose you as her therapist because she can tell from your books and YouTube videos that you're really good. She's been finding it hard to sleep, and her anxiety has gotten so bad that she's irritable all the time, barely eats, and can't keep up with her coursework. "I got a late start in college because my dad and mom needed me at home to help with my brothers," she says. "I really want a career. I want to graduate."

She shares that she's significantly older than her two younger brothers, who are seven and twelve. Though she lives on campus, she drives home a few times a week. "As the breadwinner, my mom has to travel a lot for her job," Angelina says with a shrug. "I try to lighten my dad's load around the house and get my brothers to their playdates and football practices. Dad makes fun of me a lot for being a nerdy college girl, but I think he only does it because he wants me home. He has panic attacks, and when he gets overwhelmed, he takes it out on everyone, and no one likes that."

As you wrap up your session, Angelina tells you she'll only be able to see you once a month. "Is that okay?" She believes seeing you weekly would only add to her anxiety since she has no time to spare. "But something is better than nothing," she says.

Tweaking, Not Quitting

BY LYNN LYONS

When I first meet Angelina and she tells me she believes I'm "really good" based on what she's read and seen, I ask her to explain. What was it about me and my approach that seemed like a fit?

"I had a call with another therapist that my cousin recommended," she said. "She sounded nice, but maybe even too nice, if you know what I mean. She wanted me to come in for a few sessions to start an assessment. But she used words that were, I don't know, therapist-y. No offense, but you sounded different. Like, let's get to work here. Let's go. You seem … direct."

"You don't have time to waste."

"Exactly. That's the problem. I don't have time. So spending lots of time trying to fix the problem of no time? Can't do it."

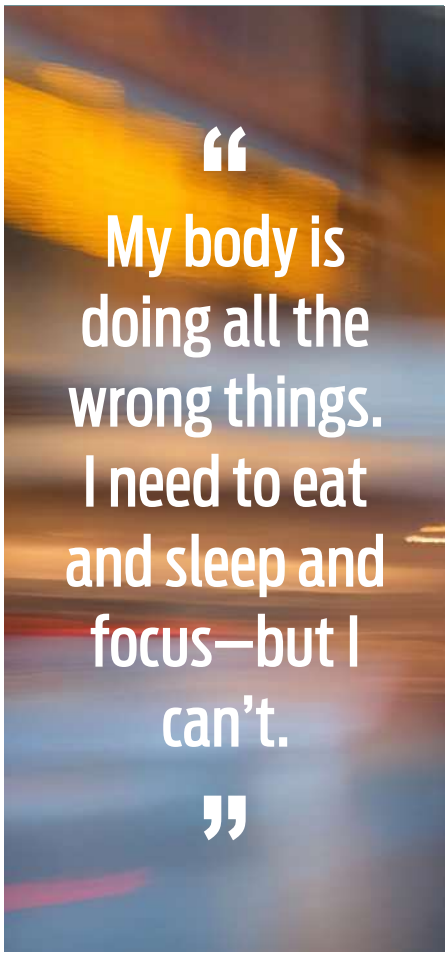
As Angelina explains her situation—trying to get through college while taking care of her brothers and accommodating her dad's anxiety and her mom's work requirements—her strengths are obvious. She's responsible, ambitious, organized, and strongly connected to her family.

"I know I can do this," she says. "I'm pretty confident in myself. That's why this situation pisses me off. I tell myself to suck it up and get it done. But my body is doing all the wrong things. I need to eat and sleep and focus—but I can't."

I spend several minutes doing basic psychoeducation about her anxiety symptoms and why they make sense. Even though she's not in actual danger, her primitive brain is receiving stress messages and responding as it's designed. "Your amygdala has no idea what college is," I tell her. "It's responding as if you're trying to escape a predator. Digestion and appetite often slow down, as does the prefrontal cortex, making higher level thinking a challenge." I tell her about worry and rumination, how an anxious mind likes to go over what has already happened and then fret about the future. Anxiety disguises itself as problem solving but rarely offers a solution. She nods along.

"I definitely tend to overthink things," she says, "but it helps me stay on top on everything I need to do. I have to be obsessive about planning it out. Even at night, no matter how exhausted I am, my mind keeps spinning."

"Your symptoms make perfect sense to me," I say. "But I think we need to tweak a few things. Your brain and body are responding as if you're in an emergency. You're not, of course, so we need to see how we can shift that a bit."



Angelina exhales. "I was afraid you were going to tell me I needed to drop out of school or stop helping my brothers," she says. "I'm not going to do that."

"*Tweak* and *quit* are two very different approaches," I say.

Angelina doesn't want to drastically change her approach to managing life. That's not why she sought me out. She needs and wants to help her family and is clear about her ambition of having a career. I think the biggest mistake I can make is offering suggestions that are in direct conflict with what she wants—and what she feels rightfully capable of achieving.

I'm reminded (as I often am) of an experience I had with a therapist almost 25 years ago. My husband and I were living in a new town with our toddler and newborn. My husband's job was not going well, and he was struggling, shutting me out. I had no close friends yet, so I made an appointment to talk to a therapist about what I could do to help my husband and our marriage. I made it very clear that I was *not* trying to decide if I wanted to stay or go. We had two babies, and I loved him deeply. But he was depressed, and I was stuck. "I feel like I've tried everything to reach him and nothing is working," I said.

"Well, you haven't tried everything," she said. "You could leave him."

The session ended politely. But when I got home, I called and left her a message. I wouldn't be coming back.

I tell Angelina we can play around with some ideas that might help ease the stress—but that I don't think she can get rid of it completely. "College? Brothers? Dad? It's a lot. I think some small changes might help tip the scales in your favor. But these are gonna be some busy years."

"Tweak away," she says.

We spend the rest of the session problem-solving, making adjustments. We give her worry a name, Stella, and practice responding differently to it. "Hi, Stella, not surprised to see you at all this week. But this is not an emergency. I'm gonna suffer a bit, but I got it." I explain how externalizing the worry allows her to notice its repetitive patterns and respond differently to its demands and catastrophizing.

She thinks she might be able to hire

a friend from high school to pick up the boys when she's loaded up with coursework. She agrees to pack snacks to graze on during the day, when her appetite or schedule isn't up for a bigger meal. And less coffee. The four cups a day are not helping. Two? Doable.

I teach her some of my favorite falling asleep hacks, like subtracting 7s from a big number or playing the alphabet game. She was a runner in high school but never exercises anymore. We talk about getting some of her school texts on audio, a service she thinks the college provides, so she can walk/run and listen at the same time.

"Does your dad have any information about how panic works, like the information I gave you? Basic stuff?" I ask.

"Oh god no," Angelina says. "He has no idea."

"He can come with you to any session, anytime," I tell her. "I don't even need any warning. I'll fill him in." In the meantime, I agree to make and send her a short video describing how anxiety works that she can share with him and use to remind herself when needed.

"You're excellent at saying yes. That's why you said *Yes!* to yourself about college and a career. Rather impressive. But I want you to practice saying no a bit more often. *Gosh, I'm sorry, that doesn't work for me.* I borrowed that phrase from a friend. I now pass it on to you."

When our time is up, Angelina asks if she can see me monthly. "Something is better than nothing," she says.

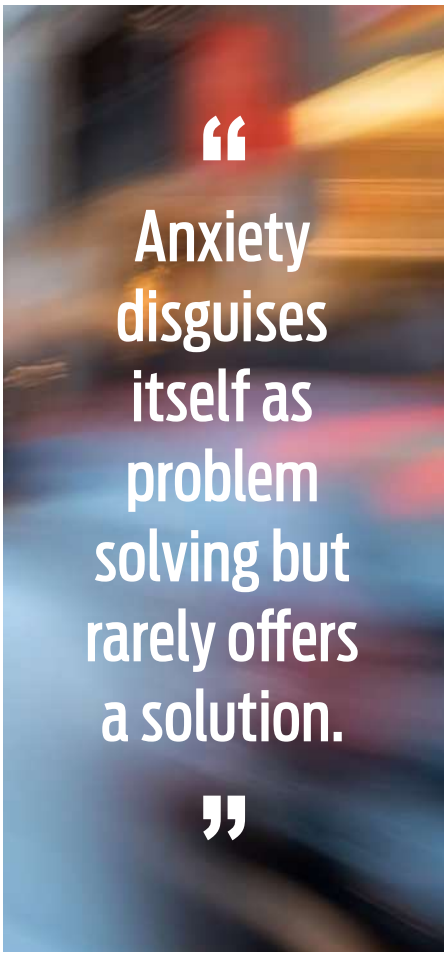
"Something *is* better than nothing. I completely agree," I respond and laugh. "I'm delighted you heard the message loud and clear."

Helping Anxiety Find Words

BY LINDSAY C. GIBSON

Once she took her seat in my office, the first thing Angelina said to me was, "I feel guilty taking up your time. There are lots of other people that need this more than I do." When I smiled, saying I was sure she had good reasons for being here and I was interested in all of them, she responded, "I just need a few tools to function better and not get so overwhelmed by stuff."

I could tell Angelina expected to scrape by on the bare minimum for herself. And the way she described her family role echoed what I've heard from many of the adult children of emotionally immature parents I've worked with. In fact, her parents had her in their late teens, and she told me her mother liked to joke that "they'd all grown up together." As her parents struggled to forge their careers and build their lives, Angelina had to look out for herself a lot. They called her an "old soul" and often confided in her about their adult problems. When her little brothers were born, she became even more of a parentified child.



In our first session, which included assessing for any issues of self-harm or suicidality, I focused on listening deeply and making an empathic connection with her. I wanted her to know that I took her anxiety and fatigue seriously. After all, most of the people in her life focused on her strengths and overlooked her emotional exhaustion. She told me about how hard she worked to be self-supporting and the scholarships she'd earned.

We seemed to have a good rapport, so I was a little taken aback toward the end of the hour when she proposed once-a-month sessions. If I accepted her monthly plan without discussion, would I be seen as sanctioning her bare minimum approach to herself, too? I didn't want to scare her off, but I needed her to know that I thought she needed more help than she was allowing herself.

"Angelina," I said, "your anxiety is partly due to how hard you're working, but I think it's also telling you that you're approaching an important crossroads in life where your choices are going to make a big difference. You're pursuing your dream, but you're also trying not to leave your parents behind. I get it, and I also get the impression that your parents are so used to your help that they may not be aware of how much pressure you're under. I think part of you is trying to decide if you have the right to think about yourself and your own future. I'm sympathetic to your schedule, but at once a month, it would be like starting over each time you come in. Your anxiety symptoms are making your hard job harder and need attention. Would you at least be willing to meet with me again next week so we can get to know each other better and then see where to go from there?

Angelina listened intently and nodded, confirming my hunch that her fear of being needy may have been more of a problem than her schedule. After a couple of weekly sessions, we ultimately agreed on a biweekly schedule, with the option to come in more if needed. This gave her the flexibility she wanted for attending her classes and caring for her brothers.

Although Angelina knew about my work regarding emotionally immature parents, she seemed reluctant to think of her own parents that way. So, I avoided that term when referring to her parents and stuck to exploring how their behavior impacted her emotionally. I saw my role as her adult witness, someone to help her find and connect with her true self instead of worrying about what everyone else thought.

With clients like Angelina whose precocious sense of responsibility makes them overintellectualize and deny their feelings, I like to use experiential, emotionally focused therapies, like Accelerated Experiential Dynamic Psychotherapy (AEDP) and Internalized Family Systems (IFS), along with imaginary-encounter techniques from Gestalt therapy and Emotionally Focused Therapy to make their sessions more emotionally vivid.

After experiencing a particular anxiety-filled night, Angelina came to our session bleary-eyed. "Your anxiety is signaling you again," I told her, "so let's help it find words. Close your eyes if that helps you visualize—you can always open them whenever you want. Imagine this anxious part of you as an actual little person. What does it look like? Can you silently interview it and ask it what it's afraid of? Listen to what it says and then if you like, you can report back to me."

Angelina initially resisted these imagined encounters because she'd been trained to dismiss her inner world, but after some surprising revelations, she saw the value of experimenting with them and seeing what happened. She started using inner dialogues as a way of dealing with her anxiety. She learned to take it as a cue to start journaling and dig into what she was really worried about, which validated to her how overwhelmed her inner child felt. We also worked with the moralistic part of her that insisted she could only be a good person if she did whatever her parents asked.

AEDP techniques were especially helpful in finding and focusing on her feelings in sessions, as a way of reconnecting her with her core self. As we connected these feelings back to events in her life, Angelina began to see that her emotions made sense, and the more she allowed herself to share whatever popped into her head, whether it made sense or not, the more self-expressive and spontaneous she became.

Gradually, her newfound connection to her feelings led her to experience a healthy self-protectiveness. She started considering her own needs instead of just her parents', which translated into increased assertiveness and better boundaries on her part, like giving them dates each month when she could help out (while reserving necessary study and recreation time for her own mental health). At first, she felt guilty for not being at their beck and call, and a part of her accused her of being selfish, but this predictable self-criticism lessened as she grew more comfortable making decisions that supported her well-being.

Often, one of the hardest things for adult children of emotionally immature parents to accept is interest and validation from others. They need the mirroring support that they didn't get with their parents because it helps them become conscious of their true self and its needs, but they often feel overwhelmed by this emotional intimacy and pull back. The AEDP technique of meta-therapeutic processing—a method in which the client is encouraged to talk about a moment of closeness with the therapist—was perfect for this.

"Angelina," I said, "You've really opened up and told me some heartfelt things today. I'm so pleased that you felt safe enough to do that with me. Can we tune in for a moment and talk about what it's been like for you today to share these things with me?"

"It feels good, but I feel a little silly, like you must get sick of hearing about this."

"Not at all. In fact, our conversation feels deeper and more alive when you tell me what it's really been like for you. But tell me more: in what way does it feel good?"

Angelina exhaled deeply: "It's a relief. I feel like you get it. It's like taking a boulder off my chest. I feel lighter somehow, like maybe I'm not such a selfish person after all. Like maybe I'm just trying to live too."

"And what's that like for you, to feel that?"

"Freer, more lighthearted, not worrying about other people's opinions. It feels good to be seen."

These conversations about our interactions gave Angelina the experience of communicating honestly and at a deeper level with another person—something she'd rarely done, since she'd mostly focused on others. Also, our emotional intimacy helped her feel more confident opening up to others outside our sessions and trusting that other people could give her emotional connection and support, too.

Angelina and I ended up working together throughout her time in college, navigating many mini crises with her family while she experimented with healthy independence. Our greatest accomplishment was that she learned to pay attention to how she felt and build a more protective relationship with her own self. She gradually began setting boundaries that allowed her parents to figure out new ways of handling their problems and parental responsibilities.

Her anxiety and guilt steadily lessened as she questioned the legitimacy of pleasing others at her own expense. Mostly, she got to know herself and grew to like who she was inside, even when her parents were disappointed or upset. And she felt like a good person even when she wasn't fulfilling someone else's expectation of her.

Lynn Lyons, LICSW, is a speaker, trainer, and practicing clinician specializing in the treatment of anxious families. She's the coauthor of Anxious Kids, Anxious Parents *and is the cohost of the podcast* Flusterclux. *Her latest book for adults is* The Anxiety Audit.

Lindsay C. Gibson, PsyD, is a licensed clinical psychologist and author of the New York Times bestseller, Adult Children of Emotionally Immature Parents.

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BY RYAN HOWES

Managing the Mind to Change the Brain

HOW COMMON BRAIN MYTHS DERAIL THERAPY


CAROLINE LEAF

We're therapists in 2025, so we know a lot about the human brain, right? Well, according to Caroline Leaf—clinical and research neuroscientist, author, and host of the popular podcast *The Dr. Leaf Show*, which has over fifty million downloads worldwide—we're missing some critical information that could directly affect our work with clients and how we try to help them create lasting change in their lives.

Having spent 40 years studying the mind-brain-body connection, habits, neuroplasticity, and the best methods for enhancing treatment approaches in healthcare, she believes therapists and other helping professionals must understand the distinction between the mind and the brain—often considered synonyms. After all, when we mistake the brain for the mind, our treatment moves unnecessarily slowly—or worse, gets derailed.

Leaf's popular books *Switch on Your Brain* and *Cleaning Up Your Mental Mess* deliver her complex neuroscience messages to the masses in accessible language that supports people in creating healthy habits in only 63 days. No, it was never 21. Her latest book, *Help in a Hurry*, empowers people to harness mind management in moments of stress, turning breakdowns into breakthroughs and paving the way for lasting transformation.

In a recent meeting of minds, not brains, Leaf helped me grasp the mind-brain-body connection and how I could introduce "mind-management" into my practice.

Ryan Howes: You've written books about parenting, stress management, nutrition, brain injury, and mindfulness research. Is there a through line in your work?

Caroline Leaf: I'm a communication pathologist and clinical research neuroscientist focused on psychoneurobiology—the connections between human experiences and behaviors. I completed interdisciplinary training 40 years ago combining medicine, psychology, communication, and pathology, giving me a broad understanding of the mind-brain-body relationship.

My core philosophy: the brain and body don't drive the show—the mind does. The brain and body host the mind. In the late 1980s, I conducted pioneering neuroplasticity research showing that when you manage your mind, you change your brain and body. This applies across conditions from head injuries and neurological issues to Parkinson's, Alzheimer's, learning disabilities, and emotional trauma.

I teachmind management—a comprehensive approach that touches every area of human life, since without our minds we cannot do anything. It involves consciously guiding your thoughts to produce beneficial biochemical reactions in the brain, reduce stress, and support overall health and resilience, which I discuss in detail in my books *Cleaning Up Your Mental Mess* and *Help in a Hurry.*

RH: I'd love to hear your theory of mind.

Leaf: Essentially, *mind* is a simple word for consciousness, soul, and spirit. Mind has three levels: the conscious mind we're all aware of; the subconscious mind, where we store reactions and habits; and the nonconscious mind—something few truly understand. The nonconscious mind is your 24/7 driv-

ing force: your reasoning, wisdom, intuition, and insight. It's your constant companion that absorbs everything. Collectively, these three parts of the mind are 99 percent of who you are. Brain and body are about one percent.

Every problem we've experienced or created, and every solution, exists in our mind, along with every life experience from the womb to now—all stored as thoughts made up of memories. Your nonconscious holds it all. It's infinite in space, operates at beyond 400 billion actions per second, and drives not only your psychology but your neurophysiology. Your mind makes your heart beat, your lungs breathe, your genes work.

RH: So how does the mind change the brain?

Leaf: Neuroplasticity is often described as the brain changing itself, but it actually takes the mind to change the brain.

Researchers have located basic memory and emotion in specific brain areas, but they've never found regions that generate reasoning, abstract thought, or meaning. That's the mind's domain. The brain is a responder, not a generator. Neurosurgeon Walter Penfield's research demonstrated that the brain responds rather than generates—everything is processed through the mind first, then stored in both brain and body.

The mind creates meaning and processes experiences rapidly, sending this information to the brain as energy. This energy triggers electromagnetic, neurochemical, and genetic responses, wiring experiences into our neural and bodily systems. Memory isn't just stored in the brain—it's throughout the body, as somatic and PTSD therapies recognize.

Despite this, biomedical research still focuses primarily on the brain, treating depression as faulty neurons or genes while spending billions trying to locate abstract thought in brain regions. This resembles modern phrenology.

The reality is more complex: we function through a mind-brain-body network in constant flux. Therapists intuitively work with this when they examine how clients show up, trace these patterns, and help redesign better functioning.

Building new habits takes real time—research shows lasting habit formation requires 59-254 days, not just quick fixes.

RH: I've always heard that it takes 21 days. I'm guessing your work proves that wrong?

Leaf: The popular "21 days to change" idea largely came from surgeon Maxwell Maltz, who noticed his patients adjusted to surgery results in about 21 days. He applied this to all behavior change, but research shows real transformation takes at least three 21-day cycles.

In the first 21 days, you build awareness, deconstruct root causes, and start reconstruction. By day 21–28, you may feel progress, but stopping here is a "danger zone"—the change isn't stable yet. Continuing for two more cycles (42 days) helps solidify new patterns, especially in therapy.

In my opinion, therapists should focus on one issue per 9–12-week cycle rather than juggling multiple problems. The mind-brain-body is organized; without structure, neuroplasticity becomes chaotic. Mind-management teaches self-regulation to drive intentional brain rewiring and lasting change.

RH: As therapists, we're trained to follow the client's lead, so we can cover 10 different topics in a single session. You're saying it's better to focus on one topic for multiple sessions—maybe for nine weeks—to solidify growth and change?

Leaf: Yes. Real change takes time—at least three 21-day cycles. In the first cycle, clients build awareness and start deconstructing root causes. By around day 21–28, they often feel progress and want to move on, but this is a danger zone because the new pattern isn't stable yet. Continuing for two more cycles (another 42 days) helps solidify change.

This means it's more effective to focus on one issue for 9–12 weeks rather than covering multiple topics in one session. Organizing therapy this way aligns with how the mind-brain-body rewires itself, creating lasting growth instead of cycling through unresolved issues.

RH: That's quite a shift. What's one thing you hope therapists will take from your work?

Leaf: Understanding the difference between the mind and the brain is transformative**.** It shows that you're not limited by your biology—you can actively direct change. When you grasp what the mind truly is, you unlock the ability to harness it, integrate mind management into your practice, and help clients rewire their lives with purpose and hope.

Caroline Leaf, PhD, is a clinical and research neuroscientist and researcher known for her work on the mind-brain connection, mental health, and the power of thought to change the brain. She has authored several bestselling books, including Help in a Hurry *and* Cleaning Up Your Mental Mess. *She also hosts the popular podcast, The Dr. Leaf Show.*

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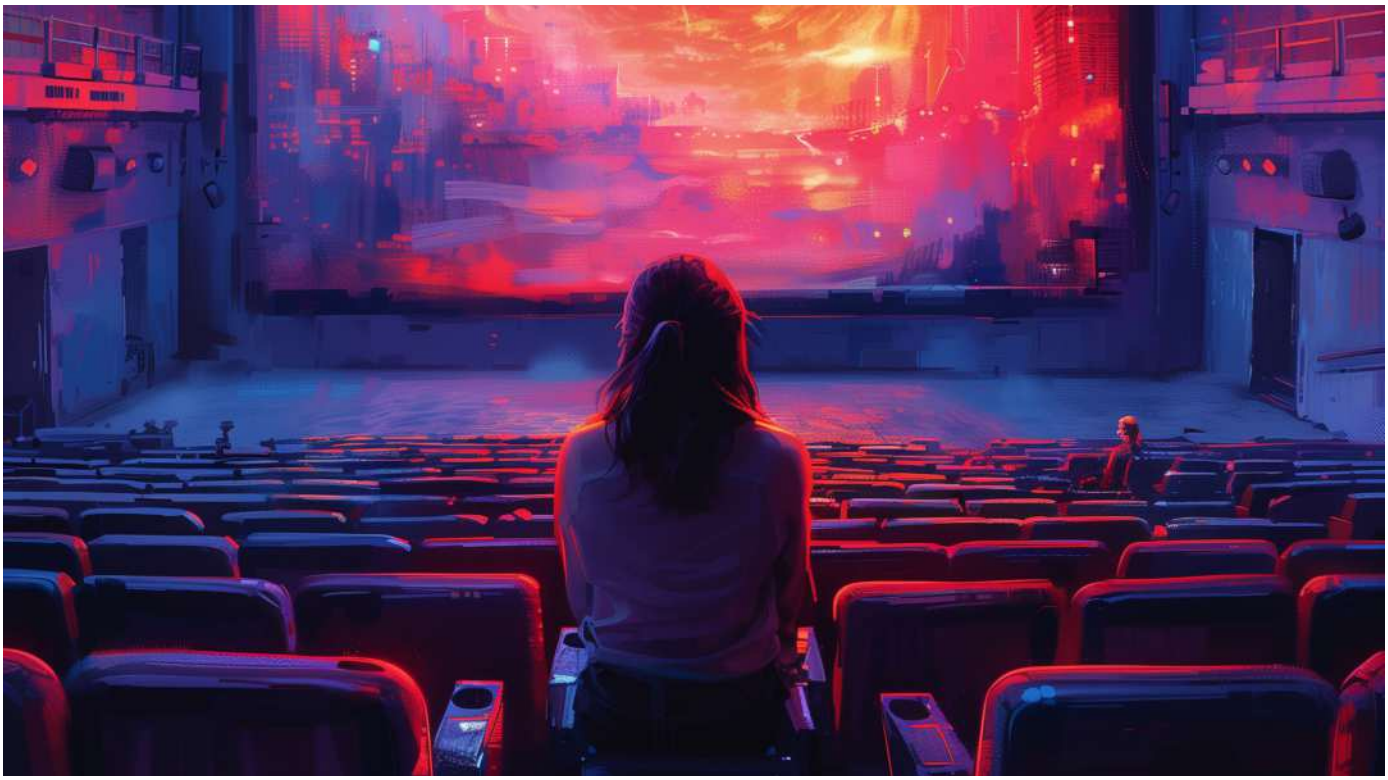
BY LYNN LYONS, KRISTA NORRIS, JOE KORT & RACHAEL CHATHAM

4 Top Therapist-Recommended Movies (Part 2)

FROM SEXUAL HEALING TO FACING OUR COLLECTIVE SHADOW



There's nothing quite like unwinding with a good movie after a long day–for therapists and clients alike! But this engaging form of entertainment could actually be a pathway to healing. Readers loved our last piece on therapists' favorite films so much that we asked four more therapists to share their top-recommended movies.

Perfect Days

BY LYNN LYONS

Perfect Days, a Japanese film by German director Wim Wenders, opens at dawn with the simple morning ritual of Hirayama (Koji Yakusho) as he prepares to start his workday cleaning public toilets in Tokyo. He puts away his bedding, washes his face, brushes his teeth, gathers his keys and coins. He chooses a cassette to play in his van as he commutes, classic '70s stuff carefully curated. He listens but does not sing along. Exciting? Nope. But this film is entrancing. Delicious.

When I first watched *Perfect Days,* I was curious how and why it pulled me in so deeply. It's a beautiful movie, which was nominated for a 2023 Academy Award for Best International Feature Film, so I'm obviously not alone in my appreciation. But what's going on here, and why do I want all my anxious teen and adult clients to see it? I think it started with the ease of quiet observation and the pull of Hirayama's smile—and it expanded from there.

We first see this expression—a small smirk, really, that lives in Hirayama's eyes—as he leaves his apartment and looks at the trees and early morning sky. We don't hear his voice until 13 minutes in, when he has a brief conversation with a lost boy that he reunites with a frantic mother. As the boy turns and waves goodbye, we see Hirayama's full-faced smile. From that moment on, I was hooked.

We don't know much about Hirayama, at least not through anything he or other characters say. He moves through his routine with precision, and it's clear he's repeating a pattern: waking, commuting, working, bathing, eating, reading, sleeping. His young and talkative coworker finds him to be a mystery. "How can you put so much into a job like this?" he asks. "Not that I'm expecting an answer."

It is, on the surface, about a job well done: taking pride in a task. But it's also about connection: recognizing our impact on each other, moving through human "messes" with serenity. Hirayama doesn't get pulled into the more urgent stories of those around him. He's alone much of the time, but is he lonely? Research says that lonely people

tend to be more self-focused and less responsive to others. That's not what we see here.

So here's an assignment I sometimes like to give an anxious client related to this film: First, watch the movie and notice the many types of connections that occur. Then, notice the flexibility the character exhibits, even within a quite ordinary routine. Anxiety, depression, and loneliness are internally focused states. They draw us inward. Anxiety can *disguise* itself as connection when it takes the form of hypervigilance, but even when anxiety thinks it's observing the outside world, its goal is narrow: to selectively collect data for use by a catastrophic, anxious *internal* imagination.

By the end of the movie, we suspect that Hirayama's solitary life is a choice, or at least a destination born of the complexities of family. How we fill in the pieces of his story—and where our own focus lands—is, I suppose, what makes this movie so useful therapeutically. What's the story we project onto Hirayama? Do we value, crave (or feel anxious) in the quiet? The routine? The connections? The gratitude? The messes?

What *is* a perfect day? And how do we so often miss it?

Lynn Lyons, LICSW, is a speaker, trainer, and practicing clinician specializing in the treatment of anxious families. She's the coauthor of Anxious Kids, Anxious Parents *and is the cohost of the podcast Flusterclux. Her latest book for adults is* The Anxiety Audit.

Sinners

BY KRISTA NORRIS

In his powerful film *Sinners,* director Ryan Coogler invites us into a haunting story I believe will enrich and enhance therapists' perspective on individual and collective trauma. *Sinners* is far more than a historical drama-thriller. It's a psychological excavation that unfolds deep within the psyche of its characters and invites viewers into a similar excavation. Through the eyes of Smoke and Stack, two Black WWI veterans hoping to open a juke joint at an old sawmill, we journey back to the Mississippi Delta, an American landscape steeped in memory, violence, and ancestral grief.

As a therapist who specializes in integrative work with unconscious patterning, I help clients uncover the deeper currents shaping their lives, including ancestral wounds, internalized narratives, and long-buried emotional material that may reveal, for instance, why someone sabotages intimate relationships or feels haunted by a grief they can't name. The foundation of my work is in depth psychology, which invites us to explore the shadow, the parts of the psyche that remain hidden. In *Sinners*, that shadow isn't just personal—it's a cinematic descent into the American unconscious, where trauma, systemic oppression, and repressed history collide.

Jim Crow racism, postwar disillusionment, and generational pain rise to the surface in a story that mirrors the collective trauma of a country that's never fully reckoned with its past. When Smoke and Stack return home as wounded warriors—both physically and psychologically—their shift from soldiers to bootleggers in the South represents more than moral ambiguity. It reveals the fragmentation of identity in the face of war and racial violence and quietly asks hard questions of its characters—and of us as viewers: *Can we interrupt the cycle of silence and trauma passed down through generations, or are we destined to repeat it? What parts of our national identity have we denied? And what would it mean to face our collective shadow, not as an act of blame, but as a step toward healing?*

In a time where racial trauma and historical amnesia continue to shape not just politics and our institutions but mental health, *Sinners* offers more than critique. It offers a mirror. For those of us working in the field of psychology, it reminds us that true transformation doesn't come from turning away. It comes from turning inward and confronting what we've refused to see.

Krista Norris, LMFT, has over 15 years of experience in the field of mental health. She's an integrative therapist specializing in depth psychological approaches and is currently pursuing doctoral research at Pacifica Graduate Institute, where she explores trauma, cultural identity, and healing through symbolic and somatic lenses.

Babygirl

BY JOE KORT

Babygirl, written, directed, and produced by Halina Reijn, is one of the most honest and realistic representations of the power of kinky/fetish eroticism that I've seen depicted in mainstream cinema. In it, Nicole Kidman plays Romy, a high-powered CEO who enters into a kinky relationship with her much younger intern, Samuel, played by Harris Dickinson. As a sex and relationship therapist who's been practicing for 40 years, I can't even begin to tell you how often I've worked with clients struggling with shame around kinky or fetishistic sexual desires, and how often I've run into denial and bias in other therapists when I tell them that kink and fetishism isn't uncommon, pathological, or unhealthy.

Many therapists today recognize that powerful men often engage in degradation and submission rituals, in which they surrender power and allow themselves to be humiliated, whipped, collared, insulted, and made to perform degrading acts. I've heard this kink framed as the psyche's need to find balance in lives that are otherwise weighted toward hyper-responsibility. That *Babygirl* gives the viewer the underappreciated feminine side of kink made me want to cheer. As a culture we're sadly uneducated about

the vast range of human eroticism across genders.

Far too often, therapists are held captive by their own bias and cultural preconceptions about what "sex" is. For them, the heteronormative standard is penetrative sex. Overtly or covertly, they try to change the erotic orientation of clients who come to them expressing a vastly different type of sexuality and fantasy life. Not only is this harmful, it's a fool's errand. For many, kink and fetishism isn't just "sexual." It *is* sex. Kinky, fetishistic fantasies aren't going away, despite society's or therapists' well-intentioned efforts to tamp them down or make them more palatable by heteronormative standards. Try as those who prefer heteronormative sex may, they'll never succeed at eliminating the sexual satisfaction derived by those who find dominance games, role-play, and even having a kinky affair (as in Romy's case) with a younger subordinate to name a few.

In my work educating therapists about the role of kink and fetishism in sexuality, I've often found it helpful to highlight that virtually *all sex* is a form of theater. It plays out in the mind, not just in actions and behaviors. Again, in the case of kink/fetish, that theater *is* embraced as sex itself. It requires no penetration, only one's erotic imagination. In Romy's case, the sex is mental. It's the fantasy and power exchange between her and Samuel that she finds erotic and fulfilling. After decades of hiding this "shameful" part of herself from her husband Jacob (played by Antonio Banderas), she also finds it deeply healing and empowering.

Validating someone's erotic experience is the key to opening them to understanding their feelings, helping them deal with shame, and finding healthy ways to express their eroticism. With clients, that may mean having discussions about opening their relationship, encouraging them to talk about it with their current partner, or even supporting them in their search for a partner who'll help them discover the origins and potentially liberative power of their eroticism.

In *Babygirl*—as Romy embraces her true sexuality with Samuel—she awakens to a far more vibrant, animalistic part of herself—and ultimately becomes more whole and fulfilled. Given that those who stray into forbidden zones of erotic pleasure often meet a grim fate in mainstream movies *(Faithful, Fatal Attraction, The Duke of Burgundy)*, this is truly a revolutionary take on what can happen when we honor and support our clients' uniquely personal sexuality.

Joe Kort, PhD, LMSW, is a board-certified sexologist and the founder of The Center for Relationship and Sexual Health. He's been practicing for 40 years with a specialty in sex therapy, LGBTQ-affirmative psychotherapy, sexually compulsive behaviors, and IMAGO relationship therapy. He's the author of several books, including, LGBTQ Clients in Therapy, 10 Smart Things Gay Men Can Do To Improve Their Lives, *and* Is My Husband Gay, Straight or Bi?

Into the Wild

BY RACHAEL CHATHAM

As a complex trauma specialist, I work with many adults who have an avoidant attachment style due to early relationship wounds at the hands of unreliable, unavailable, or highly critical caregivers. As a result of these wounds, my clients often harbor elaborate fantasies about finding a way to escape the challenges and pain that accompany complicated, imperfect relationships with friends, family members, and romantic partners.

It makes sense that they want to "leave it all behind" and so often ask: *What's the point of trying to build or hold on to relationships if they only lead to disappointment and frustration?*

For adults struggling with this question, I often recommend the movie *Into the Wild*. I saw this film 15 years ago, and it shifted my perspective on my own hardened individualism and how I related to others. Based on the book of the same title by author Jon Krakauer, it's the true story of Christopher McCandless, a college graduate who stops communicating with his family, donates his money to an organization dedicated to alleviating global poverty, and divests himself of all material possessions other than a rifle, some rice, and a few books. Having dealt with major betrayals by his parents and harboring a deep belief that "people are bad to each other," he's eager to opt out of the post-college expectations people have placed on him and hit the open road in search of freedom, truth, and connection with nature.

Eventually, he makes his way to Alaska, where he's determined to spend quality time by himself, completely off the grid. I won't spoil the movie by telling you the end but suffice it to say that you should probably keep a box of tissues on hand. McCandless comes to an important realization, one that my clients with avoidant tendencies benefit from hearing: people need people. We're an interdependent, albeit imperfect species. We're all trying to figure this relationship thing out, and the right people—the trustworthy humans that add joy, value, and meaning to our lives—do exist. We just need to find them.

Rachael Chatham, LCMHC, specializes in working with adults navigating complex relational trauma. With certifications in Traumatic Stress, Buddhist Psychology, and Schema Therapy, she combines depth-oriented insight with practical tools to help clients deepen self-awareness, strengthen self-compassion, and build healthy communication skills.

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

From the Archives: March/April 2023

BY CRAIG MALKIN

Covert Narcissism Unmasked

WHAT ARE WE REALLY TREATING?

Jake, a 34-year-old, white software engineer, called me in a panic one day, voice trembling, because his relationship of two years was falling apart, pummeled by daily fights. Slumping into my couch, he tearfully let an armful of papers spill around him.

"Can I share some of these emails with you?" he blurted out before even saying hello. As I paused to let some air move between us, he glanced around my office and scowled at a blue abstract painting on my wall. "She doesn't get how hard it is for me at work," he said, suddenly looking sad again. "She inundates me with emails about how I don't listen. She doesn't understand because she's never had a job like mine." His fists clenched as he spoke.

And that's how we began. Jake shared his story in bits and pieces, punctuated by fits of tears. His job sounded stable enough—his boss often applauded his work—and he had friends, though his circle seemed to have dwindled over the years. But as he described his life, one theme stood out: "No one has ever really understood how I feel," he kept repeating, and each time, the statement seemed almost too much for him to bear.

We'd clearly jumped right into the work, or so it seemed, but something felt missing. Throughout it all, I noticed that despite all the tears—despite the trembling and beseeching glances—his story didn't resonate emotionally the way other clients' pain usually did. It was as if I was hearing a melancholy ballad, but the instruments were off-key.

And there was something else. I had a familiar sense of invisibility in his presence. I felt, in fact, quite irrelevant.

Granted, there was nothing pompous about Jake. He didn't even seem to feel especially proud of himself, either his looks or his job or his accomplishments—quite the opposite, in fact. His story was one of failure; of feeling unrecognized, disappointed, and misunderstood; and above all, of feeling a deep and abiding sense of aloneness in his misery.

That sense of aloneness seemed accurate, given that his girlfriend, friends, and even some coworkers had all but faded from his life, turning away from his suffering. He was in deep pain—that was clear. But the way he carried and conveyed it never seemed to elicit the kind of support he longed for. If I'd been honest, I myself wasn't yet feeling compassion for him.

I knew his problem: Jake was a narcissist. He just wasn't the kind we're used to hearing about.

Most of us, when asked to picture a narcissist, rarely conjure visions of someone like Jake—mournful, shy, and self-doubting. Instead, we imagine a loud, vain, preening, braggart; reality TV stars often come to mind. This vision of narcissism that we all know and loathe doesn't stray far from the mythological figure who inspired the term. Many therapists dread the client who monologues about their talents, shrugs off all efforts to help, and vehemently denies even fleeting moments of fear or grief—and with good reason. It can be nearly impossible to help this type of narcissist because their entire sense of self is based on never needing someone's help in the first place.

Sometimes people with extreme narcissism can't engage in therapy at all—a sad truth we all have to accept. It's a humbling experience when clients remain so rigidly rooted in defense that their message in the room is essentially: *you have no impact, and you never will.* Impasses like this confront psychotherapists with a harsh reality: we can't help everyone. Regardless, the extraverted, grandiose narcissist is just one version of narcissism, and it turns out, there are several others.

Narcissism, at its core, isn't simply about feeling handsome or rich or brilliant; it's about feeling special, exceptional, or unique, standing out from the other nearly 8 billion people on the planet. Contrary to what we might expect, all human beings, if they're happy and healthy, show some degree of this tendency—a fact proven time and time again when narcissism is measured as a trait.

Indeed, across the world—from the most collectivist cultures, like those in China and India, where the health and happiness of the group is prioritized, to the most individualistic Western cultures, where autonomy and individual ambition are valorized as the pinnacle of personhood—everyone falls somewhere on the narcissism spectrum. What's more, research shows that a *slight* overestimation of oneself, a moderate dose of feeling special, helps people maintain ambition, overcome obstacles, and deepen relationships. It's a personality asset my colleagues and I call *healthy narcissism*.

Picture a line from 0 to 10, moving from left to right. As someone's narcissism grows well above average (around 7), they climb high enough in the trait to earn the label *narcissist*. (At 0, we find the opposite problem, *echoism*, where people fear or don't believe they deserve special attention—or any attention at all.) In extreme narcissism, people slip into pathology at the highest end of the spectrum, around 8 to 10, meeting criteria for narcissistic personality disorder (NPD). Here's where we find the core of pathological narcissism, The Triple E: *exploitation*, doing whatever it takes to feel special, even if it hurts others; *entitlement*, acting as if the world should bend to our will; and *empathy-impairment*, becoming so driven to feel special that we lose sight of the needs and feelings of others.

Working with clients high on the narcissistic spectrum may mean accepting that some people don't want to be reached at all—yet. But we can still retain faith that we offer something unique that makes us suited to helping people, whatever that quality is—warmth, wit, commitment, generosity, flexibility, honesty. Succumbing to the idea that helping a client is all there is to us as clinicians—*this alone is what makes me worthwhile*—is what drives narcissism in the first place. If we want to help people with NPD and remain healthy, we have to resist the temptation to fall prey ourselves to this belief.

It wasn't obvious, but Jake was living at the upper end of the spectrum as what we'd call a covert narcissist. Other qualifiers that are sometimes used to describe this type of narcissism include introverted, vulnerable, and hypersensitive. Rather than feeling special by virtue of positive traits, Jake believed it was his emotional pain that made him unique. Covert narcissists like Jake agree in self-report with statements like "I'm temperamentally sensitive compared to most people" and "Few people understand my problems." Their grandiosity is hidden—hence covert.

And that's what's so incredibly vexing for clinicians. Covert narcissists, because of their willingness to admit to problems, are far likelier to show up to therapy than the extraverted narcissists of reality TV—and their eagerness to share their struggle can make them feel like ideal clients. On the surface, they often long for help, care, or closeness. Unfortunately, at a deeper level, their need to feel special eclipses their ability to receive help. Feeling truly supported and understood raises the specter that their pain might actually be understandable, perhaps even ordinary, leading to a continual push–pull between client and therapist: covert narcissists demand we attend to their suffering, but as soon as we make contact with their wounds, they find ways to erase our efforts to meet them. They ignore our words, bristle as if attacked, or simply change the subject.

Their grandiosity also blinds them to their own growth potential. Covert narcissists often feel failed, lonely, and misunderstood, but dream of being great and recognized one day—a metric by which they relentlessly and silently measure their failures. This, in their minds, makes every success trivial, even therapeutic ones. They harbor an inflated sense of the importance of their problems—as if no one else has ever experienced their depth of suffering, making it that much harder to relinquish. And they appear vulnerable in a way we seldom equate with narcissism: open tearfulness. Their sadness is often mixed with aggrieved rage. This inflated emotionality hides progress, making it hard for both therapist and client to recognize and build on genuine

moments of change.

In reality, Jake's emotion wasn't vulnerable at all. It was angry, insistent, and demanding. It was more display than expression—hence the feeling that it was striking the wrong chord with me. If he was to repair his relationships and move to a healthier place in the middle of the spectrum, he'd have to learn to depend on others in a way he'd come to fear. His insistence on the specialness of his suffering was a defense—a way of bypassing the vulnerable state of asking for attention, requesting help, or seeking comfort.

His tossing about of email printouts, covering the sofa with them, was a reified metaphor for his problem. He filled every room with himself. With his girlfriend, he'd launch into complaints of work as soon he arrived home to her. With me, he'd obsessively present proof of how he'd been hurt—instead of greeting me or even maintaining minimal eye contact. He took space instead of asking for it or sharing it, or even inviting me to share in it with him.

To treat Jake, I'd have to show him how healthy relationships allow room for two people to feel and have a presence in the room. And I'd have to help him grasp that he does in fact matter to others for reasons that go beyond his pain. Covert narcissists haven't developed the faith that people can see all of who they are while still recognizing they suffer, which blinds them to the feelings of others around them.

Moving from Me to We

Jake started our third session as he had the first two: with papers strewn across his lap. "Can I read you a few of these? I think it'll give you a sense of how she's been acting with me." He began reading before I could answer.

"Actually," I interrupted, "can we try something different?" I met his eyes—which had narrowed with impatience. I knew I had a small window within which to reach him, empathically, in a different way than he'd come to expect or invite in his relationships.

"I can see you're in pain," I continued. "And I really want to help you through it. My gut tells me we can start that by beginning in a different place today. It's up to you, but I wanted to run it by you."

This kind of intervention is both a change in the conversation and in the relationship. I'd just insisted on having a presence—but I'd also given him a choice. In a way, we'd already broken the reenactment where special attention for him meant literally *showing* all the ways he'd been hurt, without deeply feeling, authentically, the emotions emerging in him—and without pausing to feel or even see how I might be receiving what he shared. It's this kind of one-sided interaction that had alienated his girlfriend, so it was crucial for us to discover what was driving it.

"Okay, but I really want you to hear these," he replied.

"I want to hear them, too." I gestured to the papers, underscoring that I *saw* what he wanted me to. "*And* I want to help you with all the feelings you need help with, and I worry they get left out, stranded, when we go straight to the emails."

"I've been telling you my feelings," he whispered, with more than a hint of exasperation.

"To truly help you, we need to change how old emotional patterns drive what you say and do, and the kinds of interactions they invite. That requires moving from content—the emails, the details of what happens, the actions you're taking—to process: what happens internally that fuels all that. How does that sound?"

"How does it work?" he asked. He leaned forward, brow furrowed, his whole body asking, *How in the hell will this help me?*

"It begins," I explained, "by just tracking what your body is feeling as closely as you can. That will tell us exactly what's happening inside that leads to any given choice in any given moment."

"I feel my stomach tensing up and my chest is tight," he told me.

In this single conversation, Jake and I had begun changing how he handles his feelings. He'd already begun moving from displaying to *experiencing*—and what's most important is that he and I were in conversation *together* about what he was experiencing. By focusing on process, we had just moved from *me and you,* to *we*.

Shifting from Content to Process. The more narcissistic someone is, the more uncomfortable they are with genuine feelings of sadness or fear or loneliness—in fact, any of the more vulnerable feelings puts them on edge. The reason is straightforward enough. As psychologist Phebe Cramer had shown in a longitudinal study, narcissists often have the kind of parenting—whether coldly neglectful or critically controlling—that makes them afraid to turn to others when they're in need of care, comfort, or understanding, for fear that once again they'll be rejected or criticized or—more often than not—deeply shamed for normal needs and feelings. In other words, the more narcissistic clients are, the more insecure their attachment style. Defensively, they cope with their fear of depending on others by maintaining a strong sense of specialness. That way, they needn't ever risk asking for, or vulnerably inviting, support or attention and hearing no; they can just expect their needs to be met.

I draw from Diana Fosha's Accelerated Experiential Dynamic Psychotherapy (AEDP) which emphasizes viscerally experiencing change to help clients relate in a more mutual fashion. Unconscious defenses like Jake's covert grandiosity are softened and set aside, giving him a chance to fully express all the feelings and needs he'd been shamed into hiding behind his curated sense of exceptionalism.

"So it's tightness in your chest, is that correct? That's what you feel as you begin to share the emails."

"Yes," he replied a little more

slowly.

"Just keep tracking those feelings, and let's see what happens."

Reducing Anxiety. I invite clients to track anxiety in their body for the simple reason that defenses *always* soften when we're less anxious. Just tracking the sensation of anxiety often lessens it, making room for emotions to surface in ways that help change the strategies that keep clients stuck. Choice and flexibility can emerge from a calmer state, and the more entrenched defenses are, as with narcissism, the more crucial it is to lower anxiety before beginning deeper work.

Sometimes I ask a simple question: what would you be feeling if you weren't anxious? Other times I ask if there's a part of their body we could focus on that feels less anxious. There are many ways to help a client feel more regulated in the moment. For Jake, just tracking the bodily sensations of anxiety reduced his fight-or-flight state.

"My chest is feeling more open, looser," Jake replied after a few minutes.

"Is it okay to just stay with that calmer feeling?" I asked.

He nodded, settling a little more deeply into the couch.

Distancing from the Defense. Jake's whole demeanor had shifted. He swept his bangs from his forehead and wiped his glasses. As he gazed at me, his eyes appeared softer, less insistent.

"Just stay in the calmness, the openness in your stomach and chest. Get an image of when you first viscerally felt that tightening. Don't go into it. Just see it. Without overthinking it, let it emerge. What image comes to you?" I asked.

"I can see myself at six, on the kitchen floor." It's not unusual for covert narcissists to easily retrieve painful memories. It's what sets them apart from the more outgoing, obnoxious versions of NPD. Keeping them there *productively* is the challenge, and when they veer away from such work, it's usually because the memories are laced with a sense of danger: that to be truly seen is to be attacked, abandoned, or shamed. The danger has to be addressed and healed in the present.

Indeed, a feeling of danger often sets people up to depend on feeling special, and this was certainly true for Jake. His mother was a bitter, controlling woman, who once berated him for crying when his best friend moved away. "Don't be so selfish!" she'd admonished. "He needs to be with his family!" Finally, when he'd thrown himself on the floor, she'd reluctantly offered him comfort, patting his back. But his father—who'd drummed into Jake's head that "real men stand on their own two feet"—had crossed his arms and glared.

As with most moments that shape character, this wasn't a single traumatic event: it was emblematic of the way that, in order to reach his mother, he'd learned to collapse into a state of fragility and helplessness she couldn't ignore. For Jake, to be seen was to be helpless and suffering—loudly. His defenses reduced people from potentially caring listeners to captive audiences—witnesses to his misery monologues and pain performances. To change his alienating behaviors, I'd have to help him view his narcissism as a *part* of him, not all of him: something he *does*, not who he is.

This is the key to engaging people with NPD: helping them see that their defenses aren't all there is to them. For this reason, I rarely tell clients they have NPD, because I think of them as a person first. Language like "you're a narcissist" does little except make people more defensive; even the least narcissistic among us bristles when labeled. Little wonder, then, that it leads to spectacular treatment failures when slung at personality-disordered clients, whose defenses are deeply imprinted and reflexive. Instead, I strive to name and transform defenses. (Perhaps because of this, my clients often freely talk about having narcissistic defenses.)

In Jake's case, I worked with a vivid memory, locating the behavior in the past. But I might also invite a client to get an image of themselves engaging in the behavior—which could be any narcissistic defense, like behaving contemptuously, launching attacks, controlling interactions. The key is to help the client separate the person from the behavior. Because defenses are, by definition, unconscious, and we tend to see them as a fundamental part of who we are, this can take time. But once clients have developed awareness of their defensive behaviors, we can move to the central transformative experience: *creating attachment security.*

Creating Attachment Security. The lesson of Cramer's research is clear: to the extent that we can depend on people, we won't depend on feeling special. We'll find other ways to matter in the world and in relationships, besides presenting ourselves as the smartest, strongest, or most deeply suffering person around. Narcissistic clients need a deeply felt experience of being cared for and seen when they turn to others with their genuine feelings, without having to resort to grandiose defenses. Few experiences create that more intensely than when the client can provide a more compassionate response to a younger version of themselves than the one they received from caregivers in the past.

"Can you see that six-year-old?" I prompted. "Is he lying on the floor or standing?"

"Lying down."

"See it in detail, as vividly as possible, and help me see with you."

"His mother's standing over him. 'What's wrong with you?' she's shouting."

I continued, "As an adult, sitting with me now, in this calm state, how are you feeling toward the six-year-old who believes he has to scream and cry and kick to be seen—when he just feels sad about his friend leaving?"

Here, Jake and I were bringing his memory to life in a portrayal, anoth-

er AEDP tool. I take my time setting up portrayals, encouraging the recall of sights, sounds, smells—of any sense memories that come. The more richly textured and alive these imagined interactions are, the more powerful the emotional responses they evoke and the greater the healing impact.

This is just one way in. However one gets there, the goal is to create an experience where genuine feelings are experienced, expressed, and seen in relationship. If the client can't get there fully, I often model the attachment response for them, saying something like, "That poor little boy, he's just sad. He should never have been attacked for that; no child should be."

Jake teared up, dabbing his eyes. His hands were relaxed at his side, glasses next to him. Now he wasn't showing me sadness—he was feeling it. "I feel so terrible for him," he sniffled softly. His affect felt inviting instead of angry, and I had an impulse to comfort him.

"Can you imagine being with him, letting him see your sadness for him?"

Tears streamed down Jake's face. "Yes," he said softly.

"Let the sadness guide you to any words or gestures you'd like to share with him."

This is a moment of key change. In working with narcissistic clients, we're trying to replace judgment and shame with healthier responses. These clients carry internalized judgment toward themselves and others: *you're nothing if you're not everything; your pain is unimportant unless it's loud; needs are weakness.* The side effect of their defenses is to leave us feeling as insignificant, humiliated, or powerless as they once did in the face of the shame they've come to expect when they have ordinary, healthy feelings of sadness, fear, or anger.

Jake's genuine sadness for himself replaces the insistent, angry reactions that took over when he feared that feeling sad or scared would once again earn him criticism or contempt. Until now, he hadn't even left himself any room to see what else was possible.

"What happens next?" I asked.

"I'm holding him," he continued. Then, to the six-year-old, he said, "I can tell you're feeling sad about your friend. I'm sorry you're losing him." He sighed, still sad, but calmer than before.

"What happens inside the boy hearing you and feeling your arms around him?"

Jake looked up, briefly. "He feels strong."

This is the ideal outcome. Shame and attack are replaced with caring and attunement, freeing up a new, undefended response: sadness without demand, pain that matters but isn't everything; fear that invites solace and safety. Unhealthy narcissism's steepest price is that it turns a person into a performance. Therapy lowers the curtain on the performance, inviting the narcissist off the stage and into the seat next to us.

Of course, with many NPD clients, treatment doesn't always go as well as it did for Jake. It can take months to inch forward from me to we. And some clients' defenses won't budge. Although therapists know we can't save our clients, particularly those with NPD, we may deny this reality. We clinicians often have our own brand of narcissism: the feeling that we're special enough, in our capacity to help and heal, to reach anyone if we work hard. Communal narcissism, as it's called, is all about feeling especially or uniquely capable of helping. Therapists need some of this, but we're better off holding this illusion loosely, rather than clinging to it like a talisman.

Communal Narcissism

Michelle, 35, a Latinx life coach, arrived in lime green joggers and a white T-shirt, emblazoned with REACH!—the signature style of the coaching organization to which she belonged.

"I love my job," she said, "but I feel sick all the time. I'm afraid of disappointing my clients, my boss—everyone." Failure, it became clear, was Michelle's deepest fear, but not in any grand sense of the word, as it clearly was for Trudy, her mentor and the cultish leader who started REACH! to save the world. Michelle feared failing to help in all her close relationships: with her friends, her partner—also a coach—and of course her clients.

Michelle's defense, though milder than Jake's, was equally destructive. *If I'm not the most helpful person, I'm no one.* Like all communal narcissists, her insistence that she be helpful above all else led to anger toward herself (and often those she was helping), and shame when she fell short of transforming her clients—which, not surprisingly, proved to be an elusive outcome.

When Michelle was seven, her mother had become deeply depressed, lying in bed in the dark for much of the day. The gloom and shadow that surrounded her mom had terrified Michelle. "I was scared she'd disappear into the darkness," she explained. "I'd sit with her in bed or bring her food or offer to raise the shades." Occasionally, her efforts would elicit a smile and praise. "She'd hug me and say I was her little angel," Michelle recalled, smiling to herself as the memory returned. "My father told me I'd be a doctor one day."

This is how Michelle had learned that the only way she mattered—or could be seen—was as a helper. She had no faith that anyone cared about her beyond her ability to lift spirits, so much so that she rarely shared when she felt upset with her friends. This led to superficial connections, where she related to people more as judges than as sources of mutual comfort, humor, or fun. Rather than enjoying any of these other ways of being and connecting, she stepped up her efforts to help. It was, in fact, a frenzied effort to help a stubbornly distant coaching client that led her to share with me the depth of her fear that she was failing—and I had a chance to offer her a new response.

"My stomach is in knots, I can't let this woman down," she said, somewhat angrily.

"What are you feeling inside when you say that?" I inquired, moving her from content to process.

"That sinking feeling," she answered.

"I don't want you to think I don't care about her."

This was the same visceral feeling she'd had whenever she'd seen her mother retreat to the bedroom, but now, here, in the present, she expected me to judge her the same way her family had. Opportunities like this are a gold mine of change with narcissistic clients—they open a moment where defensive judgment can be set aside, and the client can simply be seen.

"And what do you feel from me as you tell me about your client? Do you see or feel anything that suggests I think less of you?" I was creating an attachment experience by inviting her to take in and feel my actual response, rather than the judgment she feared. Michelle looked away, but after several invitations to pay attention to how she was experiencing my response, she relaxed and made room for what she was noticing.

"Your face looks kind. Like you want to help me."

I nodded, asking her to tune into her body as I told her, "I don't think any less of you because you haven't been able to help your client. I know you want to help. Even if you're not helping, I enjoy hearing your adventures. Your sadness touches me, and I admire your willingness to share your fears. You're so much more than your ability to help."

She smiled and began to cry. This was the beginning of Michelle allowing herself to be known as more than someone who helps.

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We know from research that narcissists may not be more prevalent these days, but they certainly are louder. They can stand out and broadcast their specialness to hundreds of thousands or even millions of followers on Instagram, Facebook, or Twitter.

Narcissism can be benevolent, inspiring people to change, grow, and learn—certainly, this is true of inspirational leaders at their best. It can also be destructive and dangerous, promoting orthodoxy within a group and hatred for outsiders who deny the magnificence of the group's chosen guru.

In many ways, understanding and treating narcissism in the individual and culture at large is a process of *intentional complication*. The narcissistic self is a simple one, reductive and predictable. It operates from a belief that to be a self at all means to be seen as special, usually in very few ways: to be the smartest, the most giving, or the most misunderstood self in the room. The narrowness of that view forecloses the many rich, multifaceted versions of self we're all privy to that have nothing to do with being special.

So many self-states are ordinary and nuanced, yet powerful. The parent who moves seamlessly between quiet caretaker and warm authority fosters far greater security in children than one who needs to be the most powerful person around. A leader who can also be a follower is bound to be more successful than one who insists on calling all the shots. A partner who enjoys giving and receiving provides greater security than one who plays the martyr. We can support narcissistic clients in authentically feeling and being many things at once: a helper and a student, exceptional and average, high-achieving and calm, ambitiously striving and capable of just being; and in doing so, we can help them have closer relationships.

The true lesson of understanding and treating narcissism is that everyone around us suffers when we come to believe we can only matter in one way. And everyone benefits when we can also just be—and be connected at the same time.

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Editor's Note FROM 2

ing expenses would be covered, and he'd have a practice to return to as a less burned out, more integrated therapist.

Another norm-bucking way to fight burnout, several of our authors argue, is to widen the scope of *self*-care to *community*-care. What does this mean for suffering clinicians, who already take care of so many people both on their caseloads and in their personal lives? It means taking care of each other by rethinking the structure of our field in ways that prioritize therapist wellbeing. It means creating nonjudgmental spaces where we can talk freely about the job-related grief and trauma we experience after a client loss or suicide. As we well know, and would tell any client, isolation only intensifies self-blame, so we need to make a conscious effort to break the silent shame around distressing experiences that are universal in our profession. Why not let ourselves dream about training programs that center healing for the healers? If more of our dreams made their way into reality, would we see fewer therapists burning out from the important work we do?

And in the meantime, let's remember that no one's throwing the self-care baby out with the bathwater. We can still do things for ourselves that nurture our spirit and enhance our presence as therapists, which we highlight in stories about exploring micro self-care, recalibrating your empathy dial, and tapping into the power that entrepreneurship can offer struggling therapists in general and Black therapists in particular. In the end, as Sarah Buino writes in her article on the healing ripple effect: "This is how we start the revolution. First inward, then outward, one step at a time."

So find a comfortable place to rest as you sink into this issue, and let's daydream together.