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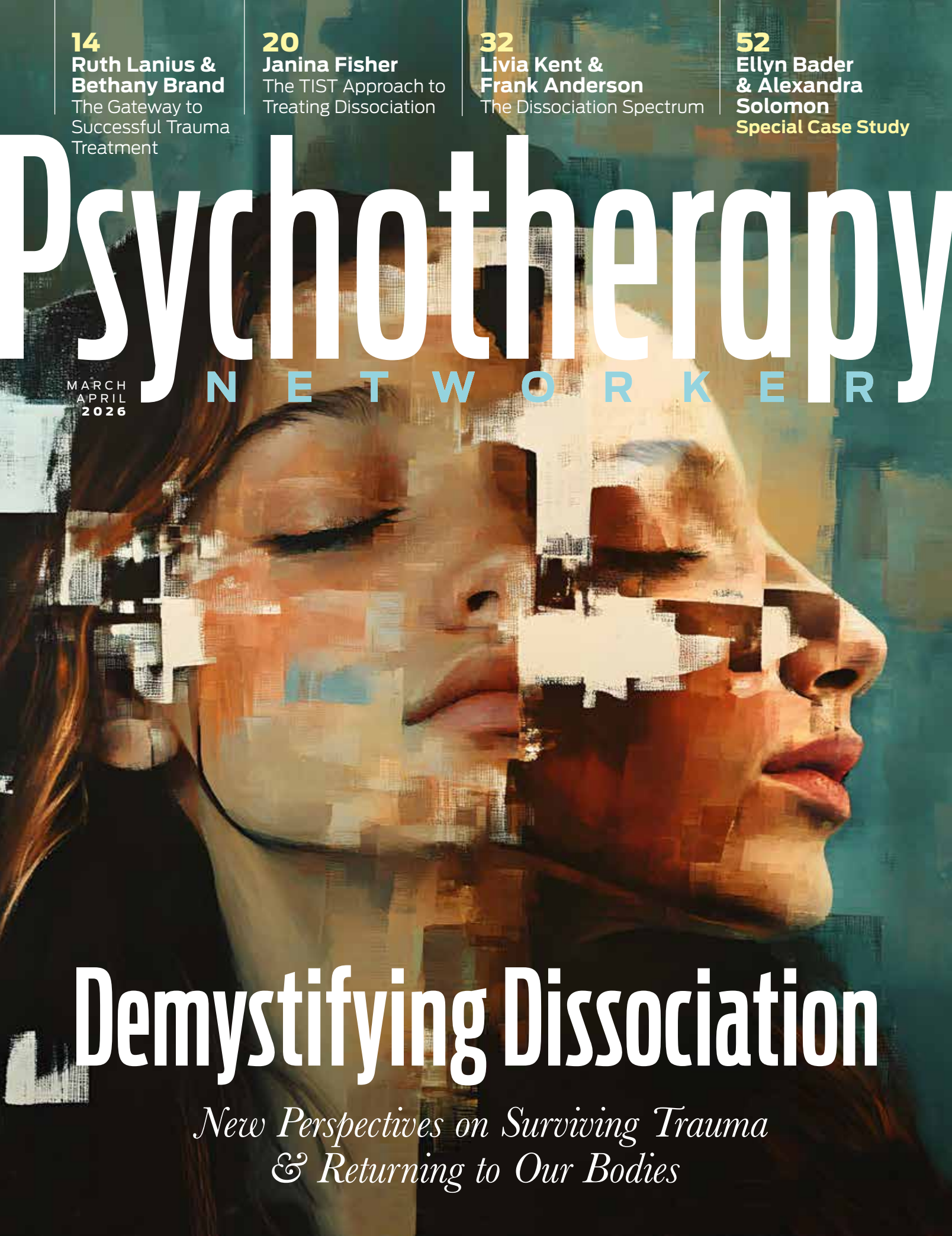

Demystifying Dissociation

New Perspectives on Surviving Trauma & Returning to Our Bodies

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Editor's Note

In putting this issue together, a deceptively simple truth came to light for me: dissociation isn't some frightening anomaly, nor is it always extreme or dramatic. More often, it's subtle—a slight shift in awareness when something feels painful, uncomfortable, or simply too much. And the more I sat with that, the more I saw how often that happens in my own life—not as a dysfunction, but as a built-in buffer, almost like a volume knob for when things get too loud. It made me appreciate neuropsychiatrist Dan Siegel's framing of dissociation as a perfectly understandable, creative act of adaptation in the face of overwhelm. And once I started thinking about it in that way, things began to shift for me.

Now, when my five-year-old is hiding in a closet because I suggested it was time to leave for school, and the house is a minefield of coats and shoes and half-eaten snacks, and I feel my awareness slide away so I'm somewhere else—a remote Australian beach in my distant memory … I pause.

Or when a difficult interaction with a friend cracks something open—an anxious wobble I can feel in my diaphragm—and I notice myself drifting, scrolling through my phone as if the glow of it could carry me off, somewhere cleaner and quieter than my own reactions … I pause.

Or when a pressing deadline looms and I'm at my desk long after I meant to be, rereading the same tangled sentence for the 13th time—yes, this one—and the room gets slightly distant as the pressure to get it exactly right drowns out the meaning of the words themselves … I pause.

Oh. I'm dissociating. Not failing. Coping.

Sometimes I let it be—the nervous system taking the edge off. And sometimes, gently, I pull myself back with a breath, or a hand to my chest. There's something powerful about naming it for what it is. The moment I do, it becomes less mysterious, more human.

But that's in the realm of everyday stress. When dissociation develops in the context of chronic or extreme trauma, the mind isn't just turning down the volume—it's leaving the room entirely. Awareness fragments. Memory disconnects. The body goes offline. What began as protection becomes a pervasive pattern of vanishing. Maybe you've seen this in your therapy room. Or maybe you've suspected something subtle was happening, but couldn't quite put your finger on what it was—or on why your work with a client seemed to be stalling.

In a truly groundbreaking interview we feature in this issue, trauma experts Ruth Lanius and Bethany Brand make this point explicit: you cannot do meaningful trauma processing with someone who isn't sufficiently present to experience it. Grounding isn't a warm-up exercise—it's the work. For people with significant trauma histories, learning to notice dissociation—to track it in real time, to name it, to gently anchor back into the body—is not just helpful, it's foundational. Without that capacity, trauma treatment risks retraumatization. With it, the nervous system builds tolerance for experience rather than defaulting to the circuit breaker of dissociation to escape it.

In other articles, trauma treatment pioneer Janina Fisher traces the history of dissociation as a misunderstood symptom and offers practical tools for treating it. Trauma expert Frank Anderson maps its full spectrum, showing how the more "ordinary" ways we disconnect can be easy to miss. Therapist Sally Maslansky, a former client of Dan Siegel's who recovered from dissociative identity disorder, gives a personal account of what integration can look like. And renowned trauma expert Lisa Ferentz reminds us that dissociation isn't the enemy: sometimes helping clients discern when it serves them and when it doesn't is transformative work.

We hope you'll come away from this issue with a deeper understanding of the many expressions of dissociation and practical ways to work with it in your practice—because ultimately, the goal isn't to eliminate it from our clients' lives (or our own). It's to gain flexibility: to stay present more often, and long enough, for healing to occur.

Livia Kent
EDITOR IN CHIEF

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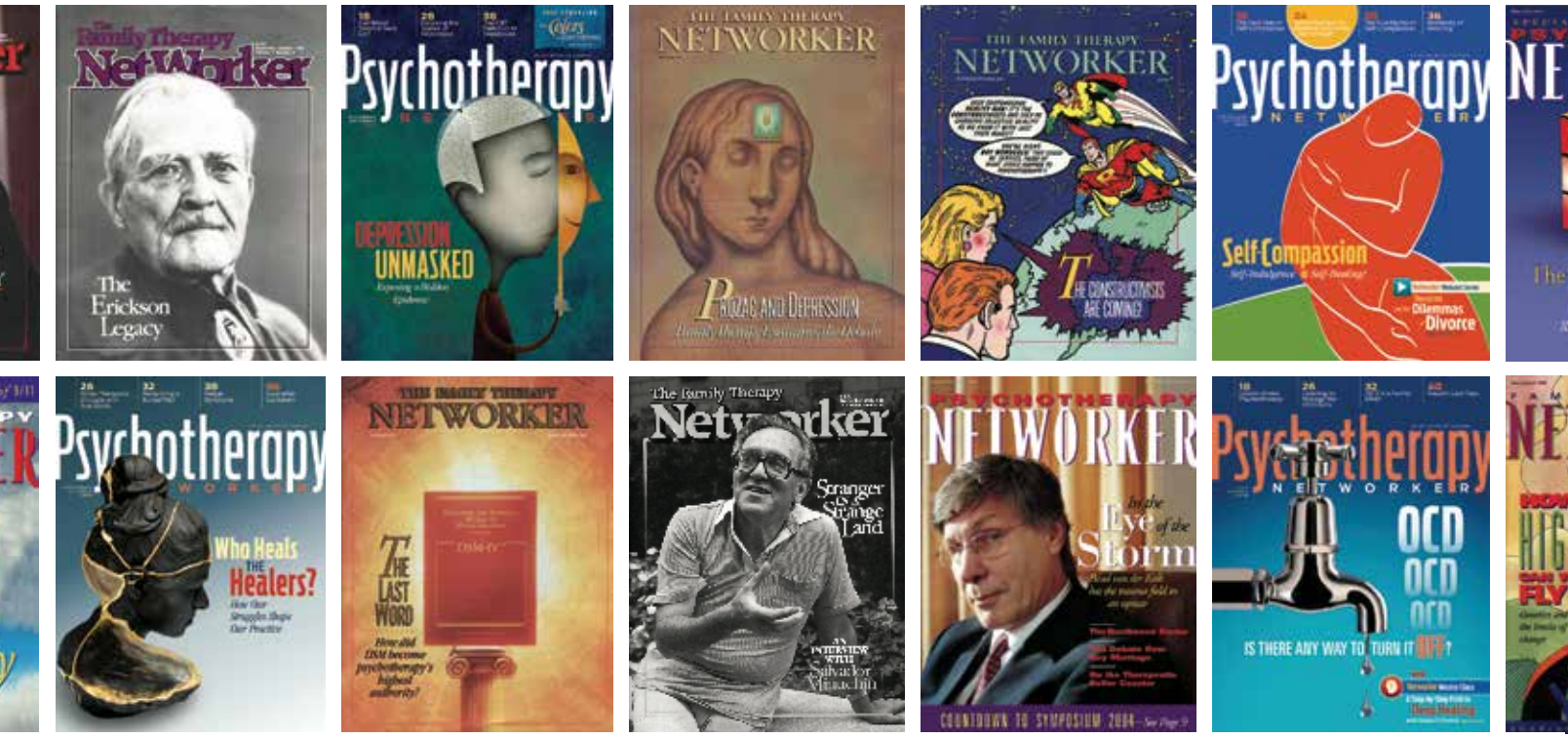

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BY CHRIS LYFORD

How the False Memory Debate Rewrote the Rules of Practice

Facing a Dark Chapter in Psychotherapy's History

When you've been writing and reporting on psychotherapy for over a decade, not much surprises you. The field is chockfull of antiquated philosophies and methods that would make most modern therapists chuckle, wince, or shake their head in disbelief. *Primal scream therapy?! Who thought of* that? Whether they're bizarre but harmless or shocking and dangerous, it's easy to dismiss most of these as mere fads, relics of a bygone era conjured up by a handful of rogue clinicians who dared to push the limits of "conventional" therapy but whose ideas were doomed to fail. Is there any point in seeking mea culpas for the strange, short-lived notions of psychotherapy's forefathers? Probably not.

But last fall, I encountered a story from psychotherapy's *recent* history that made me not only pause, but seriously question the field's infatuation with whatever topic or trend happens to be popular at a given time. It all began when I came across a newly published article in *New York Magazine's The Cut:* "The Therapy That Can Break You."

The article opens with the story of Elizabeth, a teenager who was sent by her family to Missouri's Castlewood residential treatment center in 2011 for an eating disorder. After four months, this "vivacious, gregarious" girl emerged barely recognizable—and was suddenly claiming that her father and his friends had been sexually assaulting her since age four. When Elizabeth took the stand at a later court hearing, she "appeared to act out different characters," inner parts she referred to as *managers, firefighters*, and *protectors*. This language belongs to the Internal Family Systems model, widely used by the therapists at Castlewood.

The Cut piece was a scathing takedown of IFS, claiming it, "could destabilize already fragile mental states." It went on to describe how Castlewood's staff had reportedly made numerous patients believe they'd been sexually assaulted, and even led some to believe they'd been involved in satanic cults. Eventually, these "recollections" were debunked. The evidence simply didn't exist. But the damage had been done. Elizabeth's family, like so many others who'd turned to Castlewood, had been torn apart.

I was curious how the clinical community felt about the article, but nearly every therapist I reached out to declined to speak on the record, not wanting to fan the flames. But many did point out that this story shared shocking similarities with another from our field, one so outlandish you could probably pass it off as a work of paranormal fiction: the false memory debate (or recovered memory therapy debate) of the 1990s.

Ghosts of Psychotherapy Past

Admittedly, I knew very little about

the false memory debate before I started digging. I knew they referred to a period when hundreds of Americans, mostly women, suddenly came forward with recovered memories of childhood sexual abuse, as if by some strange contagion. I knew the field had been seriously divided on whether psychotherapy—particularly hypnosis—could be used to retrieve and explore these memories.

But I soon learned that this was only the tip of the iceberg: not only did this debate pit some of therapy's biggest names against one another—like Bessel van der Kolk and Salvador Minuchin—but it landed falsely accused parents, neighbors, and doctors in jail, tore families apart, and led to countless providers being blacklisted, sued, or fired.

The positive developments that had fueled the debate—increased attention to childhood sexual abuse and survivors' stories, and a growing women's rights movement—were quickly overshadowed by overzealousness and infighting in the field. Some therapists, like renowned clinical hypnosis expert Michael Yapko—the first person I thought to call—say the ensuing fallout impacted nearly every aspect of practice today.

"How old are you, Chris?" Yapko asks when I confess my ignorance about this chapter of our history.

"Thirty-eight," I tell him.

"Ahh," he replies. "Well, that explains it. If you want to know why therapists have to fill out vast amounts of paperwork to justify their methods, and why there's such a heavy promotion of empirically validated treatments, it's largely because of the repressed memory controversy. Therapists were using arbitrary and even misinformed interventions that required stronger guardrails to protect vulnerable clients."

Yapko, now 71, wasn't just a bystander during the false memory debate. He was on the front lines, and took heat for his conviction that most of these recovered memories weren't based on real experiences, but instead due to suggestion by misguided therapists. In his 1994 book, *Suggestions of Abuse: True and False Memories of Childhood Sexual Trauma*, he recounts how some therapists would use checklists of physical symptoms, like headaches and acne, to diagnose abuse that never occurred.

But it was the methods these therapists frequently used to plumb their clients' subconscious—like hypnosis, guided imagery sessions, and imagination sessions—that Yapko says "worked in the worst of ways." Used in this manner, hypnosis "increases the amount of inaccurate recall and increases the client's level of certainty," he explains. "So the client is very wrong but very sure, which makes for a very compelling testimony."

Meanwhile, therapists pressed the issue. In 1995, as the debate reached its apex, a survey published in the journal *Ethics & Behavior* found that nearly a quarter of all psychologists were using suggestive methods to extract supposedly buried memories of sexual abuse, including sodium amytal, a fast-acting barbiturate used for sedation.

"They say in the world of religion, if you believe, you'll be saved," Yapko says. "And in the mental health profession it was *If you believe, you'll recover.* Uncovering presumably repressed memories was considered essential for healing. If a client didn't believe they had repressed memories of abuse, they were said to be 'in denial.' Some therapists literally told their clients, 'I'm not going to work with you if you can't face what happened.'"

But it wasn't long before some recovered memories began to take dark and bizarre turns. There were claims of abuse at the hands of satanic cults or alien abductors and stories of missing and murdered children. A 1993 *New Yorker* magazine article, "Remembering Satan," included one survivor's frightening "recollection":

I remember being carried from my bed by my father in the middle of the night. There were many people waiting outside by the barn.... There was a lot of blood everywhere [and] pitchforks in the ground.... They would lay the sacrifice first on the table, then the high priestess would pick it up and all the people would chant, and then the baby would be put on the table, and all of the people, including my mother and father circling the table, would stab it with knives.... They would say, "you will not remember this" over and over again, like a chant.

These stories quickly captured public attention, with nearly every major news outlet covering the debate around recovered memories. Cold cases were reopened as police departments across the country mobilized to investigate, including more than 300 precincts with forensic hypnotists on staff—with no psychology background—who would do their own subconscious digging.

Meanwhile, skeptics like Yapko continued to come under fire. "When I started discussing the potential for false memories that the research in hypnosis made clear, some therapists accused me of aiding and abetting abusers," he says. "On the contrary, I'd hoped to stop therapists from unwittingly creating victims in the name of therapy. What I clearly said was these recovered memories could be true or they could be false, but without objective evidence, there was no way to know. It got really ugly as the profession split into polarized positions. You were either a believer or a nonbeliever."

No Good Deed

How did therapists, of all people, get swept up in something so outrageous? The short answer, says therapist Bill Doherty, is good intentions.

In 1986, when the false memory debate was first gaining steam, Doherty was a young clinical supervisor at the University of Minnesota, where he "saw the debacle begin to unfold." It had only been a few years since the field had begun to turn its attention to childhood sexual abuse, he explains, after being "kind of in denial about its prevalence."

As popular media like *The Oprah Winfrey Show* and the 1988 bestselling book *The Courage to Heal: A Guide for Women Survivors of Child Sexual Abuse* began to elevate survivor testimonies of sexual abuse, "there was a collective regret that we'd ignored the issue for long," Doherty says. "So we really started to emphasize and search for it, and that's when it began to take on a life of its own."

Of course, there were other influences, too. On top of therapists' longstanding tendency to attribute current problems to past traumas, Doherty says the culture was ready to embrace this movement. "This was part of a trend—a good trend—to take clients, especially women, seriously," he says. "There was a big self-empowerment aspect to what was going on: believe women. Why would anybody make up something so horrible?"

Then, in 1991, the Soviet Union fell. "Some historians believe that countries look for evil within when they're not threatened by evil without," Doherty says. "In this case, the evil empire was gone, and the threat became not just the dysfunctional family, but a specific, heinous trauma tied into morality. There was a sense that we were combating a terrible evil."

As his case consultations continued, Doherty says he heard disturbing myths again and again, like the false statistic that 90 percent of women with bulimia had been sexually abused as children—and, he adds with a tinge of regret, he failed to challenge them. "I ask myself why I didn't," he says, "and the fact is that even though I was already an established professional, I hadn't paid any real attention to childhood sexual abuse. The skeptical side of me thought, *Where's the data for that?* But I also thought I was behind the curve."

What about the more outlandish claims—about satanic cults and alien abductions and murdered and missing children? How did therapists ever take *those* seriously?

"Some of us were starting to get off the train at this point," Doherty says, "but not everyone. So your client is describing horrible shame about satanic rituals involving murdered babies. And you're going to say you don't believe her? You're dedicated to believing! What do you do with that?"

A House Divided

The more I learn about the false memory debate, the more I wonder whether therapists are the good guys or the bad guys in this story. Do good intentions outweigh giant clinical and ethical missteps? When therapists like Yapko stand up and challenge a popular stance they know in their heart to be wrong, is that redemption enough for the field? I'm not sure.

"Here's what you should do," Yapko tells me. "Watch *Divided Memories*"—a PBS *Frontline* documentary that came out in 1995. "It's on YouTube," he says. "You'll see in a visual form how therapists are approaching this."

I find the video online. It's four hours long. Against my better judgment, I press play.

The film opens with a crackly shot of three adolescent children playing—a home movie—slowed down as if someone is operating the video with an old hand crank. Melancholy piano music begins to play, and a series of sepia-toned images appear: a child's Halloween party. A shuffling toddler in a blue dress and matching bonnet. A father scooping up his two children while their mother snaps a happy photo.

"What I remember the most is fear," a female voice says. "I can't remember a time when I didn't feel afraid."

"She seemed very outgoing," says an older, fatherly male voice. "She always just seemed like a normal, happy kid to me."

"I'd just lie there curled up in a ball," says the female voice, "and I'd cry and cry and cry. And I'd stay there for a while. I know he's not going to follow me there, and I feel safe."

What comes next is shocking: tear-filled survivor testimonies, their faces obscured by shadow. Shots from group therapy sessions, where clients collapse into their therapist's lap in a moment of catharsis. "Why would I want to spend even one minute in this office if I didn't have to!" exclaims one client. "And yet I *have to* come back to this office. It's like a magnet. I need the healing." She turns to the therapist. "I need your healing powers, Joanne." Then, she turns to the other clients in the room. "We all need each other, too."

But it's the therapists' takes, interspersed with these shots, that really bring the debate into focus. There's renowned trauma and incest researcher Judith Herman, who tells the interviewer, "If we take seriously our duty to our patients, then we are allies in their healing, and we are helping them to become more powerful, freer, more assertive, and in a psychological condition where they can hold perpetrators accountable."

The late family therapy pioneer Salvador Minuchin appears onscreen. "We need to be very clear that there are two issues," he says. "One is that at this historical point in the United States, we are discovering a tremendous amount of incest and sexual abuse. We are not challenging that fact. What *is* important is that therapists are creating together with patients memories that may be false."

About an hour into the film, we see a shot of a young Bessel van der Kolk—clean-shaven and bespectacled, with a swoop of brown hair combed neatly over his brow. Sporting a dark suit and tie, and silently reading a book in his lap, you'd be forgiven for thinking you'd accidentally changed the channel to *Masterpiece Theatre.*

"How do you know what the patient is saying actually happened?" the interviewer asks van der Kolk. He pauses for a moment. "It's like reading a novel," he replies. "When you read a bad novelist, after a while,

you put the book down because the story doesn't cohere. It doesn't make sense—people don't talk this way, or act this way, and the book is lousy. But if you read a great book and the characters are true to life, that's the way people really feel and interact with each other. And when you do clinical work with people, how the story coheres, how it all hangs together, is not all that different from what the great novelists do."

Finally, there's Yapko—whose takes the filmmakers often juxtapose against van der Kolk's. "The recovery therapist tends to view problems in terms of a presumed history of abuse," he says. "And so by looking for abuse, expecting to find abuse, it's no surprise when they uncover abuse. I think it was Abraham Maslow who said if the only tool you have is hammer, then everything around you begins to look like a nail."

A Rough Start

Of all the therapists I've met, none have been more perpetually optimistic than Lynn Lyons. But what happens when a bright-eyed optimist enters the field in the thick of one of the most schismatic debates in modern psychotherapy?

In 1990, just as the false memory debate was getting off the ground, Lyons was 24 years old, a newly minted social worker who'd just landed a job at a prominent academic teaching hospital—something she'd fought hard to get.

"I didn't know my ass from my elbow," Lyons tells me. "But I learned a ton—despite all the nonsense that was unfolding. There were very experienced clinicians and psychiatric nurses who got really sucked into this talk about satanic sexual abuse. Clients were scheduling admissions on full moons and coming in carrying their stuffed animals with *The Courage to Heal* tucked under their arm. It was craziness."

But Lyons kept her head down, despite finding her colleagues' rush to embrace these implausible claims unnerving. *Cults?! Infant sacrifices?!*

"I was a baby therapist watching this happen," Lyons says, "and it really affected me. "The therapist community was absolutely on board with this nonsense. Clinicians were testifying in court, and people were losing their businesses and going to jail. It's made me very skeptical of our field. A lot of damage was done. There's a dark cloud over our profession because of this."

As the debate raged on, accusations continued to fly, and court cases kept piling up, Lyons seriously considered calling it quits—until she met Michael Yapko.

"It was random luck that we met," she says. Interested in learning clinical hypnosis, she began attending his workshops—and his reputation as a no-nonsense clinician preceded him. "Michael was really in the minority, having said early on that using hypnosis to retrieve repressed memories was dangerous," Lyons says, "and he got tarred and feathered for it. But he was a voice of reason. Had we not met, I'm not sure I would've kept doing therapy."

The Pendulum Swings Back

Over the next several years, recovered memories continued to dominate conversation. But by the turn of the century, the commotion had largely subsided. Enough survivor testimonies had been thoroughly investigated by journalists and law enforcement, and no satanic cults, murders, missing children, or alien abductions were ever uncovered.

But the counterpunch was swift. In 1992, parents who'd been falsely accused of sexually assaulting their children created The False Memory Syndrome Foundation, engaging in a series of campaigns, legal activities, and public advocacy efforts that targeted recovered memory therapists, forcing an ideological retreat. By 1993, the American Psychiatric Association had explicitly acknowledged the difficulty of distinguishing true memories from false or suggested ones, and formally recommended that clinicians approach memory claims with caution. Two years later, the American Psychological Association followed suit.

Meanwhile, Yapko and other acclaimed memory researchers, like psychologist Elizabeth Loftus, had been poking holes in memory recall techniques and drawing attention to the prevalence of suggestion. One of Loftus's most famous experiments, which later became known as the "Lost in the Mall" study, recruited relatives of study participants to describe true and fabricated childhood events to see if the participants could identify the fake. By the end, nearly a quarter believed the false event had actually happened.

"Beth said it really well," Yapko tells me. "She said the potential vulnerability of memory is when misinformation is presented by a credible authority with no apparent motivation to deceive. That defines a therapist."

In *Suggestions of Abuse,* Yapko published his own research, a national survey of therapists who'd been asked whether they considered memories recovered during hypnosis, or ones that were richly detailed and highly emotional, to be accurate. He asked whether they thought clients could potentially recover memories of their birth or being in utero, or memories of past lives. Many answered yes.

"I gave therapists enough rope to hang themselves with the ignorance of their responses regarding memory and repression," Yapko says. "Some were so confident that they claimed they could spot an abuse victim simply by the way they stood or dressed. This is what contaminated the field and created so much division. You had 'experts' who were promoting viewpoints nothing short of wrong and dangerous."

In 1994, the hammer really came down. "'Memory Therapy' on Trial: Healing or Hokum?" read a front-page *New York Times* article, detailing an $8 million malpractice lawsuit

CONTINUED ON PAGE 57

BY AVERY HOENIG, LUCY SMITH, AND JAMIE WILSON

Self-Abandonment in Women

A NEW FRAMEWORK FOR TREATING AN OVERLOOKED PATTERN

Q: In sessions with my female clients, I often hear some variation of, "I don't know who I am anymore." These clients feel lonely, resentful, stressed, and overcommitted. How do I address this?

A: As three psychologists in private practice, we've noticed that resentment, anger, loneliness, numbness, exhaustion, detachment, and burnout arise in people focused on tending to everyone else's wants and needs instead of their own. Similarly, feelings of stress, worry, fear, or uncertainty occur when people don't trust their own knowledge and wisdom and instead constantly look to others for guidance, opinions, and expertise. These feelings are compounded when clients get caught in a cycle of self-criticism and self-loathing—or experience overwhelming pressure to fit into perfectionistic norms—deepening feelings of distress, frustration, and shame.

We believe this cluster of experiences illustrates the phenomenon of self-abandonment, which refers to an overarching pattern of consistently dismissing or suppressing one's own needs, wants, desires, emotions, or identity at the cost of personal well-being, authenticity, and connection. This dynamic doesn't happen overnight, can be conscious or unconscious, and exists on a continuum from small acts of self-neglect to large losses of personal identity. It happens whenever someone cuts off from themselves and results in exhaustion, erosion of one's sense of self, mood changes, and a "blah" existence.

Imagine two dials that allow us to make decisions and orient ourselves as we move through life. One is the external guidance system (EGS), which draws our focus towards outside influences: search engines, expert opinions, advice from family and friends, and real or imagined feedback from others. Our external environment is saturated with signals we can use as our EGS, though it also includes expectations, rules, and scripts we've internalized. The other dial is the internal guidance system (IGS), characterized by a quiet voice that exists within each of us and provides clarity—but only if we hear it.

Where the EGS communicates in flashy signposts, the IGS makes itself known through bodily sensations like gut feelings—which we sometimes refer to as intuition. Self-abandonment occurs when the volume level on the EGS dial is blasting and the volume level on the IGS dial is at a whisper. While IGS and EGS may sound similar to the concept of internal and external locus of control, they're different. Locus of control refers to our belief about who has control over an outcome whereas the IGS and EGS describe where we look and who (or what) we consult for guidance.

What Drives Self-Abandonment in Women?

Although some male clients may self-abandon, this pattern of self-dismissal is particularly common for women. Our culture tends to support men who prioritize their own needs and desires, viewing them as manly, ambitious, and strong, whereas women who put their needs, wants, and desires first are frequently viewed as selfish, unfeminine, and even mentally ill. Here are some underlying dynamics that can give rise to self-abandonment, particularly in female clients.

Not enoughness/self-judgment. The belief that we're somehow not enough—that we don't measure up, are

less than or are worthless—underlies all forms of self-abandonment. You may hear clients say things like, "I'm a mess" or "I bet you think I'm a total disaster" as they talk about common issues and life stressors. In pursuit of enoughness, many women say things like "I'm so lazy/unproductive/broken" or "I'm a complete failure" to push themselves to take on more responsibilities despite feeling exhausted and stretched too thin. Many systems in our culture (namely, patriarchy and capitalism) benefit from women's over-functioning and constant busyness and leverage not-enoughness to keep us in line and feeling small. Self-judgment makes it harder to cope and function, keeping us stuck in despair and disconnecting from ourselves and others.

Fear of discomfort. When we're afraid of experiencing discomfort, we put ourselves through all kinds of acrobatics to avoid it: staying busy, people-pleasing, overdrinking, overworking, numbing, or stuffing down our truth. You'll know that clients fear discomfort when they attempt to shift away from an uncomfortable topic. They may arrive late, cancel sessions, or resist changing their behavior if it means having difficult conversations with the people in their lives: "I can't set this rule or my teenager will hate me" or "If I tell my boss I can't work weekends, I'll get a bad review." Avoiding discomfort leads to bypassing fundamental issues and stuffing down our feelings which results in abandoning oneself.

Desire to fix, plan, control. The desire to do something—anything!—to manage our environment means we're always in motion and have never-ending to-do lists. In therapy, this shows up as difficulty letting go of responsibilities or asking others for help. These clients often carry the cognitive load for their families and may confide, "I'm barely keeping it together, but if I slow down, everything will fall apart." Some clients may feel an urgent need to "fix" whatever is ailing them and become impatient with the therapeutic process. Others may focus on tasks or projects in an effort to deflect their energy from emotional events, such as becoming fixated on decorating their youngest child's dorm room rather than thinking about what life will be like as an empty nester. In sessions, they may provide detailed content but struggle to identify and connect with the emotions underneath. When our cognitive space is overloaded with logistics, there's not much room for our feelings, so we end up ignoring and sidestepping difficult emotions.

Self-doubt. When ruled by self-doubt, we constantly question ourselves and become paralyzed by decisions, leading to a vicious cycle: The more we doubt ourselves, the harder it is to connect with ourselves, and the more disconnected we are from ourselves, the greater our self-doubt. Clients mired in self-doubt will often show up to therapy wanting to improve their self-confidence, saying, "If I were more confident, I'd be able to (fill in the blank with any number of behaviors)." They might also seek reassurance for their choices or ask pointed questions like, "What do you think I should do?" or "Just tell me what to do!" In these cases, the therapist is at risk of playing the role of the client's EGS. To truly build confidence, we can't look outside ourselves for validation. Replacing self-doubt with self-trust is an inside job.

Recognizing self-abandonment helps us respond with interventions tailored to this issue. Here are some underlying factors to keep in mind:

Clients get stuck in their heads. It's easy and exhausting to get lost in thinking, analyzing, worrying, or ruminating—getting bogged down with "shoulds," "oughts," and "musts." When we're in our heads, we ignore everything below our necks. We're so focused on our thoughts that we ignore our actual physical bodies, our sensations, our emotions, and our intuition. We become disembodied, like a head floating in space. Clients who get stuck in their heads will often get caught in planning/problem solving mode rather than dropping into their bodies and connecting with themselves. They may become paralyzed by intellectualizing and over-thinking rather than taking action and moving forward. When we get stuck in our head, thinking becomes like quicksand. The more we try to think our way out of a problem, the more stuck we become.

Numbing. Some common ways people numb include abusing alcohol, scrolling endlessly on social media, binge watching TV shows, overeating or undereating, and oversleeping. Clients who numb themselves might not be aware that they're doing it but may feel exhausted and lose track of time. As a therapist, you may notice your mind wandering or feeling bored during sessions with clients who numb as they may not have much to say, and what they do say might feel disengaged or empty. When clients numb, they don't have to be present for who they are, how they feel, the people around them, or whatever is going on in their lives.

Willful disengagement. Rather than directly asking for what they need or communicating a boundary with others, clients simply stop participating in the moment. In therapy sessions, rather than staying connected to themselves and their values or trying to collaborate with you to find a workable solution, they may throw their hands up, say "This therapy isn't working," and retreat into themselves. They believe they're "right" and know what "should" be done, so they physically or emotionally separate themselves by detaching, withdrawing, or stonewalling. At its core, willful disengagement is an attempt to set limits and meet needs, but our self-abandoning clients end up doing so in a way that's indirect and maladaptive.

Trying to "improve" themselves. Ironically, when self-improvement becomes a never-ending Sisyphean task, it can lead to self-abandonment. In therapy, this self-improvement cycle may show up as constantly seeking the fountain of youth in the form of fitness programs or beauty regimens or seeking fulfillment through landing the next big deal or job promotion. Self-improvement driven by not-enoughness leads to self-abandonment. It's difficult to stay tuned into ourselves when we feel like there is something innately "wrong" with us that we need to make "right" or something about us that's "broken" and needs to be fixed. When we believe we must fundamentally change ourselves to belong, have value, or be worthy, we're

likely to abandon ourselves.

The most common ways this dynamic plays out interpersonally are through people-pleasing, caretaking, looking to experts and authority figures for guidance, answers or solutions, blaming others/being the victim, and fierce independence. Though these behaviors are attempts to manage relationships and regulate distress, they end up distancing clients from their needs and experiences. Here's what self-abandonment looks like in relationships:

People-pleasing/caretaking. People-pleasing and caretaking are acts of suppressing our needs, wants, or interests to make others happy. Clients might hide or change parts of who they are to please others or avoid conflict, tension, or discomfort by focusing on trying to be a "good client." Underneath people-pleasing, there's a fear of being judged and rejected. This constant outward focus on what others think can block clients' access to their IGS, making it impossible to stand up for—or even be aware of—who they are and what they need.

In addition, many women are conditioned from early childhood to take on a caretaker role and prioritize the wants and needs of others as more important than their own. In adulthood, this type of caretaking can show up as a client asking the therapist about herself, expressing concern about being "too much," or apologizing for crying or expressing intense emotion. People-pleasing/caretaking clients may focus on talking about other people's problems rather than their own, repeatedly cancel their own plans to help someone else, or feel anxious or guilty whenever someone is upset. If our female clients' worth is largely contingent on them doing for others, there's not much space for them to do what they need to do for themselves.

Looking to experts and authority figures. A powerful sociocultural element shaping our EGS is all the "expert" information we're inundated with on a daily basis. There's absolutely nothing wrong with asking others for advice, consulting loved ones for their point of view, looking to experts or authority figures for information, or simply utilizing that super accessible online know-it-all, Google. The problem arises when engaging in those behaviors becomes a substitute for our IGS. It's important to be tuned into this tendency with self-abandoning clients, because they're likely to see you as an authority figure and look to you for solutions and advice.

Blaming others/being the victim. When we take on the victim role, get stuck in self-pity, or carry the belief that everything happens to us, we relinquish control over our own lives and give our power away. In therapy, clients may repeatedly complain about others' behaviors, focusing on what the other person should change. In addition, they may take on the victim role and make statements like, "This is just how my life is—I don't have a choice" or "Why bother trying because nothing will change anyway?" When we externalize blame or refuse to own up to our part in conflict, communication issues, or negative outcomes, we set ourselves up for continued self-abandonment in relationships.

Fierce independence (counter-dependence). People-pleasing, caretaking, and looking to experts orient our clients to the world outside themselves. These behaviors entail relying on other people while ignoring oneself. Fierce independence is on the other end of the dependence spectrum. Fiercely independent individuals may refuse to allow anyone to see their vulnerabilities and, in turn, disconnect from people around them. This reinforces isolation, loneliness, and anxiety. In therapy, these clients are likely to refuse medication and prematurely decrease frequency of visits because they believe they should be able to do it on their own. They may become overly reliant on themselves when they don't feel worthy of help or are unable to trust other people. As humans, we're wired for connection. Fierce independence not only causes us to disconnect from others but also from the parts of ourselves that crave belonging.

While this dynamic can show up alongside depression, anxiety, trauma, eating disorders, or relational difficulties, it isn't listed in any diagnostic manual. Rather, it's a helpful framework for understanding an experience many people have. We've noticed that many of our clients have found naming this phenomenon to be validating and empowering. Once it's identified, this concept is easily integrated into any modality of treatment clients are using to improve their connection to themselves and others.

Working with Self-Abandonment in Therapy

With clients who exhibit this ongoing pattern of disconnection, the overarching goal of therapy is to help them connect: first to themselves, then to others.

In the therapy room, we help our clients identify what they truly feel, need, and want—often for the first time—so they listen to and trust themselves again. Meditation and mindfulness are wonderful tools to help clients slow down enough to notice what they're feeling and needing in real time. A client who says they can't feel anything in their body might gradually learn to pick up on the way they clench their jaw whenever they agree to attend events they'd rather decline. Someone who has no idea what they want may practice voicing "low stakes" wants, like what to eat for dinner.

Instead of reflexively prioritizing others, clients practice checking in with themselves, first—honoring their own IGS. Clients can come up with daily rituals, like mentally reviewing the moments, however small, when they cared for themselves. They can ask themselves, first thing each morning, before scrolling through texts or emails, "What's a small thing I'd like to do today just for me?"

Self-compassion is a powerful antidote to self-judgment and the not-enoughness underlying self-abandonment. Replacing self-criticism with compassion allows clients to remain emotionally present with themselves even when they make mistakes or feel uncertain. Simple but powerful ways to increase self-compassion include repeating mantras like "This is hard," "I'm doing my best," and "How can I be kinder to myself

CONTINUED ON PAGE 58

BY RUTH LANIUS & BETHANY BRAND

The Gateway to Successful Trauma Treatment

Practical Steps for Creating Gravitational Security

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

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

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

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

vestibular system, the gateway to all experience, which—as Lanius has discovered through her research—chronic dissociation disrupts.

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

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

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

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

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

> "Many trauma survivors struggle to feel a center of gravity. They don't feel firmly rooted to the earth."

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

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

Bethany Brand: That's right. Dr. Nicholás Rodríguez, a very experienced, well-known Chilean EMDR specialist, consultant, and trainer, who participated in our study, shared how the FSG program accelerated his treatment with a particular patient after years of work. He reported a clear "before" and "after"—grounding allowed the patient to learn recovery-focused skills much more deeply. At one point, when the patient had a suicidal crisis and went to throw herself in front of a train, she remembered a phrase she'd learned in the program: "Step by step, you'll get there." She returned home, practiced grounding, and then used the safety plan she'd developed over the course of the program. That's why she survived. Now, she and Dr. Rodríguez talk publicly about the huge difference the FSG program made in their work.

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

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

PN: Is feeling like you're having the same session over and over a warn-

ing sign that a trauma client may be dissociating?

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

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

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

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

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

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

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

> "If your therapist is doing good work but you're only half-present, you're not going to remember what you learned from your session."

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

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

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

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

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

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

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

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

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

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

> "Everybody talks about the limbic system and the amygdala, but the disconnect is deeper. It's happening in the brainstem."

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

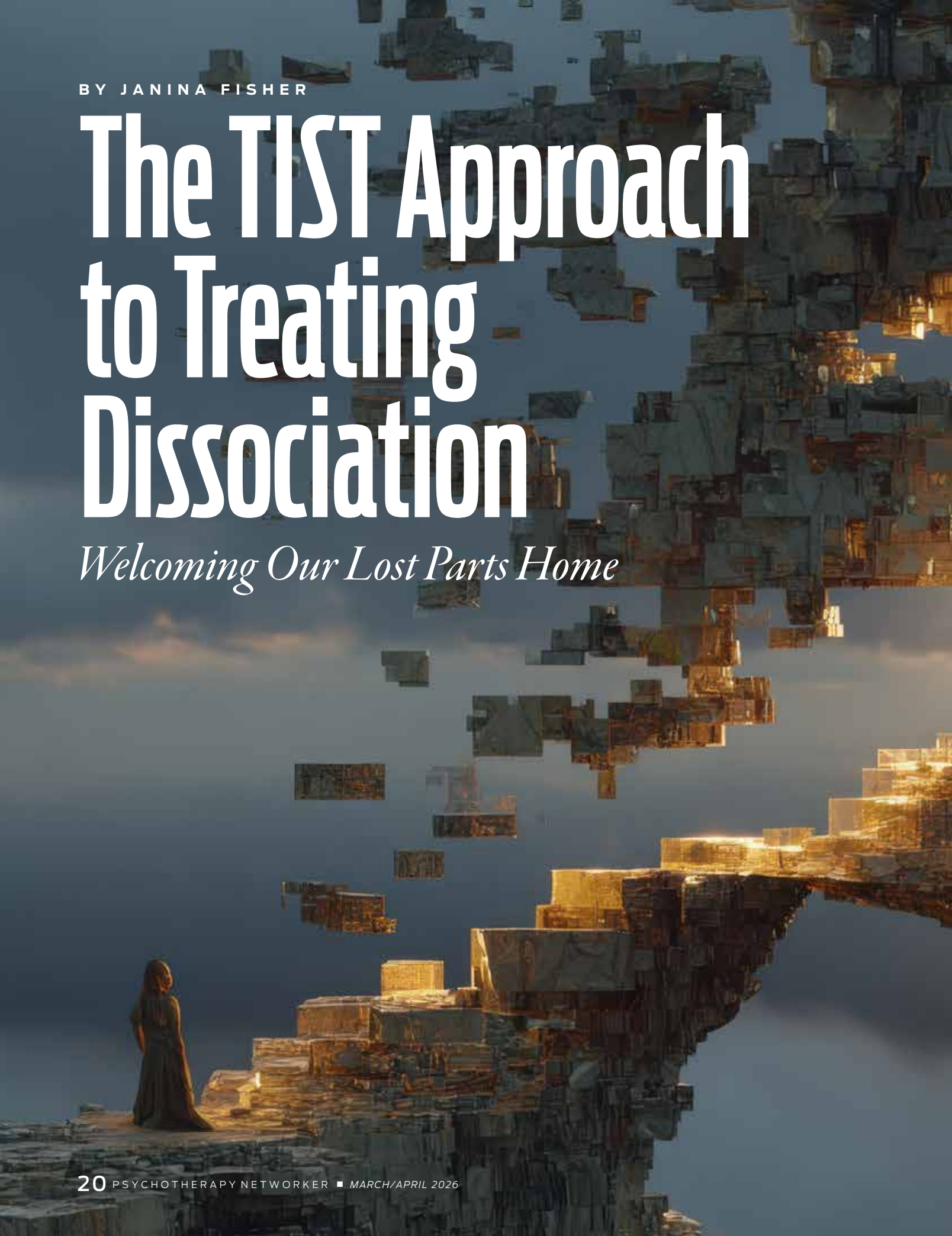
Bethany Brand, PhD, is an Emerita Psychology Professor at Towson University with over 30 years of clinical and research experience, the principal investigator on the largest prospective treatment outcome study to date of dissociative disorders (the TOP DD studies), coauthor of the therapist book, Finding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

Let us know what you think at letters@psychnetworker.org. Want to earn CE hours for reading it? Visit our website and take the Networker CE Quiz.

BY JANINA FISHER

The TIST Approach to Treating Dissociation

Welcoming Our Lost Parts Home



In 1989, I was working as a psychology predoctoral intern on a psychiatric unit when I was assigned my first patient. Rebecca, 20 years old, was a drummer with flaming red hair who'd been admitted to the unit after threatening suicide. In our first session, she described how she'd been hearing voices that would call her all sorts of nasty names and tell her she should kill herself. The standard of care for such patients was not to dispute the voices and see them as part of the disease. But not knowing that, I suggested she tell the voices she didn't want to die, and that if they wanted to get out of the hospital, they should stop telling her to kill herself. By the next morning, the voices were quiet.

A few days later, Rebecca arrived for our session looking disoriented and confused, wearing a black lace tutu and combat boots. "I didn't know how to get dressed this morning," she said. "I didn't know how to tie my shoes. It was weird!" Then, as I opened the door for her to enter my office, she suddenly froze. "I can't go in there!" she screamed in a frightened, childlike voice. "Where's my mother? I want my mother!" Luckily, I'd just spoken with Rebecca's mother that morning, so I reassured what was clearly a child that I knew her mom and had her permission to speak with her.

Reluctantly, she came in, sat down in her chair with a childlike plop, and began to tell me how much she loved school. "Guess what?" she said. "I'm in the red reading group! Everybody knows that's the *best* reading group."

I was used to talking to children, having two of my own, so we began chatting about reading groups. It wasn't long before I discovered that this child was in the first grade—the age at which Rebecca's mother told me she'd been sexually abused by her older brothers. Somehow, even though she'd suffered a horrible trauma at the hands of the family members she most adored, she could still find a way to be proud of herself.

I was deeply impressed by Rebecca's resilience and knew she possessed the tools she'd need to process her trauma and keep the voices at bay. But the truth was that, for most of us therapists, dissociation was uncharted territory. It would be years before I'd create Trauma-Informed Stabilization Treatment (TIST), a therapeutic model that treats dissociation by stabilizing the nervous system and helping clients provide reparative experiences for their traumatized parts. Even with the best of intentions and the sharpest trauma treatment tools of the time at our disposal, our interventions were flawed. All of us were in the dark.

Turning a Blind Eye?

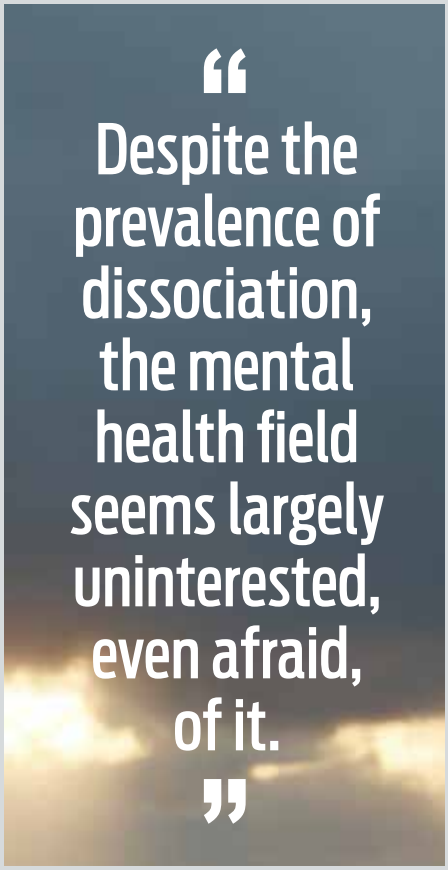
Dissociation doesn't just present one way or affect a particular kind of person. In fact, some therapy modalities, like Internal Family Systems, believe that multiplicity is normal, that all human beings have multi-consciousness rather than uni-consciousness. The truth is that we dissociate all the time, like when we daydream, or get lost in a book, or space out on the highway on long drives. Dissociation is a valuable resource for peak performers like professional athletes who, with the aid of dissociative states, can perform on little sleep, under stress, and separated from emotions that could distract them. And dissociation is essential in the work of doctors, nurses, and paramedics, who need to keep information and emotion separate during emergency situations.

Dissociation allows one part of the brain to remain alert and skilled while another part is horrified, frightened, or overwhelmed. Our brains go on autopilot so we can function without awareness of what we are doing as we do it.

Of course, these mild types of dissociation are different than those experienced by a victim of domestic violence, or a soldier in combat, or an abused child like Rebecca. For these individuals, the symptoms are often more severe, and can involve amnesia, profound detachment from self, emotions, and reality, and identity shifts that can lead to confusion, emotional numbness, distorted perceptions, and significant functional impairment.

But despite the prevalence of dissociation, the mental health field seems largely uninterested—even afraid—of it. How did *dissociation* become a bad word and a questionable diagnosis?

The answer lies in our early thinking around trauma. Trauma wasn't recognized or included in diagnoses until 1970, when PTSD was first included in the DSM, and back then, it applied primarily to combat veterans and rape survivors. Over the next decade, astonishing cases of "multiple personality disorder" were reported—not in professional journals, but in the public media and autobiographical books. At first, this disorder, in which dissociated parts of the personality took over the body and acted outside of conscious awareness, seemed too extreme to be real. Leaders in the field labeled it a "factitious disorder," in which clients sought attention by acting as if they were different people of different ages.



Meanwhile, many of the therapists who'd been working directly with these clients could feel the authenticity of their dissociated parts and see how they'd emerged organically from the client's traumatic past. Their hearts were touched by the vulnerability of wounded child parts—which frequently led to them becoming over-involved in trying to manage the chaos and care for them. Throughout the '80s and '90s, many therapists became overinvolved with their MPD clients, drawn in by their empathy.

I remember this era well. Even expert trauma specialists had few treatment approaches to MPD, and so I did play therapy with child parts, took walks with them, and tried to get my clients to believe what these younger parts were disclosing. But the more I did for my clients and their parts, the worse their symptoms became. The popular assumption was that the therapist should help each part download its memories and, in time, share them with the client or "host." This approach quickly led to the destabilization of even well-functioning clients. Doing therapy with each separate part led to more dissociation, not less.

By the early '90s, MPD was being diagnosed more frequently, and having worked with even one MPD client gave me credibility as an "expert" in working with this disorder. What we didn't realize was that none of us were experts. We were trying to apply a psychodynamic model to a syndrome we didn't fully understand.

It only took one session with Rebecca to teach me that MPD was not only real, but a normal trauma response. And yet misconceptions were rampant. By the mid-'90s, MPD had developed such a negative connotation and had been rejected by so many professionals that in 1994, the *DSM-IV* removed the diagnosis completely and replaced it with dissociative identity disorder (DID). Many lawsuits were filed against therapists because they'd made MPD diagnoses or asserted that their clients had repressed memories of abuse. The "false memory" movement did further damage, creating a backlash that ensured few individuals would be given

a DID diagnosis in the years that followed.

What the Research Says

Despite landmark advancements in trauma treatment, barriers to acceptance of the existence of dissociative splitting and dissociative disorders remain, partly due to an absence of studies demonstrating a scientific basis for such dramatic, difficult-to-treat symptoms. Theories about parts tend to be metaphorical, not biological or brain-based. But this doesn't mean there isn't strong evidence for why dissociation happens and how it functions.

In the face of abuse and neglect, especially at the hands of those they love, children need enough psychological distance from what's happening to remain psychologically intact. Preserving some modicum of self-esteem and hope for the future requires victims to disconnect from what has happened or dissociate from their experience.

Dissociation allows us to observe events from a distance, as if we were watching a movie. A trauma survivor might be horrified by what's happening to them, but in their mind, the event is happening to someone else, not to them. In their mind, *that* child is the "bad child," and because they're being treated as bad, that must mean they are bad. Dissociation capitalizes on the brain's innate capacity to split or compartmentalize. So there also exists a "good child," who might be sweet and helpful, or perfectionistic, or quiet and shy, and can remain acceptable and safe in an unsafe world. Dissociation allows one side of the child to be hypervigilant, wary, angry, or sad, while the other side plays with friends, finishes homework, and sits down to dinner with family.

As children of abuse move through adolescence and into adulthood, the splitting of the self supports another important aspect of surviving trauma: mastering normal developmental tasks, like learning in school, developing peer relationships, and finding interests. The "good" child is free to develop normally while the "other" child bears the emotional and physical imprint of the past, scans for signs of danger, and braces for the next threats and abandonments. To complicate matters, neither self is likely to have well-developed memories of the traumatic events that could aid in self-understanding.

But why does dissociation persist long after the traumatic event has ended? In order to ensure that the rejected child is kept out of consciousness, the individual must continue to rely on dissociation, denial, or self-hatred to enforce the disconnection. In the end, they have survived abuse, betrayal, and others' failure to provide safety—at the cost of disowning their most vulnerable and most wounded self. Many survivors struggle with feeling fraudulent. As they work to stay away from the "bad" self and identify with the "good" one, they have a felt sense of "faking it" or "pretending," which can lead to crippling shame and self-doubt.

Brain science also contributes to our understanding of dissociation. It's generally accepted that dissociation is the brain's approach to managing stress, and research shows that traumatic memories are encoded differently than other memories. In a landmark 1995 study from Bessel van der Kolk, subjects were asked to recall a traumatic event while undergoing a brain scan. The results showed that the areas responsible for verbal memory and expression shut down, while areas related to nonverbal emotional and somatosensory memories became highly activated, suggesting that our brains often fail to encode traumatic experiences as *past* narratives. Why? One hypothesis is that this causes an increase in vigilance and mistrust, bracing us for the next inevitable traumatic event. If we perceived a traumatic experience as over and done, we could relax. But that would be very dangerous in an unsafe world.

While the left brain handles verbal and logical operations, the right brain is emotional, intuitive, and nonverbal. Children are right-brain dominant for most of early childhood, while the left brain develops more gradually over the child's first 18 years of life. In addition, the corpus collosum, the brain structure that enables right to left-brain communication, also develops slowly and only becomes fully elaborated around age 12. This means that in the early years of childhood, right-brain experience is relatively independent of left-brain experience, making it vulnerable to dissociative splitting.

In his years researching brain development, Harvard psychiatry professor Martin Teicher observed a correlation between a history of abuse and underdevelopment of the corpus callosum, which supports the hypothesis that trauma is likely to be associated with independent development of right and left hemispheres, essentially leaving survivors with "two brains" instead of one integrated brain. And without an exchange of information via the corpus callosum, the left hemisphere may have little to no memory of the right hemisphere's affect-driven actions and reactions.

Attachment research also shines a light on dissociation. Researchers have found that children with disorganized attachment status at age one are significantly more likely to exhibit dissociative symptoms by age 19 and to be diagnosed with borderline personality disorder or DID in adulthood. Meanwhile, Structural Dissociation Theory posits that functioning and coping are instinctive in mammals and just as instinctive as our survival responses. Through the frame of these models, the creation of different parts is a survival response primed to anticipate the next threat, which gives meaning and dignity to the fragmentation and internal conflicts. They show us that parts aren't simply repositories of memory; they're a means of surviving.

Changing Our Approach

Historically, trauma treatment has focused heavily on "the talking cure," and treatment models have usually focused on traumatic events, neglecting to see trauma as the result of environmental conditions. The reality is that abuse occurs in a context, a family environment in which the child is not

safe, attachment figures are not protective, and anticipatory fear is ever-present.

I have long believed that trauma treatment must address *the effects* of the traumatic past, not the events themselves. Being able to tolerate remembering a horrific experience is not as important a goal as feeling safe right here, right now, or being able to relate to shame, grief, and anger as the feeling memories of dissociated parts. In my view, healing can't truly happen without reclaiming the lost "not me" children and welcoming them "home" at long last, making them feel wanted, needed, and valued.

How do we do this? Our first priority must be to challenge the client's subjective perception that their symptoms are indicative of current danger or proof of their defectiveness. When they are provided with psychoeducation about dissociation, encouraged to become mindful and curious instead of reactive, and helped to develop new responses to triggers, most clients begin to develop a greater capacity to self-regulate and "be here now."

Many clients feel relief when they're able to reinterpret their stuckness, resistance, chronic depression, fear of change, entrenched fear and self-hatred, crisis and conflict, and even suicidality. When the therapist helps them become curious and interested in their symptoms, they can observe their distressing feelings as cries for help from parts that fear for their lives and don't realize that the danger has passed. Knowing that each part is charged with the mission to survive, each in its own way, helps clients realize that how they survived was more crucial than how they were victimized. Understanding how each part participated in their survival creates a sense of "we, together" and replaces the sense of being abandoned and alone with a feeling of warmth and empathy for one's young, wounded selves.

The TIST Approach

To move dissociated clients toward healing, I use Trauma-Informed Stabilization Treatment (TIST), a trauma-informed parts approach that offers new possibilities for addressing the challenges of dissociation. Treating symptoms as manifestations of parts allows the therapist to encourage mindful observation. Rather than helping trauma survivors "get in touch" with the emotions of the parts—which can be overwhelming and evoke anxiety, depression, or impulsive behavior—they learn to notice or observe their experience. First, simply noticing through mindful awareness allows them to achieve dual awareness, the ability to stay connected to the emotional or somatic experience while still observing it from a distance. Second, a parts approach allows us to titrate emotions or memories. If one part is overwhelmed by emotional pain, the client's observing mind can notice it rather than drown in it.

It's important to note that the language of the brain doesn't have the same impact as the language of parts. Saying "I can sense my medial prefrontal cortex is curious about the negative mood state connected to right subcortical areas of my brain" doesn't evoke interest, emotional connection, or self-compassion. But when a client says, "I can sense in myself some curiosity about the depressed part's sadness," they feel more connected and attuned to their emotions and sensations—the first step toward being able to have compassion for themselves and their parts.

Once clients have been taught to mindfully notice their child parts' distress and understand it as *their* pain, they're encouraged to empathize with the child parts' feelings. This isn't always easy for clients whose way of distancing the "not me" parts has been to loathe their feelings. But in TIST, they are asked to practice noticing their thoughts and feelings as evidence of parts until it becomes natural and habitual.

When clients pause to be curious about the child part that's communicating fear or hurt or grief, the therapist can ask, "How old does this part feel? Does the part feel very small, or more like an adolescent child?" Acknowledging the enormity of what this child part has experienced tends to evoke compassion as long as the therapist is clearly asking, "What kinds of things has *this child* experienced?" which helps the client see the child as a helpless, innocent victim. Conversely, asking "What happened to you at this age?" can evoke narrative retelling or trigger implicit reliving.

With the help of a therapist who reframes problematic emotions and issues as communications from parts, clients learn to identify the key features that indicate signs of a part's presence. They learn to observe distressing or uncomfortable physical sensations, overwhelming or painful emotions, negative or self-punitive beliefs, internal struggles, procrastination, and ambivalence. Automatic reactions, repetitive thoughts and responses to triggers, negative reactions to positive events or stimuli, and "overreactions" should also be flagged as likely signs of parts activity. The practice of being repeatedly asked to be curious and notice all the possible signs of parts activity has a number of benefits.

Mindful observation evokes activity in the prefrontal cortex, counteracting trauma-related cortical inhibition. For the first time, clients might notice that they can have a relationship to a feeling rather than being consumed by it. They can separate from the intense reactions of a part, express curiosity or compassion toward the part's feelings or perspective, create ways of soothing or managing emotions, and choose to react differently to foreseeable events or triggers than they have in the past.

In the TIST model, the focus isn't on memories of traumatic events, but on the "legacy of trauma" as it's carried by the parts and continues to intrude into the minds and bodies of survivors. Processing the trauma requires that the therapist continue to emphasize how the parts are feeling and how they have helped the client survive. The goal isn't the elimination or "integration" of parts, but rather to create a sense of safety for these parts that's shared by the client. In the end, the parts are less easily triggered, and the client

responds compassionately to their fears and feelings rather than being threatened by their intense emotions.

Spotting Dissociation in Your Practice

Just as everyone responds to trauma differently, clients' structurally dissociated personality systems are unique. But there are commonalities you can use to identify dissociation. Individuals with complex PTSD might shift between clearcut emotional states—sometimes irritable, sometimes depressed, at other times anxious—without loss of consciousness. People with a BPD diagnosis might present as regressed and clinging in some sessions while rageful and angry in others. With mild to moderate dissociative disorder not otherwise specified (DDNOS), the therapist might encounter clearly observable compartmentalization and some difficulty with memory short of amnesia. Patients with DID can be distinguished by the classic DSM diagnostic criterion: two or more parts of the personality can take over the body and operate outside the individual's consciousness. Reports of time loss, switching, or dissociative fugue experiences are often indicators of DID. Here are some additional symptoms that can alert you to the presence of underlying structural dissociation.

Signs of internal splitting. The client functions highly at work, where there are "positive triggers," like work assignments, collaboration with peers, and responsibilities, while regressing in personal relationships. The client might also report alternating fears of abandonment followed by pushing away those who try to get close.

Treatment history. The client reports a number of previous treatments that have resulted in little progress or clarity or describes those treatments as rocky and tumultuous or having ended in some unusually dramatic way.

"Regressive" behavior or thinking. Sometimes, the client's body language seems more typical of a young child than an adult of his or her chronological age. They might appear shy, collapsed, fearful, unable to tolerate being seen, or unable to make eye contact.

Patterns of indecision or self-sabotage. Often misinterpreted as ambivalence, a client's inability to make small, everyday decisions or having problems carrying out expressed intentions can reflect conflicts between parts with opposite aims. This phenomenon often manifests in frequent job or relationship changes, in a history of success alternating with self-sabotage or inexplicable failure, high functioning alternating with decompensation, or hard work being suddenly undone by self-destructive behavior.

Memory symptoms. While memory gaps and "time loss" are cardinal symptoms of dissociative disorders, all of the following memory issues are common manifestations of parts activity: difficulty remembering how time was spent in a day, difficulty remembering conversations, blackouts, getting lost while driving somewhere familiar (such as going home from work), forgetting established skills (such as how to drive), or engaging in behavior one does not recall.

Patterns of self-destructive and addictive behavior. Many studies have demonstrated correlations between suicidality and self-harm with a history of trauma, so it shouldn't be surprising that therapists encounter traumatized clients who struggle against their own self-destructive behavior. In TIST, unsafe behavior indicates the activation of fight- or flight-driven parts by trauma-related triggers. While some parts of the client seek therapy because they're committed to living, fight parts engage in high-risk behavior or attempt to harm or kill the body in an effort to get relief from implicit memories at any cost. Parts driven by the flight response tend to be associated with eating disorders or addictive behavior that alters consciousness, allowing distance from unbearable feelings and flashbacks. Fight-related parts are prone to more violent actions, whether manifesting as aggression toward others or self-harm and suicidal behavior.

The Opposite of Dissociation

Dissociated parts want to be heard, and in trying to be heard, they disrupt the client's attempts to live a normal life to avoid being left behind in what they experience as a dangerous world. When we encourage our clients to step back and express curiosity about these struggling parts, to notice the bodily and emotional signs that communicate their feelings, and then experiment with what might help these parts feel safer, better protected, and less ashamed, we're processing post-traumatic memory. Each time these parts are acknowledged, heard, and feel the client's interest, there's a reparative emotional experience. When they assign feelings to their wounded younger selves, clients learn to feel less afraid of their intense emotions and more connected to and protective of their self-states, rather than ashamed of them and alienated by them.

When I first became a therapist decades ago, the field didn't know that healing past traumas required transforming memories, not reliving them. TIST has helped so many of my clients put words to their experiences instead of becoming overwhelmed and dysregulated by thinking about them. It's helped them experience spontaneous and heartfelt self-compassion—for their parts and for themselves. I like to say this work is the opposite of dissociation: by associating parts with compassion instead of pain, we can help our clients be truly present.

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

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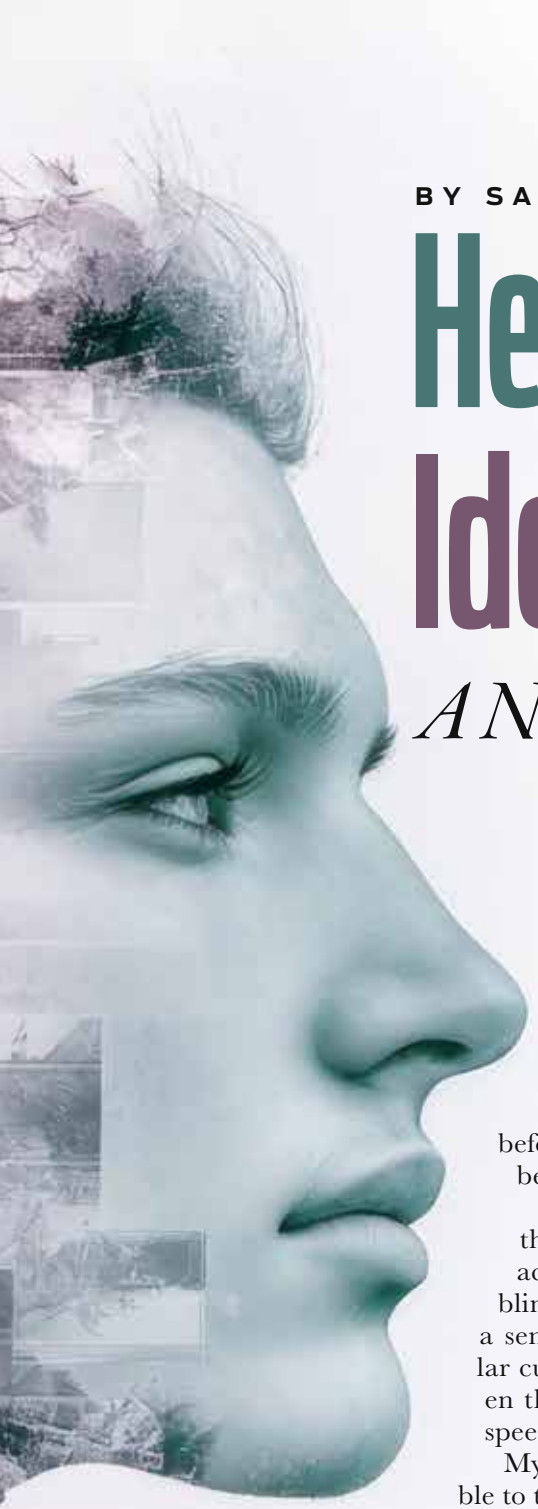


BY SALLY MASLANSKY

Healing Dissociative Identity Disorder

A Neuroscience-Informed Path to Integration

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

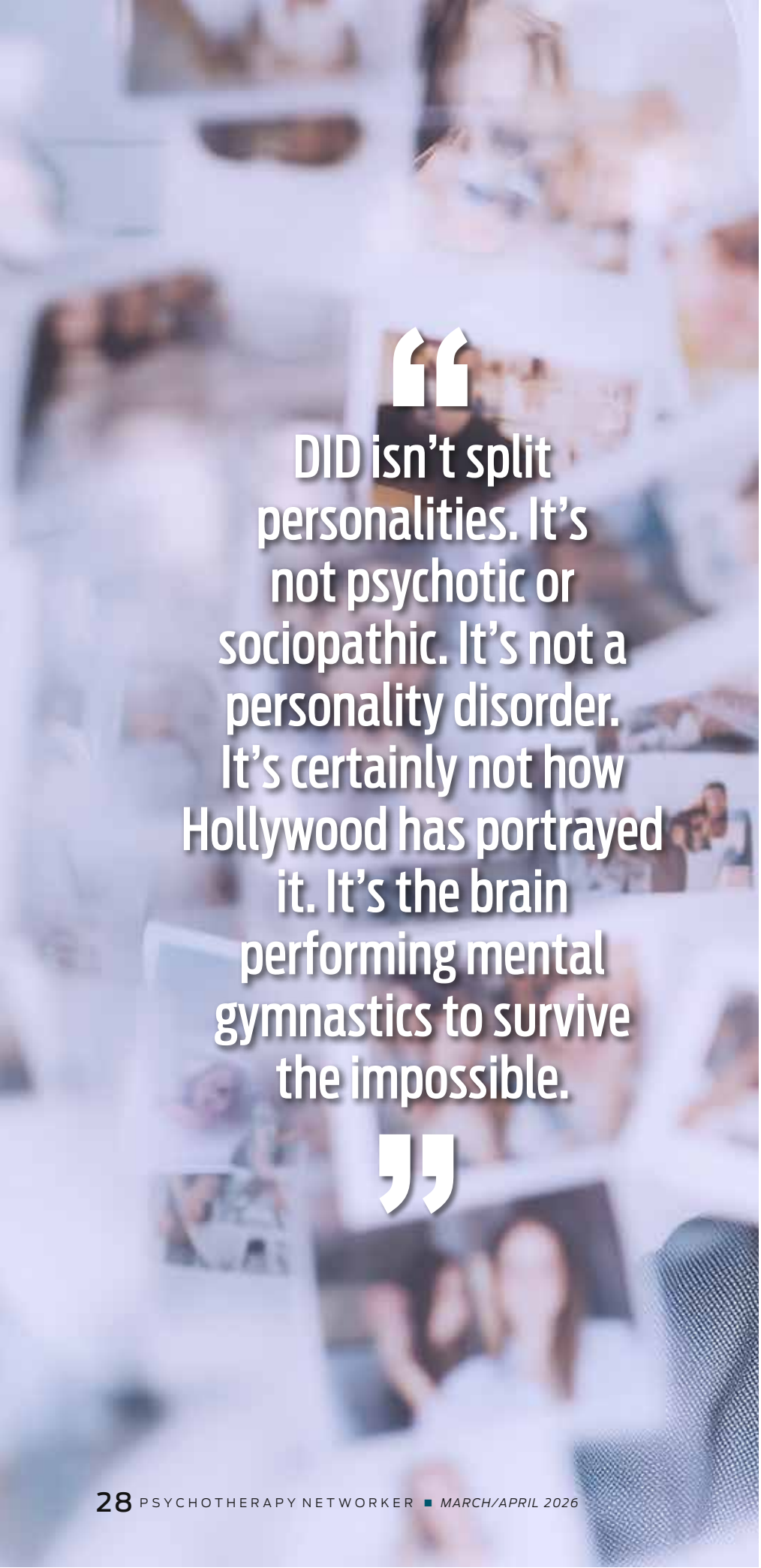
Back then, the only thing I knew about MPD was what I'd absorbed from the 1976 movie starring Sally Field. Her portrayal—dramatized for effect, not accuracy—was all "split personalities" and dizzying "switches," where in the blink of an eye she'd morph instantly into someone completely different. It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

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

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

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

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



Just the opposite of crazy. These words were the beating heart of my healing process. Out in the world, MPD meant crazy. But in therapy, within the sphere of safety and steadiness he created, I began seeing it as the healthiest thing my mind could've done as a child—a brilliant adaptation that made survival possible.

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

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

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

Memories of Feelings

A year after adopting my son from an orphanage in Romania, I'd arrived in Dr. Siegel's office suffer-

ing from intense feelings of terror that something was wrong with my son. At the time, my life felt nearly perfect, and the feelings made no sense. Dr. Siegel had met my son and knew he was fine, so he asked to take some history about *my* childhood to try to understand my fear better.

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

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

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

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

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

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

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

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

"What about your father?" he asked.

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

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

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

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

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

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

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

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

Fragments and Integration

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

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

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

While some states would say hi

when they appeared, the blank state didn't speak at first, it simply nodded, like it was coming out of hiding.

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

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

"Yes. Can you tell me your name?"

"The blank state."

In its quiet child's voice, the blank state let us know that over the weekend, when my husband—in the most loving way—had expressed a desire to be sexual with me I, well, as the blank state described it, "She kinda freaked out." With the help of another state that had a broader view of my inner fragmented world, the blank state went on to explain that as a child, I never knew when something sexual was going to happen. I had many different states that managed things but sometimes the sexual violence came too quickly. When that happened, blank state stepped in—like a placeholder—until another state could take over, or until the violence was over.

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

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

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

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

Verbs vs. Nouns

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

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

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

"I believe so."

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

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

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

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

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

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

The World Outside Therapy

As my therapy ended, I decided to go back to school to earn a master's degree in clinical psychology, and I discovered quickly that the specter of Sybil still haunted the field's perception of DID. Many of my teachers still called it MPD and even referred to people with the diagnosis as "multiples." Although most of my instructors were trauma specialists, their language and assumptions felt misguided, out of date, and out of sync with research. I kept waiting for them to teach what I'd learned about the mind, brain, and nervous system as Dr. Siegel's patient—but they didn't.

In turn, I didn't disclose that I'd been diagnosed with DID or that I'd resolved it. But when I shared I'd had a traumatic and abusive childhood, more than one teacher remarked it didn't seem possible because I was "so grounded," as if

surviving severe trauma in childhood meant a life sentence of dysfunction, making full recovery and wholeness forever out of reach.

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

An Invitation

Not long ago, I was watching *The Late Show with Stephen Colbert* and saw a comedy sketch called "MPD/DID Barbie," showcasing Barbie switching "personalities"—from crazy to depressed to suicidal to homicidal to sex addict. The studio audience roared. And I found myself wondering, *Still!? Why do we find this funny?* In 2025, with everything we now understand about child abuse, trauma, the nervous system, neuroplasticity, and relational healing, why are we still treating dissociation with so little understanding and accuracy?

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

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

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

But it is.

I'm living proof.

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

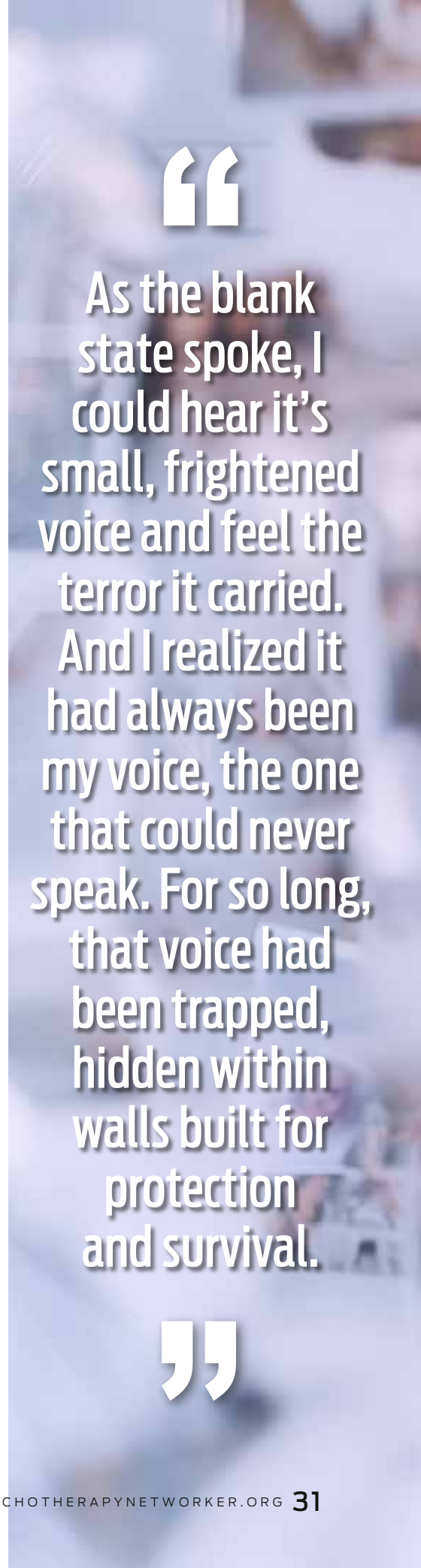
DID isn't a one-size-fits-all condition, and healing doesn't follow one path. What unites different stories of DID is that they're far more human than anything we see or hear in popular culture or even the clinical world. In listening to the people who've lived through DID, the clinicians who've done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

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

And when supported well, a human triumph.

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

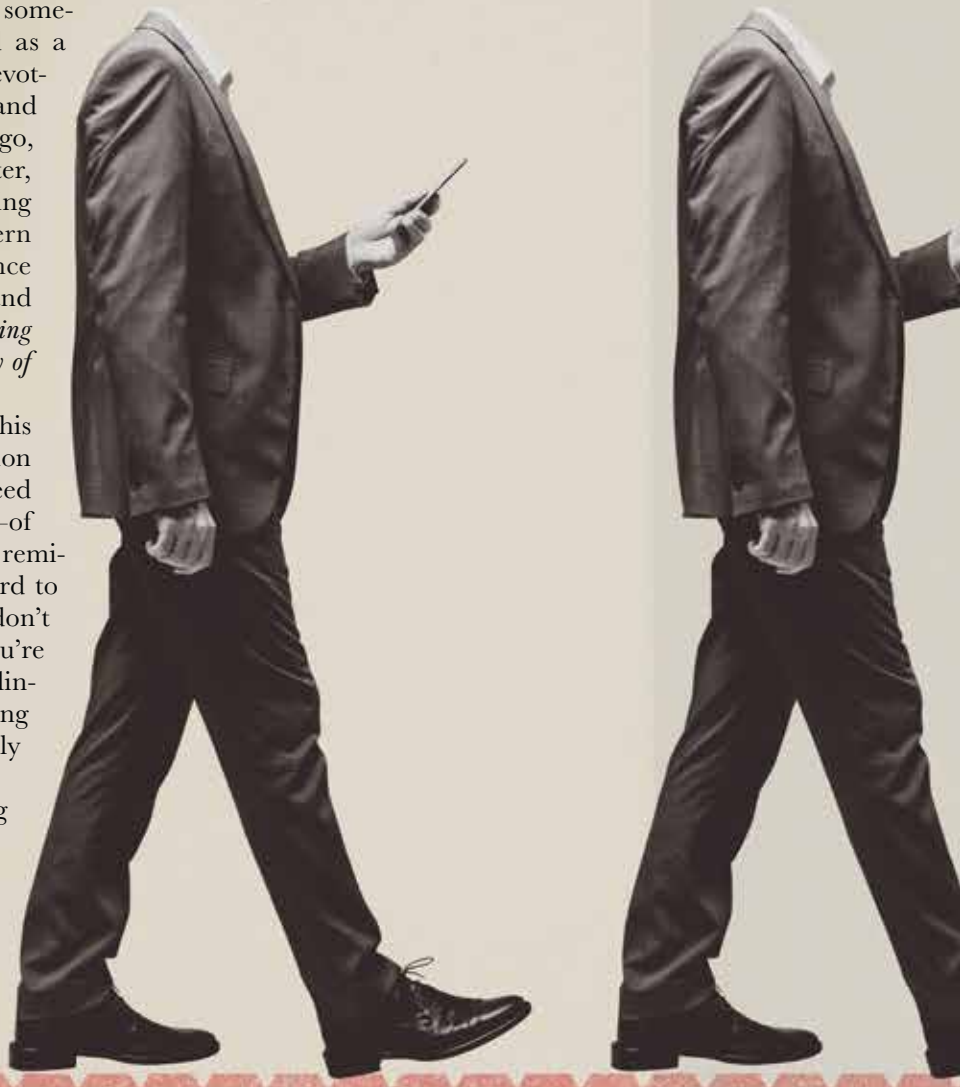
Let us know what you think at letters@psychnetworker.org.



BY LIVIA KENT & FRANK ANDERSON

The Dissociation Spectrum

Addressing Hidden Disconnection in Therapy



Psychiatrist and trauma expert Frank Anderson says we've been missing something crucial about dissociation—and as a Harvard-trained psychiatrist who's devoted three decades to understanding and treating trauma, he'd know. Over 30 years ago, he began his career at The Trauma Center, working alongside Bessel van der Kolk during some of the most formative years of modern trauma treatment as we know it today. Since then, he's become a sought-after educator and written several books, including *Transcending Trauma* and the memoir *To Be Loved: A Story of Truth, Trauma, and Transformation.*

Like other trauma experts featured in this issue, he sees our field's view of dissociation as woefully out-of-date and in desperate need of a rebrand. But dissociation's old image—of being rare, dramatic, obvious, maybe even reminiscent of a horror movie plot point—is hard to shake. According to Anderson, even if you don't consider yourself a trauma therapist, you're likely seeing dissociation regularly in your clinical work (though you may call it something else, like daydreaming, distraction, or simply spacing out.)

In this interview, along with demystifying dissociation, Anderson offers practical guidance on recognizing the subtle moments when clients shift their attention or disconnect—and most importantly, on helping them return to the present through embodied, relationally attuned interventions.

Livia Kent: What do you think most people don't understand about dissociation?

Frank Anderson: A lot of therapists don't really recognize that dissociation exists on a spectrum. It tends to only be associated with dissociative identity disorder (DID), or in the old days, multiple personality disorder (MPD). The myth is that it's always extreme and only shows up in people with the most severe trauma histories. But we know from researchers like Ruth Lanius and Stephen Porges that a common subtype of PTSD is blunted or numbing and dissociative. Some people are in the sympathetic branch with hyperarousal activation: energy, panic attacks. But many others are what Porges calls the dorsal branch, with shutdown and disconnection. Others still are cognitive and partially dissociated: they don't have access to emotion or physical sensation, but they're always in their heads thinking. In the normal range of the spectrum, daydreaming is a form of dissociation. Everybody daydreams. When you're driving in your car and thinking about something else, spacing out, that's a form of dissociation.

Even within the field, a lot of people who are not trauma specialists tend to be nervous about dissociation because they think they haven't worked with it and don't really know how to handle it. But you can get more comfortable with dissociation when you see it on a spectrum. After all, with the world being as overwhelming as it is, people are using more and more things like phones or tablets for dissociation. You get numbed out, and then it's like, *Oh my God, what have I been doing for the last two hours?* Dissociation is disconnection. There's a disconnection from being in the present moment.

LK: What are some common forms of dissociation you might see in a session that therapists often miss?

Anderson: If somebody shifts the focus of their attention or looks away even for a moment, I always wonder, *Wait a minute, what just happened there?* They could be like, "Oh, I just started thinking about a work email." And maybe that's true, but it could be a subtle form of disconnection from something that felt too uncomfortable to sit with. Neurobiologically, dissociation is a top-down process. So thoughts get suppressed first, then emotions get suppressed, then the body. And when you're having somebody recover from dissociation, it's a bottom-up process. They're going to recover in their body first, then in their emotions, and then later, they're going to recover in their thoughts. That's how healing works.

LK: Walk me through this. I'm your client. You notice that I've experienced some subtle form of dissociation. What's the bottom-up intervention here?

Anderson: Well, if you're more globally dissociated and it's obvious, I'm going to do two things. First, I'm going to focus on body sensation. I'm going to see if you can move your fingers, wiggle your toes. Is your body alive? Then I'm going to ask, "Do you have any feelings?" Last, I'd ask about what you're thinking. This helps me check to what degree you're dissociated. Usually when somebody dissociates and they space out, if I see the shoulder twitch, the fingers move, I'll know, *Ah, okay. They're recovering*. So I'm watching the body first because of that top-down wiring.

Since dissociation is a disconnection, the other thing I do is try to empathically resonate with them. I'll see if I can connect to what's under the dissociation. So I'll say I know what it's like to be really frightened, or that I've also felt really betrayed before, and kind of try to get to the emotion under the protection. That's another way to help people recover from dissociation: connection.

LK: That's beautiful. So you're using yourself, your own vulnerability, as a tool.

Anderson: In those moments, you've got to ask yourself, *What am I feeling?* Early in my career, when people would dissociate and disconnect in front of me, I'd start to talk more—blah, blah, blah—just to fill the space. And it really made them more disconnected. The more I pushed, the further away they went. Over time, I realized that my attachment wounding would get activated when somebody dissociated. My little parts inside would get nervous and anxious, which caused me to get to be way too forward-seeking in trying to get the connection with them back, which had the opposite effect. It wasn't until I was able to process my own attachment trauma that I got comfortable with silence. You have to tolerate silence in order to tolerate dissociation.

LK: I noticed you used some parts language. There seems to be a bit of a debate in our field about whether Internal Family Systems Therapy is really the best framework to use when treating dissociative tendencies. As a former IFS trainer, what are your thoughts on that?

Anderson: Well, it's interesting. Through a parts approach, IFS normalizes that our personality has different aspects. The belief in IFS is we're not supposed to be whole; having parts is normal. Naturally, you might think, *Oh, then does everybody have dissociative disorders?* One side of the debate claims, "You're fragmenting us all when we're supposed to be whole." My response to that is to refer back to the spectrum. To what *degree* are your parts separate? And to what degree are your parts communicating with or connected to each other?

Another piece of the debate comes from the mistaken belief that if you work with parts, then it's natural for you to work with DID. That's not necessarily the case, because people who are on the further end of the spectrum have much more distinct separate entities within them than the normal range of different parts or aspects of our personality. And a lot of people in the DID community take issue with how IFS distinguishes between the Self and parts. They say, "I'm whole in my parts. All my parts are part of me. It's not like my parts are one thing and myself is another." They see the parts as a sum of the whole, whereas IFS says, "Your Self is different from your parts."

Personally, I do believe that parts

have Self in them. And the distinction that I make sometimes is the difference between the human Self and the soul. So human Self could include parts or not, but the soul is more, for me, an entity that may be connected to spirit in some way different from our Self or our parts. In the end, I think there's merit in both sides of the debate. Neither is right or wrong.

LK: In your experience, does treating more extreme dissociative tendencies with IFS cause more destabilization? What's the goal in terms of integration?

Anderson: Yeah, it's interesting, what many people with DID experience is that the parts hate the Self. This is because parts feel like, *You left me to get abused by Uncle John or whomever.* With trauma, there's a chasm that gets created between the Self and the parts. Parts don't love the Self. They hate the Self for abandoning them or leaving them. There's a repair that needs to be created. I think of IFS work on parts as repairing the chasm that gets created between the Self and the parts. You're almost doing internal attachment work when you're working with DID.

Plus, there's a contingent of the DID population that says, "I'm not here to get rid of my parts. I'm not here to have them be fully integrated. Parts are normal aspects of my personality." We're aiming more for flow than integration. It's not like, "We'll solve you when you're whole." It's more like, "Your parts are a part of who you are. And healing may be seamlessly moving between Self and parts, and parts and Self.

LK: That sounds very normalizing.

Anderson: Part of the issue with dissociation is the word itself. It's very pathologizing. I think we need to come up with a new word that's more user-friendly for therapists and clients alike. Needing space, instead of dissociative. Or maybe we should just call it taking a break. In neuroscience, they call it "disconnection or blunting." Shame is a form of dissociation—a disconnection from being seen, or known. There are a lot of ways we disconnect in the service of survival. Different words might help people feel more comfortable with the concept.

But also, I think it's important to ask how the client's part wants to describe itself. No part calls itself dissociative. It may say something like, "I'm the one who shuts down. I'm the one who hides. I'm the one who protects." If we let the part name itself, it gives us a window into its function.

LK: It sounds like the answer to the question about whether IFS should be used with dissociative tendencies is, "Yes, but carefully."

Anderson: Carefully, yeah. And be careful not to impose the IFS dogma on dissociative clients. Be open to their experience using their language.

LK: Like, "This is your firefighter part. This is your manager part."

Anderson: Nobody's a firefighter or manager, unless they literally are.

LK: I know you're moving away from IFS and toward a more integrative view of practice. Are there any other modalities that you would bring into work with dissociative clients?

Anderson: IFS can be very mentalizing, and people tend to stay in their heads with it, so I'm moving to a much more integrative somatic type practice. I'm moving to embodying parts instead of just talking about them. A client might say, "I'm angry." I'm like, "Show me anger. Don't just tell me about it. Has it got sound? Has it got movement? Show me what anger looks like." I'm doing a lot of bilateral stimulation to encode therapeutic moments. It's been very effective.

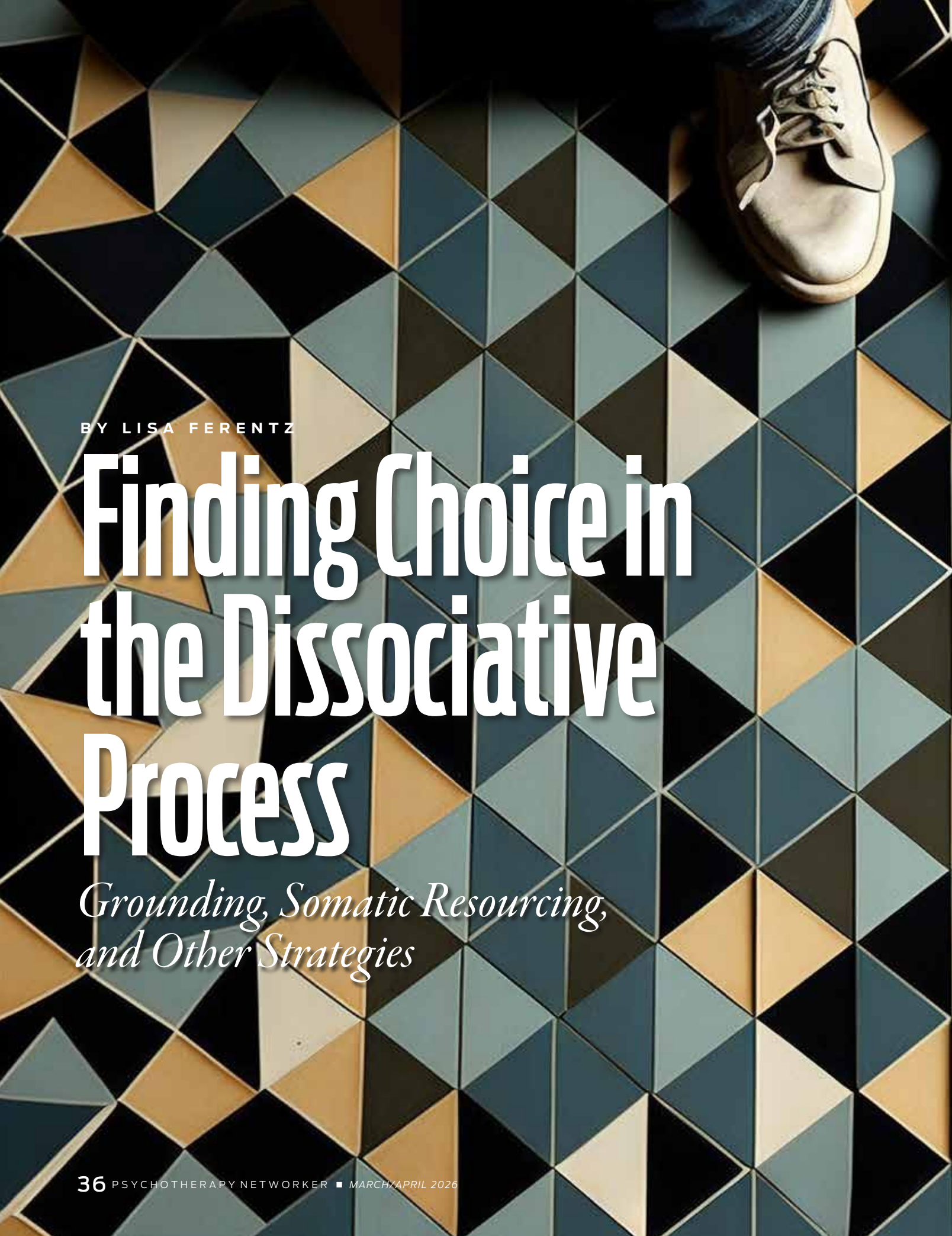
LK: Do you remember what it was like to work with dissociation early in your career?

Anderson: I worked at Bessel van der Kolk's Trauma Center in the early '90s as a psychiatrist. When I first got there, I wanted to know more about DID and dissociation, because I didn't really understand it. So, I asked someone in our supervision group, "How can you tell if someone is dissociative?" And they said, "There's a feel, a quality, you just sense it." And I was like, "What the hell are you talking about?" I was lost as to what that meant as someone new to this work. But now, I can totally see it. There's just a way about someone who's dissociating or spacing out. It doesn't have to be exhibited in dramatic shifts where you'd think, *Oh my goodness, this person speaks a new language and is in a whole different state*. But there are subtle shifts in how they process things, move their bodies or interact that you can track. You can pick up on a certain quality that's hard to describe.

LK: One of our writers who lived a long time with DID didn't even realize she was dissociative. She didn't really have a memory of her childhood, but otherwise she was just living her life. She maintains that a lot of people are living that way.

Anderson: One hundred percent. There are so many people who've suffered from traumatic childhoods and have learned how to adapt to survive. Dissociation is the ultimate protection. Disconnecting to survive protects us from the trauma, but it also protects us from the pain of knowing what happened to us. It should be handled with caution and treated with the respect it deserves. The more we know about it, the more we can honor it and help those who've heroically endured the unspeakable.

Frank Anderson, MD, is a world-renowned trauma expert, Harvard-trained psychiatrist, and global speaker. He's the coauthor of the IFS Skills Training Manual, *acclaimed best-selling author of* Transcending Trauma, *and the memoir* To Be Loved: A Story of Truth, Trauma and Transformation. *He has a long affiliation with Bessel van der Kolk and is on the board at the Trauma Research Foundation. A former Lead Trainer with the IFS Institute, he's also a member of the Clinical Advisory Board with Unyte Health. He's passionate about teaching brain-based psychotherapy and integrating current neuroscience knowledge with cutting edge models of therapy.*



BY LISA FERENTZ

Finding Choice in the Dissociative Process

Grounding, Somatic Resourcing, and Other Strategies

Picture baby Leo lying in a bassinet. Like all infants, he's been born with the ability to dissociate. His entire repertoire of affect regulation and coping skills includes the capacity to zone out, utilize the sucking reflex, and look away to avert a noxious stimulus. If Leo's caregivers are attuned and responsive to his needs, he'll soon learn to comfort himself through soothing movement and self-talk, and he'll lean on external resources when needed. He'll stop relying on dissociation for regulation, as well as the pacifier and thumb-sucking for self-soothing. In short, he'll develop the ability to autoregulate.

In contrast, picture a different infant—baby Ava—lying in a similar bassinet. Like Leo, she's biologically hardwired to reach out to caregivers for comfort, support, and reassurance, but in her case, her attempts to connect go unheeded. Her caregivers are unreliable, unavailable, and reactive. What should be her main source of comfort is a source of pain. It's like she's playing a game of tag, touching home-base, and getting an electric shock. Social engagement is not a viable option for her in the hierarchy of survival responses.

As a trauma therapist, I see countless clients who grew up like baby Ava. They had to use dissociation as a survival strategy throughout childhood and continue to use it in adulthood. This is partly because caregivers with dismissive, ambivalent, or disorganized attachment styles didn't provide them with healthy coping options. The fight, flight, and fawn responses offered them additional ways of coping, but kids know fighting or fleeing can worsen an abuser's rage and result in more harm. Although the fawn response meant abdicating their own feelings and needs, it often kept them safe. When the fawn response wasn't an option, they relied on freezing—using dissociation to mentally check out of situations they couldn't physically escape.

Abuse and neglect at the hands of primary caretakers represents one of the most profound experiences of betrayal a human can endure. In that regard, dissociation is like a superpower. Even when witnessing abuse, it can help people endure what they feel powerless to fix or change. Many of the clients I've been privileged to work with simply wouldn't have survived their horrific family of origin experiences and moved forward with their lives without it. It helped them disconnect from the physical pain of a beating or an invasive sexual violation, as well as the many emotions that get activated with abuse, like outrage, confusion, despair, self-blame, and shame.

And yet, it's a poignant paradox that the very reflex that saved my clients in childhood and during later adult traumas now adds to their vulnerability, making them like a "deer in the headlights" and creating the potential for revictimization. It also presents a challenge in therapy sessions, as any therapist who works with highly dissociative clients knows. When a client fails to respond to the re-grounding strategies

we're offering them because they've "checked out," we're likely to experience countertransferential reactions like anxiety, helplessness, and fear.

Despite these challenges, there are steps we can take to help clients increase their repertoire of coping and affect regulation skills in triggering situations. And although helping people grasp the disadvantages of a reliable survival strategy isn't always an "easy sell," providing psychoeducation about the costs of dissociation is a critical part of empowering clients.

In a Daze

My client Danny is 47 years old. Both his parents struggled with alcoholism, and his mother left the family when Danny was eight, leaving him in the care of an enraged, depressed, and violent father. After many failed attempts to appease and comfort his father, Danny came to rely more and more heavily on the survival strategy of dissociation that had served him well whenever his parents had fought violently and when his father's abuse was directed at him.

"I look back on adolescence," he said, "and I don't think I was present for any of it. I walked around in a daze. My dad would come home from work, start drinking, yell at me, and I would just check out. Even talking about it now, I can feel myself getting spacey."

"Okay Danny, go ahead and put both feet on the floor, and press your shoes into the carpet," I told him. "Can you feel any sensation in your ankles, calves, or thighs?"

"Yeah, I feel the muscles in my thighs tightening. And I can feel tension in my calves."

"Is it safe to stay with those sensations?" I asked.

"Yeah, it helps me get back into my body," he said.

"Great. Just stay with that awareness of sensation in your legs until you feel fully back in the room, and then you can stop pressing into the carpet. You know," I added, "it makes sense that checking out was such a helpful strategy for you when you had no other resources for protection or comfort. It's kind of like a superpower."

He smiled. "I never thought of it that way."

"It's important to express gratitude for that coping strategy, and how much it helped you in the past."

"In the past," Danny echoed, his face turning thoughtful. "Thing is, I still check out now, a lot, especially when I'm scared or triggered, like when we were just talking about my dad and his drinking."

"I want you to know that I can't take your dissociative powers away from you, Danny, nor do I want to," I said. "The goal is to introduce the concept of choice. Once upon a time you had no choice, it was the only viable strategy you had. But now, as an empowered adult, there are times when dissociation isn't the only strategy you have, and it might actually disempower you because it puts you into freeze. When you started talking about your adolescence, you told me you were feeling spacey. Is that one of the physical harbingers that lets you know that you're about to check out?"

"I guess so. It feels automatic. I've never really dissected it before."

"Well, maybe we can use what just happened a few minutes ago," I suggested. "Or you can think of other recent experiences when you reflexively used dissociation to navigate something scary or upsetting. A lot of people come to realize that there are physical sensations directly associated with checking out."

"Like what?" he asked.

"Some clients talk about a specific headache. Others talk about a feeling of darkness that encompasses them."

"Darkness!" he said. "It definitely feels like there's a dark curtain that comes over me. My vision gets blurry, and it feels like it's hard for me to move my arms or legs."

"A lot of clients describe feelings of immobility, feeling lightheaded, or dizzy," I assured him. "These are important signals that you're getting from your body, and when you have an awareness of what your body does right before you check out, it gives you the opportunity to begin to introduce the concept of choice."

"How do I do that?" he asked. "It feels like I never have a choice."

"It's about slowing down the process. When you dissociate, you lose executive functioning and get lost in the limbic system where there's no critical thinking, decision-making, or insight. So as soon as you have an awareness of those physical sensations, name them as dissociation or checking out. Naming it helps to light up the front part of your brain."

"So, when I feel that darkness or blurry vision or that I can't move my arms and legs, I'm supposed to say to myself I'm dissociating?" he asked.

"It's the first step," I said. "Once you recognize what's happening, the next step is to ask yourself an important question: *Is it in my best interest to check out, or would I be more empowered if I stayed grounded and present?* That question is also going to help keep your executive functioning online because answering it requires reasoning and analysis."

"You're saying if I decide it's in my best interest to check out, I can?"

"Yes! The idea is to give you genuine control of the process. And we can practice strategies that help to ground you and short-circuit dissociation for times when you do decide that it would be more empowering to stay present."

"I have to be honest," he said, "it's hard for me to imagine a situation where staying present would be safer than checking out."

"I get it. I'm suggesting the thing that saved you is at times the thing that might hurt you. That's confusing. But when you're a deer in the headlights, it means you can't use your voice, walk away, disagree, or take a stand and advocate for yourself. We both know how helpful checking out was in the past. Are you able to see that going into freeze in certain situations might actually work against you?"

Danny was quiet for a while. Then with tears in his eyes, he said, "I'm

just thinking about all the times my boss has yelled at me at work and accused me of things I wasn't responsible for, and I just stood there and took it. Frozen. I never defended myself or told him to stop yelling. It always left me feeling stupid and incompetent."

"It's understandable that being yelled at and falsely accused would trigger the need to check out. It's been your safest go-to strategy."

"Yeah, but I think it's an example of what you're saying. It doesn't allow me to push back or insist that he treat me with respect. I wind up getting hurt more," he said. "I'm also sitting here realizing that whenever my wife gets angry with me, I check out rather than staying in the conversation and expressing my point of view. She sees it as a serious flaw and criticizes me for it. And often I feel traumatized by that as well."

"Is it possible that until right now you didn't realize you had a choice about checking out?" I asked gently. "Now you're beginning to learn that there are other options."

"I'm not sure how to stay present when I want to. You'll need to teach me," he said with both anger and determination. "But sometimes I might still choose to check out."

Without engaging in a power struggle, in subsequent sessions we began to explore some alternative options.

Grounding and Somatic Resourcing

What are effective ground strategies? Sometimes the simplest ones work the best. Aromatherapy is a fast and effective way to reground if the client can find a scent they love, one that has no associations to prior trauma or abuse. The olfactory part of the brain is closest to the sensory-emotional memory part of our brain, and scent can instantly evoke either positive or negative memories and feelings.

Danny chose a citrus scent that he felt flooded his body with good energy. He carried around a small vial of orange-blossom essential oil, lit citrus candles at home, and used a citrus-scented lotion on his body. It was also helpful to have the scent on hand for therapy sessions to address dissociation and quickly get him "back in the room." Other clients are easily re-grounded by a particular piece of music, a safe image, or positive affirmations on their phone.

Teaching clients somatic resourcing is also helpful as it doesn't require external objects to reground. Danny learned simple breathing exercises that incorporate counting, placing one hand on their heart and one hand on their belly, and bringing comfort through rocking or swaying. We went over tapping from EFT and the butterfly hug from EMDR—a bilateral self-soothing technique.

Another effective strategy comes from the work of psychologist Milton Erickson. It's called 5,4,3,2,1. It's designed to simultaneously activate the prefrontal cortex and limbic system, which helps keep clients in the optimum window of arousal. Either out loud or silently, clients say five things they see, hear, and either somatically or emotionally feel. Then four of each, three of each, two of each, and one of each. It's fine if they repeat things. The point is that it quickly lights up the front part of the brain and reorients them to the present.

Setting a timer and coloring a mandala or a picture in an adult coloring book is also re-grounding. The act of coloring lights up the limbic system and choosing the colors is an executive function that keeps the prefrontal cortex online.

Both in and out of session, Danny continued noticing the physical harbingers of checking out, named the process as dissociation, and remembered to ask himself if it was in his best interest to stay present or not. He told me there were still times when he was tired, didn't want to deal with his wife's criticism or his boss's anger, and chose to check out. He also started sharing more experiences of choosing to stay grounded and present, and he was genuinely surprised and delighted by the sense of agency and empowerment that he felt in that. For those times, we created some scripts for self-advocacy and practiced assertive verbal and nonverbal communication.

"For the first time in my life, I actually feel like an adult," he recently said. "I have so much more power and control when I don't check out and escape. But when I have to sit through a meaningless three-hour meeting at work, I'm going to keep using my superpower!"

There are still times when Danny and other clients who are trauma survivors will reflexively begin to dissociate when they become triggered or dysregulated. Earlier in my career, this was always a source of anxiety and fear. I wasn't sure how to work with it, and it would often hijack the session. Now that I understand the protective intention behind dissociation and can offer simple, effective ways to reground, I can use their impulse to dissociate as a teachable moment. I invite clients to be curious about the context. "What were the thoughts, feelings, or somatic sensations that set in motion the need to check out?" And the more we work in session to practice the skills that offer comfort without compromising a sense of agency and self-advocacy, the more they can consciously choose to stay present and experience the positive reinforcement of genuine empowerment.

Lisa Ferentz, LCSW-C, DAPA, is a recognized expert in strengths-based, depathologized trauma treatment and has been in private practice for more than 42 years. She presents workshops and keynote addresses nationally and internationally and is a clinical consultant to practitioners and mental health agencies in the United States, Canada, the UK, Italy, Spain, Israel, and Ireland. In 2009 she was voted the "Social Worker of Year" by the Maryland Society for Clinical Social Work. Lisa is the author of Treating Self-Destructive Behaviors in Trauma Survivors: A Clinician's Guide, *2nd Edition,* Letting Go of Self-Destructive Behaviors: A Workbook of Hope and Healing, *and* Finding Your Ruby Slippers: Transformative Life Lessons from the Therapist's Couch.

BY ALLISON BRIGGS

Recognizing Everyday Dissociation

A Survival Strategy Hiding in Plain Sight

My child says my name once. Then again. Then a third time. I'm sitting on our living room couch with my laptop in my lap. He's sitting across from me in a chair.

I have about five tabs open on my screen. I'm jumbled—clicking back and forth, losing my train of thought. On one tab are my practice notes. Two left to finish. But wait, I think there were two from earlier in the week. When I open a client's chart from a few days ago, I see one note missing. My stomach tightens. Ugh.

Then my mind does what it always does when I feel overwhelmed. It leaves.

I don't want to live here anymore. I'm tired. I've been wanting to leave Texas for a while now. I click to another tab: houses in Colorado. I dream. I imagine a different life—one where everyone walks around healthy and whole in sandals and hiking boots, long wavy hair, unshaven legs, drinking coffee and talking about integration and alignment.

I know I'm here, technically. I can hear sound—his voice. The TV. Music in the background. He multitasks like I do, lost in his own worlds. But my attention is already somewhere else, pulled forward into imagining, budgeting, planning—constructing a future that feels safer than the present moment.

It's so hard to come back. He says my name again. This time there's frustration in it. He's now next to me, pulling my face toward him with his hands. He's autistic and doesn't wait politely for my attention to return. He brings me back.

Only then do I realize how far gone I was. I had heard the sentence he was saying, but I hadn't caught up to its meaning until several seconds later. My body was here. My mind was not. I wasn't choosing to ignore him. I was already in the future—problem-solving, fantasizing, trying to secure something that didn't yet exist.

I'd been seeing therapy clients all day, and I was running on empty.

I feel the tightness in my chest when I come back. The familiar ache. The longing I hadn't wanted to feel. I take in his face, now close to mine, and notice how hard it is to stay in this moment and how agitated I feel inside my own skin. The sensory overload feels like nails on my skin, but it's just cold hands.

Nothing dramatic happened. I didn't disappear. I didn't lose time. I just left quietly—into planning, into an illusion of certainty—until someone who needed me pulled me home.

That's what worked when I was a child. I used my imagination to escape the pain of a very broken home—cockroaches in corners, a stepmother who walked around naked with a joint in one hand, a father who went into blind rages. And this escape tactic worked—it got me this far. I'm living my dreams, kind of. I became a therapist. No one else in my family went to graduate school. I broke some generational patterns. I stopped living like women weren't allowed to belong to themselves. I learned how to take care of my body, my needs, my life—and I created stability for my own kids—and I'm proud of that.

"I'm sorry," I tell my son. "But don't pull my face—you know I don't like that."

Even as I apologize, I feel the itchy ache in my chest again, the urge to leave. And I realize what I've been doing: using the old coping tool that once kept me alive, a tool I don't want to hand down to him as absence. Imagination works great as a form of escape—until it doesn't. I don't want to repeat what happened to me. I look at him—his face, the curve of his mouth. He really is handsome, and not just because I'm his mother. We sit together on the couch.

"What is it, sweetie?" I ask.

"Nothing," he says. "I just feel kind of sad."

I know what it's about. There's been a lot lately, for him and for me: stress, uncertainty, and the way old attachment patterns resurface under pressure. When things feel like this, I tend to run into my mind. He runs toward connection with me. I'm his person and I know that, but sometimes being one person's person is a heavy responsibility.

"I know, honey," I say, using the same tone I've learned to use with my clients—and with my own inner child. "I'm right here with you."

We sit in silence. I notice my chest again, an opening, small, but still accessible.

I picture my younger self. I say to her, quietly, *I'm here. I love you. I'm not going to run from you.* I imagine holding her, telling her how sweet she is. My attention moves gently back and forth—between her (my chest) and my son. He shifts beside me. His posture softens. I can feel him coming back, too.

All it took was my presence—with myself, and with him.

When he gets up, I stay where I am. I sit with my younger self for a few more minutes. I'm learning how to do this—one small moment of awareness at a time. It doesn't come easily. It never did. But it became imperative during the pandemic, when I learned how much of life can't be planned for—and how imagination, the very tool that once saved me, can turn against me when it pulls me too far from now.

I used to think of dissociation as something dramatic—blankness, shutdown, losing time. That's how it's often taught. But more and more, I see it show up like this: quiet, functional, woven into the rhythms of ordinary life.

Everyday Dissociation

As therapists, we're particularly good at staying with others—tracking emotion, attuning to subtle cues—but we're not always good at staying with ourselves. We learn to listen exquisitely to what's external, while missing the quiet hum of our own unease.

We don't always call it dissociation when it looks like planning. Or scrolling. Or fixing. Or fantasizing about moving to a new state where everyone's already healed. But that's exactly what it is—a movement away from what's unbearable or uncertain inside us and around us.

We live in a culture that's remarkably connected and yet profoundly disconnected at the same time. We interact asynchronously on a thousand platforms—but rarely synch up to our own heart. We're not just encouraged, but often rewarded for looking outward, achieving more, staying busy. Meanwhile, the quiet truth of what lives in our bodies often goes unrecognized.

We leave ourselves to cope.

In spite of—or maybe because of—how much I do this in my own life, I've come to pay close attention to this everyday dissociation in my therapy practice. There might be a certain flicker in a client's eyes, a faraway gaze. The way someone's story gets emotionless, faster, more abstract. They're still talking, but I can feel them pulling away. Sometimes they don't even know they've left.

When I see my clients do this, I slow down, lean in, drop way down into my own body and say, "Just for a moment, see if you can notice what's happening in your body. This isn't about fixing anything. Just checking, *Where are you? What's here?*"

I pause and allow time and silence to do its job.

"Do you feel an ache? If so, how old does it feel and where does it live? Can you imagine what it might look like, if it had a shape, or a face?"

This kind of gentle imagining can reengage the part of us wired for connection, attunement, and care: the social engagement system. And when you do this regularly—not just noticing but staying with what you find—it becomes more than mindfulness.

It becomes compassion and a return to the one home that will always be yours: yourself. That ache—and how old it feels—is one way to recognize the part of yourself that you disconnect from. For me, it lives in my chest. My diaphragm tightens. So does my jaw. That's my cue: she's needing my attention. The little girl who was abandoned. I'm

learning to not abandon her. I'm learning to show up.

This is a lifelong practice. Not something you arrive at in one moment, but in many small ones, strung together over time. Going back to sleep—and waking up. One conscious breath, one moment of awareness, at a time.

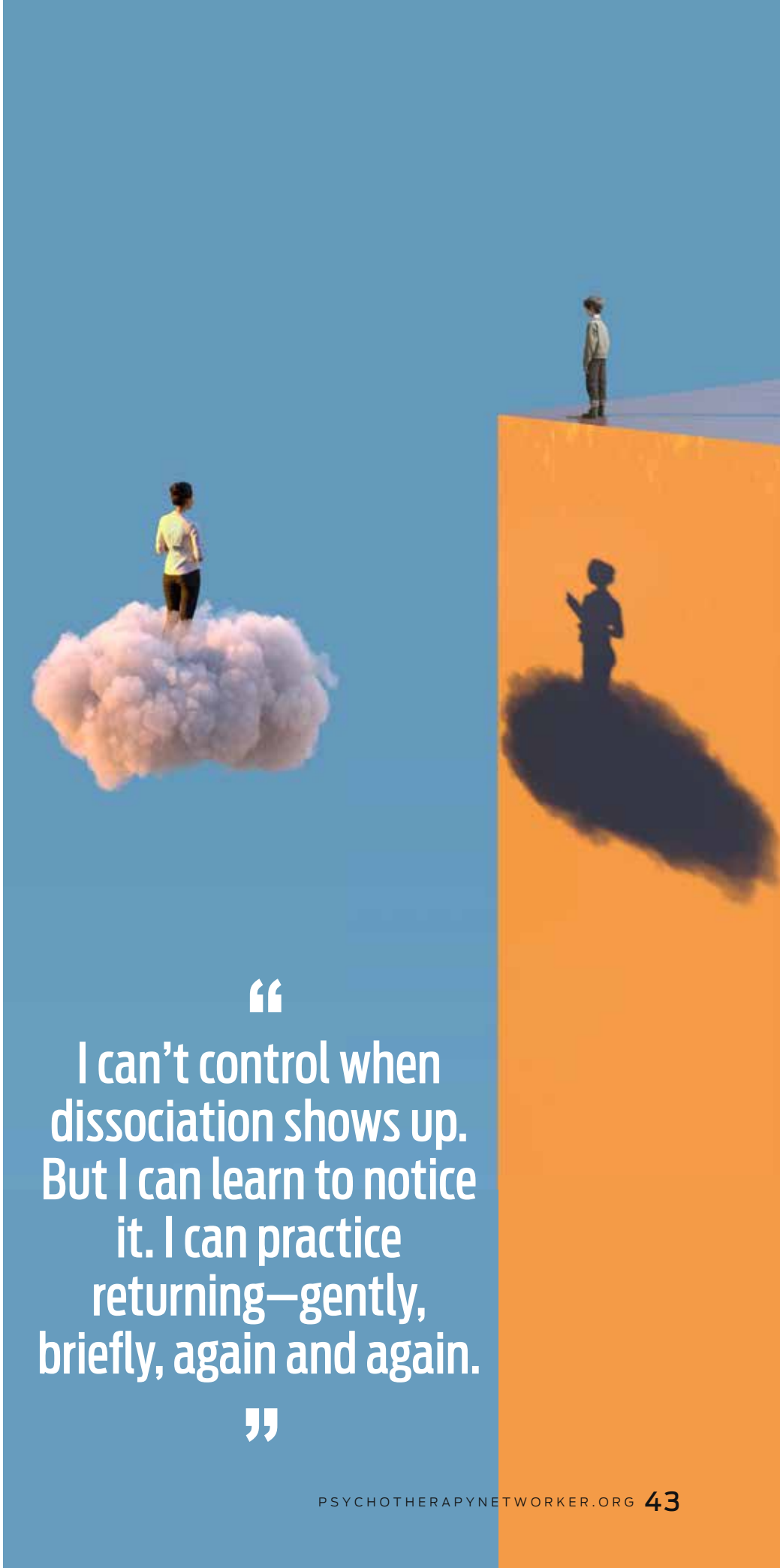
This is not about making dissociation wrong. It's a brilliant survival tool. It's how many of us made it through the parts of life that were too much. It's how I became who I am. And it's how many of my clients have protected what was most sacred in them.

But survival isn't the same as presence. And eventually, our old tools start asking to be updated. For me, the shift doesn't happen through effort. It happens through contact. My son's hand on my face. My own breath. The ache in my chest reminds me I'm still here. It lets me know that something in me still longs to be met.

I can't control when dissociation shows up. But I can learn to notice it. I can practice returning—gently, briefly, again and again. That's the work. And it doesn't have to be heroic. Sometimes it's just sitting with someone you love and staying.

There's no finish line with this kind of healing, no arrival. Just moments—small and sacred—where I catch myself leaving, and choose, for a breath or two, to stay instead. With my son. With myself. With the ache and the aliveness of being here. It's not always graceful. But it's real. And for now, that's enough.

Allison Jeanette Briggs, LPC, is a trauma therapist and writer specializing in developmental trauma, codependency, and relational healing. She integrates EMDR, Brainspotting, and other trauma-informed modalities to help clients break free from survival patterns and reconnect with their authentic self.



"I can't control when dissociation shows up. But I can learn to notice it. I can practice returning—gently, briefly, again and again."

BY DANIEL OPPENHEIMER

Psychiatry Has a New Hero

Awais Aftab Envisions a Humbler Approach to Mental Illness

There's a moment I love, in a recent Substack post by psychiatrist Awais Aftab, that captures well the promise, and challenge, of his far-reaching vision of how the field of psychiatry needs to change.

Aftab, a 38-year-old émigré from Pakistan now practicing in Cleveland, is reviewing *Unshrunk*, the new memoir by anti-psychiatry activist Laura Delano. Much of the review is a deeply empathetic synopsis of her story of feeling mistreated by the mental health establishment, but then Aftab steps back to bring his own perspective on psychiatry to bear. It's not a defense of the profession exactly—he concedes that psychiatry seems to have done wrong by Delano—but it's optimistic. It begins from the presumption that the endeavor is worth reforming, and is capable of it.

"I can't help but wonder," he writes, "how Delano's experiences would have turned out had she been offered an accurate explanation of the nature of mental disorders, psychiatric diagnoses, and psychiatric treatment instead of the bullshit story she was fed. Imagine if she had been told: You can recover, you can be well, and even medications may be unnecessary at some point in your life. . . . Mental health problems exist at an intersection of temperament, physiology, development, and interpersonal challenges and cannot be understood in isolation. Descriptive diagnoses are fuzzy and fluid, especially early in life. They can change over time, and professionals often disagree. Diagnostic categories do not capture your essence or your identity. What you are experiencing is maladaptive, but it does not lack meaning. Engage with your psychological pain, understand what it is trying to tell you, and seek a meaningful life. Medications are imperfect tools that can assist you in the process. They have the ability to both help

and harm, and we will work closely to address any problems you experience with them. If the balance ever shifts such that the medications are hurting more than they are helping, you have other resources at your disposal. The treatment of mental illness does not substitute for family, work, education, and community as sources of meaning and fulfillment."

If Aftab is doing something important here, and I believe that he is, it's not something that's easy to distill into a simple phrase or concept. The mouthful of a name that Aftab gives to his perspective, which he'll be fleshing out much more fully in the book he's now writing for Harvard University Press, is "integrative critical psychiatry." A simpler way of putting it is simply "pluralism." Or maybe pluralism plus humility plus wisdom.

The word that came to mind for Allen Frances, one of the major figures of modern psychiatry, when he first met Awais Aftab in 2019, was "throwback."

Aftab was 31 at the time, and a fellow in geriatric psychiatry at UC San Diego. He'd reached out to Frances, who'd chaired the *DSM-IV* task-force for the APA, to see if he'd speak to the fellows and residents at the hospital. Also because Frances, who has spent much of the past two decades leveraging his reputation to criticize the discipline of psychiatry, was a personal hero of Aftab's.

The two met for drinks, and Frances sensed very quickly that the young man was special. "I knew immediately he was going to be a star in psychiatry," says Frances. "He was a throwback to the kind of people you saw more in psychiatry 50 years ago, when it was one of the broadest professions in the world, when it encompassed everything about human nature. He was that kind of person at a time when most psychiatric residencies had reduced themselves to teaching medication management."

A few months after that first conversation, Aftab asked Frances to be his first conversation partner in a series of "Conversations in Critical Psychiatry" that Aftab was launching with *Psychiatric Times*, the main trade journal of the profession.

Frances agreed, and their conversation, which was conducted in person and then refined via email, was published in May of that year. It was a fascinating dialogue, which touched incisively on many of the critiques that Frances had been levying against his fellow psychiatrists for many years, including the systemic overdiagnosis and overmedication of patients, the philosophical fuzziness of many of even the most widely used categories of mental illness, and profound flaws in recent editions of the DSM, including the *DSM-IV*, which Frances himself had overseen the development of.

The conversation was also an intellectual coming out for the young Aftab. He was able to keep up with Frances as they traversed decades of disciplinary history and controversies, and to expertly negotiate a critique of psychiatry with a recognition of its virtues. It's very tough on the discipline, but it's tough love. He's talking to his colleagues from the inside, beginning from the premise that most psychiatrists are acting in good faith and doing more good than harm, even if they're sometimes doing more harm and less good than they should.

Aftab followed the interview with Frances with dozens more installments of the "Conversations" series, talking over the course of two years with an extraordinary range of leaders, reformers, critics, and antagonists of psychiatry, meeting each expert on his or her own terms, bringing to each conversation a fierce desire to understand from almost every conceivable angle what we mean when we talk about things like mental illness, mental health, diagnosis, depression, anxiety, institutionalization, medication, the biological basis of the psyche, the genetic disposition toward mental illness, and the inescapable ambiguity that creeps in whenever we seek to ameliorate the suffering of other human beings.

In an interview with Lithuanian psychiatrist and human rights advocate Dainius Pūras, to give a typical example of Aftab's method, he spends much of the interview generously positioning Pūras to elucidate his critique of the prevailing approaches to psychiatric care in the west. He also, however, gently pushes him to complicate the critique when it runs the risk of seeming too reductive.

"That [failure] is certainly true of the United States, where the seriously mentally ill experience much higher rates of homelessness and incarceration," says Aftab. "Conversely, in many other parts of the world, conditions are no better, as reported by the Human Rights Watch. Shockingly large numbers of individuals with mental illness around the world spend their lives chained like cattle. I myself, when I lived in Pakistan, saw an individual with a psychotic illness shackled to a tree in a village, with no access to medical care, and with the family possessing a premedical conception of madness. This suggests to me that focusing exclusively on biomedical diagnoses and treatments as the boogeyman is naïve, and severely underestimates the collective societal effort that is required to ensure humanistic and effective care for the mentally ill. Your thoughts on this dynamic?"

The series ended in 2022. Aftab then launched his Substack newsletter, *Psychiatry at the Margins,* which now has more than 17,000 readers, among them an impressive array of elite journalists, academics, and clinicians. He's continued to run in-depth interviews on the Substack, along with long essays and reviews authored by himself and others in the field. He also uses the space as an occasional clearing house for links to interesting research, news, and writing in the world of mental health.

In addition, somehow, he's published a steady stream of papers in peer-reviewed journals of psychiatry, psychology, and philosophy of science, as well as an anthology from Oxford University Press of the best interviews from the *Psychiatric Times* series. And this year, he signed a contract to write the big book that clearly has been germinating in his brain over the course of all this work. It's provisionally

titled *Remaking Psychiatry: A New Understanding of Mental Disorders.*

The effect of all this work is that Aftab has established himself in a unique space at the intersection of academia, journalism, and clinical practice. He's a highly credentialed clinician who's been able to ingest pretty much all the relevant realms of academic expertise—genetics, neuroscience, psychiatry, psychology, philosophy, public health—and he's an extremely lucid and compelling writer who's very much in touch with the human muddle at the heart of it all.

The Philosophy of Psychiatry

Growing up in Pakistan, Aftab's first intellectual love was philosophy. He felt restricted, but also stimulated, by the religious and cultural orthodoxies that structured so much of the life around him. He didn't understand why things were the way they were, nor why the discussion around them seemed so limited and fraught. Philosophy seemed a way into these dilemmas.

"If I had had the right opportunities, I may have gone into academic philosophy," he says, "but in Pakistan, that was basically not a viable option at all."

Instead, like his older sister and others in his family, he turned to medicine. In medical school in Lahore he found psychiatry and began a self-directed education in the philosophy of science and medicine, at first just reading on his own and then eventually connecting to other people who were interested in the questions that were preoccupying him.

"The philosophy of the psychiatry field is very richly interdisciplinary," he says. "So you have psychiatrists, psychologists, philosophers, historians, anthropologists, sociologists, and they all talk and discuss these things."

After finishing medical school, he began his residency in Doha, Qatar, working there for a year while waiting for his U.S. visa to come through, soon moving to America to complete his training at Case Western Reserve University in Cleveland, Ohio. His clinical practice and philosophical exploration continued to feed each other but also began to come into tension.

In the hospital, he was expected to assign his patients a diagnosis, quickly, and then to explain it to them, and their families, as though the words he was using to describe their suffering were scientific, the causes were generally understood, and the treatments were developing steadily toward greater precision. It was a basically orderly conceptual universe.

In the philosophical literature he was reading, on the other hand, everything was uncertain. Basic concepts of disease, disorder, diagnosis, and biology were treated with skepticism. And it wasn't just the philosophers. Psychiatric insiders like Frances were subjecting the whole edifice of the DSM to withering criticism. And the cutting-edge researchers in the field were coming up short in their efforts to ground psychiatry in a coherent and predictive genetic paradigm. They weren't locating discrete forms of mental illness in the genome, repeating the cycle of optimism and disappointment that previous cohorts experienced in their efforts to find answers in chemical imbalances, brain scans, and schizophrenogenic mothers.

Psychiatry seemed to be under protracted siege, and yet Aftab saw very little of this complexity reflected in how his supervisors and clinical colleagues talked to each other and patients about their work.

"There was this huge disconnect," he says, "between the kinds of really thoughtful, rich conversations that academics and philosophers were having and what the average clinical psychiatrist was getting exposed to. So I felt compelled to do something about it."

He didn't yet have a big theory to offer the world of how we should be talking about mental illness, to replace the incoherent ways we were talking about it, but what he did have, he thought, was the capacity to initiate a more useful conversation.

Beyond Tidy Narratives

"He [Aftab] doesn't inhabit any familiar particular narrative," says Rachel Aviv, staff writer for *The New Yorker* and author of the quite wonderful 2022 book *Strangers to Ourselves: Unsettled Minds and the Stories That Make Us.* "He's feeling his way through with an independent mind, and reading him makes the idea of these tidy narratives seem obsolete."

Aviv was first introduced to Aftab's writing by a good friend of hers, a doctor who writes about issues of public health and medicine. She sent Aviv an email with a link to a post by Aftab with the injunction that Aviv had to read it immediately. Also on the email chain was another friend, a psychiatrist. Now the three of them occasionally share new stuff from Aftab via email or text, usually with a quick prefatory note that says something like, "He did it again."

What he did–does–is bypass the binary that structures, or imprisons, so much of the conversation and conflict about mental health and illness in America. I sometimes visualize this conversation as a kind of tableau in which two figures are standing on either side of a chasm, glaring across at each other with deep suspicion. The rest of us are huddled down below in the chasm. We're vastly more numerous but far less organized and far less clear on what we think, and so we defer, uneasily, to the figures above.

One figure is the Scientist, the very model of a modern biological psychiatrist. He's in his 50s, has an MD-PhD from Harvard, is chair of a department at a major research university, and is the principal investigator on a big, multisite study of treatment for first episode psychosis. He's aware in an ambient way that people have suffered, in the past, from the profession's excessive faith in its own expertise, and that his field has yet to establish a really firm biological understanding of the kinds of distress it treats and studies. This doesn't, however, inspire in him much skepticism. Instead, his core motivating belief is that by doing the science and treatment better this time around, we can

improve people's lives in small ways in the short term and move inexorably toward truly transformative conceptualizations and treatments for mental illness in the long term.

Opposite him is the Survivor. She's in her 50s as well. When she was a teenager, she began acting out in ways that so alarmed her parents they brought her to a psychiatrist, who diagnosed her with bipolar disorder I, prescribed her some meds, and conveyed to her and her parents that the best she could probably hope for, long term, was a simple, highly medicated, highly managed life. A half-life, basically, but one that was tolerable. For the next few decades, like so many people with severe mental distress, she rode a roller coaster of dysfunction that involved occasional institutionalizations, periods of relative stability, long stretches of living with her parents, various revisions and additions to her diagnoses, and increasingly complex cocktails of medications. At some point, after reading the right book or finding the right online forum, she decided to get off most or all of her medications, joined a community of fellow survivors with similar stories, and reoriented her identity around a root-to-branch critique of psychiatry, the mental health system, and the medicalization of human distress and neurodiversity.

Both the Scientist and the Survivor are good, caring people. They're both driven to help others, and they rely on their hard-won insight into the nature of the human psyche and human suffering to aid them in doing so. But they're each, unfortunately, trapped within a too-rigid framework for understanding the world in which they, and we, live.

One way to conceptualize Aftab's project, in this schema, is that he's trying to listen closely to what these two figures have to say, assimilating what's valuable in their perspective, while adding more voices to the conversation, each with their own valuable but incomplete perspective. A scan of recent posts on his Substack includes: an interview with a researcher integrating psychoanalysis with computational science; a review of a new book by a neuroscientist proposing a new paradigm for how her field will solve "brain disorders"; a brief commentary on a statement from the American Psychiatric Association on the efficacy and safety of psych meds; and a summary of a new peer-reviewed paper that Aftab and a colleague wrote on what they call the "Rumpelstiltskin Effect," which is about how the act of diagnosis itself can have healing benefits.

It's a chorus of voices and overlapping ways of understanding and approaching the mind and its discontents, not a single paradigm or silver bullet. "Psychiatry has had a tendency to rely on single answers based on different kinds of faddish paradigms," says Aftab. "Pretty early in my career, I realized that that's not going to take us anywhere meaningful. So we have to do two things. One, we give up the search for simple answers and embrace complexity in a meaningful way. Secondly, we embrace a very strong form of humility. We recognize that, scientifically speaking, we are in a very premature state. We are just scratching the surface of these questions, and we can look at mental health phenomena through a variety of lenses and perspectives. Each brings with it a certain advantage or disadvantage, and sometimes they're contradictory in interesting ways, or incompatible, but we are not yet in a position to sort them out."

It's not, on the surface, a radical way of looking at a topic that everyone concedes is immensely complex. What's radical in it, perhaps, is the revision that truly, madly, deeply adopting it would demand to psychiatrists' sense of themselves and their way of being with patients.

Aftab gets at this in the introduction to his 2024 anthology, when he draws a parallel between psychiatry and policing. Both professions, he writes, deal with humanity at its worst and most vulnerable. Both are authorized to exercise control over people to an unusual degree. Both have a checkered history of abuse and error. Both, even at their best, produce a lot of "unhappy customers." And both seem to be necessary, unavoidable, to the adequate functioning of society.

The result, in both cases, is that they attract a constant and often quite intense barrage of scrutiny and criticism. This often feels unfair to their practitioners, and no doubt much of it is unfair. The key point for Aftab, though, is that in a global sense it's utterly fair that psychiatrists (and police too, surely) receive this level of skepticism. It's simply the job, with all its privileges and burdens. Psychiatrists are paid well, accorded high social status, legally vested with the power to prescribe psychoactive drugs, and charged with managing profound decisions about not just what kinds of lives many of us will lead but the very terms by which we will understand them. How could it be otherwise?

To be a psychiatrist in America in 2026, then, isn't a bad thing to be, but it's complicated. And the ethical demand is to honor that complexity, within pragmatic reason, to the best of your ability.

What this looks or sounds like is highly context dependent. It will look different in a cozy office with a worried-well patient than in a hospital ER confronting someone with severe psychosis, and different yet again in the pages of an academic journal of philosophy of science. To read Aftab over time, however, is to get an increasingly strong sense of the *feel* of it.

Above all, perhaps, it feels literary, devoted at its core to representing the beauty, uncertainty, and poignancy of the human condition, and—more pragmatically—to maximal flexibility when it comes to the right diction, or genre, for the occasion and patient.

Such an approach would've felt very familiar to Sigmund Freud and William James, the fathers of modern psychiatry and psychology, respectively, both of whom were deeply influenced by literature and were themselves exceptional writers. But it's not, to say the least, the current vibe of how 21st century psychiatry or psychology imagines itself. It's also, too often, not what the rest of us want from the discipline. We want answers, categories, diagnoses, science.

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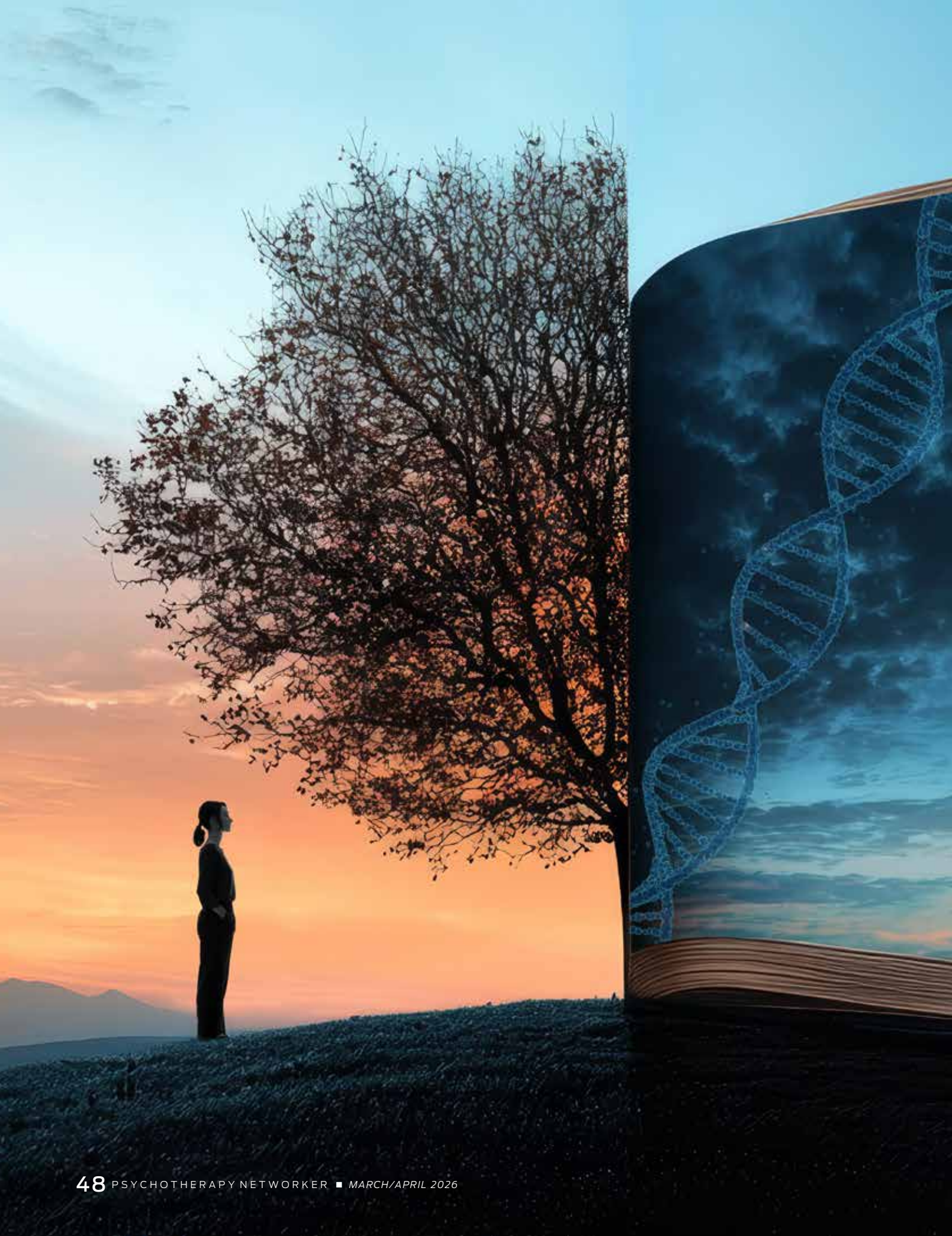
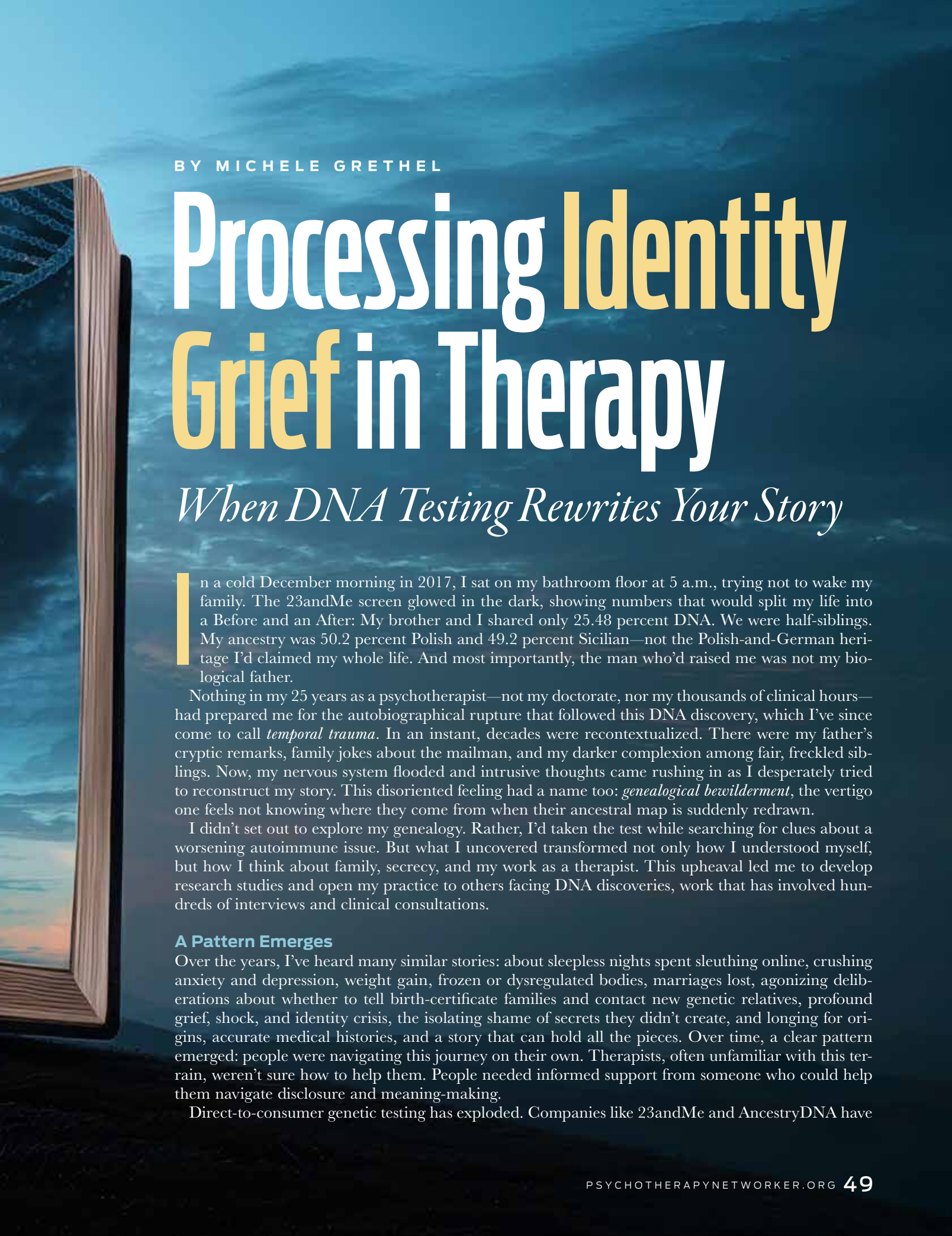




BY MICHELE GRETHEL

Processing Identity Grief in Therapy

When DNA Testing Rewrites Your Story

In a cold December morning in 2017, I sat on my bathroom floor at 5 a.m., trying not to wake my family. The 23andMe screen glowed in the dark, showing numbers that would split my life into a Before and an After: My brother and I shared only 25.48 percent DNA. We were half-siblings. My ancestry was 50.2 percent Polish and 49.2 percent Sicilian—not the Polish-and-German heritage I'd claimed my whole life. And most importantly, the man who'd raised me was not my biological father.

Nothing in my 25 years as a psychotherapist—not my doctorate, nor my thousands of clinical hours—had prepared me for the autobiographical rupture that followed this DNA discovery, which I've since come to call *temporal trauma*. In an instant, decades were recontextualized. There were my father's cryptic remarks, family jokes about the mailman, and my darker complexion among fair, freckled siblings. Now, my nervous system flooded and intrusive thoughts came rushing in as I desperately tried to reconstruct my story. This disoriented feeling had a name too: *genealogical bewilderment*, the vertigo one feels not knowing where they come from when their ancestral map is suddenly redrawn.

I didn't set out to explore my genealogy. Rather, I'd taken the test while searching for clues about a worsening autoimmune issue. But what I uncovered transformed not only how I understood myself, but how I think about family, secrecy, and my work as a therapist. This upheaval led me to develop research studies and open my practice to others facing DNA discoveries, work that has involved hundreds of interviews and clinical consultations.

A Pattern Emerges

Over the years, I've heard many similar stories: about sleepless nights spent sleuthing online, crushing anxiety and depression, weight gain, frozen or dysregulated bodies, marriages lost, agonizing deliberations about whether to tell birth-certificate families and contact new genetic relatives, profound grief, shock, and identity crisis, the isolating shame of secrets they didn't create, and longing for origins, accurate medical histories, and a story that can hold all the pieces. Over time, a clear pattern emerged: people were navigating this journey on their own. Therapists, often unfamiliar with this terrain, weren't sure how to help them. People needed informed support from someone who could help them navigate disclosure and meaning-making.

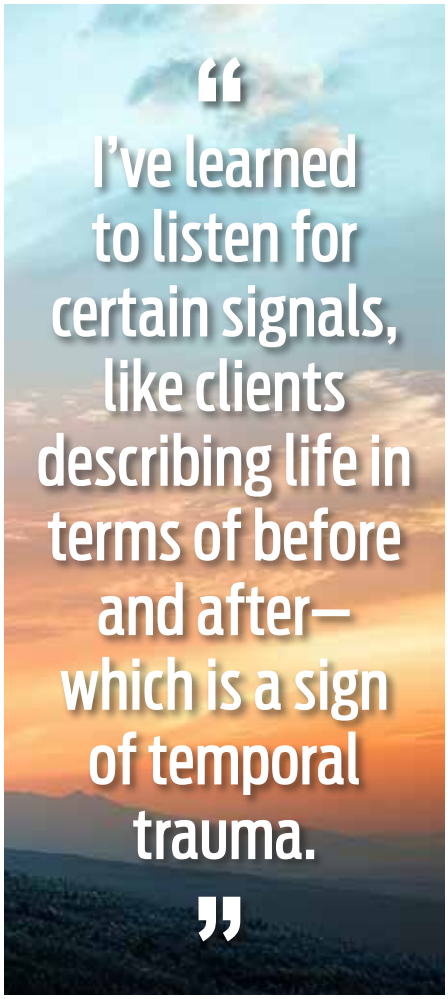
Direct-to-consumer genetic testing has exploded. Companies like 23andMe and AncestryDNA have

made it possible to connect with relatives at the click of a mouse, surfacing family secrets once thought safely buried. The sheer volume of testing means these cases are now commonplace in clinical practice. Historically, we lacked respectful language for these experiences, most of which carried stigma and blame. Medicine leaned on "misattributed paternity." Genealogy used "nonpaternity event." The community has increasingly adopted NPE, or "not parent expected," to humanize the experience and name the identity shock without judgment. Many of us also use MPE, or "misattributed parentage experience," as an umbrella term that includes NPE, donor-conceived individuals, and late-discovery adoptees.

When Therapists Reinforced Secrecy

For decades, mental health professionals operated in a culture that prioritized family stability over truth-telling. When families came to therapy with secrets about parentage, whether from affairs, donor conception, or adoption, many clinicians supported maintaining these secrets, particularly when children were involved. The reasoning was protective: why disrupt a family when a child knows no different? Even today, therapists are split on this stance, and many continue the trend, relying on outdated procedures and disregarding the growing evidence that lying to individuals about an essential part of their personhood causes profound harm. DTC genetic testing has made this approach untenable. We need to shift from supporting secrecy to helping families navigate how to disclose the truth honestly and compassionately.

In my own work, I've identified patterns in these unexpected DNA discoveries, with several phases. For many, the initial discovery brings shock and trauma. Clients describe their nervous system going into overdrive, being unable to sleep or think about anything else. This is followed by identity exploration, and anxiety peaks as people engage in seemingly obsessive genealogical detective work, scrolling through DNA matches, researching family trees, and confronting relatives about family narratives. This isn't pathology; it's an adaptive attempt to restore coherence to a fractured story. Eventually, identity reconstruction begins. New connections form. People start reconciling competing stories about who they are, where they come from, and what family means. Finally, identity synthesis emerges, a shift in worldview where trusting family becomes a shaky concept and the self finds new anchors.



These phases can be recurring, and for some, it's a process that takes years or may never fully resolve. Life events like the birth of a child or grandchild or the loss of a family member involve continuously reworking your self narrative. Even seemingly small moments like writing your name or celebrating a new ethnic or racial holiday can trigger confusion and imposter syndrome.

The Disclosure Dilemma

While a DNA discovery itself is traumatic, sharing this news with others adds another layer of complexity. I call this the disclosure dilemma—the challenge of narrating your discovery while gauging reactions, anticipating consequences, and managing stigma, betrayal, and anger, often all at once. What makes this disclosure uniquely complicated is that the secret belongs to someone else. When you disclose what you've discovered, the revelation reverberates across your entire family system. You're not just voicing your truth; you're potentially exposing someone else's decades-old secret, disrupting other people's sense of family identity and forcing them to face questions they might not want to.

My own DNA discovery was followed by halting phone calls with my biological father and hope braided with dread. A child-part of me braced for abandonment, but I also knew the thread of abandonment had been stitched throughout my early life. The lifelong anxiety I'd felt, which I call *ambient anxiety*, a constant hum of unease I couldn't quite place, suddenly made sense. This discovery of trauma not only changed my past, but shook my present and clouded my future. I didn't want to be anyone's secret, nor did I want to be the grenade in my family or another family's home. I didn't feel rage as much as I felt sadness and loss for imagined histories and love that might have been. Naming both truths became an act of survival: the dad who raised me was still my father in a thousand ways, and the man whose genetics I carried was too.

What Therapists Need to Know

When I sit with clients who've experienced a DNA discovery, I recognize the tremor in their voices. They're trying to metabolize shock while making impossible decisions—about whether to contact a biological parent, how to tell their children, whether to confront the parent who kept the secret, how to rewrite their medical history, and how to reconceptualize their child-

hood. I've learned to listen for certain signals, like clients describing life in terms of *before* and *after*—which is a sign of temporal trauma. I recognize that those who focus obsessively on resemblance, ethnicity, or genetic connection are experiencing identity grief. Those who express disorientation about their origin are experiencing genealogical bewilderment, while those who feel distress about the disconnect between felt identity and genetic reality are experiencing a kind of genetic dysphoria. I listen for a sense of paralysis around who to tell, when, and how, which signals disclosure anxiety. Feeling responsible for protecting someone else's lie reveals the crushing burden of secrecy. These signals indicate that my client needs specialized support.

In the weeks and months following a DNA discovery, there are certain therapeutic approaches that consistently help. Most clients arrive in a state of physiological alarm where their nervous systems are screaming "Danger!" Before doing anything else with these clients, we need to stabilize their bodies by supporting basic functioning like sleep, hydration, movement, and paced breathing. I often suggest setting "sleuthing windows"—limited times when clients allow themselves to research, which prevents spirals into endless online searching. This isn't about stopping their investigation; it's about containing it so their nervous system can find moments of safety.

Once their body begins to settle, I'll help clients understand the phases of identity transformation so they can figure out where they are in the process. For instance, knowing that you're currently in the exploration phase, where it's normal to feel obsessed about finding out more information, offers hope without false promises. It normalizes the client's experience and reminds them that they're not losing their mind, they're simply having a predictable response to an extraordinary situation.

Next, it's essential to communicate to the client that the grief they feel is real. I validate both their ambiguous and disenfranchised losses. The disappearance of an imagined genetic lineage is a real loss. The loss of resemblance—of looking in the mirror and seeing your parent—is real. The rupture of trust is real. I don't minimize these losses because "nobody died." Instead, I help clients create rituals that honor what's been lost, like writing unsent letters, revisiting family photographs with new eyes, and creating new narratives that hold both the old story and the new truth. These rituals transform chaos into meaning, giving the grief somewhere to land.

The disclosure dilemma is almost inevitable, so I help clients plan for it as a process rather than a single event. We explore their motivations: Are they seeking validation? Their medical history? A relationship? We identify who needs to know first, what language they'll use, how they'll handle secrecy requests from family members, and what boundaries they'll need around this information. I prepare them for mixed outcomes. Often biological parents embrace contact; others reject it entirely. Most people seek validation of their identity. Framing this clearly helps clients manage their expectations and reactions without shame when things don't go as hoped.

Language matters. I use person-first, non-stigmatizing terms like NPE or MPE rather than legacy phrases that carry moral judgment. The language you choose communicates whether you understand what's happening to them. But it's not just about avoiding outdated terms; it's also about respecting where clients are in their journey. Well-meaning therapists often rush to comfort with phrases like, "the man who raised you is still your father" before the client is ready to hold that both/and, and they may never be able to again. In the early stages of discovery, clients need space to grieve what they've lost before they can integrate what remains. Shifts in language create safety in the room.

Preparing our Profession

Our field is only beginning to equip therapists for this work. In workshops and continuing education, I invite clinicians to examine their own stories and countertransference. I teach therapists how to sit with identity shock without trying to fix it, plan disclosures that account for complex family systems, treat ambiguous and disenfranchised loss as legitimate grief, and navigate the ethical complexities when family secrets surface. We need reflective supervision that normalizes the parallel process of holding clients' revelations while tending our own reactions. We need skills training in disclosure-planning and stigma-informed care across NPE, late discovery adoptee, and donor-conceived populations.

For me, reclaiming my story has meant holding space for contradictions that don't resolve neatly. My mother loved me fiercely, yet made choices I'll never fully understand. My truth became other people's trauma, half-siblings who didn't ask for this disruption, and children in another family facing their own reckonings. Acknowledging the damage of secrecy while honoring the complexity that produced it isn't about forgiveness or blame. It's about recognizing that DNA discoveries rarely have heroes or villains. They're just people trying to survive.

A part of my work now includes trying to help our profession see what's already in the therapy room. MPE isn't a niche curiosity; it's an evolving reality of modern kinship. Medical and mental health policies that encouraged families to protect secrets no matter the cost are no longer tenable. DTC testing has pulled back the curtain, and we must modernize the way we practice and shift from encouraging families to lie, presumably to protect others, to supporting them in coming clean. It's an invaluable stance, one that honors everyone's right to know where they came from.

Michele Grethel, PhD, is a licensed therapist specializing in supporting individuals and families navigating DNA discoveries. Her research includes interviews with individuals, families, and healthcare providers. She serves as part-time faculty at the USC Suzanne Dworak-Peck School of Social Work, offering professional development training and consultation in this evolving field. Contact: FAIRDNA.com and Michelegrethel.com.

A Special Case Study

BY ELLYN BADER & ALEXANDRA SOLOMON

The Case of the ANGRY COUPLE

TWO THERAPISTS, TWO DIFFERENT APPROACHES TO RECONNECTION

Jess, a retired engineer in her mid-50s, and Liam, a math instructor 10 years her junior, have lived together for 20 years. They met skydiving, though they haven't been doing anything adventurous for a while due to Liam's worsening sciatica.

They're coming to therapy because they've grown increasingly distant since Liam took medical leave, although occasionally he tutors online. Their fighting has escalated to the point where they barely speak. "He's so passive aggressive," Jess says. "When I come home late, he double locks the door so I can't get in unless I repeatedly knock and call his phone."

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

Jess laughs out loud and mumbles something unintelligible.

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

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

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

Becoming a Team Again

BY ELLYN BADER

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

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

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

Early on, I need a commitment from both partners that they're willing to engage in behavior that will lead to change. I proceed with a process intervention, a structured "meta-argument" exercise designed to illuminate the futility of *how* they fight, not what they fight about.

A New Dream

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

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

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

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

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

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

"I felt very heated," Jess says.

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

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

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

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

It's a bit of an aha moment for both, and they tell me

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

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

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

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

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

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

Jess and Liam nod affirmatively.

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

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

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

> "Who do you get to be now in this season of your life? What do you get to claim and experience, separately and together?"

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

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

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

"Sure," he replies.

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

He nods.

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

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

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

"Yeah, a small part," he replies.

"That's enough," I say. "I'm not asking you to leap out of a plane today. But I am curious whether each of you would be willing to do another brief experiment. It's something that all great teams do, it'll take less than five minutes, and you won't have to commit to anything."

Both Liam and Jess agree.

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

Saying what you value is about the other person. Describing why it's meaningful lets them know about

you. This is a critical step toward building a strong team that brings out the best in everyone. It means being acknowledged for what you do and who you are. "Take your time with this," I tell them.

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

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

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

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

Processing Transitions

BY ALEXANDRA SOLOMON

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

I make a mental note that although

> "When someone protects themselves *this* hard, it usually means the relationship still matters."

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

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

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

Three Lenses

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

Each of us brings our own proclivities and coping strategies to transitions, often honed over many decades. Some of us ritualize all developmental milestones. Some of

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

I help couples to locate themselves and talk explicitly about transitions for three important reasons. First, the journey is often strangely invisible to the traveler. It's hard to see the forest when you're entangled in the branches of the trees. I've found that naming the transition itself feels validating and orienting for couples. Second, silence is itself a communication. The unspoken still shapes the space, leaving partners to import their own—often inaccurate—stories about the other's experience. A couple who doesn't talk about their experiences of transition will still embody and enact those experiences. Third, talking about it together with me puts the couple in the ideal position relationally—shoulder to shoulder, looking together at "the problem."

My goal is to help Jess and Liam grieve *together* the losses of the passage of time and changes connected to aging and health. Although it seems paradoxical, when we're brave enough to grieve, we create fertile soil from which something new can grow. We move away from asking, "Who do you have to be now that you are older?" and into asking, "Who do you get to be now in this season of your life? What do you get to claim and experience, separately and together?"

As we move further into the session, I learn about the ways they each pull away from the other to self-protect. Jess shares her belief that Liam purposefully locked her out during their most recent fight, and we explore the possibility that she feels forgotten, or rejected by Liam. Here I think about the problem-saturated narrative keeping them stuck, given the brain's relentless tendency to seek confirmation for its beliefs and fears. If Jess truly believes that Liam doesn't care about her, she'll see this evidence everywhere. We'll want to shake up this belief system so that Jess can extend Liam the benefit of the doubt.

Jess mentions her childhood experiences of caring for younger siblings from a young age, and the sense that she wasn't a priority for her overworked parents. With Liam immersed in his chronic pain and the challenges of going from a 40-hour to a 5-hour workweek, she seems to be experiencing a sense of loneliness that feels all too familiar, deepening her hurt and fueling her hostility. Liam argues that no matter what he says, "it gets twisted", and I can see the hurt underneath his anger.

With some prompting, Liam shares that he struggled in school and often felt rejected by his classmates. Every time Jess critiques him or sees the worst in his behavior, he feels the sting of not being "enough," leading him to pull away to avoid that feeling. The cycle is polarizing: when Jess feels forgotten by Liam, she withdraws by turning toward her friends, seeking out the warmth and acceptance that she isn't feeling from Liam. The more she pulls away, the more Liam feels rejected and withdraws in anger. His retreat confirms her aloneness.

Liam was likely drawn to Jess's energy and spirit of adventure. He must miss being the beneficiary of her big, warm attention, and maybe he even feels jealous of her friends. I want to encourage Liam to connect with and name the sadness, shame, and fear of disappointing Jess that lie beneath his angry retreat, and to help Jess witness it, accept it, and offer him compassion. Conversely, it will be important for Jess to connect with and name the worry, sadness, and loneliness that lie beneath her frenzied, distracted behavior, and help Liam witness it, accept it and offer her validation and care.

As they connect with the needs and emotions underlying their behavior, and witness each other's pain, I feel confident they'll find a way forward, shoulder to shoulder, through these difficult but wholly inevitable transitions. When couples are courageous enough to turn toward themselves and each other, transitions become initiations—into wisdom, self-awareness, and connection.

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Alexandra H. Solomon, PhD, is a couples therapist, speaker, author, professor, podcast host, retreat leader, and media personality passionate about translating cutting-edge research and clinical wisdom into practical tools people can use to bring awareness, curiosity, and authenticity to their relationships. She's on faculty in the School of Education and Social Policy at Northwestern University and is a licensed clinical psychologist at The Family Institute at Northwestern University. Her hit podcast, Reimagining Love, *has reached listeners across the globe and features high-profile guests from the worlds of therapy, academia, and pop culture. Her latest bestselling book is* Love Every Day. *Contact: DrAlexandraSolomon.com and on Instagram at @dr.alexandra.solomon.*

that had been filed by two parents against their child's therapist for "conning" her into remembering childhood sexual abuse that never occurred.

"Experts expect the trial to start a new wave of malpractice lawsuits against psychotherapists, members of a largely unregulated profession," the article reads, "and to alter the way they are trained and supervised."

The false memory debate, it seemed, was finally over.

Case Closed?

It's tempting to consign the false memory debate to the dustbin of history, to wipe our hands clean and say what's done is done. But the therapists who prevailed say there's no justice in this scenario. Where's the lesson? Where's the closure?

"We just moved on. We just *moved on*," Bill Doherty sighs. "There was no reckoning. Apparently, we can move on quickly from our convictions when our livelihoods are affected, when we're going to get sued or lose our license."

Make no mistake, Yapko says: the false memory debate "*literally* changed the practice of therapy. You'll notice that almost every therapist, no matter their orientation, now puts the phrase *empirically supported* or *empirically validated* before whatever therapy they're promoting" to avoid accusations of malpractice or quackery.

But it's not just the field that's suffered, says Elizabeth Loftus. It's *everyone*.

"The public standing of the mental health profession was seriously damaged, and virtually nothing was done to cure the patients themselves," she later wrote. "The uncritical acceptance of even the most dubious claims trivialized the experiences of the survivors of genuine abuse, and increased their suffering. Happily, that harm has lessened, but I do not believe the war is over. Innocent people remain in prison, unable to disprove the charges against them. Thousands of families have not fully recovered from years of estrangement."

So did the field take any lessons from the false memory debate to heart? Surely, I ask Yapko, Doherty, and Lyons, something on this scale could never happen today, right?

"Even now there are therapists who never got the memo that this thing was crazy," Lyons tells me. "I still hear things from clinicians like 'children never make things up.' I still hear them say you can use hypnosis to recover memories. I still hear about repression, or that physical symptoms must be indicative of hidden trauma."

"The psychotherapy field is a field of fads and fashions," Yapko says. "Do you know how many models of therapy I've seen come and go over the last 50 years? There's a herd mentality and a lot of hero worship for whatever the therapy du jour happens to be. This isn't nice to say, but it's true: therapists aren't always the most critical thinkers, and it's why so many questionable methods are used in the name of therapy."

"The lack of soul-searching means that a generation later, when we forget, it comes back," Doherty says. "That *New York Magazine* article on IFS was appalling, because that's exactly what was happening 35 years ago. We never learned that when we're arguing about widespread, terrible behavior, we need to have some data to back it up." Take the clamor around trauma, he adds. "Now, everything is 'trauma' or 'attachment wounds.' Estrangement and cutoffs were big in the '90s—you discovered the abuse, you cut off your parents. Now that's back big time, and therapists are participating in it."

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At this point in my journalistic journey, I'm beginning to feel a bit weary—and not just because I sat through four hours of the *Divided Memories* documentary. It pains me to think that maybe therapists—and I—have always been operating under some sort of hypnotic delusion, that whatever clinical subject we deem important isn't so much a choice as it is a sneaky cultural influence. Some zombie mistake we're destined to repeat. A ticking time-bomb wrapped in good intentions.

I desperately search for something that indicates the field will turn a corner. *Maybe it's the next generation of therapists!* I think to myself. *Maybe they'll think more critically than the last about the fads sweeping our field. Maybe they'll do better.*

"When I do my clinical trainings," Yapko tells me, "I ask the audience, 'How many of you learned about false memories during your academic program?' Hardly anybody raises their hand. When therapists don't know about the malleability of memory, the danger is that they'll suggest memories that may seem plausible but aren't actually true. That's what puts therapy clients at risk today."

Ugh. Well, I tried.

But right before I decide to give up, I think back to a moment from my phone call with Bill Doherty.

"I want to normalize our blind spots," he says. "Because we're not trained as cultural anthropologists. We're trained as therapists. Every profession has their blind spots. If we want to prevent another repeat, we need to start with some humility. We need to step back and ask ourselves what trends we're experiencing now, why we're focusing on them, and what the potential downsides might be. We need to ask ourselves how much this thing that we embrace has value, and acknowledge that it's not the gospel truth."

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In Consultation FROM P 13

in this moment?"—all statements that encourage compassion and normalize challenges. By attuning to your client and the activities they already enjoy or wish they had more time to do—like cooking, journaling, painting, taking walks, or spending time with pets—you can help clients cultivate compassion organically, in a way that feels authentic rather than like therapy homework.

In addition, we've found embodiment work—any practice that quiets the mind and increases a client's somatic awareness—to be incredibly effective in addressing this phenomenon. Body-based practices help clients notice sensations that accompany self-abandonment—for example, fogginess in the head, fatigue in the arms, or heaviness in the chest. Once clients recognize their own somatic markers for these experiences, they can make a conscious choice to respond differently to a situation where they typically people-please, ruminate, numb out, blame themselves, seek guidance from an authority figure, or caretake. Ultimately, they can practice attending to their discomfort instead of avoiding it.

Communication and boundary setting strategies are essential in managing self-abandonment. A client who respectfully communicates to her boss or partner that she can't do a report or pick up the laundry is combating the self-abandonment she's experienced in the past by chronically saying "yes" when she's already stretched too thin. Therapy can reframe setting boundaries as acts of care for oneself and others. Working with clients to help them ask for help, say no, and hit the "easy button"—allowing themselves to relax and enjoy downtime—reinforces the importance of intentionally prioritizing their own time, space, and resources. Ultimately, this translates into making themselves a priority.

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BY RYAN HOWES & MEGAN CONNELL

The Clinician Game Master

HOW DUNGEONS & DRAGONS CAN HELP CLIENTS EXPLORE NEW SKILLS

MEGAN CONNELL

When therapists talk about approaches and developments in our field, we're likely to discuss the latest brain science research, the impact of AI, and the pros and cons of telehealth—in other words, advances connected to science and technology. But there's an unconventional new therapeutic approach that taps into the decidedly non-tech era of the '70s and '80s: the world of wizards, spells, and 20-sided dice.

Dungeons & Dragons (D&D) has entered the consultation room. And for some, it's a genuine clinical game changer—pun intended.

Megan Connell is one of this new breed of therapist innovator/dungeon master who uses tabletop role-playing games (TTRPG) to help clients access emotion, learn social skills, and create relational depth in ways traditional therapeutic dialogue can't. A psychologist and former Army officer, she's also a leading voice in the emerging field of applied gaming.

Her book *Tabletop Role-Playing Therapy: A Guide for the Clinician Game Master* is the first comprehensive guide on using role playing games therapeutically. She's also the cofounder of Geeks Like Us, a media company dedicated to geek and gaming culture. She spoke with me about ways that therapists can use the collaborative storytelling of TTRPGs—which leverages structure and creativity in ways that engage the imagination—to help clients learn and grow.

Ryan Howes: Were you a role-playing gamer as a kid?

Megan Connell: I played quite a bit in middle school. This was back when we had character sheets and wrote everything out by hand. I took a very long hiatus from it after middle school, and only returned to role-playing games during my PsyD training.

RH: When you started back up, did you have in mind that you wanted to integrate role-playing games into your clinical work?

Connell: I stumbled upon it. I was playing in two different campaigns—which in Dungeons & Dragons refers to an ongoing storyline or adventure. I was thinking about the characters I created in each campaign and how different they were, and then I was like, "Well, they're both from my brain. They have to have something in common." When I realized what the commonalities were, I recognized that those were two of my central issues that I really needed to work on. It was a breakthrough moment for me! I also realized this would have taken years to get to in therapy because I had so many defensive walls around these things.

Within a month or so of playing a role-playing game, I was not only able to see these issues more clearly but to have insights into them. And I was like, this is too cool of a tool not to use in therapy.

RH: In many standard board games, you're the blue piece or the race car, but in TTRPGs, you're creating the characteristics and the conflicts for your player, correct?

Connell: Yes. In role-playing games, you'll have one player create the world that the characters are going to interact with and the plot points you're going to discover. This is the game master, narrator, or dungeon master.

All the other players are responsible for creating a character from the ground up that exists within that world and has ties to that world, and we often project our wants and desires onto the character. So you create a backstory. You create other people your character knows and who have ties to other people's characters at the table. And then you go on adventures together. A defining factor of role-playing games is that the choices you make as a player affect the world of the game. Your actions matter.

RH: It sounds more like writing fiction than playing a video game.

Connell: It is. In a video game, most of the time, you're stepping into the role of an established player. When you play TTRPGs and build relationships with other characters and work on solving problems, it gives you a different lens for understanding and seeing yourself that gets behind defense mechanisms. Besides TTRPGs, the only other thing I've ever seen help people gain insight in this way is comedy.

Have you ever watched a standup comedian say something, and you're like, "Yeah, I do that" while you're laughing? You can see and acknowledge something hard in the moment without being defensive. In role-playing games, because

we're able to project our stuff onto the character we've created, we can own it more easily.

That's my stuff coming up again in the form of Kragnar the Barbarian, but that's still my stuff. And maybe I do need to work on that. And I can practice working on it through role-playing. If we go back to modalities like psychodrama, role-playing has been used in therapy for a very long time.

RH: So the game and characters offer us a degree of detachment that makes it a little easier to address difficult issues.

Connell: Exactly, because you're not you, you're Thangal the wizard. How did Thangal get his power? What did he learn? We think about the character's motivations, wants, needs, and experiences. Then how do we pull that in and create an interesting dynamic for them to engage in?

RH: Your book mentions the concepts of "bleeding in" and "bleeding out" related to the player/character relationship. Could you explain that?

Connell: For obvious reasons, I've replaced those terms with a new term: "emotional permeability." Essentially, the emotions can come from the game into you, and from you into the game. "Bleed in" is player into the character. If I'm having a bad day and I'm frustrated, I may have my character in the game be testy and frustrated, even though there's nothing going on narratively in the game that would make them feel that way. That's my own stuff coming through.

In contrast, if something happens to my character and I feel it very deeply, that's "bleed out." It comes out from the character into me. If a character that your character really cares about dies, you might cry, right? Nobody's died in your life, but it still impacts you. You may feel those emotions very deeply, which allows for behavioral rehearsal.

There was an interesting study done in the early 1980s at a youth center where they found the kids who play D&D were learning conflict resolution and valuing diverse friend groups more than the kids who weren't. At the gaming table, if the thief steals something and gets the whole party arrested, that's now conflict within the group that needs to be resolved.

I ran a group where a thief character did something that got the whole group into trouble. They'd just recovered and resolved it, and one of the players looked at the player who was controlling the thief and said, "My character really wants to punch your character right now. I think what you did is funny, but my character's really mad right now." And the player with the thief character was like, "I get it."

I love that the players were able to talk through the conflict and hold space for a part of them, which is their character, that's angry and in high conflict with another character. They have to work as a group to resolve that and figure out how to meet everybody's needs.

RH: It's a great example of different feelings in different parts of self. I can have seemingly opposite feelings at the same time, right?

Connell: I work with the autistic population, and a lot of folks with autism don't know when they've made a mistake. They benefit so much from these difficult conversations where they learn what behavior is rude or hurtful, or challenging but helpful. This is crucial for this population, but people seem afraid to have these conversations today; they'd rather just not talk to someone who made them uncomfortable.

A lot of people diagnosed with autism play all types of tabletop gaming. I think the reason for this is fairly straightforward: it's a social event with rules that everybody agrees to follow. You're not just sitting around, having to make small talk. These games allow you to socialize, to have friends, to go on adventures, to have an impact in a way where you don't get punished for misreading social cues because you can actually ask for help. You can be in the middle of a role-play with your game master and be like, "Wait, I'm really confused. What's going on here?" And the game master may say, "They're trying to intimidate you. They're trying to hint at one thing or another." You have permission to ask questions without it causing a problem to the narration of the story. Support in the real world isn't always accessible like that.

RH: Are clients learning how to apply these gaming lessons into their real life?

Connell: For sure. At the most basic level, these are just fun games that can help build social skills. Clinically though, it does do a lot for us. I was working with a client who had a very hard time standing up to their friends, had a lot of social anxiety, didn't want to say no to people, didn't want people to dislike them. After playing a session of D&D, they came to me saying, "I've got to let you know something. One of my friends wanted a ride to the mall, but I said no." This chronic people-pleaser had never done anything like this before.

"I didn't want to go to the mall," this client told me. "And I felt myself about to say yes. And I realized my D&D character would say no. And so, I said no." We'd been working on that in individual work—I kid you not—for months. It took playing a role-playing game to move them from that thought to action.

RH: I'm curious about the pragmatics of this. Is this a group-therapy format? I know that for some of these games, the campaigns can take a long time. How do you manage the timing?

Connell: I train people to do closed groups that are set for a certain number of weeks. Twelve weeks is the standard practice for most groups, but I've found that 10 weeks tends to work a little bit better with school schedules. And you can tell a pretty good story in 10 sessions, one that really allows people to shine and have healing experiences. And we know from the research that group therapy minute-for-minute is so much more effective than individual therapy across the board.

Another fascinating thing that happens in TTRPG groups is that people show up. People really, really want to be there. When I was running my groups, when people were traveling, they'd still find a

CONTINUED ON PAGE 65

BY ALEXANDRA SOLOMON, CHRIS WILLARD, AMY CLAY, JACKIE MOORE & CHRISTINE MARK-GRIFFIN

5 Popular Therapist Memes II

HUMOR AND INSIGHTS YOUR COLLEAGUES ARE SHARING

You don't normally see *memes* and *therapy* in the same sentence. At first glance, memes seem disposable—we scroll through them, laugh at them, and forget about them. But this is exactly how their therapeutic value sneaks in: they turn complex emotional experiences into something instantly recognizable and shareable. A good meme instantly says, *It's not just you*. It bypasses our left-brain thinking and becomes an emotional truth.

What can therapists do with memes? When shared in sessions, they can jump-start deep conversations, help clients name feelings they'd otherwise struggle to articulate, and reduce shame by shining a light on universal human challenges.

Recently, we showcased five memes your colleagues are sharing—and it was such a hit that we decided to share five more! Whether these simply bring a smile to your face or become the little tool you use to build rapport with a client or two, we hope you'll enjoy more of these gentle reminders that healing doesn't always have to be serious business.

Learning to Take Up Space

BY ALEXANDRA SOLOMON

One of my favorite memes, which I sometimes share with clients, shows two pictures of a big, fluffy golden retriever and a tiny dog bed. In the first picture, the dog lies uncomfortably on the ground with its large, adorable head barely fitting on the small bed. In the other picture, the dog has positioned its large body on top of the bed like an elephant perched on a lily pad. Underneath, the caption reads, "Woman Accidentally Orders TINY Dog Bed, Dog Pretends Everything Is Fine."

Some of us are a bit more like this sweet pup than we'd like to admit. We tend to plow ahead as if everything in our life is fine when really it isn't. Maybe we show up for work sick when we should be home. Maybe we wear sunglasses to hide our teary eyes when we've been crying. Maybe we put on a happy face even though we're mad at someone.

But let's not mistake problems that are systemic in nature for personal problems. In a hypercapitalist society, workplaces convey to employees that they're replaceable, creating the conditions for working while ill. Our culture confounds busyness with self-worth, treating exhaustion like a status symbol. And it judges sadness as weakness, making it nearly impossible for us to honor our pain and be honest about how we feel with all but a few trusted confidants. Our world has yet to value relationship education, so most of us have zero clue about what to do with our anger besides stuff it down or blow up. Our culture sets us up to act like the doggie in this meme, pretending like we can carry on when we clearly need to make a change.

Growing up, many of my clients learned to paper over their pain. When a family system is struggling with addiction, for example, homeostasis is maintained when everyone acts like they don't see what they see, feel what they feel, and know what they know. Do that for long enough and you'll even stop remembering how to identify what's going on inside of you. The beautiful part about being alive is you can always come home to yourself. You can learn to recognize that you're squishing your

big, fuzzy body onto a teeny, tiny cushion. You can cultivate relationships that celebrate you when you speak up without fear and say, "Excuse me, I'll be needing a larger bed to accommodate all this damn fluff!" You can come home to yourself.

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

What it Takes to "Calm Down"

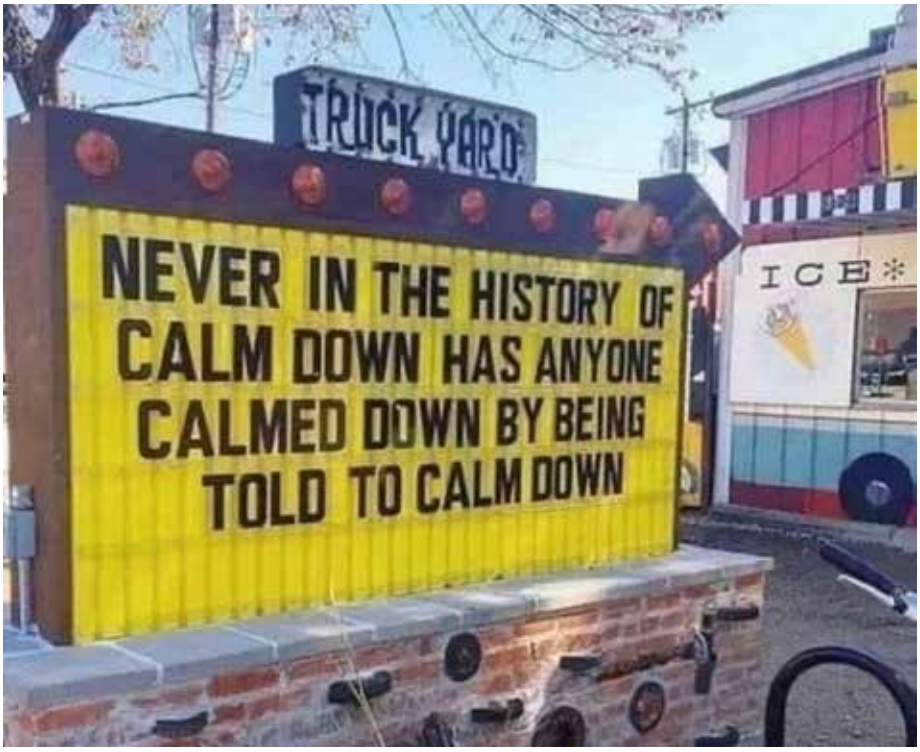
BY CHRIS WILLARD

Meme wisdom is far from perfect, but some memes can offer us spiritual or philosophical aphorisms, with a dose of humor to boot.

One of my all-time favorites is this one: "Never in the history of calming down has anyone ever calmed down by being told to calm down." It's resonated with me for a long time on a number of levels, and it's a line I use in workshops and in therapy.

On the basic level, it reminds us that our work as therapists is much deeper than just conversation. If telling people to calm down worked to cure anxiety, we'd be the best therapists in the world—not to mention we'd put ourselves out of business in no time! It calls back to the Bob Newhart sketch where the psychiatrist tells their phobic patient to "Just stop it!" If only!

But it's also a reminder to therapists, parents, caregivers, teachers, and even managers and bosses, of the limits of what they can and can't do. As I like to say, people don't "calm down" until they feel safe enough to calm down. And that comes down to the kind of holding environment we cultivate with our own compassionate, co-regulating presence. The more we regulate ourselves, the more our clients can safely attach to us and do the



healing work that can only happen in relationship. It's about cultivating what Deb Dana calls the "glimmers," or people, places, and things that create safety, as opposed to the triggers that put our nervous system in defense mode.

In Buddhist psychology, we aren't trying to make people change; the best we can do is create the conditions in which they're most likely to change. And how do we do that? In part, it's by changing ourselves, and then co-regulating nervous system change with our clients through mindfulness and other regulating practices.

If we want calm clients, we need to calm ourselves first. Of course, while we might sometimes wish we could do it, nobody wants a stressed-out therapist shouting at them to calm down, take a breath, and relax!

Christopher Willard, PsyD, is a psychologist and consultant In addition to serving on the faculty of Harvard Medical School, he has authored multiple books on psychology, child development, and contemplative practice.

Finding the Right Fit

BY AMY CLAY

There's a meme going around that was taken from a poignant scene from the movie *Barbie*. Weird Barbie, a breakout character with spiky hair whose legs are stuck in a permanent split position, presents Stereotypical Barbie with a choice: a high heel or a Birkenstock. The meme tags Weird Barbie as a therapist, which made me laugh hard—but with a pang, because it represents the unappealing choice I often feel like I'm offering clients as a relationship and trauma therapist.

It's a visual metaphor for the struggle between choosing something idealized and seemingly picture-perfect (represented by a sleek, pink, uncomfortable high-heeled shoe) and the authentic experience of real life (represented by a crunchy, comfortable, and sometimes smelly Birk). When fitting, I've been sending this meme to colleagues who need a laugh and some validation for how hard the therapeutic process can be. For clients, it's been a lighthearted way to explore the "fit

of their shoe."

In particular, my clients who grapple with conforming to societal expectations, superficial standards, and perfectionism eventually realize these "high heels" can only be worn for so long. They can then choose to slip into a "Birkenstock," realizing that only they can mold the shape of their lives. So this meme reflects a critical part of therapy—the tension between maintaining a polished façade (faking it) and choosing to recognize and embrace our authentic selves (working toward self-actualization).

When Weird Barbie encourages Stereotypical Barbie to consider her options, Barbie leans toward the high heel. Therapists and clients alike know that change is often daunting, unknown, and straight-up scary. Weird Barbie's response to Stereotypical Barbie's reluctance to choose the Birkenstock: "We'll do a redo." As a therapist, I know the work is continuing to offer clients a redo, allowing them to reclaim agency in the process and ultimately in their lives. Acknowledging that we all get stuck speaks to a truth therapists know well: growth sometimes requires a redo.

Helping clients recognize their power to choose is a fundamental part of therapy. The concept of a redo reinforces that we can change our circumstances and our past doesn't have to define our future. How can we challenge ourselves to put down our heels and slip on our Birks? Maybe we want to try on a different shoe altogether, or even go barefoot! The key is making sure we're grounded in whatever shoe we choose rather than forcing ourselves into a fit that isn't right.

Amy Clay, LPC, is a Northern Virginia/DC-based pending AASECT-certified sex therapist and Imago relationship therapist in private practice.

A Collective Laugh—and an Exhale

BY JACKIE MOORE

Is it weird to choose a meme you created as your favorite meme? Maybe. But hear me out. In 2022, I began posting on social media. For so many of us, the world had begun to feel increasingly overwhelming and scary, and doomscrolling on social media was a gluttonous escape. At the time, I'd been a licensed therapist for seven years, specializing in play therapy with children and families, but I was far from a social media expert. Still, I was committed to creating a sense of community online that felt safe, supportive, and fun.

As I studied what resonated with my audience, I noticed something: the content I engaged with most wasn't the polished educational posts. It was the funny stuff. Not just lighthearted humor, but deeply relat-

able, sometimes dark humor that captured the absurdities of our work as therapists.

One trend I loved featured therapists typing notes with on-screen text: "Born to write _____" vs. "Forced to write _____." The format nailed one of the unique tensions in our work. We thrive on authenticity and vulnerability in session, but then we have to translate those moments into clinical jargon so the "insurance gods" will approve them. The comments ("relatable!" "I feel seen!" "Omg this is hilarious!") made it clear. Humor was the fastest way to therapists' hearts.

So I tested the theory. I made a meme that leaned right into the heart of play therapy. Anyone who's worked with kids knows the willingness to be silly pays huge dividends in building connection. I chose a template from New Girl that I knew millennial therapists would recognize. I couldn't stop laughing as I made it, but I wasn't sure if anyone else would find it funny. The next day, I closed my eyes and hit post.

It took off. Within weeks, the meme had over a million views. But more than the numbers, it was the comments that told the story. Therapists tagged friends, filled the thread with laughing emojis, and even rewrote the "clinical language" to describe their own ridiculous sessions. One thing was abundantly clear: other therapists craved community and connection just as much as I did.

That moment crystallized something for me: memes aren't just jokes, they're connection points. They're little reminders that behind all the charts, diagnoses, and heavy conversations, we're humans doing deeply human work. Sometimes we need a collective laugh to exhale, to feel less alone, and to remember that our weirdness—the very thing we once worried might not be professional enough—is actually part of what makes us effective, resilient, and real.

Jaclyn Moore, LCPC, RPT-S, is a registered play therapist supervisor with experience in schools, private agencies, and nonprofits, as well as the co-owner of Play Therapy House, Inc.

The Joy—and Weight—of Wonder

BY CHRISTINE MARK-GRIFFIN

Scrolling through Instagram after my two little humans finally crashed for the night this past holiday season, I found myself in full-on spiral mode. Questions rapidly popped through my head: *Do I dare do Elf on the Shelf this year? How should I decorate? Are there any holiday events we have to take the kids to? And reindeer pancakes–Christmas Eve or Christmas Day? (Honestly, do they even care? It's all about the whipped cream and sprinkles anyway.)*

And then a post smacked me right in the feels: *"Becoming an adult is realizing the magic behind Christmas was always just your mom."*

Cue the instant chuckle, followed by a slower, heavier realization that I am now the mom. I'm the mom lying awake, scrolling for recipes, hunting for Pinterest-perfect ideas, planning every detail so my kids can experience the magic I once took for granted.

As a therapist specializing in maternal mental health and a mom of two little ones who fully believe, this meme didn't just feel relatable, it hit me with a surprising ache. Before I had kids, Christmas magic felt simpler. Now as a mom, I see all the quiet labor that goes on behind the scenes: the lists, the planning, the budgeting, the remembering, the emotional attunement.

Some days? I *love* it. I get to create the nostalgia my kids will one day treasure. I soak up the rituals of matching pajamas, Christmas pop playlists on repeat, and immersing myself in the smell of cookies and hot chocolate wafting throughout the house. There's joy in being the keeper of wonder, in offering your kids a sense of safety, abundance, and magic in a world that often feels uncertain. It connects me to my children, and to generations of mothers who did the same, quietly, year after year.

And then there are the other days, the ones we don't Instagram. When the magic feels heavy, the mental load relentless, the lists multiplying faster than hours in the day. When finances feel tight and the pressure to "make it special" starts to creep into my body as tension. When I'm tired both physically and emotionally from holding everyone else's experience so carefully. On those days, this meme hits differently. It's revealing. It reminds me that so much of the magic comes at a cost.

As a therapist, I tell myself that it's okay for these experiences to exist at the same time. You can be grateful *and* overwhelmed. Honored and exhausted. Joyful and stretched thin. Loving the magic doesn't erase the weight. Feeling the weight doesn't mean you're failing.

That post, playful as it was, quietly reminds us that the magic was made by a human who is capable of carrying joy and pressure. The magic matters—and it wouldn't happen without you.

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place to be alone and phone in so they could participate. That kind of investment isn't always there in run-of-the-mill group therapy. The fact that people are willing to show up every week is going to improve treatment outcomes.

In role playing games, you also have built-in reinforcement, something you don't get to have in traditional groups. This is a game, and leveling is part of the game. You get points to level up, and you can figure out how you want to do that. Plus, getting powerful magical items for your character is awesome.

One of the things I figured out was to have players create a therapeutic goal for their character. I'd ask, "How do you want to see your character grow and change over the course of our campaign?" If they engaged in those growth behaviors with their character, they would get rewarded with magic items. Then I'd give award experience points for processing and engaging in the prosocial behaviors that were the goals of the group.

RH: Do people in your gaming groups also have individual therapy to talk about what happened in their campaign?

Connell: Oh, yeah. With TTRPG therapy, it doesn't feel like therapy to the people in the room. Once in a while, we'll have something big and deep happen, and we'll all process and talk about it. But most of the time, the therapeutic impact is a sneaky thing that creeps in, and they don't even recognize they've learned tools or grown until it's pointed out. Like, look at how far your character has come. Look at how far you've come. Look at the things that are changing for you. A lot of times it doesn't sound like they're talking about therapy. It just sounds like they're talking about D&D.

RH: You're training therapists to do this kind of work in their own practice, to become a game master?

Connell: Yes, exactly. And we train people who aren't therapists, but are game masters who are working under therapists. This allows a therapist to be another player at the table. Thinking about all the psychological things that are happening, running the story, and remembering the rules of the game can be a lot to manage. You're wearing a lot of hats when you're a therapeutic game master. It can be helpful to offload a couple of those hats to somebody so you can just run the games.

RH: What's the age range of people who engage in this? I'd imagine it's teens and young adults, but D&D was around in my own Gen Xer childhood. Are there AARP D&D groups?

Connell: Most of the groups I've seen or gotten to run are for kids. It's much easier to get kids to show up for things than adults. A joke in a lot of tabletop role-playing spaces is that the true big bad monster you're trying to defeat is scheduling. That said, there've been adult groups run at VAs with high success rates. I want to get more adult groups running.

RH: You've very publicly embraced the term *geek*, which historically has been derogatory at times. What does that term mean for you?

Connell: I've always identified myself as a geek or nerd. I like to think of it as being passionate. I'm excited about things. A few years ago, I even started a company, Geeks Like Us. Our definition of geek is being unapologetically enthusiastic about anything—football, board games, video games, science. It's just liking or loving something fully.

I think in psychology, too often we've ignored the things people love. It's vitally important to know what these things are because when we understand what's meaningful to our clients, our connection deepens.

I have a client who's read a lot of the same books I have. They'll be talking about a challenge in their life, and I can say, "You know, this is a lot like this one character in that book." And they're like, "Oh my God, it is." And now we can take that character and ask, "How did they work through this? What are the tools that they used?" I think one of the big strengths of geek-based therapeutics and geek-based psychology is being able to take the tools the client already has and help them use those tools to improve their life.

Too often, we tell people, "This is how you have to behave. This is what you need to do." I don't think that's as helpful or as meaningful as meeting people where they are.

RH: Who is the ideal TTRPG therapy client? And who wouldn't it work for?

Connell: It seems to work with a wide range of clients. There are disorders that I didn't think would benefit, specifically eating disorders, since group therapy is usually contraindicated—but it can even work there. I've consulted with a few people using tabletop role-playing games in eating disorder clinics. They're making participation in the group a reward for other positive behaviors. And the games are teaching positive social support and helping people build resilience.

I don't think TTRPG would work as well for more profoundly disabled folks who have a hard time staying in touch with reality, because you do have to hold different frames of reference. If you have a hard time distinguishing what's real and what's not, these exercises would be very hard.

I'm sure there are cases and situations where this kind of therapy isn't optimal, but we're still uncovering those. It seems like every time I think there's a limit to who these games are good for, I talk with someone who's been using them with that population with great success.

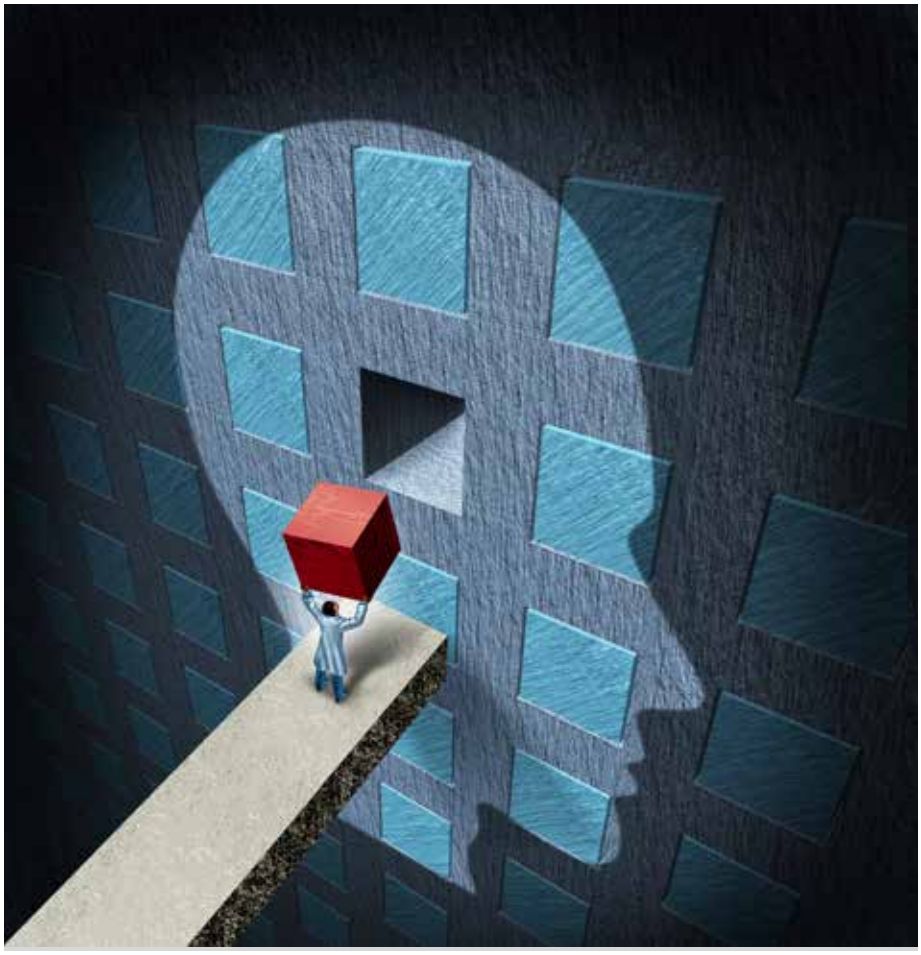
Ryan Howes, Ph.D., ABPP is a Pasadena, California-based psychologist, musician, and author of the Mental Health Journal for Men.

Megan Connell, PsyD, ABPP, is a psychologist, cofounder of HealthQuest, and author of Tabletop Role-Playing Therapy: A Guide for the Clinician Game Master. *She's also the cofounder of the media company Geeks Like Us. She speaks nationally on the intersection of gaming and psychology and is passionate about training therapists to use role-playing games in clinical practice. Contact: MeganPsyD.com.*

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

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

5 THERAPISTS' STORIES ABOUT GOING AGAINST THE GRAIN



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

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

Leaning into My Mistakes

BY BEN YALOM

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

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

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

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

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

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

A few weeks later, Patrick came in for

our session and sat down on the couch with a defiant smirk that seemed to say, "Well?" He looked ready to pounce.

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

He chuckled, clearly a bit taken aback.

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

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

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

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

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. Contact: www.yalomtherapy.com

Accepting Imperfection

BY OONA METZ

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

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

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

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

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

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

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

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

Taking the Scenic Route

BY KATHRYN HALL

In graduate school, I learned that therapy was supposed to be deep, that therapists should probe beyond symptoms. I believe this to be true. I was instructed that therapists shouldn't spend precious therapy time or energy on *superficial* topics. Sure, pleasantries were fine, but then get down

to business. Start with the symptom and drill down. My problem is that I'm directionally challenged. Drill down? That requires a directional ability I just don't have. I don't know north from south or east from west. These challenges followed me into the therapy room. My therapy GPS kept taking me on the scenic route when I was supposed to be exploring the depths of my clients' psyches. My curiosity about seemingly irrelevant subjects looked directionless, and I was asked by my supervisors whether this was due to my anxiety about the deeper work of therapy. I worried about that for a while.

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

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

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

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

Rethinking "Ethical Therapy"

BY TERRI COLE

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

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

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

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

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

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

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

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

Nearly three decades into this work, I don't assume any single approach is right for every clinician or every client. What I do believe is that psychotherapy is a relational discipline that asks us to hold complexity, tolerate uncertainty, and remain accountable to both ethics

and humanity. My training gave me a foundation, but my lived experiences taught me how to practice.

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Embracing Laughter

BY CHINWÉ WILLIAMS

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

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

I froze. I blinked, I smiled awkwardly, and fumbled through an apology for being too loud. The moment she left, I began searching online for the strongest white-noise machine I could find. But her comment stuck with me. I replayed it in my head for days, wondering if I'd crossed some invisible ethical line. Had I been unprofessional? Unwise? A less-than amazing therapist because I dared to laugh?

This was early in my career, back when I still believed the implicit grad school message: *Great therapy is serious. Intellectual. Slightly aloof. Minimal laughter, please.*

Eighteen years in, I can confidently say this: I've belly-laughed, cried, sighed, and shared countless deeply human moments with my clients. And those moments have been some of the most healing.

Of course, not all laughter in therapy is the good kind. Sometimes it lands, well, sideways. When a client laughs from anxiety, or cracks up while describing something that is objectively *not* funny—like abuse or profound loss—I gently name the dissonance.

Humor can be a brilliant coping strategy, but it can also be a clever way to keep pain at arm's length. It works for a while, but therapy invites something more intimate. When a client seems to be masking their pain with humor, I'll point out how their laughter doesn't quite match the story they're telling, and invite them to explore the messier feelings underneath.

Yes, therapy is a container for insight, healing, and growth, but it's also a place where our clients get to rediscover glimmers of hope. When those glimmers disappear—when joy, levity, or even a single amused exhale becomes rare—it's a sign that someone's emotional world is getting heavy.

Laughing in session isn't a silver lining. It's not toxic positivity. And it's not pretending that something sad, hard, or horrible didn't happen. It's a breath of fresh air. A moment of shared humanity. It's a recognition that life is absurd, beautiful, painful, and hilarious—often all at once.

It's a reminder that despair and joy don't cancel each other out. They often coexist.

Chinwé Williams, LPC, is a trauma specialist, a licensed and board-certified EMDR therapist, and a counselor educator and supervisor with close to two decades of experience supporting individuals in trauma recovery. She's the author of Seen: Healing Despair and Anxiety in Kids and Teens Through the Power of Connection.

Oppenheimer FROM 47

In "You aren't in the DSM," a recent essay of his for the journal *Asterisk*, Aftab addresses this challenge: "In my own clinical work, I often find myself attempting to deflate the power of these categories. I remind patients not to lean too heavily on the label I'm offering. Not because the label is meaningless, but because the problems it captures are typically imprecise, shifting, deeply contextual. I describe symptom patterns in relation to broader psychological structures, early experiences, temperament, and life stressors.

"My hope in these conversations with patients is to plant a seed of resistance, to offer an account of suffering that acknowledges complexity, contingency, and context beyond categories. I try to say, in effect: this pattern of symptoms reflects something meaningful about your psychological life, but it doesn't define you. It shouldn't be the scaffold upon which you build your entire self. You're free to acknowledge it, even to use it as a lens, but don't let it confine you. Do not let it determine your story."

It's a tall ask, in other words, not just of the profession of psychiatry but of the rest of us as well, that we accept that we'll have to live, and suffer, without the kind of certainty that clean diagnoses or hard science seem to promise. The best case for choosing to step into this uncertain world is simply that it's the actual world we live in, and we'll be best equipped to navigate it, generally speaking, if we can be honest about that. And maybe have the help of some smart, humane people along the way.

Daniel Oppenheimer is a writer and podcaster from Austin, Texas. His next book, provisionally titled The Good Enough Marriage, *is scheduled to come out in 2027 from Simon Element. He's co-writing it with his wife, couples therapist and author Jessica Grogan. He writes and podcasts about the contemporary American intellectual scene via his Substack, Eminent Americans.*