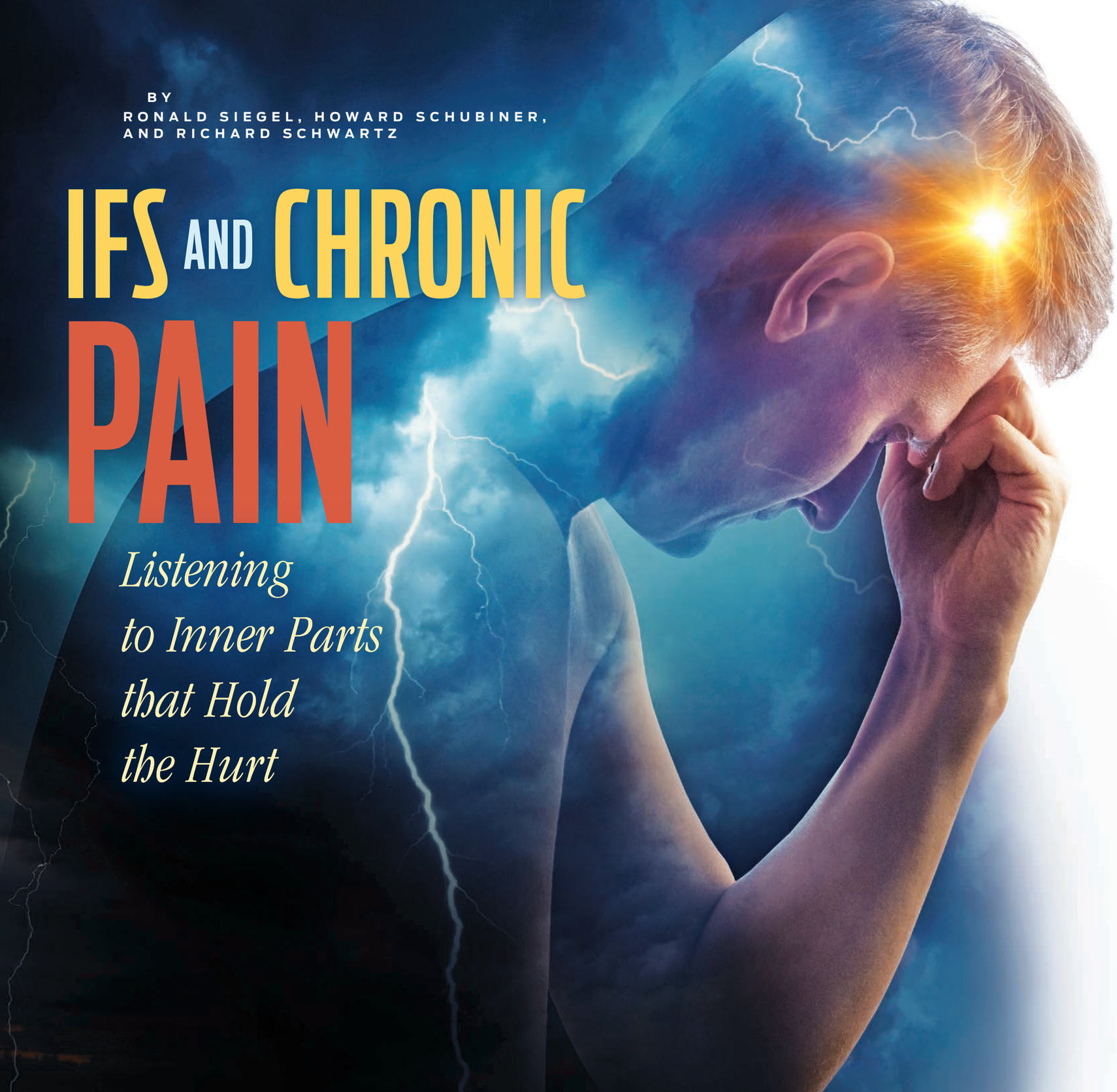
BY
RONALD SIEGEL, HOWARD SCHUBINER,
AND RICHARD SCHWARTZ

IFS AND CHRONIC PAIN

Listening to Inner Parts that Hold the Hurt



Susan is a dance teacher in her mid-30s who performs regularly. For years now, she's lived in constant fear that her back will go out. She's haunted by chronic low-level backaches, which flare up without warning every few months, turning into days-long bouts of excruciating pain.

Two years ago, on the day of a big recital, she could barely get out of bed. Her right side was spasming, and even tying her shoes was a challenge. She managed to muddle through the final dress rehearsals and the show itself while tanked up on benzodiazepines and pain medications. But as soon as she got home, she crawled into bed and stayed there for two weeks.

In the aftermath of that dreadful episode, Susan's general practitioner prescribed more meds and referred her to an orthopedist, who suspected bulging disks with scoliosis. Convinced that her back was vulnerable and needed protecting, she started sleeping with pillows under her knees, carrying a special cushion in her car, and not lifting heavy objects. She went so far as to give up jogging and bike riding. She stared compulsively strengthening her core in an attempt to compensate, and warming up for hours before performances—much longer than any of the other dancers.

No matter how stringently she cared for it, however, her back never felt fully healed. She eventually went in for an MRI, and the results showed that the wear and tear on her discs was typical of people her age, most of whom experienced no back pain at all because of it.

Though others might've been comforted to learn this, Susan was upset. Why was she so riddled with pain when others weren't? She started to feel desperate. Who, she thought with some dread, would believe her pain and help treat it now?

SEEING PAIN CLEARLY

When in physical pain, we understandably think that there's a structural cause for our suffering. But to the surprise of doctors and patients alike, research suggests this often isn't the case. It turns out that most chronic pain, and an astonishing variety of other medical maladies, have little to do with damaged tissues or untreated infections. They're maintained by complex mind–body interactions, in which our brain's natural proclivity to avoid pain traps us.

We've begun to learn, for example, that histories of childhood sexual or physical abuse are significant risk factors for chronic back pain, and that job dissatisfaction is a much stronger predictor of it than having a job that requires heavy lifting, lots of sitting, or other physical strains. We've seen placebos turn out to be effective treatments for countless pain syndromes and related disorders; and for some maladies, such as irritable bowel syndrome, they can work even when people know that they're taking a placebo.

When we're anxious, states of chronic fight-or-flight arousal can disturb the normal function of our organs. We see this when anxiety causes our stomachs to produce too much acid and gives us heartburn, or our intestines to dysregulate and bring on irritable bowel syndrome, or our muscles to seize and result in chronic back pain. Sometimes, even when our physical systems are functioning normally, our brains actually produce or amplify pain and other troubling sensations either out of fear or to fulfill psychological needs.

Effective treatment of chronic pain involves understanding the roles that psychological factors play and finding ways to address them. One particularly useful way to do this is through Internal Family Systems therapy (IFS), a psychotherapy that's rooted in a clear understanding of the interplay of psychology and the body. IFS is based on the observation that each of us comprise many psychological "parts," seen as valuable members of an inner family, which exist to help us thrive and to protect us from pain.

Trauma and attachment injuries, however, force many of our parts into serving functions that can be problematic. One such group of parts, called exiles, are young and vulnerable, and carry early emotional injuries (what IFS calls burdens), such as a sense of worthlessness, terror, or emotional hurt. Before the trauma, they were the lively, creative "inner children," but after they began to carry the burdens of trauma, we locked them away to keep them from overwhelming us with their raw emotions and vulnerability.

Once we develop exiles, the world feels more dangerous, and we feel more fragile being in it. As a result, another group of parts tries to protect our exiles from getting triggered. To do that, these protector parts take on roles like the harsh internal critic, the overachieving perfectionist, or the frightened avoider. In IFS terminology, these protectors function as managers, dictating our day-to-day activities to make sure our exiles don't get emotionally injured.

During times of increased stress, when these managers can't adequately manage our emotional pain, another set of protectors, termed firefighters, jump into action at an even higher level of defense. Firefighters are emergency responders, and their activities include acute depression and suicidal thoughts, cutting, binging, alcohol or drug use, and panic attacks. Both protector-managers and firefighters may use physical pain to protect our exiles.

Susan eventually found her way to an IFS therapist, who helped her understand that her fears and resulting avoidance of normal movement were playing a role in her ongoing struggle with pain. Therapy focused on exploring the parts of her that were driving this behavior.

In one session, Susan zeroed in on what she called her pusher part, which she physically located in her forehead. When she listened to it closely, she learned that it was young, feisty, and determined to conquer her back problem, no matter what. She said she relied on this pusher because it had helped her succeed in school and was responsible for her success as a dancer, teacher, and businessperson. It was diligent and obsessive, and once it identified a goal, it pursued it at the expense of all competing needs. This part was going to fix her back pain at any cost.

After compassionately validating this part's desperation and asking it to step aside for a moment, Susan noted a very vulnerable exile that her pusher part was working to protect. This part was even younger—an innocent little girl, who'd fallen, hurt herself, and felt helpless and alone. It was hard for Susan to stay with this part, who longed for a mommy or daddy to hold and comfort her. It's not that Susan's parents weren't caring, just that they'd communicated to her from as far back as she could remember that people shouldn't wallow in their misery. She realized that this made it feel unsafe to be in pain, so she'd panic whenever she started to feel any. Beneath her panic, she realized this part was frozen in time.

This discovery led Susan to notice another part that also didn't get much attention in her daily life: a nurturing part, which was pretty good at holding her own daughter when she was in distress. This maternal part could be with her daughter's pain without immediately needing to fix it. She recognized that while she could provide that kind of nonjudging compassion to her daughter, her pusher part wouldn't let her do that for herself.

Connecting with these different parts, Susan began to find it easier to risk giving up her vigilant, fearful approach to her back pain. She began to see that when she could relax into resuming normal activities, her fear around her back diminished, and this shift made it less likely that she'd have another episode.

She also realized that her back going out before the recital was related to her fears of things going wrong that day: fears of experiencing her vulnerable, tender part, who sometimes just wanted mommy or daddy to hold her. She discovered that the more she could connect with this young part, the more her capacity for wise and compassionate awareness and action (called Self in IFS) could care for it, thereby making the prospect of another back episode less terrifying.

Eventually Susan gave up her back props, began sleeping normally in her bed, and went back to riding her bike and jogging. She now understands that she may have another back spasm, but she feels better equipped to deal with it. Her vigilant, diligent pusher part can relax more, and she has confidence that she can self-nurture when she needs to. In fact, she's come to view recurrences of back pain as an alarm or a barometer of a vulnerable part being activated by challenging situations.

HOW DO WE KNOW IF PAIN IS PSYCHOLOGICAL?

Before treating chronic pain psychologically, tumors, infections, inflammatory conditions, and other physiological conditions need to be ruled out. That said, most patients with chronic pain don't actually have dangerous medical disorders. Rather, they've probably received other kinds of worrisome diagnoses, like tension or migraine headaches, trigeminal neuralgia, fibromyalgia, small fiber neuropathy, irritable bowel syndrome, interstitial cystitis, pelvic floor dysfunction, pudendal or occipital neuralgia, bulging or herniated disks, or functional dyspepsia. More holistic practitioners might've offered alternate diagnoses such as adrenal fatigue, chronic Lyme disease, leaky gut syndrome, toxic heavy metal accumulation, or candida overgrowth.

It's useful to inform patients that most of these terms merely describe the condition: they don't reveal its cause. Helping clients understand that they don't have something dangerous, incurable, or necessarily disabling is an important first step in treatment. This relaxes their protector parts and helps them trust that returning to normal activities is safe and even wise.

The next step is to look for clues that will help them see that their mind might be playing a role in their distress, such as pain that comes and goes, shifts location, or gets triggered by innocuous activities or stimuli, such as lights, sounds, weather changes, and foods. Pain that's widespread or spreads over time in a pattern that isn't typical for known diseases—like a whole arm or leg, or one side of the body—is also likely to be psychologically induced.

If clients have had other mind–body disorders, such as anxiety, depression, eating disorders, chronic fatigue, and other pain-related syndromes, the probability that their pain is psychophysiological increases. Finally, if there's a history of adverse childhood events or a client can trace the onset of symptoms to significant life stressors, it's even likelier that the mind is playing a major role.

DESPERATE PARTS CHASING FUTILE TREATMENTS

Many patients with chronic pain have devoted their lives to finding cures. They may have begun with conventional medical evaluation and treatment, which itself can make things worse. When their condition is diagnosed as being due to structural problems, they may wind up enduring unnecessary procedures while painful symptoms spread and worsen. Frightening diagnoses often lead to depression and frustration, further activating an already overactive fight-freeze-flight system.

Many have spent a great deal of money and time seeking additional tests and alternative treatments. Some of these may have shown promise for a while, since the hope of relief helps reduce the fear that so often plays a role, but when they fail to provide truly lasting relief, patients sink back into despair.

Henry was a successful engineer in his mid-60s, who struggled with chronic back pain that had started after a football injury in his youth. His pain disabled him for decades, preventing him from lifting his children or enjoying sports. He eventually had the good fortune to encounter a rehabilitation team that convinced him his so-called MRI abnormalities were often found in the pain-free population, and subsequently helped him regain full physical functioning.

Soon after he'd gotten over his fear of back pain, however, his knee started to hurt. He tried to push through it, but that seemed to make things worse. He began to fear that after finally getting over his back disability, now he'd be disabled by his knee.

Henry began to see specialists, traveling hundreds of miles to consult with the best knee surgeons, rehabilitation doctors, and physical therapists. He sought out acupuncture, massage, braces, taping, and every conceivable stretching and strengthening exercise. None of his imaging showed damaged structures other than typical mild osteoarthritis, but this didn't stop the various practitioners from offering interventions. Each of these would help for a bit, but then his pain would return. The pain even spread to the other knee—which really scared him.

Near the end of his rope, Henry decided to see if psychological forces might be contributing to his condition. When his therapist first met with him, she asked him to stop pursuing physical cures for six months to create an opportunity to explore his emotional landscape instead.

Frightening medical diagnoses often lead to depression and frustration, further activating an already overactive fight-freeze-flight system.

The first of Henry's parts they encountered in their work together was desperate to find a cure. It was obsessive, determined, indefatigable. What did this part fear would happen if it didn't continue to investigate every possibility? That at 66, he'd stop being able to enjoy a physically active life.

As is often the case, this obsessive, treatment-seeking part was protecting another, deeply wounded part—one that had suffered through many years of back-related disability. As he connected to his vulnerability, torrents of tears came. He remembered all the opportunities he'd missed because of back pain, all the moments of feeling like a failure as a father and a husband. This exiled part carried the deep humiliation of his wife having to carry the groceries and laundry for years, while his son resigned himself to having a dad who couldn't even toss a baseball.

We worked to understand, hold, and comfort this deeply wounded part in therapy. As that part was acknowledged, Henry's desperate treatment-seeking part could begin to relax. Of course, he wanted his knee pain to go away, but perhaps this wasn't a binary situation. Perhaps he could tolerate some knee discomfort as he continued to lead an athletic life as an older man.

Our brains alert us to emotional distress through the same pathways they use to tune us into physical injury—and both types of pain can feel equally intense.

CHANGING MINDS ABOUT WHAT PAIN IS

To get clients to believe that their mind might be powerful enough to produce their pain often requires some psychoeducation.

It's useful to explain that so-called spinal abnormalities aren't so abnormal after all. As Susan discovered, some 50 percent of 30-year-olds and 80 percent of 50-year-olds who have absolutely no back pain show evidence of "degenerative disc disease" on an MRI.

Spinal stenosis is common in older pain-free individuals, while scoliosis, leg-length discrepancies, mild osteoarthritis, and imbalance in muscle group activations can be found in people of all ages without chronic pain. These findings are often coincidental to chronic pain, rather than causative.

There's also evidence that structural interventions, including surgery, often fix the structural issue, such as a bulging or herniated disk, without improving patients' pain. But vigorous exercise is often helpful, too, which wouldn't make sense if the body were really injured, as are a wide variety of alternative interventions that influence the mind, rather than the body. This all suggests the powerful effect of placebo and expectation, and that pain does not necessarily equal injury or disease. But it's important to explain this to clients in a way that doesn't invalidate their experience.

It can be helpful to share with clients the evolution of our scientific understanding of pain. For centuries, physicians assumed that, as Descartes had suggested in the 1600s, pain was like a rope pulling on a bell. Something happens to disturb tissues somewhere in the body, nerves transmit that information to the brain, and we experience pain.

During World War II, however, the Harvard anesthesiologist Henry Beecher noticed that soldiers with serious injuries who were being carried off the battlefield alert, awake, and not in shock, often refused morphine, whereas in civilian practice, patients with far less severe injuries were in agony. This led to the laboratory exploration of how psychological factors—like the difference between being relieved to be leaving the battlefield versus fearing going into surgery—could radically affect the experience of pain.

One classic experiment involved ice water. If you tell subjects that they'll need to submerge their hand for 30 seconds and ask them after 20 seconds to rate their pain, they'll typically report "not too bad." Duplicate the experiment but tell subjects that they'll need to submerge their hand for 10 minutes, and after 20 seconds they'll tell you it really hurts and yank their hand out.

Placebo studies offer another useful perspective to help clients grasp the influence of the mind on pain. In the 1950s, for example, a woman struggling with pregnancy-related morning sickness was told there was a miracle drug to cure it, and after being given syrup of ipecac (which typically makes people vomit), felt her nausea resolve. More recently, patients who received small arthroscopic incisions (the placebo group) got as much relief from knee pain as those who received standard arthroscopic surgery. In fact, placebos can be so powerful for subjective symptoms that drug manufacturers often struggle to demonstrate that active medications are more potent.

FEELINGS CAN REALLY HURT

What's often surprising to clients is how much emotional pain and physical pain are intertwined. In fact, our brains have evolved to alert us to emotional distress through the same pathways they use to tune us into physical injury, and both types of pain can feel equally intense. We've all felt the common physical effects of emotional upset: tension in our neck and shoulders, headache, nausea, or abdominal discomfort.

Our brains use a process known as predictive coding to decide which situations will activate the neural networks to create pain, and conditioned expectations play a central role. If little Frankie had a bad reaction to a needle poke for a blood draw, he's likelier to start crying when he sees the needle for a vaccination—and he's likely to experience increased pain at subsequent needle pokes as an adult. Similarly, if Tracy was the victim of emotional abuse in an early marriage and at the time experienced headaches and nausea as a result, she's likelier to develop the same symptoms when in a new relationship that's becoming serious. Pain is thus a subjective experience created by the brain, heavily influenced by beliefs, fears, and other psychological processes.

The concept of predictive coding helps explain how acute pain can become chronic. After you experience a trauma, parts of you continue to view new situations in your life through their distorted trauma-based lenses, interpreting subsequent events as dangerous, even if they're unrelated to the initial events. They become frozen in the time of the trauma and consequently believe you're still in constant danger.

Over time, these desperate parts alert us to what they believe to be dangerous emotional situations, not through obvious alarms, such as anxiety and insomnia, but through less obvious, physical ones, such as fatigue, urinary frequency, nausea, and numbness, tingling in the hands or feet, and pain. If trauma happens in conjunction with certain foods, weather conditions, or other external factors, such as light, sound, smell, or touch, young parts can form neural connections that trigger pain in response to those stimuli, which can lead to significant avoidance behavior and impairment.

Finally, the response an individual has toward pain plays a critical role in whether pain becomes chronic. Common and completely understandable reactions to pain include fear of it, obsessive focus on it, becoming frustrated by it, wanting to fight it, dissociating from it, and trying to fix it. All these responses suggest to our brains that the pain is, in fact, dangerous, and, as a result, make it more trenchant.

PARTS EXPRESSING UNMET NEEDS THROUGH PAIN

Needs like rest, self-care, and intimacy are often overridden by parts that view performance, achievement, caretaking, or some other building block of self-esteem to be paramount. But the neglected needs don't just go away: they press for expression, sometimes by generating chronic pain.

When that's the case, recognizing these unmet needs is necessary for effective treatment. This was the case with most of the subjects in a study using IFS to treat rheumatoid arthritis.

A group of 37 chronic rheumatoid arthritis patients received nine months of group and individual IFS therapy. They were compared to a control group of 40 rheumatoid arthritis patients who received

PHOTO © ISTOCK ISTOCK/ISTOCK.ENES ERTAN

only an educational intervention. The results were impressive. The IFS treatment group showed significant improvement in overall pain and physical function, as measured by blinded physicians and blood tests, as well as in self-assessed joint pain, self-compassion, and depressive symptoms.

Unlike most other psychological approaches to working with pain by focusing on the stress believed to be causing it, the therapists in this study took the bold step of asking subjects to focus on the pain itself, become curious about it, and ask what it wanted them to know. The subjects, many of whom were Irish Catholic mothers from Boston, did this readily and were often shocked by what they learned.

Forty-nine-year-old Mary, for instance, had arthritis so severe that she was using a walker, and her hands and knees were chronically aching. She rarely let anyone know how much she was hurting, instead remaining the upbeat matriarch to whom everyone in the family turned for care. The idea of talking to her pain initially seemed absurd to her, but she said she was so desperate that she was willing to try anything. When, from a place of genuine curiosity, she asked the pain in her wrist what it wanted her to know, it said, "I hate you!"

Startled, she managed to remain curious and asked the pain why. "You do things for everyone else and never us," it told her. In that and ensuing sessions, Mary learned that she wasn't talking to the pain itself but to the parts of her that were using the arthritis to try to get her attention and punishing her because they were so frustrated with her incessant caretaking.

The therapist then had Mary focus on her caretaker part, which she initially insisted was just herself, and ask it why it never let up. It showed her images of the women in her family, all of whom had been caretakers themselves and most of whom had arthritis. Thus, caretaking was what is called a legacy burden in IFS. The part also showed scenes of her as a child waiting on her mother, who was so incapacitated by the arthritis that she'd been in a wheelchair through most of Mary's childhood. Her father, an alcoholic who spent most of his time at work or at a local bar, would come home drunk and scare the family with angry ravings. The compulsive caretaking part was driven by that child part's belief that she was worthless, aside from her ability to please and nurture everyone.

As Mary helped retrieve that child from those dreadful scenes and unburden those beliefs, she began listening more to the assertive parts that were using her pain. She embarked on making important, initially disruptive changes in her home, but with the support of her therapist, she persisted. By the end of the study, the pain in her wrists and knees was negligible—she no longer needed a walker—and stayed that way through the follow-up.

Some of Mary's parts were trying to get her to face how imbalanced her life was. Not only was she in exploitative relationships, but her caretaker part had taken on so much responsibility that her body was in a state of constant stress and exhaustion. These pain-provoking parts were like inner rebels, who wanted to create a coup and make her prioritize the well-being of her neglected inner family over her external one.

In some other subjects in the study, these rebels had become like terrorists who were so angry at the oppressive caretaking that they were simply punishing or sabotaging the subjects, creating enough pain and disability that they'd no longer be able to care for everyone else in their life. For others, the pain-provoking parts used the arthritis to try to achieve two things the caretaker parts wouldn't allow: to get people to nurture them without having to ask directly, and to set boundaries by giving people an excuse to say *no* because they wouldn't otherwise. All these parts were expressing how much they hated and felt oppressed by the massive caretaking parts that dominated the subjects' lives.

The therapists then helped subjects get acquainted with their extreme caretaking parts. As they did, they learned that these parts believed that their main value as human beings was wrapped up in that role. If they took care of everyone else, they were worthy of existing, but if they asked for anything for themselves, they were selfish. When subjects asked the caretaking parts where they got those ideas, not only did they remember times when they were given the message that caretaking is what women did, but they often began seeing themselves as children who'd been abused or neglected, and whose experiences had left them with the belief that they were worthless.

In this way, they found parts that were frozen in those dreadful scenes, carried the burden of worthlessness, and had been locked away inside so that the subject didn't constantly feel a sense of shame. These locked-away inner children, known as exiles in IFS, can powerfully and unconsciously mold people's lives.

PARTS DISTRACTING FROM EXILES

It's not just caretaking women who exile inner parts amid pervasive patriarchy. Exiling can result from typical male socialization, in which men are left with emotional repertoires limited to anger or sexual interest—with sadness, fear, or vulnerability banished from conscious awareness. For some men, even feelings and behaviors typically construed as male are off limits. Whatever the disavowed emotion may be, when it threatens to surface, the body will react as though it's in danger.

Take Jorge, for example, a bookkeeper in his mid-40s, who, by everyone's account, was "a nice guy"—remarkably pleasant and helpful. He hadn't always been this way, though. As a boy, he'd gotten into trouble a lot for fighting at school, and he'd often felt like a misfit.

His father, however, was highly critical and insisted on good behavior, so by the time he was a teenager, Jorge had begun to conduct himself in an exemplary manner. As an adult, he made a point of being on time, eating a healthy diet, exercising regularly, and keeping his apartment organized. His reports at work were so complete and accurate that his boss used them to train new employees.

Yet even though Jorge was healthy and exercised regularly, he'd been suffering from frequent headaches for a decade. He'd had several MRIs of both his brain and neck over the years, but all the tests had come back normal, with the only finding being that his neck muscles were chronically tense. Complicating matters more was the fact that when Jorge found himself in stressful situations, on top of the headaches he'd also have abdominal pain and loose stools.

In therapy, it soon became clear that Jorge's emotional life was seriously restricted. While he felt lonely and was often anxious, he never got angry at anyone, and hardly ever felt excitement or joy.

Jorge had told many doctors the story of his headaches and had received numerous medication prescriptions and even trigger-point injections. But no doctor had asked how he was feeling emotionally or what events were occurring in his life when the pain first appeared. As it turns out, when Jorge was 35, he was deeply in love. He got up the courage to ask his love to marry him, but she turned him down, and they broke up.

In working with Jorge, his therapist found that this heartbreak wasn't the only issue in play. Suspecting that his pain might be related to his difficulty connecting with anger, his therapist began doing some parts work with him, starting with a "good" part—one that always wanted to do the right thing. It didn't take long to identify what might happen if that part wasn't performing its duties. His angry part, though locked away, was quite threatening. If his "good" part didn't keep it in check, who knew what might happen?

Jorge had lots of images of himself as a kid, getting into all sorts of trouble for yelling and fighting. After convincing the "good" part to step aside to allow him to interact with young Jorge more, this angry part quickly came alive. When asked to reflect on the time that his chronic pain had arisen, the conflict became apparent. Along with feeling hurt when his beloved had rejected him, Jorge's' angry part was very much activated by her refusal. But having long ago exiled that part, and feeling threatened by it, headaches ensued.

We can understand this process in a couple of ways. One is simply that the fear of the angry part emerging created some combination of tension in his neck muscles, changes in blood flow in his head, and activation or amplification of pain circuits. Another way to see it is that his "good" part generated the pain to distract attention from—and protect him from—his angry part. Of course, it's possible that the cause of his pain was a combination of these mechanisms.

The important point is that by connecting with and accepting his different parts, Jorge was able to allow his angry feelings to arise and then to befriend them. He came to see that his anger made sense,

For some clients, pain became a window into a fascinating inner world of parts. When parts trust us to listen to them, they no longer need to use pain to communicate with us.

given his father's overly demanding attitude. More at home with his angry part, he even found a way to talk to his dad about his experience. Over time, this allowed him to relax and his pain to diminish.

WHAT PAIN TEACHES

It's difficult for us to ignore severe pain, which can overwhelm our senses and render all other priorities moot. This makes it an excellent tool for any part that wants to be heard or to control a person. Pain can keep us from getting close to emotional situations that evoke childhood events deemed too upsetting to face; or it can help us avoid emotions deemed dangerous, such as anger, fear, and sadness. It can arise when boundaries are challenged by unwanted sexual interests or by getting lovingly close to others. It can distract us from feelings that we fear might make us crumble or act in dangerous ways.

Pain can also bring us secondary gains, like avoiding situations likely to create emotional conflicts. It doesn't usually begin for this reason—rather with a random injury or illness—but our parts, unbeknownst to us, often learn to use pain to accomplish all sorts of aims and keep us from feeling vulnerable, lacking, or overwhelmed.

When the pain is emanating from parts, fighting with them typically backfires. That's why we encourage approaching all parts that are involved in the creation and persistence of pain with curiosity and compassion. Compassion helps us access underlying burdens and integrate previously split off or disavowed experiences.

We can use parts work to help patients develop a mindful, accepting awareness of painful sensations, appreciate pain for its importance in protecting and messaging, and reengage in life-affirming activities. Many patients gain significant relief from addressing the parts that contribute to avoiding normal activities and fighting pain sensations. Others need to translate the message that the pain may be trying to communicate. This usually leads to exploration of previously unrecognized longings, fears, injuries, and life imbalances. It often connects clients to childhood or later traumas that have never been fully integrated. While it's not always necessary to integrate all of these to transform a chronic pain syndrome, recognizing them can help avoid recurrences.

In many cases, allowing these parts to speak transforms the pain and often resolves the disorder entirely. Many of our clients say some version of how they wouldn't wish the pain on their worst enemy, but they're glad for the psychological growth it prompted. For them, pain became a window into a fascinating inner world of parts they had no idea existed. These clients come to learn something invaluable—when parts trust us to listen to them, they no longer need to use pain to communicate with or punish us.

Ronald Siegel, PsyD, is a part-time assistant professor of psychology at Harvard Medical School, coauthor of Back Sense: A Revolutionary Approach to Treating Chronic Back Pain, *author of* The Mindfulness Solution: Everyday Practices for Everyday Problems, *and coeditor of* Mindfulness and Psychotherapy. *Resources and contact: DrRonSiegel.com.*

Howard Schubiner, MD, is an internist and the director of the Mind-Body Medicine Center at Ascension Providence Hospital in Southfield, Michigan, and a clinical professor at the Michigan State University College of Human Medicine. He's the author of Unlearn Your Pain, Unlearn Your Anxiety and Depression, *and* Hidden from View, *written with Allan Abbass.*

Richard Schwartz, PhD, director of the IFS Institute and originator of the Internal Family Systems therapy model, is on the faculty of Harvard Medical School.

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

Dockett FROM PAGE 27

crowded me for hugs, hysterical at the thought that they could make me smell as bad as they did. I pulled their blankets over them and stayed in their room long enough to sing them the Irish lullaby my mom used to hum in our kitchen. They told me they loved me, and I said it back. It was the first time in months that we'd gotten to this place together, so content to be with one another and delighted by the world.

It was everything we needed, I told my partner once they were softly snoring. "It's out there," he said. He meant the old world, the one we used to know and take for granted, waiting for us to inhabit it again.

I know it won't be that easy.

This time has changed us, and them, irrevocably. Maybe it's shown our kids that they'll be able to survive great disruptions in their lives, and that we'll forever have their backs. But I fear we've also revealed harsh sides of ourselves that may give them pause about keeping us as confidantes in the coming decades.

Either way, something about this unnatural time together has strengthened our desire to get better at putting our little unit back together after a rift. And we'll keep working to move toward laughter and song in the face of terrible stressors, to find solace and expression in our bodies, and to come to grips with the idea that we're indeed complex creatures, made of shifting, redeemable parts.

I tell myself, as giggling bedtimes and early-morning snuggles keep bearing out, that our family remains connected—that, despite all the sniping, squabbling, and screaming at each other over these long months, we haven't fallen entirely apart. Not yet, at least. And maybe, since we've come this far already, we won't ever.

Lauren Dockett is the senior writer at the Networker.

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

Eno FROM PAGE 33

session. Instead of following along during class, she said that she typically spent the time making lists of all the things she wanted to change about her appearance. The worst was French class. Every night, she had to upload a video of herself speaking French for homework. And every night, the combination of her perfectionism and gender dysphoria resulted in hours of her picking through the video she'd recorded, while her mood spiraled downward. "The videos are torture!" she said.

"Does your teacher know how hard it is for you to make the videos?" the therapist asked. She knew that Charlie had been hesitant to share details of her transition with her current school. A few of her teachers had been inconsistent with their use of her new pronouns, leaving her weary and distrustful of their support. "What's the point" she sighed, resigned. The session ended with the therapist feeling increasingly distressed about the erosion in Charlie's self-confidence that they'd worked to build together.

Charlie's therapist understood that the first task was to help Charlie's French teacher understand that she wasn't simply avoiding the homework assignments. And she knew that Charlie would have to be the one to talk with her about this as a way to regain the sense of personal pride and efficacy that seemed to be slipping away. That night, the therapist wrote out several sample scripts of what Charlie could say to the teacher in which she could propose sending in audio recordings of the homework, without revealing more at this time. She sent the scripts the following morning, and Charlie was quick to choose one of them.

A brief conversation between Charlie and her teacher resolved the current crisis since it was evident that Charlie was making an effort to find a solution. The therapist, who'd worked with Charlie's school before, was certain that the student-support staff would eventually connect with Charlie around her social-emotional needs. They had an active LBGTQ student club, with an advisor who was often called in to help students identify activities and other avenues for making friends and getting the support they need. For now, Charlie simply needed a practical pathway for getting there—and her therapist was able to help.

■■■■■

It's never been easy to take those oh-so-familiar systems principles and put them to work in real life. In the break between sessions, emailing a friend or paying a bill online can supersede the wish to contact the teacher of the child you just saw over Zoom. We always have something else to do, even though so much of our life is now virtual. Yet as I sit in my office longing for the ordinary, maskless, up-close human contact with which we're deeply familiar, I'm encouraged by the therapists embracing the challenges of the time and going above and beyond to support the kids in their communities.

We have the opportunity to take a world that one school principal called disconnected and look for ways, old and new, to make essential connections. Though we have reason to be discouraged, we can still be the bridge that schools and families desperately need. By adding crucial information, empathy, kindness, and clinical understanding to a situation, we can ignite the common motivation to do our best for struggling kids and the families who love them.

Mary Eno, PhD, was on the teaching faculty at the University of Pennsylvania and then Bryn Mawr College for nearly four decades. She's a therapist in private practice in Philadelphia and served as a consulting psychologist in multiple schools. Her book is The School-Savvy Therapist: Working with Kids, Families and Their Schools.

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

Baker FROM PAGE 39

actually spend time in the communities where their clients live. If your only exposure to your client's neighborhood is your drive to and from work, any attempt at offering affirming, culturally relevant treatment will be a lost cause. Seriously addressing disparities means making an effort to become intimately familiar with the everyday realities of the underserved.

I learned this firsthand. In graduate school, I made a point of taking public transportation into North Philadelphia, where I interned, far away from the bubble of the University of Pennsylvania and downtown tourist destinations and into the more segregated, neglected, economically disadvantaged communities on the city's outskirts. This exposure was key to developing a trusting, therapeutic bond with my beloved students.

It was something I needed to do, even as a Black person. Despite elements of identity that my students and I shared, I felt a vast gulf between my reality and theirs. I'd come from a middle-class family, from schools that serve predominantly upper-middle class communities. Impoverished communities weren't new to me, but I was still unsettled by witnessing the degree to which under-resourced communities in major cities are left to fend for themselves. In contrast to downtown, it seemed as if Philadelphia's city government was actively divesting from communities farther north, as if to say, *No one there is going to contribute economic growth, so why would we clean it up or improve the infrastructure? Why would we be concerned with the kids' nutrition there or the environmental hazards from power plants? Or that their schools have no librarians or new books?*

Certainly not all Black communities are impoverished. Yet many of them suffer from the legacy of segregation and present-day divestment, gentrification, and redlining.