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 servitude and was responsible for being problematic. One such group of parts, called exiles, are young and vulnerable, and carry early emotion-al injuries, and they love to be in control, such as a sense of worthlessness, terror, or emotional hurt. Before the trauma, they were the lively, creative “inner children,” but whenever 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 evolve, the world feels more dangerous, and we feel more fragile being in it. As a result, another group of parts tries to protect our exits from getting triggered. To do this, these protector parts take on roles like the hard internal critic, the overarching perfect-fan, or the frightened avoider. In IFS terminology, these protectors function to regulate the day-to-day activities to make sure our exits 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 fire-fighters, jump into action at an even higher level of defense. Firefighters are emergency responders, and their activities include acute depression and suicidal thoughts, cutting, bingeing, alcohol or drug use, and panic attacks. Both protector-managers and firefighters may use physical pain to protect our exits.

Susan eventually found her way to an IFS therapist, who helped her understand that her fears and resulting “inner children,” but whenever she began to carry the burdens of trauma, we locked them away to keep them from overwhelming us with their raw emotions and vulnerability.

Once in session, Susan zeroed in on what she called her pusher part, which included her own daughter when she was in distress. This maternal part 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 about it, and she’s even taking a moment 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. 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 pro-provide that kind of nonjudgmental compan-sion 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, fear-ful approach to her back pain. She began to see that when she could relax into resuming normal activities, her fear made her back diminish, 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 call 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 mak-ing the prospect of another back episode less terrifying. Eventually Susan gave up her back props, begun 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 about it, and she’s even taking a moment 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. 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 pro-provide that kind of nonjudgmental compan-sion 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, fear-ful approach to her back pain. She began to see that when she could relax into resuming normal activities, her fear made her back diminish, 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 experienc-ing her vulnerable, tender part, who sometimes just wanted mommy or daddy to call 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 mak-ing the prospect of another back episode less terrifying. Eventually Susan gave up her back props, begun 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 about it, and she’s even taking a moment 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. 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 pro-provide that kind of nonjudgmental compan-sion 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, fear-ful approach to her back pain. She began to see that when she could relax into resuming normal activities, her fear made her back diminish, 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 call 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 mak-ing the prospect of another back episode less terrifying. Eventually Susan gave up her back props, begun 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 about it, and she’s even taking a moment 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. 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 pro-provide that kind of nonjudgmental compan-sion 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, fear-ful approach to her back pain. She began to see that when she could relax into resuming normal activities, her fear made her back diminish, 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 call 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 mak-ing the prospect of another back episode less terrifying. Eventually Susan gave up her back props, begun 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 about it, and she’s even taking a moment 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. 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 pro-provide that kind of nonjudgmental compan-sion 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, fear-ful approach to her back pain. She began to see that when she could relax into resuming normal activities, her fear made her back diminish, and this shift made it less likely that she’d have another episode.
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 sat, listened, and comforted 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.

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 anymore. 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 degeneration 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 there is 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 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 these psychological factors—like the difference between being relieved to be leaving the battlefield versus fearing going into surgery—that could radically affect the experience of pain.

One classic experiment involved ice water. If you tell subjects that they’ll have 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. 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, placebo can be so powerful for subjective symptoms that drug manufacturers often struggle to demonstrate that active medications are more potent.

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.

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. Perhaps one’s body has had a bad reaction to a needle poke for a blood draw, he’s likely to start crying when he sees the needle for a vaccination—and he’s likely to experience increased pain at a subsequent needle poke 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’d likely 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 your 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. One of the desperate parts alert us to what they believe to be dangerous emotional situations, not through obvious alarms, such as tears or insomnia, but through less obvious, physical ones, such as fatigue, urinary frequency, nau- sea, and numbness, tingling in the hands, and sexual dysfunction. Our brains 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 fighting it, becoming frustrated by it, wanting to fight it, dissociating from it, and trying to fix it. All these responses are useful 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, care-taking, 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 we help our clients make sense of the experience, it’s critical to recognize these unmet needs are 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 rheuma-toid arthritis patients received nine months of group and individual IFS therapy. They were compared to a control group of 40 rheuma-toid arthritis patients who received
only an educational intervention. The results were impressive. The IFS therapy group revealed a significant improvement in overall pain and physical functioning, 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, the therapy was focusing on the stress believed to be causing it, the therapists in this study took the bold step of asking subjects to focus their attention on the parts that were being curios 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.

Fifty-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 had no idea how much she was hurting, instead remaining the upbeat marriage 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 parts trust us to listen to them, they no longer need to try to achieve two things the subject didn’t constantly feel a sense of shame. These locked-away inner children, known as exiles in IFS, can peacefully and unconsciously mold people’s lives.

Mary’s parts were driven by that child part’s desire to be taken on so much responsibility that her caretaker part had hated and felt oppressed by the massive caretaking parts that dominated the subjects’ lives.

As Mary helped parts 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 member over her external one because they were so frustrated with her incessant caretaking.

The therapist then had Mary focus on her caretaker part, which the initially insisted was just herself, and ask why it never let up. It showed her that all of those endless hours, 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 heavily incapacitated by 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 a local bar, would come home drunk and scare the family with angry rants. The compulsive caretaking part was driven by the belief that she was worthless, aside from her ability to please and nurture everyone.

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 their incessant caretaking.

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 their incessant caretaking.
given his father’s overly demanding attitude. More at home with his angry feelings than with any notion of talking 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 leave us without the ability to hold onto your thoughts. Many of our clients say they’re having close emotional situations that evade childhood events deemed too upsetting to face; or can help us avoid emotions deemed dangerous, such as anger, fear, and sadness. It can arise when boundaries are challenged by unwanted sexual interests such as anger, fear, and sadness. 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 feel as though we’re trading pain for a random injury or illness—but our parts, unbeknownst to us, often trade pain for the ability to accomplish all sorts of aims and keep us from feeling vulnerable, lacking, or overwhelmed.

When 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 functions back into a whole system.

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.

Lauren Dockett is the senior writer at the Networker. Let us know what you think at letters@psychotherapynetworker.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, hysterial at the thought that they could make me smell as bad as they did. I pulled their blankets over them and stayed with them for making 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 knew 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 they can trust us to listen to them, no longer need to use pain to communiate with or punish us.


**Eno FROM PAGE 33**

session. Instead of following along during class, she said that she typi- cally spent the time making lists of all the things she wanted to change about herself or her world. The worst was French class. Every night, she had to upload a video of herself speaking French for homework. And even though she knew her perfectionism and gender dyspho- ria resulted in hours of her picking through the video she’d recorded, while her momspiraled 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 sup- port. But when she sighed, resigned. The session ended with the therapist feeling increasingly dis- tressed about the erosion in Charlie’s self-esteem and wondered 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 home- work assignments. And she knew that they were deeply rooted. By addressing crucial information, empathy, kind- ness, and clinical understanding to a situation, we can ignite the com- mon motivation to do our best for struggling kids and the families who love them.

Mary Eno, PhD, was on the teaching fac- ulty 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.

Baker FROM PAGE 39

It’s never been easy to take those oh-so-familiar systems principles and put them to work in real life. In the dark spaces, 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. That’s why we’re embracing the challenges of the time and going above and beyond to sup- port the kids in their communities.

We’re finding new ways to take a world that one school principal called disconnected and look for ways, old and new, to make essen- tial connections. Though we have reason to be discouraged, we can still be the bridge that schools and communities need to build.

It’s never been easy to take those oh-so-familiar systems principles and put them to work in real life. In the dark spaces, 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. That’s why we’re embracing the challenges of the time and going above and beyond to sup- port the kids in their communities.

We’re finding new ways to take a world that one school principal called disconnected and look for ways, old and new, to make essen- tial connections. Though we have reason to be discouraged, we can still be the bridge that schools and communities need to build.

PSYCHOTHERAPYNETWORKER.ORG

FROM PAGE 39

Eno from page 33

It’s never been easy to take those oh-so-familiar systems principles and put them to work in real life. In the dark spaces, 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. That’s why we’re embracing the challenges of the time and going above and beyond to sup- port the kids in their communities.

We’re finding new ways to take a world that one school principal called disconnected and look for ways, old and new, to make essen- tial connections. Though we have reason to be discouraged, we can still be the bridge that schools and communities need to build.

It’s never been easy to take those oh-so-familiar systems principles and put them to work in real life. In the dark spaces, 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. That’s why we’re embracing the challenges of the time and going above and beyond to sup- port the kids in their communities.

We’re finding new ways to take a world that one school principal called disconnected and look for ways, old and new, to make essen- tial connections. Though we have reason to be discouraged, we can still be the bridge that schools and communities need to build.

PSYCHOTHERAPYNETWORKER.ORG