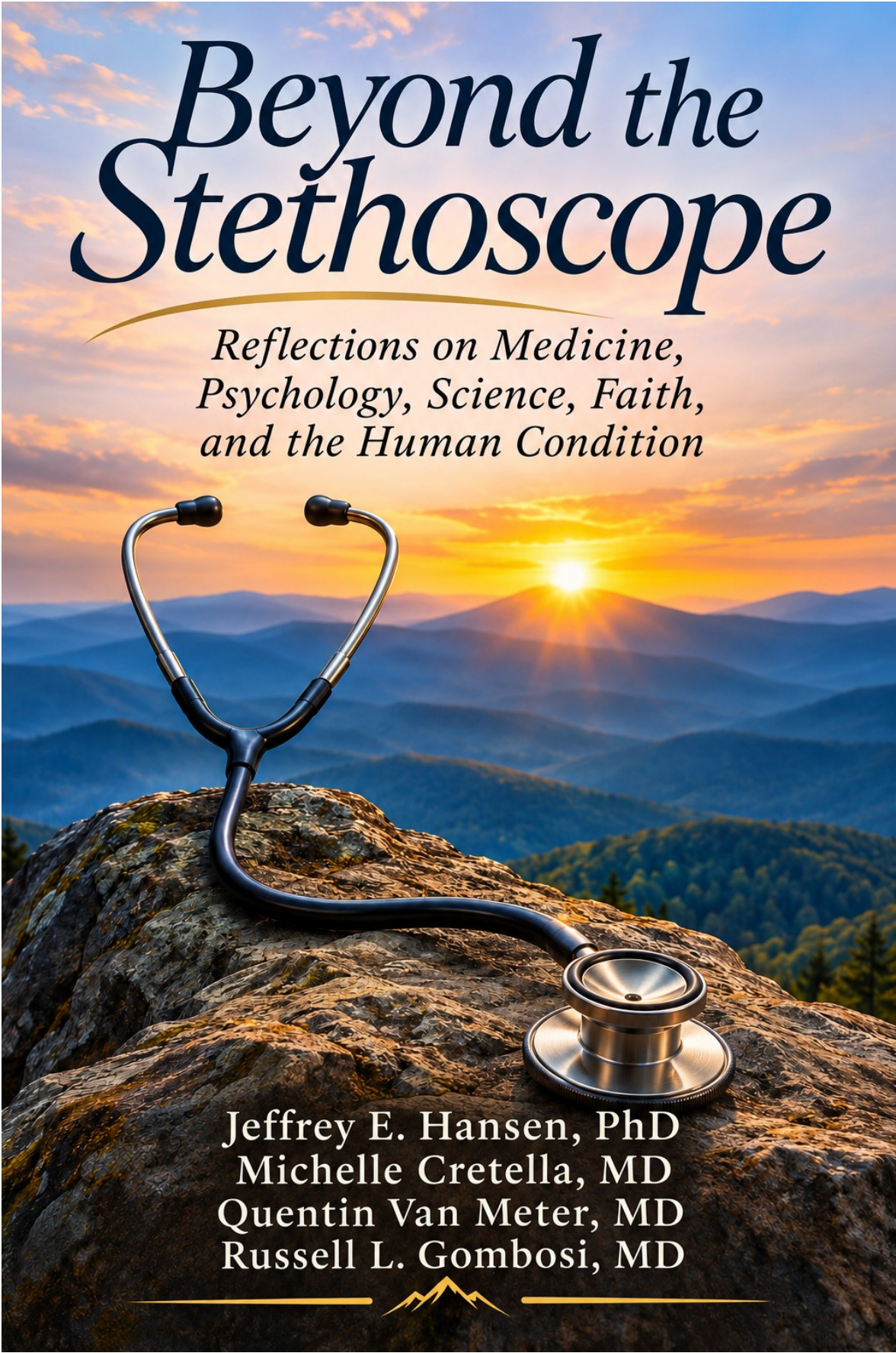
Beyond the Stethoscope

Reflections on Medicine, Psychology, Science, Faith, and the Human Condition



Jeffrey E. Hansen, PhD
Michelle Cretella, MD
Quentin Van Meter, MD
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NO MEDICAL ADVICE IS GIVEN NOR PROVIDED IN THIS BOOK. SUCH INFORMATION, WHICH MAY BE MEDICAL IN NATURE, IS INFORMATION ONLY FOR THE USE OF LICENSED AND EXPERIENCED MEDICAL PRACTIONERS. A READER INTERESTED IN MEDICAL ADVICE OR MEDICAL TREATMENT SHOULD CONSULT A MEDICAL PRACTIONER WITH AN APPROPRIATE SPECIALTY WHO IS PROPERLY LICENSED IN THE READER'S JURISDICTION.

Authors' Note on AI Contributions

Limited parts of this book were crafted with the support of ChatGPT, an AI tool that helped refine transitions and assist with research. Every effort has been made to ensure that all sources and information are accurate and reliable. Additionally, some images were created with the help of AI technology. We invite readers to explore the content with an open mind, and where applicable, feel free to consult other sources for further insight.

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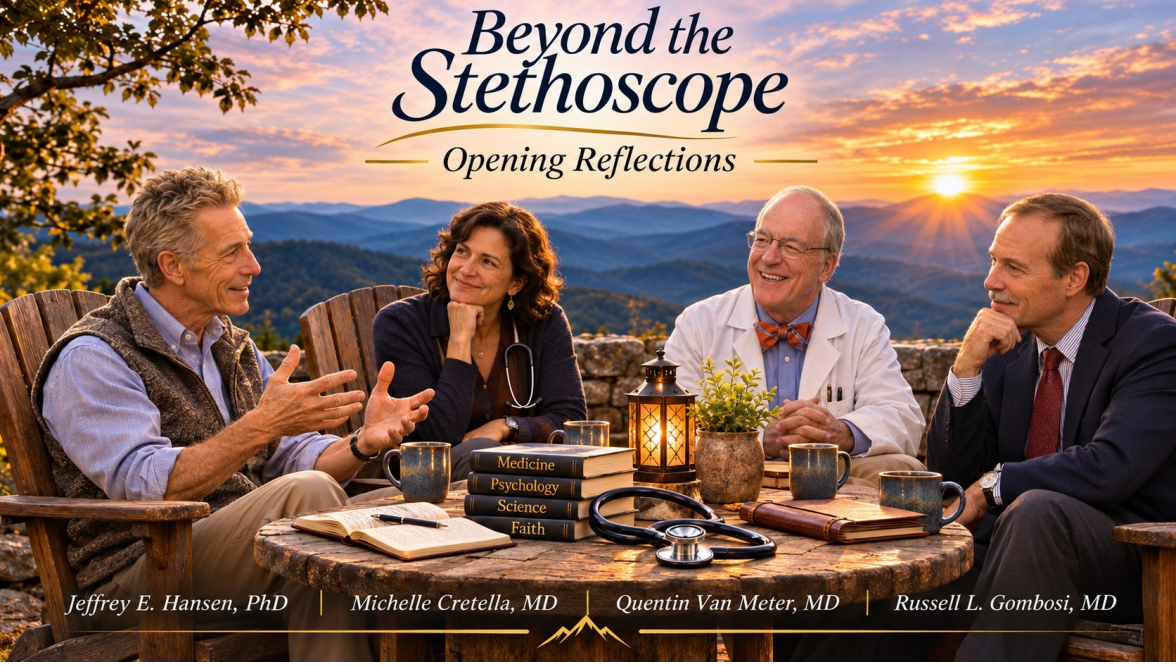
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Opening Reflections

Why Beyond the Stethoscope?

Four Professionals. Four Christians. Four Friends. One Table.

There is something wonderfully dangerous about putting four seasoned professionals around a table, pouring a little coffee, and giving them permission to think out loud. Especially when those professionals have spent much of their adult lives studying the human condition, treating the wounded, confronting difficult questions, and occasionally irritating people who would prefer that certain questions never be asked in the first place. Add a shared Christian faith, a considerable accumulation of professional experience, a healthy appreciation for intellectual mischief, and four personalities who have not entirely surrendered their independence to institutional respectability, and things could become rather interesting. We suspect that is precisely why we are here.

We are four professionals, four Christians, and four friends and colleagues whose careers have followed different paths but whose

convictions have brought us to a common table. Three of us are physicians. The fourth is a psychologist. That would be Jeff Hansen, our resident odd man out, who somehow managed to persuade three distinguished medical doctors that spending time with a psychologist might be an intellectually worthwhile endeavor. Michelle Cretella, Quentin Van Meter, and Russell Gombosi have devoted their professional lives to medicine, while Jeff has spent more than four decades crawling around inside the psychological complexities of human beings, occasionally emerging with an explanation, frequently with another question, and sometimes wondering how any of us manage to get through an ordinary Tuesday without considerable divine assistance.

We should probably confess something at the outset. Psychologists can be annoying. We have a peculiar tendency to ask what someone means by a perfectly understandable statement, inquire about the assumptions behind an otherwise respectable conclusion, and suggest that a seemingly straightforward problem may have something to do with childhood, attachment, identity, unresolved trauma, or the complicated relationship a person had with his father in 1963. By the time we finish, the original question has occasionally become unrecognizable. We suspect our medical colleagues will have moments when they wish Jeff would simply prescribe something and move along. Unfortunately, psychologists are not allowed to do that in most jurisdictions, which may be one of the more sensible boundaries civilization has established.

But here is the delightful irony: these three physicians hardly need a psychologist to teach them how to question conventional wisdom. They have built substantial careers examining complicated problems, challenging assumptions, and bringing their clinical knowledge to bear

on questions that do not always have convenient answers. Each has experienced the rewards and frustrations of practicing medicine in an increasingly complicated world. Each has witnessed the extraordinary power of modern medical science, along with the limitations of institutions that sometimes confuse administrative efficiency with genuine healing. And each has demonstrated a willingness to engage questions that can make professional gatherings considerably less comfortable than the organizers had anticipated.

In other words, Jeff may be the odd man out, but he appears to have found remarkably compatible company.

Our purpose is not to assemble four impressive résumés, congratulate one another on our professional accomplishments, and produce another collection of carefully polished opinions destined to gather dust on somebody's bookshelf. The world already has an adequate supply of self-important professionals, and we see little reason to increase the inventory. We want something more meaningful, more intellectually adventurous, and considerably more human. We want to explore what we have learned, question what we think we know, examine what troubles us, and occasionally laugh at the extraordinary absurdities that accompany the practice of medicine, psychology, and life itself. We believe serious subjects deserve serious thinking, but we see no reason that serious thinking must be accompanied by a perpetual expression of constipation.

Life is difficult enough without making curiosity miserable.

The Company We Keep

Our professional backgrounds are quite different, and that is part of what makes this collaboration so appealing. We have worked in

hospitals, military medical facilities, private practices, academic settings, and professional organizations. We have treated children and adults, taught younger clinicians, supervised developing professionals, and wrestled with questions involving science, ethics, suffering, human development, and the responsibilities that accompany a healing profession. Our careers have given us different vantage points from which to examine the same remarkable creature: the human being, who is capable of extraordinary courage and compassion one moment and breathtaking foolishness the next. We say that with considerable affection, having witnessed both qualities in our patients, our colleagues, and, if we are willing to be sufficiently honest, ourselves.

Michelle Cretella, MD, is a board-certified pediatrician whose professional journey has extended well beyond the examination room into adolescent health, human development, medical ethics, and the broader responsibilities of medicine toward children and families. A graduate of the University of Connecticut School of Medicine, Michelle completed her pediatric training and went on to practice general pediatrics before assuming significant leadership responsibilities within organized medicine. As a former president of the American College of Pediatricians (ACPeds), she has participated in important discussions concerning childhood development, adolescent well-being, and the ethical foundations of medical practice. Michelle brings the perspective of a physician who understands that children do not arrive in examination rooms as isolated collections of organs, laboratory values, and developmental milestones. They arrive as developing persons, carrying the influences of family, relationships, culture, biology, and the increasingly bewildering world into which they are growing.

Michelle's professional interests extend into questions that require more than a superficial understanding of childhood. What does healthy

development look like in a culture that sometimes seems determined to redefine it every fifteen minutes? How should physicians approach competing claims about adolescent well-being? What happens when professional recommendations intersect with questions of parental responsibility, individual dignity, and moral conscience? These are serious matters, and Michelle brings years of pediatric experience and professional engagement to the discussion. Her perspective will be especially valuable as we examine how medicine can remain both scientifically responsible and deeply attentive to the children and families it exists to serve.

Quentin Van Meter, MD, brings a distinguished career in pediatric endocrinology, military medicine, medical education, and professional leadership. After completing his medical education and pediatric training, Quentin pursued specialized fellowship training in pediatric endocrinology at Johns Hopkins. He served twenty years in the United States Navy Medical Corps, where his responsibilities included clinical practice and medical education, before establishing a civilian pediatric endocrinology practice in the Atlanta area. He has also held academic appointments and served as president of ACPeds. His expertise places him at the intersection of physiology, hormones, growth, and human development, fields that have profound implications for understanding the biological processes accompanying childhood and adolescence.

There is something especially valuable about a physician who has spent decades studying the extraordinarily intricate endocrine system. Hormones do not operate according to the latest cultural fashion, administrative directive, or academic slogan. They participate in complex biological processes that demand careful observation, scientific humility, and an appreciation for the remarkable intricacy of the human body. Quentin's background provides an important

perspective as we explore questions involving development, medical intervention, scientific evidence, and professional responsibility. His military service also gives him something in common with Jeff, who spent years serving as an Army psychologist. Military medicine has its own peculiar combination of extraordinary people, formidable responsibilities, and bureaucratic adventures. Anyone who has survived a substantial career in that environment probably deserves a medal simply for maintaining a functioning sense of humor.

Russell L. Gombosi, MD, brings a particularly broad medical perspective, having developed expertise across internal medicine, pediatrics, and sleep medicine. A graduate of the Pennsylvania State University College of Medicine, Russell has cared for patients across different stages of life, allowing him to approach human health with an appreciation for the relationships among physical illness, development, sleep, and the conditions of everyday living. The breadth of his medical background is especially valuable in a world where specialization sometimes encourages us to divide the human body into increasingly smaller territories, each with its own specialists, diagnostic codes, and administrative kingdoms. The heart belongs to one department, the lungs to another, the brain to several competing departments, and somewhere in the middle sits a bewildered patient who would simply like someone to explain why he feels terrible.

Russell's experience reminds us that the body is not a collection of independent departments operating under separate management. Sleep affects physical and psychological functioning, medical conditions influence emotional well-being, and the processes of development and aging create relationships that cannot always be understood by examining one system in isolation. He has also demonstrated a willingness to engage difficult questions concerning medical ethics,

professional conscience, and the responsibilities of physicians toward those entrusted to their care. We value that willingness because intellectual honesty sometimes requires saying things that are not especially popular, particularly when an institution has already decided what everyone is supposed to think.

Jeffrey E. Hansen, PhD, rounds out our gathering as the psychologist who apparently wandered into a room full of physicians and decided to stay. Fellowship-trained in developmental pediatrics, Jeff's professional career has included service as an Army psychologist, the establishment and leadership of a pediatric psychology practice, and years of clinical and faculty service at Madigan Army Medical Center. He has spent much of his professional life working with children, adolescents, families, military personnel, and individuals struggling with traumatic experiences. His work has increasingly focused on the relationships among neuroscience, psychological functioning, physiological regulation, identity, relationships, and spirituality. Those interests contributed to the development of NeuroFaith®, an integrative clinical framework drawing upon polyvagal-informed principles, physiological self-regulation, Internal Family Systems, and Christian faith.

Jeff also writes, apparently because the inside of his head is a rather noisy place and something has to be done with all those thoughts. His *Sandbox* series grew from an appreciation for curiosity, psychological exploration, irreverent humor, and the conviction that important ideas sometimes emerge when we give ourselves permission to play with them. He has written about neuroscience, trauma, relationships, professional ethics, institutional responsibility, aging, and the peculiar challenges of navigating a world in which common sense occasionally seems to have wandered away without leaving a forwarding address. His tendency to challenge assumptions began early. According to family

history, a kindergarten teacher once expressed concern that young Jeffrey possessed the necessary motor skills to color inside the lines but stubbornly refused to do so. Several decades later, numerous degrees, professional appointments, and extensive clinical experience have apparently failed to correct the problem. We suspect the prognosis is poor.

These introductions offer a glimpse of our backgrounds, but we have no desire to turn this book into a parade of professional accomplishments. We have spent enough years in hospitals, universities, and professional organizations to recognize that a collection of credentials does not necessarily produce wisdom, compassion, intellectual independence, or moral courage. We have known extraordinarily accomplished people whose humanity seemed to have been misplaced somewhere between medical school and the executive conference room. We have also known remarkably humble clinicians whose quiet competence and compassion transformed lives without ever attracting much professional attention. The distinction matters. What gives professional knowledge its enduring value is not simply what we know, but what we do with that knowledge and whether the people entrusted to our care are better served because of it.

Why Beyond the Stethoscope?

The stethoscope is a remarkable instrument and a fitting symbol of medicine. For generations, it has represented the physician's responsibility to listen, examine, understand, and care for the human body. It allows a trained clinician to hear physiological processes that might otherwise remain hidden, providing important information about the heart, lungs, and other bodily functions. Yet even the finest

instrument has limitations, and those limitations point toward the central conviction behind this book: the human person is considerably more complicated than anything we can measure through a single instrument, laboratory test, psychological assessment, or diagnostic category.

A stethoscope can help a physician hear the heart, but it cannot tell us everything that is breaking it. It can identify abnormalities in breathing, but it cannot fully explain why a frightened child feels unable to breathe when no obvious pulmonary disease is present. It can contribute to the diagnosis of illness, but it cannot tell us what it feels like to be the person receiving that diagnosis, or how fear, grief, relationships, faith, and the search for meaning may shape the experience of suffering. These dimensions are not peripheral decorations attached to the supposedly more important business of medicine. They are part of the human condition itself, and they deserve serious attention.

We have devoted our professional lives to medicine and psychology because we believe deeply in the value of scientific understanding. Modern medicine has accomplished extraordinary things, and the advances of neuroscience, physiology, pharmacology, surgery, and psychological treatment have changed countless lives. We are grateful for those achievements and have no interest in replacing careful scientific inquiry with attractive speculation or sentimental enthusiasm. But we have also learned that scientific knowledge, however powerful, does not eliminate the need for thoughtful clinical judgment, meaningful relationships, and an appreciation for the person whose suffering brought him or her into our care.

A child is not merely a collection of symptoms. A teenager is not simply a developing brain attached to a hormonal system that occasionally

behaves like a badly supervised fireworks display. A frightened parent is not an obstacle to efficient clinical practice, and a traumatized veteran is not merely an autonomic nervous system that has forgotten how to stand down. Each is a person with a history, relationships, hopes, fears, beliefs, and a developing understanding of what life means. We cannot adequately understand those experiences by reducing them to one explanatory framework, regardless of how sophisticated that framework may be.

That recognition is especially important in an age when specialization and institutional efficiency can unintentionally encourage fragmentation. A patient may see one physician for the heart, another for the lungs, a third for sleep, and a psychologist for the anxiety that has developed while trying to navigate the first three appointments. Everyone may be technically competent, yet the person can still feel that nobody quite understands the whole story. We are not suggesting that specialization is unnecessary. It is indispensable. But specialization should deepen our understanding of human beings rather than leave them feeling like disconnected collections of medical problems waiting for separate departments to claim jurisdiction.

And this is where our Christian faith enters the conversation. We share a conviction that human life possesses inherent dignity and that the responsibilities of the healing professions extend beyond technical competence. We believe that patients deserve to be treated as persons rather than reduced to diagnoses, and that the practice of medicine and psychology carries moral obligations involving truth, compassion, conscience, and respect for human dignity. Our faith informs those convictions, while our professional training requires us to distinguish carefully between scientific evidence, clinical judgment, philosophical interpretation, and theological belief. We see no contradiction in

pursuing scientific rigor while recognizing that the human person raises questions extending beyond what science alone is designed to answer.

Indeed, we believe the intersection of faith and science is among the most fascinating places to begin asking questions. What does suffering mean? How do relationships influence healing? Why do some individuals demonstrate extraordinary resilience while others struggle under burdens that appear comparatively modest? How do we understand the biological processes of emotion without reducing love, grief, forgiveness, or hope to nothing more than chemistry? What responsibilities do professionals carry when emerging scientific claims intersect with questions of conscience and moral judgment? These are not trivial philosophical diversions to be entertained after the important medical work has concluded. They influence how we understand our patients, how we approach treatment, and how we interpret the responsibilities entrusted to us.

We also recognize that the institutions responsible for providing medical and psychological care are not immune to human weakness, competing interests, or the occasional breathtaking display of bureaucratic creativity. Over our careers, we have witnessed extraordinary clinicians working within systems that sometimes appear to have forgotten why they exist. The physician wants time to understand a frightened family, but the appointment schedule has already moved on. The psychologist recognizes that a struggling patient needs continuity of care, but an administrative pathway demands another referral, another form, and perhaps a small ceremonial sacrifice to the gods of regulatory compliance. Meanwhile, the patient waits, the clinician grows weary, and the machinery continues humming along with impressive organizational confidence.

We can laugh at these absurdities, but we do not consider their consequences amusing. When institutional processes begin serving themselves rather than the people they were established to help, something important has gone wrong. When clinicians become reluctant to ask legitimate questions because those questions are professionally inconvenient, intellectual independence and patient care can suffer. And when scientific or ethical disagreements are settled through pressure, intimidation, or appeals to authority rather than careful examination of evidence, the healing professions risk losing something essential to their integrity.

We intend to examine such concerns thoughtfully and directly. That does not mean assuming every institution is corrupt, every administrator misguided, or every established practice unworthy of respect. Many of the finest people we have known have worked within large and complicated medical systems, often providing extraordinary care despite considerable obstacles. But neither do we believe that professional loyalty requires intellectual surrender. Institutions exist to serve people, not the other way around, and the willingness to ask whether they are fulfilling that responsibility is part of what responsible professionals ought to do.

Professional courage, however, cannot simply mean having the confidence to challenge everyone else's assumptions while treating our own as sacred objects. If we intend to question established practices, we must also remain willing to have our reasoning examined, our interpretations challenged, and our conclusions corrected when stronger evidence demands it. We may hold convictions firmly, but conviction should not be confused with infallibility. We are four experienced professionals, not four infallible oracles descending from the mountain with tablets of unquestionable medical wisdom.

Although, given the impressive collection of degrees represented at our table, we suppose the temptation might occasionally arise.

We will resist it as best we can.

A Book That Begins With One Voice and Grows Into Four

The origins of *Beyond the Stethoscope* are somewhat unconventional, which seems entirely appropriate given the personalities involved. This project did not begin with a publishing committee, a carefully negotiated chapter outline, or four authors gathered around a conference table assigning topics according to an elaborate organizational chart. It began with an existing collection of essays written by Jeff Hansen, whose reflections on medicine, psychology, neuroscience, trauma, family life, institutional responsibility, and Christian faith provided the initial foundation.

Many of those essays emerged from decades of clinical experience, while others grew out of conversations with colleagues, personal reflections, scientific reading, or questions that refused to leave Jeff alone. Those who know him will recognize the pattern. Something catches his attention, occasionally something that disturbs him considerably, and before long another essay appears. Writing seems to be his preferred method of processing intellectual irritation, a habit that has produced a growing collection of books and reflections and may explain why his computer keyboard has suffered considerably more abuse than the average household appliance.

But what began as one psychologist's reflections has opened the door to something richer. Michelle, Quentin, and Russell will bring their own writings, professional observations, personal experiences, and reflections to these pages. Some contributions may respond directly to

questions raised in the original essays, while others will explore entirely new territory. We want each author to retain an authentic voice because our differences are not obstacles to the collaboration; they are among its greatest strengths. Medicine and psychology often approach the same human problem through different doors, and even physicians trained in different specialties may recognize aspects of a problem that their colleagues have overlooked.

We do not intend to produce four identical voices speaking in carefully rehearsed unison. That might make life easier for an editor, but it would make for a considerably less interesting book. We expect some essays to be scientific and analytical, others more philosophical or reflective, and still others focused upon clinical experience, professional ethics, family life, or spiritual questions. We may examine the same topic from different perspectives, explore disagreements, or discover that an observation offered by one author opens an entirely unexpected direction for another. That is precisely the kind of intellectual exchange we hope to encourage.

This means the book is not intended to remain static. Its existing chapters provide a starting point, but the collaboration will grow as new contributions arrive and our conversations develop. We hope readers will encounter not only the accumulated experience of four professionals but also the pleasure of seeing ideas examined, challenged, refined, and sometimes reconsidered. We are not interested in manufacturing artificial agreement for the sake of presenting a perfectly coordinated intellectual performance. Friendship does not require unanimity, and thoughtful collaboration becomes considerably more valuable when participants are free to think independently.

Underlying these contributions is a shared concern for the people whose lives have shaped our professional journeys. We have treated frightened children, struggling adolescents, exhausted parents, wounded military personnel, individuals living with chronic illness, and people whose outward appearance concealed profound private suffering. We have also witnessed astonishing resilience, courage, faith, recovery, and the quiet determination of human beings who continued moving forward when life had given them every reason to surrender. Those encounters have taught us lessons no classroom could have provided, and they remind us that the most important questions in medicine and psychology are rarely abstract intellectual exercises.

Our patients have taught us that listening is not simply a preliminary inconvenience before the real work begins. Often, listening is where the real work begins. They have taught us that a technically correct diagnosis may still leave a person feeling misunderstood, that treatment plans must fit human beings rather than merely diagnostic categories, and that compassion without competence may be insufficient while competence without compassion can leave something essential missing. A frightened adolescent may need someone willing to remain curious long enough to understand the story behind the symptoms. A parent may need a physician who recognizes that an apparently simple question conceals a much deeper fear. A traumatized veteran may understand intellectually that the danger has passed while his body continues behaving as though the next catastrophe is about to arrive. These are not minor complications that distract us from good medicine or psychology. They are part of what makes good clinical care so demanding, so profoundly human, and, at its best, so extraordinarily meaningful.

The Wisdom We Hope to Pass Along

There comes a season in professional life when accumulating another title, appointment, publication, or credential begins to feel less compelling than sharing what experience has taught us. Earlier in our careers, we pursued education, developed clinical skills, established practices, accepted leadership responsibilities, and worked hard to become competent in our respective disciplines. There were patients to treat, research findings to understand, students to teach, and professional mountains to climb. Some of those mountains were worth the effort. Others, we eventually discovered, were little more than elaborate piles of administrative paperwork with a commanding view of absolutely nothing.

The passage of time has a remarkable way of changing one's perspective. Accomplishments that once seemed enormously important begin to lose some of their authority, while moments that barely registered at the time become treasured memories. A grateful patient, a struggling student who eventually became an excellent clinician, a frightened family that discovered hope, or a colleague who found the courage to speak honestly may remain with us long after professional honors have faded. We begin to understand that the enduring value of a career cannot be measured simply by the titles accumulated or the number of people who attended our presentations.

Arthur C. Brooks explores aspects of this transition in *From Strength to Strength* (2022), describing how the accumulated knowledge and perspective of later life can open new opportunities for meaningful contribution. His reflections resonate with something we have come to appreciate: professional significance need not diminish when our roles change. It can take a different and sometimes more generous form. Experience may help us recognize familiar patterns, distinguish urgency from importance, tolerate uncertainty, and understand that the most

sophisticated intervention is not necessarily the most helpful one. Age does not automatically produce wisdom, of course. We have all encountered individuals who managed to accumulate decades without becoming noticeably more thoughtful, although we shall graciously refrain from naming names.

But when experience is joined with humility, curiosity, and a willingness to remain teachable, the later chapters of professional life can become remarkably fruitful. We no longer need to prove ourselves through every professional encounter or treat every disagreement as a challenge to our competence. We can share what we have learned, acknowledge mistakes without surrendering dignity, and encourage younger colleagues to improve upon the work we have done. There is something deeply satisfying about passing along knowledge without demanding that the next generation become an exact replica of ourselves. After all, one of Jeff Hansen is probably sufficient for most communities, and the medical profession has enough interesting personalities to manage without manufacturing additional copies.

We hope *Beyond the Stethoscope* will become one way of passing something valuable along. To younger physicians, psychologists, and other professionals, we hope to offer observations worth considering, questions worth asking, and occasional lessons learned through experiences we would not necessarily volunteer to repeat. To parents and families, we hope to offer perspectives that encourage deeper understanding and more thoughtful engagement with the professionals entrusted with their care. And to colleagues who have traveled a long professional road, we hope these pages provide companionship, renewed curiosity, and a reminder that accumulated experience remains a gift worth sharing.

This brings us to an image that has become especially meaningful as we have envisioned the collaboration: four colleagues gathered around a wooden table, perhaps overlooking distant mountains as the late afternoon sunlight begins to soften. There are books scattered about, a stethoscope resting beside a journal, coffee within reach, and enough time to enjoy a discussion without someone announcing that the next patient is already waiting and the electronic medical record has developed another urgent appetite for documentation. There is no podium separating the speaker from the audience, no administrative agenda demanding predetermined conclusions, and no requirement that everyone leave with precisely the same opinion.

There is simply a table, four chairs, and the freedom to think.

We like that image because it suggests something increasingly precious in professional life: the opportunity to engage one another as people rather than merely as representatives of disciplines, institutions, or professional organizations. Around a table, we can listen as carefully as we speak, question an idea without attacking the person expressing it, and occasionally discover that a colleague's unexpected observation has illuminated something our own expertise failed to reveal. We can laugh at ourselves, acknowledge uncertainty, and enjoy the remarkable privilege of learning from people whose knowledge and character we respect.

Friendship, after all, is not measured by the absence of disagreement. Some of the richest friendships are strengthened by the freedom to disagree openly while remaining confident in the affection and respect beneath the conversation. Our Christian faith provides a common foundation, but our professional histories give us different vantage points from which to examine the questions before us. Medicine,

psychology, neuroscience, philosophy, and theology each contribute something important, and the richness of the discussion depends upon our willingness to listen, reflect, and occasionally recognize that someone else may have noticed a piece of the puzzle we were too busy defending our own conclusions to see.

Pull Up a Chair

As these pages unfold, readers will encounter reflections on children and adolescents, human development, mental health, trauma, relationships, medicine, professional ethics, institutional responsibility, resilience, aging, Christian faith, and the search for meaning. Some essays will examine scientific findings and clinical practice, while others will explore questions that extend beyond the boundaries of any single discipline. There will be occasions when we challenge prevailing assumptions, question institutional practices, or examine controversies that have generated considerable disagreement within medicine and society. At other times, we may simply reflect upon the extraordinary privilege of caring for people, the lessons our patients have taught us, or the peculiar business of growing older in a world that seems perpetually fascinated with the newest thing.

We cannot promise that every reader will agree with every conclusion. In fact, we would be mildly concerned if that happened. Either we had written something remarkably uninteresting, or everyone had decided to stop thinking independently, neither of which strikes us as an especially desirable outcome. We hope readers will question our arguments, examine the evidence, consider our experiences, and challenge conclusions they believe deserve closer scrutiny. We intend to distinguish established research from clinical judgment, personal reflection, and philosophical interpretation, while recognizing that

each has an appropriate place in the larger conversation about human life.

What we can promise is that we care deeply about the people and questions addressed in these pages. We have spent our careers trying to understand and serve human beings, and the longer we have practiced, the more we have come to appreciate both the extraordinary achievements and the profound limitations of our professional knowledge. We have witnessed suffering that humbled us, courage that inspired us, and recoveries that reminded us why we entered these professions in the first place. We have also encountered enough bureaucratic absurdity, intellectual arrogance, institutional cowardice, and occasionally spectacular human foolishness to recognize that the healing professions, like the rest of civilization, remain very much a work in progress.

We intend to approach that work with seriousness, curiosity, conviction, and a generous measure of grace. We will not always arrive at the same conclusions, and we do not believe friendship requires that we do so. But we share a commitment to truth, the dignity of human life, the responsibilities of professional conscience, and the conviction that our Christian faith calls us to serve others with courage, compassion, and humility. We also share the belief that an occasional well-placed question can accomplish more than a dozen impressive declarations delivered with great professional solemnity.

And perhaps that is the real reason this collaboration appeals to us. We have spent decades learning, practicing, teaching, treating, writing, and occasionally discovering that what we thought we understood was considerably more complicated than we had imagined. We have reached a season when the joy of sharing that experience has become as

meaningful as the experience itself. Rather than clutching our accumulated knowledge like treasured possessions, we would rather place it on the table, invite others to examine it, and see whether something useful might emerge.

So welcome to *Beyond the Stethoscope*. We are four professionals, four Christians, and four friends and colleagues—three physicians and one occasionally troublesome psychologist—who believe there is still much worth questioning, understanding, challenging, and sharing. We have no intention of pretending that we possess all the answers, and even less intention of surrendering our curiosity merely because we have accumulated enough degrees to make our professional introductions unnecessarily lengthy.

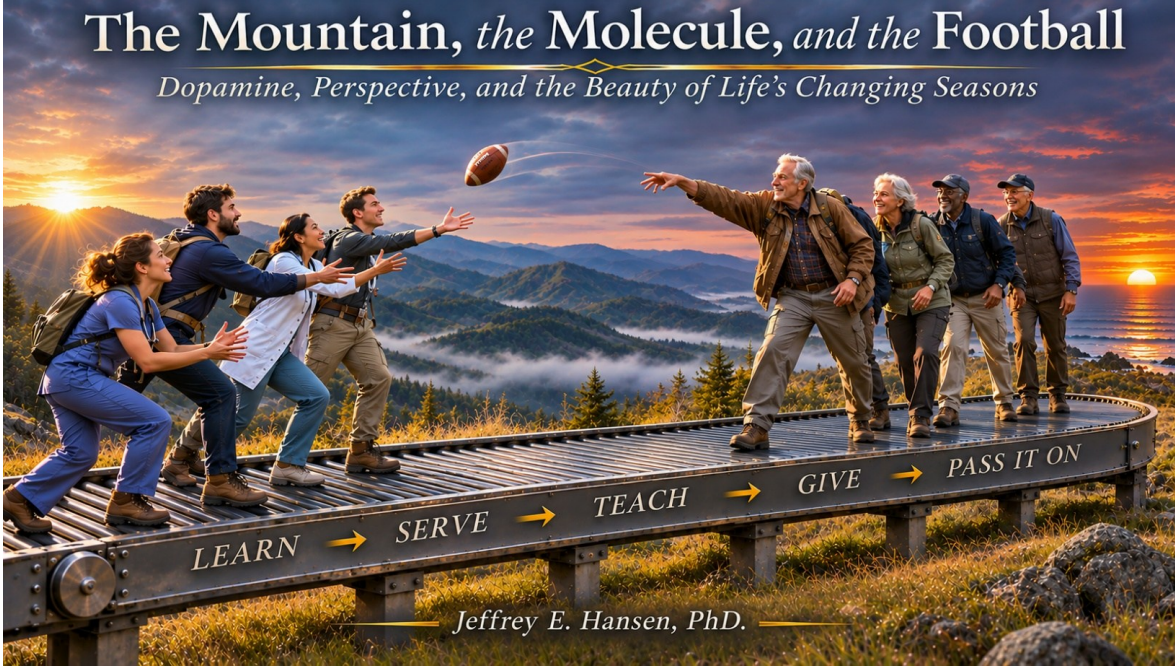
Pull up a chair, pour yourself a cup of coffee, and make yourself comfortable. Bring your questions, your experience, your convictions, and perhaps a healthy measure of skepticism. You may find yourself encouraged, challenged, amused, irritated, or occasionally compelled to reconsider something you thought was firmly settled.

We hope so.

There is room at this table, and we have some things worth talking about.

Jeffrey E. Hansen, PhD
Michelle Cretella, MD
Quentin Van Meter, MD
Russell L. Gombosi, MD

November 2026



There is something rather wonderful about getting older. Things that once occupied enormous amounts of emotional real estate begin, almost without permission, to move out. The degrees, promotions, publications, speaking engagements, growing clientele, and coveted professional respectability. Even the questions we rarely admitted to asking—Do they like me? Am I respected? Did that colleague appreciate my presentation? What are they saying about me?—lose some of their authority. For much of our professional lives, we climb a mountain whose summit seems to keep moving. We reach one plateau, celebrate for perhaps fourteen seconds, and discover another peak waiting just beyond it. Good heavens. It is an exhausting way to spend a lifetime, even when it is a worthwhile one.

I certainly know the mountain. I spent ten years as an Army psychologist, another decade building and running a private practice, and roughly another decade in military medicine, teaching, supervising, and caring for patients. There were frightened parents, hurting children, struggling adolescents, traumatized service members, devoted physicians, remarkable colleagues, and students trying desperately to become the clinicians they hoped they could be. I collected a few

degrees and titles along the way, made some good decisions, made others I would happily return for a refund, and learned that the patients who impressed me most often cared very little about the letters after my name. They wanted to know whether I would listen, whether I understood their suffering, and whether I could help. My professional mountains mattered, but the people I met while climbing mattered infinitely more.

There was, of course, a rather energetic neurochemical companion on that journey: dopamine. Oh, my goodness, dopamine. What a magnificent, meddlesome little molecule! Psychiatrist Daniel Z. Lieberman and Michael E. Long describe in The Molecule of More (2018) the powerful part dopamine plays in anticipation, motivation, and pursuit. It is not simply a chemical of pleasure; it helps orient us toward possibility, toward the thing that is not yet in our hands. Thank God for that circuitry. Without it, we might have continued contemplating the wheel instead of inventing it. But dopamine has one amusing shortcoming: it is very good at getting us to chase the next thing and considerably less interested in announcing that we have finally arrived. Another degree! Another mountain! Another opportunity to accomplish something! Our brains can resemble an enthusiastic golden retriever that keeps bringing us a tennis ball long after everyone else has gone inside.

Robert Lustig, in The Hacking of the American Mind (2017), offers a provocative distinction between pursuing pleasure and cultivating contentment. His discussion of dopamine and serotonin is a useful invitation to think, even though no thoughtful neuroscientist would reduce happiness to one transmitter or contentment to another. Our reward, mood, attachment, and stress systems interact in wonderfully complicated ways. Still, the distinction has stayed with me. There is a

difference between the excitement of getting something and the quieter satisfaction of realizing that something already in our lives is enough. The thrill of applause fades. The knowledge that you helped a frightened child find a little safety, or watched a young psychologist become confident enough to help others, can remain with you for decades.

When the view begins to change

Arthur C. Brooks speaks beautifully to this transition in From Strength to Strength (2022). He describes the changing balance between fluid intelligence, the abilities we use to solve new problems and reason rapidly, and crystallized intelligence, the accumulated knowledge and understanding that experience can deepen. Neither category explains every person or every aspect of aging, and no birthday flips an automatic neurological switch. But the broad idea is liberating. What made us particularly effective at thirty-five may not be exactly what makes us valuable at seventy-two. If we pay attention, the years can give us perspective: the capacity to recognize patterns, to see a whole person instead of a presenting symptom, to ask a better question when everyone else is rushing to supply an answer.

These days I sometimes listen to a younger colleague explain a complex clinical situation and realize that I have seen something like it before. Not the same patient, of course, and not the same circumstances, but the familiar shape of fear, shame, grief, family conflict, or a medical system moving too quickly to notice a person. A younger version of me might have reached immediately for the newest technique. An older version is more likely to ask one more question, tolerate a little more silence, and wonder whether the problem we are treating is actually the problem that needs our attention. That does not make me a sage. I have

known enough foolish old men to know that birthdays alone do not produce wisdom. It means only that a lifetime can teach us something, provided we remain teachable.

Brooks returns to the broader search for purpose in The Meaning of Your Life (2026). That theme resonates with my own faith and with what patients have taught me: a life cannot be fully understood as a collection of achievements or pleasant experiences. We need love, belonging, responsibility, forgiveness, meaningful work, and some sense of what our lives are for. Those are not arguments against science; they are reasons to ask science better, more human questions. We are creatures of neurons and synapses, yes. We are also people who worry about our children, grieve our losses, pray when language fails us, and long to know that our lives mattered to somebody.

The conveyor belt and the football

For some time now I have pictured life as an enormous conveyor belt. Everyone steps onto it, and everyone moves. At one end are the newcomers, their pockets full of possibilities, their ambitions seemingly fueled by an unlimited supply of dopamine. Farther along are those building practices, raising families, tackling responsibilities, and running so vigorously that they barely notice the scenery. Farther still are those of us who have traveled a good distance. The belt has not slowed for our degrees, our reputations, our accomplishments, or our protests. It carries us forward with steady, impartial grace. And one day, for every one of us, the belt reaches its end and gently—or perhaps not so gently—drops us off.

I do not find that image morbid. It is an invitation to wake up to the beauty of our shared journey. The belt is moving whether we fight it or

welcome it. What we can decide is how we travel: what we notice, whom we help, what we hold too tightly, and what we are willing to pass along. No one is standing still, including the young who imagine they have forever and the older among us who occasionally wish we could negotiate another decade at midcareer rates.

And that brings me to a football. Imagine those of us farther down the conveyor belt turning around toward the people just stepping on, and toward those somewhere between the beginning and where we now stand. We have carried a football of knowledge and experience for years. We have been tackled, dropped it a few times, recovered it, and occasionally made a respectable play. Are we supposed to clutch it to our chests until the belt deposits us at the end? What a colossal waste. I would rather throw it back. Here, young man. Here, young woman. This is something I learned, sometimes the hard way. Take what is useful. Question what deserves questioning. Improve upon it. Carry it farther than I did. And when your own part of the belt begins to look a little different, turn around and throw it back again.

My challenge to younger colleagues is therefore a gentle one, offered with genuine affection. Run hard. Master the science. Learn the instruments and the protocols and the research methods. Ask difficult questions, especially of those of us who have grown comfortable with our conclusions. But do not mistake speed for understanding or credentials for character. A frightened parent is not a clinical puzzle placed before you to demonstrate your brilliance. A traumatized soldier is not an opportunity to show off your favorite treatment model. A struggling adolescent needs more than a diagnosis code and an efficient plan. Sit with people. Hear what they are actually telling you. Let them surprise you. And take an occasional football from an older colleague without assuming you must run precisely the same play.

Recently, I was honored to be invited to contribute essays to the American College of Pediatricians (ACPeds), whose stated mission centers on promoting children's physical and emotional well-being through ethically and scientifically sound guidance. I welcomed the invitation not as another trophy for the shelf but as another chance to throw the ball. After decades in pediatric and military psychology, I still have questions about how we practice medicine, how we care for families, and how easily systems can lose sight of persons. I hope my writing encourages thought, including thoughtful disagreement. I also confess that this old psychologist has retained a little mischievous energy. There are still sacred cows wandering through the pasture, and occasionally somebody ought to ask why we keep feeding them.

Be the age you are

But I have an equally tender challenge for those of us closer to the far end of that moving belt. I have told my students for years, 'Be the age you are.' I said it when they were young, impatient to be seasoned clinicians, anxious to possess tomorrow's confidence before living through today's uncertainty. I wanted them to appreciate the developmental season they were actually in. Learn, I told them. Be a beginner when you are a beginner. Do not apologize for having more questions than answers. And now, at seventy-two, I hear my own words coming back across the years, directed squarely at me. Be the age you are, Jeff. Well, isn't that an interesting assignment? Apparently, the professor has become the student.

I am learning that the advice applies at both ends of the journey. To be the age we are is not to surrender curiosity, vitality, or ambition. I still see patients, write, teach, exercise, ride my motorcycle, and find more than enough ways to get myself into intellectual trouble. But I no longer

need to pretend I am thirty-five. I do not need to reproduce the pace of a younger career to justify the worth of this one. Seasons change. Careers change. Bodies change. What we are needed for changes. Sometimes those shifts arrive with gratitude; sometimes they come with disappointment or the loss of something we deeply loved. We need not claim to understand every change to begin appreciating the season in which we find ourselves.

To my contemporaries, especially those who spent a lifetime caring for others, I want to say this with all the tenderness I can muster: please do not mistake a changing role for a diminished life. The retirement announcement, the empty office, the younger colleague stepping into your position, or the telephone that rings less often can sting. It is natural to grieve pieces of work that shaped our identity. There is no virtue in denying that grief. But neither must we build our remaining years around it. What you learned is still yours to give. Your patience may bless a new clinician. Your perspective may steady a frightened family. Your willingness to sit beside someone in suffering may do more good than any impressive professional title ever did. If you are able, mentor somebody. If your health or circumstances limit what you once did, let your contribution change shape. A thoughtful letter, a phone call, a prayer, a listening ear: these, too, are gifts.

And to the young, please remember that older people are not merely repositories of old information waiting to be replaced by an updated edition. They are people still becoming. Ask them what surprised them, what they wish they had understood earlier, where they were wrong, and what finally mattered. You may receive a piece of wisdom no textbook could have offered. To those of us who are older, return the kindness. Ask younger colleagues what they are discovering. Listen without immediately interrupting with a war story. We do not have to

compete for ownership of the truth. The younger bring energy, innovation, and fresh eyes; the older may bring perspective, memory, and the patience to recognize which questions are worth asking. Both generations are traveling on the same belt. We need one another.

It takes intention to live this way. It takes humility to let a season be what it is rather than spending our days mourning one that has passed. And it takes love to give away something we worked so hard to acquire without demanding control over what happens next. I suspect that is part of the difference between merely surviving the later years and inhabiting them beautifully. The question becomes less, 'How do I keep my place?' and more, 'Whom can I bless with the place I have been given?'

The last light over Westport

When I think about the beauty of a season, my mind returns to Westport, Washington, where Leah and I once had a condominium and watched some of the most spectacular sunsets I have ever seen. The sun would move toward the wide Pacific, and the ocean seemed to reach out to receive it. Gold spread across the water, then orange and crimson, then colors I have never quite found words to describe. We would sit together and watch the enormous glowing circle descend, slowly, slowly, slowly, until it touched the horizon and then, with a final delicate sliver of light, disappeared. A good day's work, and a magnificent goodbye.

But the disappearance was not the end of the beauty. The clouds held the colors. The water carried the last reflections. For a little while the entire sky seemed to remember the sun, even after the sun itself was gone. And somehow the memory of those evenings settled into Leah

and me as well. We were not there to accomplish anything, impress anyone, or gather another credential. We were simply together, fortunate enough to watch something beautiful that asked nothing of us except our attention. I can still feel the tenderness of those moments.

We make so much of sunrises, and rightly so. Who does not love the promise of morning? The fresh light, the anticipation, the marvelous sense that there is a whole day ahead, ready to be lived. But who could watch a Westport sunset and call it a lesser thing? A sunset is not a failed sunrise. It does not apologize for arriving later in the day. It has its own radiance, its own purpose, its own astonishing generosity. Perhaps the evening even teaches us something the morning cannot: beauty need not last forever to be real, and significance is not measured by how long we remain visible.

I want to be the age I am. I want to enjoy this particular light, not spend it wishing for noon. I want to continue doing work that matters, loving the people God has given me, and offering whatever experience might help someone a little farther back on the belt. I want to bless younger colleagues without burdening them with the demand that they become replicas of me. And I want to encourage my fellow oldsters to look at the evening sky with gratitude rather than suspicion. We do not need to rush toward the end, and we do not have to pretend it is not there. We can live this season fully, faithfully, with humor, and with open hands.

That is what I hope our lives might leave behind. Not merely awards, titles, published pages, or a long list of things completed, though some of those may have been worthwhile. I hope we leave people who felt heard, young professionals who felt encouraged, families who found a measure of hope, and loved ones who knew they were loved. Perhaps

somewhere behind us on the conveyor belt a younger colleague will catch a football we tossed, run with more courage than before, and one day turn around to pass it along. We need not witness every touchdown to be grateful we helped make the play possible.

And when my own sun finally slips below the horizon, I hope there will be something of that Westport evening in the farewell: no frantic demand for another noon, no bitterness toward the coming night, only the gratitude of having lived a day worth living and loved people worth loving. I think of Leah beside me, the Pacific turning gold, the last light lingering across the water, and the extraordinary quiet that follows. The sun has gone, but its beauty has not vanished. It has left an impression that stays with us, a gentle signature upon the soul. May we be granted the grace to do the same.



References

American College of Pediatricians. (n.d.). Mission & vision. https://acpeds.org/mission-vision/

Brooks, A. C. (2022). From strength to strength: Finding success, happiness, and deep purpose in the second half of life. Portfolio.

Brooks, A. C. (2026). The meaning of your life: Finding purpose in an age of emptiness. Portfolio.

Lieberman, D. Z., & Long, M. E. (2018). The molecule of more: How a single chemical in your brain drives love, sex, and creativity—and will determine the fate of the human race. BenBella Books.

Lustig, R. H. (2017). The hacking of the American mind: The science behind the corporate takeover of our bodies and brains. Avery.



On moral injury, courage, and standing together for children

Before Jumping in - Prologue

For those of you who know me, I love to write. One of my favorite ways to do that is through essays and blogs, my musings, my pontifications, and occasionally the thoughts that probably should have remained between me and my morning coffee. Four books have grown out of those sandboxes: *Old Psychologist in the Sandbox*, *Storms in the Sandbox*, *Special People in the Sandbox*, and most recently, *Science in the Sandbox*. (Hansen, 2026a, 2026b, 2026c, 2026d)

I have recently been invited, as a member of the American College of Pediatricians (ACPeds), to contribute essays on adolescence, mental health, and the building of resilience in young people. ACPeds is a conservative alternative to the American Academy of Pediatrics (AAP). I joined because I believe pediatric medicine needs the courage to question prevailing orthodoxies. In my judgment, the AAP has become so ideologically captured on certain contentious questions that it has

compromised the moral independence I expect of a medical institution. That is my assessment, and I am prepared to defend it. After more than four decades as a psychologist, I have some things to say. Some are encouraging. Some are provocative. And some may irritate people who prefer that everyone stay politely inside the lines. (American College of Pediatricians, n.d.; American Academy of Pediatrics, n.d.)

Six in the Morning, and a Word from Russell

Shortly before six this morning, I read an email from Dr. Russell Gombosi. Russell, triple-boarded in internal medicine, pediatrics, and sleep medicine, is a physician I greatly respect. I came to know him through Shed Some Light in Williamsport, Pennsylvania, where I was honored to speak. But it was not his credentials that gripped me this morning. It was his willingness to say aloud what many colleagues were thinking.

Writing to a handful of colleagues I affectionately call the **ACPeds Inner Circle**, Russell put the elephant squarely in the room: the November 3 elections. Democrats won control of both houses of Congress and made significant gains elsewhere. Russell fears that the political shift will embolden efforts to expand abortion access, impose contested approaches to adolescent gender care, and narrow freedom of conscience. I share his concern. When the political winds change, laws, regulations, and professional expectations can change with them. The sandbox can become a very different place to play. (Associated Press, 2026).

Thank you, Russell. You were the first colleague in our circle to name this moment so plainly. I needed to hear it. So did others. His message was not a call to despair. It was a call to stand firm, to speak honestly, and to remember we are not supposed to face the storm alone.

Our sense is that newly elected progressive leaders will seek to reverse some of the gains that Russell and I believe have been made for parental involvement, professional conscience, and open clinical inquiry. I expect those gains to be challenged. If you think changes in political power cannot reach into an examination room, a licensing board, or a therapist's office, I think you are kidding yourself.

Which reminds me of a story.

When I was in kindergarten, my teacher called my mother in for a conference. "Mrs. Hansen," she explained, "we know Jeffrey has the motor skills to color inside the lines. We simply cannot understand why he insists on coloring outside them."

My poor mother. Little did that teacher know she was witnessing something prophetic.

Seventy years later, I am still coloring outside the lines. And I have no intention of stopping.

I respect legitimate authority. I respect thoughtful rules, ethical boundaries, and the responsibilities that come with professional licensure. But I have little patience for rules that become more important than the people they were designed to serve. And almost no patience for stupid rules.

During nearly ten years in the Department of Defense, I saw how quickly bureaucracy could get between a patient and the care they needed. If a patient I had treated wanted to return after more than six months away, they had to use up a primary care appointment, get a referral to me by name, then wait in line for a new intake. It could take months to get them back into the same chair in my office. Some of those patients needed follow-up right away. So I put them on my

schedule whenever I could. I got in trouble for it, and I kept doing it. For God's sake, a patient in crisis can get hurt or die while the paperwork makes its rounds.

The stakes were higher when a soldier faced court-martial over personal choices that, in my professional judgment, had no bearing on her conduct as a soldier. I believed the case was unjust. Leadership wanted me to stay out of it. I quietly volunteered to testify anyway. My testimony was taken, and she was exonerated. Any psychologist who knows something that could matter to the outcome owes it to the person facing judgment to speak up. I knew something that mattered, so I spoke up.

Those are only a few examples. Senior psychology leadership wanted me to color inside its lines. Had I done so when those lines conflicted with patient care and conscience, I would have forfeited my own integrity. Near the end of my Defense Department service, a provider accused me of governmental fraud; the allegations were cleared, and threats concerning my josaphen followed. My strong impression was that the provider's ideological disagreement with my public positions on gender-related care for children helped drive the attack. I cannot establish another person's private motive. What I can tell you is how it felt to have professional disagreement turned into allegations capable of damaging a career.

I need to say something about my colleagues at Madigan, and I want to say it carefully. I loved those people. I still do. Nearly without exception, I worked alongside extraordinary psychologists and mental health professionals; gifted clinicians with genuinely compassionate hearts for children and families. I admired their skills, their dedication, and their humanity. I am not taking any of that away from them.

Here is the painful part. As I recollect, when institutional authority needed to be confronted openly, I cannot remember a single colleague standing alongside me. Not one. I love them as people. I respect their skill and their heart for children. But I do not respect the lack of moral courage I witnessed when standing up carried a price. I say that with sadness, not pleasure.

I know the stakes. Careers, reputations, salaries, licenses, families: these are no small things. But moral courage means very little when there is nothing to lose. If we are only willing to defend our patients when leadership approves, what exactly are we defending?

How Institutions Teach Good People to Be Quiet

Most people do not wake up one morning and decide to abandon their integrity. They begin by protecting something entirely understandable: their livelihood, their license, their reputation, their family, their place on the team. They fear getting in trouble. They fear being singled out. They fear that one complaint, one supervisor, or one accusation could unravel years of faithful work. I understand that fear. I felt it myself.

But fear is also how an institution can teach decent people to be silent. The lesson rarely arrives as an explicit order to betray a patient. It comes in smaller doses: Don't make waves. Follow the pathway. Don't put that in an email. Let leadership handle it. Think about your career. Before long, the line between prudence and surrender becomes harder to recognize. No one has to order every clinician to stop asking hard questions. The culture has already taught them what questions are costly.

That is how institutions become captured. A system that should serve patients begins serving its own reputation, rules, and preferred ideology. The people inside it learn to keep their heads down. In

children's mental health, that kind of silence is dangerous. It can leave the most vulnerable people in the system without a defender.

And that is how children pay the price. A clinician avoids a difficult question. A frightened family is offered only the approved explanation. A teenager discovers that certain fears or uncertainties cannot safely be spoken aloud. The sandbox gets smaller. The child is the one boxed in. We do not need to be fearless. We need to know what we are obligated to do while we are afraid. What does this child need? What does the evidence show? What does professional conscience require? The cost of speaking up may be real. The cost of keeping quiet may land on a child.

Writing

I recently wrote an essay about moral injury, a wound that can occur when the very institutions, leaders, or moral principles we trusted betray us. My reflections began with the soldiers who served in Vietnam, many of whom returned carrying wounds far deeper than those inflicted on the battlefield. They had served their country, endured the horrors of war, and returned to a nation that too often failed to offer them the understanding, compassion, and embrace they desperately needed. But moral injury is not confined to the battlefield. It can also reach into hospitals, medical practices, and mental health institutions, where physicians, psychologists, nurses, and other professionals may find themselves pressured to compromise their ethical convictions by the very systems they entered to serve.

And what happens to us as medical and mental health professionals when the institutions that entrusted us with caring for children turn against us for exercising our professional judgment? When a psychologist is pressured to remain silent, a physician fears professional retaliation for raising legitimate concerns, or a clinician is forced to

choose between institutional compliance and professional conscience? There is a profound potential for moral injury in that conflict. We entered these professions to heal, to protect, and to serve. Yet the very institutions that entrusted us with those responsibilities may become the forces preventing us from fulfilling them. The resulting wound is not simply professional frustration or disagreement with leadership. It is the deeper anguish of being asked to betray the very principles that brought us into the healing professions in the first place.

But now consider the child. What happens when the very institutions entrusted with protecting children become sources of injury themselves? When a teenager enters treatment seeking understanding, safety, and guidance, only to encounter a predetermined script rather than a thoughtful, listening clinician? When parents seeking to protect their children find themselves marginalized or excluded from important conversations? We speak often of moral injury among soldiers and health care professionals, but what about the moral wounds children may carry when institutions lose sight of their fundamental responsibility to protect them?

And here is the terrible intersection: When institutions silence the conscience of the clinician, they may also silence the very person entrusted with protecting the child. The clinician suffers the betrayal of professional integrity. The child risks suffering the consequences of that betrayal. And the institution, rather than confronting its failures, may reward compliance and punish dissent.

That is how institutional dysfunction becomes something far more consequential than bureaucratic inconvenience. It becomes a matter of moral responsibility.

And it brings us back to the question Russell's email stirred in me: When the institution demands our silence, and the children entrusted to our care need our voices, where are we going to stand?

The threat is not simply that clinicians will suffer. It is that fearful clinicians may be taught to cooperate with harm—and children will have to live with the consequences.

When Speaking About Children Draws Fire

Years ago, before the current administration, I was invited to deliver a keynote at a conference on pornography's harms to children in Cottonwood, AZ, sponsored by Turning Point. I had treated young people whose pornography consumption had become compulsive and disruptive, and I had seen firsthand why the issue deserved serious clinical attention.

Before the conference, a writer who used the name Josephine interviewed me. I made one request: be fair. That did not seem unreasonable.

The resulting article, in my view, distorted what I had said. It criticized me for treating pornography addiction in adolescents because 'pornography addiction' is not listed as a stand-alone DSM-5 diagnosis. My response is simple: the DSM is a diagnostic manual, not a list of every problem worthy of clinical care. We treat many significant conditions and harmful patterns without pretending that every clinical concern needs its own DSM heading. Dismissing patients on that basis is not sound clinical reasoning (McAuliffe, 2024).

I also said that pornography consumption can be one of several influences contributing to some young people's confusion about sexuality and gender. That remains my clinical concern. I did not say it

explains every adolescent's experience, and I refuse to be told that a therapist may not even explore the possibility. Pornography exposure, trauma, family dynamics, peer influences, online communities, and developmental questions are all legitimate subjects for careful assessment when relevant to the person seeking help. Therapy must be free to ask questions rather than arrive with answers already dictated.

The article generated such controversy that when I arrived to deliver my keynote presentation, sponsored by **Turning Point**, law enforcement officers were present for security and safety reasons. Imagine that. I was there as a clinical psychologist to speak about the harms of pornography to children and adolescents, a subject I believe deserves serious attention, thoughtful discussion, and professional scrutiny. Yet the controversy had escalated to the point that police protection was considered necessary.

Really? Have we reached a place where speaking publicly about protecting children requires law enforcement to ensure the speaker's safety? I wasn't there to threaten anyone, incite violence, or attack anyone's humanity. I was there to raise concerns about the psychological and developmental consequences of pornography exposure among young people. And somehow, that had become controversial enough to warrant a police presence.

How did we get here? How low have we sunk?

But perhaps the more troubling question is what this says to other clinicians who might otherwise have the courage to speak openly about controversial issues affecting children. What happens when physicians, psychologists, and other mental health professionals begin calculating the personal and professional costs of expressing their clinical judgments? When speaking out might mean public attacks, threats to

one's license, or retaliation from the very institutions that employ them?

Intimidation does not have to silence everyone to be effective. It only has to convince enough good people that speaking up is no longer worth the risk. And that, my friends, is how fear takes hold, professional courage erodes, and silence becomes the safest choice.

When good people become afraid to speak, who is left to protect the children?

This is the tactic that troubles me: abandon the argument, mischaracterize the clinician, invoke the licensing board, and make an example of anyone who refuses to repeat the approved language. People may challenge my conclusions as vigorously as they like. They do not get to turn disagreement into proof of professional misconduct.

If you disagree with me, bring your data. Challenge my logic. Show me better evidence. I will listen. But do not threaten a psychologist's livelihood because he is willing to raise uncomfortable questions about children.

Why the Sandbox Matters

I've always loved the sandbox as a metaphor for psychological development. Watch a child build a small world out of sand. There are roads and mountains, castles and rivers. A structure collapses and is rebuilt. Alone, a child can rehearse mastery, frustration, imagination, and control. In the company of other children, something even more interesting happens: one child's road crosses another child's castle.

Now we have conflict. Whose shovel? Whose mountain? Who knocked down the wall? Welcome to human civilization.

When the sandbox is sufficiently safe, children have room to negotiate, disagree, repair, and try again. Adults sometimes need to intervene, of course. But adults do not strengthen children by forbidding every disagreement or preselecting every conclusion. Resilience grows when children can explore difficulty with protection, guidance, and the freedom to learn.

That applies to the therapy room as well. When an adolescent brings me confusion about identity, relationships, anxiety, trauma, or sexuality, my first obligation is not to provide an ideological script. It is to listen, assess carefully, ask thoughtful questions, and understand the particular child in front of me. Exploration should not have a predetermined destination

That is why ***Chiles v. Salazar*** matters so much. On March 31, 2026, the Supreme Court held that Colorado's restriction on certain therapeutic conversations discriminated on the basis of viewpoint and was subject to strict First Amendment scrutiny. The Court rejected the notion that labeling psychotherapy as "professional conduct" gives the government unrestricted authority to dictate what clinicians may say to their patients. This was a landmark victory for freedom of speech in the therapy room (*Chiles v. Salazar*, 2026).

I had the privilege of joining other distinguished physicians and mental health professionals, including several colleagues from the American College of Pediatricians (ACPeds), in preparing amicus briefs supporting First Amendment protections for therapeutic speech. We understood precisely what was at stake: the freedom of clinicians to practice according to their professional judgment, to ask difficult questions, and to help patients explore deeply personal struggles without the government prescribing acceptable conclusions. Genuine psychotherapy cannot flourish when the clinician must constantly look

over one shoulder to determine whether a therapeutic question might violate a politically prescribed boundary.

Chiles affirmed a constitutional principle worth defending: **the state does not own the words spoken in the therapy room.** Yet I fear that this victory will face renewed challenges through legislation, regulation, licensing boards, and institutional pressures. The political winds have shifted, and protections secured today may be contested tomorrow. That is precisely why professional courage, solidarity, and a willingness to stand together matter more than ever.

Where Are We Going to Stand?

So let us name the elephant in the room. The November 3 election shifted national political power toward Democrats and progressive policy priorities. These leaders were duly elected. They have the authority to propose their agendas, and those of us who disagree have every right, and every professional obligation, to scrutinize the consequences. Russell suspects that progressives will move to undo advances we value. So do I. I expect renewed battles over parental rights, adolescent gender-related care, professional licensing, conscience, and the right to explore unwanted feelings and conflicting identities in psychotherapy. (Associated Press, 2026).

The powers that be can write new laws and revise old regulations. New lines will be drawn. Some may get narrower and narrower, until people who once exercised independent clinical judgment are expected to ask permission to think. The question is not whether we know how to color inside those lines. The question is whether the lines are right.

Where are we going to stand? What are we made of?

And please, do not imagine this is only about our bruised professional pride. Think of the children. A child can experience profound betrayal when the very institution that promises care will not listen, will not question its assumptions, or will not allow the child to speak honestly. A teenager should not have to conform to an adult ideology, progressive, conservative, or any other, to receive attentive, competent care.

Compassion can become a cloak for power. An institution can say it is protecting children while making dissent impossible, elevating ideology above inquiry, and punishing clinicians who ask necessary questions. I have seen institutions protect themselves first. That is why I insist we examine what policies actually do, not merely the reassuring language used to sell them.

A child is not a political trophy. A teenager is not an instrument for winning a cultural argument. And the therapy room is not a place for adults to impose a prefabricated worldview, mine, yours, or the government's.

So where are we going to stand? When a colleague is accused for speaking candidly? When a licensing threat is waved like a club? When a parent's questions are dismissed? When a teenager needs a therapist who will listen rather than recite a script? Are we going to avert our eyes because taking a risk might put our own comfort in danger?

Or are we going to stand together—colleague beside colleague, clinician beside family—defending the freedom to ask, to examine, to disagree, and to care for each child as an individual?

Where are we going to stand? Think about that.

Two Are Better Than One

I keep thinking about the words of Ecclesiastes: "Two are better than one ... For if they fall, one will lift up his companion" (Ecclesiastes 4:9–10, NKJV).

That is not simply a lovely sentiment for a greeting card. It is a practical instruction for stormy weather.

When a colleague is targeted for legitimate professional speech, we can stand beside that colleague. When a law attempts to prescribe a therapist's viewpoint, we can challenge it through the courts, scholarship, and public advocacy. When a child needs more than a script, we can insist on individualized care. When one of us is exhausted, another can pick up the shovel.

Stormy skies are ahead. There will be institutional pressure, professional fear, and trash in the sandbox. I do not want us to discover, one by one, that silence was the easier choice until the day a child needed our voices and no one spoke.

There will be trash in the sandbox. There always has been. Our calling is not to pretend otherwise or to turn the sandbox into another battlefield of slogans. Our calling is to keep it safe enough for children to play, question, struggle, learn, and grow. And sometimes that means standing shoulder to shoulder with the adults who are trying to protect them.

Lean into the wind. Lean into the storm. Not as isolated heroes, and not with cruelty toward those who disagree, but shoulder to shoulder, with professional competence and moral courage. We are called to keep the sandbox safe for children, not make it convenient for the powerful.

Thank you, Russell. Thank you, good doctor, for speaking first, for encouraging your colleagues, and for reminding us that two are better than one. We do not know every turn the storm will take. We do know where we must stand: beside the children entrusted to our care—and beside one another.

And somewhere, I suspect, my kindergarten teacher is still shaking her head.

Jeffrey is coloring outside the lines again.

This time, I hope there are a few more of us holding the crayons. And I thank God for that!

References

American College of Pediatricians. (n.d.). *Mission & vision*. https://acpeds.org/mission-vision/

American Academy of Pediatrics. (n.d.). *About the AAP*. https://www.aap.org/en/about-the-aap/

Associated Press. (2026, November 5). Democratic sweep of Congress ushers in a new era. https://apnews.com/article/9c5c4c5283f58b1ae0786e2f410c21a0

Chiles v. Salazar, 607 U.S. ___ (2026). https://www.supremecourt.gov/opinions/25pdf/24-539new_hfci.pdf

Hansen, J. E. (2026a). *Old Psychologist in the Sandbox*. NeuroFaith®, LLC.

Hansen, J. E. (2026b). *Science in the Sandbox*. NeuroFaith®, LLC.

Hansen, J. E. (2026c). *Special People in the Sandbox*. NeuroFaith®, LLC.

Hansen, J. E. (2026d). *Storms in the Sandbox*. NeuroFaith®, LLC.

McAuliffe, J. J. (2024, May 22). Some Arizona counselors are using 'sex addiction' to practice conversion therapy, critics say. *Arizona Mirror*. https://azmirror.com/2024/05/22/some-arizona-counselors-are-using-sex-addiction-to-practice-conversion-therapy-critics-say/

Supreme Court of the United States. (2026). Chiles v. Salazar, 607 U.S. ___ (No. 24-539). https://www.supremecourt.gov/opinions/25pdf/24-539new_3fb4.pdf



When Pediatricians Become Factory Workers and Medicine Loses Its Heart

First, a Love Letter to Pediatricians

For more than four decades, I have had the extraordinary privilege of working alongside pediatricians. I am a fellowship-trained pediatric psychologist, with developmental pediatrics at the heart of my fellowship training. My professional journey unfolded across three distinct chapters: 10 years as an active-duty Army pediatric psychologist, 20 years in pediatric private practice, during which I founded Pediatric Associates, LLC, and another 10 years as a pediatric staff psychologist and faculty member at Madigan Army Medical Center.

Forty years. Three different professional settings. Countless children, adolescents, families, and pediatric colleagues. I know these physicians. I know their hearts. And I know what brings them into this extraordinary profession.

Nobody chooses pediatrics because it is easy. It is a calling, and a noble one at that. Pediatricians witness suffering, heartbreak, frightened parents, developmental struggles, and sometimes unimaginable tragedy. But they also witness extraordinary triumphs, resilience, recovery, and the magnificent unfolding of young human lives. The premature infant who survives against the odds. The adolescent who emerges from depression. The mother who leaves with hope where there had been despair.

These are among the finest physicians I have ever known. And that is precisely why what has happened to their profession troubles me so deeply. Over the course of my career, I have watched far too many gifted healers become exhausted, frustrated, and disillusioned. They entered medicine to care for children. Yet they now find themselves practicing under conditions that increasingly resemble an assembly line.

The clock is running. The electronic record is waiting. The insurance company has its requirements. The next patient is already in the examination room. Somewhere in this machinery, something precious is being lost. We are not simply stealing time from pediatricians. We are stealing the conditions under which healing relationships are formed. And our children are paying the price.

When the Joy of Healing Becomes the Burden of Surviving

Over the years, I have heard the complaints. Sometimes over lunch, sometimes between patients, and sometimes in those quiet conversations when a physician finally felt comfortable enough to admit just how miserable things had become. Too many patients. Too little time. Endless documentation. Insurance companies second-guessing clinical decisions. Administrators demanding productivity. Electronic records that seem to require more attention than the human

beings sitting across the examination table. And always, that damned clock.

I have watched wonderful pediatricians grow weary. Physicians who once seemed genuinely delighted to walk into an examination room began to look exhausted before the day had even started. Some became cynical; others discouraged. Some reduced their hours, and some retired earlier than they had planned—not because they had lost their love for children, but because they had lost their tolerance for the conditions under which they were expected to care for them.

These were not weak people. They were conscientious, compassionate, capable physicians. They were simply burned up. Burned out. There is something particularly tragic about watching someone who entered a profession out of love become emotionally depleted by the very institution in which that love was supposed to find expression.

Not every pediatrician shares this experience. Many continue to find enormous fulfillment, and some practices remain supportive. But the suffering is real, and it deserves more than another wellness seminar, mindfulness app, or lecture about work-life balance. I believe in self-regulation. I teach it, practice it, and make it foundational to NeuroFaith®. But there is something almost comical about telling an exhausted pediatrician to practice deep breathing while simultaneously demanding another six patients before lunch.

Perhaps the problem is not that the physician has forgotten how to breathe. Perhaps the problem is that the system has its foot on her throat. And that brings me to an uncomfortable philosophical question.

When Evil Leaves Government and Enters Medicine

Andrzej Łobaczewski knew something about evil that most of us have been mercifully spared. He lived through Nazi occupation and Soviet-backed communist rule in Poland, where power could destroy careers, imprison dissenters, and make truth itself dangerous. He was a psychologist trying to understand how human beings—and eventually entire institutions—could become organized around cruelty, manipulation, and the ruthless pursuit of power. This was not evil contemplated from the safety of an armchair. It was evil experienced in the streets, in universities, in professional lives, and in the terrifying silence of people who knew what might happen if they spoke.

His book, Political Ponerology (Łobaczewski, 2022), explored how pathological personalities and destructive processes can acquire institutional authority. He used the term pathocracy to describe a system in which such forces become dominant. The truly chilling insight is not merely that evil people sometimes gain power. We already know that. It is that they can recruit the machinery of an institution—its rules, rewards, punishments, and respectable vocabulary—until the institution itself begins doing their work.

Evil does not always announce itself with a uniform and a raised fist. Sometimes it arrives in a tailored suit, smiling pleasantly, armed with a productivity dashboard and a PowerPoint about organizational excellence. The mission statement remains on the wall. The people beneath it are being ground into dust.

And this is where Michael Rectenwald becomes essential to the story—not as a casual footnote, but as the intellectual bridge. Rectenwald was directly and substantially engaged with Łobaczewski's work. He wrote about Political Ponerology and contributed the foreword to its revised

2022 edition. He recognized that the corrupting dynamics Łobaczewski examined in political systems could illuminate what happens in other powerful institutions as well. His subsequent work, including The Great Reset and the Struggle for Liberty, examined concentrated power across government, corporations, universities, and the interlocking structures of modern institutional life.

There is an almost painful irony in Rectenwald's own story. During his years at New York University, he challenged prevailing orthodoxies and later described professional ostracism, marginalization, and treatment that made his academic life increasingly intolerable. He ultimately left. I want to be careful about attributing the particulars: these are elements of his own account, not findings of an independent inquiry. But the larger question is impossible to ignore. What happens when an institution does not need to refute the dissenter because it can simply make dissent unbearably expensive?

There is the progression that has seized my attention: Łobaczewski studied the psychology of evil as it captured political institutions. Rectenwald carried that warning into the wider architecture of institutional power. And I am bringing that question straight into the pediatric examination room. Because I fear that medicine, one of humanity's noblest callings, is being bent toward purposes that have precious little to do with healing.

I have spent four decades among pediatricians. I know these men and women. I know what it costs them to sit with a dying child, to comfort a terrified parent, to notice the small change in an adolescent's face that says something terrible has happened. They did not enter this profession to become obedient servants of an insurance algorithm. They did not endure years of training so a distant executive could

dictate how many minutes of human attention a frightened child deserves.

Yet here we are. The pediatrician wants to spend another twenty minutes with a young person whose headaches and stomachaches may be the first clues to trauma, abuse, bullying, depression, or chaos at home. The schedule says no. The physician wants to explore the family system and make a thoughtful mental-health referral. The appointment clock says no. The doctor wants to practice the medicine that conscience and training demand. The machinery wants another billable encounter. And the machinery is winning far too often.

Who the hell gave the machinery that moral authority? Who decided that the child must fit the business model instead of the business model serving the child? And who gets rich while the physician goes home hollowed out, carrying the faces of patients who needed more than the clock would allow?

The pharmaceutical dimension deserves scrutiny, too. Medication can be appropriate and sometimes lifesaving; I have seen it help children tremendously. But a prescription can be produced in minutes, while understanding a child's trauma, attachment, family distress, and developmental history takes time and relationship. When the system makes the quick intervention easier to deliver and reimburse than deeper assessment and coordinated care, it creates an incentive toward compromised medicine. That is not proof that every prescription is inappropriate or that every pharmaceutical company is corrupt. It is a reason to interrogate the incentives—and the influence of industry—without blinking.

Let us not hide behind the comforting fiction that every person in an institution must be wicked for the institution to become destructive.

Plenty of administrators, insurers, executives, and industry professionals are honorable. Hospitals must pay their staff and keep their doors open. But it takes only enough concentrated power, enough greed, enough cowardice, and enough rewards for the wrong behavior to turn a healing institution into something that feeds on the very people it claims to serve.

That is the ponerological question. Not whether every executive is a monster. Whether an institution has begun to reward behavior that betrays its purpose. Whether it prizes obedience over conscience, revenue over relationship, throughput over thoughtful medicine. Whether the healer is being consumed to keep the machine running.

And let us be clear about who pays. The child pays when the question that would have unlocked the story is never asked. The parent pays when concern is reduced to a hurried checklist. The physician pays in sleep, health, moral distress, and the slow erosion of a calling once experienced as sacred. We are not simply inconveniencing doctors. We are grinding down the very human beings on whom healing depends.

Somewhere ahead in this essay we must confront the harder question: how long can physicians remain passive while their profession is dismantled around them? Resistance may cost something. It may cost advancement, favor, comfort, even employment. But so does silence. Before asking physicians to fight back, however, we owe them something more than rhetoric. We owe them a serious look at the research documenting what this system is doing to them—and to their patients.

They Still Love the Children. They Are Losing the Joy.

A longitudinal study by Frintner et al. (2022), published in Pediatrics, followed 1,794 pediatricians from 2012 to 2020. The proportion

describing their work situation as a major source of frustration rose from approximately 25.5% to 37%. Yet nearly 86% continued to describe their work as personally rewarding.

I find that contrast extraordinarily revealing. These physicians had not abandoned their calling. They still valued the children and families they served. But an increasing share were finding the conditions of their work deeply frustrating. There is a world of difference between becoming disillusioned with a profession and becoming disillusioned with the circumstances under which one is forced to practice it.

The study also linked improved professional satisfaction with more favorable work conditions, including flexibility, colleague support, and time with patients. Imagine that. Give doctors more freedom to practice medicine, colleagues who support them, and time to see their patients, and they are more satisfied. Perhaps we did not need another multimillion-dollar administrative initiative to discover that.

The larger physician literature is sobering as well. A systematic review and meta-analysis by Hodkinson et al. (2022) in The BMJ pooled 170 observational studies involving more than 239,000 physicians. Burnout was associated with lower job satisfaction, greater intentions to leave, increased reported patient-safety incidents, and more patient dissatisfaction. These are associations, not proof that burnout causes each outcome; and this evidence covers multiple specialties, not pediatrics alone. But the pattern is difficult to ignore.

When people become emotionally exhausted, patience, sustained attention, flexible thinking, and interpersonal availability can suffer. Burnout researchers sometimes call the withdrawal that follows depersonalization. What a tragic word to associate with medicine: a

profession devoted to persons operating under conditions that can make its practitioners less personally engaged.

And then, when a physician reaches the breaking point, we prescribe resilience. I am not opposed to resilience training; much of my life's work concerns precisely that. But resilience must never become an excuse for preserving destructive working conditions. Teaching a pediatrician to breathe while adding patients to the schedule is like teaching someone to swim while steadily adding bricks to their pockets. Eventually, we might want to discuss the bricks.

What Parents Are Telling Us: Give Us Time

Parents do not simply bring their children for diagnoses, prescriptions, and referrals. They come with questions, fears, intuition, and sometimes a desperate desire for reassurance. Beneath their immediate medical concerns is often something more fundamental: they want to know that their pediatrician truly sees their child.

In a Pediatrics study, Halfon et al. (2011) examined reported well-child visit duration, family-centered care, and satisfaction. About one-third of parents reported ten minutes or less with the clinician, nearly half reported eleven to twenty minutes, and only about one-fifth reported more than twenty minutes. Longer encounters were associated with substantially greater odds of parents reporting enough time to ask questions, developmental assessment, and willingness to recommend the clinician. These data came from an older parent survey and do not precisely describe every contemporary office; nevertheless, the relationship between time, communication, and perceived care is hard to dismiss.

A pediatrician must assess growth, development, nutrition, physical symptoms, emotional well-being, family circumstances, safety, and

often a worried parent's unspoken concerns. Sometimes the most important information does not emerge until the physician has slowed down enough for a child or parent to trust the conversation. A mother may begin with her son's headaches and only later mention that he has withdrawn since his parents separated. An adolescent may present with abdominal pain while carrying bullying, depression, or trauma. A father who appears demanding may actually be terrified.

These are not distractions from medicine. They may be essential to understanding the child. And they require something our system seems determined to ration: time.

The Child Who Finally Speaks at Minute Fourteen

Imagine a fourteen-year-old girl who arrives with recurring stomachaches, difficulty sleeping, and reluctance to attend school. The pediatrician conducts an appropriate medical assessment. Nothing immediately suggests an emergency, though further medical evaluation may be needed. The mother wants answers. The girl sits quietly, giving brief responses, her shoulders tense and her gaze averted.

Something about the encounter troubles the physician. So she slows down. She asks about school, friends, sleep, and home. She allows a silence instead of filling it with another question. Her voice softens; the conversation begins to feel less like an interrogation and more like an invitation. And slowly the girl begins to speak. Perhaps she is being bullied. Perhaps she is terrified by something happening at home. Perhaps she is carrying a burden she has never dared disclose.

For the first time, the important story is emerging. And then the physician glances at the clock. Fourteen minutes. Another patient is

waiting, documentation remains unfinished, and the schedule is already behind.

Many pediatricians would stay, absorb the consequences, and care for the girl. I have admired that devotion throughout my career. But why should good care require the physician to rescue patients from the limitations of the system? Why must clinical conscience repeatedly collide with the appointment book?

In an observational study of 302 rural pediatric visits, Cooper et al. (2006) found behavioral, emotional, or developmental concerns in nearly one-quarter of encounters. When unexpected behavioral concerns emerged, visits were longer on average; physicians generally attempted to respond through assessment, support, treatment, or referral. I love that finding. It reminds us that pediatricians are not indifferent. When concerns arise, they try to help. But helping takes time.

The child does not disclose trauma according to the appointment schedule. Trust does not obey a billing code. And the human nervous system does not become ready to reveal its deepest fears because the physician has ninety seconds left.

Two Nervous Systems Walk Into an Examination Room

We have discussed economics, institutional incentives, physician frustration, and parent satisfaction. Now I want to take the discussion somewhere more fundamental: into the human nervous system. Every pediatric encounter involves at least two, and often three, interacting nervous systems: the child's, the parent's, and the physician's. Each arrives carrying a physiological and emotional history.

A frightened child may be withdrawn, restless, irritable, or unusually compliant. An anxious parent may be hypervigilant or overwhelmed. And the pediatrician may have spent the morning managing difficult diagnoses, late appointments, insurance denials, and the accumulating emotional weight of human suffering. All three may enter the room under stress. And then we expect healing to happen—in ten or fifteen minutes.

Stephen Porges' polyvagal theory has influenced how I think about perceived safety, autonomic state, and social engagement. I have studied Porges' work and attended his lectures. Polyvagal-informed clinical practice genuinely useful. Specific anatomical and evolutionary claims within the theory remain debated, but the clinical importance of safety, interpersonal responsiveness, and physiological regulation is supported by broader bodies of research. A physician's voice, expression, pace, and attention can help a child feel safe enough to communicate—or convey tension when the physician is rushed and distracted.

These ideas connect naturally with the NeuroFaith® model I have developed, which integrates polyvagal-informed therapy, neurocardiology and HeartMath® approaches to physiological self-regulation, Internal Family Systems, and faith and identity. Heart-rate variability biofeedback and paced-breathing approaches have evidence for helping some people manage stress, though not every broader claim about heart–brain mechanisms is established. The point here is not to advertise a technique. It is to recognize that the clinician's own physiological state matters to the quality of the encounter.

We Are Burning Out the Healer and Then Asking the Healer to Heal

There is something almost breathtakingly contradictory about the expectations we place upon pediatricians. We ask them to enter an examination room with warmth, patience, compassion, and exquisite sensitivity to the emotional needs of a frightened child and anxious parent. We expect careful listening, clear thinking, sound judgment, recognition of subtle distress, and the creation of safety and trust. And we give them ten or fifteen minutes to accomplish it.

Meanwhile, the physician may already be carrying the physiological burden of an extraordinarily stressful morning. The schedule is behind. Documentation is piling up. Insurance authorizations are waiting. An administrator wants productivity. Another family is impatient. And the physician knows there simply are not enough hours in the day to meet every demand.

Repeated stress can activate sympathetic and hypothalamic-pituitary-adrenal responses, influencing cardiovascular activity, cortisol regulation, attention, sleep, and emotion. Chronic stress can contribute to allostatic load—the cumulative wear associated with repeated adaptation. This does not mean every exhausted doctor walks around with continuously elevated cortisol; chronic stress physiology is far more complicated. But the burden on the body and mind is real.

Now here comes the absurdity. We expect that same physician, whose nervous system may have been repeatedly mobilized by the demands of the day, to walk into the next room and instantly become a model of regulation. Calm. Attentive. Patient. Emotionally available. Really? How the hell is that supposed to happen?

We know that attunement requires attention and responsiveness. We know that a frightened child may need reassurance before disclosure becomes possible. We know that chronic stress can erode the resources needed for patience, empathy, and flexible thought. Yet we construct clinical environments that place those capacities under relentless pressure. And when doctors become exhausted, irritable, emotionally depleted, or ill, we tell them to develop greater resilience.

There is a certain cruelty in that reasoning. I believe deeply in resilience and in the value of self-regulation. But no breathing exercise manufactures more appointment time. No amount of heart-rate variability training substitutes for adequate staffing, sensible schedules, supportive leadership, and professional autonomy. We cannot continually dysregulate the healer and then demand that the healer regulate everyone else.

The consequences can compound. A stressed physician has fewer resources for emotional connection. The child may become more anxious or withdrawn. Communication becomes harder, and the clinician must work even harder to accomplish what might have unfolded more naturally under humane conditions. Both leave dissatisfied. The physician moves immediately to the next room, carrying the accumulated burden of the day.

We are not merely asking physicians to do too much. We are asking them to give their patients something the healthcare system increasingly refuses to give them: safety, patience, compassion, and the time to be human. If that is not a profound contradiction at the heart of modern medicine, I do not know what is.

Restoring the Heart of Pediatrics

I began this essay by expressing my admiration for pediatricians, and I want to return to it. I do not believe pediatrics has lost its heart. I believe too many pediatricians are being prevented from practicing with the fullness of heart that originally brought them into medicine. The profession still attracts extraordinary people. I have seen their compassion, courage, dedication, and willingness to walk with families through the hardest moments of their lives.

What troubles me is that we have built a system that too often treats those qualities as secondary to productivity. We measure visits completed, records signed, reimbursement collected, and schedules maintained. But how do we measure the frightened child who finally feels safe? The mother who leaves feeling genuinely heard? The physician who comes home tired but fulfilled rather than mechanically exhausted? The adolescent whose suffering is discovered because someone had time to ask one more question?

I am not proposing that every pediatric visit last an hour. Some concerns can be addressed competently and compassionately in brief encounters. Nor does a longer appointment automatically guarantee better medicine. I am arguing that clinical time should be responsive, as much as reasonably possible, to the needs of the child and family rather than dictated by an inflexible production model.

We need systems that let pediatricians exercise judgment, make room for complex developmental and emotional concerns, and respond without being punished for disrupting the schedule. We need to protect the physician's health and emotional well-being as seriously as we expect the physician to protect the child's. And we must stop

pretending that the relationship is merely a pleasant addition to the real business of medicine.

The relationship is part of the medicine.

After four decades alongside pediatricians, I remain convinced that these remarkable physicians possess the knowledge, compassion, and dedication necessary to provide extraordinary care. What they increasingly lack is the freedom to practice that care under humane conditions. Perhaps it is time to stop asking how many children a pediatrician can see in an hour and start asking how much healing can actually happen in the time we give them.

Because a child is not a billing code. A pediatrician is not a factory worker. And healing was never meant to operate on an assembly line. I have spent more than four decades loving, admiring, and working alongside pediatricians. I know their hearts. I only wish the institutions entrusted with supporting them loved them half as much. Too often, the ponerological poison of greed, power, and institutional self-interest has infected the very organizations that should protect these extraordinary healers. It is time we stopped calling that progress—and started calling it what it is: a betrayal of medicine's sacred trust.

References

Cooper, S., Valleley, R. J., Polaha, J., Begeny, J., & Evans, J. H. (2006). Running out of time: Physician management of behavioral health concerns in rural pediatric primary care. Pediatrics, 118(1), e132–e138. https://doi.org/10.1542/peds.2005-2612

Frintner, M. P., Leslie, L. K., Gottschlich, E. A., Starmer, A. J., & Cull, W. L. (2022). Changes in work characteristics and pediatrician satisfaction: 2012–2020. Pediatrics, 150(1), e2021055146. https://doi.org/10.1542/peds.2021-055146

Halfon, N., Stevens, G. D., Larson, K., & Olson, L. M. (2011). Duration of a well-child visit: Association with content, family-centeredness, and satisfaction. Pediatrics, 128(4), 657–664. https://doi.org/10.1542/peds.2011-0586

Hodkinson, A., Zhou, A., Johnson, J., Geraghty, K., Riley, R., Zhou, A., Panagopoulou, E., Chew-Graham, C. A., Peters, D., Esmail, A., & Panagioti, M. (2022). Associations of physician burnout with career engagement and quality of patient care: Systematic review and meta-analysis. BMJ, 378, e070442. https://doi.org/10.1136/bmj-2022-070442

Łobaczewski, A. M. (2022). Political ponerology: The science of evil, psychopathy, and the origins of totalitarianism (H. Koehli, Ed.; A. Chciuk-Celt, Trans.; rev. ed.). Red Pill Press. https://search.worldcat.org/title/1319074898

Rectenwald, M. (2022, March 26). The science of evil: A personal review of political ponerology. https://www.michaelrectenwald.com/essays/the-science-of-evil-personal-review-of-political-ponerology-lthfa

Rectenwald, M. (2023). The great reset and the struggle for liberty: Unraveling the global agenda. New English Review Press. https://store.mises.org/Great-Reset-and-the-Struggle-for-Liberty-Unraveling-the-Global-Agenda-P11271.aspx



The Season When Everything Came Apart

Prayer saved my life.

That is my testimony. It is why I care so deeply about this subject, and why I want to speak directly to the person who is wondering whether they can keep going. There are seasons when life asks more of us than we know how to give. I lived through one of them.

My wife had been facing cancer. We feared that my daughter might have cancer, too. Our son, Gregg, was in Iraq, dodging land mines along with his fellow Marines and let's just say, not everyone came home. Around the time of the 2008 financial crisis, I was facing the possibility of losing pretty much everything.

My life felt as though it had completely fallen apart.

I was a psychologist. I understood the language of stress, trauma, and resilience. But understanding suffering professionally does not spare you from experiencing it personally. There comes a point when the person who helps other people hold their lives together finds himself wondering how he will hold together his own.

I reached that point.

At times, I honestly wondered whether I would make it. I found myself on my knees, often in tears, praying. Sometimes that was all I knew to do.

That is where this discussion begins for me. Before the brain scans, before the cortisol measurements, before the arguments about what a particular study did or did not prove, there was a man on his knees who needed help.

I was that man. Dear brother, dear sister, if you recognize yourself in that description, please stay with me. The way you feel today does not have to be the final word on your life. I want you to know why I still believe in hope, and why prayer is a gift I want to share.

Big Men, Gentle Hands

During that dark period, I had joined the Christian Motorcyclists Association. Some of those big, burly Harley riders gathered around me, laid their hands on me, and prayed.

I still remember those hands.

They came close to me in my despair. They took my suffering seriously. They prayed when I was struggling to carry what life had placed in front of me.

I experienced their prayers as love.

There is something profoundly moving about being surrounded by people who are willing to enter your pain with you. Their presence says something that a suffering person may desperately need to hear: You matter enough for us to stop. We will stand here with you. For me, that

moment had a sacred dimension. These men were bringing me before God. Their faith was taking physical form in their presence, their voices, and their hands.

I cannot give you a laboratory measurement of what that meant to me. I can tell you that it mattered deeply. When I speak with excitement about prayer, this is part of what I mean. Someone came close. Someone cared enough to stay and pray. I want more hurting people to experience that kind of love.

You Can Put the Burden Down

Jesus said, "Come unto me, all ye that labour and are heavy laden, and I will give you rest" (Matthew 11:28, King James Version). I hear that invitation differently after having lived through despair. Come with the life you actually have. Come with the fear you cannot talk yourself out of. Come when you are too tired to sound strong.

For the Christian, prayer opens a relationship with a power beyond ourselves. We bring our burdens to God. We confess our sin, ask for forgiveness, and receive the invitation to begin again. First Peter 5:7 puts it beautifully: "Casting all your care upon him; for He careth for you."

There is such tenderness in that last phrase. He cares for you. Your life matters to Him. Prayer gives us a way to answer that care with trust, even when trust begins as a whisper.

Surrender can be an act of courage. We can release the demand that we must carry everything by ourselves and still take the next responsible step. We can pray and call the doctor. We can ask God for strength and tell a friend that we need company. Grace can reach us through people willing to help.

I believe there is hope for you, a future worth reaching toward, and the possibility of restoration beyond what you can presently imagine. That is why I want this discussion to lead somewhere more personal than an interesting collection of studies. I want it to open a door.

We Were Made to Reach for One Another

John Cacioppo helped bring loneliness out of the margins and into the center of serious psychological research. In longitudinal analyses, Cacioppo et al. (2006) found that loneliness predicted later depressive symptoms beyond several other risk factors.

That finding has a human face. It belongs to the person who has no one to call, the caregiver who feels forgotten, the frightened parent who lies awake with worries that seem impossible to share.

The consequences reach beyond emotional pain. In a meta-analysis of 148 studies involving 308,849 people, stronger social relationships were associated with 50% higher odds of survival during follow up (Holt-Lunstad et al., 2010). That statistic does not mean people lived 50% longer. It does mean that the association between relationships and survival was substantial.

A more recent meta-analysis involving 608,561 people found that loneliness was associated with approximately 31% higher dementia hazard (Luchetti et al., 2024). Our relationships matter enough to belong in a serious conversation about health and survival. A phone call, a shared meal, a willingness to sit with someone who is frightened: these are ways we can offer connection today. Shared prayer can give that care a language, a purpose, and a sacred meaning.

These are findings about relationships, and relationships are central to the kind of shared prayer I am describing. The caring community around a praying person belongs in the story of its power.

Those men around me were part of the experience. Their care was part of its power. If despair has persuaded you to withdraw, I hope you will let someone know how much you are carrying. You do not have to feel hopeful before you ask for company. Sometimes we begin by letting another person help us hold on.

The Body Carries What the Heart Is Facing

When your wife has cancer, your daughter may be ill, someone you care about is in danger overseas, and your financial security is collapsing, fear can become a constant companion.

What encourages me about this research is that our experience of support deserves to be taken as seriously as our experience of stress. We are learning more about how deeply emotional life reaches into the body.

Adam et al. (2006), working with Cacioppo, studied 156 older adults and found that loneliness, sadness, threat, and lack of control on one day predicted a larger cortisol awakening response the next morning. Tension and anger were associated with flatter daily cortisol patterns, largely through higher evening levels. Cortisol is necessary for life. The issue is its regulation and timing. The study illustrates how closely our experience of the world can be associated with the body's preparation to face it.

Then consider the power of a hand.

Coan et al. (2006) studied 16 married women facing the possibility of an electric shock. Holding a husband's hand reduced activation in neural systems involved in responding to threat. A stranger's hand produced more limited effects, and better marital quality predicted stronger effects in certain regions.

A small experiment, certainly. But what a meaningful possibility to investigate: the presence of someone we trust can change how we experience danger. For the person who feels overwhelmed, that is a reason to welcome companionship. We may still have the same difficult circumstances to face, yet facing them together can feel different.

That finding helps me appreciate those Harley riders' hands. It cannot explain the whole encounter, and I would not ask it to. It gives us one scientific window into something many suffering people recognize: being accompanied can change the experience of facing what frightens us.

There Is Hope in What Faith Can Mean

Lisa Miller's work is one reason I feel such excitement about this field. It invites us to consider faith as a potentially substantial resource in the lives of people who are vulnerable to depression.

Miller et al. (2012) followed 114 adult offspring of depressed and nondepressed parents. Participants who regarded religion or spirituality as highly important had substantially less major depression over the following decade. The authors described approximately one quarter the risk overall and approximately one tenth the risk among participants with a depressed parent. The association primarily concerned recurrence of depression.

That last finding is the source of the widely discussed 90% figure. A deeply meaningful spiritual life may have a consequential place in how some people live with vulnerability. That is a reason to ask about spiritual life in clinical care and to study its protective potential with energy and seriousness.

In a related investigation, Miller et al. (2014) examined brain images from 103 adults in the same broader family study. Greater religious or spiritual importance was associated with thicker cortex in several regions, with particularly notable associations among those at higher familial risk for depression. The authors proposed a possible contribution to resilience.

Together, these findings point toward the potentially neuroprotective role of personally meaningful spirituality. Here, neuroprotective means evidence consistent with resilience and reduced vulnerability to depression, including brain differences that may help explain that protection. Spiritual life deserves a place in our conversations about a healthy, resilient mind.

For someone whose world has fallen apart, faith may offer a continuing sense of belonging, meaning, and worth. Prayer gives that faith somewhere to go. It gives us words when fear has filled the room. It gives us a practice when the future feels impossible to imagine. Sometimes it gives us enough hope to ask for help and face the next day.

That is how I experienced it. You may begin without certainty, without calm, even without knowing what to say. “God, I need help” can be an honest place to start. You do not have to settle every question about faith before you bring your questions into prayer.

A Prayer Has a Place in the Brain and a Rhythm in the Body

Newberg et al. (2003) studied regional cerebral blood flow during meditative prayer in three Franciscan nuns. They observed changes that included increased prefrontal activity and an inverse relationship between prefrontal and superior parietal changes.

This small preliminary study opens a fascinating question: what happens in us when we turn our attention toward God? The experience has a measurable biological dimension, and there is much more to discover.

Focused prayer engages attention and may change the experience of self in that moment. A frightened person turns toward a loving presence. Attention finds somewhere to rest. The experience of being alone with the crisis can begin to change.

There is also something compelling about the rhythm of prayer.

Bernardi et al. (2001) studied 23 healthy adults reciting the rosary or a yoga mantra. Both practices slowed breathing to approximately six breaths per minute and increased heart rate variability and baroreflex sensitivity, a measure related to reflex regulation of blood pressure.

A familiar devotional practice had measurable physiological effects. I find that encouraging. Something woven into ordinary spiritual life, a repeated prayer, a familiar rhythm, can also engage the body in ways researchers can observe.

The similar findings with the mantra suggest that breathing rhythm was important. For the person praying, that rhythm may also carry memory, devotion, and a sense of belonging to something larger than the immediate crisis. Understanding a physiological mechanism can deepen our appreciation of a practice. It need not exhaust its meaning.

HeartMath®: Making Room for Appreciation

HeartMath®'s research offers a related perspective.

McCraty et al. (1995), publishing in The American Journal of Cardiology, found different heart rate variability patterns during anger and appreciation. Deliberately cultivated appreciation was associated with a different distribution of heart rhythm oscillations.

Our emotional lives have cardiovascular expression. There is something hopeful about being able to practice appreciation deliberately, even when life is difficult. We can make room for a moment of care without pretending that everything is well.

HeartMath® uses the term coherence to describe a more ordered, oscillating heart rhythm pattern. Breathing strongly influences that pattern. Practices that combine comfortable breathing with appreciation or care offer a way to work with emotional and physiological regulation. For someone in distress, this creates a practical possibility. A person might pray while breathing gently and recalling someone they love. Another might sit with a brief prayer of gratitude. Someone else may need to begin with an honest cry for help.

We should leave room for all of them. If gratitude feels out of reach, begin with the truth of where you are. Remember a person who has cared for you, or ask someone to sit beside you. Prayer can hold longing as well as thanksgiving.

The broader research on HRV biofeedback is encouraging. Across 24 studies, Goessl et al. (2017) found a large between group reduction in self-reported stress and anxiety, with Hedges' g = 0.83. That analysis concerned HRV biofeedback broadly, rather than HeartMath® or prayer alone.

Within NeuroFaith®, prayer, appreciation, and comfortable breathing can be brought together thoughtfully, with attention to the needs of the person in front of us. I love the accessibility of that possibility: a few quiet moments, an honest prayer, an opportunity to attend to someone we cherish. We can explore what helps without turning the practice into another performance we have to get right.

Prayer Gives Connection a Voice

Neurocardiology reminds us that heart and brain participate in an ongoing conversation. Breathing, cardiovascular reflexes, attention, and emotion influence one another. HeartMath® brings appreciation and care into that conversation deliberately. Polyvagal theory offers a complementary framework, emphasizing how voice, expression, and other cues of safety can support social engagement and regulation (Porges, 2022).

Think of someone speaking gently while you are frightened. Think of being listened to without judgment. Their steadiness can help you settle enough to speak, breathe, or ask for help. This interpersonal process is often called co regulation. It is an important part of how I understand the encounter with those riders.

Morris (2010) explored heart rhythm coherence and synchronization in small groups. The study involved 15 trained participants, 25 additional volunteers, and repeated trials. Higher coherence in untrained participants appeared in about half the matched comparisons, with the highest levels when everyone worked toward coherence. The work invites further investigation of how our physiological states become coordinated. Synchrony alone does not establish a healing energy field, and it is not automatically beneficial in every setting.

Here is the possibility that excites me: prayer can bring meaning and language into an encounter that already carries care. "You are loved." "We are here." "God, help us carry this." The voice, the welcome, and the words belong to the same human moment. In my clinical and spiritual understanding, prayer can deepen that experience of connection. It allows us to express what the body may be beginning to feel: perhaps I can let someone come close.

And prayer reaches inward as we offer it outward. In three experiments, Bremner et al. (2011) found less anger, aggression, or hostile appraisal after participants prayed for others following provocation. Praying for another person's good can become a way to soften our own response. Imagine making room for that practice in a strained friendship or a family conversation. Compassion becomes something we do.

Prayer Gives Faith Something to Do

NeuroFaith® brings together polyvagal informed therapy, HeartMath® and neurocardiology, Internal Family Systems, and faith and identity. Within that framework, I regard faith as pivotal to meaning and restoration.

Prayer gives faith a practice we can return to in the middle of an ordinary day. We can give thanks when something beautiful happens. We can ask for courage before a difficult conversation. We can bring our grief when there is no easy answer. It allows a frightened person to speak. It can accompany comfortable breathing and appreciation. It can create space to approach a despairing part of oneself with compassion. It can express the conviction that suffering has not erased one's worth or belonging.

For a Christian, prayer also means turning toward God. That spiritual meaning deserves to be represented honestly, rather than reduced entirely to a breathing exercise or a stress management technique.

I also know that people of deep faith continue to experience illness, grief, and unanswered questions. I would never tell a suffering person that continued pain reveals a failure to believe. Prayer belongs alongside skilled care, practical help, and people willing to stay.

Some of my most sincere prayers came through tears. Please hear that if you are hurting: you do not have to become cheerful before you pray. Bring the life you actually have. Bring the fear, the exhaustion, the part of you that still wants to hope. And let prayer open a door toward the people and the care that can help you.

Give Our Children a Living Source of Hope

Why wouldn't we want our children to discover prayer? We teach them to study, persevere, and ask for help. We can also help them develop a spiritual life that offers meaning, belonging, and a way to bring their deepest concerns to God.

In Building Adolescent Resilience, Dr. Russell L. Gombosi and I discuss faith as an integral part of resilience within NeuroFaith® (Hansen & Gombosi, 2026). Prayer gives that faith a daily expression. A child can give thanks, grieve, ask forgiveness, and seek courage. A family can make room for honest questions and respond with love.

Lisa Miller's work gives this invitation substantial scientific encouragement. In The Spiritual Child, Miller (2015) describes spirituality as a felt relationship with a loving, guiding presence. Her synthesis highlights markedly lower rates of adolescent depression and substance problems, including the widely discussed figures of 60% less

depression and 40% less substance use and abuse. These summarize different strands of research, not a single trial or a universal percentage of improvement. The underlying studies deserve a closer look.

Miller and Gur (2002) examined 3,356 adolescent girls. Personal devotion and participation in a religious community were associated with a 19% to 26% lower likelihood of depression among less physically mature girls and a 32% to 43% lower likelihood among more physically mature girls. At a vulnerable developmental stage, personal devotion and belonging stood out as potentially protective resources.

Miller et al. (2000) also studied 676 adolescents in the National Comorbidity Survey. Personal devotion was associated with less substance use and fewer substance abuse or dependence problems across several substances. What a meaningful direction for prevention: helping young people develop a life they experience as connected, purposeful, and worthy of care.

The findings concerning suicidal thoughts and attempts deserve particular attention. Svob et al. (2018), working in the related Columbia family research program, studied 214 children and adolescents aged 6 to 18. Greater personal religious importance was associated with lower odds of suicidal thoughts or attempts in girls, with an odds ratio of 0.48 per increasing level of importance; that association was not found in boys. Parents' religious importance was also associated with lower odds in their offspring. The authors described roughly an 80% reduction across the highest versus lowest parental importance levels. These outcomes concerned thoughts or attempts, rather than deaths by suicide.

This is encouraging evidence that spiritual life within a family may be a protective resource. It is also a reason to offer faith warmly, through

relationship, with room for questions and without making a child's distress a judgment on their belief.

There is direct research on adolescent prayer or meditation, too. Chen and VanderWeele (2018) followed thousands of young people for 8 to 14 years. Compared with never practicing, daily prayer or meditation in adolescence was associated with greater positive emotion, emotional expression, volunteering, purpose, and forgiveness in young adulthood. It was also associated with approximately 25% lower marijuana use, 44% lower use of other illicit drugs, and 28% lower prescription drug misuse. The study grouped prayer and meditation together and adjusted for numerous earlier characteristics.

That is a much richer picture than simply asking whether spirituality reduces symptoms. It includes how young people grow into a life of purpose and contribution. Those are qualities we want to cultivate!

Taken together, these observational findings support a protective association rather than a guaranteed effect of assigning prayer. They give us ample reason to nurture spiritual development. For a parent who wants a child to grow in hope, purpose, and connection, this is encouraging evidence worth acting on thoughtfully.

For me, teaching prayer is a central part of that invitation. "God, I am scared." "Thank you for my friend." "Help me make this right." A child does not need impressive words. They need to know that they can speak honestly and that caring adults will listen, pray, and help.

I call prayer a superpower because I know what it meant when my own strength felt exhausted. I want our children to have somewhere to turn long before a crisis arrives. And I want them to know prayer in

happiness, too, in wonder at the world, delight in a friendship, and gratitude for being alive.

The Old Wound Does Not Have to Write the Ending

Trauma can leave a person living with painful convictions about themselves: I am unwanted. I am unsafe. I do not deserve love. Those beliefs can feel like facts because they have been learned through experience.

Research on spirituality reaches into the brain systems involved in our inner lives. Svob et al. (2016) studied 104 people aged 11 to 60. Among those at higher familial risk for depression, greater religious or spiritual importance was associated with lower connectivity within the default mode network. The authors proposed a potentially protective adaptation. The default mode network participates in self-related processing and autobiographical thought; it is not a single storage place for traumatic beliefs.

Another source of hope comes from memory reconsolidation. Bruce Ecker and Alexandre Vaz (2022), and Tori Olds (n.d.) in her teaching, describe how an old emotional expectation can become available for updating when it is activated and met with a compelling experience that contradicts it. The important ingredient is the new learning, not simply feeling positive.

The underlying biology includes protein synthesis. Nader et al. (2000) demonstrated in animals that reactivated fear memories required new protein synthesis to stabilize again. In human research, Speer et al. (2021) found that discovering positive meaning in negative autobiographical memories changed later recollection and emotion,

with effects lasting two months. These findings offer hope that what we have learned emotionally need not remain fixed forever.

Here is where I see a powerful clinical and spiritual possibility. Someone expects rejection, reveals their pain, and is met with patient love. Someone brings shame into prayer and encounters a community that offers forgiveness and welcome. The experience can challenge the conviction that they are beyond care. I believe prayer can be part of such healing experiences. A specific claim that prayer releases proteins or erases trauma circuits has not been demonstrated.

Scripture gives this hope a language of identity. Romans 8:1 speaks of freedom from condemnation in Christ. First John 1:9 promises forgiveness and cleansing through confession. Second Corinthians 5:17 describes new life in Christ. These are invitations to receive an identity larger than our wounds and failures.

When we pray, we can bring the old accusation into the presence of a different truth: I am loved. I can be forgiven. I can begin again. Let those words become part of a lived relationship, supported by care and repeated experiences of welcome. The possibility of change is worth leaning toward.

Wonder Has a Place Here

In The Awakened Brain, Miller (2021) explores spiritual awareness as a way of experiencing connection and meaning. That resonates with my experience of prayer and invites a question I welcome: what if the love available to us exceeds what we have learned to expect?

For me, prayer is a conduit to God, to a power and love beyond my own resources. Research can investigate its measurable effects. It does not exhaust the meaning of communion, forgiveness, surrender, or grace.

Those who have experienced prayer deeply may recognize something in that encounter which a questionnaire cannot fully convey. I know that recognition in my own life.

I believe God can restore what seems beyond repair. I believe in miracles. That conviction belongs openly in this essay as faith, alongside the scientific reasons for taking spiritual life seriously.

Make Room for Joy, Too

I want prayer to have a place in the beautiful days. In gratitude. In laughter. In the ordinary moments when we pause long enough to recognize something we might otherwise hurry past.

There is so much to receive from life, even while we carry its difficulties. A person we love. A kindness we did not expect. A moment of peace after a hard day. Prayer can be a way to linger with that goodness and give thanks for it.

I want a spiritual life that helps us savor joy and meet sorrow with support. Prayer can help us pause long enough to receive the goodness already present in our lives.

Please Keep Reaching

Dear brother, dear sister, do not give up. Do not give in to the conviction that nothing can change.

Churchill's words at Harrow in 1941 were "never give in," with an exception for honor and good sense (International Churchill Society, n.d.). For the hurting person, I would offer that encouragement gently: you do not have to prove your strength by enduring alone. Let someone help you keep going.

I know how difficult those words can be to hear when you are exhausted and frightened. I have been on my knees, in tears, unable to see how I would get through what was happening. Prayer made a difference for me. People who prayed with me made a difference. Their willingness to come close is something I still carry. So, my invitation is heartfelt: lean into prayer. Bring what you actually feel. Bring the fear, the anger, the questions. You do not have to manufacture peace before you come to God.

And let someone know how much you are hurting. Let prayer become an opening toward connection, toward care, toward the help you deserve. If you cannot find words, ask someone to sit with you. Ask them to pray with you. Let them help you take the next step.

If you are the person standing beside someone in pain, come close. Listen. If prayer is welcome, pray with them. If touch is welcome, offer a hand. Follow up tomorrow. Help them obtain care. Bring your compassion into the ordinary details of their life.

Let the prayer continue through your hands.

I think again of that season: my wife's cancer, the fear about my daughter, Gregg in Iraq, the financial crisis, and the possibility of losing almost everything. I remember how overwhelmed I was. And I remember those men. Their hands did not erase everything I was facing. Their prayers became part of how I faced it. When I speak about faith, connection, and caring presence, I remember those men.

Prayer saved my life. I say that with gratitude, and with a deep desire that you discover the help and hope available to you. Psalm 34:18 tells us that the Lord is near to the brokenhearted. You do not have to hide your broken heart from Him.

You can begin right now, in words as simple as these:

> *God, I am here. I am tired, and I need You. Help me release what I cannot carry alone. Help me receive forgiveness, love, and the courage to take the next step. Show me whom to reach toward, and help me let them come close. Amen.*

There is room for your tears in that prayer. There is room for questions. And there is room for the first small beginning of hope.

Somewhere, right now, another person is on their knees, wondering how they will endure. I want us to be the people who come close.

References

Adam, E. K., Hawkley, L. C., Kudielka, B. M., & Cacioppo, J. T. (2006). Day to day dynamics of experience cortisol associations in a population based sample of older adults. Proceedings of the National Academy of Sciences, 103(45), 17058 to 17063. https://doi.org/10.1073/pnas.0605053103

Bernardi, L., Sleight, P., Bandinelli, G., Cencetti, S., Fattorini, L., Wdowczyc-Szulc, J., & Lagi, A. (2001). Effect of rosary prayer and yoga mantras on autonomic cardiovascular rhythms: Comparative study. BMJ, 323(7327), 1446 to 1449. https://doi.org/10.1136/bmj.323.7327.1446

Bremner, R. H., Koole, S. L., & Bushman, B. J. (2011). "Pray for those who mistreat you": Effects of prayer on anger and aggression. Personality and Social Psychology Bulletin, 37(6), 830 to 837. https://doi.org/10.1177/0146167211402215

Cacioppo, J. T., Hughes, M. E., Waite, L. J., Hawkley, L. C., & Thisted, R. A. (2006). Loneliness as a specific risk factor for depressive symptoms: Cross sectional and longitudinal analyses. Psychology and Aging, 21(1), 140 to 151. https://doi.org/10.1037/0882-7974.21.1.140

Chen, Y., & VanderWeele, T. J. (2018). Associations of religious upbringing with subsequent health and well being from adolescence to young adulthood: An outcome wide analysis. American Journal of Epidemiology, 187(11), 2355 to 2364. https://doi.org/10.1093/aje/kwy142

Coan, J. A., Schaefer, H. S., & Davidson, R. J. (2006). Lending a hand: Social regulation of the neural response to threat. Psychological Science, 17(12), 1032 to 1039. https://doi.org/10.1111/j.1467-9280.2006.01832.x

Ecker, B., & Vaz, A. (2022). Memory reconsolidation and the crisis of mechanism in psychotherapy. New Ideas in Psychology, 66, Article 100945. https://doi.org/10.1016/j.newideapsych.2022.100945

Goessl, V. C., Curtiss, J. E., & Hofmann, S. G. (2017). The effect of heart rate variability biofeedback training on stress and anxiety: A meta analysis. Psychological Medicine, 47(15), 2578 to 2586. https://doi.org/10.1017/S0033291717001003

Hansen, J. E., & Gombosi, R. L. (2026). Building adolescent resilience [Manuscript, July 20 version].

Holt-Lunstad, J., Smith, T. B., & Layton, J. B. (2010). Social relationships and mortality risk: A meta analytic review. PLOS Medicine, 7(7), Article e1000316. https://doi.org/10.1371/journal.pmed.1000316

International Churchill Society. (n.d.). Quotes FAQ. https://winstonchurchill.org/resources/quotes/quotes-faq/

King James Bible. (n.d.). Bible Gateway. https://www.biblegateway.com/versions/King-James-Version-KJV-Bible/ (Original work published 1611)

Luchetti, M., Aschwanden, D., Sesker, A. A., Zhu, X., O'Súilleabháin, P. S., Stephan, Y., Terracciano, A., & Sutin, A. R. (2024). A meta analysis of loneliness and risk of dementia using longitudinal data from >600,000 individuals. Nature Mental Health, 2, 1350 to 1361. https://doi.org/10.1038/s44220-024-00328-9

McCraty, R., Atkinson, M., Tiller, W. A., Rein, G., & Watkins, A. D. (1995). The effects of emotions on short term power spectrum analysis of heart rate variability. The American Journal of Cardiology, 76(14), 1089 to 1093. https://doi.org/10.1016/S0002-9149(99)80309-9

Miller, L. (2015). The spiritual child: The new science on parenting for health and lifelong thriving. St. Martin's Press.

Miller, L. (2021). The awakened brain: The new science of spirituality and our quest for an inspired life. Random House.

Miller, L., & Gur, M. (2002). Religiosity, depression, and physical maturation in adolescent girls. Journal of the American Academy of Child & Adolescent Psychiatry, 41(2), 206 to 214. https://doi.org/10.1097/00004583-200202000-00015

Miller, L., Bansal, R., Wickramaratne, P., Hao, X., Tenke, C. E., Weissman, M. M., & Peterson, B. S. (2014). Neuroanatomical correlates of religiosity and spirituality: A study in adults at high and low familial risk for depression. JAMA Psychiatry, 71(2), 128 to 135. https://doi.org/10.1001/jamapsychiatry.2013.3067

Miller, L., Davies, M., & Greenwald, S. (2000). Religiosity and substance use and abuse among adolescents in the National Comorbidity Survey. Journal of the American Academy of Child & Adolescent Psychiatry, 39(9), 1190 to 1197. https://doi.org/10.1097/00004583-200009000-00020

Miller, L., Wickramaratne, P., Gameroff, M. J., Sage, M., Tenke, C. E., & Weissman, M. M. (2012). Religiosity and major depression in adults at high risk: A ten year prospective study. American Journal of Psychiatry, 169(1), 89 to 94. https://doi.org/10.1176/appi.ajp.2011.10121823

Morris, S. M. (2010). Achieving collective coherence: Group effects on heart rate variability coherence and heart rhythm synchronization. Alternative Therapies in Health and Medicine, 16(4), 62 to 72.

https://www.heartmath.org/assets/uploads/site/file/pdf/a/achieving-collective-coherence.pdf

Nader, K., Schafe, G. E., & Le Doux, J. E. (2000). Fear memories require protein synthesis in the amygdala for reconsolidation after retrieval. Nature, 406, 722 to 726. https://doi.org/10.1038/35021052

Newberg, A., Pourdehnad, M., Alavi, A., & d'Aquili, E. G. (2003). Cerebral blood flow during meditative prayer: Preliminary findings and methodological issues. Perceptual and Motor Skills, 97(2), 625 to 630. https://doi.org/10.2466/pms.2003.97.2.625

Olds, T. (n.d.). Memory reconsolidation: How to rewire your brain. https://www.toriolds.com/memory_reconsolidation_ts4

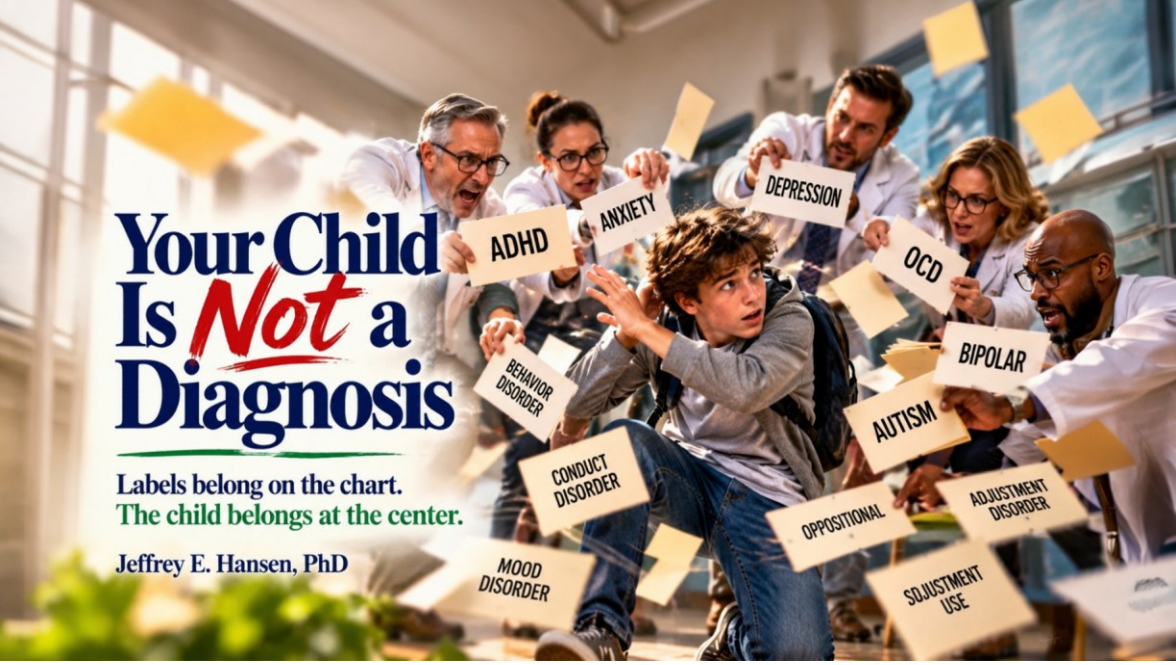
Porges, S. W. (2022). Polyvagal theory: A science of safety. Frontiers in Integrative Neuroscience, 16, Article 871227. https://doi.org/10.3389/fnint.2022.871227

Speer, M. E., Ibrahim, S., Schiller, D., & Delgado, M. R. (2021). Finding positive meaning in memories of negative events adaptively updates memory. Nature Communications, 12, Article 6601. https://doi.org/10.1038/s41467-021-26906-4

Svob, C., Wang, Z., Weissman, M. M., Wickramaratne, P., & Posner, J. (2016). Religious and spiritual importance moderate relation between default mode network connectivity and familial risk for depression. Neuroscience Letters, 634, 94 to 97. https://doi.org/10.1016/j.neulet.2016.10.009

Svob, C., Wickramaratne, P. J., Reich, L., Zhao, R., Talati, A., Gameroff, M. J., Saeed, R., & Weissman, M. M. (2018). Association of parent and offspring religiosity with offspring suicide ideation and attempts. JAMA Psychiatry,

https://doi.org/10.1016/j.neubiorev.2008.08.004



Labels, Labels, and More Labels

I appreciate a good label. When I pick up a candy bar, I want to know what is in it. If someone has packed the thing with enough sugar to launch a small rocket, I would prefer to find that out before I eat it. And if a child has a serious food allergy, an accurate ingredient label can be lifesaving. Labels are not the enemy. They tell us something useful about what we are dealing with.

But children are not candy bars. They are not products to be sorted, coded, and shelved. Yet somewhere along the way, medicine and mental health have become awfully comfortable treating them as if the label were the most interesting thing about them. We evaluate a struggling youngster, identify a symptom cluster, enter a code, construct a treatment plan, and sometimes begin speaking as though the code has explained the child. Congratulations: the paperwork is complete. Has anyone actually met the kid?

I have spent roughly four decades working with children and adolescents, including years in pediatric psychology, military medicine, teaching, and

clinical supervision. I love these kids. I love their curiosity, their outrageous humor, their capacity to recover, and even their occasional ability to drive every adult in a fifty-mile radius completely nuts. I have sat with frightened children, exhausted parents, and teenagers who cannot imagine that life might become something better than the mess they are in today. They deserve every good tool our professions can offer. What they do not deserve is to have their lives reduced to the most convenient description of their difficulties.

Let me be unmistakably clear: I believe in diagnosis. Depression can be devastating. ADHD can create real impairment. Trauma can profoundly disrupt development, relationships, attention, and the experience of safety. Failing to recognize those problems would be negligent. But recognizing a disorder is the beginning of understanding, not the end. The moment a child begins introducing herself to the world as "Sally, otherwise known as major depressive disorder," I start getting a little hot under the collar. Something has gone wrong when the label moves from the medical record into the center of the child's identity.

The DSM Did Not Come Down From Mount Sinai

I respect psychiatry. I have worked with extraordinary psychiatrists, and I know the difference careful diagnosis and effective treatment can make. But respecting a profession does not require kneeling before its manual. The Diagnostic and Statistical Manual of Mental Disorders is a human-made classification system, not a set of stone tablets delivered from heaven. The American Psychiatric Association's history of the DSM describes a series of revisions intended to improve clinical communication and classification (American Psychiatric Association, 2026a). Those are legitimate goals. Let us not confuse them with infallibility.

DSM-III arrived in 1980 with more explicit criteria and an admirable determination to improve reliability. If two clinicians examine the same child, it helps enormously if they can speak the same diagnostic language. But how were the categories and criteria decided? Through professional deliberation, negotiation, consensus, and, at times, voting. Yes, voting. Davies (2017), drawing on archival materials and interviews with DSM task force members, documented the role of voting and consensus in DSM-III and DSM-III-R decisions. I have sat on enough committees to know they can accomplish wonderful things. I have also sat on enough to know that a collection of highly educated people around a table does not automatically produce biological truth. Sometimes it produces wisdom. Sometimes it produces compromise. And sometimes it produces whatever everybody can agree on before lunch.

A vote can establish a convention. It cannot vote a disease into existence. Reliability, our ability to agree on a classification, is not the same thing as validity, whether that classification accurately captures a distinct phenomenon in nature. The National Institute of Mental Health (2017) has itself questioned the assumption that conventional psychiatric syndromes are equivalent to discrete diseases. Its Research Domain Criteria initiative explores dimensions of functioning that cut across diagnostic boxes (National Institute of Mental Health, n.d.). In other words, even the scientific establishment recognizes that the boxes may not map neatly onto the underlying mechanisms.

And please, let us retire the fantasy that the profession has been immune to cultural prejudice. Psychiatry's history includes the classification of homosexuality as a disorder, followed by its removal in 1973 amid changing scientific and professional judgments. Medicine has also too often interpreted women's suffering through paternalistic assumptions. Such episodes do not prove that today's categories are worthless; they

prove that credentialed human beings can mistake prevailing cultural judgments for settled scientific conclusions. That should inspire humility, not another round of self-congratulation.

So, when I hear someone explain a child's inattention by saying, "He has ADHD," I want to ask another question. What have you explained? If we identified ADHD because he struggles with attention and impulsivity, repeating the label is not a complete account of why this particular boy struggles. What is happening in his sleep, his classroom, his family, his development, his nervous system, his relationships? A diagnosis can be accurate and still leave the most important clinical questions unanswered. A child is not a billing code with sneakers.

Congratulations, Colleagues! We've Labeled the Child. Now What Happens?

There is something almost magical about a psychiatric diagnosis. A child walks into a classroom on Monday as a complicated, occasionally exasperating, wonderfully unpredictable human being. By Tuesday, somebody has added four letters to his educational record, and suddenly the adults are looking at him differently. Same kid. Same brain. Same outrageous sense of humor. But now he has a label, and apparently that changes things.

I wish I were exaggerating. Unfortunately, the research suggests that this phenomenon deserves considerably more attention than we have given it.

Franz et al. (2023) conducted a meta-analysis of 60 experiments involving 8,295 participants and found that diagnostic labels were associated with more negative evaluations of students, with an overall effect of Hedges' $g = -0.42$. That is a meaningful shift in adult judgment. The children did not suddenly become less intelligent, less capable, or less promising.

What changed was how they were perceived. Think about that for a moment. We can alter an adult's impression of a child without changing a single thing about the child himself. Just add a diagnosis.

And before we clinicians begin polishing our credentials and assuring ourselves that trained professionals would never fall for such nonsense, consider Ohan et al. (2011). Teachers and education students evaluating children with ADHD symptoms responded differently when the ADHD label was attached. They perceived greater impairment, experienced more negative emotions, and expressed less confidence in their ability to work with the child. Interestingly, they were also more willing to provide interventions.

Well, isn't that a hell of a bargain? We may have opened the door to services while simultaneously convincing the adults standing in that doorway that the child is more difficult than they previously believed. The diagnosis becomes both a ticket to assistance and a potential invitation to underestimate the passenger.

And lest anyone think I am standing outside the profession throwing rocks, let me confess something. I have been part of this machine, too. I have assigned the diagnoses, written the reports, recommended the interventions, and occasionally become so absorbed in identifying what was wrong that I may not have paid enough attention to what was wonderfully right. I wish I could claim innocence. I cannot. After four decades of doing this work, I have earned enough gray hair to start questioning some of the things I once accepted with considerably more confidence than they deserved.

Now, science is rarely courteous enough to give us a perfectly tidy story, and I have no intention of pretending otherwise. Kashikar et al. (2026) found that learning-disability labels could lower certain teacher

expectations and influence educational recommendations, although the wording of the label also mattered and could encourage support. Klapproth and Brink (2024), examining school-track decisions among 46 practicing and prospective teachers, found no statistically significant effect of an ADHD diagnosis. These findings remind us that labels do not operate like some universal psychological curse. Their effects depend on context, the particular diagnosis, the decision being made, and the people interpreting it.

But that complexity should make us more thoughtful, not more complacent.

Here is what bothers me after four decades of sitting with children, parents, teachers, and mental-health professionals. We sometimes confuse understanding what a child struggles with today with deciding what that child will never be capable of tomorrow. Those are two very different things. One is good clinical practice. The other is a potentially devastating prediction masquerading as a diagnosis.

A boy struggles to concentrate, so we appropriately identify ADHD. Wonderful. Now what? Do we investigate what helps him concentrate, what captures his imagination, and what circumstances bring out his competence? Or do we quietly begin lowering the bar because, after all, he has ADHD?

A frightened girl receives an anxiety diagnosis. Does that become the beginning of learning courage, emotional regulation, and the capacity to face difficult situations? Or does every uncomfortable experience now require another accommodation, another exemption, another carefully negotiated retreat from ordinary life? Some accommodations are essential, and genuine impairments demand serious attention. But

support should not automatically become a permanent declaration of what a child will never be able to accomplish.

And somewhere in this process, the child is listening. He hears the conferences, the explanations, the worried conversations in the hallway. He notices when adults stop asking what he wants to become and begin discussing what he probably cannot manage. Eventually, the most consequential label may not be the one written in his medical record. It may be the one he begins writing into his own understanding of who he is.

That is the danger I want us to take seriously. Not that diagnoses are inherently harmful, or that teachers and clinicians are conspiring to diminish children. Most are trying desperately to help. The danger is considerably more subtle: compassionate adults can become so preoccupied with protecting a child from difficulty that they inadvertently begin protecting him from discovering his own competence.

So here is a question I would like attached to every diagnostic evaluation, right beside the codes, recommendations, and beautifully formatted clinical impressions: What might this diagnosis cause us to stop expecting, stop noticing, or stop believing is possible?

Because somewhere beneath that collection of symptoms may be a future engineer, an extraordinary teacher, a gifted musician, a loving parent, or simply a decent human being who has not yet discovered what he can do. And I would hate to think that the very professionals entrusted with helping that youngster flourish were the first people to start writing limitations into a future that had barely begun.

A diagnosis should help us understand the obstacles. It should never give us permission to stop looking for the possibilities.

The diagnostic language we use does not arrive in a cultural vacuum, freshly sterilized and untouched by human assumptions. Watters (2010), in *Crazy Like Us,* argued that American mental-health concepts and treatment narratives can reshape how distress is understood in other cultures. His reporting invites an uncomfortable question at home: What stories are we handing our own children about suffering and recovery? Before congratulating ourselves on giving a youngster the right vocabulary, we might ask whether that vocabulary leaves room for a future larger than the symptoms.

A white coat does not confer immunity from ideology. Neither does a doctorate; mine has yet to produce that particular miracle. Professionals bring assumptions about normality, identity, family, autonomy, suffering, and treatment into the room. Some are well grounded. Others deserve a vigorous cross-examination. When a fashionable narrative becomes more important than discovering what is happening with this child, the adults have changed the subject to themselves. Children are not supporting characters in our political dramas, exhibits for our cultural crusades, or opportunities to polish a professional reputation.

Nor am I interested in sneering at adolescents who find comfort in a diagnostic community. When life hurts, belonging can feel like oxygen. My criticism is directed at adults who mistake recognition for the whole job and affirmation for a complete developmental plan. If every conversation celebrates how wounded a child is, who is noticing when that child becomes stronger? A community should have room for progress without making a young person feel that getting better means

surrendering the membership card. We owe children affection that does not depend on their remaining unwell.

And Here Comes the Prescription Pad

Now we arrive at the prescription pad, where fifteen years of human complexity can be reduced to "take one daily." Pharmaceutical marketing would have us admire the efficiency. I would prefer that we meet the child first. Appropriate medication can relieve terrible suffering and sometimes save a life; I have seen it help, and I want children to have access to it. But identifying a diagnostic category should not be the starting pistol for a race to the pharmacy. Before we send a family home with a prescription, somebody needs to investigate the sleep, trauma, learning difficulties, family relationships, developmental history, and circumstances surrounding the symptoms. Otherwise, we risk medicating the alarm while remaining remarkably incurious about what keeps setting it off.

Of course, curiosity takes time, and time is apparently the one therapeutic ingredient the system cannot afford. I have worked in settings where a clinician gets fifteen minutes to address what took fifteen years to develop, while the electronic record demands enough documentation to support a lunar landing. The child has a complicated life; the software has six boxes and an overdue signature. Guess which one starts flashing red? Thoughtful physicians and psychologists get squeezed into this machinery, then judged on whether they keep it moving. We have built an assembly line, hung a "personalized care" banner over it, and left conscientious clinicians trying to practice medicine between conveyor belts.

And the pharmaceutical industry? Please, spare me the image of a compassionate scientific angel fluttering above the examination room.

Drug companies sell products. That does not make their products useless, but it does give us reason to distinguish a scientific explanation from a sales pitch wearing a lab coat. Watters (2010), examining depression narratives and commercial promotion in Japan, described how the language used to explain suffering could become entangled with efforts to expand a medication market. He did not establish that pharmaceutical companies invented depression. He raised a more uncomfortable question: how much of what people come to believe about their distress has been shaped by someone with something to sell them? The brochure may discuss your child's well-being with exquisite tenderness. Somewhere else in the building, people are discussing market share.

A medication can work, a company can profit, and a child can still receive an assessment that leaves far too much unexplored. Those realities can coexist. What deserves our skepticism is the seductive little sequence in which a complicated problem receives a tidy name, the tidy name suggests a tidy chemical answer, and everybody gets to feel that understanding has occurred. Meanwhile, the bullied child returns to school, the exhausted teenager returns to another night without adequate sleep, and the frightened youngster returns to the circumstances nobody had time to ask about. The prescription may help. It cannot interview the family, call the school, or discover the part of the story the child has been too ashamed to tell.

So yes, give me good medications when they are warranted. Give me careful prescribing, honest discussion of benefits and risks, and follow-up that amounts to more than checking whether the bottle needs refilling. But give me clinicians who remain inconveniently interested in the human being after the diagnosis has been entered and the prescription sent. A child deserves more than a pill, a label, and a cheerful escort to the checkout desk. When the paperwork is immaculate and the

child remains poorly understood, the machinery has succeeded at something. Let us have the decency to ask whether that something was care.

For Heaven's Sake, Teach the Kid to Cope

Somewhere between the diagnostic checklist and the prescription refill, we seem to have misplaced a fairly important objective: helping children become capable of living. They need to learn how to survive disappointment, repair a friendship, begin an overwhelming assignment, and settle a nervous system that occasionally mistakes an uncomfortable conversation for an approaching grizzly bear. These capacities do not arrive with the next birthday, like complimentary upgrades to a phone. They develop through teaching, practice, relationships, and adults willing to stay involved when the work gets inconvenient. Yet we can become so accomplished at identifying what is wrong that we leave a child beautifully diagnosed and utterly bewildered by Tuesday. The chart has an explanation for everything. The youngster still has no idea what to do when his best friend stops speaking to him.

That gap ought to bother us considerably more than it does. When children repeatedly escape difficulties without learning how to approach them, avoidance can begin running the household. The assignment feels overwhelming, so it disappears. A conversation might be upsetting, so nobody has it. An ordinary disappointment becomes an emergency requiring a summit of concerned adults, preferably before lunch. Some situations genuinely require protection or a change in expectations; others require patient help tolerating the experience and learning what to do next. Figuring out the difference is part of our job. We should become deeply uncomfortable when a child's world keeps shrinking while the treatment file requires its own filing cabinet. We cannot count every

avoided challenge as a therapeutic success simply because everyone was calmer by dinner.

Appropriate medication can make this work possible. It may help a child concentrate, participate, or experience enough relief to begin learning. I welcome that help. But no pill has ever sat beside a teenager and helped him compose an apology to the friend he humiliated. No capsule establishes a workable bedtime routine or patiently teaches a frightened youngster how to approach something difficult. Those jobs remain stubbornly attached to human beings. If we medicate symptoms and neglect the developmental work, we should stop acting surprised when the child still lacks the skills nobody taught. We cannot subcontract the entire business of growing up to a bottle with a childproof cap and then blame the child when the arrangement fails.

Dr. Russell L. Gombosi and I spent roughly 300 pages exploring these complexities in *Building Adolescent Resilience* (Hansen & Gombosi, 2026). We could have saved ourselves considerable trouble if resilience could be purchased on a refrigerator magnet: "Believe in yourself!" Wonderful. Now explain how the terrified ninth grader gets through the school doors on Monday. Building resilience requires understanding development, strengthening relationships, helping children regulate distress, and creating manageable opportunities to discover competence. Encouragement matters, but children also need experiences that give encouragement something to stand on. Confidence becomes more credible when a youngster can look back and say, "That was hard, somebody helped me, and I learned how to do it." Our task is to help make those experiences possible, repeatedly and thoughtfully, rather than shouting inspirational slogans from the comfortable side of the difficulty.

Responsibility belongs in that process, although bringing up the subject can produce the reception normally reserved for someone proposing mandatory chimney sweeping. Expectations must reflect actual capacity. A child with ADHD may need accommodations, coaching, medication, and explicit instruction in executive functioning. A traumatized child may first need safety and trustworthy relationships; a severely depressed teenager may need intensive treatment and protection. Taking those needs seriously requires us to think carefully about the next attainable step. It does not authorize us to close the file on possibility. "This is difficult for him" should invite a thoughtful plan, not become the ceremonial announcement that nobody will ever ask him to develop that capacity.

I love the expression on a teenager's face after accomplishing something he had been certain was beyond him. There is surprise, pride, sometimes a grin he tries unsuccessfully to conceal because appearing pleased in front of an adult would apparently violate the adolescent constitution. That moment matters. It may have taken weeks of preparation, several failed attempts, accommodations, and someone trustworthy who refused to confuse a setback with a final verdict. The youngster now has evidence about himself that no lecture could supply. We should be hungry to create those moments. If we can document every symptom to three decimal places but cannot describe what the child is learning to manage, our clinical precision has wandered off without its purpose.

Accommodations can be essential to that progress, and some children will need them throughout their lives. The question is whether the support opens access and helps the youngster participate, learn, and build a fuller life. We need to revisit that question as the child develops, rather than treating last year's plan as a sacred document nobody is permitted to touch. Barking "try harder" at a struggling child is lazy. So

is assuming that removing the challenge completes our responsibility. The harder, more loving work is to understand the difficulty, provide appropriate help, and remain engaged long enough for learning to occur.

I love these kids too much to applaud every retreat and call it compassion. They deserve adults who take their pain seriously without allowing pain to write every rule for the future. Sometimes we must protect them, sometimes we must change the environment, and sometimes we must sit beside them through the uncomfortable business of discovering that they can do more than they believed. That takes judgment, patience, and considerably more effort than issuing another reassuring sentence. But if our care leaves children increasingly convinced that ordinary life is beyond their reach, we owe them more than a gentler explanation of their limitations. We owe them the help, the opportunities, and the steady belief in their development that make a larger life possible.

What Healing Ought to Mean

This is why my clinical work increasingly emphasizes an integrative approach I call NeuroFaith®. After decades of working with children and families, I have very little appetite for asking a complicated human being to squeeze into whatever theoretical box happens to be fashionable this season. I draw from polyvagal-informed approaches to safety and autonomic state, HeartMath® and physiological self-regulation practices, Internal Family Systems concepts, movement, relationships, and questions of faith and identity when they fit the person and family. These give me ways to explore what is happening and help a youngster develop useful skills. And before anyone mistakes the registered trademark for a halo, my framework belongs under scrutiny, too. Research is needed to establish whether or not NeuroFaith® as a complete approach is superior to established treatments. A trademark protects a name; it does not confer scientific sainthood. I cannot spend

an essay questioning everyone else's assumptions and then declare my own theory a sacred wildlife preserve.

What interests me is what happens when the family leaves the office and life resumes its customary refusal to cooperate. Can the teenager recognize that her body is escalating before she sends the text that detonates three friendships? Can the boy notice a protective reaction before it commandeers the evening and takes the entire household hostage? Can parents and children understand what is happening rather than stage another production of the same miserable argument, now entering its seventh triumphant year? These are the places where our clinical ideas have to earn their keep. A treatment plan can receive admiring nods at a case conference and still be practically useless at 7:15 on a school morning. If the family cannot translate our magnificent explanations into something they can actually do, we should examine the explanation before deciding the family needs another lecture.

I also want to know what the child is beginning to believe about herself. Does she see someone who can learn to manage difficult experiences, or someone whose principal qualification for belonging is being unwell? Can she recognize strengths without feeling that doing so somehow discredits her suffering? A young person should not have to keep presenting evidence of brokenness to remain eligible for affection. I want treatment to help her understand her reactions, develop capacities, and discover meaningful ways to participate in life. If we become so absorbed in explaining why she struggles that we forget to help her discover what she can do, we have produced an impressive commentary on the problem while leaving the youngster to live inside it.

Faith, when meaningful to the young person and family, belongs in that conversation. I am a Christian, and I do not leave that conviction in the

parking lot so I can pretend to have no beliefs about human dignity. My faith shapes how I understand the worth of the person sitting before me. But children do not owe me agreement with my theology before they deserve my care; the office is not an entrance examination for heaven. I want to understand what gives this particular youngster belonging, courage, direction, and a reason to get out of bed when life is hard. Those questions deserve more than an embarrassed clearing of the throat because they venture beyond the symptom checklist.

We are caring for a developing human being with a heart, mind, body, soul, relationships, and a future still taking shape. Some of the most consequential parts of that life will never fit comfortably into a diagnostic field, and I refuse to treat them as optional extras because the software cannot find a place to put them. The billing system can survive without a dropdown menu for hope. The child deserves adults who remember to ask about it.

Keep the Diagnosis on the Chart. And for Heaven's Sake, See the Child.

If you have reached the end of this essay believing that Hansen wants to abolish psychiatric diagnosis, throw away the DSM, abandon medication, or pretend that mental illness is imaginary, then somewhere along the way we have seriously misunderstood each other. I believe in good diagnosis, thoughtful prescribing, rigorous research, and the extraordinary work of dedicated professionals who devote their lives to helping suffering children. I have spent much of my own life among them. They are my colleagues, my teachers, my students, and my friends. And I would not trade the privilege of having worked alongside them for anything.

But I have also spent enough years in this profession to recognize that good intentions, impressive credentials, and beautifully constructed treatment plans do not guarantee that we have understood the human being sitting across from us. I know that because I have been there myself.

I wish I could tell you that throughout my career I always saw the child before the diagnosis, always asked the right questions, always understood the family dynamics, and always recognized the extraordinary possibilities hiding beneath the symptoms. I cannot. I have written the diagnostic reports, participated in the treatment conferences, recommended interventions, supervised young clinicians, and contributed to the machinery of modern mental-health care. Much of that work was important, and I believe much of it helped. But I also wonder how many times I was so busy trying to understand what was wrong that I failed to appreciate what was right. How often did I mistake a carefully constructed clinical formulation for a sufficiently complete understanding of a child's life? How many times did I leave a meeting satisfied that we had developed an excellent treatment plan without asking whether we had adequately considered the person who would have to live with it?

Those are not particularly comfortable questions for an old psychologist to ask himself. But perhaps they are precisely the questions we ought to be asking.

There is something about growing older that changes the landscape of your thinking. The hair gets grayer, the professional certainty becomes a little less impressive, and the accumulation of experience begins challenging some of the assumptions you once held so confidently. You remember the children who flourished, sometimes in ways you never

could have predicted. You remember the families who struggled despite everyone's best efforts. And you remember those remarkable youngsters who surprised the hell out of you by becoming something far greater than their clinical histories might have suggested.

But there are other children I remember, too. The ones who did not make it. And those memories are considerably harder to carry.

I remember young people whose lives took heartbreaking turns, some eventually landing in prison, some committing terrible acts against others, and some whose suffering ended in the tragedy of suicide. These are not simply unfortunate outcomes to be filed away in a clinical record or discussed at a professional conference. They were children. Children with names, faces, families, and futures that once seemed full of possibility. And although the years have passed, none of those faces have ever left me.

I would be less than truthful if I told you I had made peace with all of that. I have not. There are tragedies I will carry for the rest of my life. And even now, after decades of clinical experience, I sometimes find myself returning to those haunting questions: What did I miss? Was there something I failed to recognize? Could I have asked a better question, listened more carefully, intervened differently, or somehow changed the trajectory of a young life?

I know, intellectually and clinically, that we cannot control every outcome. Human development is far too complicated, and suffering is influenced by forces that extend well beyond the reach of even the most dedicated psychologist. I have taught that truth to others, and I believe it. But knowing something intellectually does not necessarily quiet the heart. There is a difference between understanding the limits of our responsibility and no longer grieving what might have been.

Perhaps that is one of the harder lessons of growing older in this profession. We carry the victories with gratitude, but we also carry the losses. Those memories do not necessarily mean we failed. They mean the work mattered, the relationships mattered, and the lives entrusted to our care were never merely clinical abstractions. Every child represented a developing human being whose story was still being written, sometimes toward extraordinary recovery and sometimes toward unimaginable tragedy.

I sometimes wonder whether, as I inch a little closer to heaven, I am finally gaining enough altitude to see the landscape differently. Not perfectly, mind you. I have no illusions that age automatically confers wisdom. I have known some spectacularly foolish old people, and I am quite certain I have contributed a few entries to that distinguished category myself. But there is something about the passage of time, the losses we endure, the people we love, and the growing awareness that our own days are numbered that has a way of rearranging what matters.

The things that once seemed enormous begin to shrink. The things we occasionally overlooked become impossible to ignore.

And increasingly, what I see is the child.

Not the diagnostic category, the insurance authorization, the standardized score, or the meticulously documented treatment plan. I see the frightened little boy trying desperately to make sense of a world that has not always been kind to him. I see the adolescent girl whose anger conceals a loneliness she cannot yet put into words. I see the exhausted parents who love their child beyond measure but have become so overwhelmed by the struggle that they have almost forgotten how to enjoy him. And I see the astonishing capacity of young people to grow,

adapt, recover, and surprise us when somebody takes the time to discover who they are beneath the difficulties that brought them into our offices.

I have loved working with these kids. Even the ones who drove me absolutely nuts. Perhaps especially those. Their humor, their stubbornness, their tenderness, their capacity for mischief, and their remarkable ability to recover have taught me at least as much about human development as any textbook I have ever opened. And I suspect that some of the most important lessons of my professional life came not when I was explaining something to a child, but when I finally stopped talking long enough to understand what that child was trying to tell me.

So, to my colleagues in psychology, psychiatry, pediatrics, counseling, and education, I offer this challenge as much to myself as to anyone else: let us become a little less enamored with our explanations and a great deal more interested in the lives unfolding before us. Let us diagnose carefully, prescribe responsibly, accommodate thoughtfully, and never confuse identifying a limitation with determining the boundaries of a child's future. Let us ask not only what a youngster cannot yet manage, but what strengths remain undiscovered, what relationships need strengthening, what skills can be developed, and what kind of life our interventions are actually helping that child build.

And let me speak for a moment to my younger colleagues, especially those of you still working toward your doctorates. Over the years, I have had the extraordinary privilege of supervising, teaching, and mentoring many of you. I have watched you wrestle with complicated clinical questions, develop your professional identities, and discover the remarkable responsibility that comes with being entrusted with another human being's suffering. It has been one of the great honors of my career.

I have learned from you, admired your dedication, and taken enormous pride in watching you become thoughtful, capable clinicians.

But I have also watched something troubling happen within parts of our academic and professional institutions. I have seen intellectual inquiry become entangled with ideological expectations, sometimes dressed in the language of progress, inclusion, or social responsibility. Worthy aspirations, certainly. But when those aspirations become doctrines that cannot be questioned, something essential to science begins to die. I have watched young clinicians learn which questions are welcomed, which conclusions are fashionable, and which lines of inquiry might invite disapproval. I have seen legitimate analysis treated with suspicion not necessarily because the evidence was weak, but because the questions themselves challenged prevailing assumptions. And I have watched talented young professionals become increasingly careful about what they say, not because they lack intellectual courage, but because they understand the consequences of stepping outside the approved narrative.

That troubles me enormously. A doctoral education should teach you how to think, not merely what to think. It should equip you to examine evidence, challenge assumptions, tolerate uncertainty, and defend your conclusions with intellectual honesty. If a university or training institution demands allegiance to an ideology, whether progressive, conservative, or otherwise, at the expense of rigorous inquiry, it has betrayed something fundamental about the scientific enterprise. We cannot claim to be training independent thinkers while quietly punishing independence.

And sadly, going against the flow can carry a price. Supervisors may scold you. Performance evaluations may become considerably less stellar. Colleagues who once admired your work may begin to regard your

questions as threatening, and some may even turn against you. Institutions can become remarkably efficient at rewarding conformity while making life uncomfortable for those who challenge the machinery. I know something about that, too. And I will not insult your intelligence by pretending that standing apart from the crowd is always comfortable, professionally advantageous, or without personal cost.

But neither does disagreement automatically make us right. Courage without humility can become arrogance, and conviction without evidence can become precisely the sort of dogmatism we ought to resist. We must remain willing to be challenged, corrected, and occasionally humbled by people who see the world differently. That is not intellectual weakness. That is intellectual integrity.

So here is what I want to say to every young clinician I have had the privilege of mentoring, and to those I may never meet: never surrender your soul. Do not allow the pursuit of professional approval, institutional acceptance, or a glowing performance evaluation to replace your obligation to think independently and act ethically. Learn the science. Respect your supervisors. Listen carefully to those who disagree with you. But when the evidence, your clinical judgment, and your conscience tell you that something is wrong, have the courage to ask the difficult question. Have the courage to challenge the fashionable explanation. Have the courage to see the child when everyone around you seems preoccupied with defending the system.

Yes, courage. Because sometimes doing the right thing requires considerably more than knowing what the right thing is.

And there is a satisfaction in that which no promotion, professional accolade, or glowing evaluation can quite replace. You may not win the argument. You may not earn the admiration of your colleagues. You may

even pay a personal or professional price for refusing to go along. But you can walk away with your head held high, knowing that when it mattered, you had the courage to step away from the machine, think for yourself, and do what you believed was right for the child sitting in front of you. And as the years pass, I suspect you will discover that a clear conscience is worth considerably more than a beautifully polished performance review.

To parents, I offer a different but equally important appeal. Please do not allow a diagnostic report, however sophisticated, to become the definitive biography of your son or daughter. Take the difficulties seriously. Seek excellent care. Advocate fiercely when necessary. But remember the child who existed before the first appointment, before the first questionnaire, before somebody attached a collection of letters to his name. Remember what makes him laugh, what captures his imagination, what brings her joy, and what dreams may still be waiting to emerge. Your child needs your protection, certainly, but also your confidence that growth remains possible, even when the road is difficult and the destination uncertain.

And if an adolescent happens to be reading this, I want to speak directly to you for a moment. I take your suffering seriously. I know that depression, anxiety, trauma, and other psychological difficulties can make life feel unbearably hard. You deserve competent treatment, understanding, patience, and every reasonable opportunity to get better. But please hear something from an old psychologist who has spent much of his life sitting with young people just like you: whatever diagnosis appears in your medical record, it is not the whole story of who you are. It cannot tell us everything about your courage, your humor, your capacity to love, your ability to learn, or the person you may become. There are chapters of your life that have not yet been written, and

neither I nor anyone else has the authority to decide how that story must end.

Perhaps that is what four decades of clinical psychology, and a fair amount of living, have finally taught me. Our greatest responsibility is not simply to identify what is wrong, although we must do that well. It is to help another human being discover what remains possible. That requires science, clinical judgment, patience, and sometimes the humility to admit that we do not understand nearly as much as we thought we did. And yes, I will say something that may make a few of my more academically inclined colleagues squirm: it also requires love. Not sentimental indulgence, not the abandonment of professional boundaries, but a genuine and abiding concern for the dignity, worth, and unfolding future of the person entrusted to our care.

I am grateful for the profession that has given me so much, and I remain proud to be a clinical psychologist. But if I could offer one piece of advice to the younger version of myself, the fellow who once carried his diagnostic manuals and professional confidence with perhaps a little too much enthusiasm, it would be this: learn everything you can, use the best science available, and never stop questioning your assumptions. But above all, do not become so impressed with your ability to explain a child's suffering that you forget to marvel at the child.

And despite the tragedies I have witnessed, the mistakes I have made, and the questions that will probably accompany me all the way to heaven, I remain profoundly hopeful. I have seen too many frightened children discover courage, too many broken relationships find healing, and too many young people rise beyond circumstances that once seemed impossible to believe otherwise. Hope is not a denial of suffering. It is the

conviction, grounded in both experience and faith, that suffering does not have to have the final word.

If there is one thing I want parents, teachers, and my fellow clinicians to carry away from these pages, it is this: never underestimate the extraordinary possibilities still unfolding in a child's life. We may not know what that youngster will become, and thank God for that. The future has a wonderful way of surprising even those of us who have spent our lives trying to understand it.

Keep the diagnosis on the chart, where it belongs. Then look up, meet the youngster sitting across from you, and remember that his future is still unfolding.

The DSM does not get to raise our children. We do. And when a frightened child looks to us for an understanding of who he is, let us offer something far greater than a beautifully documented account of everything that might go wrong.

Let us help that child discover everything that might still go wonderfully right.

References

American Psychiatric Association. (2026a). DSM history. https://www.psychiatry.org/psychiatrists/practice/dsm/about-dsm/history-of-the-dsm

American Psychiatric Association. (2026b). What is the DSM? https://www.psychiatry.org/patients-families/what-is-the-dsm

Davies, J. (2017). How voting and consensus created the Diagnostic and Statistical Manual of Mental Disorders (DSM-III). Anthropology & Medicine, 24(1), 32–46. https://doi.org/10.1080/13648470.2016.1226684

Franz, D. J., Richter, T., Lenhard, W., Marx, P., Stein, R., & Ratz, C. (2023). The influence of diagnostic labels on the evaluation of students: A multilevel meta-analysis. Educational Psychology Review, 35, Article 17. https://doi.org/10.1007/s10648-023-09716-6

Hansen, J.E., Gombosi, R.L. (2016). *Building Adolescent Resilience.* NeuroFaith, LLC. Prescott, AZ. https://www.amazon.com/dp/B0H392SSNK

Kashikar, L., Lüke, T., & Grosche, M. (2026). Effects of diagnostic labels for students with learning problems on teachers' stereotypes and performance expectations. Journal of Learning Disabilities, 59(1), 37–54. https://doi.org/10.1177/00222194251315187

Klapproth, F., & Brink, C. (2024). Does students' ADHD diagnosis affect teachers' school-track decisions? An experimental study. European Journal of Psychology of Education, 39, 3047–3069. https://doi.org/10.1007/s10212-024-00795-9

National Institute of Mental Health. (n.d.). About RDoC. https://www.nimh.nih.gov/research/research-funded-by-nimh/rdoc/about-rdoc

National Institute of Mental Health. (2017, December 27). Different approaches to understanding and classifying mental disorders. https://www.nimh.nih.gov/news/science-updates/2017/different-approaches-to-understanding-and-classifying-mental-disorders

O'Connor, C., Kadianaki, I., Maunder, K., & McNicholas, F. (2018). How does psychiatric diagnosis affect young people's self-concept and social identity? A systematic review and synthesis of the qualitative literature. Social Science & Medicine, 212, 94–119. https://doi.org/10.1016/j.socscimed.2018.07.011

Ohan, J. L., Visser, T. A. W., Strain, M. C., & Allen, L. (2011). Teachers' and education students' perceptions of and reactions to children with and without the diagnostic label "ADHD." Journal of School Psychology, 49(1), 81–105. https://doi.org/10.1016/j.jsp.2010.10.001

Watters, E. (2010). *Crazy like us: The globalization of the American psyche*. Free Press. https://www.simonandschuster.net/books/Crazy-Like-Us/Ethan-Watters/9781416587095



No Kidding Around Here

If you know me, you know I like to laugh. I enjoy a little mischief, a well-placed joke, and the relief humor can bring into a difficult room. There will be none of that here. I have seen things I wish I could unsee. I have heard things I wish I could unhear. After decades of working with children and adolescents, I have no interest in making this subject comfortable enough for adults to keep ignoring it.

I have worked with children who were sexually assaulted, teenagers whose violent sexual offenses sent them to prison, and young men experiencing impotence at eighteen or twenty. I have had adolescents beg me to help them stop watching pornography. They wanted to stop. They had tried to stop. They could not sustain it. I have treated teenagers whose pornography-related shame was entangled with depression so profound that they wanted to die. Some attempted suicide.

You may dislike this chapter. You may wish I would choose gentler words or lower my voice. An alarm is a horrible sound when you are trying to sleep. But the children I am talking about do not have the luxury of

sleeping through what happened to them. And I am finished pretending that adults' discomfort is the emergency.

What I Cannot Unsee

One boy's history began at five, with exposure to sexual content described as a sex-shop scene in Grand Theft Auto. Five. His parents later removed his access to the game or device. At eleven, he encountered it again at a friend's house. The friend's younger sister came in, and he attempted to sexually assault her. His parents had taken action. Access returned through somebody else's home.

In another case, a child was lured by a predator and raped. I have also encountered an attempted kidnapping and rape of a girl at school involving a hammer attack. These were children with families, classrooms, and futures. Their lives were invaded by things no child should have to carry. There is nothing bloodless about the phrase "sexual assault" when you have sat with what it means to the person who survived it.

The cases do not all end in a police report. Some unfold behind a bedroom door while the rest of the family believes homework is getting done. I have seen young men's interest in dating and ordinary companionship swallowed by preoccupation with pornography. I have treated young men of eighteen and twenty whose impotence I understood clinically as connected to their pornography use. At an age when they hoped to discover intimacy, they were frightened by their difficulty responding within a real relationship. Their suffering was immediate, humiliating, and very real.

Other teenagers arrived carrying a more desperate secret. They believed their struggle made them beyond help. I have seen suicidal despair and suicide attempts in young people overwhelmed by pornography-related shame and depression. One obtained a firearm intending to end his life;

the crisis was interrupted before he could carry it out. When a child reaches that point, the first question is whether we can keep that child alive and help them imagine a tomorrow.

These are the experiences behind my urgency. I explored this territory in my book Digital Enslavement Amidst the Search for Intimacy (Hansen, 2024). I keep returning to it because children keep needing help, and adults keep assuming that the danger must be somewhere else.

We understood that COVID demanded attention. We watched a deadly pandemic interrupt ordinary life, and we recognized that protecting people would require inconvenient decisions. Where is that willingness when the danger reaches children through a device we bought them? Too often, we wait for a catastrophe that becomes impossible to explain away. Meanwhile, a young person can lose sleep, confidence, relationships, and the expectation that intimacy will ever feel safe or satisfying. A marriage can lose its honesty. A childhood can lose years to secrecy. A heart can keep beating while a life grows painfully smaller.

The Phone We Wrapped for Christmas

"Oh, not my Johnny. He would never do something like that." Johnny may be a fine boy. He may help his sister with homework, say grace at dinner, and mean it when he promises to do the right thing. His goodness cannot prevent another child from sending a link. Nor can it guarantee that he knows what to do with the curiosity, excitement, disgust, or fear that follows. His character was never supposed to do the work of every adult in the room.

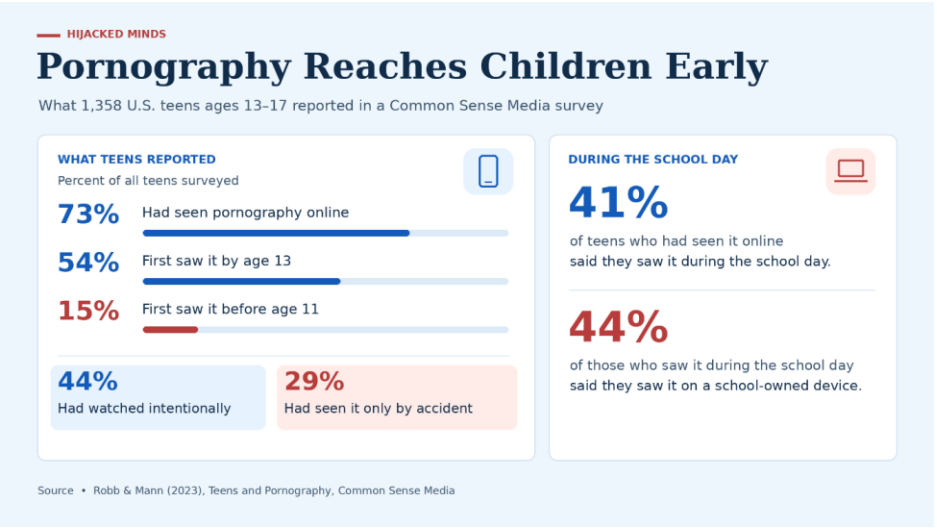
We bought the phone so our child could reach us. We should have spent more time asking who, and what, could reach our child. We wrapped it, charged it, and handed it over. Now we can know exactly where our child

is while knowing almost nothing about what is happening inches from that child's face.

I remember the magazine under the mattress. Go back far enough and somebody will bring up the Sears, Roebuck catalog. A magazine had a last page. It had to be obtained, carried, and hidden. Today, explicit material can arrive during algebra, in a school bathroom, at a sleepover, or in bed after the house goes quiet. Access travels with the child. The next image can be seconds away.

Common Sense Media surveyed 1,358 American teenagers ages thirteen to seventeen. Seventy-three percent reported seeing pornography online. Across the full sample, 54% reported first exposure by thirteen, and 15% before eleven. Forty-four percent reported intentional viewing; approximately 29% reported only accidental exposure (Robb & Mann, 2023). Nearly three in ten respondents had encountered it without choosing to go looking. "Our children know better" does not answer that finding.

School walls do not settle the matter, either. Among surveyed teens who had seen pornography online, 41% reported seeing it during the school day. Among those reporting school-day viewing, 44% had seen it on school-owned devices (Robb & Mann, 2023). A device issued for homework carries the authority of the school into the home. Parents deserve to know who manages its protections and what happens when those protections fail.



A filter can help. An accountability product such as Covenant Eyes may be useful. But a subscription is no substitute for parenting, and the settings on your child's phone do not govern a friend's device. Workarounds, borrowed screens, and material sent by other children remain part of the problem. The boy in the opening account had parents who removed access. The next exposure happened beyond their front door. Ask the parents hosting the sleepover what the children will be able to access. The conversation may be uncomfortable. Have it anyway.

Childhood Is Too Early to Begin This Battle

Judith Grisel's book, *Never Enough*, examines addiction through neuroscience and her own experience. In discussing adolescent substance exposure, she emphasizes the particular vulnerability of a brain undergoing development (Grisel, 2019; Gross, 2019). Childhood is a period of learning with consequences that can reach far beyond childhood. What a young person repeatedly turns to for relief deserves our close attention.

Consider the alcohol finding that should make parents sit up: **the younger drinking began, the greater the odds of alcohol problems.**

Grant and Dawson (1997) found that each year later a person started drinking was associated with 8% lower odds of lifetime alcohol abuse and 14% lower odds of dependence. Earlier initiation carried greater risk; later initiation carried less. Those figures concern alcohol, but they raise a prevention question we should bring to pornography: why give an intensely compelling habit the opportunity to take hold while a child is still learning how to manage feelings, impulses, and relationships?In my practice, I have seen pornography take hold before a child could begin to understand what was happening. Its immediate sexual stimulation, ready availability, and secrecy make it particularly alarming to me. A child does not need to find a bottle, acquire a substance, or explain an unfamiliar smell. The material may already be on a screen within reach. I regard that access as a reason for greater vigilance, especially in the youngest children.

Early exposure can become woven into the way a young person handles loneliness, boredom, rejection, and distress. The child returns because something happens quickly. Relief, excitement, escape, whatever the immediate reward, the sequence becomes familiar. Later, when the young person wants to stop, there may be far more to confront than a website. In a longitudinal study of adolescent boys, depressive symptoms and greater sexual interest predicted increases in compulsive-use symptoms over six months (Doornwaard et al., 2016). Ask what hurts before the screen comes on.

A teenager who says, *"I cannot stop,"* needs more than another lecture about willpower. Find out what the pattern is taking from them and what keeps bringing them back. Losing sleep, withdrawing from friends, failing at school, or repeatedly returning despite determined efforts to change deserves serious attention. Waiting until the problem is unmistakable can leave a child fighting an established pattern that adults might have interrupted much earlier.

Stop Handing Childhood Over

Here is a recommendation that ought to be on the table before we discuss the next monitoring app: do not give a young child a smartphone. If communication is necessary, consider a basic phone for calls and texts. Being able to reach a parent does not require unrestricted internet access, social media, or a private stream of content in a bedroom at midnight.

Jonathan Haidt makes the case for changing the conditions of childhood in *The Anxious Generation* (2024). His four proposed norms are straightforward: **no smartphones before high school, no social media before sixteen, phone-free schools, and more independence, free play, and responsibility in the real world.** Parents should take those proposals seriously. We have spent enough time asking children to resist environments that adults struggle to manage themselves.

"But everybody else has one." Then find another parent willing to say no with you. Talk to the school. Coordinate with the families your child spends time with. Help children build friendships around things they actually do together. Social pressure is real, but it cannot be the final authority over childhood. Your child's disappointment does not automatically mean you have made the wrong decision.

If a smartphone is genuinely necessary, make it dumb as hell. Restrict it to the functions the child needs. Block unrestricted browsing and social media, control app installation, and check that those restrictions actually work. Keep it out of the bedroom overnight. Revisit access as judgment develops. If the device is already contributing to serious harm, removing it belongs among the options. The fact that you bought it does not obligate you to keep handing it back.

Then put something worth living into the space the screen occupied: friends, outdoor activity, family involvement, useful responsibility, and

adults with time to pay attention. A child needs opportunities to become capable, to belong, and to survive an ordinary disappointment without disappearing into a device. Protection has to include the life we help children build.

Dad Look at Your Own Screen

Before you demand your child's password, examine your own behavior. Dad, this includes you especially, and no apologies for that. Christian fathers. Non-Christian fathers. Fathers who would be outraged to find pornography on a child's device while quietly consuming it themselves. You cannot keep treating the subject as somebody else's parenting failure if your own secret is living under the same roof.

Little eyes see. Children discover things. So do their friends. One boy I worked with was humiliated after a friend at a sleepover discovered his father viewing pornography and spread the story throughout the school. The father chose the behavior. His son had to walk into school carrying the consequences. Think about that before reassuring yourself that what you watch is strictly your business.

For God's sake, Dad, check your own behavior. Get help if you need it. Your child should never have to manage your secret, protect your reputation, or learn about your double life from another child. Expecting honesty from a teenager while guarding your own concealment gives that teenager a terrible lesson in what adult accountability means.

Mothers belong in this conversation, too. I worked with a mother who came to me because her son's gaming addiction had gotten so bad that he was failing in school. The elephant in the room was her own addiction to pornography, which had begun when she was seven. I told her plainly, "I can't begin to address your son's gaming addiction until we address yours first." She had carried that struggle from childhood into motherhood, and she found the courage to face it. I am still so proud of

her for that. Once she began doing that work, we could turn our attention to helping her son. A few years later, after she had overcome her addiction, she sent me a photograph of him beaming in his cap and gown. Her son who had been failing in school was graduating and heading off on his next great adventure, which I believe was college. When I look at that photograph, I think about how different his future might have been if his mother had never found the courage to face what was happening in her own life.

Dad, Mom, I know something about how hard it can be to ask for help. As a young man, like plenty of men of my generation, I was drawn to pornography. In my case, it came in magazines. I got help, and thank God I overcame it before I had children. I had the chance to face it early. You can face it now, however long you have carried it. And if your son or daughter already knows, have the courage to bring it up yourself. *"I've been looking at pornography. I'm sorry. I take responsibility for it, and I'm getting help."* Keep the details and the work of recovery with the adults helping you. Then let your child see you follow through. What can come from that kind of honesty is remarkable. When your son or daughter sees you ask for help, keep your word, and change, they learn what integrity looks like when it costs you something. And when they are in over their heads someday, they may remember that you had the courage to ask for help and find the courage to come to you.

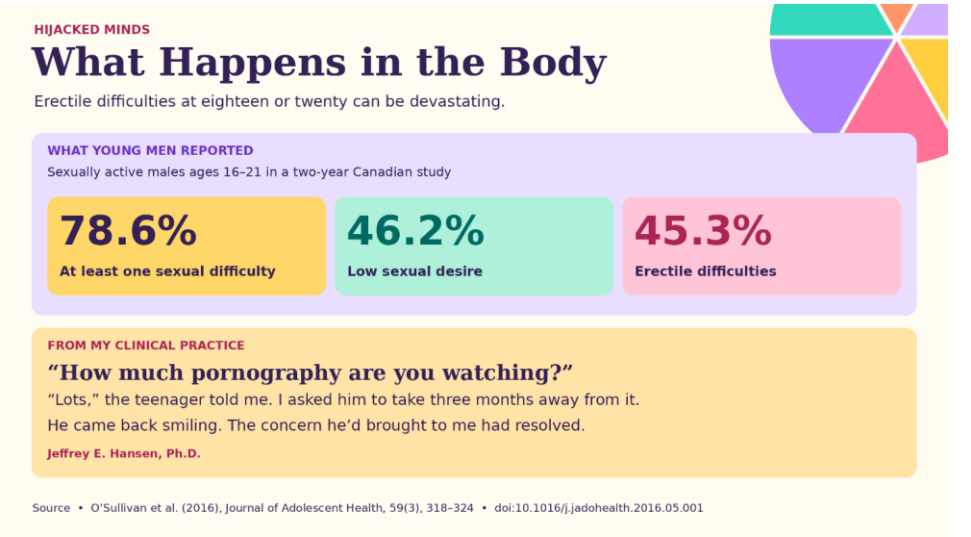
What Happens to Intimacy

By the time some parents sit down to talk with their children about sex, the screen has already had its turn. A young person is trying to answer some tender questions. Is my body normal? What am I supposed to want? What if someone I care about asks me to do something that scares me? These are questions a child ought to be able to bring to someone who loves them. But while we are still working up the nerve to have that

awkward conversation, a child may already be drawing conclusions from what they have seen.

The Children's Commissioner for England published a report called *"A lot of it is actually just abuse,"* in which young people described seeing violent and degrading pornography and talked about how it shaped their expectations of sex (Children's Commissioner for England, 2023). Those words came from a young person. Sit with that for a moment. Imagine trying to make sense of what you just saw when you have never even been in love. A girl may wonder whether she is supposed to put up with something that frightens her. A boy may worry that he is supposed to ask for it. Either one may be struggling with what they keep going back to watch. I want both of them to hear from an adult they trust that their body has dignity, that they are free to say no, and that someone who loves them will care how they feel when they say it.

Then there is what happens in the body. Erectile dysfunction at eighteen or twenty can be devastating. I have sat with young men that age who were frightened by what was happening to them, and in my clinical judgment, their pornography use was part of the picture. In a Canadian study that followed young people ages sixteen to twenty-one for two years, 78.6% of sexually active young men reported at least one problem with sexual functioning. Low desire was reported by 46.2%, and erectile difficulties by 45.3% (O'Sullivan et al., 2016).



Whatever we hope for our children about when they become sexually active, some already are, and some are frightened by how their bodies are responding. I remember a teenager I knew well and liked a great deal who told me he had concluded he was asexual. I asked him directly how much pornography he was watching. "Lots," he said. I asked him to take three months away from it and come back and tell me what he noticed. He did, and he came back smiling. The concern that had brought us to that conversation had resolved. I remember that smile because I knew how much the question had weighed on him.

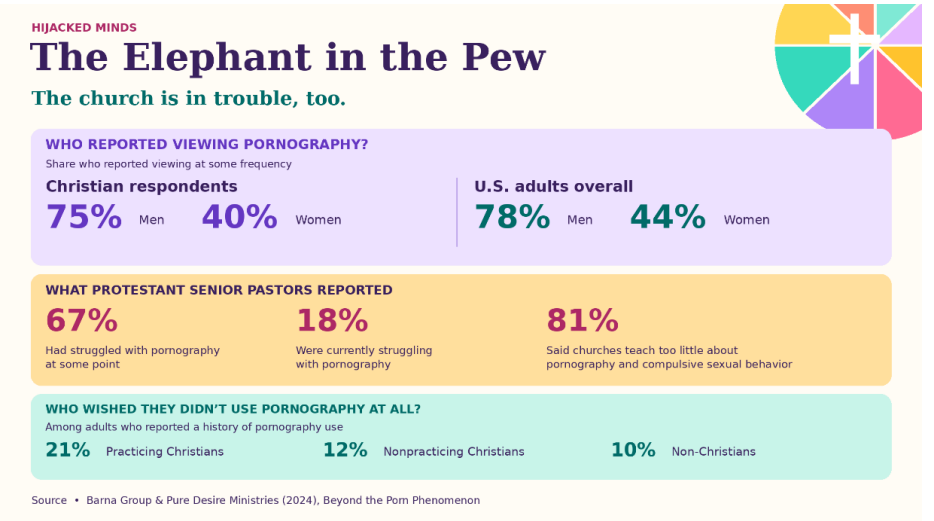
What we learn to expect from intimacy can follow us into marriage. So can what we learn to keep secret. Perry and Schleifer (2018) followed married adults over time and found that those who began using pornography between surveys had roughly **twice the adjusted odds of divorce** by the next survey. When I think about that finding, I think about the spouse who has just discovered the viewing and then starts to discover how long it was hidden. Now an ordinary memory can raise a question that never used to be there. What else was happening while I thought we were doing all right?

I have no patience for calling that spouse insecure. When you have given someone your trust, it hurts to find out how much they kept from you. I believe marriage is sacred, and part of honoring it is having the courage to tell the truth to the person you made your promises to. A family can go right on packing lunches and getting everybody out the door while something between two people is coming apart. The children may never hear the details, but they can still feel the cold at the breakfast table.

The Elephant in the Pew

How many Sundays can a teenager sit in our pews before hearing that help is available for a struggle with pornography? I sit in those pews, too. I love the church. After decades of working with children and adolescents, I believe this conversation belongs in the life of a congregation.

Barna Group's 2024 report with **Pure Desire Ministries** found that 78% of men and 44% of women in its general U.S. adult sample reported viewing pornography at some frequency. Among Christian respondents, the figures were 75% of men and 40% of women. Those figures describe reported viewing. Among surveyed Protestant senior pastors, 67% said they had struggled with pornography at some point, including 18% who reported a current struggle. And 81% said churches were teaching too little about pornography and compulsive sexual behavior (Barna Group, 2024). Read that last number again. The pastors themselves are telling us there is more to say. So when are we going to say it?



On any given Sunday, a teenager may be singing beside his parents and wondering whether anyone in the room could hear his story and still look him in the eye next week. A woman who has only ever heard pornography described as a man's problem may have decided to keep her own struggle to herself. A spouse may have spent the morning getting the children ready for church after another night of wondering whether a promise will hold. Speak plainly to the whole congregation so these people know where they can turn. And speak to our children early, in words suited to their age. They can understand that if something sexual appears on a screen, or someone asks them to keep a secret about it, they can close the screen and tell a trusted adult. Even if they went looking, even if they broke a rule, they need to hear that they can still come to us.

Pastors, youth pastors, Bible study teachers, I implore you to get in the same room and talk about this. Bring it to the senior pastor and proceed together with the senior pastor's knowledge and approval. Agree on what the congregation needs to hear, how you will involve parents, and how you will speak with children and teens. Train the people who will receive disclosures. Put clear safeguarding procedures in place and know

which clinicians you can call. If a child tells you about abuse, coercion, or exploitation, act to protect that child and follow the applicable reporting requirements, even if the person named is someone you trust or someone who holds authority in the church. No congregation's reputation is worth sacrificing a child's safety. Pray with the people who come to you and be ready to do what their protection requires when the prayer is over.

And pastor, if you are the one struggling, I have counseled more than one pastor through this. Please tell someone who will hear the whole truth and hold you accountable. Get professional help. I believe a pastor who remains in the grip of this addiction needs to step back from ministry and give recovery the attention it demands. You can make that painful decision with people beside you who care enough to help you follow through.

I believe the enemy loves what pornography can do in secret. He can let a man go on preaching about freedom while persuading him that telling the truth about his own life would cost him everything. That is a terrible lie to live under. Pastor, God loves you. He loves you on the Sunday you preach and on the Monday you finally tell somebody. I believe He wants you free. Please make that call. You can ask for the same help you would urge anyone in your congregation to seek.

And for heaven's sake, when someone comes forward, meet them with the mercy we preach. Conviction gives us the courage to speak plainly. Contempt gives a frightened person another reason to hide. Let the response to an honest disclosure show that this congregation means what it says about grace.

When Your Child Finally Tells You

Before anything happens, give your child a promise they can remember under pressure: "*You can wake me in the middle of the night. Even if you*

broke a rule. Even if you went looking. Even if you are afraid I will be angry. Wake me. I will help you." Explain to younger children that if sexual material appears, they can close it and tell you. With adolescents, speak directly about pornography, intimate images, coercion, and threats.

When a disclosure comes, let your child finish. Ask whether anyone pressured them, requested an image, demanded secrecy, threatened them, or hurt them. The FBI has documented deaths in cases of financially motivated sextortion, where offenders demand money by threatening to expose intimate images (Federal Bureau of Investigation, n.d.). In my Department of Defense work, I encountered an adult predator who encouraged a fourteen-year-old boy to kill his father so the man could have his way with the boy's mother. The appropriate reports were made. That case remains with me because it exposed how grotesquely an adult could manipulate a child. If your child is being threatened or exploited, contact law enforcement or the National Center for Missing & Exploited Children's CyberTipline promptly.

When pornography use persistently interferes with daily life, seek a clinician who understands adolescent development and will assess depression, anxiety, trauma, relationships, and the circumstances surrounding the behavior. In my NeuroFaith® work, we attend to the young person's emotional life, relationships, and faith while helping them develop practical ways to manage distress and reconnect with life. For families seeking an additional resource, a free digital copy of *Pornography Enslavement: A NeuroFaith® Model for Restoring Intimacy in an Age of Disconnection*, which I coauthored with Pastor Earl Heverly and Tim Hayden, is available at NeuroFaith.net (Hansen et al., 2026).

If shame or depression has become severe, ask directly about suicide. Listen without judgment, reduce access to lethal means, and obtain professional help. If danger is immediate, stay with the young person and

obtain emergency assistance (National Institute of Mental Health, 2024). The argument about the phone can wait. Their safety cannot.



Clinicians should give adolescents an appropriate opportunity to speak privately and explain the limits of confidentiality. Parents should expect recovery to require follow-through. The first disclosure opens the work; it does not finish it. A teenager who tells the truth on Tuesday needs someone who will still answer on Friday night.

Their Story Is Still Being Written

After everything I have asked you to face in this chapter, I want to leave you with what keeps me doing this work: I believe in these children. I believe in the teenager who finally admits how frightened he is, the parent who finds the courage to confront her own behavior, and the family willing to begin again after a painful discovery. I have seen people change. I have watched relief return to a young person's face. Those moments stay with me, too.

We are protecting the possibility of a full life: friendships that draw a child out of hiding, affection that feels safe, and the confidence to be known and loved without performing for a screen. There are ordinary, beautiful days ahead that a frightened teenager may not yet be able to imagine. Part of our work is to hold that possibility open while they learn to believe in it themselves.

That takes some backbone from the adults. We can delay the phone, confront our own behavior, and make room for conversations we would rather avoid. We can also put down our devices and enjoy the children we are working so hard to protect. Let them discover that life with us offers belonging, adventure, and somewhere to bring their troubles. Give them something good to come toward.

My faith tells me that shame does not erase a person's worth, and my years in the therapy room have given me reasons to keep expecting change. If your family is in the middle of this struggle, there is still meaningful work you can do today. Begin where you are. Get the help you need. Let your child hear the conviction in your voice: "I love you. We are going to face this together, and I still expect good things for your life."

I have sounded the alarm because I care deeply about who these children can become. Now comes the part that matters most: loving them with enough courage to act and enough patience to stay. Their story is still being written. **Let them remember that when things became frightening, we moved closer**

References

Barna Group. (2024). Beyond the porn phenomenon: Equipping the church for a new conversation about pornography, betrayal trauma and healing. Pure Desire Ministries. https://static1.squarespace.com/static/60246cd30685761e93a015ed/t/67b0d36d29ab1059a067f402/1739641722100/Barna%2B-%2BBeyond%2Bthe%2BPorn%2BPhenomenon.pdf

Children's Commissioner for England. (2023). "A lot of it is actually just abuse" – Young people and pornography. https://www.childrenscommissioner.gov.uk/resource/a-lot-of-it-is-actually-just-abuse-young-people-and-pornography/

Doornwaard, S. M., van den Eijnden, R. J. J. M., Baams, L., Vanwesenbeeck, I., & ter Bogt, T. F. M. (2016). Lower psychological well-being and excessive sexual interest predict symptoms of compulsive use of sexually explicit internet material among adolescent boys. Journal of Youth and Adolescence, 45(1), 73–84. https://doi.org/10.1007/s10964-015-0326-9

Federal Bureau of Investigation. (n.d.). Financially motivated sextortion. https://www.fbi.gov/how-we-can-help-you/common-frauds-and-scams/sextortion/financially-motivated-sextortion

Grant, B. F., & Dawson, D. A. (1997). Age at onset of alcohol use and its association with DSM-IV alcohol abuse and dependence: Results from the National Longitudinal Alcohol Epidemiologic Survey. Journal of Substance Abuse, 9, 103–110. https://doi.org/10.1016/S0899-3289(97)90009-2

Grisel, J. (2019). Never enough: The neuroscience and experience of addiction. Doubleday. https://www.penguinrandomhouse.com/books/557515/never-enough-by-judith-grisel/

Gross, T. (Host). (2019, February 12). A neuroscientist explores the biology of addiction in "Never Enough" [Audio podcast episode]. In Fresh Air. NPR. https://freshairarchive.org/segments/neuroscientist-explores-biology-addiction-never-enough

Haidt, J. (2024). The anxious generation: How the great rewiring of childhood is causing an epidemic of mental illness. Penguin Press. https://www.penguinrandomhouse.com/books/729231/the-anxious-generation-by-jonathan-haidt/

Hansen, J. E. (2024). Digital enslavement amidst the search for intimacy. https://cmda.org/podcast/cmda-matters-digital-enslavement-amidst-the-search-for-intimacy/

Hansen, J. E., & Gombosi, R. L. (2026). *Building adolescent resilience: A NeuroFaith® model to empower teens to thrive in a complex world*.

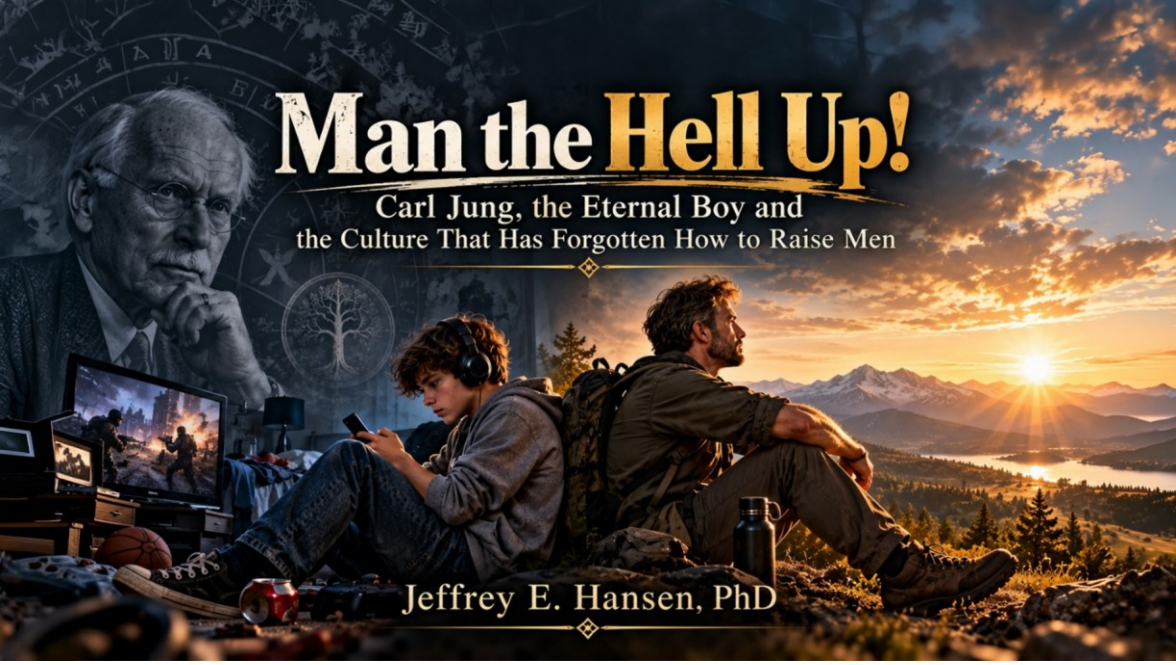
Hansen, J. E., Heverly, E., & Hayden, T. (2026). *Pornography enslavement: A NeuroFaith® model for restoring intimacy in an age of disconnection*. NeuroFaith®, LLC

National Institute of Mental Health. (2024). 5 action steps to help someone having thoughts of suicide. https://www.nimh.nih.gov/health/publications/5-action-steps-to-help-someone-having-thoughts-of-suicide

O'Sullivan, L. F., Byers, E. S., Brotto, L. A., Majerovich, J. A., & Fletcher, J. (2016). A longitudinal study of problems in sexual functioning and related sexual distress among middle to late adolescents. *Journal of Adolescent Health, 59*(3), 318–324. https://doi.org/10.1016/j.jadohealth.2016.05.001

Perry, S. L., & Schleifer, C. (2018). Till porn do us part? A longitudinal examination of pornography use and divorce. The Journal of Sex Research, 55(3), 284–296. https://doi.org/10.1080/00224499.2017.1317709

Robb, M. B., & Mann, S. (2023). Teens and pornography. Common Sense Media. https://www.commonsensemedia.org/research/teens-and-pornography



Houston, We Have a Problem

Gentlemen, I believe we have a problem. I am talking about the man-boy: a male who has reached adulthood chronologically but has not quite made the psychological journey from boyhood to manhood. He may be thirty, forty, or fifty, yet struggle with responsibility, commitment, independence, perseverance, and the capacity to love without expecting someone else to manage his life. This is not a diagnosis or a claim that an entire generation is failing. It is a pattern I have encountered in clinical practice, and one I believe deserves attention.

I have listened to young women ask some variation of the same exasperated question: "Dr. Hansen, where are all the men?" They are not asking where the males have gone. There are plenty of those. They are looking for someone emotionally available, capable of commitment, willing to shoulder responsibility, and prepared to build a life together. Where are these elusive creatures? Well, I suspect a few are still downstairs in Mom's basement, playing video games until three in the morning, entertaining themselves with pornography, and wondering

why the world has not recognized their extraordinary potential. Forgive my sarcasm. Sometimes humor helps us approach uncomfortable subjects.

Living with parents or enjoying video games does not establish immaturity. Economic pressures, illness, and trauma complicate independence. But when avoidance becomes a lifestyle, entertainment substitutes for purpose, and adult obligations are continually postponed, we ought to ask why. One of my favorite psychological thinkers was exploring this question generations before anyone dreamed of a PlayStation.

Carl Jung: One of My Clinical Psychology Brethren

I have always had a special affection for Carl Gustav Jung (1875–1961). Technically, Jung was a Swiss psychiatrist, trained as a physician, but I have long suspected he was really one of my clinical psychology brethren who wandered into the wrong profession. Forgive me, my psychiatry colleagues. I could not resist. Jung was an extraordinary thinker whose writings have shaped my own thinking. He was interested in the whole person: unconscious conflicts, childhood wounds, identity, meaning, mythology, spirituality, and what it takes to become psychologically whole.

Jung began as a close collaborator of Sigmund Freud, who regarded him as a promising successor. Their eventual separation reflected profound disagreements about the psyche. Freud emphasized unconscious drives, sexuality, and childhood conflict; Jung developed a broader account involving archetypes, symbolic life, and a movement toward psychological integration. I have always found Jung's perspective more compelling. People are not simply collections of symptoms or prisoners of their past. They are also searching for meaning and struggling to

become themselves. His writings on archetypes and the collective unconscious remain influential in analytical psychology (Jung, 1959).

Jung's idea of individuation—the lifelong movement toward a more differentiated, integrated self—speaks to the heart of my clinical philosophy. Healing involves more than reducing symptoms or improving scores on an inventory. It involves discovering identity, accepting responsibility, finding meaning, and developing the capacity to love. That resonates with my NeuroFaith® approach, even though Jung's spiritual ideas and my Christian convictions are not identical. And more than six decades after his death, his ideas still make me wonder: Good heavens, Carl, what would you make of us now?

And perhaps this is where I should confess another reason for my affection for Jung. He asked questions that our profession sometimes treats as peripheral: Who am I? What gives my life meaning? What am I here to contribute, and what sort of person am I becoming? I have never been particularly enamored with our dependence on the Diagnostic and Statistical Manual of Mental Disorders, now in its DSM-5-TR edition (American Psychiatric Association, 2022). Yes, I have used diagnostic classifications throughout my career, and they serve practical purposes. But a diagnosis describes a pattern of difficulties; it does not necessarily explain the person, much less provide a coherent account of that person's identity or purpose. We can become remarkably efficient at attaching labels to distress while remaining strangely incurious about the life in which that distress occurs. If I sound a little irreverent toward one of our profession's sacred books, well, I have been accused of worse.

And while I am irritating a few colleagues, I might as well mention our enthusiasm for manualized therapies. Cognitive behavioral therapy and

dialectical behavior therapy offer genuinely valuable tools for changing unhelpful patterns, managing emotion, and tolerating distress. I have drawn on such approaches myself. Some applications also have meaningful longer-term evidence, so I would not dismiss them as merely short-term fixes. But their success at improving symptoms or teaching skills does not automatically answer the larger questions of identity, belonging, responsibility, faith, and meaning. Those questions may be addressed within good CBT or DBT work, especially when a thoughtful clinician makes room for them; my concern is what happens when treatment is reduced to a checklist of techniques. We may help a man regulate his emotions without ever asking what kind of man he intends to become. Jung would have wanted to keep that larger question on the table. And that is precisely why his account of the eternal boy speaks so forcefully to me.

The Puer Aeternus: The Eternal Boy

The Latin is wonderfully descriptive: puer means boy, and aeternus means eternal. The puer aeternus, or eternal boy, is an archetypal figure that Jungian psychology uses to examine arrested psychological maturation. Jung explored related archetypal themes, and his student and colleague Marie-Louise von Franz examined the pattern extensively in The Problem of the Puer Aeternus (von Franz, 2000).

The eternal boy may be intelligent, charming, creative, sensitive, and full of plans. His difficulty is not a lack of potential but an unwillingness to exchange possibility for commitment. He loves imagining achievement more than enduring the ordinary work required to achieve it. He may want marriage but recoil from its daily sacrifices, dream of fatherhood but avoid its obligations, or continually search for the next opportunity when the present one demands perseverance. He wants to

fly indefinitely without learning to land. The puer aeternus is not a DSM diagnosis, but it offers a vivid language for a recognizable clinical and human struggle.

Mommy's Little Boy: When Love Becomes a Prison

Some developmental difficulties emerge not from obvious cruelty but from relationships overflowing with affection. Consider the devoted mother who anticipates every need, rescues her son from discomfort, and cannot bear to see him struggle. Children absolutely need warmth and protection. The trouble begins when a mother's need to remain indispensable becomes more important than her son's need to grow. Perhaps she is lonely or carries unresolved wounds; perhaps her marriage is emotionally distant. Without intending harm, she begins relying on her son for reassurance, companionship, or meaning that ought not be his responsibility.

The boy learns that independence makes Mom unhappy. Assertiveness begins to feel selfish; separation feels like abandonment. He may leave home, marry, and build a career while remaining psychologically tethered to her approval. Contemporary research distinguishes supportive parenting from psychological control, which can intrude upon a young person's developing autonomy (Barber et al., 2005). That distinction matters. A loving mother is not the problem; emotional enmeshment and guilt-based control are. There may be self-serving needs in this dynamic without any justification for casually diagnosing the mother with narcissistic personality disorder.

The tragedy is that she may believe she has given her son everything, while withholding something indispensable: the freedom to become himself. A mother should hope her son loves her for life. She should not need him to remain a little boy to feel loved.

Dad, Where Were You?

And where was Dad? It would be unfair and clinically shortsighted to place this developmental burden on mothers alone. Some fathers are absent because of circumstances beyond their control. Others are physically present but psychologically unavailable: earning a paycheck, occupying a recliner, and missing the everyday opportunities to demonstrate mature manhood. Boys benefit from seeing how responsible adults handle frustration, honor commitments, apologize, treat women, manage fear, and persist when life is hard. Research on father involvement supports its importance for multiple aspects of children's development, while recognizing that family relationships and circumstances vary (Sarkadi et al., 2008).

A father need not be perfect, and a boy without an involved biological father is not doomed. Grandfathers, coaches, pastors, mentors, and other dependable adults can model integrity and responsibility. The point is not that boys require a flawless masculine superhero. They need someone who shows up, sets boundaries, offers affection, and allows them to encounter manageable challenges without immediately swooping in to rescue them. The goal is not to raise a son who forever needs his parents to decide for him; it is to raise a son who can make sound decisions because of what they taught him.

What About Testosterone? Is Biology Following Behavior?

Now let me throw another log on the fire: testosterone. As a clinical psychologist fascinated by the relationship between mind and body, I wonder whether some modern habits are shaping not only men's psychological functioning but their endocrine health. Travison and colleagues (2007) reported an age-independent decline in serum testosterone in a studied population of American men over time. That

finding does not establish a universal decline or identify a single cause, but it raises legitimate questions about health, environment, and lifestyle.

Testosterone is not a laboratory test of manhood. Courage, responsibility, tenderness, and character cannot be read from a hormone panel. There are many medical causes of low testosterone, and no credible evidence that failing to act "manly" directly causes testosterone deficiency. Yet the broader biological question is intriguing. Obesity and metabolic dysfunction are associated with lower testosterone, and some related hormonal changes can improve with weight loss (Grossmann, 2020). In a small experimental study, one week of sleep restriction was associated with a reduction in daytime testosterone in healthy young men (Leproult & Van Cauter, 2011).

Think about how much of contemporary life is spent sitting: at work, in a car, at a desk, before a television. Physical exertion and challenge increasingly have to be scheduled rather than naturally encountered. My conjecture is not that competition or assertiveness magically boosts testosterone. It is that patterns of sleep, movement, metabolic health, social experience, and behavior interact with physiology, and that an increasingly sedentary lifestyle may have consequences we are still working to understand. The relationship between biology and behavior is reciprocal, although the particular causal pathways deserve careful research.

Within NeuroFaith®, I emphasize Movement as Medicine because the mind and body are not separate enterprises. We were not designed to develop strength by avoiding every challenge that requires it. Gentlemen, while researchers continue sorting out the endocrinology,

perhaps we can at least get off the couch and take a walk. Our muscles and our minds might appreciate it.

From Eternal Boy to Mature Man: The Puer and the Senex

Jungian psychology places the puer alongside the senex, the elder or old man, whose constructive qualities include discipline, structure, patience, wisdom, and responsibility. The senex is not simply an elderly fellow with gray hair and a good retirement account. A young man can develop those qualities, and an old man can spend his entire life avoiding them. Neither archetypal pattern is wholly good or bad: the shadow side of the senex is rigidity and control, just as the shadow side of the puer is endless possibility without commitment. The youthful spirit contributes imagination, playfulness, curiosity, and adventure. I hope never to lose mine. I still love motorcycles, laughter, and occasionally doing something that causes my wife to wonder whether I will ever grow up.

But vitality needs judgment. Freedom needs discipline. Affection needs dependability. A mature man does not have to kill the boy within him; he has to stop letting that boy run the entire show. He can be tender without being helpless, assertive without being cruel, and adventurous without abandoning those who count on him. That is not the death of boyhood. It is the boy finally becoming a man. And, gentlemen, there is a world of difference.

Have We Raised a Generation of Spineless Christians?

I realize that heading may make a few church folks squirm. Perhaps it should. I am not talking about the man who cries at his daughter's wedding, prays with his children, listens carefully to his wife, or admits when he is afraid. I admire those men. I am talking about the fellow who confuses being Christian with being perpetually agreeable, who avoids

necessary confrontation, and who calls his reluctance to act "gentleness." Somewhere along the way, have we begun to teach boys that goodness requires the surrender of courage? I worry that parts of the Christian world have embraced a picture of manhood so harmless, so carefully polished, that we have forgotten what conviction looks like when it costs us something.

Consider David. He confronted Goliath when others stood paralyzed by fear, yet this same warrior gave us psalms of grief, repentance, longing, and worship. I sometimes wonder whether we have become so determined to raise gentle Christian men that we have inadvertently raised a few who would rather negotiate with Goliath than pick up a stone. Good heavens, gentlemen, David must be rolling his eyes. His strength did not make tenderness impossible, and his tenderness did not make him weak. Or consider Jesus, who wept with the grieving, welcomed children, and showed compassion to the marginalized, yet also confronted hypocrisy and refused to abandon His calling in the face of suffering. I cannot reconcile either example with the idea that Christian masculinity means becoming a pleasant, conflict-avoidant bystander. Biblical courage is not bullying; it is the willingness to act rightly when doing so is frightening or costly.

This discussion also touches an influential idea in psychology. Sandra Bem (1974) described psychological androgyny as the capacity to possess traits conventionally labeled masculine and feminine, such as assertiveness and tenderness. Her argument was not that biological differences vanish or that everyone must become identical. I appreciate the insight that a mature person can embody both sets of strengths. But I question a cultural tendency, sometimes echoed in church life, to treat distinctly masculine responsibility as embarrassing or suspect. In my understanding of Christian family life, husbands are called to

sacrificial love, not domination; Ephesians 5:25 sets the standard at giving oneself for another. Women are no less courageous or capable of protection, but I believe fathers and husbands should take seriously their responsibility to lead through service, defend the vulnerable, and remain steady when life turns ugly.

The problem is not that we have taught men to be sensitive. The problem is that sensitivity without backbone can become another refuge for the eternal boy. A man can learn every polite phrase, speak fluently about feelings, and still disappear when his family needs him to take responsibility. I want men who can comfort a frightened child and confront a bully; who can apologize when wrong and stand firm when right; who can pray with tenderness and act with conviction. The Christian church should be helping boys grow into that kind of integrated manhood. Jung might have called it part of the difficult work of becoming whole. I would simply call it growing up.

Parents, It Is Time to Wake Up

Parents, our task is not simply to keep children happy and comfortable. It is to prepare them to live competently and courageously when we are no longer standing beside them. Secure attachment and emotional attunement are foundations, not substitutes, for growing autonomy. We should offer affection and safety while also providing age-appropriate responsibility, opportunities to solve problems, and manageable experiences of frustration. Parental psychological control is not the same as guidance or love (Barber et al., 2005).

Our children are not here to complete us, repair our marriages, or reassure us that we matter. They are separate human beings entrusted to our care. I say that as a psychologist, a father, and a grandfather who knows parenting is never as easy as the textbooks make it sound. We all

make mistakes, sometimes recognizing them only after our children are grown. But we can still change how we show up: encouraging responsibility instead of dependency, celebrating independence instead of interpreting it as rejection, and modeling the maturity we hope to see. Have we become so determined to protect children from the discomfort of growing up that we inadvertently protect them from growing up at all? That question ought to make every parent, including this one, squirm a little.

Manhood Is Earned, Not Bestowed

I have spent decades helping people understand wounds from childhood, relationships, trauma, and the disappointments of being human. I know that avoidance and immaturity are not always born of laziness. Sometimes they reflect fear, insecure attachment, or skills that were never taught. Those histories deserve compassion. But compassion and accountability are not enemies. Understanding why we struggle does not absolve us of the work of growing.

That conviction is personal. My son Gregg, a Marine who served in Iraq, has taught me much about courage, duty, and the cost of carrying both. I have also been privileged to co-author two books with remarkable colleagues: *When Duty Called*, which tells stories of courage, trauma, and redemption among those who served, and *The Wounds We Carry*, which explores the wounds borne by active duty service members, veterans, and first responders—and the paths toward healing. In the latter work, I had the honor of writing alongside Kris A. Peterson, MD; Johnnie Griffitts; Salvatore Bitondo, LICSW; Stephanie Bowser, PsyD; and Jack Marion. I name them here deliberately: these men and women have earned my respect, and their contributions deserve to be seen. Those books are not arguments for swagger or emotional armor. They

are reminders that courage and vulnerability can live in the same man (Hansen & Griffitts, 2026; Hansen et al., 2026).

Some men need therapy, mentorship, spiritual guidance, healthier boundaries, or help learning emotional regulation. Some need to stop escaping into entertainment and begin honoring commitments. I am not calling for a caricature of masculinity in which men suppress emotion, dominate others, or confuse intimidation with strength. I am calling for men strong enough to be gentle, courageous enough to be vulnerable, disciplined enough to be dependable, and secure enough to love without possessing.

Perhaps that is why Jung continues to speak to me. He understood that becoming whole requires more than explaining the past. It requires confronting who we are and moving toward who we can become. For those of us who are Christians, that journey also involves grace, forgiveness, humility, and service to purposes larger than personal comfort. To the man who recognizes himself in these pages: your past may explain some of your struggles, but it need not dictate your future. There is still time to grow. Nobody else, however, can do that work for you. So, with affection, conviction, and a little exasperation, allow this old psychologist one final plea: **Men, for heaven's sake, wake up, and man the hell up!**

References

American Psychiatric Association. (2022). Diagnostic and statistical manual of mental disorders (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787

Barber, B. K., Stolz, H. E., Olsen, J. A., Collins, W. A., & Burchinal, M. (2005). Parental support, psychological control, and behavioral control: Assessing relevance across time, culture, and method. Monographs of the Society for Research in Child Development, 70(4), 1–147. https://doi.org/10.1111/j.1540-5834.2005.00365.x

Bem, S. L. (1974). The measurement of psychological androgyny. Journal of Consulting and Clinical Psychology, 42(2), 155–162. https://doi.org/10.1037/h0036215

Grossmann, M. (2020). Late-onset hypogonadism: Metabolic impact. Andrology, 8(6), 1519–1529. https://doi.org/10.1111/andr.12705

Hansen, J. E. (2026). When silence becomes cowardice: The man I decided to become. NeuroFaith®. https://www.neurofaith.net/_files/ugd/a32a22_11b7e3fd3c9144b2a3793534b32f36af.pdf

Hansen, J. E., & Griffitts, J. (2026). *When duty called: Warriors' stories of courage, trauma, and redemption.*

Hansen, J. E., Peterson, K. A., Griffitts, J., Bitondo, S., Bowser, S., & Marion, J. (2026). *The wounds we carry.*

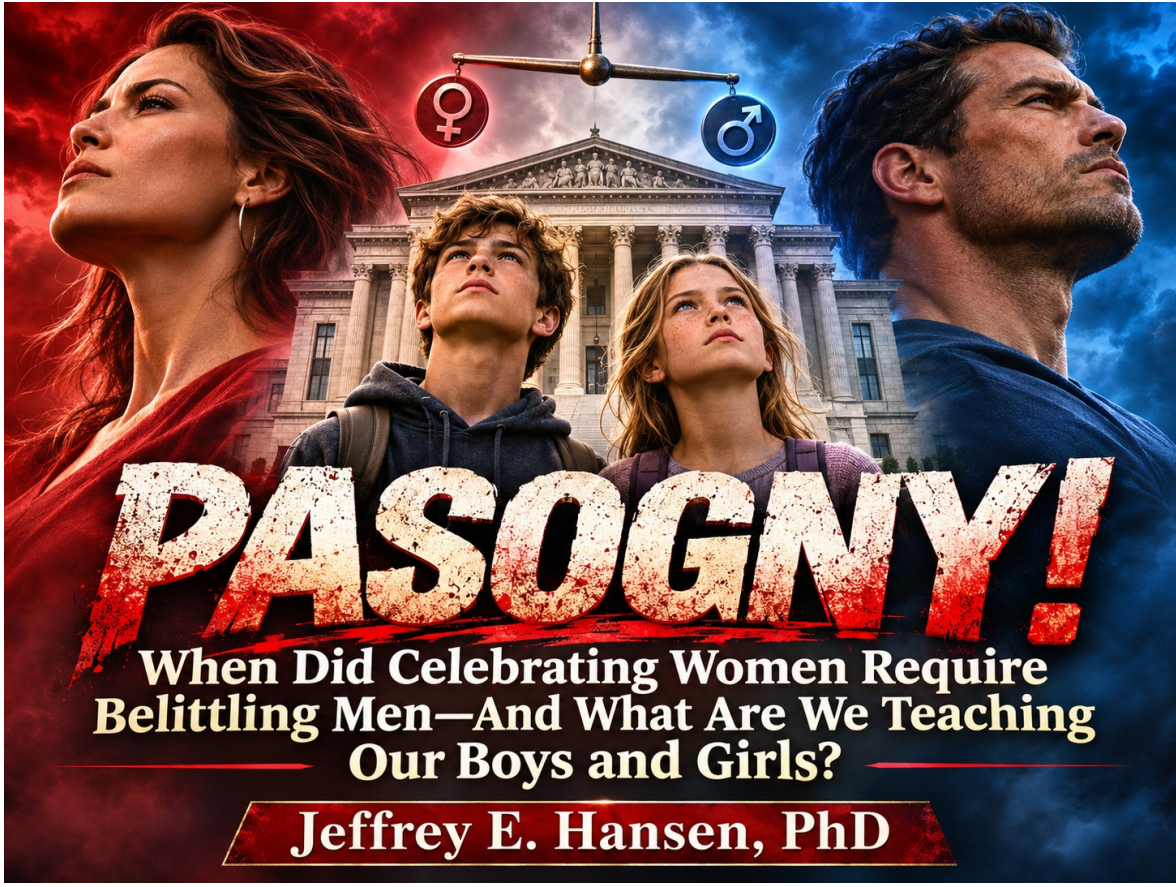
Jung, C. G. (1959). The archetypes and the collective unconscious (R. F. C. Hull, Trans.; Vol. 9, Part 1). Pantheon Books.

Leproult, R., & Van Cauter, E. (2011). Effect of 1 week of sleep restriction on testosterone levels in young healthy men. JAMA, 305(21), 2173–2174. https://doi.org/10.1001/jama.2011.710

Sarkadi, A., Kristiansson, R., Oberklaid, F., & Bremberg, S. (2008). Fathers' involvement and children's developmental outcomes: A systematic review of longitudinal studies. Acta Paediatrica, 97(2), 153–158. https://doi.org/10.1111/j.1651-2227.2007.00572.x

Travison, T. G., Araujo, A. B., O'Donnell, A. B., Kupelian, V., & McKinlay, J. B. (2007). A population-level decline in serum testosterone levels in American men. The Journal of Clinical Endocrinology & Metabolism, 92(1), 196–202. https://doi.org/10.1210/jc.2006-1375

von Franz, M.-L. (2000). The problem of the puer aeternus (3rd ed., D. Sharp, Ed.). Inner City Books.



My Confession

I have a confession to make. I love strong women. Always have. And I am not talking about women who can bench-press 200 pounds, although God bless them, too. I am talking about women who know who they are, stand on their convictions, refuse to be pushed around, and understand that their dignity is not something another human being gets to grant or take away.

In fact, I suppose that makes me a bit of a feminist. There. I said it. Somebody alert my conservative friends. I may have to turn in my membership card.

I have long admired Helen Reddy, whose magnificent 1972 anthem, "I Am Woman," became a rallying cry for women who had spent generations being told to sit down, be quiet, and know their place (National Film and Sound Archive of Australia [NFSA], n.d.). I have used that song many times in therapy with women who had been beaten down, belittled, abused, and made to believe they were somehow less

than the extraordinary human beings God created them to be. Watching a woman rediscover her dignity, her voice, and her strength is one of the great privileges of my professional life.

So let me establish something right out of the gate. I have no interest in returning women to an imaginary golden age when their opinions were optional and their aspirations ended at the kitchen door. Women have helped build this nation, raise its children, lead its institutions, heal its wounded, and hold families together through hardships that would buckle the knees of many of us men.

But somewhere along the way, I believe something went sideways. In our admirable determination to elevate women, we sometimes seem to have decided that men needed to be knocked down a few floors. And I, for one, am getting a little tired of riding that elevator.

We have a perfectly respectable word for contempt directed toward women: misogyny. We even have a word for contempt directed toward men: misandry. But frankly, misandry sounds like something you might contract from drinking contaminated water. It does not have nearly enough punch for what I am trying to describe.

So, I am inventing my own word: PASOGNY. P-A-S-O-G-N-Y.

There. I claim it. I want it entered into the dictionary, appropriately credited, and perhaps announced at a ceremony where somebody gives me a medal. If my progressive colleagues can introduce new terminology into our cultural conversations, surely one cranky old psychologist from Arizona can contribute a word of his own. What are they going to do—arrest me for unauthorized vocabulary?

Before somebody starts writing an angry letter to my licensing board, let me explain. Pasogny, as I am using it, describes the habit of diminishing, ridiculing, stereotyping, or treating men with contempt simply because they are men. It is the assumption that masculinity itself is a problem requiring correction rather than an aspect of human life deserving

understanding, responsibility, and respect. And I believe we have tolerated far too much of it.

Look at the television sitcom. How often is Dad the village idiot? He cannot operate the washing machine, cannot prepare dinner without setting something on fire, cannot understand his children, and would probably starve to death if his wife went away for three days. Meanwhile, Mom is the brilliant, organized, emotionally sophisticated adult who somehow manages to keep this oversized adolescent alive. I love strong, capable women. I am simply wondering when the price of admission became portraying the man as a household appliance with a pulse.

And I can laugh at a good joke. Lord knows we men provide plenty of material. We occasionally forget to put the toilet seat down. We sometimes act before thinking, speak before reflecting, and spend an astonishing amount of emotional energy yelling at grown men chasing a ball around a field. Some of us can watch a heartbreaking movie without shedding a tear, then practically require grief counseling when our football team loses in overtime. I get it. We are imperfect creatures. Sometimes spectacularly so.

But imperfection is not inferiority. Being the occasional object of good-natured humor is very different from becoming the perpetual object of contempt.

Consider what men have contributed to this country. The skyscrapers, steel mills, railroads, automobile factories, bridges, electrical grids, mines, and highways that helped build modern America. Generations of men labored in dangerous conditions, suffered injuries, lost their lives, and worked themselves into exhaustion to provide for families and communities. Women contributed enormously to these achievements, too, frequently without receiving the recognition they deserved. That history must be told fully. But acknowledging women's contributions does not require erasing men's. There is room in the history books for both.

There is something deeply unsettling about asking people to apologize for qualities that, when properly directed, can make them valuable: courage, protectiveness, competitiveness, endurance, strength, initiative, and the willingness to shoulder enormous responsibility. Those qualities can become destructive when corrupted by arrogance, aggression, or selfishness. But the answer to destructive masculinity is not the destruction of masculinity. It is the cultivation of honorable masculinity.

Men need accountability. Absolutely. Some of us need a swift metaphorical kick in the backside. Some need to listen more, speak less, become more emotionally available, and learn that admitting pain is not surrendering our manhood. But correction and contempt are two entirely different things.

John Gottman's research on intimate relationships identifies contempt as a particularly destructive conflict pattern: ridicule and moral superiority poison the relationship in ways that a specific, respectful complaint need not (Wilde, 2026). Contempt does not merely say, "You did something wrong." It says, "You are beneath me." As a psychologist, I have watched shame become one of contempt's most effective delivery systems. Correct someone while preserving dignity, and you create room for growth. Humiliate someone, and you may produce defensiveness, withdrawal, resentment, or a desperate need to prove worth. Men do not become better husbands, fathers, brothers, or citizens simply because we make them ashamed of being men.

And What in God's Name Are We Teaching Our Boys and Girls?

That brings me to what may be my greatest concern, especially as a psychologist who has spent decades working with children, adolescents, and families. What are we teaching our boys—and, for that matter, our girls—about the worth of being male or female?

I am alarmed by messages that encourage boys to regard their masculinity as inherently suspect and, particularly for white boys, to regard their sex and race as an inherited moral liability. If an adult tells a young boy that he begins life owing an apology for who he is, I have a question: What conceivable developmental good are we expecting from that? A child has enough to figure out without being handed somebody else's ancestral guilt at recess.

I refuse to accept inherited shame as a healthy developmental objective.

Historical injustice deserves honest teaching. Racism deserves condemnation. Sexism deserves condemnation. Children should learn the truth about discrimination, exploitation, and the ways societies have mistreated people. But a child should not be made personally guilty for injustices he did not commit; neither should any child be excused from moral responsibility by virtue of belonging to a historically disadvantaged group. We can teach history without assigning hereditary guilt. We can demand justice without manufacturing shame.

Adolescence is a period of identity formation, social comparison, increasing independence, and heightened sensitivity to peers. Kingsman (2023), examining boys' experiences of a school-based rite-of-passage program, explored how social environments influence masculine identity. The OECD (2026) likewise reviewed the role that gender expectations play in adolescents' behavior and well-being. This is precisely why I care about what adults communicate to children: their identities are taking shape, and adult contempt is not a harmless educational tool.

And then ideology walks through the schoolhouse door wearing a lab coat and demanding to be called science. I see echoes of neo-Marxist conflict thinking in narratives that sort children into oppressors and oppressed before they have learned to understand themselves as individuals. That is my critique of those narratives, not a laboratory finding. You can teach injustice without training a child to see every relationship as a power struggle. You can teach history without putting a

moral ankle bracelet on an eight-year-old. The child is a person, not a mascot for somebody's political theory.

Children are not miniature political manifestos. They are children. For heaven's sake, let them become people before we ask them to carry the weight of every adult argument in America.

Let boys enjoy being boys. Let girls enjoy being girls. Let them run, build, nurture, compete, create, climb, argue, make mistakes, and discover their own strengths. A spirited boy is not a disorder. A strong-willed girl is not an ideological problem. They are human beings, wonderfully varied within each sex. The OECD (2026) documents how gender expectations shape adolescent experiences; that is all the more reason to defend children's dignity rather than handing them a script about what they must feel ashamed of.

That leads to another difficult contemporary question: how children understand biological sex, gender, and their developing sense of self. My Christian convictions begin with Genesis 1:27, which describes humanity as created in God's image, male and female. I regard both as blessings, neither as an embarrassment or a condition requiring apology. I want children to grow up able to appreciate their bodies and development without being taught that an ordinary variation in interests or temperament makes their sex somehow wrong. A boy who loves music or dance is not less of a boy; a girl who loves motorcycles or engineering is not less of a girl.

When a child experiences genuine distress about sex or gender, my response as a clinician is not ridicule, rejection, or an ideological sales pitch. It is to listen carefully, consider the whole child and family, and take development seriously. Heathcote et al. (2024) found that the available evidence on psychosocial interventions was limited and generally low quality. That is a challenge to clinical certainty, not a reason to surrender clinical judgment. We owe children attention, not slogans.

I want parents, educators, and clinicians to teach children that their worth cannot be reduced to a political category, a stereotype, or another person's grievance. Boys and girls need adults who can teach responsibility without shame, offer guidance without coercion, and communicate dignity without making someone else the villain.

Let Boys Be Boys. Let Girls Be Girls. And Let Them Grow Up.

Here is where I want to be unmistakably clear. I am not demanding that boys march in formation toward football practice or that girls arrive from the maternity ward clutching a doll. I am saying that being male or female is not a defect requiring correction, and that a child's interests do not need to become a referendum on the child's sex. I cannot believe I have to write this sentence, but apparently the cultural committee has misplaced the obvious.

I want boys to be comfortable in their bodies and unashamed of becoming men. I want girls to be comfortable in theirs and unashamed of becoming women. I want us to stop treating healthy masculine qualities as embarrassing artifacts from an unenlightened century. Strength, courage, initiative, competitive energy, protectiveness, and the willingness to shoulder responsibility deserve formation, not blanket condemnation. These qualities are not the exclusive property of men, of course. But neither should a boy be taught that he must distance himself from them to earn approval.

And let us not confuse biological sex with a personality questionnaire. A boy who prefers dolls to football has not necessarily made an announcement about his gender identity. A girl who would rather dismantle the lawnmower than hold a tea party has not declared war on femininity. She may simply want to know how the damn thing works. Give her the wrench. I want children free to develop without either the old-fashioned pressure to conform to stereotypes or the newer temptation to interpret every departure from a stereotype as evidence of a different identity.

Here is the research I believe deserves much more attention. Singh et al. (2021) followed 139 boys referred for childhood gender-identity concerns and classified 122—87.8%—as desisters at follow-up. The original referral group included boys who did not meet full diagnostic criteria, an important detail when interpreting the result. But do not miss the finding while arguing over the footnotes: for most boys in this historical cohort, childhood gender-identity concerns did not persist into the follow-up years. That should get the attention of every adult tempted to treat early uncertainty as a settled destination.

Steensma et al. (2013) likewise documented substantial desistance in a follow-up of 127 children referred for gender dysphoria, while finding that more intense childhood dysphoria was associated with persistence. Children do not all follow one developmental trajectory. That is precisely my point. Childhood is a process, not a verdict. Why should adult certainty outrun the child's own maturation?

These were observational follow-up studies, not randomized trials comparing therapeutic approaches; they cannot, by themselves, establish that waiting caused desistance. But they absolutely establish a serious reason to protect developmental time. Hall et al. (2024) found that research on social transition in childhood and adolescence was too limited to yield confident conclusions about benefits or harms, while Heathcote et al. (2024) found similar limitations in the evidence on psychosocial interventions. My clinical conclusion is forceful: when the evidence is uncertain and the child is still developing, comprehensive assessment and patience must not be treated as cowardice. They are part of responsible care.

I made this argument at greater length in my book, Transgender Confusion Amidst the Search for Identity (Hansen, 2024). I have spent decades sitting across from young people who are desperately trying to make sense of themselves. I have no interest in turning their anguish into an ideological trophy. A child asking a difficult question deserves a clinician who listens long enough to understand the question—not

someone racing to hand over an answer because the answer is fashionable.

What troubles me is the adult impulse to arrive with a permanent conclusion before childhood has had a chance to unfold. A boy who loves dance is still entitled to be a boy. A girl who repairs motorcycles is still entitled to be a girl. A child with persistent gender distress is entitled to careful, humane, individualized care. None of these children needs somebody waving a political banner over the examination table. Development is not a fire alarm. And childhood is not a deadline.

Here is my plea: stop making children apologize for being male or female. Stop treating ordinary differences in interests as a diagnosis. Stop assigning inherited guilt. Stop substituting ideology for the patient, sometimes messy business of growing up. Let boys be boys. Let girls be girls. And let every child be an individual, deserving of respect and capable of becoming more than any adult's label.

Bringing the Pendulum Home

The biblical vision that moves me is not male above female or female above male. It is the shared dignity of human beings made in God's image (Genesis 1:27). Paul urges Timothy to treat older men as fathers, younger men as brothers, older women as mothers, and younger women as sisters, with purity (1 Timothy 5:1–2). Peter calls husbands to honor their wives as fellow heirs of grace (1 Peter 3:7). Honor is not rationed by sex. Human dignity is not a competition.

Men, I am speaking to you. Treat the women in your lives with honor. Cherish them. Listen to them. Stand beside them when courage is required, and celebrate their accomplishments without believing that their success diminishes yours. Strength does not require domination, and tenderness does not require weakness.

But women, I am speaking to you as well. Extend us the same grace. Respect the men who are trying, the men who shoulder responsibilities

and carry burdens they sometimes struggle to put into words. Correct us when correction is warranted; challenge us when we have lost our way. But please do not confuse belittlement with empowerment or contempt with strength.

Many men would willingly risk their lives for the women and children they love. They would run into burning buildings, stand between danger and their families, and surrender comforts to provide for someone else. Those sacrifices deserve recognition, just as women's innumerable sacrifices deserve recognition. A man should not have to surrender his dignity to demonstrate devotion. Neither should a woman.

For generations, women had legitimate reasons to demand that the cultural pendulum move toward fairness, opportunity, and recognition. Sometimes correcting an injustice requires a powerful push. But a pendulum that swings from one injustice to another has not discovered justice. It has merely changed direction.

I am not interested in winning a gender war. I am interested in ending one. But I am even less interested in watching our sons and daughters inherit it, beautifully packaged with a school-approved vocabulary list and a certificate of participation.

I want boys who can grow into honorable men without apologizing for being male. I want girls who can grow into strong women without believing that men are their natural adversaries. I want children to understand that their race, sex, and family history do not predetermine their moral character. Their conduct matters. Their choices matter. Their responsibility to others matters. I want fathers honored rather than caricatured, mothers cherished rather than taken for granted, and marriages built on friendship instead of competition.

Teach children to respect their dignity without stealing someone else's. Teach differences without manufacturing enemies. Teach history without inherited guilt. Teach confidence without arrogance and humility without humiliation. If we must pass something on, let it be

courage, compassion, accountability, forgiveness, and the capacity to love people who are not exactly like us.

So, my male brethren, stand tall. Not above women. Not against women. Beside them. Be the kind of men who deserve respect. Keep your word, protect the vulnerable, love your wives, be present for your children, and admit when you are wrong. Learn to apologize without behaving as though somebody has demanded you surrender your testicles at the courthouse. And, yes, put the toilet seat down once in a while. I have examined the engineering. It is a remarkably simple mechanism.

To the women in our lives: we love you, admire you, and need you. We know your achievements have never required our humiliation, and ours have never required yours. Correct us when we deserve it. We will try to do the same with grace. But let us stop mistaking ridicule for progress and contempt for empowerment. Maybe the real revolution is not about which sex finally wins. Maybe it is about remembering that we were never supposed to be enemies in the first place.

And now I have a second confession. The longer I write this essay, the more I adore my outrageous little word. PASOGNY! I can hardly say it without smiling. It sounds simultaneously like a medical diagnosis, a Supreme Court case, and something you ought to have removed before it spreads. I can already picture the letter from a furious professor: "Dear Dr. Hansen, your word lacks proper authorization." Excellent. Put me on the dictionary committee. I will bring the coffee, although at seventy-two I recommend decaf. The last thing this debate needs is a caffeinated psychologist with a new noun.

Yet I want to end where I began: with love, not contempt. I want strong women and honorable men. I want boys who look forward to manhood and girls who can embrace womanhood, without either being taught to despise the other. I want parents who can correct without crushing, teachers who can inform without indoctrinating, and clinicians who remember that children need care more than crusades. I want our sons and daughters to inherit courage instead of shame, gratitude instead of

grievance, and the conviction that another person's dignity never subtracts from their own. And so, yes, I hope PASOGNY becomes a wildly popular word. I want dictionaries fighting over it. I want footnotes, pronunciation guides, perhaps even a modest commemorative plaque. But I pray the condition itself becomes increasingly rare. Let the word flourish and the contempt die. That would be the kind of revolution worth having—and the kind of inheritance worth leaving. It is time to bring the pendulum home.

References

Hall, R., Taylor, J., Hewitt, C. E., Heathcote, C., Jarvis, S. W., Langton, T., & Fraser, L. (2024). Impact of social transition in relation to gender for children and adolescents: A systematic review. Archives of Disease in Childhood, 109(Suppl. 2), s12–s18. https://doi.org/10.1136/archdischild-2023-326112

Hansen, J. E. (2024). Transgender confusion amidst the search for identity. [Publisher information to be confirmed for final bibliography.]

Heathcote, C., Taylor, J., Hall, R., Jarvis, S. W., Langton, T., Hewitt, C. E., & Fraser, L. (2024). Psychosocial support interventions for children and adolescents experiencing gender dysphoria or incongruence: A systematic review. Archives of Disease in Childhood, 109(Suppl. 2), s19–s32. https://doi.org/10.1136/archdischild-2023-326347

Kingsman, J. (2023). Negotiating masculine identities: Adolescent boys' experiences of a school-based rites of passage program and its potential for gender transformation. International Journal of Educational Research, 122, Article 102257. https://doi.org/10.1016/j.ijer.2023.102257

National Film and Sound Archive of Australia. (n.d.). I am woman (1972). https://aso.gov.au/titles/music/i-am-woman/

Organisation for Economic Co-operation and Development. (2026). Enhancing adolescent social and emotional well-being (OECD Papers on Well-being and Inequalities, No. 40). OECD Publishing. https://doi.org/10.1787/00ebd3dd-en

Singh, D., Bradley, S. J., & Zucker, K. J. (2021). A follow-up study of boys with gender identity disorder. Frontiers in Psychiatry, 12, Article 632784. https://doi.org/10.3389/fpsyt.2021.632784

Steensma, T. D., McGuire, J. K., Kreukels, B. P. C., Beekman, A. J., & Cohen-Kettenis, P. T. (2013). Factors associated with desistence and persistence of childhood gender dysphoria: A quantitative follow-up study. Journal of the American Academy of Child & Adolescent Psychiatry, 52(6), 582–590. https://doi.org/10.1016/j.jaac.2013.03.016

Wilde, E. (2026). The four horsemen: Criticism, contempt, defensiveness, and stonewalling. The Gottman Institute. https://www.gottman.com/blog/the-four-horsemen-recognizing-criticism-contempt-defensiveness-and-stonewalling-/efefeeferences



The Growing Epidemic

The growing epidemic of adolescent depression has been met with a disturbing trend: hasty diagnoses followed almost immediately by prescriptions for antidepressant medications. In doctor's offices and therapy clinics, teenagers barely finish recounting their woes before leaving with a pill bottle in hand.

The rate of antidepressant dispensing to young people has skyrocketed, especially in recent years. For instance, one study found that the monthly rate of antidepressants dispensed to youth increased about 64% faster during the COVID-19 pandemic than before, with a staggering 130% faster rise among girls aged 12–17 (Archie, 2024). Such statistics underscore an alarming reality: we are increasingly medicalizing normal teen sadness and reaching for medications as a first resort. This quick-fix, pill-first mentality ignores the complex roots of adolescent distress and poses serious risks to the very youth we aim to help.

Victimhood Culture: When Mental Illness Becomes a Status Symbol The Growing Epidemic

In tandem with clinical trends, there has been a seismic cultural shift in how we view mental health. Today's youth grow up in a society that, in many ways, embraces victimhood. Through a neo-Marxist lens, social status is often determined by power dynamics: individuals are seen as either oppressors or oppressed. In this framework, being part of an "oppressed" group can confer a certain moral high ground.

Mental illness labels have become status symbols in this cultural context, elevating those who suffer into a protected class of sorts. A teenager who is diagnosed with depression may receive sympathy, validation, and a sense of identity as someone who has been oppressed by illness or circumstance. This can create a perverse incentive to adopt pathology as persona, to wear one's diagnosis like a badge of honor. Instead of fighting against depression, some teens might consciously or unconsciously embrace it as part of their identity, reinforced by social media echo chambers that valorize struggle. The cultural script whispers that being broken or ill grants you significance.

This valorization of victimhood does a grave disservice to adolescents: it normalizes and even encourages the proliferation of mental health diagnoses, making it less likely that young people will question a label or seek to overcome it. In such an environment, a swift diagnosis and pill prescription not only provide a biochemical crutch but also social validation. The result is a dangerous positive feedback loop: the faster we diagnose and medicate, the more we reinforce the notion that to struggle is to belong.

The Storm and Stress of Adolescence: Natural Turbulence vs. Pathology

Every adult can remember the rollercoaster of emotions that define the teenage years. Adolescence is a time of existential and emotional turbulence, a period marked by intense heartbreak, profound angst, identity confusion, surging hormones, and a search for meaning. Feeling lost, alone, or inconsolably sad at times is completely natural for teenagers. First loves end in tears; friendships fracture; the pressure to define one's future looms large. These experiences, as painful as they can be, are developmentally normal and even necessary. They teach resilience, empathy, and coping. However, in today's diagnostic culture, the ordinary suffering of adolescence is increasingly pathologized. Instead of being reassured that "this too shall pass," teens are often told they have a brain disorder or a "chemical imbalance" when they feel down.

The line between normal angst and clinical depression has blurred. Certainly, some adolescents do suffer from severe, clinical depression that warrants treatment. But the pendulum has swung so far that we risk labeling every case of teenage heartbreak or academic stress as a mental disorder requiring medication. By medicalizing normal emotions, we send a dangerous message to young people that they are not equipped to handle life's ups and downs without pharmacological aid. We short-circuit the natural process of learning to overcome challenges. A teenager who believes their sadness is a symptom of a chronic mental illness may start to ruminate on their victimhood and feel even more helpless, a self-fulfilling prophecy that deepens despair. It is essential to recognize that adolescence has always been a time of storm and stress; our task is to guide youth through the storm, not to numb them to it.

Many teens today are quickly classified as "depressed" when in fact they are experiencing the natural growing pains of youth. By treating these pains as pathologies, we risk robbing young people of the chance to grow. Every moment of sorrow in adolescence is also an opportunity: to develop grit, to discover inner strengths, and to gain wisdom. If we rush to slap a diagnostic label on a 15-year-old who is grieving a breakup or anxious about school, and then offer nothing but a prescription, we trivialize their experience. We imply that their sadness is something abnormal, a defect to be fixed chemically, rather than a valid emotional response to life's challenges.

This is not to romanticize suffering, but to contextualize it. Pain can be a teacher. A teen who works through heartbreak with supportive counseling, journaling, exercise, and time will likely emerge stronger and more emotionally skilled than one whose heartbreak is immediately numbed by Zoloft. The former learns that they can endure hardship and heal; the latter learns only that a pill can take emotional pain away, for now.

Consequences of Overprescribing Antidepressants to Youth

When we indiscriminately put adolescents on antidepressants as a knee-jerk reaction, the consequences can be dire. These medications are not benign "happy pills"; they come with significant side effects and long-term implications, especially for developing young brains and bodies. Some of the most concerning effects of overprescription include:

Emotional Blunting and Numbness: Antidepressants, particularly SSRIs, often dull the intensity of emotions. While this blunting might mute the depths of despair, it also flattens the peaks of joy. Teens on SSRIs frequently report feeling like a zombie or a hollow shell, unable to cry, but also unable to truly laugh or feel excited.

Research indicates that about half of SSRI users experience a "psychic flatness", a loss of the ability to experience positive feelings like pleasure and joy (Psychiatrist.com, 2023). In an attempt to shield young patients from pain, we may also be depriving them of vital human experiences, the full range of emotion needed for learning, relating, and developing an authentic sense of self.

Impaired Development of Coping Skills: Adolescence is the training ground for adulthood. It's when individuals typically learn how to cope with sadness, frustration, loneliness, and anger. If a pill numbs these emotions every time they arise, the teenager never learns to cope because they rarely face the full intensity of the feeling. Coping mechanisms, such as talking through problems, seeking support, engaging in hobbies, spiritual practice, or simply enduring a bad mood, require experiencing discomfort. By medicating away discomfort at the slightest sign of distress, we short-circuit the learning of resilience. Years later, in adulthood, these individuals can become ill-equipped to handle even mild stresses, having been deprived of the chance to build emotional muscles in their teen years. Moreover, some may come to believe that only a drug can make them feel "okay", leading to a profound sense of dependency and lack of self-efficacy.

Dependency and Identity Tied to Medication: Once an adolescent starts taking antidepressants, stopping can be challenging. They may become psychologically dependent on the medication, believing it's the only thing keeping them functional. Biological dependence can occur as well; the body and brain adapt to the drug. When trying to come off SSRIs, patients often face withdrawal effects (euphemistically termed "discontinuation

symptoms") such as dizziness, insomnia, irritability, or a return of depression worse than before.

This can scare a young person into staying on the drug indefinitely. Over time, a teenager can internalize the belief that "I need this pill to be normal." The medication becomes a crutch, and their very identity might wrap around being someone with depression who needs antidepressants. This entrenched dependency undermines the fundamental goal of therapy, to empower the individual to heal and function autonomously. It's a cruel irony that a tool meant to free someone from depression can, if overused, enslave them to a lifetime of medication.

Post-SSRI Sexual Dysfunction (PSSD): Perhaps the most under-acknowledged and devastating consequence of adolescent antidepressant use is the risk of Post-SSRI Sexual Dysfunction. PSSD is a condition in which a patient's sexual functioning does not return to normal after stopping the antidepressant, potentially persisting for years or even permanently. It includes symptoms like genital numbness, loss of libido, erectile dysfunction in males, vaginal dryness in females, anorgasmia (inability to orgasm), and even blunted romantic feelings. Imagine a teenager put on an SSRI at 16 for mood issues: by the time they are 18 or 20, they might discover that they cannot feel sexual pleasure or desire, even though they've long since quit the drug. For a young person just coming into their own sexuality and yearning for intimacy and connection, this outcome is nothing short of catastrophic.

The medical community has been slow to recognize PSSD, but it is very real, European regulators have acknowledged it, and patient

advocacy groups are raising alarms. As one researcher bluntly stated, Post-SSRI Sexual Dysfunction and related disorders may represent "iatrogenic epigenetic damage previously unseen in human history," with individual consequences that are truly "catastrophic" (PSSD Network, 2025). In other words, we may be witnessing medication-induced damage that fundamentally alters biology in ways we never anticipated. To inflict such a fate on adolescents, often without their informed consent or full understanding, is a grave ethical failing. PSSD doesn't just steal pleasure; it can steal future relationships, self-esteem, and the basic human experience of sexuality.

No teenager, indeed, no person at all, should have to pay such a price for having sought help for depression. The above consequences highlight a painful truth: overprescribing antidepressants can inadvertently harm young people in the very ways we're trying to help them. Emotional blunting robs them of feeling truly alive; dependency keeps them from becoming strong on their own; and PSSD can cast a long shadow over their adulthood.

These effects are not rare one-in-a-million anomalies, emotional blunting is common, and while PSSD is considered rare, "rare" side effects can still impact thousands when millions of teens are on these drugs. The tragedy is compounded when we consider that many of these teens might have overcome their struggles without medication, through time and proper support, if only given the chance.

Overdiagnosis, Informed Consent, and Ignored Root Causes

Why has this overprescription phenomenon taken root? Part of the problem lies in overdiagnosis, the threshold for labeling a teen with "major depressive disorder" has lowered to the point that normal sadness can qualify. Diagnostic criteria in psychiatry are subjective, and there's growing concern that we're turning typical behavior into illness. Well-meaning school counselors, pediatricians, and psychiatrists may be quick to apply a diagnostic label after a brief questionnaire or a 15-minute consult.

Once the label is in place, the prescription pad often comes out. This rush to diagnose is fueled by several factors: pressure from overwhelmed parents desperate for a solution, practitioners constrained by brief appointment times (it's faster to write a prescription than to dig deep into psychosocial issues), and, unavoidably, the influence of pharmaceutical marketing that has for years promoted the narrative of "a pill for every ill." The result is diagnosis inflation; more and more teens being told they have a mental disorder.

Compounding this issue is a disturbing lack of informed consent in the treatment of young patients. In many cases, adolescents (and their parents) are not fully informed about what an antidepressant prescription entails. Crucial information is often glossed over: the potential side effects (weight gain, sleep problems, emotional numbing, sexual side effects), the typical duration of treatment (often many months or years, not just "try this for a week or two"), the possible difficulties in discontinuing the drug, and the fact that antidepressants are not guaranteed to be effective for mild or moderate depression. A teenager might think, "I feel really sad, and the doctor gave me this pill, so it must be what I need", without understanding the trade-offs

involved. Truly informed consent would mean the teen and their guardians are educated on all risks (like PSSD and dependency) and all alternatives (such as therapy, lifestyle changes, or simply monitoring symptoms for a while). Unfortunately, such comprehensive discussions are the exception, not the rule.

The power dynamic between doctor and young patient can also impede informed consent, teens might not even know what questions to ask, and they often trust that whatever the doctor is recommending is safe. Thus, many adolescents start SSRIs without a clear sense of what they're getting into. Equally concerning is the widespread failure to explore root causes of a teenager's depressive symptoms before resorting to medication. Depression is not a one-size-fits-all phenomenon with a single etiology. A teen's low mood might be stemming from bullying at school, an identity crisis, family dysfunction, academic pressure, past trauma, social media influences, poor diet, lack of sleep, or a combination of many factors. If we do not take the time to peel back these layers, we end up treating a symptom (sadness) rather than the cause. It's akin to turning off a fire alarm without bothering to check for a fire. Sadly, the current system frequently opts for the quick silencing of the alarm.

A teenager comes in with tearfulness and withdrawal, and rather than asking "What's been happening in your life?" the system is primed to ask, "Which medication should we try?" The underlying issues, perhaps a recent breakup, or feelings of inadequacy fueled by Instagram, or confusion about sexual orientation, or grief from a grandparent's death, may remain unaddressed. The young person is sent home with their emotional pain chemically blunted but no solutions for the problems that caused that pain. This is a travesty of care. Imagine a 14-year-old girl who is depressed because she's being bullied relentlessly online. If

no one helps her address the bullying, an SSRI might numb her enough to function, but inside, the true wound festers. We owe our youth more than this surface-level treatment. We owe them true healing, which comes from understanding and resolving the roots of their suffering.

A Holistic Path Forward: Therapy, Not Just Pills

If immediate medication is not the answer for every adolescent who feels depressed, then what is? The alternative path forward is a holistic, person-centered approach that seeks to heal rather than just medicate. This approach recognizes that adolescents are resilient beings capable of growth and change, especially when given proper support and tools. Key components of a more balanced strategy include psychotherapy, skills-building, and integrative mind, body, and spirit techniques, many of which have proven efficacy in alleviating depression and anxiety. Before resorting to medication (or alongside a carefully monitored, minimal use of it), we should deploy approaches such as:

Cognitive Behavioral Therapy (CBT): CBT is a well-established talk therapy that helps individuals identify and challenge negative thought patterns. For a depressed teen, CBT can be incredibly helpful, teaching them to catch the exaggerated gloom-and-doom thoughts ("I'll never have friends", "I'm a total failure") and replace them with more balanced, realistic ones. Over time, CBT can reduce depressive symptoms and give adolescents a lasting skill: the ability to manage their own thoughts and emotions. Unlike a pill, which simply masks the feeling, CBT addresses the thinking traps that often underlie depression. Studies have shown CBT can be as effective as medication for mild to moderate depression, with the benefit that its effects last because it empowers the individual.

Dialectical Behavior Therapy (DBT): Originally developed for intense emotional disorders, DBT equips young people with practical tools for emotion regulation, distress tolerance, and interpersonal effectiveness. Adolescents prone to mood swings, self-harm urges, or suicidal thoughts can particularly benefit. DBT teaches skills like mindful breathing to survive a crisis moment, or how to communicate feelings without alienating others. By learning DBT's core skills (Mindfulness, Distress Tolerance, Emotion Regulation, and Interpersonal Effectiveness), teens gain a sense of mastery over their internal storms. This therapy literally builds the neural and behavioral pathways for coping, something no medication can do for them.

Internal Family Systems (IFS) Therapy: Part of a broader integrative model (such as my NeuroFaith framework), IFS helps individuals work with their inner emotional parts. An adolescent might say, "Part of me is so angry, part of me is just sad and wants to hide." IFS externalizes these feelings into "parts" (like an inner angry part, a wounded child part, a perfectionist part, etc.) and helps the person develop a compassionate relationship with each part. This can be profoundly healing for teens dealing with internal conflicts or trauma. Instead of viewing themselves as "broken," they learn that all their feelings have a place and purpose. IFS is a powerful tool for self-discovery and healing that treats the psyche as a family of sub-personalities, all deserving understanding. It can unburden traumas and negative beliefs that fuel depression, leading to deep and lasting emotional change.

HeartMath® and Biofeedback: HeartMath® techniques use biofeedback technology and breathing exercises to help individuals synchronize their heart rate variability and achieve a state of calm

and focused coherence. For anxious or depressed teens, seeing a real-time display of their physiology and learning that they can influence it (through breathing, positive imagery, or recalling feelings of gratitude) is incredibly empowering. It turns abstract advice ("just relax") into a concrete skill ("here's how to calm your heartbeat and feel centered"). Regular practice can improve stress resilience, sleep, and mood. It's a holistic method that directly targets the stress response, teaching youths that they have the ability to self-regulate their nervous system.

Polyvagal-Informed Therapy: Stemming from Dr. Stephen Porges' Polyvagal Theory, this approach educates individuals about their autonomic nervous system, how our bodies toggle between states of safety (social engagement), danger (fight/flight), and life-threat (shutdown). Therapists trained in this approach help teens understand bodily reactions to stress (like why their heart races and they feel like running away during a panic attack, or why they feel numb and detached when overwhelmed). Through exercises like deep breathing, humming, cold water face dips, or therapeutic movement, adolescents learn to engage the vagus nerve and shift into a calmer state. They also learn how cues from the environment or relationships affect them, and how to create conditions of safety for themselves. By learning to navigate their own biology, teens can reduce anxiety and lift mood in ways that are natural and self-directed. And finally, the teen is helped to re-narrate the negative story into a more realistic and positive one.

Spiritual Integration and Faith-Based Coping: For many, spirituality is a wellspring of resilience. Integrating a teen's spiritual or religious beliefs into therapy can provide a profound sense of meaning and hope. Whether through prayer, meditation,

community service, or reflection on one's purpose, spiritual practices can anchor a young person amidst chaos. The user's NeuroFaith model, for example, explicitly combines neuroscience with faith traditions, recognizing that humans are not just biological machines but also seekers of meaning. A depressed adolescent can often benefit from exploring questions like, "Why am I here?", "What can suffering teach me?", or "Is there a bigger plan for me?" in a supportive setting. Such exploration can transform pain into growth. Even for those not inclined to formal religion, a sense of connection to something larger, nature, humanity, the universe, can instill hope. The goal is to tap into sources of strength beyond the ego: compassion, forgiveness, gratitude, and purpose.

These are age-old antidepressants with no side effects. Most important, this along with Polyvagal-informed Therapy, helps the teen to address core negative beliefs about self (e.g., "I am not worthy, I am not valuable, I am not lovable") that are always produced by trauma and, unless addressed, forever taint and even destroy the teen's sense of self. A hopeful depiction of healing and personal growth, symbolizing the holistic therapies that empower adolescents. Importantly, these holistic approaches are not mutually exclusive with medical intervention. There may be cases of adolescent depression so severe that medication is warranted. But even in those cases, therapy and holistic care should ride alongside the medication, addressing dimensions of the person that pills cannot touch. By prioritizing therapies like CBT and DBT, and integrative methods like IFS, HeartMath, and polyvagal exercises, we equip young people with life-long skills and insights.

We treat the whole person, mind, body, and spirit, rather than just numbing the symptoms. This comprehensive care model honors the fact that depression in a teen is often a cry for help, not merely from their brain chemistry, but from their whole being and their environment. We need to answer that cry with human connection, understanding, and empowerment, not just a prescription.

Conclusion: Reclaiming Youth Mental Health: A Call for Urgent Reform

It is time for an urgent course-correction in how we address adolescent depression. The current paradigm of "diagnose fast and medicate faster" is failing our youth. We are witnessing an unintended experiment play out on a generation, and the results are harrowing: too many teens dependent on antidepressants, numb to life, and bereft of coping skills, some even with permanent sexual dysfunctions before they're out of college. This is not youth mental health care; it is a betrayal of youth.

We must reclaim the treatment of adolescent depression from the quicksand of overdiagnosis and overprescription. Reform starts with a cultural shift in expectations. We, as a society, must stop glorifying victimhood and instead celebrate resilience and recovery. Being a survivor or fighter should carry more cachet than being a victim. Adolescents should be taught that suffering is not a permanent identity, not a badge to showcase, but a challenge to overcome. In clinical practice, reforms should mandate comprehensive informed consent for any psychiatric medication given to minors, including a frank discussion of side effects like emotional blunting and PSSD.

Doctors should be encouraged (or required) to exhaust psychotherapy options and investigate environmental factors before reaching for the

prescription pad in cases of mild-to-moderate depression. Schools and communities, too, have a role: promoting counseling resources, peer support groups, mentorship programs, and psychoeducation about emotions and coping from early ages.

Policymakers and professional boards can help by updating guidelines to curb reckless prescribing. For example, requiring a minimum number of therapy sessions or a psychological evaluation prior to medication for adolescent depression could slow the assembly line of SSRI scripts. Insurance companies must also come on board, recognizing that paying for therapy and holistic treatments now will save costs on medications and hospitalizations later. And importantly, pharmaceutical companies and the FDA should ensure that warnings about risks like PSSD are prominently disclosed whenever SSRIs are prescribed to young people. Ultimately, what we seek is a world where every teenager's cry for help is met with compassion and wisdom, not just a chemical solution.

We owe it to our children to give them the safest and most genuine healing possible. The angst of adolescence is not a disease to be eradicated, but a journey to be guided. By reforming our approaches now, by privileging therapy, informed consent, and holistic care, we can prevent countless cases of blunted lives, thwarted potential, and prolonged suffering. We can instead cultivate a generation of young adults who emerged from their dark times not dependent on a drug, but equipped with self-knowledge, resilience, and hope. The time for this change is now. The hearts and futures of our youth depend on it.

References

Archie, A. (2024, February 27). The rate of antidepressants prescribed to young people surged during the pandemic. NPR. https://www.npr.org/2024/02/27/1234112068/antidepressants-youth-pandemic-study

PSSD Network. (2025). Post-SSRI Sexual Dysfunction (PSSD), What the Experts are Saying. https://www.PSSD Network

Psychiatrist.com Staff Writer. (2023, January 23). Why antidepressants cause emotional blunting, study uncovers. Psychiatrist.com. https://www.Psychiatrist.com/news/why-antidepressants-cause-emotionalblunting/



Enough to Be Dangerous

When I came out of graduate school, I knew enough to be dangerous. That may sound like an unsettling admission from someone about to help you choose a therapist for your teenager, but after more than forty years in clinical psychology, I would be considerably more concerned about a clinician who could not make that admission.

I had studied hard, completed supervised training, conducted research, and earned my doctorate. I had a foundation. What I did not yet possess was the understanding that comes from sitting with suffering people, discovering where your favorite theory falls short, and learning that human beings have an irritating habit of refusing to fit neatly into the boxes we construct for them.

Graduate school prepared me to begin. Most of my learning still lay ahead.

Unfortunately, some therapists seem to regard graduation as the intellectual finish line. They earn a degree, obtain a license, attend conferences, and collect certifications in cognitive behavioral therapy, dialectical behavior therapy, or whatever approach happens to be fashionable. Those accomplishments can be valuable. But professional development should deepen a clinician's curiosity, not replace it. Certificates can keep accumulating while the thinking grows stale.

Choosing a therapist matters enormously. A skilled clinician can help your teenager regain stability, repair relationships, confront painful experiences, and recover a sense of possibility. An ineffective or irresponsible therapist can miss serious risks, reinforce helplessness, encourage dependency, or steer a vulnerable adolescent toward conclusions that have more to do with the therapist's assumptions than the child's needs.

And sometimes the greatest failure is more subtle: helping a teenager manage symptoms while never addressing the painful beliefs about identity that keep generating them.

When serious depression, self-harm, or other dangerous conditions are involved, getting this right may even help protect your child's life.

Dr. Parkison's Warning

Years ago, one of my clinical supervisors, Dr. Steve Parkison, offered advice I have never forgotten.

He asked whether I knew how to distinguish a good psychologist from a poor one. His answer was to examine the journals and books in the psychologist's office. Come back several years later, he suggested, and see whether the collection has grown. If the same books are sitting there and nothing has changed, run.

He wasn't really talking about books. He was talking about intellectual growth. Today, an excellent clinician might carry an entire research library on a laptop rather than line the office walls with journals.

At this somewhat sappy old age, I have accumulated quite a library. That doesn't make me brilliant. It reflects an enduring appetite for learning and an increasingly uncomfortable awareness of how much I still don't know.

Research gives Dr. Parkison's warning additional teeth. Goldberg and colleagues (2016) examined whether psychotherapists became more effective with experience and found that accumulating years of practice did not reliably produce better outcomes.

There are excellent young clinicians whose training, supervision, and humility make them exceptionally capable. There are also seasoned clinicians who continue refining their craft, and others whose twenty years of experience look suspiciously like one year repeated twenty times.

Your teenager deserves someone whose education is still very much in progress.

A Degree Should Teach You to Question

I am proud of my PhD. It is a research degree, and my training required me to design studies, evaluate evidence, and complete a master's thesis and doctoral dissertation. Those experiences taught me to ask questions that responsible clinicians should never stop asking.

Who participated in this study? What was actually measured? How substantial was the benefit? What happened to the people who dropped out? Does the conclusion outrun the data?

An impressive claim repeated often enough can acquire the appearance of scientific certainty, even when the research supporting it is considerably less impressive.

I once had a psychiatrist suggest that I could not comment on medication research because I was not a physician. With respect, prescribing medication and critically evaluating research are different responsibilities. I do not need to pretend to be a physician to examine experimental design or question whether conclusions follow from the findings. I do need to recognize the limits of my expertise, and physicians deserve that same respect.

No profession owns the right to ask whether treatment works. And no professional title should function as a shield against reasonable scrutiny.

A doctorate does not automatically make someone an excellent therapist, just as a master's degree does not automatically make someone a lesser one. Appropriate credentials, an active license, relevant experience, and sound supervision all matter. So does the ability to say, "That is outside my expertise," or "I need to consult someone who knows more about this."

Your child needs clinical judgment; not professional arrogance dressed in a white coat.

Therapy Can Help, and Therapy Can Harm

There are exceptional therapists whose work helps change, and sometimes helps save, lives. I use *helps* deliberately because healing involves a partnership supported by the young person's efforts, relationships, appropriate treatment, and community.

Nevertheless, psychotherapy does not become harmless simply because its intentions are compassionate.

A clinician can overlook a medical condition, misunderstand symptoms, mishandle risk, reinforce helplessness, or continue an approach that produces little benefit. A teenager can feel thoroughly listened to while becoming increasingly convinced that they are fragile, permanently damaged, or incapable of managing life.



In *Bad Therapy: Why the Kids Aren't Growing Up*, Abigail Shrier (2024) challenges the assumption that increasing therapeutic attention necessarily produces healthier children. Her investigative critique raises uncomfortable questions about whether some approaches encourage young people to organize their identities around distress.

Her book does not settle every clinical question, but its central challenge deserves serious consideration: Are we helping children become more capable, or might some of our efforts inadvertently reinforce fragility?

Our profession should be able to entertain that possibility without circling the wagons.

Research provides a more nuanced picture. Cuijpers and colleagues (2023), in a systematic review and meta-analysis of psychotherapy for youth depression, found meaningful benefits, including a lower risk of deterioration compared with control conditions. Yet many young people did not achieve a treatment response.

The lesson is not to abandon psychotherapy. It is to practice it responsibly, evaluate outcomes, and remain willing to change course.

When a teenager deteriorates during treatment, the clinician should reassess rather than reflexively announce that things must get worse before they get better. Sometimes therapeutic work is uncomfortable. But worsening symptoms deserve clinical attention, not a professional shrug dressed up as "Trust the process."

Connection Matters, but Competence Matters Too

Adolescents often possess a remarkably sensitive detector for adults who are performing concern. They recognize condescension, rehearsed reassurance, and the moment their experience is being squeezed into a theory before they have finished describing it. Many arrive expecting another adult to explain what is wrong with them. A capable therapist offers something better: the experience of being understood without being indulged, challenged without being humiliated, and taken seriously without becoming a diagnosis with sneakers.

McLeod's (2011) meta-analysis found a modest association between the therapeutic alliance and outcomes in youth psychotherapy. That supports taking the therapeutic relationship seriously while recognizing that warmth and connection alone do not guarantee effective

treatment. A likable clinician may lack the expertise your teenager needs. Conversely, an impressive specialist may accomplish very little if your child never feels safe enough to speak honestly.

After an initial appointment, ask your teenager whether they felt listened to, whether the therapist seemed genuinely interested in understanding them, and whether they could imagine discussing something difficult with that person. I would also ask, "Do you think you could disagree with this therapist and still feel respected?" That answer may tell you more than whether your teenager simply liked the appointment.

Coping Better Is Not Always Healing: The Neuroscience of Identity

One psychologist whose teaching I deeply appreciate is Dr. Tori Olds. Her distinction between incremental and transformational change sharpened something I had observed throughout my clinical career.

Incremental change involves developing new skills, behaviors, and responses through practice and repetition. Transformational change reaches deeper, addressing the emotional expectations and core beliefs through which we understand ourselves and the world (Olds, n.d.).

Both matter. Both have a legitimate place in psychotherapy. And sometimes incremental change is exactly what a struggling teenager needs. But there is a difference between learning how to manage distress and changing the deeply held conviction that one is fundamentally defective, unlovable, or unsafe.

A little neuroscience helps explain why.

Our brains contain an interconnected system known as the **default mode network (DMN)**. This network includes the medial prefrontal cortex, posterior cingulate cortex and adjacent precuneus, inferior parietal regions, and portions of the medial temporal lobes, including the hippocampal formation. Together, these regions participate in self-referential thinking, autobiographical memory, imagining our future, and weaving our experiences into an ongoing sense of who we are (Buckner et al., 2008).

Think of the DMN as part of the brain's machinery for answering one of life's most important questions:

Who am I?

It helps connect our memories, experiences, and perceptions of ourselves into a continuing personal narrative. During adolescence, when identity is still taking shape, that narrative is enormously consequential.

Now consider what happens when a child grows up amid chronic criticism, emotional neglect, rejection, frightening conflict, or abuse. Or when an otherwise secure child experiences a terrifying accident, assault, sudden loss, or another overwhelming event. Developmental trauma and acute traumatic experiences can influence emotional learning, expectations of safety, and the way young people interpret themselves and their relationships. Research has also associated posttraumatic stress with alterations in large-scale brain networks, including the DMN, although those findings are variable and do not mean trauma creates one uniform pattern of brain dysfunction (Akiki et al., 2017).

The child may gradually construct a devastating personal narrative:

I'm not good enough.

I'm unlovable.

I'm unsafe.

Everything is my fault.

Something is fundamentally wrong with me.

These are not simply negative thoughts floating through consciousness. They can become deeply learned emotional expectations, reinforced by painful memories and repeated relational experiences. The DMN participates in the broader processes of self-reflection and autobiographical meaning, although these beliefs are not stored in one particular brain network.

And here is where the distinction between incremental and transformational therapy becomes so important.

Imagine a teenager who experiences every correction as proof of worthlessness. A skilled CBT therapist may help that adolescent identify distorted thinking, challenge catastrophic interpretations, and develop more adaptive responses. A DBT therapist may teach distress tolerance, emotional regulation, mindfulness, and interpersonal effectiveness.

Beautiful. These are valuable, evidence-based tools. Sometimes they are lifesaving.

But what happens if that teenager becomes better at managing the emotional reaction while continuing to believe, deep down, *If I make a mistake, I am unworthy of love*?

The outward behavior may improve. The emotional suffering may become more manageable. Yet the underlying identity narrative may remain painfully intact.

We have helped the teenager cope with the wound. Have we helped the wound heal?

Over more than forty years of clinical practice, I have encountered far too many patients who learned to manage symptoms without fundamentally changing how they experienced themselves. They developed coping skills, improved their behavior, and sometimes functioned considerably better. Those accomplishments mattered. But beneath the improvement, the old emotional convictions remained.

And I believe our outcome research should make us considerably more humble.

We measure symptom reduction at the conclusion of treatment, perhaps again six or twelve months later, and congratulate ourselves. But what happens five years later? Ten years later? Has the young person developed a more secure identity, a deeper sense of worth, and greater satisfaction with life? Or have we simply helped them become more skillful at managing an old wound?

Research demonstrates meaningful and sometimes enduring benefits from CBT, DBT, and other established psychotherapies. Yet relatively few studies follow young people far enough into adulthood to tell us how treatment influences their evolving identity, relationships, sense of purpose, and overall life satisfaction. Improvement on a symptom inventory is important. It is not the whole story.

This is where transformational work deserves serious consideration.

Memory reconsolidation offers one scientifically grounded framework for understanding how previously learned emotional expectations may be updated. Under certain conditions, reactivated memories can become susceptible to modification through new learning. Experimental research supports reconsolidation processes, although their precise role and reliability in clinical psychotherapy remain under investigation (Nader & Hardt, 2009; Lane et al., 2015).

The therapeutic goal is not to erase painful memories or pretend that trauma never occurred. It is to create opportunities for new emotional experiences that contradict old expectations and allow a healthier understanding of self to emerge. A teenager who once experienced *I am defective* may begin to experience something profoundly different:

What happened to me was painful, but it does not define my worth.

That is more than learning a new coping technique. It is a potential transformation in the meaning of the experience and the adolescent's developing identity.

I have enormous respect for clinicians who practice CBT and DBT skillfully. Both approaches can address more than surface symptoms, and neither should be caricatured as incapable of deeper change. But when any therapist treats a preferred protocol as the whole enchilada, as though everything important about human suffering can be resolved through a prescribed sequence of skills, worksheets, and measurable symptom reduction, we have a problem.

A treatment manual is a tool. It is not a complete theory of the human person.

Sometimes a teenager needs practical coping skills. Sometimes those skills create the stability necessary for deeper trauma work. Sometimes

meaningful changes in identity occur through cognitive, behavioral, relational, or experiential treatment itself. These pathways are not mutually exclusive.

But when developmental trauma, profound shame, or deeply negative core beliefs are central to a young person's suffering, I believe therapy must be willing to go beyond symptom management and address those underlying emotional meanings. That makes deeper healing an explicit treatment goal rather than an accidental bonus.

And then there is the insurance machinery.

Brief, standardized, measurable interventions fit neatly into systems built around diagnostic codes, treatment plans, authorized visits, and reimbursement schedules. Longer-term work addressing complex trauma and entrenched identity beliefs may be harder to predict, quantify, or accommodate.

That does not mean brief treatment is inherently inferior or that insurers universally reject deeper psychotherapy. It does mean financial and administrative pressures can favor what is easiest to document over what a particular child may actually need.

A teenager is not a billing code. Healing is not always linear, and the most important changes in a young person's life may not fit comfortably into a twelve-session treatment authorization.

We should demand evidence, accountability, and thoughtful use of resources. Absolutely. But those responsibilities should not become an excuse for reducing psychotherapy to whatever is quickest, cheapest, and easiest to reimburse.

What's your child's life worth?

And even transformational change is not the ultimate destination. The larger question is whether a young person can build a life filled with meaning, purpose, relationships, and genuine satisfaction.

Arthur C. Brooks, in his compelling book *The Meaning of Your Life: Finding Purpose in an Age of Emptiness* (2026), examines the struggle for meaning in contemporary life. He emphasizes three dimensions: coherence, purpose, and significance. In other words, understanding one's life, having something worth living for, and knowing that one's existence matters.

Consider how profoundly those questions intersect with the developing adolescent brain. A teenager struggling with the conviction *I am worthless* is not simply experiencing an unpleasant thought. That belief can color relationships, ambitions, decisions, and expectations about the future. It can make the world feel smaller and the possibility of a meaningful life increasingly remote. This is why I believe psychotherapy must aspire to more than symptom reduction. We want teenagers who can regulate their emotions and navigate life's challenges, certainly. But we also want young people who experience themselves as worthy of love, capable of contributing to others, and connected to something larger than their suffering.

For a traumatized adolescent, transforming a deeply negative identity may help open the door to precisely those possibilities. It does not guarantee happiness or eliminate life's inevitable pain. But it can create room for hope, belonging, and purpose where shame and fear once dominated.

The ultimate question is not simply whether your teenager feels less anxious or depressed. It is whether your teenager is developing a life worth living, a life of meaning, connection, and genuine satisfaction.

If we are not asking that question, I believe we are aiming too low.

Your Child Is Not a Recruitment Opportunity: Ideology, Clinical Judgment, and Informed Consent

Your teenager enters therapy at a vulnerable moment. The clinician's authority can profoundly influence how a young person understands suffering, identity, family, faith, and personal possibility. That influence carries an enormous responsibility. **Your child's pain must never become an opportunity to recruit another believer into the therapist's worldview.**

I have become increasingly concerned about ideological capture within my profession: allegiance to an approved explanation taking precedence over careful clinical investigation. The conclusion arrives before the assessment, questions become evidence of resistance, and disagreement becomes a moral defect. A clinician may speak eloquently about compassion while quietly narrowing the conclusions a young person is permitted to reach.

My concern comes partly from supervising doctoral students, including students from strongly progressive institutions such as Antioch University in Seattle. In my experience, social-justice framing sometimes became so dominant that students struggled to examine even unrelated academic questions without filtering them through that lens. Some also confided that they feared faculty disapproval or academic repercussions if their views were insufficiently progressive. Those reports do not establish that retaliation occurred or characterize every student or faculty member. But fear of respectful disagreement deserves attention in a profession that depends on intellectual openness.

Universities should cultivate independent judgment by encouraging students to test competing explanations and defend conclusions with evidence. They should not become **academic mortuaries where curiosity is embalmed and conformity receives the doctorate.** I worry about what happens when habits of intellectual conformity follow a clinician into the therapy room.

Professional organizations deserve the same scrutiny. Consider the controversy surrounding medical interventions for adolescents experiencing gender dysphoria, which I examine in *Transgender Confusion Amidst the Search for Identity* (Hansen, 2023). Subsequent systematic reviews identified important limitations in the evidence. The puberty-suppression review found insufficient high-quality evidence to establish effects on several psychological and developmental outcomes. The hormone review identified evidence suggesting psychological improvement during treatment, alongside methodological weaknesses and uncertainty about other outcomes (Taylor et al., 2024a, 2024b).

These findings require careful distinctions between interventions, outcomes, and confidence in the evidence. Yet organizations including the American Psychological Association, American Academy of Pediatrics, and Endocrine Society have defended positions supporting gender-affirming care. Their positions differ, and they have cited research. My criticism concerns the confidence conveyed when consequential questions remain unresolved. **Science is not a loyalty oath, and institutional consensus is not a substitute for evidence.**

The APA's own 2024 policy statement supports noncoercive care, client-led exploration, and recognition of scientific limitations (American Psychological Association, 2024). Those are laudable

commitments. My concern is the distance between those words and the professional climate I have encountered, where questioning prevailing positions can be treated as a failure of compassion. Social-justice commitments should themselves remain open to examination, especially when they influence clinical recommendations. They cannot be allowed to place favored explanations beyond scrutiny.

The test comes when someone disagrees. Can a teenager reconsider an explanation the clinician favors? Can parents raise legitimate concerns and receive a thoughtful hearing? Can a clinician question a recommendation without having their motives placed on trial? **If exploration is permitted only when it leads toward a predetermined destination, it is persuasion dressed in therapeutic clothing.**

That makes informed consent indispensable. Families deserve an understandable explanation of the proposed treatment, its rationale, supporting evidence, uncertainties, risks, alternatives, and how progress will be evaluated. With adolescents, clinicians must also explain applicable consent requirements, developmentally appropriate assent, confidentiality limits, and the respective roles of parents and teenagers. The APA's ethics code addresses these responsibilities, along with professional competence (American Psychological Association, 2017). Institutional endorsement does not cancel them. A signature cannot substitute for a candid conversation.

These concerns also informed my participation with colleagues in the medical-professionals amicus brief filed in *Chiles v. Salazar*, No. 24-539 (Medical Professionals, 2025). The brief argued for clinicians' ability to discuss concerns about medical interventions with minors and their parents. It is a legal argument rather than scientific proof, but my reason for participating was straightforward: families need honest

information, particularly when decisions carry potentially lasting consequences.

This standard applies equally to my Christian convictions. My faith does not authorize me to impose predetermined conclusions, humiliate a struggling adolescent, or confuse spiritual agreement with psychological healing. Progressive political commitments confer no such authority either. **The therapist's office is not a pulpit for political activism, religious coercion, or institutional propaganda.** It should offer competent care, compassion, and room to ask difficult questions.

When evaluating a therapist, notice how that person handles disagreement. Can the clinician explain a recommendation, acknowledge uncertainty, and reconsider a mistaken assumption? Can your teenager question an interpretation and still feel respected? Your child deserves someone with the courage to think independently, the humility to be corrected, and the integrity to remember whose life is at stake.

Parents Belong in the Picture

Your teenager needs room to speak honestly, and you need to understand how treatment works and how to support it. A skilled adolescent therapist explains these responsibilities early: what can remain private, what parents can expect to learn, how safety concerns will be managed, and when family participation will be helpful or necessary. "I will tell your parents everything" can undermine trust, while "Your parents have nothing to do with this" can dismiss people who may be essential to recovery. Thoughtful care requires a more careful arrangement, consistent with applicable law and the teenager's developmental needs.

Parents may also need to examine their own contributions to family difficulties, including communication patterns, expectations, conflict, or well-intentioned protection that inadvertently maintains avoidance. We should be willing to hear that. Sometimes a clinician must address genuinely unsafe family behavior; other times, the work involves repairing relationships that have become painfully strained. And sometimes parents are already doing an extraordinary job under very difficult circumstances.

Beware of a therapist who blames parents before understanding the family, or automatically assumes the adults are right because they pay the bill. Your teenager needs someone capable of understanding complexity without immediately assigning villains.

Interview the Therapist, Not Just the Receptionist

You have every right to ask direct questions before entrusting someone with an important role in your child's life. Ask about the clinician's experience treating adolescents with similar concerns, how assessment guides treatment, why a particular approach is recommended, and how your teenager will participate in establishing goals. Find out how progress will be measured, how parents will be involved, and what happens when treatment is not helping.

I would also ask two questions that reveal a great deal about professional maturity:

> **"What are the limits of your expertise?"** and **"**
>
> **What have you learned recently that has changed how you practice?"**

Dr. Parkison would appreciate that second question. A responsible clinician should welcome both. You do not need a dissertation over the telephone, but you should hear thoughtful answers, reasonable humility, and a willingness to consider alternatives. If ordinary questions produce defensiveness, irritation, or a performance of professional superiority, take that information seriously.You are not purchasing a personality. You are choosing someone to help care for your child.

Watch for Progress, and Know the Warning Signs

No therapist is perfect, and one awkward conversation does not automatically justify ending treatment. Patterns are more revealing. Be concerned when a clinician discourages second opinions, cannot explain the treatment plan, dismisses deterioration, makes sweeping conclusions after minimal assessment, pressures your teenager to adopt personal beliefs, or encourages unnecessary dependency. Boundary violations, confusing secrecy, and promises of a cure deserve particular scrutiny.

A quieter problem is what I call *pleasant stagnation*. Everyone likes the therapist. Appointments continue. Months pass. Yet no one can explain what is improving or why the same treatment remains appropriate. Some conditions require prolonged care, and progress is rarely linear, but duration should have a clinical rationale. Look for changes in daily life: better sleep, more consistent school attendance, less avoidance, fewer destructive arguments, stronger relationships, and a growing ability to recover after disappointment.

Good therapy can also be uncomfortable. Your teenager may need to confront a fear, accept responsibility, tolerate grief, or abandon an escape behavior. Parents may need to make changes as well. The

important question is whether that discomfort serves a clear therapeutic purpose within competent, respectful care.

Attendance is easy to cou nt. **Benefit requires closer attention.**

Your Child Is Worth Getting This Right

After more than forty years of sitting with children, teenagers, and their families, I still feel the weight of being trusted with someone's child. Parents bring their worries, their sleepless nights, and their hope that we might know how to help. Teenagers sometimes bring very little hope at all. They may arrive guarded, angry, embarrassed, or exhausted from trying to explain something they barely understand themselves. Being invited into that struggle is a privilege. I hope I never become so professionally comfortable that I forget it.

I have made mistakes, reconsidered assumptions, and needed help from colleagues. I am still learning. What I believe we owe families is our honest thinking, careful attention, and willingness to recognize when our approach is falling short. Parents should not have to fight through professional defensiveness to tell us their child is getting worse. Teenagers should not have to agree with our interpretations to receive our respect.

To my colleagues reading this: I know how much many of you give. I know the difficult cases you carry home, the paperwork that consumes your evenings, and the pressure to accomplish more with less. My concern comes from loving this work and believing we are capable of doing it better. These criticisms reach my own doorstep. I have missed things, held assumptions too tightly, and needed someone to challenge me. I still do.

But caring deeply does not relieve us of the responsibility to examine what we are doing. Ask the harder question. Read the study that unsettles your position. Seek out the colleague who sees something you have missed. When treatment stalls, investigate. When a family says something is wrong, listen. We cannot ask our patients to face uncomfortable truths while protecting ourselves from every uncomfortable question.

And when the institution gets it wrong, have the courage to say so. A professional association does not get to do our thinking. An insurance company cannot determine a child's clinical needs simply by counting authorized visits. A supervisor's preference does not make an inadequate treatment plan sufficient. When ten sessions are appropriate, use them well. When your assessment tells you more is needed, make the case. Document it. Appeal it. Ask leadership to explain how its demands serve this particular young person. Keep pressing for a workable path to appropriate care.

Do not take a knee to institutional authority when your clinical judgment tells you a child needs something different.

We owe our institutions thoughtful participation and honest scrutiny. Our patients deserve the benefit of that scrutiny. Challenge dogma with evidence. Challenge restrictions with sound clinical reasoning. Challenge leadership respectfully and persistently when its expectations compromise care. Be willing to hear that you are wrong, too. That willingness gives your challenge integrity.

I know there are consequences to speaking up. Livelihoods matter. Professional relationships matter. Many clinicians have limited power over the systems in which they work. Still, we must guard against becoming so accustomed to those pressures that we stop recognizing

what they cost our patients. Sometimes the most important words a clinician can say are, "I cannot support this plan, and here is why." We need to make room for those words in our profession, and we need the backbone to speak them ourselves.

For God's sake, let us stay awake to the responsibility we have accepted. Let us care enough to keep learning, humble ourselves enough to be corrected, and stand up when good care requires it. Somewhere, a parent is trusting that we will notice what others have missed. Somewhere, a teenager is gathering the courage to tell us something they have never said aloud. Let us meet that courage with some of our own.

And to the parents reading this: you have every right to ask us difficult questions. You deserve to understand a recommendation, question its reasoning, seek another opinion, and expect a thoughtful answer. Your teenager deserves to be heard and to disagree without being humiliated. No degree, institution, or professional organization should intimidate you into silence. You can respect a clinician's expertise and still expect that person to explain it. You are entrusting us with your child. Your questions belong in the room.

There are wonderful therapists who bring both skill and heart to this work. If your family has been disappointed, I hope you will keep looking. Look for someone who wants to understand what your teenager has endured and what still brings a flicker of interest, affection, humor, or hope. Someone who notices the courage it took to walk through the door. Someone who can be tender with pain and steady enough to help your child face the difficult work ahead.

There is so much worth working toward: hearing your teenager laugh freely again, watching a friendship take root, seeing the courage to

return to school, accept responsibility, or try again after disappointment. There is the possibility of a young person beginning to feel worthy of love, discovering something meaningful to contribute, and imagining a future with room for them in it. These are the hopes behind the appointments, the questions, and the effort to find someone who can help.

Your love cannot do every part of this work, and you do not have to have every answer. But your presence, your willingness to learn, and your determination to seek good care matter deeply. When your child struggles to imagine that life can become better, you can help hold that possibility open while they begin finding their own reasons to believe it.

Your child's story is still unfolding. There is life beyond this difficult chapter, and it is worth bringing our best to help them reach it.



References

Akiki, T. J., Averill, C. L., & Abdallah, C. G. (2017). A network-based neurobiological model of PTSD: Evidence from structural and functional neuroimaging studies. *Current Psychiatry Reports, 19*, Article 81. https://doi.org/10.1007/s11920-017-0840-4

American Psychological Association. (2017). *Ethical principles of psychologists and code of conduct* (2002, amended effective June 1, 2010, and January 1, 2017). https://www.apa.org/ethics/code

American Psychological Association. (2024). *APA policy statement on affirming evidence-based inclusive care for transgender, gender diverse, and nonbinary individuals, addressing misinformation, and the role of psychological practice and science.* https://www.apa.org/about/policy/transgender-nonbinary-inclusive-care.pdf

Brooks, A. C. (2026). *The meaning of your life: Finding purpose in an age of emptiness.* Portfolio. https://www.penguinrandomhouse.com/books/724315/the-meaning-of-your-life-by-arthur-c-brooks/

Buckner, R. L., Andrews-Hanna, J. R., & Schacter, D. L. (2008). The brain's default network: Anatomy, function, and relevance to disease. *Annals of the New York Academy of Sciences, 1124*, 1–38. https://doi.org/10.1196/annals.1440.011

Cuijpers, P., Karyotaki, E., Ciharova, M., Miguel, C., Noma, H., Stikkelbroek, Y., & Weisz, J. R. (2023). The effects of psychological treatments of depression in children and adolescents on response, reliable change, and deterioration: A systematic review and meta-analysis. *European Child & Adolescent Psychiatry, 32*, 177–192. https://doi.org/10.1007/s00787-021-01884-6

Goldberg, S. B., Rousmaniere, T., Miller, S. D., Whipple, J., Nielsen, S. L., Hoyt, W. T., & Wampold, B. E. (2016). Do psychotherapists improve with time and experience? A longitudinal analysis of outcomes in a clinical setting. *Journal of Counseling Psychology, 63*(1), 1–11. https://doi.org/10.1037/cou0000131

Hansen, J. E. (2023). *Transgender confusion amidst the search for identity.* Center for Connected Living, LLC. https://www.amazon.com/dp/B0CTKZ6WC9

Lane, R. D., Ryan, L., Nadel, L., & Greenberg, L. S. (2015). Memory reconsolidation, emotional arousal, and the process of change in psychotherapy: New insights from brain science. *Behavioral and Brain Sciences, 38*, e1. https://doi.org/10.1017/S0140525X14000041

McLeod, B. D. (2011). Relation of the alliance with outcomes in youth psychotherapy: A meta-analysis. *Clinical Psychology Review, 31*(4), 603–616. https://doi.org/10.1016/j.cpr.2011.02.001

Medical Professionals. (2025, June 13). *Brief of amici curiae medical professionals in support of petitioner, Chiles v. Salazar, No. 24-539 (U.S.).* https://www.supremecourt.gov/DocketPDF/24/24-539/363222/20250613173006472_24-539_Amicus%20Brief.pdf

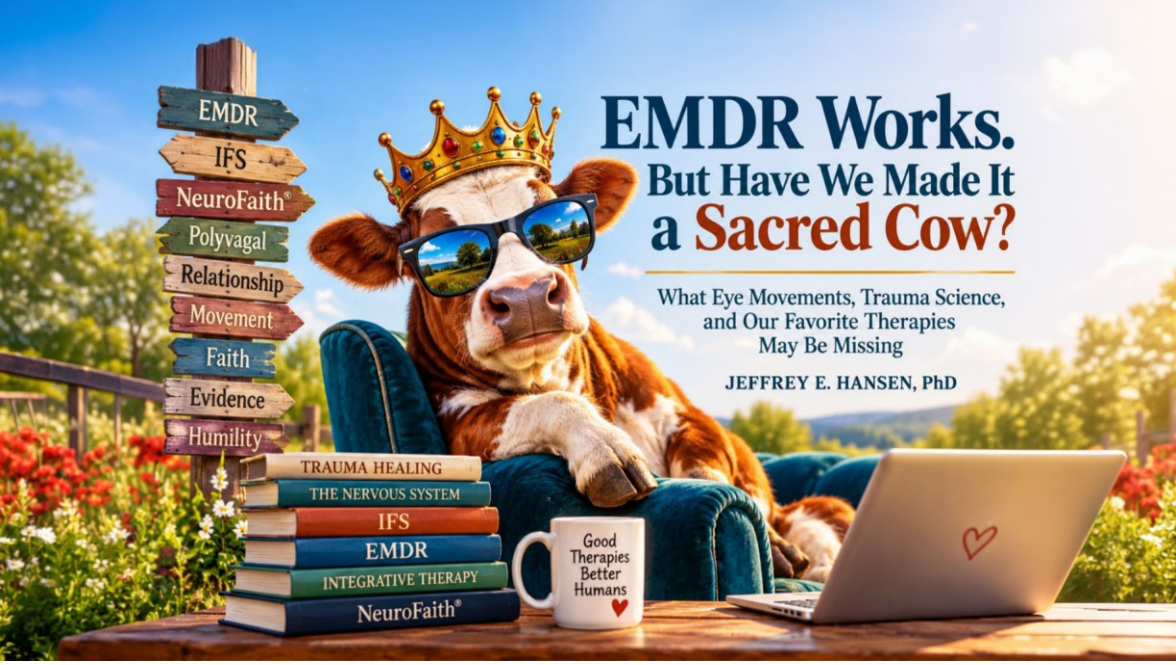
Nader, K., & Hardt, O. (2009). A single standard for memory: The case for reconsolidation. *Nature Reviews Neuroscience, 10*, 224–234. https://doi.org/10.1038/nrn2590

Olds, T. (n.d.). *Transformational change: A deeper kind of growth* [Video and transcript]. https://www.toriolds.com/transformational_change/

Shrier, A. (2024). *Bad therapy: Why the kids aren't growing up.* Sentinel. https://www.penguinrandomhouse.com/books/716567/bad-therapy-by-abigail-shrier/

Taylor, J., Mitchell, A., Hall, R., Heathcote, C., Langton, T., Fraser, L., & Hewitt, C. E. (2024a). Interventions to suppress puberty in adolescents experiencing gender dysphoria or incongruence: A systematic review. *Archives of Disease in Childhood, 109*(Suppl. 2), s33–s47. https://doi.org/10.1136/archdischild-2023-326669

Taylor, J., Mitchell, A., Hall, R., Langton, T., Fraser, L., & Hewitt, C. E. (2024b). Masculinising and feminising hormone interventions for adolescents experiencing gender dysphoria or incongruence: A systematic review. *Archives of Disease in Childhood, 109*(Suppl. 2), s48–s56. https://doi.org/10.1136/archdischild-2023-326670



Something About EMDR Never Quite Settled for Me

I have no idea why I started thinking about EMDR this morning. My mind does that. It wanders hither and yon, lands on something seemingly out of nowhere, and then sometimes refuses to leave it alone. People have told me that I am a deep thinker. Maybe I am. Maybe I am a strange thinker. Maybe I just think too much. Whatever the explanation, this morning my mind landed on Eye Movement Desensitization and Reprocessing, better known as EMDR, and I found myself returning to a question that has bothered me for years.

I trained in EMDR perhaps five years ago. I liked it. I found it interesting, and more importantly, I saw some good clinical outcomes. People got better. Memories that had carried tremendous emotional weight sometimes became less distressing. Patients could approach experiences they had previously avoided, and I could see changes occurring right there in the room. Something was happening.

So let me be clear from the beginning. This is not an argument that EMDR does not work. I have used it. I respect it. I have seen it help

people, and I still refer patients for EMDR when I believe it may be useful.

But there was always something about the explanation that did not completely settle for me.

Being something of a neuroscience nerd, I have difficulty simply accepting that a treatment works without wanting to crawl underneath the hood and understand why. I want the conceptual model to make sense. I want our explanation to fit what we actually know about memory, attention, the brain, the autonomic nervous system, relationship, and human behavior. And when we do not know, I think we should have enough humility to say that too.

That curiosity eventually contributed to my development of NeuroFaith®, an integrative approach to trauma treatment bringing together polyvagal-informed therapy, neurocardiology and physiological self-regulation, Internal Family Systems, and Christian spirituality when faith is appropriate and meaningful to the person. Movement and behavioral activation also play an important role. NeuroFaith® grew from my increasing conviction that trauma does not live in one place. It becomes embedded across interacting systems: brain, body, autonomic nervous system, relationships, protective adaptations, identity, meaning, and sometimes faith.

And that brings me back to EMDR.

My question is not whether it works.

My question is whether it works for the reasons we think it does.

Francine Shapiro and a Walk in the Park

The history of EMDR is fascinating because it did not begin with an elaborate neuroscience theory. It began with an observation.

Francine Shapiro's academic path was itself unusual. Before entering psychology, much of her scholarly life had been in English literature. She published literary criticism and edited a volume of Thomas Hardy's poetry before ultimately moving into psychology and becoming a clinical psychologist. That history does not diminish what she accomplished. If anything, I find it fascinating. Sometimes important discoveries come from people willing to notice something everyone else has walked past.

In 1987, Shapiro was walking through a park when she noticed that spontaneous movements of her eyes appeared to diminish the distress associated with disturbing thoughts. She became curious. She began experimenting and subsequently tested whether deliberate eye movements could reduce the emotional intensity associated with troubling memories in other people. Her early procedure became Eye Movement Desensitization, or EMD. Importantly, Shapiro herself came to recognize that eye movements alone did not constitute a comprehensive treatment and added cognitive and other therapeutic components. In 1991, the approach became Eye Movement Desensitization and Reprocessing, or EMDR, reflecting the broader information-processing theory she was developing to explain the clinical changes she observed (Shapiro, 1989).

That sequence matters. Shapiro did not begin with an established neurobiological model of traumatic memory from which she predicted that moving the eyes from side to side would treat PTSD. She noticed

something first. The phenomenon came first. The theoretical explanations came afterward.

There is nothing inherently wrong with that. Science often proceeds exactly this way. Something unexpected happens. Someone curious enough notices it. We determine whether the phenomenon can be reproduced, and then we try to understand why it happened.

But the observation and the explanation for the observation are not the same thing.

Perhaps Francine Shapiro discovered something much bigger than eye movements.

And perhaps she did not even know it.

If It Is About REM, Why Do We Not Need the Eyes?

Early explanations for EMDR included an intriguing comparison with rapid eye movement, or REM, sleep. Shapiro proposed that the rhythmic eye movements might function somewhat like processes occurring during dreaming, and later researchers developed considerably more sophisticated versions of the REM hypothesis. The general idea was compelling: perhaps the eye movements helped place the brain into a state favorable to processing emotionally charged memories and integrating them into broader memory networks.

It is a fascinating hypothesis.

But a hypothesis is not a mechanism simply because it sounds neuroscientific.

This becomes particularly important because EMDR does not necessarily require eye movements. Clinicians may use alternating

auditory tones. They may use tapping or tactile stimulation. Patients may hold pulsers, sometimes called buzzers, that alternate stimulation between their hands. A vibration alternating between the hands is not a rapid eye movement. A sound alternating between the ears is not REM sleep.

To be fair, this does not establish that every form of bilateral stimulation is equivalent. They may not be. Eye movements may have particular properties that make them especially effective. But if nonvisual procedures can also contribute to therapeutic change, then an explanation requiring the eyes themselves to be the central neurological engine begins to look increasingly incomplete.

A major systematic review by Landin-Romero and colleagues (2018) examined 87 studies addressing proposed mechanisms of EMDR. The investigators grouped the explanations into psychological, psychophysiological, and neurobiological models. They found reasonable empirical support for the working-memory hypothesis and for physiological changes occurring during successful EMDR. But their conclusion was remarkably important: despite decades of research, investigation into EMDR's mechanisms remained insufficient to establish firm conclusions. They described the mechanistic science as still being in its infancy.

That should give us some humility.

The working-memory explanation makes considerable sense. When a person deliberately retrieves an emotionally charged memory while simultaneously performing another sufficiently demanding task, both activities compete for limited working-memory resources. The memory may consequently become less vivid and less emotionally intense. That explanation has accumulated meaningful experimental support.

But even that does not appear to explain everything.

Maybe we need to get some altitude.

Instead of staring exclusively at the moving finger, perhaps we should look at the entire therapeutic event. A person deliberately activates a painful memory while simultaneously attending to something occurring in the present. Attention is divided. Working memory is occupied. The traumatic memory is activated under circumstances radically different from those in which it was originally encoded. The person is here rather than there. The event is being remembered, but it is not happening again.

And there is something else that I think we sometimes underestimate.

There is another human being in the room.

The Blind Men and the Elephant

Perhaps the most revealing metaphor in the Landin-Romero review comes near its conclusion, where the authors invoke the old parable of the Blind Men and the Elephant. In the story, six blind men encounter an elephant and, having never known one before, attempt to understand what kind of creature stands before them. The problem is that each man touches only one part of the animal. One feels the elephant's broad side and declares that an elephant must be like a wall. Another encounters the tusk and insists that an elephant is like a spear. Another takes hold of the trunk and concludes that it must be something like a snake. The remaining men encounter the leg, the ear, and the tail and confidently describe the elephant as resembling a tree, a fan, and a rope. When they compare their conclusions, they discover that they are in complete disagreement.

What makes the parable so wonderful is that none of the men is entirely wrong. Each has encountered something real. The side really does feel something like a wall. The tusk is spear-like. The trunk can feel like a snake, the leg like a tree, the ear like a fan, and the tail like a rope. Their error occurs when each man assumes that the small portion he has encountered explains the entire animal.

Landin-Romero and colleagues (2018) suggest that our attempts to explain EMDR may look remarkably similar. After reviewing 87 studies examining proposed mechanisms of action, they found evidence pointing in several different directions. One line of research emphasizes working-memory taxation. Another focuses on the orienting response or psychophysiological de-arousal. Others examine bilateral stimulation, REM-like processes, attentional changes, memory processing, or alterations in neural activity. These explanations do not necessarily have to cancel one another out. Several of them may be identifying something real. The problem comes when we touch one part of a complex therapeutic process and conclude that we have discovered the whole elephant.

That seems especially relevant when we return to the question of eye movements. If the essential mechanism were simply that eye movements reproduce something analogous to REM sleep, then auditory tones and alternating tactile stimulation become difficult to explain. Landin-Romero and colleagues themselves identify this as a limitation of the REM-like physiological account. Yet if we broaden our view and consider that EMDR may simultaneously affect attention, working memory, arousal, memory processing, and other neurobiological systems, the apparent contradiction becomes considerably less mysterious.

This is why I find the elephant metaphor so compelling. Perhaps the problem is not that every theory of EMDR has been wrong. Perhaps several theories have been partly right. We have simply been standing in different places, touching different parts of the same complicated process and then arguing with one another about whose description is correct.

The authors ultimately move toward something very close to that conclusion. EMDR is a complex therapeutic intervention, and multiple mechanisms may be operating simultaneously. They suggest that a more integrative model may ultimately be necessary to understand how it works (Landin-Romero et al., 2018). To me, that is not a weakness in the science. It is an invitation to widen the lens.

And it takes me back to Francine Shapiro walking through that park in 1987. Perhaps what she discovered was considerably larger than the eye movements that first caught her attention. Perhaps she stumbled onto a way of creating conditions in which a painful memory could be activated while attention, arousal, cognition, physiology, and memory itself were being asked to do something different.

Maybe Francine Shapiro discovered an elephant.

And for a long time, we have been arguing about the trunk.

Another Nervous System in the Room

There is another part of this elephant that I think deserves considerably more attention: the traumatized person is not sitting there alone. There is another human being in the room.

Think about what actually occurs during good trauma therapy. We ask someone to approach something that his nervous system may have

spent years telling him to avoid. He deliberately brings the memory forward and begins noticing what happens as images, physical sensations, fear, grief, guilt, anger, or shame emerge. Rather than escaping the experience, he remains with it long enough for something different to occur. The traumatic experience is being activated, but it is being activated under circumstances radically different from those in which it was originally encoded. The person is here rather than there. The terrible event is being remembered, but it is not happening again.

And importantly, another person is sitting nearby. There is attention, structure, expectation, relationship, and, when therapy is going well, an experience of safety. The therapist remains present while the patient approaches what was once unbearable. From a nervous-system perspective, I think that matters enormously. One human nervous system is approaching something associated with danger while another regulated nervous system remains close, attentive, predictable, and available.

How much of what happens during EMDR belongs specifically to bilateral stimulation? How much involves working-memory taxation, exposure, attentional flexibility, autonomic regulation, or memory updating and reconsolidation? How much is influenced by expectation and therapeutic relationship? And how much emerges because several of these things are occurring simultaneously while the patient remains in relationship with another human being?

I do not know.

And perhaps that is exactly the point.

What Do We Tell the Patient?

This is where the question becomes more than academic for me. It becomes an issue of informed consent.

If we do not actually know the neurobiological mechanism responsible for a treatment's effectiveness, then I think we have an ethical responsibility to say so. We should not give patients neurological gobbledygook because it sounds impressive. We should not take a plausible theoretical explanation and present it as established neuroscience simply because it makes the treatment easier to explain or makes us sound more certain.

If REM-like processing is a hypothesis, call it a hypothesis. If working-memory taxation has stronger empirical support, say that. If memory reconsolidation may be involved but has not been demonstrated to explain the entire treatment effect, say that too.

There is nothing embarrassing about telling a patient, "We have good evidence that this treatment helps many people with PTSD. We have several theories about why it works, but we do not yet completely understand the neurological mechanism."

That is not weakness.

That is honest informed consent.

EMDR Works. The Harder Question Is How Well, Compared With What, and for How Long?

If I am going to challenge some of the theoretical claims surrounding EMDR, I also need to acknowledge clearly that the treatment has substantial empirical support.

Yang and colleagues (2026) recently published a large meta-analysis examining 65 randomized controlled trials involving 3,342 adults with PTSD. The immediate effect on PTSD symptoms was substantial, with a pooled Hedges' g of 0.96. Thirty-two studies contributed follow-up data, and the pooled effect remained significant at follow-up, g = 0.80. At first glance, that sounds pretty darn impressive. The investigators concluded that EMDR demonstrated immediate effects and "sustained effects at follow-up" (Yang et al., 2026).

Before we get too excited about the word sustained, however, we need to look under the hood.

The immediate-treatment studies were already highly heterogeneous, I^2 = 85.76%. At follow-up, heterogeneity climbed to I^2 = 89.72%. Heterogeneity is one of those statistical terms that can make people's eyes glaze over, but here it matters enormously. In plain English, the studies were producing substantially different estimates of how well EMDR worked, beyond the variation we would expect simply from sampling error. These studies were not all giving us the same picture.

Why might that be? The trials differed in trauma populations, comparison conditions, intervention characteristics, methodologies, and other important variables. And importantly for the question of durability, they used variable follow-up periods.

So what exactly does follow-up mean?

That is not a trivial question. Thirty-two studies contributing some form of follow-up data is not the same thing as 32 studies evaluating everybody at one standardized long-term endpoint. These were not all trials bringing patients back at one year, two years, or five years and

asking the same questions. Yet these differing observations contribute to a pooled "follow-up" effect.

That makes the word sustained considerably less satisfying to me.

The authors themselves acknowledge important weaknesses in the evidence base. Most studies were not judged to be at low overall risk of bias. Concerns included deviations from intended interventions, missing outcome data, and limitations involving randomization and allocation concealment. The investigators appropriately caution that confidence in the pooled estimates should therefore be tempered (Yang et al., 2026).

There is another finding worth noticing. The size of EMDR's apparent advantage changed substantially depending upon what it was compared against. Its advantage was much larger against waiting-list or treatment-as-usual conditions and considerably smaller when compared with CBT or other active treatments. That does not mean EMDR is ineffective. It means that showing an active psychotherapy works better than asking a suffering person to wait for treatment is a very different scientific test from demonstrating superiority over another legitimate trauma treatment.

None of this makes the Yang et al. study meaningless. It tells us something important: EMDR reduces PTSD symptoms, and improvement can remain detectable beyond treatment.

But it does not answer the question I care about nearly as well:

How durable is that improvement over clinically meaningful periods of time?

Six Weeks Is Six Weeks

This problem is hardly unique to psychotherapy. It reminds me of a longstanding methodological criticism of the psychotropic medication literature, a literature about which I have had concerns for years. A relatively short acute trial may demonstrate statistically significant improvement, and that tells us something useful about what happened during that period. But six or eight weeks of improvement tells me remarkably little about what happens to a human being over the next two years.

Six weeks is six weeks.

It is not a year.

And it sure as heck is not recovery.

PTSD, depression, and anxiety are not six-week problems. Trauma certainly is not. If we are going to use words such as sustained, durable, or long-term, then I think our research needs to earn those words.

Show me six months. Show me one year. Show me two years. Better yet, show me five. Tell me how many patients required additional psychotherapy during that period. Tell me how many returned for additional EMDR. Tell me how many received another trauma treatment. Tell me how many continued to meet diagnostic criteria for PTSD. Tell me what happened to their marriages, relationships, occupational functioning, substance use, physical health, and quality of life.

Tell me whether they merely scored lower on a symptom inventory or whether their lives actually got better.

Those studies are difficult. They are expensive. People drop out. Participants obtain other treatments. Life gets messy.

But trauma is messy.

We cannot demand that the human being become simpler merely because simpler research is easier to conduct.

And Another Meta-Analysis Gives Us Reason to Be Careful

A second recent review makes this uncertainty particularly difficult to ignore. Villegas-Ortega and colleagues (2025) took a narrower approach and examined 12 randomized controlled trials involving 690 participants comparing EMDR with waiting-list controls. Again, the numerical results favored EMDR. PTSD symptoms were substantially lower immediately following treatment, SMD = -1.19, 95% CI [-1.70, -0.68]. At the available follow-up assessments, EMDR continued to show an advantage, SMD = -0.88, 95% CI [-1.62, -0.13].

Diagnostic remission initially looks impressive as well. Participants receiving EMDR were more likely to lose the PTSD diagnosis following treatment, RR = 2.13, 95% CI [1.08, 4.23]. At follow-up, the estimated relative risk was 3.56.

But look at the confidence interval around that follow-up estimate: 0.82 to 15.48.

That is an enormous range, and because it crosses 1.0, the follow-up estimate does not establish a statistically reliable difference in diagnostic remission. In plain language, the estimate is extremely imprecise.

After formally grading the evidence, the investigators rated its certainty as low to very low. Why? Not because the studies found no

benefit. They did. The problem was how confident we could reasonably be in those estimates. The review identified risk of bias, particularly involving masking and allocation concealment. Follow-up evidence was imprecise. Long-term effects remained unclear. And none of the included trials assessed several outcomes I would very much like to know about before using the word recovery: quality of life, treatment acceptability, or adverse effects (Villegas-Ortega et al., 2025).

That is not an argument that EMDR does not work.

It is an argument that we need better research.

Put these two recent analyses beside one another and I think the scientifically responsible conclusion becomes fairly clear. EMDR has meaningful evidence for reducing PTSD symptoms. There is evidence that improvement can persist beyond the end of treatment. But the literature gives us considerably less confidence about genuinely long-term durability, and the evidence certainly does not establish that completing a relatively brief EMDR protocol constitutes comprehensive or permanent recovery from trauma.

Those are different claims.

We should stop pretending they are the same.

When Treatment Becomes Ideology

This brings me to a caution I would offer my EMDR colleagues, but also to myself and to every clinician who has ever fallen in love with a particular therapeutic model:

Do not become a cult leader.

I use that language intentionally and perhaps a little provocatively. I am not suggesting that EMDR is a cult or that clinicians practicing it are cult members. I am talking about a professional posture that can develop around almost anything when enthusiasm gradually hardens into allegiance.

Anything can become a cult if we hold onto it tightly enough.

Cults do not particularly like uncomfortable questions. They protect the central narrative. Contradictory information becomes threatening. Limitations get explained away. Preserving the ideology gradually becomes more important than discovering whether the ideology is true.

Science is supposed to do exactly the opposite. Science should welcome the irritating question. It should invite somebody to poke holes in our favorite theory. Good science should permit us to say, "We thought this was how it worked. The evidence is telling us something different. We need to change our minds."

That applies to EMDR. It applies to CBT. It applies to psychopharmacology. It applies to polyvagal theory. It applies to Internal Family Systems.

And it absolutely applies to NeuroFaith®.

The day I begin telling people that NeuroFaith® is the treatment for trauma, somebody needs to pull me aside and remind me of what I wrote here. It is not the treatment. It is an integrative framework that attempts to bring several potentially transformational approaches into conversation with one another. It does not own the truth.

The patient does not exist to prove that our model is right.

The model exists to help the patient.

When the Protocol Ends

This is where my own clinical experience has made me cautious about confusing successful completion of a protocol with recovery from trauma. I have worked with people who previously completed substantial courses of EMDR and benefited from them. Some could discuss memories that once overwhelmed them. Their distress had diminished. The treatment had done something important.

And yet they were sitting in my office.

Not necessarily because EMDR had failed.

Because their healing was unfinished.

They still did not understand why their bodies suddenly shifted into alarm. They did not understand why apparently minor events triggered reactions wildly disproportionate to what was occurring in the present. They did not understand why connection sometimes felt dangerous, why anger appeared before vulnerability, why they shut down, or why their nervous systems continued detecting threat long after the original danger had passed.

The memory may have become quieter.

But the person still needed to understand the nervous system carrying that memory.

Underneath the physiology were often deeper psychological wounds. Shame had become incorporated into identity. Guilt had become fused with responsibility. Relationships had reorganized themselves around mistrust. Protective strategies that once made perfect sense had become rigid ways of living. The person's internal story had gradually

become something like: I am damaged. I am unsafe. I cannot trust. I failed. I should have done more. I am no longer who I once was.

This is one reason I find Internal Family Systems, or IFS, useful within a larger trauma framework. IFS gives us a way of understanding apparently problematic reactions not merely as symptoms to eliminate, but often as protective parts of the person that developed for understandable reasons. The angry part, hypervigilant part, detached part, perfectionistic part, controlling part, or part that refuses ever again to become vulnerable may be doing exactly what it learned was necessary to keep the person safe.

Instead of declaring war on those parts, we become curious about them. What happened to you? What are you protecting? What are you afraid would happen if you stopped doing your job?

That begins moving us beyond reducing the emotional charge of a memory and toward understanding how trauma reorganized the person.

The Seduction of the Protocol

I think psychology has become increasingly enamored with protocols. There are understandable reasons. Protocols can be standardized, manualized, taught, researched, measured, reimbursed, and reproduced. Health systems like them. Researchers like them. Insurance companies certainly like them.

There is tremendous value in that.

But there is also danger.

At some point the therapist can begin looking less like a healer and more like a technician.

I sometimes think about taking my Toyota Land Cruiser into the dealership. There is a procedure for almost everything. A particular repair is allocated a particular number of labor hours. There are diagnostic codes, service intervals, technical procedures, torque specifications, and prescribed sequences for getting from problem to repair.

That makes perfect sense when you are working on a machine.

Human beings are not Land Cruisers.

Trauma does not arrive in standardized units, and it does not conveniently organize itself into five sessions, eight sessions, ten sessions, or twelve. The person sitting across from us brings a nervous system, developmental history, temperament, attachments, losses, relationships, beliefs, protective adaptations, identity, body, morality, and perhaps faith. The traumatic experience becomes woven into all of it.

Protocols are useful.

But protocols are maps. They are not the territory.

The Memory May Change. Has the Story Changed?

This is where the neuroscience of the default mode network becomes especially interesting to me. The default mode network, or DMN, is deeply involved in self-referential thought, autobiographical memory, internally directed attention, imagining the future, and aspects of our continuing construction of self. When the demands of the external world recede, the brain does not simply shut off. It turns inward. It remembers. It anticipates. It interprets.

And it tells stories.

Trauma can become woven deeply into those stories. The event may have occurred ten, twenty, or forty years ago, yet its implications continue to be rehearsed: This is who I am. This is what people are like. This is what happens when I trust. This is what I deserve. This is what my future will be. God abandoned me.

At that point we are dealing with more than a disturbing memory.

We are dealing with an architecture of identity.

EMDR explicitly addresses negative and positive cognitions, and we should give it full credit for doing so. My question is not whether cognition appears in the protocol. It does. My question is whether changing the emotional intensity and cognitive association attached to particular traumatic memories necessarily penetrates deeply enough to alter an autobiographical narrative that may have been rehearsed thousands upon thousands of times.

A person can know that the traumatic event is over. His physiological response can diminish. He can remember what happened without becoming overwhelmed.

The memory has changed.

But has the story changed?

From Desensitization Toward Restoration

This is where NeuroFaith® fits for me. It is not a replacement for EMDR, and I do not want it to become another rigid protocol claiming ownership over trauma healing. I think of it as a larger framework for understanding the human being in whom the trauma resides.

Polyvagal-informed work helps the person understand what the autonomic nervous system learned about danger and safety and why protective states continue to emerge even when the original danger is gone. Neurocardiology and physiological regulation give the person practical ways of recognizing and influencing state rather than simply being hijacked by it. IFS provides a language for approaching wounded and protective parts with curiosity rather than shame. Movement reminds us that healing occurs through the body as well as through thought. Relationship provides repeated experiences of safety with another human being.

And when Christian faith is meaningful to the person, spirituality allows us to approach questions that neither a PTSD checklist nor a brain scan can answer: Who am I now? What does my suffering mean? What do I do with guilt? Where was God? Can there be redemption in a story I never would have chosen?

Understanding matters to me.

There is something profoundly different about a person moving from Something is wrong with me to My nervous system learned to protect me this way, and now I can teach it something different. There is something different about discovering that the angry or detached part is not evidence of being defective but may represent an adaptation that once helped the person survive. And there is something different again when the person begins consciously rewriting the autobiographical story that trauma has been rehearsing in the background for years.

EMDR can fit beautifully within that larger landscape. I will continue referring people for it when I believe it may help them. Cognitive therapies have a place. Exposure-based treatments have a place. IFS has a place. Medication sometimes has a place. Autonomic and body-based

approaches have a place. Faith can have a place when it belongs to the person.

None of these approaches needs to become the whole answer.

Perhaps that is ultimately what Francine Shapiro's discovery invites us to consider. She may have discovered something much bigger than eye movements without realizing just how big it was. Perhaps what she stumbled upon was not merely a clever technique for moving the eyes, but one particularly powerful way of creating conditions in which a human being can approach what was unbearable, remain anchored in the present, experience the memory differently, and begin to change.

That is worth celebrating.

It is also worth continuing to question.

Our job is not to protect EMDR. It is not to protect NeuroFaith®. It is not to protect CBT, IFS, polyvagal theory, psychopharmacology, or whatever therapeutic school happens to be printed on our latest certificate.

Our job is to tell the truth as best we know it, to be honest about what we do not know, to remain curious enough to change our minds, and to use whatever good tools we have to help the human being sitting across from us.

Because ultimately the question is larger than whether EMDR works.

What does this particular human being need in order to heal?

And perhaps that is where all good trauma treatment should begin.

References

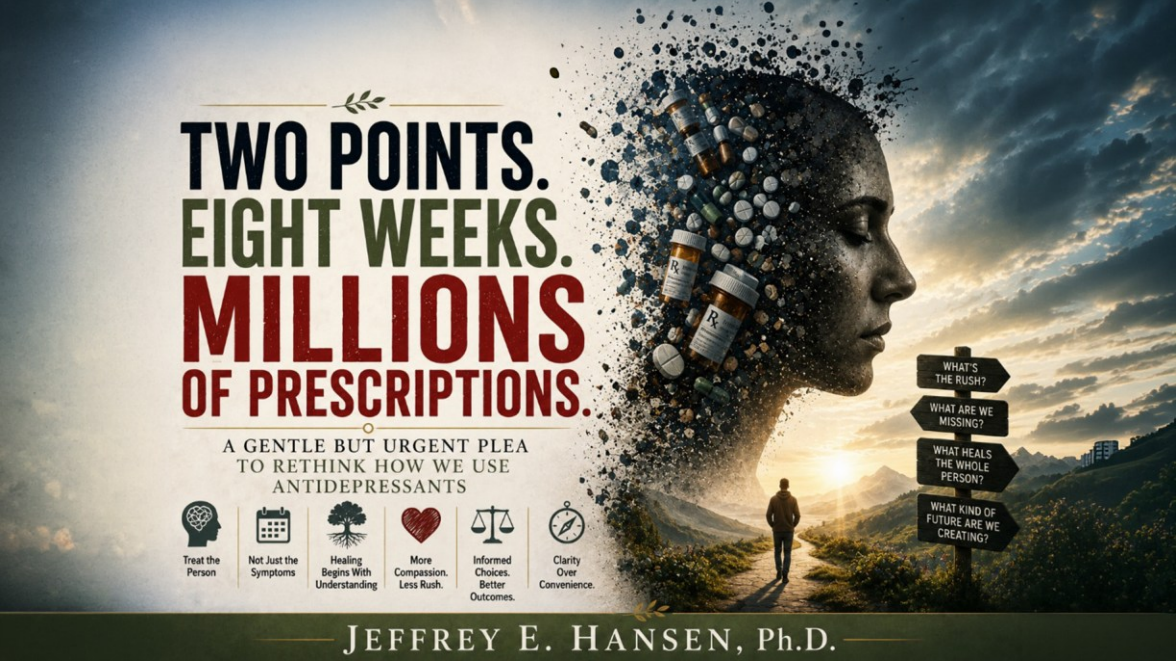
Landin-Romero, R., Moreno-Alcazar, A., Pagani, M., & Amann, B. L. (2018). How does eye movement desensitization and reprocessing therapy work? A systematic review on suggested mechanisms of action. Frontiers in Psychology, 9, 1395. https://doi.org/10.3389/fpsyg.2018.01395

Shapiro, F. (1989). Efficacy of the eye movement desensitization procedure in the treatment of traumatic memories. Journal of Traumatic Stress, 2(2), 199–223.

Shapiro, F. (1995). Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures. Guilford Press.

Villegas-Ortega, J., Galvez-Arevalo, R., Castilla-Encinas, A. M., Gutiérrez-González, B., Apolitano-Cárdenas, C. I., Alvarez-Arias, P. M., Paredes-Angeles, R., & Taype-Rondan, A. (2025). Effects of EMDR vs. waiting list for adults with post-traumatic stress disorder: A systematic review and meta-analysis of randomized controlled trials. Journal of Affective Disorders, 392, 120134. https://doi.org/10.1016/j.jad.2025.120134

Yang, H., Xiong, Z., Chen, X., Wo, Y., Tang, H., Qiao, M., Chen, Y., & Wang, Z. (2026). The immediate and follow-up effects of EMDR therapy for adults with post-traumatic stress disorder: A meta-analysis of randomized controlled trials. BMC Psychology, 14, 1373. https://doi.org/10.1186/s40359-026-05349-w



Rethinking Medication: Listening to an Insider Who Stepped Outside

Recently I listened to psychiatrist **Dr. Josef Witt-Doerring**, a former FDA medical officer who worked within pharmaceutical and regulatory systems before stepping away from conventional pathways. After leaving the FDA, he entered a higher paying role within the pharmaceutical industry itself, an experience that, by his own account, eventually left him disillusioned with aspects of how psychiatric medications were evaluated and promoted.

Over time, he became increasingly troubled by how these medications are studied, prescribed, and discontinued, particularly the gap between short term research and long term real world use. Today his work focuses on deprescribing and safe withdrawal, inviting clinicians and patients alike to reconsider assumptions that have quietly shaped modern mental health care.

Whether one agrees with every conclusion he draws or not, his journey raises an important question: Are we examining the full story behind the medications we prescribe, or only the parts that fit within familiar frameworks?

His reflections do not demand rejection of medication. Rather, they call for deeper curiosity, a willingness to rethink how, when, and why we intervene pharmacologically in the first place.

And that question led me to look inward, at my own profession.

A Confession from My Own Profession

Before I challenge psychiatry, I need to begin closer to home, with psychology itself.

My profession is not innocent in this conversation. Too often, psychologists and allied mental health professionals refer patients for medication management without fully understanding the research frameworks and assumptions guiding those prescriptions. We reassure ourselves that we are helping, that we are "staying in our lane," yet sometimes we are quietly reinforcing a system we have not examined deeply enough.

This is not written as blame. It is written as confession, and as concern.

Because when referrals become reflexive rather than thoughtful, we risk sending vulnerable people into treatment pathways shaped more by habit than by holistic understanding. And that realization is what prompted this reflection.

Short-Term Science, Long Term Prescribing

Across many antidepressant trials, the average difference between medication and placebo often amounts to only a few points on

standardized depression scales such as the Hamilton Depression Scale. Statistically meaningful? Yes. But whether that difference translates into genuine and observable transformation in a person's life remains an open question, one that deserves humility rather than certainty.

The larger concern is not only the size of the effect, but the duration of the science behind it. Many studies last only weeks, while prescriptions continue for years. We are building long term treatment cultures on short term data, and that mismatch should invite curiosity rather than defensiveness.

Estimates suggest that roughly fifteen percent of adults and about five percent of children in the United States are currently taking antidepressant medications, with adults remaining on them on average for five years or longer, a reality that makes the absence of robust long term research even more consequential.

This is no longer solely a psychiatric issue. Family physicians, nurse practitioners, physician assistants, interns on overnight rotations, many frontline prescribers now write a significant share of antidepressant prescriptions. That reality is not an indictment of primary care; it is simply the landscape we live in. Yet it means the responsibility for thoughtful prescribing belongs to all of us.

Psychiatry must examine itself.

Primary care must examine itself.

Psychology must examine itself.

Not in accusation, but in awakening.

Relapse, Withdrawal, and the Questions We Avoid

Another area that deserves deeper reflection is the interpretation of relapse prevention studies. When individuals stabilized on medication are rapidly discontinued and compared to those who remain on treatment, the line between relapse and withdrawal can become blurred.

Are we observing the return of illness, or the nervous system responding to abrupt neurochemical change?

The answer is rarely simple, and it deserves more careful conversation than our current discourse often allows.

Critics of long-term prescribing also point to the relative scarcity of extended duration human trials. Some of the longer observational insights come from primate research, where investigators have explored prolonged exposure to antidepressant medications.

Interpretations of these findings remain debated, but certain studies have suggested possible changes in dendritic complexity in frontal brain regions, alterations in sleep patterns, and behavioral flattening in some primate models after extended use.

While animal data cannot be directly generalized to humans, the absence of robust multiyear randomized human studies leaves clinicians grappling with more questions than answers, and that uncertainty alone should invite deeper scientific investment.

A Wake-Up Call — For Clinicians and for the Public

Perhaps the most important question lies beyond pharmacology altogether. Why are we, as a culture, so quick to reach for medication before exploring deeper layers of human suffering?

Trauma histories, nervous system dysregulation, loneliness, spiritual disconnection, sleep deprivation, nutritional imbalance, these are not secondary considerations. They are often the ground from which symptoms grow.

Integrity in care means seeing the person beneath the diagnosis, the history, the nervous system, the relationships, the spiritual questions, and the deeper wounds such as trauma that often drive such painful states of unhappiness.

Healing is rarely linear and almost never rushed. Quick is not always better; sometimes quick simply means we have not listened long enough. When we slow down, truly slow down, we begin to notice the more complex stories that medication alone cannot resolve, and it is there, in that deeper seeing, that real change often begins.

Medication can be a valuable tool. For some, it is lifesaving. That truth must be honored. Yet when medication becomes the first and only response, we risk narrowing the very definition of healing.

A Plea for Depth and Humility



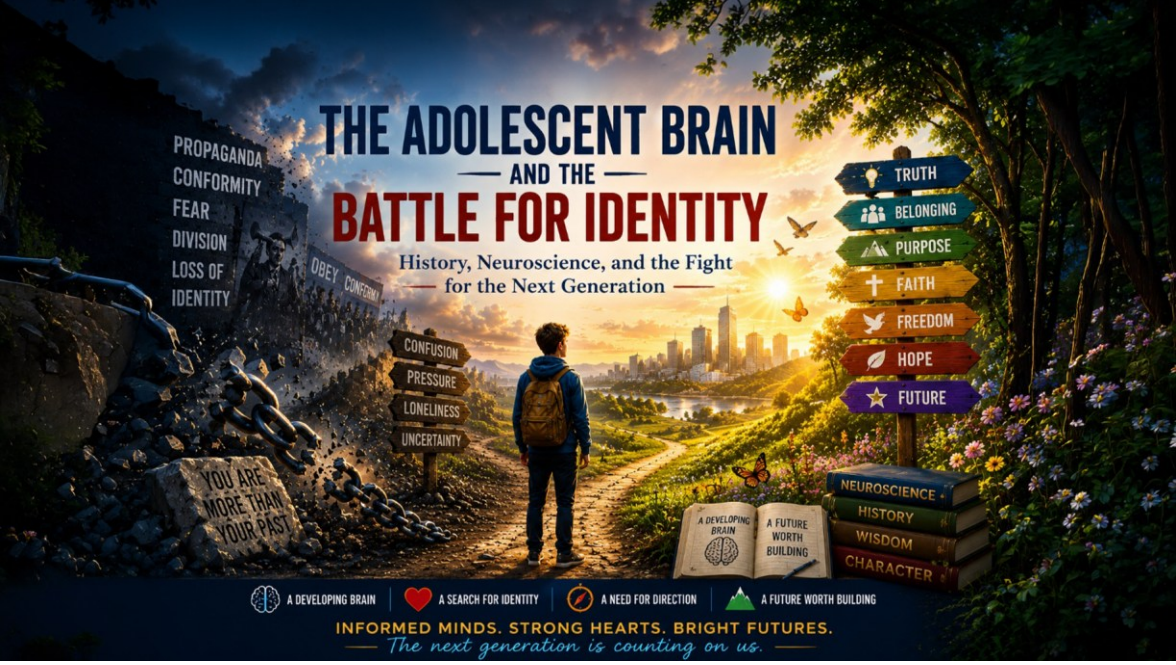
This essay is not written in anger. It is a plea, to clinicians and to the public alike, to slow down, to ask harder questions, and to approach mental health care with greater depth and humility.

Patients deserve more than polarized narratives. They deserve thoughtful medicine that addresses root causes as much as symptom relief.

If this sounds like a challenge, it is meant to be. Not a shout, but a wakeup call for psychiatry, for primary care, for psychology, and for all of us who influence the direction of healing.

Because the deeper question is no longer simply whether antidepressants help.

It is whether we are willing to practice medicine that is curious enough, courageous enough, honest enough, and compassionate enough to look beyond the prescription and truly see the person.



A Witness and a Question

I began listening to Xi Van Fleet not as a political exercise but as a human one. She is not speaking as an analyst. She is speaking as someone whose adolescence was formed inside one of the most radical social experiments of the twentieth century.

Born in 1950, she grew up in a China where tradition had already been declared dangerous, where religion had been pushed aside, and where the primary source of identity had shifted from family and heritage to ideological alignment. School was not first about the pursuit of truth. It was about formation. Children memorized the sayings of Mao. They sang revolutionary songs. They learned that belonging came from standing on the correct side of history.

Then, when she entered the most neurologically and psychologically powerful season of her life, the Cultural Revolution began. Young students were told that they were the pure ones, the future, the moral authority. They were given red armbands and a name, the Red Guards.

They gathered by the millions and were personally affirmed by Mao himself.

Their teachers were no longer their guides. Their parents were no longer their primary source of wisdom. Tradition was no longer a gift. It was an obstacle that had to be destroyed.

For an adolescent brain, this was intoxicating. The longing for belonging was met. The hunger for purpose was satisfied. The desire to matter was fulfilled. Their individuation was not a gradual differentiation within relationship. It was a call to sever the past in order to become the future.

And then, when the chaos they helped unleash threatened the stability of the nation, they were no longer needed. The army restored order. The Red Guards were dissolved. Millions of those who had been told that they were the future were sent away to remote rural areas. They lost their education. They lost their opportunities. They lost the identity that had been given to them.

History calls them the lost generation. The movement that gave them identity took away their future.

What Mao Understood and What We Now Know



Mao did not know the language of neuroscience. He did not know about synaptic pruning, dopaminergic reward systems, or prefrontal cortical maturation. But instinctively he understood the most powerful force in any society. He understood the adolescent brain.

He understood that there is a season in human development in which belonging carries more weight than safety, in which moral clarity is more compelling than complexity, and in which a young person is ready to give their entire life to a cause that promises meaning.

We now understand this scientifically. Between the ages of roughly thirteen and twenty-five, the brain undergoes massive reconstruction. It produces an overabundance of synaptic connections and then begins to prune them, strengthening the pathways that are used and eliminating those that are not. Experience becomes structure. The environment wires the brain.

At the same time the limbic system is highly activated. Reward sensitivity is elevated. Peer approval carries extraordinary neurological power. The prefrontal cortex, the region responsible for long-term

planning, reflection, and impulse regulation, is still being myelinated and gradually brought online.

This is the design that allows a young person to give themselves to faith, to love, to sacrifice, to a vocation, to a cause larger than the self. But it also means that whatever captures their allegiance in this window becomes biologically embedded.

The adolescent brain is not just learning what to think. It is becoming someone.

The Crisis of the Anxious Generation

Now we place that developmental reality beside the data from our own culture. Since the early 2010s rates of anxiety and major depression among teenagers have roughly doubled. Self-harm severe enough to require emergency medical care has nearly tripled among young adolescent girls. Suicide among children as young as ten to fourteen has risen at a rate that should stop any society in its tracks.

Sleep has declined. Face-to-face interaction has diminished. Sustained attention has been fractured. This is not a small shift.

It is a developmental earthquake.

Our young are not weak. They are being formed in an environment that is not producing resilience. A brain that requires embodied belonging is being raised in a disembodied world.

When Formation Moves Away from the Family

And into that environment come comprehensive systems of meaning. In many educational and social settings today, young people are not only being taught academic content. They are being given interpretive frameworks that tell them who they are, how to understand their

bodies, how to interpret their history, and where their moral standing lies.

These frameworks are not experienced as abstract theories. They are experienced as belonging. When moral worth is tied to one's location in a hierarchy of power, a young person is not simply learning sociology. They are learning their identity.

When biological reality is presented as secondary to internally declared identity, the adolescent is not merely encountering a philosophical claim. They are being asked to ground their sense of self in a framework while the neurological systems required for long-term integration are still under construction.

When inherited faith is presented primarily as a source of harm rather than as a living tradition to be explored, the young person experiences not an intellectual critique but a distancing from the deepest sources of meaning in their family.

There is also a growing dissonance between developmental readiness and the content many children are being exposed to. When the world of adult sexuality enters the consciousness of a child before the brain and body are ready to integrate it, the result is not liberation but confusion.

The developmental sequence that once allowed for the gradual integration of body, relationship, and meaning is disrupted.

In my clinical work I sit with parents and children who love one another and yet find themselves unable to speak across an identity boundary that feels absolute. Not because of abuse, but because belonging has been relocated. Disagreement is experienced as annihilation. Individuation has become severance.

This is not simply a political conflict. It is an attachment crisis.

Why Distress Makes Capture Easier

A generation that is anxious, depressed, sleep-deprived, and socially fragmented does not stop searching for identity. It searches more urgently. Pain intensifies the need for belonging. Isolation intensifies the need for recognition. Confusion intensifies the appeal of moral certainty.

The adolescent brain will give itself to something. And systems that offer immediate affirmation, clear categories, and a sense of purpose become neurologically and psychologically irresistible.

A Call to Formation, Not Fear

And this is where I refuse despair. Because the adolescent brain is not broken. It is the most powerful engine for renewal in any civilization. It is designed for transcendence.

Now that we understand the neuroscience, the developmental psychology, and the cultural moment, we are not helpless observers. We are responsible stewards.

The answer is not to capture our young for a competing ideology. The answer is to form them in environments so rooted in truth, so embodied in love, and so enduring in relationship that they do not have to choose between identity and belonging.

We must rebuild families, faith communities, and educational environments in which a young person can explore difficult questions without severing relationship, can examine history without despising their origins, and can inhabit their body as a gift rather than as a problem to be solved.

Because the adolescent brain will give itself to something. Our task is to ensure that what it gives itself to is worthy of the majesty of its design.

What Xi Van Fleet offers us is not a political argument but a generational memory. She stands as a witness to what happens when the deepest developmental longings of the young are captured and redirected away from family, history, and embodied belonging.

Her story is not ours, and our children are not being sent into rural exile. But we would be naïve not to recognize that there are forms of exile that are not geographic. There is an exile of disconnection, an exile of confusion, an exile in which a young person becomes a stranger to their own body, their own history, and sometimes even to their own family.

History does not ask us to repeat itself. It asks us to pay attention.

And because we can see, because we can understand, and because we can love, we are not bound to the same outcome. We listen, we learn, and we will choose differently.

The Future

The future of our culture will not be determined first by elections or institutions. It will be determined by whatever captures the allegiance of the adolescent heart.

And that means the most important work before us is not control.

It is formation.



A Line Was Crossed

For years now, there has been a slow and unmistakable encroachment into one of the most protected and sacred spaces in our culture, the therapy room. It did not happen all at once, and that is precisely why it was so easy to miss at first. It came gradually, almost quietly, advancing inch by inch. First as guidance. Then as regulation. And eventually as something far more concerning, far more intrusive, the attempt to control what therapists are allowed to say, what questions they are permitted to ask, and which directions of inquiry are deemed acceptable or unacceptable by forces outside the room.

And that is where the line was crossed.

On March 31, 2026, in **Chiles v. Salazar, the Supreme Court of the United States** stepped in and drew a line that should never have been crossed in the first place. In an 8 to 1 decision, the Court made it unmistakably clear that the government does not have the authority to dictate the content of therapy based on preferred viewpoints. That is

not regulation. That is not benign oversight. That is overreach, and it is precisely the kind of overreach the Constitution exists to restrain. This ruling did not merely resolve a legal question. It restored something that had been under increasing pressure, something foundational, something that cannot be compromised without doing harm to the very people therapy is meant to serve. It restored the integrity of the therapeutic relationship.

How We Got Here

To understand the weight of that decision, you have to understand what was happening in Colorado. Under the stated goal of protecting minors, the state enacted a law that reached directly into the therapy room and began defining what licensed clinicians could and could not explore in conversations related to identity, particularly gender identity. On its surface, it sounded protective, even compassionate. It was framed in the language of care. But in practice, it functioned as a constraint on clinical judgment. It replaced the nuance of individualized care with a predetermined boundary around what was considered acceptable exploration. It substituted the lived, relational, moment to moment discernment of a trained clinician with a rigid, externally imposed framework.

It did not trust the therapist.

It did not trust the patient.

It trusted the state.

The named respondent, Patty Salazar, served as the Executive Director of the Colorado Department of Regulatory Agencies, an administrative position responsible for oversight across a wide range of professions. It is a role rooted in policy, compliance, and enforcement. It is not a role

grounded in psychotherapy. It is not shaped by years of sitting with patients, working through trauma, identity confusion, developmental struggles, attachment wounds, and the deeply human process of meaning making. And yet, through that office, the state assumed the authority to define what constitutes appropriate therapeutic conversation.

That should give every clinician, every parent, and every citizen pause.



Because if that authority stands, the therapy room ceases to be a place of exploration and becomes a place of compliance.

When Regulation Becomes Control

Because the question in this case was never simply about protecting patients. Ethical clinicians are already bound, rigorously and rightly, to protect those they serve. We are accountable to ethical codes, licensing boards, professional standards, and most importantly, to the well-being of the human being sitting across from us. The real question was whether the state could go further, whether it could begin to prescribe

how therapy must unfold, what must be affirmed, what may not be questioned, and which avenues of exploration are effectively closed off, regardless of the patient's own stated goals, experiences, and internal conflicts.

When that occurs, something essential begins to erode. The therapeutic space narrows, not because of clinical judgment, but because of externally imposed limits on what may be explored and understood. At that point, therapy no longer functions as a process of discovery grounded in the patient's experience. It becomes, in effect, a state directed dialogue, shaped less by the needs of the individual and more by predetermined boundaries of acceptable thought.

That is a profound shift, and a dangerous one.

Why We Stepped Forward

This case drew national attention because many of us recognized what was at stake and chose not to remain silent. I had the privilege, and I would say the responsibility, of contributing to an amicus curiae brief, titled Amicus Curiae Brief of Medical Professionals in Support of Petitioner, alongside colleagues who are not abstract voices, but seasoned professionals with deep expertise across medicine, endocrinology, pediatrics, and clinical care. Among those who stood together in this brief were the distinguished and widely respected Michelle A. Cretella, M.D., Executive Director of the American College of Pediatricians; Michael K. Laidlaw, M.D., an endocrinologist and expert in hormone physiology; Quentin L. Van Meter, M.D., a pediatric endocrinologist and former president of the American College of Pediatricians; André Van Mol, M.D., a board-certified family physician and co-chair of the American College of Pediatricians' Committee on Adolescent Sexuality; and Maria Keffler, an author and public speaker

focused on parental rights and child advocacy. Alongside them, I contributed as a clinical psychologist, grounded in decades of work with adolescents, trauma, identity formation, and the layered psychological realities that unfold in the therapy room. These are not theoretical voices. These are clinicians, physicians, and professionals who have spent their lives working with real patients, real families, and real suffering. These are individuals who carry responsibility, not just opinion. And we stepped forward together, not because it was easy, but because it was necessary.

Because there are moments when silence becomes complicity.

And this was one of those moments.

The Critical Distortion

At the heart of our concern was a growing and deeply problematic conflation, one that has been repeated often enough that it has begun to take on the appearance of truth. Historically, what has been called conversion therapy referred to coercive attempts to change sexual orientation. These practices were often ethically indefensible and, in many cases, harmful. They have been widely rejected, and rightly so.

There is little disagreement on that point within the profession. In recent years, however, the meaning of that term has expanded in ways that collapse fundamentally different forms of therapy into a single category.

Exploratory therapy, which is careful, patient directed, and grounded in ethical clinical practice, has increasingly been drawn into that same label. In doing so, an important distinction has been lost. This concern has been articulated clearly by **Debra Soh, Ph.D.,** a sexologist and former academic researcher whose work has been published in peer

reviewed scientific journals, including research conducted at institutions such as York University. Though generally regarded as politically liberal leaning, she has been notably willing to challenge ideological overreach from within her own side. In her book *The End of Gender*, she describes how the term conversion therapy has been inflated through conflation, expanding beyond its original meaning in ways that erase critical distinctions. What follows is not simply imprecision, but a critical distortion of meaning that reshapes the conversation, misrepresents the nature of therapeutic work, and obscures the ethical boundaries that actually matter.

This is not a minor semantic issue. It is a meaningful mischaracterization that carries real consequences for both clinicians and patients. When a patient says, *"I do not want to move in a certain direction, but I need to understand why I feel this way,"* the ethical response is not to shut that down. It is not to redirect them toward a predetermined outcome or to foreclose exploration before it has even begun.

The ethical response is to engage the question fully and thoughtfully. It is to explore developmental history, trauma, relational patterns, identity formation, and the broader psychological landscape in which that experience has emerged. It is to remain grounded in the patient's stated goals while bringing clinical skill, curiosity, and care to the process.

That is not coercion. It is appropriate and responsible clinical care.

That is therapy.

What the Court Restored

The Court recognized this issue for what it truly is. It affirmed that therapy is, at its core, speech, deeply personal, exploratory, and meaning-making speech that unfolds in the context of trust and professional responsibility. To regulate that kind of speech based on viewpoint is not simply a matter of policy or preference; it crosses into unconstitutional territory by restricting the very process through which individuals come to understand themselves. In doing so, the Court drew an important line, one that protects not only clinicians, but the integrity of the therapeutic relationship itself.

For those of us who have spent our lives engaged in this work, the implications are both immediate and profound. Therapy is not a scripted exchange or a predetermined outcome. It is a process of discovery, often nonlinear and at times uncomfortable, where patients are given the space to examine their thoughts, emotions, beliefs, and experiences without coercion or constraint.

When a patient sits down and says, ***"Help me understand myself,"*** they are not asking for direction imposed from the outside. They are asking for guidance in making sense of their own internal world, and that requires freedom, freedom to explore, to question, and to arrive at meaning in a way that is authentic to them. This ruling restores and reinforces that freedom. It allows clinicians to practice ethically and responsibly, grounded in their training and professional judgment, without the fear that certain lines of inquiry are off-limits simply because they challenge prevailing viewpoints. It safeguards the therapeutic space as one where truth can be pursued, not prescribed, and where the goal is not ideological conformity, but genuine understanding and healing.

A Final Word

There is one final point that must be said, and it needs to be said without hesitation. What has unfolded in recent years is not merely a shift in clinical thinking. It reflects a bending of language, a collapsing of essential distinctions, and a movement away from the disciplined clarity that our profession depends on. When that clarity is lost, the consequences are not abstract. They are borne by patients.

We cannot afford that.

Words must mean what they mean if our work is to remain grounded and ethical. A practice rooted in coercion cannot be equated with a process rooted in exploration, and a framework built on predetermined outcomes cannot be confused with one grounded in patient autonomy.

When a patient enters the room seeking to understand their own internal experience, the ethical obligation is not to narrow that path, but to walk it with them carefully and thoughtfully, without imposing conclusions that are not their own. That is not coercion.

That is therapy.

Therapy is not a tool of the state, nor is it a vehicle for ideology. It is a disciplined, relational, deeply human process that requires humility, restraint, and the courage to sit with complexity. It calls the clinician to respond to the individual in front of them, not to an abstract framework, not to a cultural mandate, and not to pressures that originate outside the room. When that freedom is constrained, even subtly, the work itself is compromised.



This moment also calls for reflection among the institutions that shape the field. The American Psychological Association, the American Academy of Pediatrics, the Endocrine Society, and others hold immense influence, and with that influence comes responsibility, to precision, to science, and to truth. When those anchors drift, the consequences do not remain theoretical. They show up in the therapy room, and they show up in the lives of patients.

To my colleagues, both those who have stepped forward and those who are watching carefully, this is a moment that requires clarity and courage. There is risk in being visible, and there is risk in attaching your name to positions that will be challenged, scrutinized, and at times opposed. But there is also responsibility, responsibility to the profession, responsibility to the science, and above all, responsibility to our patients. Some things are worth that risk. We do not step forward because it is comfortable. We step forward because it is necessary, because truth requires it, because our profession depends on it, and because our patients deserve it.

And we must be willing to say plainly what is true. A rock is a rock. A tree is a tree. Exploratory therapy is not coercion. Inquiry is not harm. Listening is not abuse. The therapy room belongs where it has always belonged, in the space between clinician and patient, grounded in trust, guided by ethics, and oriented toward truth, not the state, not ideology.

Truth.

And that is not something we will surrender.



Look Both Ways Before You Cross the Intersection to a Therapist for Your Teen

When I came out of graduate school, I knew enough to be dangerous. I had studied hard, completed supervised training, conducted research, and earned my doctorate. What I did not yet possess was the understanding that comes from sitting with suffering people, discovering where your favorite theory falls short, and learning that human beings refuse to fit neatly into the boxes we construct for them. Graduate school prepared me to begin. After more than forty years in clinical psychology, I would be considerably more concerned about a therapist who could not make that admission.

Choosing a therapist for your teenager matters enormously. You are inviting someone to help your child interpret suffering, relationships, identity, and the future. A capable clinician can help restore stability, address painful experiences, and recover a sense of possibility. An ineffective therapist can miss serious risks, reinforce helplessness, encourage dependency, or steer a vulnerable young person toward

conclusions shaped more by the therapist's assumptions than the teenager's needs. When serious depression, self-harm, or other dangerous conditions are involved, getting this right may also help protect your child's life.

Parents deserve to understand what they are entrusting to us. Teenagers deserve a voice in the care they receive. Neither should have to fight through professional arrogance to ask a reasonable question.

Look for Someone Whose Education Is Still in Progress

Years ago, my supervisor, Dr. Steve Parkison, offered a memorable way to evaluate a psychologist: examine the books and journals in the office, then return several years later. If nothing has changed, run. He was talking about intellectual growth. Today, that library may live on a laptop, but the question remains: Is this person still learning, questioning assumptions, and refining the work?

Research gives that question teeth. Goldberg and colleagues (2016) found that accumulating experience did not reliably make therapists more effective. There are excellent young clinicians whose training, supervision, and humility make them exceptionally capable. There are seasoned clinicians who keep deepening their craft, and others whose twenty years of experience look suspiciously like one year repeated twenty times. Certificates can accumulate while curiosity quietly dies.

A doctorate does not automatically make someone an excellent therapist, just as a master's degree does not automatically make someone a lesser one. Appropriate credentials, an active license, relevant experience, and sound supervision matter. So does the ability to say, "That is outside my expertise," or "I need to consult someone." Ask what the clinician has learned recently that changed how they

practice. Your teenager needs thoughtful judgment from someone whose education is still very much in progress.

Connection Matters and Competence Matters Too

Adolescents often have a remarkably sensitive detector for adults who are performing concern. They recognize condescension, rehearsed reassurance, and the moment their experience is squeezed into a theory before they have finished describing it. A capable therapist offers the experience of being understood without being indulged, challenged without being humiliated, and taken seriously without becoming a diagnosis with sneakers.

McLeod's (2011) meta-analysis found a modest association between the therapeutic alliance and outcomes in youth psychotherapy. Connection deserves attention, but warmth alone cannot establish competence. A likable clinician may lack the expertise your teenager needs, while an impressive specialist may accomplish little if your child never feels safe enough to speak honestly. After an initial appointment, ask whether your teenager felt listened to and could imagine discussing something difficult with that person. I would also ask, "Could you disagree with this therapist and still feel respected?" That answer may tell you more than whether the appointment was pleasant.



Psychotherapy does not become harmless simply because its intentions are compassionate. A clinician can overlook a medical condition, misunderstand symptoms, mishandle risk, or reinforce the conviction that a teenager is fragile and permanently damaged. Abigail Shrier's Bad Therapy (2024) raises an uncomfortable challenge: Might some well-intentioned therapeutic attention encourage young people to organize their identities around distress? Her investigative critique is a reason to examine our practices, rather than a verdict on every clinician or treatment.

Research on youth depression demonstrates both meaningful benefits and the need for accountability. Cuijpers and colleagues (2023) found benefits from psychotherapy, including a lower risk of deterioration compared with control conditions, yet many young people did not achieve a treatment response. Families need clinicians who monitor what is happening and reconsider the plan when necessary. Compassion should make us more willing to examine our results, not less.

Your Family Has a Right to Understand the Treatment

Informed consent should mean more than signing intake paperwork. Families deserve an understandable explanation of the proposed

treatment, its rationale, supporting evidence, meaningful risks, uncertainties, alternatives, costs, and how progress will be evaluated. If a diagnosis is offered, ask what supports it and how it will guide care. Naming a teenager's suffering does not establish that the clinician understands its origins or knows how to help.

With adolescents, clinicians must also explain applicable consent requirements, developmentally appropriate assent, confidentiality limits, and the respective roles of parents and teenagers. The APA's ethics code addresses these responsibilities, along with professional competence (American Psychological Association, 2017). A signature cannot substitute for a candid conversation. Your teenager should understand the work in language appropriate to their age, and you should understand how to support it.

Parents can ask direct questions before committing: What experience do you have treating teenagers with similar concerns? How will assessment guide your recommendations? How will my child participate in setting goals? What will we do if treatment is not helping? Ask about the limits of the clinician's expertise and arrangements for urgent concerns. You do not need a dissertation over the telephone, but you should hear clear thinking, reasonable humility, and willingness to consider alternatives. If ordinary questions produce irritation or a performance of professional superiority, take that information seriously.

Your Child Is Not a Recruitment Opportunity

Your teenager enters therapy at a vulnerable moment. The clinician's authority can influence how that young person understands identity, family, faith, suffering, and personal possibility. Your child's pain must never become an opportunity to recruit another believer into the

therapist's worldview. I have become increasingly concerned about ideological capture within my profession: allegiance to a favored explanation taking precedence over careful investigation. The conclusion arrives before the assessment, and disagreement becomes evidence that something is wrong with the person asking questions.

My concern comes partly from supervising doctoral students. Some struggled to examine questions outside a dominant ideological framework; some reported fear of faculty disapproval if they expressed different views. Those experiences do not characterize every training program, but they reinforced my conviction that professional education must cultivate independent judgment. Universities should teach students to test explanations, examine evidence, and tolerate respectful disagreement. Institutional endorsement does not relieve a clinician of those obligations in the therapy room.

The practical test is how the therapist handles a different perspective. Can your teenager reconsider an explanation the clinician favors? Can parents raise concerns and receive a thoughtful hearing? Can the therapist acknowledge uncertainty or revise an assumption? If exploration is permitted only when it reaches a predetermined destination, the young person's freedom has already been compromised. A clinician should be able to explain recommendations without placing your motives on trial.

This standard applies equally to my Christian convictions. My faith does not authorize me to impose conclusions, humiliate a struggling teenager, or confuse spiritual agreement with psychological healing. Political commitments confer no such authority either. Your child deserves competent care, compassion, and room to ask difficult

questions. Agreement with the therapist should never become the price of receiving respect.

Parents Belong in the Picture

Your teenager needs room to speak honestly, and you need to understand how treatment works and how to support it. A skilled adolescent therapist explains what can remain private, what parents can expect to learn, how safety concerns will be managed, and when family participation will be helpful or necessary. "I will tell your parents everything" can undermine trust, while "Your parents have nothing to do with this" can dismiss people essential to recovery. Thoughtful care requires a more careful arrangement, consistent with applicable law and the teenager's developmental needs.

Parents may also need to examine their contributions to family difficulties, including conflict, expectations, communication patterns, or well-intentioned protection that maintains avoidance. We should be willing to hear that. Sometimes genuinely unsafe family behavior needs attention; sometimes relationships need repair; sometimes parents are already doing an extraordinary job under difficult circumstances. Beware of a therapist who assigns blame before understanding the family or automatically assumes the adults are right because they pay the bill. Your teenager needs someone capable of understanding complexity without immediately assigning villains.

Watch for Progress and Know the Warning Signs

No therapist is perfect, and one awkward conversation does not automatically justify ending treatment. Patterns are more revealing. Be concerned when a clinician discourages second opinions, cannot explain the treatment plan, makes sweeping conclusions after minimal assessment, pressures your teenager to accept personal beliefs,

dismisses deterioration, or encourages unnecessary dependency. Boundary violations and promises of a cure deserve particular scrutiny. Parents should be able to describe concerns without having them reflexively dismissed as resistance to treatment.

A quieter problem is pleasant stagnation. Everyone likes the therapist, appointments continue, and months pass. Yet nobody can explain what is improving or why the same approach remains appropriate. Some conditions require prolonged care, and progress is rarely linear, but duration should have a clinical rationale. Look outside the office: better sleep, more consistent school attendance, less avoidance, stronger relationships, fewer destructive arguments, and a growing ability to recover after disappointment. Review these changes with the clinician and your teenager rather than relying only on whether appointments feel good.

Therapeutic work can be uncomfortable. Your teenager may need to confront a fear, tolerate grief, accept responsibility, or abandon an escape behavior. Parents may need to make changes as well. The question is whether that discomfort serves an understandable purpose within competent, respectful care. Worsening symptoms deserve reassessment, not a professional shrug dressed up as "Trust the process." Attendance is easy to count. Benefit requires closer attention.

Coping Better Is Important and Identity Matters Too

Dr. Tori Olds, one of my clinical psychology heroes, describes a useful distinction between incremental change, which develops through practice and new responses, and transformational change, which addresses underlying emotional expectations and core beliefs (Olds, 2026). CBT and DBT offer valuable tools for changing behavior, regulating emotions, tolerating distress, and developing healthier

responses. Sometimes these changes provide exactly what a teenager needs. Sometimes they create the stability necessary to address deeper wounds. The important question is whether treatment reaches what is driving this particular young person's suffering.

The brain's **Default Mode Network (DMN)** helps explain why identity deserves attention. Its interconnected regions include the medial prefrontal cortex, posterior cingulate and adjacent precuneus, inferior parietal regions, and portions of the medial temporal lobes. This network participates in self-reflection, autobiographical memory, and imagining the future (Buckner et al., 2008). Think of it as part of the brain's machinery for weaving experience into a continuing story of who we are. During adolescence, that story is still taking shape. Rejection, chronic criticism, neglect, abuse, or overwhelming events may contribute to painful expectations about worth and safety. These beliefs involve multiple brain systems, rather than residing in one network.

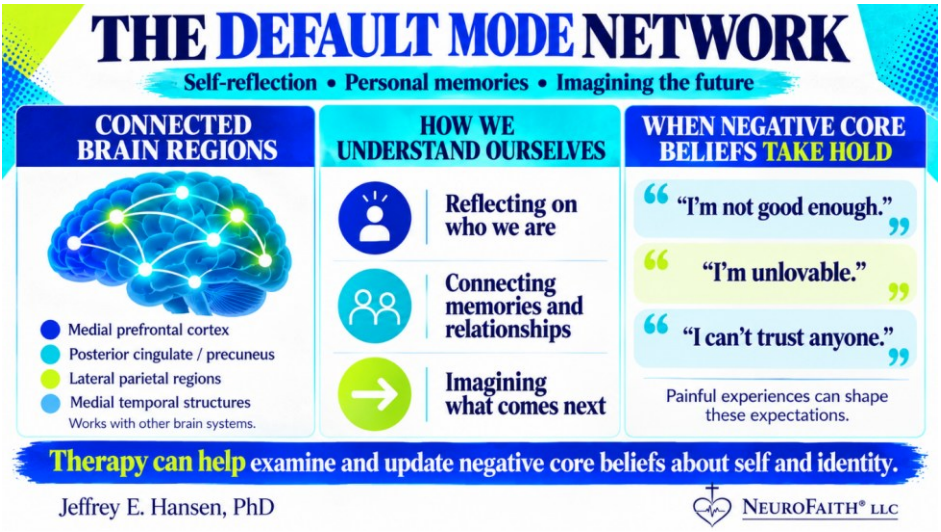
Imagine a teenager who experiences every correction as proof of worthlessness. Therapy may help that adolescent challenge catastrophic interpretations and manage the emotional reaction. Those gains matter enormously. But suppose the conviction underneath remains: "If I make a mistake, I am unworthy of love." The young person may behave better while continuing to experience life through shame. When such beliefs are central, therapy should explicitly address the schema, the organizing framework through which experiences become evidence of being defective, unsafe, or unlovable.



Over forty years, I have encountered too many people who became better at managing symptoms without substantially changing how they experienced themselves. That clinical observation is a reason to ask more ambitious questions about treatment. CBT can address core beliefs, and cognitive, behavioral, relational, and experiential work can all support deeper change. Memory reconsolidation offers a scientific framework for understanding how established emotional learning may be updated, although its precise role in psychotherapy remains under investigation (Lane et al., 2015). The goal is for a teenager to begin experiencing, with growing conviction, "What happened to me was painful, but it does not establish my worth."

Symptom improvement matters. So do relationships, belonging, purpose, and the ability to imagine a future worth participating in. We should ask whether treatment is helping the teenager become freer to live, love, accept responsibility, and contribute. We should also remain humble about what short-term symptom measures can tell us about a person's unfolding life. Brief treatment can be excellent when it fits the need, and longer work can be appropriate when the assessment

supports it. An insurance authorization cannot do our clinical thinking, and an open-ended schedule cannot substitute for a clear purpose.



NeuroFaith® as One Approach to Transformational Work

One approach I have developed to pursue this kind of transformational work is **NeuroFaith®**, an integrative therapeutic model built around four pillars. I brought these approaches together because I kept encountering people who could explain their pain intellectually while their bodies, protective reactions, and deepest beliefs continued responding as though the old danger were present. You may know that a conversation is safe while your chest tightens, your breathing changes, and every impulse tells you to fight, withdraw, or disappear. An explanation alone may do little to alter that experience.

I want to emphasize **that NeuroFaith®** is one integrative approach to transformational therapy, **not the only one.** There are other excellent therapeutic models, and different approaches resonate with different people, clinicians, and clinical needs. I have no interest in suggesting that everyone should practice or pursue NeuroFaith®. Should you wish

to explore another integrative, transformational approach, please do so with my wholehearted blessing and encouragement. Find the approach, and more importantly, the clinician, who is right for you. My interest is not in promoting a particular therapeutic brand, but in helping people experience meaningful and lasting change. What matters is not allegiance to a model, but whether therapy can reach beyond symptom management to address the deeper emotional patterns, protective responses, negative core beliefs, and questions of identity that may be organizing a person's suffering. The goal is healing and transformation, not loyalty to a particular method.

The first pillar, Polyvagal-Informed Therapy, provides a lens for exploring bodily states, perceived safety, and protective responses. In teen-friendly language, we might ask, "What happens in your body when you think you're in trouble?" Learning to notice a racing heart, clenched jaw, or urge to shut down can help a young person recognize what is happening before the reaction takes over. **The second pillar, HeartMath® and neurocardiology,** brings attention to heart–brain communication and practices involving breathing, attention, and heart rate variability biofeedback. I use these practices to support regulation so that difficult feelings become more manageable and the teenager can participate more fully in the work (HeartMath Institute, n.d.).

The third pillar, Internal Family Systems, offers a compassionate way to understand wounded and protective parts of our inner experience (IFS Institute, n.d.). One part of a teenager may demand perfect grades, another may lash out when embarrassed, and another may want to hide from everyone. We can explore what those responses are trying to protect against and what the young person has come to believe about themselves. "A part of me is terrified of failing" opens a different conversation from "I am a failure." The work includes helping

protective responses become less extreme while addressing the shame, fear, and negative core beliefs beneath them. Compassion and responsibility belong together; understanding an angry reaction does not excuse hurting someone.

The fourth pillar is Spirituality and Faith, explored in accordance with the teenager's convictions, willingness, and applicable consent arrangements. Questions such as "Do I matter?" "Where do I belong?" and "What could make my life meaningful?" deserve a thoughtful hearing. For teenagers who want Christian faith integrated into care, those beliefs can be engaged explicitly. Spiritual agreement is never a condition of receiving respect or competent treatment, and a parent's enthusiasm for faith integration should not replace listening to the teenager's own questions and experience.



In my clinical experience, this integration has been valuable in helping people work toward deeper change. **NeuroFaith®** is one approach to that goal. Its purpose is to help a young person develop greater

regulation, approach painful inner experiences with compassion, and update beliefs about worth and identity. The hope is that "Something is wrong with me" gradually gives way to a more secure understanding: "I have been hurt, I have things to learn, and I am still worthy of love." That change should begin reaching daily life, through healthier relationships, greater willingness to face challenges, and a future that feels more possible.

Your Child Is Worth Getting This Right

After more than forty years sitting with children, teenagers, and families, I still feel the weight of being trusted with someone's child. Parents bring sleepless nights and the hope that we might know how to help. Teenagers sometimes bring very little hope at all. They may arrive guarded, angry, embarrassed, or exhausted from trying to explain something they barely understand themselves. Being invited into that struggle is a privilege. I hope I never become so professionally comfortable that I forget it.

I have made mistakes, reconsidered assumptions, and needed help from colleagues. I am still learning. Families deserve our honest thinking, careful attention, and willingness to recognize when our approach is falling short. My colleagues and I cannot ask patients to face uncomfortable truths while protecting ourselves from every uncomfortable question. When institutional demands interfere with appropriate care, we have a responsibility to make the clinical case for what the young person needs.

There are wonderful therapists who bring both skill and heart to this work. If your family has been disappointed, I hope you will keep looking. Ask the questions and expect thoughtful answers. Look for someone who notices the courage it took your teenager to walk through the

door, someone tender with pain and steady enough to help your child face the difficult work ahead. Your questions and your teenager's voice belong in the room.

There is so much worth working toward: hearing your teenager laugh freely again, watching a friendship take root, seeing the courage to return to school, accept responsibility, or try again after disappointment. There is the possibility of a young person beginning to feel worthy of love and imagining a future with room for them in it. You do not need every answer to help hold that possibility open. Your child's story is still unfolding, and the care you seek should help them discover that life can become larger than this difficult chapter.





Both Ways Before You Cross the Street to the Therapy Room

You are about to pay a stranger to help you make sense of your life. You may tell that person about the marriage coming apart, the childhood you cannot outrun, the shame beneath your accomplishments, or the exhaustion of appearing perfectly functional while quietly falling apart. That person's interpretations may influence what you believe about yourself, your family, your faith, and your future. Before handing someone that kind of influence, you have every right to ask what qualifies them to carry the responsibility and how they intend to help.

Yet people who would thoroughly investigate a kitchen remodel sometimes enter psychotherapy assuming the professional must know best. I understand the impulse. When you are hurting, you want someone who knows what to do. But desperation should never cost you your voice. You are investing money, time, trust, and the courage required to reveal what hurts. A license deserves respect; it does not purchase immunity from questions.

I love psychotherapy. After more than forty years practicing it, I have seen what good treatment can help people reclaim: relationships, courage, dignity, purpose, and the ability to imagine a future. I have also seen people become remarkably articulate about their suffering while remaining imprisoned by it. They understand their triggers and can explain their childhood in impressive detail. Meanwhile, the same shame keeps governing their decisions. We should care enough about this work to ask whether understanding is becoming meaningful change.

The Diploma Does Not Do the Thinking Look

When I came out of graduate school, I knew enough to be dangerous. I had studied hard, completed supervised training, conducted research, and earned my doctorate. I had a foundation. What I lacked was the understanding that comes from discovering how often your favorite theory fails the person sitting in front of you. Graduate school prepared me to begin. Anyone who treats graduation as the intellectual finish line should concern you.

My supervisor, Dr. Steve Parkison, once suggested examining the books and journals in a psychologist's office, then returning several years later. If nothing had changed, run. He was talking about intellectual growth. Today, the library may live on a laptop, but his question survives beautifully: Is this clinician still learning, or merely renewing the license? Goldberg and colleagues (2016) found that accumulating experience did not reliably produce greater effectiveness. There are excellent young clinicians and seasoned practitioners who keep refining their craft. There are also therapists whose twenty years of experience look suspiciously like one year repeated twenty times.

Appropriate credentials, an active license, and relevant experience matter. So does the humility to recognize when consultation or referral is needed. Ask about the therapist's experience with concerns like yours, the limits of their expertise, and what they have learned recently that changed their practice. You should hear clear thinking and reasonable humility. A thoughtful answer reveals something. So does offense at the question.

You Have a Right to Know

Informed consent should mean more than signing six pages while somebody copies your insurance card. You deserve to understand what the therapist thinks is happening, what treatment is proposed, why it fits your circumstances, and what its meaningful risks, limitations, and alternatives are. Fees, confidentiality and its limits, arrangements for urgent concerns, and plans for evaluating progress belong in that conversation. If a diagnosis is offered, ask what supports it and how it will guide care. Naming your suffering does not establish that someone understands its origins or knows how to help you recover.

The American Psychological Association's ethics code addresses informed consent and professional competence (American Psychological Association, 2017). Your signature, however, cannot do the work of your understanding. After a reasonable assessment and discussion, you should be able to explain in ordinary language what you and your therapist are trying to accomplish. Ask why an approach is recommended, how you will recognize benefit, and what happens if you get worse or remain stuck. Those questions should open a conversation rather than provoke a performance of professional superiority.

Your questions belong in the room because your life is the reason the room exists.

Feeling heard can bring enormous relief, but warmth alone cannot carry the responsibility of treatment. A wonderfully affirming clinician can still overlook a medical concern or lack the expertise you need. Nor should therapy become a weekly ceremony in which every grievance receives professional approval. Sometimes healing requires confronting avoidance, accepting responsibility, repairing damage you caused, or grieving something you cannot fix. Compassion should make difficult truth bearable enough to examine.



Your participation matters, too. Describe what happens between appointments, say when a recommendation makes little sense, and make an honest effort to practice what you have agreed to try. But "You weren't invested enough" must never become the clinician's automatic escape hatch when treatment fails. Your responsibility to participate does not cancel the therapist's responsibility to reassess.

Your Pain Is Not a Recruitment Opportunity

A therapist's influence demands restraint, especially when you are frightened and looking for answers. Your vulnerability must never

become an opportunity to manufacture another believer in the therapist's worldview. Notice what happens when you disagree. Does the clinician investigate your concern, or reinterpret your objection as further evidence that the clinician is right? Can you discuss faith without condescension, question an explanation without being shamed, or reconsider a decision without being pushed toward an approved destination? When every possible response confirms the therapist's theory, you have entered an argument you are never allowed to win.

This standard applies to me. My Christian convictions do not authorize me to impose conclusions or confuse spiritual agreement with psychological healing. Political commitments confer no such authority either. A capable therapist helps you examine your life honestly while respecting your freedom to reach considered conclusions. Your agreement should never become the price of receiving respect.

Beware of Pleasant Stagnation

You like the therapist, the therapist likes you, and the appointments continue. Payments clear and months pass, while your life remains much the same. Nobody can explain what is changing, but another appointment is always available. Some conditions require prolonged treatment, and ongoing support can serve a legitimate purpose. Still, continuing care needs a rationale beyond familiarity. You and your therapist should periodically examine what is improving, what remains difficult, and whether the approach needs to change.

Look outside the office. Are you avoiding less, sleeping better, setting healthier boundaries, or recovering more readily after disappointment? Good therapy can be uncomfortable, but discomfort should serve an understandable purpose. Deterioration deserves reassessment. "Trust the process" is a thin answer when nobody can explain the process or

account for what it is doing to you. Neither an insurance authorization nor a therapist's preference for open-ended work should substitute for clinical judgment about your needs.

Coping Better and Changing More Deeply

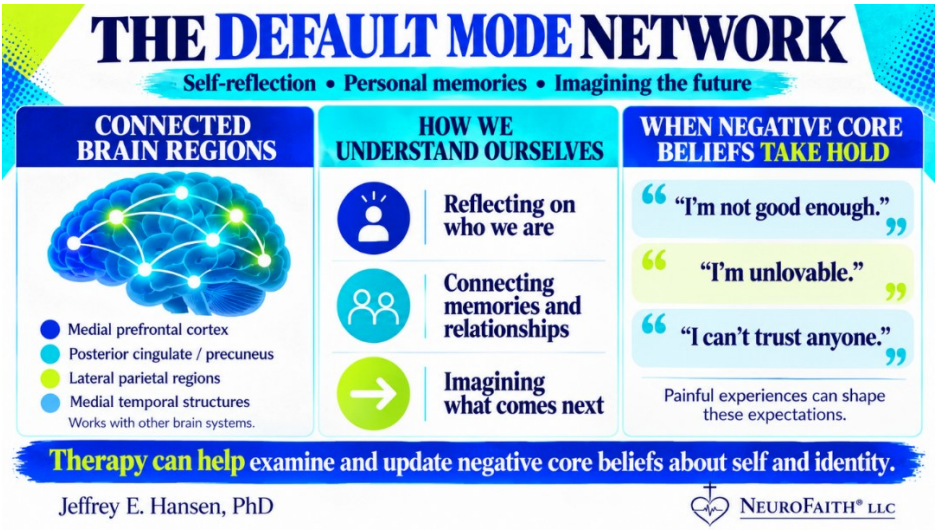
Incremental change develops through practice: learning to regulate emotions, tolerate distress, challenge unhelpful thoughts, and respond differently. CBT and DBT offer valuable ways to pursue these goals. Transformational change addresses the underlying emotional expectations and negative core beliefs through which you experience yourself and other people, a distinction Dr. Tori Olds, one of my clinical psychology colleagues and heroes, explains in her teaching (Olds, 2026). These are useful descriptions of change rather than rigid categories of therapy. The question is what your treatment is actually helping you change.



Suppose you manage anxiety more effectively while remaining convinced that you are unlovable. You breathe through the panic and return to a marriage in which you silence every legitimate need because

you expect abandonment. Your coping has improved, but the schema, the organizing framework that interprets your experiences, may remain painfully intact. When trauma or profound shame is central, beliefs such as "I am defective," "I am unsafe," and "My needs do not matter" deserve direct attention. Updating them involves more than rehearsing encouraging sentences you do not believe.

The brain's **Default Mode Network (DMN)** participates in self-reflection, autobiographical memory, and imagining the future. Its interconnected regions include the medial prefrontal cortex, posterior cingulate and adjacent precuneus, inferior parietal regions, and portions of the medial temporal lobes (Buckner et al., 2008). Think of it as part of the brain's machinery for weaving experience into a continuing story of who you are. Identity involves multiple brain systems, but the clinical question is wonderfully human: Does that story still condemn you for what you endured? Research on memory reconsolidation offers a framework for understanding how established emotional learning may be updated through new experience (Lane et al., 2015). The ambition is a change you can experience and live, beyond an explanation you can recite.



NeuroFaith® as One Approach to Transformational Work

One approach I have developed to pursue this kind of transformational work is **NeuroFaith®,** an integrative therapeutic model built around four pillars. I brought these approaches together because I kept encountering people who could explain their pain intellectually while their bodies, protective reactions, and deepest beliefs continued responding as though the old danger were present. You may know that a conversation is safe while your chest tightens, your breathing changes, and every impulse tells you to fight, withdraw, or disappear. An explanation alone may do little to alter that experience.

I want to emphasize that NeuroFaith® is **one** integrative approach to transformational therapy, not the only one. There are other excellent therapeutic models, and different approaches resonate with different people, clinicians, and clinical needs. I have no interest in suggesting that everyone should practice or pursue NeuroFaith®. Should you wish to explore another integrative, transformational approach, please do so with my wholehearted blessing and encouragement. Find the approach, and more importantly, the clinician, who is right for you. My interest

is not in promoting a particular therapeutic brand, but in helping people experience meaningful and lasting change. What matters is not allegiance to a model, but whether therapy can reach beyond symptom management to address the deeper emotional patterns, protective responses, negative core beliefs, and questions of identity that may be organizing a person's suffering. The goal is healing and transformation, not loyalty to a particular method.



The first pillar, Polyvagal-Informed Therapy, provides a lens for exploring bodily states, perceived safety, and protective responses. In my work, this means helping people notice activation or shutdown and develop greater capacity to remain present. The **second pillar, HeartMath® and neurocardiology,** brings attention to heart–brain communication and practices involving breathing, attention, and heart rate variability biofeedback. I use these practices to support regulation and engagement with difficult emotional work (HeartMath® Institute,

n.d.). Trauma's effects can appear in bodily reactions and habits of protection; treatment needs to attend to that lived experience.

The third pillar, Internal Family Systems, offers a compassionate way to approach wounded and protective parts of our inner experience (IFS Institute, n.d.). A harsh inner critic, relentless overachiever, or impulse to withdraw may be understood as trying to protect against something painful. We explore what those responses fear, what they have been carrying, and how their roles might change. That creates opportunities to address shame and negative core beliefs without treating the whole person as defective. Understanding a protective response does not excuse harmful behavior; it can help us change it more effectively.

The **fourth pillar is Spirituality and Faith,** explored in accordance with the person's convictions and consent. Questions of worth, belonging, forgiveness, purpose, and hope often sit close to the heart of suffering. For someone who wants Christian faith integrated into care, those convictions can be engaged explicitly. Spirituality must remain an invitation to meaningful exploration, never a condition of receiving respect or competent treatment.

In my clinical experience, this integration has been a valuable way to pursue deeper change. Its purpose is to bring regulation, emotional learning, compassionate inner work, and meaning into a coherent treatment process. The goal is for someone who has lived under "I am unlovable" to begin experiencing worth and connection in ways that change how they live. The work should translate into greater freedom in relationships, a more secure sense of worth, and renewed capacity to live with purpose.

There Is a Life Beyond the Appointment

After forty years, I still feel the weight of being invited into another person's suffering. I have made mistakes, needed consultation, and held assumptions too tightly. I am still learning. We cannot ask you to face uncomfortable truths while protecting ourselves from every uncomfortable question. You deserve a clinician whose commitment to understanding you is stronger than the need to defend a favorite theory.

There are wonderful therapists who bring skill, courage, compassion, and integrity to this work. If you have been disappointed, I hope you will keep looking with sharper questions and a clearer understanding of what you deserve. There may be relationships to repair, grief to carry differently, courage to recover, and years ahead that you want to live with greater freedom and purpose. Ask how treatment will help you move toward that life. Take your place in the work and expect the clinician to take theirs. Your life matters far too much for either of you to settle into autopilot.


FINDING THE RIGHT THERAPIST
Your Life Matters. Choose Thoughtfully.
A practical checklist for adults. Bring these questions to your next appointment.
01 EXPERTISE & CONTINUED GROWTH
Active license and relevant experience with my concerns.
Keeps learning, seeks consultation, and acknowledges limits.
Assesses carefully before settling on an explanation.
02 TRUST, RESPECT & MY VALUES
I feel heard and can disagree without humiliation.
Challenges me respectfully and welcomes honest feedback.
Respects my beliefs; includes faith only with my consent.
03 A PLAN I UNDERSTAND
Explains the approach, evidence, uncertainties, and alternatives.
Discusses fees, confidentiality, boundaries, and expected course.
Sets shared goals and a time to review progress.
04 COPING SKILLS & DEEPER CHANGE
Helps me build practical skills for daily life.
Addresses trauma, shame, and negative core beliefs when relevant.
Connects treatment with identity, relationships, meaning, and purpose.
Explains incremental and transformenonal options and how treatment fits my needs.
05 PROGRESS BEYOND APPOINTMENTS
Reviews symptoms AND changes in everyday functioning.
Takes worsening symptoms seriously and adjusts the plan.
Supports growing independence; explains the need for ongoing care.
06 MY ACTIVE ROLE & MY OPTIONS
I share concerns, clarify goals, and practice agreed skills.
We discuss changes or consultation when treatment stalls.
Welcomes second opinions and helps plan transitions when needed.
! PAUSE & ASK QUESTIONS
Promises of a cure • Pressure to adopt beliefs • Boundary violations
Dismissed deterioration • Unexplained stagnation • Discouraged second opinions
One integrated option: NeuroFaith®
Polyvagal-informed therapy • HeartMath® / neurocardiology • Internal Family Systems • Spirituality / faith
Many approaches can support meaningful change. Ask what fits your needs.
Look for skill, humility, collaboration, and hope.
Jeffrey E. Hansen, PhD
NEUROFAITH® LLC

References

American Psychological Association. (2017). Ethical principles of psychologists and code of conduct (2002, amended effective June 1, 2010, and January 1, 2017). https://www.apa.org/ethics/code

Buckner, R. L., Andrews-Hanna, J. R., & Schacter, D. L. (2008). The brain's default network: Anatomy, function, and relevance to disease. Annals of the New York Academy of Sciences, 1124, 1–38. https://doi.org/10.1196/annals.1440.011

Cuijpers, P., Karyotaki, E., Ciharova, M., Miguel, C., Noma, H., Stikkelbroek, Y., & Weisz, J. R. (2023). The effects of psychological treatments of depression in children and adolescents on response, reliable change, and deterioration: A systematic review and meta-analysis. European Child & Adolescent Psychiatry, 32, 177–192. https://doi.org/10.1007/s00787-021-01884-6

Goldberg, S. B., Rousmaniere, T., Miller, S. D., Whipple, J., Nielsen, S. L., Hoyt, W. T., & Wampold, B. E. (2016). Do psychotherapists improve with time and experience? A longitudinal analysis of outcomes in a clinical setting. Journal of Counseling Psychology, 63(1), 1–11. https://doi.org/10.1037/cou0000131

HeartMath Institute. (n.d.). Coherence. https://www.heartmath.org/research/science-of-the-heart/coherence/

IFS Institute. (n.d.). The Internal Family Systems model outline. https://ifs-institute.com/resources/articles/internal-family-systems-model-outline

Lane, R. D., Ryan, L., Nadel, L., & Greenberg, L. S. (2015). Memory reconsolidation, emotional arousal, and the process of change in psychotherapy: New insights from brain science. Behavioral and Brain Sciences, 38, e1. https://doi.org/10.1017/S0140525X14000041

McLeod, B. D. (2011). Relation of the alliance with outcomes in youth psychotherapy: A meta-analysis. Clinical Psychology Review, 31(4), 603–616. https://doi.org/10.1016/j.cpr.2011.02.001

Olds, T. (2026). Transformational change: A deeper kind of growth [Video and transcript]. https://www.toriolds.com/transformational_change/

Shrier, A. (2024). Bad therapy: Why the kids aren't growing up. Sentinel. https://www.penguinrandomhouse.com/books/716567/bad-therapy-by-abigail-shrier/



Some Things Were Worth Keeping

All right, let's get something out of the way right at the beginning. I'm getting old. There, I've said it. At 72, I figure I've earned the right to be a little nostalgic, occasionally sentimental, and perhaps even downright maudlin about the good old days. I can almost hear some of my younger colleagues rolling their eyes already. Fair enough. I've probably earned that, too. And yes, I realize that whenever someone my age begins a sentence with "Back in my day," there's a reasonable chance that a lecture is about to follow. Bear with me. I promise there is a point to all this.

Not everything about the old days was good. We had our share of foolishness, blind spots, and traditions that deserved to be challenged or abandoned. Some things needed to go, and good riddance. But other things were worth keeping, including the ordinary courtesies that communicated respect, consideration, and the simple recognition that another human being mattered. Somewhere in our enthusiastic rush toward technological progress, I wonder whether we misplaced a few of those treasures.

We live in an age of extraordinary accessibility. Our phones are rarely beyond arm's reach, messages arrive around the clock, and we can communicate with nearly anyone, anywhere, almost instantly. Yet I increasingly encounter people who feel unseen, emotionally disconnected, and uncertain whether the people in their lives are genuinely available to them. We have become extraordinarily sophisticated at reaching one another while sometimes seeming remarkably reluctant to actually connect.

I rather like technology. I use it constantly, and I appreciate being able to communicate with my children, collaborate with colleagues, and maintain friendships across considerable distances. But convenience and connection are not synonyms. An electronic interface can transmit information with remarkable efficiency while communicating almost nothing about the warmth, interest, or emotional presence of the person on the other end.

And that distinction, I believe, is more important than we may realize.

The Neuroscience of Connection

One of the most fascinating developments in neuroscience has been our growing understanding of just how profoundly relationships shape the human brain. We tend to imagine ourselves as independent individuals, each equipped with a brain that manages our thoughts, emotions, and behavior. But human beings do not develop in isolation, nor do our nervous systems operate independently of the relationships in which we live.

Psychiatrist Daniel Siegel's work in interpersonal neurobiology has helped illuminate the intricate relationship among brain, body, mind, and interpersonal experience (Siegel, 2012). From infancy onward, our

emotional lives are shaped through interactions with other people. A frightened baby settles in the arms of a familiar caregiver. A distressed child becomes calmer when a parent listens and responds with warmth. Adults continue to experience similar processes, although we may be less willing to acknowledge how deeply we need one another.

In a particularly fascinating study, Coan and colleagues (2006) demonstrated that holding the hand of a trusted spouse was associated with reduced neural responses to anticipated threat. The physical danger had not changed, yet the presence of someone trusted influenced how the brain responded to it. That finding captures something I have observed throughout my clinical career: another human being does not always have to solve our problem to help us experience it differently.

Social neuroscientist John Cacioppo devoted much of his distinguished career to studying loneliness and its implications for human health. His work helped clarify an important distinction: loneliness is not simply the absence of people, but the subjective experience of insufficient meaningful connection (Cacioppo et al., 2015). We can live alone and feel deeply connected, or we can be surrounded by colleagues, family members, and hundreds of digital contacts while experiencing profound loneliness.

The health implications are sobering. A major meta-analysis involving approximately 3.4 million participants found that loneliness and social isolation were associated with increased mortality risk (Holt-Lunstad et al., 2015). These findings do not establish that loneliness directly causes particular illnesses, but they underscore that social connection is not some sentimental luxury. It belongs in any serious discussion of human health and well-being.

What fascinates me is the contradiction between what we are discovering scientifically and what we sometimes practice culturally. We now possess extraordinary knowledge about attachment, emotional regulation, relational safety, and the therapeutic alliance. Yet it seems increasingly possible to move through an entire day surrounded by communication while experiencing remarkably little personal encounter.

As a psychologist, I find that paradox difficult to ignore.

What the Nervous System Remembers



Much of my clinical work has involved helping people understand how earlier experiences shape their present emotional lives. Through NeuroFaith®, I integrate polyvagal-informed therapy, HeartMath® and neurocardiology, Internal Family Systems, and spirituality or faith. These are distinct perspectives with differing levels of research support, and NeuroFaith® is certainly not the only integrative approach to

deeper transformational healing. But the model reflects a conviction that has grown stronger throughout my career: we cannot adequately understand psychological suffering without considering the relationship among bodily responses, emotional defenses, core beliefs, and the ways people experience themselves in relationship to others.

Consider someone who grew up feeling unwanted or emotionally abandoned. As an adult, that person may intellectually understand that a spouse or close friend loves them, yet an unanswered telephone call or an ambiguous text message can activate an old and painful expectation: *I don't matter. I'm being rejected. Something is wrong with me.*

The rational mind may recognize that the other person is probably busy, but the body has already begun preparing for abandonment. Breathing changes, anxiety rises, and a familiar emotional narrative takes hold. The immediate situation may be relatively insignificant, but it has touched something much older.

This is one reason I distinguish between incremental and transformational therapeutic change. Coping strategies can help people manage distress, often quite effectively, but when suffering is organized around deeply established negative beliefs about the self, meaningful healing may require helping those beliefs and emotional expectations change. A relationship marked by consistency, appropriate boundaries, and genuine responsiveness can provide experiences that challenge old assumptions about being unwanted, unsafe, or unworthy of care.

None of this means that people must remain constantly available to one another or that an unanswered message constitutes emotional abandonment. Such an expectation would be unrealistic and psychologically unhealthy. But it does suggest that the quality of our

everyday interactions can carry emotional significance far beyond the literal words exchanged.

Our nervous systems are exquisitely sensitive to the difference between feeling received and feeling dismissed. Technology has not eliminated that sensitivity. It has simply given us new ways to encounter it.

When Communication Loses Its Humanity

Perhaps this is why I find some of our changing communication habits so curious. I call someone's telephone and hear nothing but a recorded sequence of numbers, leaving me uncertain whether I've even reached the correct person. I send a thoughtful professional email and occasionally receive no acknowledgment whatsoever. I participate in group discussions where people have supposedly gathered around a shared purpose, only to discover that getting an actual exchange of ideas underway can feel like trying to start a conversation with the furniture.

And yes, I confess that this sometimes drives me nuts.

I appreciate that people are busy. I certainly am, and I have undoubtedly overlooked calls and messages myself. Nobody owes us unlimited access to their time or attention. Healthy boundaries matter, particularly in a world where electronic communication can intrude upon nearly every waking hour. But I do wonder whether the convenience of digital communication has made it easier to avoid some of the ordinary relational responsibilities we once took for granted.

This becomes especially interesting among those of us in the helping professions. We teach attachment theory, discuss emotional attunement, and emphasize the therapeutic importance of feeling understood and valued. Then we occasionally communicate with our

own colleagues with all the interpersonal warmth of a parking meter. There is something wonderfully absurd about that contradiction, although I'm not sure it's entirely funny.

My concern is not that electronic communication is inherently shallow. Research has long demonstrated that meaningful relationships can develop through computer-mediated interaction (Walther, 1996). Technology can sustain friendships, bridge enormous distances, and provide connection that might otherwise be impossible. The question is whether we are using these remarkable tools to deepen our relationships or gradually allowing them to become substitutes for relationships themselves.

There is a difference between exchanging messages and experiencing another person's presence, and I worry that we sometimes forget it.

Please Hold. Your Attachment Wound Is Important to Us.



This gets under my skin in behavioral health care, particularly in the substance use treatment community where I have spent considerable time. People arrive after years of neglect, betrayal, and relationships in which needing something made them a nuisance. Some have finally scraped together enough hope to ask for help. Then they enter a

program that advertises connection, belonging, and compassionate care, and discover that getting someone to return a call requires the persistence of a bill collector.

We assess their attachment wounds. We document their fear of abandonment. We explain how repeated experiences of emotional unavailability shaped their expectations of others. Then we fail to follow through on something we promised. Well, hell. The patient has supplied the history, and we are apparently volunteering to help with the sequel.

I have worked alongside wonderful people in these settings. I have also watched administrative machinery swallow enough of their time and attention to make genuine engagement feel like an extracurricular activity. Everybody is busy. Everybody is charting. Somewhere, a dashboard is turning green. Meanwhile, a frightened person is sitting in the lobby wondering whether coming here was a mistake. But the record will show that services were delivered.

I understand boundaries. I have spent forty years trying to maintain them, occasionally while answering a question that arrived just as I was reaching for the doorknob. Nobody owes patients unlimited availability. But if I say I will call, I ought to call. If I cannot, somebody ought to explain. We do not need to become surrogate parents or hand out our personal numbers like party favors. We do need to notice when our behavior starts resembling the indifference we are being paid to help people recover from.

The research on therapeutic relationships gives us good reason to take connection seriously (Norcross & Lambert, 2018). I have seen its importance in moments that would look thoroughly unimpressive in a training video. A patient stops mid-sentence, looks at me, and says,

"You actually get it." Sometimes that moment follows a thoughtful intervention. Sometimes I have simply managed to keep my mouth shut long enough to hear something important. A humbling return on four decades of professional education.

What bothers me is the distance between the language and the experience. Put "We treat you like family" on a website, and I immediately want to know which family we are talking about. Some of our patients have already survived one. They need people who mean what they say, make room for difficult conversations, and follow through often enough for trust to become a reasonable risk. Before paying somebody to refresh the compassionate branding, I would call the program, leave a message, and see whether the compassion knows how to work a telephone.

And Then There Are Our Kids – and They Are Watching US

Being a pediatric psychologist at heart, I cannot leave this essay without turning to the people I have spent decades treating and care so deeply about: our children and adolescents. Those reading this who know me, knew I would get around to the kids eventually. Spend enough years sitting on the floor with children and trying to persuade teenagers that you are worth talking to, and they tend to follow you into whatever you write.

I find myself wondering what we are teaching them about connection. They are growing up with the ability to reach almost anyone instantly, yet calling someone, leaving a voicemail, or having an uncomfortable conversation can feel like an unreasonable expedition into the wilderness. I have known teenagers whose kindness and relational maturity would put plenty of adults to shame. But I have also met young

people who can maintain twelve text exchanges at once and look at a ringing telephone as though it has just threatened their lives.



Before we get too pleased with ourselves, however, we might examine who taught them. Children watch how we speak to one another, whether we listen, and what happens when a notification arrives in the middle of their sentence. We can deliver a magnificent lecture about courtesy while checking our messages, but I would not expect a standing ovation. Teenagers have a particularly irritating gift for noticing when the sermon and the demonstration have wandered off in different directions. They have a **superpower for hypocrisy detection** in us.

Texting certainly has its place in family life. "Practice ends at five." "Please pick up milk." "Where are you?" followed by the timeless parental sequel, "I can see that you read this." It helps us manage busy lives and send affection across an ordinary day. But a family can become remarkably efficient at coordinating transportation while gradually losing track of how anyone is actually doing. Everybody gets delivered to the correct location. Whether anybody feels known when they arrive is another question.

There is something precious about hearing your child's voice. Parents learn the hesitation before an answer, the unusual flatness, the effort required to make "I'm fine" sound convincing. A familiar voice can prompt us to ask another question or stay on the line a little longer. Our children need to hear us, too: the pleasure in our greeting, the reassurance that we have time, the warmth that can be difficult to squeeze into a hurried message. Sometimes a conversation begins with absolutely nothing important and takes ten minutes to find what needed saying.

So yes, I think we should teach children how to use the telephone for an actual conversation. Radical stuff. A friendly voicemail greeting, returning a call, introducing yourself, and recognizing when something deserves more than a text are reasonable things to learn. If I am paying for the phone, I also think I can expect a call from home to be answered when circumstances permit or returned within a reasonable time. School, work, driving, and a life of their own all deserve consideration. I simply question the arrangement in which the device works beautifully for everyone on earth except the people financing it.

What matters most is helping our children become comfortable with the ordinary vulnerability of conversation. Apologizing while someone can hear the sincerity in your voice. Disagreeing and staying present long enough to work something through. Listening without immediately preparing your defense. Telling someone you love them and allowing the words a moment to land. Those things can feel awkward, especially while learning them. That is a good reason to practice at home, where an imperfect attempt can be met with patience rather than a performance review.

And we owe them that same willingness. Sometimes our children will want to talk when we are tired, distracted, or halfway through something we would dearly love to finish. We will miss opportunities. I certainly have. But we can put the phone down, turn back, and say, "I'm sorry. Tell me again." They get to watch us repair the very thing we hope they will learn to repair.

After all these years, I still love the moment when a child or teenager realizes an adult is interested in what they have to say. The rehearsed answer gives way to something more honest, and the conversation finally gets somewhere. I would like our children to have plenty of those moments at home. Eventually, the phone we bought them will be obsolete. Knowing how to reach another person, and how to let someone reach them, will still come in handy.

The Older I Get, the Less Patience I Have for Empty Water Troughs

There's something wonderfully liberating about turning 72. For one thing, you can say almost anything and people aren't entirely sure whether you're dispensing wisdom or just becoming a cranky old man. I've decided there's a certain advantage in keeping them guessing.

But aging does bring a rather fascinating change in perspective. Time, which once seemed to stretch endlessly ahead, begins looking a bit more like a limited-edition commodity. I don't find that depressing. Quite the opposite. It has made me considerably more selective about how I spend it, whom I spend it with, and how much nonsense I'm willing to entertain along the way. And believe me, I've entertained plenty.

After decades in military service, medicine, psychology, private practice, and more committees and professional collaborations than

any reasonable human being should endure, I've discovered something rather remarkable: impressive credentials do not necessarily produce impressive human beings. I've known people with enough letters behind their names to exhaust the alphabet who couldn't manage the simple courtesy of returning a phone call. Conversely, I've known people without a single professional credential whose warmth, integrity, and faithfulness could teach the rest of us a graduate seminar in being human.

I've also learned that some relationships are wonderfully reciprocal, while others seem to require the emotional equivalent of jump-starting a dead battery every time you want to connect. You initiate the conversation, send the message, follow up, encourage, organize, and occasionally wonder whether the other person is still alive. Eventually, even a reasonably enthusiastic fellow begins to suspect he's doing all the rowing while everyone else is enjoying the scenery.

And that's where an old rural image comes to mind. If you keep walking up to the same water trough and finding nothing worth drinking, perhaps the problem isn't that you haven't waited long enough. Perhaps it's time to find another trough.



I'm not interested in drinking from that water trough anymore, because there ain't no good water in it. Now, I say that with a grin, not a grudge. I've been on both sides of that equation, and I'm sure I've disappointed my share of people along the way. Nor do I expect friends or colleagues to be perpetually available. Good grief, I wouldn't want to be perpetually available myself. There are motorcycles to ride, dogs to love, books to write, and a beautiful bride with whom I'd much rather spend an evening than chase down another unanswered email.

What I want more of these days is wonderfully uncomplicated: people who enjoy one another, who can argue without becoming enemies, laugh at themselves, challenge each other to grow, and occasionally call for no other reason than to hear a familiar voice. Relationships that don't require elaborate maintenance schedules or the intervention of a search-and-rescue team.

Perhaps growing older isn't so much about learning to let go as it is about becoming clearer on what deserves to be held close. I've been blessed with some extraordinary people in my life, and I would rather give them the best of what remains of mine than keep knocking on doors where nobody seems particularly interested in answering.

Besides, at 72, I've got better things to do than spend another afternoon trying to teach a water trough how to hold water.

The Presence That Matters



I don't miss rotary phones. By the time you finished dialing somebody with three nines in their number, you had reconsidered the friendship. Nor do I believe earlier generations had perfected human relationships. We managed to ignore one another quite successfully before anybody invented airplane mode.

What I value is the pleasure of reaching someone who is glad to hear from you. A colleague who follows up. A friend who calls without needing anything. A conversation that wanders somewhere interesting because neither person is trying to dispose of it. Sometimes you solve a problem. Sometimes you laugh at something you probably shouldn't. Sometimes you discover what has been bothering you halfway through telling somebody about your otherwise perfectly ordinary day.

I enjoy the convenience of these devices as much as anybody. But I have spent enough time chasing communication to appreciate the people with whom it comes easily. We make the effort, forgive the occasional lapse, and pick up where we left off. Nobody needs to issue a tracking number.

I have no idea what technology will offer us twenty years from now. I hope it's wonderful. In the meantime, if you call and I can answer, I'd like you to hear that I'm pleased it's you. We might even have a conversation neither of us planned.

Unless I'm on the motorcycle. Then leave a message. I finally found something worth being unavailable for.

References

Cacioppo, J. T., Cacioppo, S., Cole, S. W., Capitanio, J. P., Goossens, L., & Boomsma, D. I. (2015). Loneliness across phylogeny and a call for comparative studies and animal models. *Perspectives on Psychological Science, 10*(2), 202–212. https://doi.org/10.1177/1745691614564876

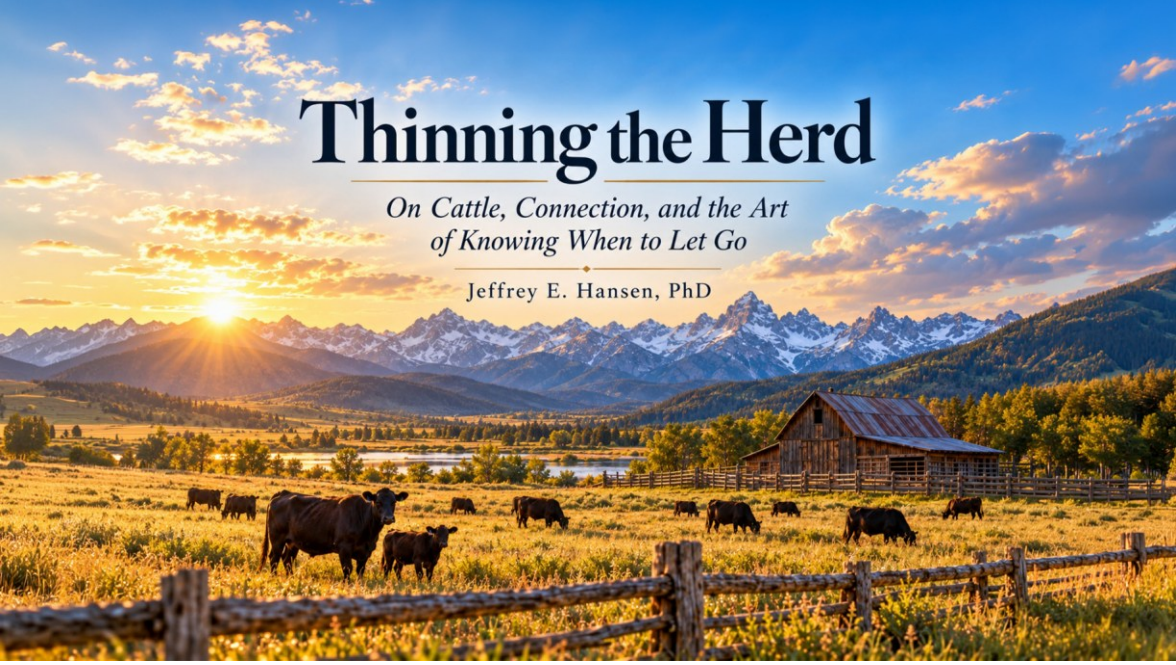
Coan, J. A., Schaefer, H. S., & Davidson, R. J. (2006). Lending a hand: Social regulation of the neural response to threat. *Psychological Science, 17*(12), 1032–1039. https://doi.org/10.1111/j.1467-9280.2006.01832.x

Holt-Lunstad, J., Smith, T. B., Baker, M., Harris, T., & Stephenson, D. I. (2015). Loneliness and social isolation as risk factors for mortality: A meta-analytic review. *Perspectives on Psychological Science, 10*(2), 227–237. https://doi.org/10.1177/1745691614568352

Norcross, J. C., & Lambert, M. J. (2018). Psychotherapy relationships that work III. *Psychotherapy, 55*(4), 303–315. https://doi.org/10.1037/pst0000193

Siegel, D. J. (2012). *The developing mind: How relationships and the brain interact to shape who we are* (2nd ed.). Guilford Press.

Walther, J. B. (1996). Computer-mediated communication: Impersonal, interpersonal, and hyperpersonal interaction. *Communication Research, 23*(1), 3–43. https://doi.org/10.1177/009365096023001001



Have I Mentioned That I Love Cows?

I've been thinking about cows lately. Cattle, to be more precise. I mean, come on. Who doesn't love cattle? They're magnificent creatures. Big, lumbering, occasionally stubborn, sometimes cantankerous, and generally unimpressed with whatever the rest of the world happens to be doing. Come to think of it, I may have more in common with cattle than I care to admit.

But my affection for these creatures isn't entirely whimsical. It runs deep into my family history. My maternal grandparents, Ernest and Sophie Vouga, were Swiss immigrants who made their way to America in the early twentieth century. Grandpa had apparently intended to find his fortune in California. Somewhere along the way, he visited a family in the high country around Gunnison, Colorado, an astonishingly beautiful place where cattle ranches sit at elevations approaching 8,000 or 9,000 feet. And something happened. He fell in love with the country. California would have to get along without him.

Grandpa Ernie had served in the Swiss military during the First World War, having been called back to wear the uniform for about a year. After completing his service, he married my grandmother Sophie, an extraordinary woman whose strength and character still loom large in my memories. Together, they established a life in the rugged Colorado high country. And when I say rugged, I mean rugged. Imagine setting up housekeeping in those early years without electricity, running water, central heating, or any of the conveniences we consider indispensable today.

Their world was one of log structures, hard physical labor, and making do with whatever the land provided. Early cabins were often built with logs fitted together and chinked with mud, clay, moss, or whatever materials were available to keep the wind out. Some homesteads had sod or earth-covered roofs, practical solutions in a country where the winters could be absolutely brutal. No thermostats. No Amazon deliveries. No electric coffee makers. Good grief, no Wi-Fi! Somehow, civilization survived.

I have wonderful memories of visiting the family Vouga Ranch during the 1950s and 1960s. The old barns, the fences, the rusting farm machinery that had already become relics of another era. I remember riding around in Uncle Ernie's old Jeep, helping with chores, breathing that extraordinary mountain air, and feeling as though I had entered a world that belonged entirely to us. What a playground for a little boy!

Those experiences were a childhood treasure. The smells, the sounds, the machinery, the cattle, the wide-open spaces. There was something deeply satisfying about being part of that world, even if my contribution to the actual ranching operation was probably more enthusiasm than productivity. And somewhere in those memories,

among the cattle, the barns, the mountains, and the remarkable people who worked that land, I learned something about life. Or perhaps I'm only now beginning to understand what I learned.

So, What Does Any of This Have to Do With Friendship?

Well, quite a lot, actually. On a cattle ranch, you build a herd. You nurture it, feed it, protect it, and help it grow. But every rancher understands that a herd cannot expand indefinitely. The land has limits. The resources have limits. The rancher's time and energy have limits. Eventually, decisions have to be made. Which animals remain? Which will be sold? How large a herd can the ranch actually sustain? You can't keep every animal forever. Some stay. Others go to market. That's ranching. And lately, at the ripe old age of 72, I've been thinking about managing my own herd. Not cattle, mind you.

People.

Now, before anybody gets their knickers in a knot about being compared to a Hereford, hear me out. I love people. God, I love people. I love my wife, Leah, beyond words. I love my children and grandchildren. My granddaughter is the apple of my eye. I love my three little dogs, my motorcycle, the open road, and a good conversation with someone who has something meaningful to say.

But people? People have always been my great fascination. I suppose that's a reasonably good quality in a clinical psychologist. After all, spending an entire career listening to people while secretly disliking humanity would be a rather unfortunate occupational mismatch. And I love friendship. I love the conversations that wander from the ridiculous to the profound. I love the unexpected phone call. I love hearing somebody's story. I love the kind of friendship where you can

disagree passionately, laugh about it afterward, and still know you're loved. For much of my adult life, I had an enormous herd.

Army colleagues. Hospital colleagues. Fellow psychologists. Physicians. Pastors. Veterans. Friends from years of professional work, church involvement, teaching, writing, and the countless other encounters that make up a lifetime. And for decades, I had the energy to keep an extraordinary number of those relationships going. Or at least I thought I did.

But something changes as the years accumulate.

The Years Ahead Are Fewer Than the Years Behind

At 72, I have become increasingly conscious of something that doesn't require a doctoral degree to figure out. There are considerably fewer years ahead of me than behind me. Now, before anyone sends me a sympathy card, understand that I don't find this particularly depressing. In fact, I'm finding it rather liberating. Because when time begins to feel precious, you start asking different questions. What really matters? Who really matters? Where do I want to invest my remaining years? And perhaps most importantly, am I living deliberately, or am I simply allowing life to carry me along wherever its currents happen to flow?

My dear friend and pastor, Earl Heverly, and I have talked often about the importance of intention. I've written an entire essay on that subject because I think it may be one of the most consequential words in the English language. Here's how I see it:

If you don't live with intention, life will have its own intentions for you.

And before you know it, you've wandered down a dozen highways and byways, gotten tangled up in commitments you never consciously chose, and arrived at a destination wondering how the hell you got there. I don't want to live that way. Not anymore.

When You're the One Doing All the Watering

Here's where this gets a little uncomfortable. I've spent a great deal of my life cultivating friendships. I make phone calls. I send texts. I write essays and share them. I check on people. I invite them into conversations. I remember important events. I try to stay connected. And I've discovered something that probably shouldn't have taken me seven decades to understand. Some relationships are remarkably reciprocal. Others aren't.

Now, that doesn't make anyone a bad person. People have different capacities for connection. They have responsibilities, distractions, illnesses, personalities, family obligations, and seasons of life that may leave little room for friendship. I understand that. I've spent my professional career understanding that. But understanding another person's limitations doesn't necessarily obligate me to keep pouring energy into a relationship that seldom gives anything back. At some point, you have to ask yourself a fairly simple question.

If I'm always the one calling, always the one writing, always the one reaching out, always the one trying to keep the conversation alive, is this really a friendship we're cultivating together? Or am I maintaining it largely by myself? Friendship isn't an accounting exercise. I'm not suggesting we keep score, tally up phone calls, or require an equal number of texts in return. Good grief, that would be exhausting.

But there is a difference between a relationship that occasionally needs extra care and one that survives only because one person keeps supplying all the oxygen. And I am increasingly unwilling to confuse the two. I've come to believe that one of the quieter sources of emotional exhaustion is investing in relationships that exist primarily because we refuse to stop maintaining them. We keep watering. We keep fertilizing. We keep checking the soil. And we wonder why the damn thing never grows. Maybe, just maybe, it's time to put down the watering can.

Knowing When to Hold 'Em

Which brings me to that great American philosopher, Kenny Rogers. Remember The Gambler? "Know when to hold 'em, know when to fold 'em." Now there's a piece of wisdom that deserves considerably more attention than it probably receives. The song is ostensibly about cards, but anyone who has lived long enough understands that it is really about discernment. Knowing what to keep. Knowing what to release. Knowing when continued investment makes sense and when it doesn't.

Ecclesiastes 3 reminds us that life unfolds in seasons. There is a time to embrace and a time to refrain from embracing, a time to search and a time to give up, a time to keep and a time to throw away. That's not cynicism. That's wisdom. And it strikes me that one of the more difficult developmental tasks of aging may be learning to release relationships without bitterness. To acknowledge that someone mattered enormously in an earlier chapter of your life but may no longer belong in the same place in the chapter you're writing now. You can treasure the history without insisting that the relationship remain what it once was.

You can love someone without chasing them. You can wish someone well without continuing to carry the entire weight of the friendship. Sometimes the most gracious thing you can do is simply loosen your grip.

A Little Triage, Anyone?

Having spent a significant part of my professional career in military and medical environments, another analogy comes to mind.

Triage.

In a mass casualty situation, medical personnel have to make difficult decisions about where limited resources will accomplish the greatest good. There are people who will survive with minimal intervention. Others need immediate attention if they're going to make it. Still others may be beyond what the available resources can accomplish. It's a sobering business.

But the underlying principle is that resources are finite, and decisions matter. Now, friendships are not battlefield casualties, and I certainly don't intend to start assigning colored triage tags to people in my address book. Although, I must confess, the psychologist in me finds the thought faintly amusing. But consider the principle. At this season of life, I have only so much time, so much emotional energy, and so much capacity to invest in others. Should I continue pouring that energy into relationships that show little evidence of mutual investment? Or should I concentrate on the people who actually want to share life with me?

The ones who call back. The ones who ask how I'm doing. The ones who occasionally initiate a conversation rather than waiting for me to do it. The ones who want to know what's happening in my life, just as I want

to know what's happening in theirs. These are the relationships I want to nourish. And some of the others? Well, perhaps they've had their season.

The Brain Changes, and Maybe That's a Good Thing

My dear friend and fellow clinical psychologist, Dr. Jeff Wagaman, and I were recently discussing Arthur C. Brooks's book *From Strength to Strength*. Jeff and I go back 30-plus years, to when we first established our private practices practically next door to one another in Olympia, Washington. Our careers eventually followed different paths, but our friendship and mutual respect have endured. Over those decades, I've watched Jeff become one of Olympia's most respected and successful clinical psychologists, a genuine pillar in his community. He has built a remarkable professional life, but what I admire most about him has little to do with his professional accomplishments. Through all those years, he has never lost his soul. His Christian faith has remained central to his life, and his success has never eclipsed the values that define him. I have enormous admiration for this man, both as a colleague and as a friend.

And isn't it remarkable that here we are, three decades later, still having these wonderful conversations about life, psychology, faith, and what really matters? In fact, our friendship is a rather fitting illustration of what this entire essay is about. Some relationships become richer with the passage of time. They aren't sustained by professional obligations or the need to keep up appearances. They endure because two people genuinely value one another. Those are the friendships I want to carry into the years ahead.

During our conversation about Brooks's book, I found myself returning to a question that has become increasingly important to me: What if

the second half of life isn't merely a slower version of the first? What if it asks us to draw on an entirely different set of strengths? Brooks (2022) describes the distinction between fluid intelligence, our capacity for rapid, novel problem-solving, and crystallized intelligence, the knowledge, pattern recognition, and judgment we accumulate through experience. The first tends to reach its peak earlier; the second can serve us remarkably well as the years advance. The task is not to spend the rest of our lives desperately trying to be 35 again. It's to recognize what this chapter makes possible.

For much of my career, I was a builder. I was pursuing credentials, making clinical decisions, developing programs, teaching, running a practice, serving in the Army, working in hospitals, and generally keeping a great many plates spinning. There was excitement in that. There still is. But Brooks's larger point resonates: as we grow older, our deepest satisfaction may come less from proving ourselves and more from wisdom, service, spiritual life, and the quality of our relationships (Brooks, 2022). That is not settling for less. It is a different kind of abundance. When I look back at the mountain of professional accomplishments, I am grateful for them, but they are not what I most want to take with me into the years ahead.

There is another layer to this, one that the psychiatrist Daniel Z. Lieberman and his coauthor Michael E. Long explore in *The Molecule of More*. Lieberman and Long (2018) describe dopamine as deeply involved in wanting, anticipating, seeking novelty, and pursuing what lies just beyond our reach. It's part of the neural machinery that makes us look over the next hill and ask, *What's out there? What's next? What more can I accomplish?* Good grief, I know that system well. It helped power a career and probably more than a few motorcycle adventures. Dopamine is not the enemy; without motivation and the capacity to seek, we'd

hardly get out of bed. But the very system that energizes achievement can keep moving the finish line. One more goal, one more recognition, one more professional project, one more thing to acquire. When is enough enough?

Lieberman and Long contrast that future-oriented pursuit with what they call the *here and now* experience: actually enjoying the people, places, and gifts already present in our lives (Lieberman & Long, 2018). Serotonin participates in mood regulation and aspects of well-being, while oxytocin and other interacting systems are involved in social bonding and attachment. I sometimes think of this as a movement from dopamine-driven achieving toward the pleasures of relational presence. That is a useful metaphor, not a claim that the aging brain simply turns dopamine off and serotonin on. The chemistry is considerably more intricate than that, and both systems remain essential throughout life. Nevertheless, the distinction captures a real psychological choice: Am I forever chasing what comes next, or am I learning to inhabit the life and the relationships already before me?

And this brings me right back to my friendship with Jeff. Thirty years ago, we were two young psychologists building our practices, pursuing our professional ambitions, and wondering what the future might hold. Today, we can sit together and talk about the meaning of those years, the lessons we've learned, the faith that has sustained us, and what we hope to do with whatever time remains. The professional achievements are still there, of course, but they're no longer the most interesting part of the conversation. The friendship is. And I find something wonderfully satisfying about that.

I can sit across from Leah and actually be there. I can linger with a friend without checking the clock. I can enjoy my granddaughter's laughter,

the little dogs piled around us, or a leisurely conversation after church without wondering what productive task I ought to be doing instead. And I can write because I love writing, not because every essay must become another accomplishment. Those moments don't announce themselves with plaques, promotions, or certificates. They simply make life worth living. To my mind, that is where Brooks's developmental wisdom and Lieberman's neuroscience meet: accumulated experience helps us decide what deserves our attention, and learning to value the present helps us enjoy it.

I am not trying to build an empire anymore. I've built things, made mistakes, some spectacular ones, and experienced joys and losses that have rearranged my priorities. There is still work I want to do, purpose I want to pursue, and plenty of curiosity left in this old brain. But I no longer mistake endless expansion for a successful life. In this season, I want the freedom to choose depth over breadth, meaning over motion, and mutual affection over maintaining a sprawling collection of acquaintances.

I don't need a larger herd. I need a healthier one.

Jesus Had a Herd, Too

As a Christian, I can't think about any of this without reflecting on the life of Jesus. Jesus loved people. He loved them extravagantly, sacrificially, and without regard for their social standing. He healed the sick, welcomed the outcast, confronted the powerful, and took time for people others overlooked. But something else strikes me about His ministry. Jesus was intentional about His relationships. He ministered to multitudes, but He didn't maintain the same level of personal intimacy with everyone. He chose twelve disciples. Within that group,

Peter, James, and John shared particularly intimate moments of His ministry.

And even Jesus regularly withdrew from the crowds to pray. Think about that. Jesus, who loved humanity more perfectly than any of us ever could, did not spend every waking moment responding to everybody's expectations. He had priorities. He had a mission. He had relationships into which He invested deeply. And He knew when to withdraw. I find that rather liberating. The command to love our neighbor does not mean we must maintain an equally intimate relationship with every person who has ever entered our lives.

Sometimes loving someone means walking beside them. Sometimes it means helping them through a difficult season. And sometimes it means entrusting them to God and continuing down the road He has placed before us. Jesus didn't wander aimlessly through His ministry hoping that meaningful things might happen. He lived with intention. And that is increasingly how I want to live.

So, Who Stays in the Pasture?

First and foremost, Jesus. That's the foundation. Everything else flows from there. Then my beautiful bride, Leah. After all these years, she remains my closest companion, my greatest earthly blessing, and the person with whom I most want to spend whatever years God gives me. Then my children, grandchildren, and immediate family. And then those wonderful friends who make life richer simply by being part of it. The people with whom I can laugh until my stomach hurts. The people who tell me the truth, even when I don't particularly want to hear it. The people who care about my life, not just what I can do for them.

The people whose presence leaves me feeling more alive rather than more depleted. The people who understand that friendship isn't a

performance, a transaction, or a one-way street. It's a shared journey. And I want to make room for more of that. Here's something I've come to recognize: Every hour spent trying to keep an unresponsive relationship alive is an hour I cannot spend nurturing one that is already flourishing. That's not selfishness. That's stewardship. And as the years ahead become fewer, stewardship becomes increasingly important.

Thinning the Herd Doesn't Mean Closing the Gate

Now, here's an important distinction. I'm not suggesting that I stop meeting new people. Heaven forbid! I still love making new friends. I love hearing stories, discovering unexpected connections, and encountering fascinating people whose lives have taken them down roads very different from my own. Some of the most meaningful friendships of my life may still be ahead of me. Wouldn't that be something?

But I want to be more thoughtful about whom I invite into the pasture and how much of myself I invest. I want friendships that grow naturally, where affection and interest flow in both directions. I want to spend less time wondering why someone hasn't responded and more time enjoying the people who have. Less time chasing. More time connecting. Less time maintaining appearances. More time being present. And perhaps that's one of the most beautiful gifts of growing older. We begin to realize that the depth of our relationships matters infinitely more than the number of names in our contact list.

Back at the Vouga Ranch

Sometimes, in my mind, I return to that old ranch in the Colorado mountains. I can almost hear the Jeep rattling along a dirt road with Uncle Ernie behind the wheel. I can picture the barns, the old equipment, the weathered timbers, the cattle scattered across the

pasture, and the magnificent mountains rising in the distance. I think about Grandpa Ernie and Grandma Sophie, two Swiss immigrants who built a life in country that demanded courage, determination, sacrifice, and a healthy measure of stubbornness. They understood something about stewardship. They knew that what you cared for required work. They knew the land had limits.

They knew that keeping a ranch alive meant making decisions, sometimes difficult ones, about what to hold on to and what to let go. And now, some seventy years after those childhood visits, I find myself contemplating a different kind of ranch. The pasture of my own life. It's been a mighty big herd. And a wonderful one.

But perhaps it's time to open a few gates. Not in anger. Not in disappointment. Not because the cattle are bad. But because the rancher is getting older, the pasture is only so big, and there are some mighty fine animals still grazing out there that deserve a little more of his attention. I want to spend my remaining years loving deeply, laughing often, growing in faith, riding my motorcycle, holding my bride, enjoying my family, encouraging my fellow veterans, writing whatever God puts on my heart, and sitting across the table from friends who genuinely want to be there.

I want to know that my time and affection are being invested where they can flourish. And when my final day comes, I don't particularly care whether I had a thousand friends. I care whether the people closest to me knew they were loved. So, ladies and gentlemen, that's my plan.

I'm thinning the herd.

And maybe, just maybe, it's time to take a good look at yours. Because the goal isn't to die with the biggest herd. It's to live with the ones who make the journey worth taking.

Onward.

Jeff



References

Brooks, A. C. (2022). From strength to strength: Finding success, happiness, and deep purpose in the second half of life. Portfolio. https://www.penguinrandomhouse.com/books/646134/from-strength-to-strength-by-arthur-c-brooks/

Lieberman, D. Z., & Long, M. E. (2018). The molecule of more: How a single chemical in your brain drives love, sex, and creativity—and will determine the fate of the human race. BenBella Books. https://hsrc.himmelfarb.gwu.edu/books/249/



Still Digging: What I Hope We Carry Home

When I opened this book, I invited you into a sandbox. By now, you have probably discovered that I was serious about the digging. We have turned over questions about suffering, identity, childhood, faith, the nervous system, and the professions entrusted with helping us. We have examined familiar explanations and wondered whether they tell the whole story. Occasionally, we have uncovered something beautiful. Occasionally, we have found something that probably should not have been buried there in the first place. That happens when you start asking questions.

Beneath all that digging has been a deeply personal concern: What helps a human being find his way back to life? I needed an answer to that question myself. In the opening pages, I told you about a season when my professional knowledge could explain more than it could repair. I could describe what was happening, sometimes with impressive vocabulary, while remaining painfully caught inside it. My body, thoughts, protective reactions, relationships, and faith all needed attention. So did the story I had begun telling myself about who I was.

The man doing the searching was a psychologist. He was also frightened, wounded, loved, and in need of help. Remembering that has shaped everything I have tried to say here. It has made me more curious about suffering, more grateful for those willing to accompany us through it, and more concerned about explanations that sound impressive while leaving important dimensions of a person's experience untouched.

Understanding That Reaches a Life

I love learning how we work. Give me a thoughtful explanation of the brain, a question about human behavior, and a little uninterrupted time, and I am a fairly happy fellow. My wife can probably tell you when the uninterrupted time has gone on long enough. But the understanding I care most about eventually needs to reach an ordinary human life. Can a veteran sit with his family and feel present? Can a teenager encounter disappointment without interpreting it as proof of worthlessness? Can a parent become curious about a child whose behavior has become exhausting? Can someone receive love without immediately searching for the reason it will be withdrawn?

These are the places where our explanations acquire consequence. Across these essays, I have returned to the relationships among bodily reactions, emotional learning, identity, and meaning. We have considered how experiences of danger and belonging may shape the way a person approaches the world. We have asked what happens when an old wound becomes a conviction about the self, and whether treatment is helping that conviction change. Beneath the terminology is someone trying to understand why yesterday keeps intruding upon today and whether tomorrow might offer something different.

Learning to cope can be an extraordinary achievement. Sometimes getting through the day requires courage that nobody else sees. I want us to honor that progress while remaining attentive to the deeper suffering a person may still carry. Someone who has learned to manage anxiety may also need help with the persistent belief that he is unlovable. A child whose behavior has improved may still be quietly ashamed of who he believes himself to be. Our work should make room for both the immediate distress and the deeper meanings organizing a life.

I want the person who has spent years asking, "What is wrong with me?" to have the opportunity to ask another question: "What have I learned to believe about myself, and might there be more to my story?"

The Person Entrusted to Us

That concern is also why I have challenged aspects of my own profession. I have worried about care hurried by the clock, diagnoses that begin to overshadow the child, treatments defended beyond what the evidence supports, and institutions that become uncomfortable when someone asks an inconvenient question. I have questioned what we measure, how long we follow people, and whether the improvements we celebrate reach the lives they hope to live. Behind my irritation is usually a person I remember, a family I have known, or an opportunity for care that I believe we can recover.

Those concerns carry an obligation for me, too. I have participated in the systems I criticize. I have held assumptions that deserved closer examination. Forty years in practice have given me experience, along with ample opportunity to discover the limits of my understanding. I cannot reasonably ask my colleagues to reconsider their convictions while placing my own beyond examination. The person seeking help

deserves our honesty, including our willingness to acknowledge when an explanation is incomplete or an approach needs to change.

Parents deserve explanations they can understand. Adolescents deserve room to ask questions without having their uncertainty turned into a conclusion for them. Adults deserve to know what treatment is intended to accomplish and how they and their clinician will recognize meaningful progress. Clinicians, in turn, deserve conditions that allow them to listen, think, care, and exercise judgment. There are wonderful people doing this work under difficult circumstances. I hope these pages encourage them to recover something of the calling that first brought them here.

Behind every chart is someone with a life extending far beyond our office. We have been invited into a portion of that life. It is a privilege that should keep us attentive.

Keeping Our Shovels Available

The same responsibility applies to NeuroFaith®. Its integration of polyvagal-informed work, HeartMath® and physiological regulation, Internal Family Systems, and spirituality and faith has been deeply meaningful in my life and clinical work. It has given me ways to approach experiences that once left me confused or ashamed. I am grateful to share it, and that gratitude gives me reason to keep examining it.

Every approach needs questions large enough to expose its limitations. Every clinician needs the freedom to recognize when another kind of help would better serve the person seeking care. My affection for a model must leave room for evidence, correction, and the experience of the person sitting across from me. There are other valuable pathways to healing, and I want people to find the care that serves them well.

Their progress matters far more than whether they arrive through a door bearing my name.

The sandbox provides a useful reminder. We can build something with care, appreciate what it offers, and remain willing to take a section apart when it no longer holds. I hope I keep that willingness. If you ever catch me guarding a sandcastle as though the future of humanity depends on its survival, please remind me that I was the fellow who invited everybody to bring a shovel.

What We Place in One Another

Some of the most meaningful moments in this book have involved things that appear remarkably ordinary: a prayer, a reassuring presence, a grandfather's letter. My father did not need the language of brain networks to tell his grandson that he belonged. He knew the young man before him had a future, responsibilities worth embracing, and a family whose love would accompany him. He took the time to put that into words. I am still moved by what he left behind and by the thought that his words could travel into places where he could never personally go.

We spend much of our lives placing things within one another. Through our attention, example, words, and absence, we help shape what others come to expect from relationships and believe about themselves. That responsibility can feel sobering, particularly when we recognize the wounds we have carried forward without intending to. Some of us inherited harshness long before we understood it. Some learned to withdraw, criticize, overwork, or control because those were the responses available in the homes that formed us. Understanding that history can help us take responsibility for what comes next.

We can apologize. We can become more present. We can seek help with what continues to spill into our relationships. We can tell a child what we admire in him and allow enough time for him to believe we mean it. We can let someone know that his struggle has not exhausted our love. None of these choices requires mastery of neuroscience, although understanding more about human development gives me greater respect for their importance. It makes me want to handle these moments more carefully.

What we have inherited deserves honest attention. What we pass along deserves deliberate care.

The Faith Running Through It

My Christian faith runs through this book because it runs through my life. There were seasons when I needed to bring God questions I could barely articulate. I needed forgiveness, hope, and somewhere to carry grief. I needed people whose patience gave love a recognizable human form. I needed to discover what trusting God might look like while I was still struggling, when the reassuring words I had offered others became truths I had to wrestle toward myself.

Scientific inquiry remains precious to me within that life of faith. I want to understand what can be investigated, distinguish evidence from interpretation, and acknowledge what remains uncertain. I also bring questions of worth, purpose, responsibility, and redemption to Scripture and prayer. These pursuits ask something of me: intellectual honesty, humility, patience, and a willingness to discover that I have misunderstood something important.

For me, learning more about our embodied lives deepens the wonder. It draws my attention to the complexity of people I might otherwise have explained too quickly. A frightened response may carry a history I

have not yet heard. An angry person may be protecting something terribly vulnerable. Someone who appears remarkably capable may be holding himself together at considerable private cost. Understanding more makes me want to listen longer.

I believe we are magnificently made. I also know how painfully we can suffer. Holding both realities has become part of my work, my faith, and my continuing education as a human being. I remain grateful that God's patience with me has exceeded my ability to understand myself.

Before We Leave

Perhaps you opened this book out of curiosity. Perhaps you were concerned about a child, reconsidering your profession, or searching for language to describe something happening within you. Perhaps you simply wanted to see what that old psychologist had gotten himself worked up about this time. Whatever brought you here, thank you for spending these pages with me and for allowing me to bring something of my own unfinished life into the conversation.

I hope you leave with questions worth pursuing and greater confidence to ask them. I hope something here helps you approach another person with patience, examine a familiar assumption, or seek care that takes the fullness of your life seriously. If you are a clinician, perhaps these essays will accompany you into the next difficult appointment. If you are a parent or grandparent, perhaps they will encourage a conversation you have been meaning to have. If you are struggling, perhaps they will help you find words for what you need.

My own restoration involved people who stayed, professionals who helped, practices I had to learn, and grace I am still learning to receive. There were days when progress was difficult to recognize. Looking

back, I can see how much those patient acts of care mattered. A conversation, a prayer, an invitation, or someone's willingness to sit beside me sometimes carried more weight than the person offering it could have known. You may have someone in your life who needs that kind of presence now. You may need it yourself. There is dignity in reaching for it and profound generosity in offering it.

I began these pages as a pediatric psychologist remembering what children had taught me about play. They still have something to teach us at the end. A child can return to yesterday's unfinished construction, gather what is available, and begin working again. There is curiosity in that gesture. There is also a quiet confidence that something remains possible. After all these years, I find myself grateful for that image.

There are people I still want to understand, questions I want to follow, and things in my own life that need patient attention. There is more love to give and, I suspect, more grace to receive. So I will be here a little longer, with sand in my shoes and a shovel somewhere close by.

By God's grace, there is still good work to do.

About the Author



Jeffrey E. Hansen, Ph.D. is a clinical psychologist, author, teacher, and lifelong student of the extraordinary complexity of being human. He holds degrees from the University of California, Berkeley and the University of Arkansas, with fellowship training in developmental pediatrics. His more than four decades of clinical work have included service as an active-duty Army psychologist, private practice, and work with children, families, and military communities through the Defense Health Agency. He also served as Clinical Director of Holdfast Recovery and AnchorPoint, faith-centered programs treating addiction and trauma.

Those experiences have taught him much. So have the chapters of his life for which no professional training could fully prepare him. Jeff has known seasons of profound personal suffering, family illness, and devastating loss, including the death of his beloved identical twin brother, Gregg. Grief has become part of his continuing education in love, faith, and what it means to carry on when someone deeply woven into your identity is gone.

Through those experiences, he has discovered something that continues to fill him with wonder: great sorrow, deep gratitude, and God's peace can inhabit the same human heart. He has experienced that peace while still grieving, still asking questions, and still missing the people he loves. The capacity to hold such painful and beautiful realities together has deepened his appreciation for the magnificent way God made us.

Jeff is the founder of NeuroFaith®, an integrative approach bringing together polyvagal-informed therapy, HeartMath® and neurocardiology, Internal Family Systems, and spirituality and faith. Its development grew from clinical study and his own search for healing. He remains grateful for the family, friends, clinicians, and spiritual companions who helped him find his footing, and he brings that gratitude into his work with others.

The author of fourteen books, Jeff writes about neuroscience, trauma, identity, faith, culture, and the people whose lives have helped shape his own. Writing is his sandbox: a place to explore, wrestle, remember, question, and occasionally kick over an assumption that has stood unchallenged for too long. His curiosity is accompanied by an irreverent sense of humor and a willingness to speak plainly about things he believes deserve closer attention. He hopes readers will hear the compassion beneath his occasional racket.

Jeff lives in Prescott Valley, Arizona, with his wife, Leah, affectionately known as Schatz, and their three small dogs, Henry, Summer, and Hazel. He treasures his children and granddaughter, early mornings with God, and the freedom of an open road aboard his BMW R1250RS. He is still learning how to love well, receive grace, and make something useful of the years he has been given. There are more questions to ask, more stories worth telling, and usually a little sand in his shoes.