Normalizing Ourselves for the Other: Inviting Humanitarian Conversations Beyond Formulaic Relationships. Part I[1]

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In an era marked by increasing complexity in human relationships, marriage and family therapy is called to evolve beyond traditional frameworks. This article explores the transformative potential of Collaborative-Dialogic methodologies as practiced at the Swim et al., (2024). Drawing on decades of qualitative research and international application, we advocate for a human-centered and collaborative dialogical approach that prioritizes dignity, freedom, and genuine dialogue. Through diverse narratives from clients and communities, we illuminate how these practices have reshaped lives across cultural and systemic boundaries.

> *In the broad field referred to as mental health we have contributed a language of description: thousands of words over the last century, most of which might be called "deficiency language" in that they create a world of description that understands only through what is wrong, broken, absent, or insufficient… What I am challenging is the language of description through which we have created this world that we call mental health and mental illness* (Goolishian, 2017, p. 70).
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> *"So often times it happens that we live our lives in chains, and we never even know we have the key"* (The Eagles).

[1] Due to the length of this paper, it will be presented in two parts. The reference list will appear at the end of Part Two.

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Introduction

Qualitative research informs all of our work. This approach, as described in *Process Ethics* (2003), enhances reflexivity by using questions as springboards for further open dialogue. Our goal is to foster appreciative inquiry and generate stories of strength, hope, and resilience-particularly within narratives shaped by previously unsuccessful treatment histories. We seek to promote consciousness-raising for populations who did not find success in traditional treatments, often experiencing them as oppressive. In many cases, symptoms emerged or worsened during treatment, whereas they were not present beforehand. Thus, the recovery process often includes healing not only from life struggles, but also from the impact of prior treatments. All cited transcripts were collected between 2022 and 2025.

Now I See A Person Institute is a nonprofit training and research institute using Collaborative Dialogical Practices for mental health-wellness and substance challenges. We are devoted to serving those hopeless and vulnerable people who have not succeeded in traditional mental health therapies, medication therapies, hospitalizations or residential institutionalizations. Our roots are in social constructionism and collaborative dialogical practices.

Our focus is on human relational and linguistic perspectives and not on diagnostic labels people have been assigned to describe human suffering. We believe such diagnostic themes often bind personal narratives to deficiency rather than strength-based and self-solving narratives and have the propensity to increase trauma and suffering (Anderson, 1997; Anderson & Gehart, 2007; Swim, 2022a; Swim, 2022b; Tennov, 1975). Through equal, caring, immediately present, and mutually trusting relationships, we collectively highlight the voices of the individuals and their families. A chorus of voices with polyphonic beauty collectively find solutions that can dramatically create life-saving changes. This dramatic change can often be quite simple and the necessity for psychotropic medications, isolation from peers, or intensive therapy does not need to occur. To date, this is what we see. Simple solutions and endless possibilities that arise from genuine, caring and nurturing conversations, where there are no villains to blame and no formulaic paradigms to learn.

We learn from the voices of our clients. Trust, care, timing, and pacing-along with the recognition that, as clinicians, we do not hold all the answers but are taught by those we engage with-lead to individually tailored sessions. As educators and researchers, we often observe well-intentioned clinicians searching for *“the thing in the bushes”,* as

Lynn Hoffman described. Similarly, as educators and supervisors, we notice learners grappling with their anxieties. The intensity of sessions often drives them toward quick solutions, an absence of listening and relying heavily on theories and diagnostic labels to guide their efforts.

> *Over the last few years, my family and I, were involved, in individual, marriage and family therapy with interns, social workers and marriage and family therapists. I want to share my story in the hope that it might inspire professionals like you to reflect deeply on your practice… Instead of helping soothe and connect us better to one another, the therapy we received tore us apart. Each of us was assigned to different therapists who worked in silos, unable or unwilling to share crucial insights. For instance, my children's therapist couldn't communicate even overarching concerns or suggestions with us, their parents unless it was life threatening and dangerous. How were we supposed to support each other and our children better when the very system designed to help us created barriers? The disconnection bred confusion and isolation, leaving us feeling more fragmented than when we began* (A story in their own words-transcript of a mother, 2024).

We view each person and their community as possessing inherent strengths and self-agency to transcend diagnosis, symptoms, and trauma. As Kostic (Karter, 2024); Seikkula (Barnes, 2022); Sharma (2023); and Nardi (Siem, 2024) have recently observed, responses to extreme stress-manifesting as psychosis, severe depression and anxiety, or other parity diagnoses-aid clients in coping. Thus, the effort to eliminate symptoms entirely can, paradoxically, perpetuate oppression (Swim, 2021). We define oppression as the creation of obstacles to symptom reduction and the elimination of symptoms. Too often, when a client and their family enter therapy, symptoms tend to worsen. The soothing and validation that should be provided in *"high-acuity"* or *"chronic cases"* can disappear. Severe symptoms and suffering can be coping mechanisms and do not need to be eliminated. When individuals no longer see themselves as defined by a mental illness label but as being a person, they flourish. Suicidal ideation or psychosis ceases. Families reunite. Most of the people we see go off to college or create preferred lives. They were perhaps too overwhelmed with suffering to have had the opportunity to do so previously. And the focus on medicalization limited self-solving possibilities.

For example, in 2019, a family collaborated on research regarding how change can occur from life-threatening experiences (Swim, 2020). Megan, who was referred to us after being abruptly discharged from residential care just before her 18th birthday, had recently attempted suicide there after her therapist left the room. She was

struggling with feelings of self-hatred and a lack of connection to her parents. Over the years, she and her family had experienced numerous psychiatric treatments and programs that, instead of helping, reportedly caused more trauma, damaging their relationships and self-identities.

Our treatment focused on open, individually tailored, and client-directed collaborative dialogue, treating each meeting as a fresh opportunity for change (Andersen, 1997). We view each session as a dialogical endeavor where we are led to explore what types of possibilities may emerge. We met with Megan twice a week and communicated daily, often multiple times a day. Initially, Megan's goal was simply to survive each day, and her parents just wanted to find her alive each morning. Over time, their goals shifted from survival to thriving-Megan aimed to attend college, build friendships, have a boyfriend, and pursue her future like any other young adult, all of which she achieved. Her parents, in turn, began to see her not as someone with a mental illness, but as a person with strengths and aspirations, capable of building the life she desired (Swim, 2019).

We find that in cases where people suffer from suicidal ideation or psychosis, a shift takes place when they are recognized for their humanity; they are heard within contexts and relationships (Swim, 2020; Swim et al., 1998). The seemingly simple act of being heard by someone who genuinely cares expands options and detailed constructional pathways to change. Symptoms vanish, and families frequently reunite with a new shared understanding. These actions-feeling heard, knowing you are believed, and knowing your practitioner genuinely cares and creates a dialogical space for options to flourish-are not simple acts. We will describe the intentionality behind them later in what we call Process Ethics.

> *As a recovery consultant-I, at one point in my life, experienced times when I contemplated such themes. I found that when life changed, those urges dissipated. When I experienced changes in the context of my life, suicidal ideations dissolved, and I found new meaning-meaning that invited me into this world and left behind the themes of despair. What inspires hope to live life will be different for everyone, and therapy cannot change your life directly. However, therapy can be a place where you feel supported, can talk, and explore what is important to you. Rehashing old hurts was unhelpful and amplified my pain. In contrast, focusing on what is going well in life and what feels good invites hope for a better tomorrow.*

In 2023, we documented the case of a young adult who had been hospitalized over 33 times between the ages of 12 and 17. Over time, the number of diagnoses grew incrementally with each new provider. With every new clinician and treatment team, the once-acute symptoms became chronic and dangerous. During this process, no effort was made to explore the isolation or loss of hope and dreams exchanged for the construct of severe mental illness. Conversations occurred exclusively within the family and were framed in the language of pathology, which the family was required to adopt (Swim, 2024).

> As Kostic (Karter, 2024) explains: *“There are a variety of problems, each one complex enough to discuss for hours. My main issue is that the starting premise is wrong. When your premise is flawed, no matter how excellent your studies are, you’ll end up with gibberish. We’re comparing apples and oranges here, and this is often called the heterogeneity of depression. However, I prefer not to use that term because it implies that depression is just a set of different types of the same disorder. Instead, I think it’s more accurate to talk about the heterogeneity of human experience. Words carry weight. When we say ‘depression,’ we typically mean ‘major depressive disorder,’ and when we say ‘disorder,’ it implies something is wrong with the brain”.*
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> Nardi (Siem, 2024) highlights the importance of context, noting how clinicians often overlook it in favor of finding the *"right"* diagnosis and treatment: *“One of these basic emotional needs is to have relationships. What I find is that people are terribly deprived of different basic emotional needs that come right after, in terms of relevance, to the physiological needs”.*

Both Nardi and Kostic suggest that psychiatric treatment can pathologize normal human emotions. When we pathologize clients through deficiency-based explanations-whether in psychiatry, psychology, or marriage and family therapy-we risk worsening their condition, missing opportunities for self-resolution, and fostering hopelessness (Andersen, 1991; Andersen, 1997; Swim et al., 2022; Swim et al., 2023; Swim et al., 2024; Barnes, 2022). These perspectives on freedom emphasize the importance of viewing experiences from the client’s point of view, rather than prioritizing professional paradigms or pathological frameworks.

As Hoffman (1998) stated: *"The mental health profession itself has been held up as an oppressive discourse, and as a result, a much-needed consciousness-raising is taking place"* (p. 145). Including and making *visible* (Anderson, 2001, p. 5) the voice of the

consumer. Complaints by consumers made public moral assertions and introduced change.

> *And being in the hospitals kind of exacerbated all of that because, you know, they were very quick to stick a lot of labels on me. They wanted to tell me I had this disorder and that disorder, and that this was something I was going to be dealing with for the rest of my life, that I'd need to be on medication for the rest of my life, and basically that I couldn't trust my own brain* (A story in their own words-transcript of an adult female, 2023).

> *At 12, I feel like I am traumatized from the hospital and rehab. I feel a sharp emotional pain when I experience a sensation or sudden state of déjà vu, but the déjà vu is not something that hasn't happened. It is something that I experienced in confinement. In a way I am scared that I will somehow always be confined by the acceptance of astonishing destruction from my time in confinement* (A story in their own words-transcript of a 12-year-old, 2024).

We view our work as consciousness-raising and grounded in an ethical stance. Our research began in the 1980s, and since 2007, we have conducted continuous qualitative research based on client interviews to understand what is helpful, right, and good for each person in conversation. We call this Process Ethics (Andersen, 2001; Anderson, 2001; Swim, 2001).

Process Ethics guide us as clinicians. Our clients have significant success rates reflecting the cessation of previous symptoms or *Shedding Severe Mental Health Labels* (Swim, 2022a; Swim, 2022b). Our clients co-participate in creating lives full of purpose and meaning. For decades our clients transcend labels and symptoms. They rebuild and redesign their lives. They see being assigned labels either psychiatric or theory driven as harmful to their journey to wellness. Despite the trauma of previous treatment, they are able to redesign their selves in manners that far outweigh their lives before their severe symptoms. We have called this transforming into Extraordinarily Normal (Swim, 2022b).

> And you guys just shed so much hope into my situation where I thought there was none, and it really just helped me see that, you know, I was going to be able to come out the other end of this situation. You know, I hadn't heard any hope in the hospital. I hadn't heard any hope from the doctors. You know, it was all medication. It was all, you know, *"We're gonna treat this."* You know, but no talk of healing. And, you know, it was just so discouraging for me. I thought,

like, I would never be, *"normal"* again. (A story in their own words-transcript of an adult female, 2023).

Context and Need for Innovation

> And I was scared that everything they told me in the hospital was true, that I was going to be just another, you know, diagnosis. So, you know, around the time I had gotten out of the hospital-my third visit in one year-I was introduced to the Institute. I was able to talk to you guys and hear your encouragement, to hear that I would get through it, that you've seen so many people get through it. (A story in their own words-transcript of an adult female, 2022).

> *"No one ever talked like this with me before." "They didn't force." "They listen and never force you, and they do not make assumptions about you." "You are unique and do not compare yourself to other people's journeys… do not make permanent decisions about things that will change in time."* (A story in their own words-transcript of an adult female, 2022).

The purpose of this article is to share the voices of consumers gathered over the last few decades. We hope that by presenting these voices, practitioners can hear the need for change. These are reflections drawn from published case studies. Our research comes from teams who collaborate across different parts of the world. What is common to us all is the need to share our research and lived experiences as licensed psychiatrists, psychologists, marriage and family therapists, and recovery coaches. We draw on each other's experiences and conversations so that our clients benefit from approaches that aim to humanize therapeutic and consulting conversations. Our recent interest was propelled by the conference hosted by *Metalogos*, which further inspired us to bring these voices to the forefront.

In *Normalizing or Humanizing ourselves for the Other*, we invite words of hope and remedy, fostering dignity, dialogue, and freedom within therapy, coaching, recovery consulting, and mentoring. We create a space for reopening possibilities and futures for those we collaborate with. Our work addresses *"tough"* issues, collectively rebuilding feelings of normalcy, trust, hope, self-agency, and self-determination-the basic elements of recovery and freedom in marriage and family therapy.

We wish to highlight that practitioners enter our field to help people. Their intention is to alleviate suffering and help both individuals and families find mental health and

wellness. However, often in their journey, their efforts to listen and support are replaced by theoretical ideas that do not include the client. John Shotter referred to this as 'counterfeit therapy' (Shotter, 2004). He mused that therapy had become mechanistic, focused on skill sets and tools that the client often did not understand or use. Instead of the therapist listening, they interpreted what they felt the client was saying or needed. These processes, he argued, did not lead to the alleviation of symptoms but to more confusion and impossibility (Shotter, 1993; Shotter, 2004; Swim, 1995; Swim, 2001).

> As therapists you hold an immense power – one that can heal or harm in ways that you cannot begin to imagine and may never fully comprehend. The unsettling truth is that while I assume you all work to provide care, I imagine that you very rarely know the long-term outcomes of your interventions and diagnoses. Once your clients leave your offices, you lose sight of their lives. We may never know if the *"tools"* we assumed you provided helped them build a better future or left them grappling with unintended and at times devastating consequences (A story in their own words-transcript of a mother, 2024).

We collaborate with clients to ensure our process is supportive, less frightening, and filled with hope. This is often achieved through a team of clinicians and life and recovery coaches who work with individuals and families to design services best suited to their needs. You may ask, how do we know if this is suited for their needs? We ask them. We ask our clients, and they inform us.

No two clients receive identical services. Clients and their families are true collaborators, shaping their views and goals together. We learn to participate in this therapeutic alliance based on what they state they need and what they wish to accomplish during their time with us. We do not believe this is simply a model of therapy, but rather a philosophy or a way of being. We think in terms of how we can normalize ourselves for those we work with, and how we can avoid causing harm by not listening or discounting their words.

> Yes, people do and can be cured from mental illness. My child healed and became their normal self again. After so many other clinicians pushed for medications and changing medications. All it took was being listened to and being see and heard (A story in their own words-transcript of a mother, 2025).

Our research reflects it is crucial for professionals to approach their clients or with humility, uncertainty, empathy and humanity. It speaks to the profound impact that being treated as a *"case"* or just a diagnosis can have on a person, and how healing

goes beyond simply following procedures. These quotes also underscore the importance of truly listening-not just for the purpose of collecting information, but for understanding and recognizing the person as a whole, which is vital for fostering trust and connection.

Being seen and heard can profoundly affect someone's mental and emotional well-being, while feeling invisible or dismissed can have serious consequences. The mention of feeling *"suicidal"* underscores the severity of being ignored or misunderstood in a therapeutic relationship. It serves as a call for more compassionate and holistic care that values people as individuals, not just clients.

> Listening means great care. It is not about fact-finding. The degree of distance you maintain from understanding the client's experience reflects how little you care about me as a person. Diagnosis is not reverse engineering. You cannot heal without care and seeing us as ordinary humans. You cannot help a client by simply following bullet points for treatment or diagnosis. Healing comes from being seen, heard, and valued as a human being. The opposite of that made me feel suicidal. In this particular case, what I said didn't matter; the preconceived ideas made me invisible. The diagnosis is fixed. There was nothing I could do to change the diagnosis that happened in week 2. (A story in their own words-transcript of a mother, 2024).

Duncan (2024) discusses the therapeutic alliance as a key factor in fostering change. Practitioners often need confidence in themselves as agents of change, rather than in their skill sets. He states, *"I bring a deep belief in the therapeutic process. I trust in the client, the power of the therapeutic relationship, and in myself - my ability to be present and dedicated to facilitating change."*

We tend to believe all clients are resourceful and deserve to be seen by their strengths. People who carry labels-or have family members with labels-often feel trapped, unable to separate themselves from these identities. However, it is possible to shed such labels. Systemic or family therapy in the 1980s was meant to develop theories that challenged dominant paradigms and encouraged more relational ways of understanding human struggle. We now need to revisit this work. By doing so, we can offer ideas that shift the field away from a disease-based model and toward more relational, contextual, and human-centered practices, as exemplified in the concept of *Shedding the Limits of Severe Mental Illness Labels* (Anderson & Goolishian, 1992; Swim et al., 2022).

In an interview with a young woman, she discussed the liberation she found while studying abroad in Florence, Italy. She developed a deep appreciation for a slower pace of life that focused on the arts. The study abroad experience gave her the space needed to find her own truth and freedom. *"I learned so much about how to prioritize the things that make life worth living"* (Swim et al., 2024).

> "The journey of traveling to a new land allowed her the opportunity to discover her true values and find purpose, all while surpassing the worries and uncertainties that often come with establishing a career and self-identity. Prior treatments as a teen infringed and complicated uncertainties that are ordinary to all of us. *"Maybe we're not supposed to have it all figured out. Maybe there's strength in allowing things to reveal themselves to us, and maybe we don't need a set, concrete path that has worked for someone else before… We're all so individual and unique that we can't be prescribed a career or life path or be bound to the expectations of others."* (Transcript of an adult woman, 2024).

When someone is trapped inside the limiting beliefs of mental illness narratives, they can become stuck in a cyclical pattern of symptoms and behaviors. Placing oneself in a new environment can help break this cycle and create new narratives. People deserve to be seen and heard as they see fit. They deserve to be responsible for the creation of meaning in therapy and their lives (Swim et al., 2024; McNamee & Gergen, 1999).

In the early 1980s, Harry Goolishian, a pioneer in postmodern collaborative therapy, argued that diagnoses neither explain mental processes nor define a person. Treating individuals based on labels derived from symptoms often isolates them from their families and themselves, leading to despair and even suicidal ideation (Swim, 2022; Tomm, St. George, Wulff, and Strong, 2014). Goolishian considered labels as deficiency language used to describe people and their suffering (Swim, 2003; Swim, 2021; Swim, 2022a).

From Promising Beginnings to Narrowing of Options

In presenting this challenge I will focus mainly on some issues surrounding the history of schizophrenia. It is my strong conviction, however, that the dimensions of this problem and our continuing reliance on deficiency language permeate our entire endeavor and have created for us a social reality that will be most difficult to move and change. These problems are now embedded in our professional identities, our universities, our public language, our legal system, our educational systems, our

economic system, and have become part of the fabric of our entire social narrative. At the same time, I am optimistic that change can take place and in fact that it is taking place (Goolishian, 2017, p. 70).

Marriage and Family Therapy was originally conceived as a rebellion against the paradigm of individual pathology (Swim, personal experience). The field aimed to see beyond individual diagnoses, focusing instead on family systems. This shift was revolutionary, as it acknowledged that humans exist in relationships and dialogue. As relationships evolve, so do the meanings we create through conversation. Systemic interventions were seen as the key to alleviating symptoms.

However, over time, theories emerged that created new deficiencies and labels. Emotions become categorized as mental illnesses. And these emotions that at one point in time held normalcy led to new diagnoses and family therapy theories designed to treat these diagnoses. Lynn Hoffman spoke of the complexity of human emotions, noting that neither joy nor pain could be fully encompassed within a diagnosis or theory, regardless of its origin (Swim, personal communication).

In decades of clinical work, academic research, and training, we have not encountered anyone who lacked a valid reason to suffer or exhibit symptoms. However, the proliferation of diagnostic criteria and theories has made it increasingly challenging for clinicians-both those in training and those in practice-to truly see the person behind the symptoms (Swim & Kinman, 2018). It is particularly difficult for clinicians to listen to challenging stories or navigate intense situations. It is not necessary to uncover the root cause, as that is impossible. Instead, we must focus on understanding what, in the present, will make life worth living for our clients-how and why they might wish to continue living. Through these actions, a discursive map begins to take shape, guiding both clinicians and clients in their conversations for hope and sustainable change.

A newer challenge is the widespread access to labels online. Once confined to hospitals or clinical settings, these labels are now readily accessible. Many people read about symptoms and feel they apply to them, even if the labels are inaccurate. Trauma and high stress, for example, are sometimes interpreted as biological deficiencies. Our recovery consultants speak to the membership of those who enter into hospitals. It is no coincidence their support systems are those with similar backgrounds. With the diagnoses children and teen especially seek out others who they assume will understand their disabilities. Imagine if we all identified with the worst thing that happened to us in our lives. Novel thought becomes narrowed.

We view social media as the *'commercialization and social construction of mental health'* (Cunniffe, 2024). The algorithms specifically target young adults, continuously exposing them to content that suggests human suffering has no cure. For one client, being depressed and going online created the reality that there was no hope for her recovery. She did not know that an algorithm was learning her behavior and providing content based on her initial searches. What she did know at seventeen was that the diagnoses she had received during over thirty hospitalizations had no cure and offered no hope. She decided *"to give up, and she realized she had lost her life"* (Swim et al., 2023).

Another client shared their experience of feeling overwhelmed and searching for help on social media, only to encounter discussions about euthanasia (Swim, 2022b; Swim et al., 2023; Swim et al., 2024). This led her to favor this option, should she be unable to recover, and seek out countries like Belgium. Too often, we hear stories of people breaking off engagements, losing hope, and becoming more fearful of symptoms that can actually be managed-all influenced by the opinions of social media influencers.

A former client who had recovered from symptoms of psychosis never heard our team mention this diagnosis. Instead, we focused on their hardships, exploring how these symptoms arose and discussing their recovery journey. After taking a break from social media, they returned to find a flood of content that contradicted their experience, reinforcing a narrative that doesn't align with their recovery. Because she was asymptomatic and had no symptoms of psychosis, she was not jolted. However, she shared that if she had seen this earlier in her transformation, it would have set her back (Swim 2022b; Swim et al., 2022).

> *"When we are told we are a diagnosis it becomes a self-fulling prophecy. We become demotivated to participate in normal life. We become emotionally handicapped"* (Transcript of a recovery consultant, 2024)

> *"I think there are a few things therapists should know about their clients. Firstly, prescribing ADHD medication needs to be done in person, otherwise it can be dangerous. My 13-year-old brother was 9 when he got diagnosed with ADHD from his rocking chair during a Zoom call. The following week he was put on stimulants that are known to make children more impulsive and sleep less. He was then put on antidepressants, which say that the side effect ironically is suicidal idealization. Of course, less than 2 weeks after being put on both these medications, he started self-harming for the first time. Within 1 month was his first suicide attempt"* (A story in their own words-transcript of a brother, 2024).

Adversarial Relationships- A Side-Step

> "My 12-year-old, under psychiatric care and placed on a dangerous cocktail of medications, was driven to despair. What followed was 18 months of hell. My child cycled through inpatient residential treatment, intensive outpatient programs, and partial hospitalization programs. They were sometimes removed from our home for as long as 12 weeks or attended therapy five days a week for six hours a day. I watched their emotional and mental state crumble under the weight of these interventions. Please remain humble and deeply aware of the fragile human experience of those you call clients". (A story in their own words-transcript of a mother, 2024).

> "I don't know if that was their point or reasoning. It made me, I never knew what was going on with me. I was tired and I was physically sick. All the meds would make me sick. Thinking back now it was like I was medically put in a calm state just so I would be compliant. So, but at that point of time you thought the medication was helping you… Yeah, I thought I couldn't survive without it". (A story in their own words-transcript of a mother, 2024).

"We believe that treatment approaches often do not succeed because they are adversarial: they set up a struggle between the 'identified patient' and the persons or systems 'treating' them" (Swim, 2003; Swim, 2023). In our research (Swim, 1995; Swim et al., 1998; Swim et al., 2018; Swim, 2022a; Swim, 2022b; Swim, 2020; Swim & Swim, 2022; Swim et al., 2023), we observed that the first step into this posture of adversity and subjectivation often occurs when individuals enter treatment-therapeutic services (Sharma, 2023). This dynamic reinforces a hierarchy that silences client agency and diminishes the possibility for collaborative, healing relationships.

Due to the constraints of licensure and emergence of third-party reimbursement in most westernized countries, as well as adherence to standardized therapeutic techniques, therapy is mandated to begin with a diagnosis. When seen through lenses, clients who initially attribute their experiences to trauma and its resultant symptoms are frequently presented with a biochemical explanation for their suffering. This shift is particularly evident when therapy exceeds the typical 50-minute session. When symptoms persist despite intervention, providers may assess for biological causes, labeling the client as *"ill"* and framing treatment as a battle against this illness. In previous research this is described as a death sentence (Swim & Lopez, 2022).

In this scenario, the person becomes their diagnosis-in effect, both the victim and the enemy. Often, they are coerced into therapy, especially when the severity of symptoms makes their caregivers appear more like jailers. Such clinicians monitor and admonish

‘wrong’ thoughts and focus on the outcomes they desire rather than what the client truly wants (Swim, 2022). We asked consumers for their thoughts while preparing this article. One shared:

> “But therapists, I urge you: be aware of the power dynamics at play because your authority can blind you to the strengths, perspectives, and needs of the humans sitting across from you. When you view your clients through the lens of a previous therapist's diagnostic, you will be missing the gifts they bring, further entrenching them in a narrative of deficiency. You can be the therapist that will help a client *"loose"* the label of their diagnosis”. (A story in their own words-transcript of an adult female, 2022).

Our role is to sidestep these points of reference and support clients to find their own solutions (Swim, 1995; Swim et al., 1998; Swim et al., 2001). We encourage them to explore multiple worldviews rather than limiting themselves to what they’ve read online, their past experiences, or prior therapeutic interventions. We focus on hope and positivity, working from strengths. We do not avoid problems, as challenges are inherent or possible in most conversations. We do not see problems as fixed entities or patterns. Instead, we honor and value the narratives that unfold when mutual trust and care are foremost (Swim, 2022).

Our lead is the consumer, and we enter into humanitarian conversations (Swim, 2022). We have previously referred to this as *“the client is the expert”* (Swim, 1995; Anderson, 1997, Swim et al., 1998). Upholding and honoring multiple narratives create spaces of trust, hope, and change.