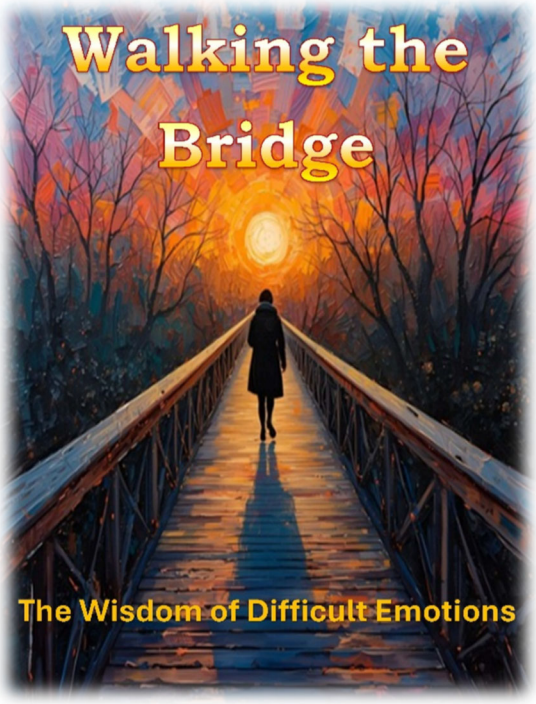

Listening to What Sadness, Anger, Fear,

and Guilt Are Trying to Tell Us

WALKING THE BRIDGE™

The Wisdom of Difficult Emotions

Walking the Bridge

Author

Dr. Margaret (Meg) Robertson

DMin, LPC, LMHC, LCDR, CHC, USN-Ret.

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where research meets recovery

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Dedication

For the ones who have and are having to walk that dark bridge in life. Hope awaits.

Epigraphs

"If you don't like where you are, you won't like where you're going."— Meg

"Yea though I walk through the valley . . ."—Pslam 23

Table of Contents

Preface

This book began, in many ways, in the quiet moments after sessions ended.

I would close the door, take a breath, and feel the weight of what had just been shared: a mother's exhausted worry, a veteran's unspoken terror, a teenager's shame, a caregiver's resentment, a pastor's grief. Often, the presenting question was some version of, "What is wrong with me that I feel this way?"

Over time, that question started to bother me more than the emotions themselves.

It wasn't that sadness, fear, anger, or guilt were easy. They weren't—and aren't. But again and again, I watched people judge themselves for feeling exactly what any human being would feel in their situation. Instead of seeing emotions as meaningful responses to pain, loss, or injustice, they saw them as evidence of weakness, failure, or spiritual immaturity.

This book, Walking the Bridge: The Wisdom of Difficult Emotions, grew out of a deep desire to answer that question differently. Not, "What is wrong with me?" but, "What are my emotions trying to tell me—and how can I listen in a way that leads toward healing rather than harm?"

What I Hope This Book Will Do

My hope is not that you will finish this book with fewer emotions. If anything, I hope you will find yourself more emotionally awake—but with a different posture toward what you feel.

I hope you will:

- See “negative” emotions as information, not as moral verdicts
- Learn to recognize how your body, thoughts, and relationships all participate in your emotional life
- Discover that faith, science, and lived experience do not need to be enemies in this conversation
- Find language and tools that you can use personally, and also share with those you walk alongside

This project sits at the intersection of psychology, trauma-informed practice, adult learning theory, and Christian theology. It reflects years of listening—to research, to colleagues, to Scripture, and most of all to the stories of people who were brave enough to name what hurt.

Why a Book on “Difficult” Emotions?

There is no shortage of advice about “how to be happier” or “how to get rid of anxiety.” Much of it is well-intentioned. But when pain is profound or chronic, quick fixes can deepen shame.

We need a different approach—one that honors complexity.

In these pages, we will explore emotions like sadness, anger, fear, guilt, shame, jealousy, and the hollow ache of worthlessness. We will also look at experiences like apathy, anxiety, pain, grief, mourning, and resentment. These states are often treated as problems to eradicate,

yet each carries its own kind of wisdom when approached with curiosity and care.

Rather than labeling them as enemies, we will ask:

- What is this emotion trying to protect?
- What does it reveal about what I value or what I've survived?
- What happens when culture, family, or theology misinterpret this emotion?
- What practices actually help, and which ones unintentionally cause harm?

This book is part of a larger series, *Bridging the Gap*, produced through the Center for Trauma & Resilience Research. Each topic—apathy, anxiety, depression and sadness, fear, grief and mourning, jealousy, pain, resentment, shame, and worthlessness—is explored through a video, an essay, and practical handouts. Together, they offer multiple ways to engage: visually, reflectively, and experientially.

Why "Walking the Bridge"?

The image of a bridge came to me as I was thinking about how many people feel torn between worlds:

- Between what they feel and what they think they should feel
- Between their body's alarms and their mind's theology
- Between the language of psychology and the language of faith
- Between wanting to be honest and fearing judgment or rejection

A bridge connects two sides without erasing either one. It doesn't demand that the river below disappear. It simply offers a way across.

This book is meant to function like that—an invitation to walk between emotion and meaning, body and belief, science and story. You do not have to choose one side and reject the other. You can learn to move back and forth, carrying insight from both.

A Gentle Word of Caution

Some sections of this book may stir memories or feelings that are tender, raw, or long-buried. That is not a sign that you are "going backwards" or "doing it wrong." It may be a sign that your inner world is finally being given language and attention.

Even so, please move at a pace that feels safe enough for you.

- Take breaks when you need to.
- Pause to breathe, stretch, or step outside.
- Reach out to a trusted friend, counselor, spiritual director, or support person if material feels overwhelming.

This book is not a substitute for therapy, medical care, or crisis support. It is a companion—a structured conversation partner meant to sit alongside the other resources and relationships in your life.

How to Use This Book

You can move through the chapters in order, or you can begin with the emotion that feels most present right now. At the end of many sections, you'll find reflective questions or practical exercises drawn from the corresponding handouts in the series. Use them as invitations, not assignments.

This book may be helpful if you are:

- Navigating your own difficult emotions
- Supporting loved ones through seasons of pain, loss, or change
- Serving as a counselor, pastor, chaplain, caregiver, educator, or leader
- Seeking a more integrated way to understand emotional life from psychological, cultural, and theological perspectives

If you are reading as a helper or professional, I hope these pages provide language and frameworks you can adapt to your own context. If you are reading in the middle of your own storm, I hope you feel less alone.

A Final Invitation

- If you have ever wondered, "If I really trusted God, would I feel this anxious?"
- If you have ever asked, "Why can't I just be over this by now?"
- If you have ever felt guilty for being sad, or ashamed for being angry, or worthless when you were simply exhausted—this book is for you.

You do not have to clean up your emotions before stepping onto the bridge. You only need enough will to take one honest step at a time.

As you read, you may discover that your emotions—especially the difficult ones—are not proof of your failure, but evidence that you are human, alive, and capable of growth.

Thank you for the privilege of walking a little way with you.

Walking the Bridge

Introduction

Most of us were taught, in one way or another, to "get over it," "cheer up," or "have more faith" when hard emotions show up. Sadness, anxiety, jealousy, shame, resentment, or a sense of worthlessness are often treated like intruders to be pushed away, fixed, or hidden. We learn to judge these experiences as evidence that something is wrong with us, our relationships, or our faith.

This series starts from a different assumption: so-called negative emotions are not moral failures or spiritual defects. They are messengers. Each difficult feeling carries information about our needs, our history, our values, and our wounds. When we learn how to listen to those messages with curiosity and compassion, emotions that once felt overwhelming or dangerous can become guides on the path toward healing and growth.

Walking the Bridge: The Wisdom of Difficult Emotions is designed to help you step onto that bridge—moving from avoidance or shame into a wiser, more integrated relationship with your emotional life. Drawing from psychology, neuroscience, trauma studies, cultural perspectives, and Christian theology, the Value of Negative Emotions series invites you to see your inner world not as an enemy to conquer, but as a landscape to explore with support and care.

Why Talk About "Negative" Emotions at All?

The word negative is used here in the way our culture commonly speaks of these emotions—not because they are bad or unwanted in themselves, but because they are often painful, misunderstood, or misused. When we ignore them, they tend to intensify. When we judge them, they often turn against us. But when we recognize their purpose, they can become:

- Early warning systems when something is unsafe or misaligned
- Signals of grief, loss, and love
- Invitations to set boundaries or repair relationships
- Indicators of injustice, unmet needs, or internalized shame
- Opportunities to grow in wisdom, compassion, and resilience

This series begins with a foundational exploration of the value of negative emotions—why they exist, what they are trying to do for us, and how psychological, cultural, and theological frameworks can either support or distort the way we relate to them. From there, each module focuses on a specific emotional theme, offering a video, an essay, and a practical handout designed for everyday use.

What This Book Covers

Each emotion-focused module grounds you in core concepts and then moves toward practical, usable strategies:

Anxiety

Anxiety is not simply "a lack of trust" or "overreacting." It is often the body's attempt to prepare for danger, even

when that danger is invisible or rooted in past experiences. Here we explore anxious thoughts and sensations, identify what anxiety is trying to protect, and introduce evidence-based coping strategies that calm the nervous system without shaming the struggle.

Apathy

When life feels flat and nothing seems worth the effort, apathy may be signaling exhaustion, hopelessness, or self-protection. This module explores how apathy can develop, how it can sometimes keep us safe, and what gentle steps can help us move from numbness back toward engagement and meaning.

Depression & Sadness

Sadness and depression are often treated as problems to erase as quickly as possible. Yet sadness can mark what matters most to us, and depression can be a signal of chronic overload, grief, or disconnection. This module differentiates between sadness and clinical depression, explores multidimensional contributors (biological, psychological, social, and spiritual), and offers ways to respond that honor both the pain and the person.

Fear

Fear is a survival emotion—it exists to help us live. But when fear becomes overwhelming or stuck, it can shrink our world. This module examines psychological interventions that can either help or unintentionally worsen fear, and it provides concrete examples of how to process fear in ways that are grounded, compassionate, and growth-oriented.

Grief & Mourning

Grief is the internal experience of loss; mourning is how we express and live that grief in community and before God. Rather than treating grief as a problem to solve, this module traces the journey of grief and mourning, making space for the complexity of love, loss, anger, confusion, and hope that accompany major and minor losses.

Jealousy

Jealousy is often labeled as purely sinful or immature, but it can also reveal where our attachments, fears, and values lie. This module explores the costs and benefits of jealousy—how it can harm relationships when unmanaged, yet also highlight longings for security, recognition, or fairness that need honest attention and wise boundaries.

Pain

Emotional pain and physical pain are deeply connected, yet often treated as separate worlds. This module introduces pain as a multidimensional journey, comparing processes of physical and emotional healing and exploring how both kinds of pain can be acknowledged, cared for, and integrated instead of minimized or spiritualized away.

Resentment

Resentment often grows where hurt and injustice have not been named, validated, or addressed. It is a sign that something has been carried alone for too long. This module explores how resentment forms, why it is

understandable, and how it can be gently transformed through boundaries, lament, repair, forgiveness, or release—without demanding that people "just get over it."

Shame

Shame is the painful sense that "there is something wrong with me." Left unchecked, it can undermine relationships, faith, and mental health. This module examines evidence-based strategies for processing shame, including compassionate self-reflection, corrective experiences in safe relationships, and theological frames that emphasize dignity, grace, and belonging.

Worthlessness

Feelings of worthlessness are more than low mood; they shape how we see ourselves, others, and God. This module compares worthlessness with self-esteem, helping you identify internal and external messages that have shaped your sense of worth. It then offers practical tools for rebuilding a more grounded, resilient sense of identity.

How to Use This Book

The Value of Negative Emotions series is designed to be flexible and accessible. You might use it:

- For personal reflection, working through videos, essays, and handouts at your own pace
- In counseling or spiritual direction, as a shared language and resource for exploring difficult emotions

- Within groups, churches, classrooms, or workshops, to foster trauma-informed, emotionally honest conversations

As part of professional development for helpers, clergy, and caregivers who want to respond to suffering with both wisdom and compassion

You do not need to move through the modules in strict order. You may find yourself drawn first to the emotion that feels most present in your life right now. Over time, you may choose to revisit different modules as your story unfolds and new seasons of life emerge.

Walking the Bridge

Difficult emotions can feel like deep water—unpredictable, overwhelming, and unsafe. This series is meant to offer a bridge: sturdy concepts, practical tools, and compassionate perspectives that help you cross between what you feel and what you value, between your lived experience and the larger story of healing and hope.

As you engage with these materials, you are invited to move at your own pace, honoring your limits and your courage. The goal is not to eliminate "negative" emotions, but to listen well to what they are trying to tell you—and, in doing so, to walk more steadily, wisely, and kindly on the bridge of your own inner life.

Chapter 1

Valuing Difficult Emotions

In many contemporary Western settings, the emotional life is often divided into two camps: "positive" emotions that are welcomed and celebrated, and "negative" emotions that are treated as problems to solve.

Happiness, enthusiasm, confidence, and optimism are held up as signs of health and success. Sadness, anger, fear, guilt, and shame are frequently interpreted as weaknesses, spiritual failures, or evidence of psychological dysfunction.

This simple split between good and bad feelings is appealing—but ultimately misleading. It obscures the complexity of human emotion and can deepen shame in those who are already suffering. Emerging work across psychology, cultural studies, theology, and cognitive science challenges this dichotomy and invites a far more nuanced view. Rather than asking, "Is this emotion positive or negative?" a better question is, "What is this emotion trying to do for me?"

This chapter introduces the core argument that so-called negative emotions are not enemies to be eliminated but essential dimensions of human flourishing. When understood in context, emotions like fear, sadness, anger, guilt, and even worthlessness can become sources of information, moral insight, relational authenticity, and spiritual depth (David, 2016; Wong, 2011). They alert us

to what matters, reveal where something has gone wrong, and invite us into growth and repair.

Rethinking the Role of Negative Emotions

From a psychological standpoint, emotions are functional. They evolved to help us adapt to our environment, survive danger, and navigate social life. Susan David (2016) describes emotions as "data, not directives"—signals that illuminate unmet needs, violated values, or emerging threats. Fear orients us toward safety; sadness slows us down to process loss; anger mobilizes us in the face of injustice; guilt and remorse prompt us to repair relationships and reconsider our choices (Walker & Pitts, 1998).

Yet many people have been taught to interpret these signals as evidence that something is fundamentally wrong with them. When anxiety, grief, or anger arise, they immediately move into self-judgment: I shouldn't feel this way. If I were stronger, healthier, or more faithful, this would not be happening. Under this lens, the problem is not simply the pain itself—it is the meaning attached to that pain.

"Positive Psychology 2.0," as described by Wong (2011), offers a corrective by integrating suffering and adversity into our understanding of a good life. Rather than focusing only on happiness and life satisfaction, Wong argues for a model that embraces both light and dark as coexisting realities. Emotional pain can be a catalyst for growth, resilience, and wisdom, especially when it is

acknowledged and worked with rather than avoided or pathologized.

Emotional agility, a term also popularized by David (2016), refers to the ability to move with and through emotions—recognizing them, naming them, making space for them—without being dominated by them. This agility does not come from suppressing "negative" feelings but from learning to approach them with curiosity, compassion, and discernment.

Psychological Functions: What Negative Emotions Are Trying to Do

Each emotion, even the most distressing, has a job.

Consider a few examples:

Fear warns us of danger, real or perceived, and prepares the body to respond. It can be lifesaving in crisis and instructive in more subtle situations, signaling when something feels unsafe, misaligned, or overwhelming (David, 2016).

Sadness points to loss. It slows our pace, encourages reflection, and often opens the door to connection and comfort. Grief, as an extended form of sadness, marks what mattered and still matters to us.

Guilt and remorse are moral emotions. They help us recognize when we have harmed others, violated our own values, or fallen short of commitments. When not distorted into shame, guilt becomes a guide toward

repair, reconciliation, and deeper moral maturity (Walker & Pitts, 1998).

Anger draws attention to perceived injustice, boundary violations, or unmet needs. While it can be frightening—especially for those who have experienced anger as abusive—it can also be harnessed for advocacy, protection, and change when managed wisely.

Psychologically, then, negative emotions are part of the organism's adaptive toolkit. They provide critical information about our internal states and external circumstances. Problems arise when we 1) misinterpret the message, 2) lack skills or support to respond constructively, or 3) live in environments that punish emotional honesty rather than welcome it.

A trauma-informed lens adds further nuance. For people with histories of trauma, emotional responses may be intensified, mis-calibrated, or tied to earlier experiences rather than current reality. Even then, the emotion is not meaningless; it is saying something about what the nervous system has learned about danger and safety over time. Rather than shaming these reactions, trauma-informed care seeks to understand them and gradually renegotiate them in a safe relational context.

Cultural Stories About Which Emotions "Count"

Our experience of emotion is not only biological or personal; it is also cultural. Different societies tell different stories about which emotions are desirable, how

they should be expressed, and what they say about a person's character.

In American culture, deeply shaped by individualism and achievement, high-arousal positive emotions—such as excitement, enthusiasm, and pride—are often held up as ideals (Tsai, 2007). These emotions fit a cultural script of striving, self-expression, and visible success. Low-arousal or painful emotions, by contrast, may be quickly labeled as "negativity," "weakness," or "mental illness," even when they fall within a normal human range.

By comparison, many East Asian cultures emphasize emotional moderation and balance. Instead of relentlessly pursuing happiness, emotional maturity may be defined by the ability to hold joy and sorrow together, acknowledging the impermanence and interdependence of emotional states (Qiu et al., 2025). In such contexts, emotions like guilt or sadness can be interpreted as evidence of relational attunement and ethical sensitivity rather than personal failure.

This contrast matters. When a culture treats negative emotion as abnormal or undesirable, people are more likely to suppress or deny their feelings, which can contribute to emotional dysregulation, social disconnection, and mental health struggles. A more culturally inclusive approach to emotional health would normalize a wide range of feelings and recognize that "being okay" does not always mean "feeling good."

For counselors, educators, and ministry leaders, cultural humility is essential. We must recognize that our

assumptions about what “healthy” emotion looks like are not universal. A learner from a collectivist culture, for instance, may experience and express distress differently than someone from an individualistic one—and may also bring powerful resources for emotional integration that Western models have often overlooked (Qiu et al., 2025; Tsai, 2007).

Grounding: Lament, Sorrow, and the Presence of God

For many people of faith, the tension around negative emotions is intensified by spiritual questions: If I really trusted God, would I feel this anxious? If I had more faith, would I still be this sad? In some settings, spiritual teachings are quietly (or loudly) used to pressure people into a premature positivity that does not match the depth of their pain.

A close reading of Christian Scripture, however, paints a different picture. Throughout the Psalms, we encounter raw expressions of anguish, anger, confusion, and longing. The psalmists accuse, plead, weep, protest, and wait. Their prayers of lament are preserved—not censored—in the biblical canon. Emotional honesty is portrayed not as a failure of faith but as a profound act of faith: a decision to bring the full self into relationship with God.

Jesus himself embodies a fully human emotional life. He weeps at Lazarus’s tomb (John 11:35), grieves over Jerusalem (Luke 19:41–44), and agonizes in Gethsemane, sweating “like drops of blood” as he faces his impending suffering (Luke 22:42–44). He expresses righteous anger

in the temple when confronted with injustice and exploitation (Matthew 21:12–13). These narratives affirm that sorrow, distress, and anger are not incompatible with holiness; they are woven into the story of redemption.

The Beatitude, "Blessed are those who mourn, for they shall be comforted" (Matthew 5:4, New International Version), goes further still. Mourning is not something to rush past; it is a place where God promises comfort. The Christian tradition, especially in voices like Dietrich Bonhoeffer and Henri Nouwen, has long recognized that suffering can become a site of grace—a place where vulnerability opens space for deeper communion, compassion, and solidarity.

In this sense, negative emotions are not spiritual detours but potential pathways into intimacy with God and others. When held within a framework of lament, hope, and community, they can deepen spiritual maturity rather than diminish it.

Emotion, Language, and Meaning-Making

Emotions do not float in isolation from our thoughts, words, and stories. Cognitive science and linguistics highlight how language shapes emotional experience, both internally and in relationships. The ability to name what we feel—sadness versus numbness, anger versus resentment, guilt versus shame—is a cognitive act that supports emotional regulation and integration (Jończyk, 2016).

Jończyk's neuropragmatic work illustrates how language and emotion interact in the brain for both native and non-native speakers. The words we choose to describe our inner world can either clarify or blur our experience. For example, using a broad label like "stressed" for everything from grief to fear to anger may limit our ability to respond wisely. More precise emotional language allows for more targeted coping and more attuned support (Jończyk, 2016; Whissell, 2023).

Narrative also matters. Whissell (2023) emphasizes that emotionally rich language and storytelling can facilitate learning, creativity, and ethical reflection. When people frame their suffering solely as evidence that "I am broken" or "Life is hopeless," their emotions may spiral into despair. When they are helped to tell more complex stories—stories that honor pain, name injustice, and still make room for growth or grace—emotional experience can shift from chaos to coherence.

In the digital age, our shared emotional life is increasingly mediated by social media. Wu et al. (2020) demonstrate how deep learning models can analyze online posts to detect patterns of fear, anger, and grief in public discourse. While this research is technical, its implications are pastoral and educational: the words people use online reveal collective emotional states that deserve careful listening. Understanding how communities name and share their pain can inform public health interventions, policy decisions, and community support efforts (Wu et al., 2020).

Learning, Leadership, and the Courage to Feel

Negative emotions are especially likely to surface in moments of challenge: a classroom where a student fears failing, a workplace undergoing change, a church reckoning with harm, a family confronting loss. In these settings, the way leaders respond to emotion can either open or close pathways to growth.

In education, Mourlas, Tsianos, and Germanakos (2009) argue for integrating cognitive and emotional processes in web-based learning design. Anxiety, frustration, and confusion are not signs that learning has failed; they are often indicators that a learner is stretching into new territory. When educators acknowledge and normalize these emotions, students are more likely to persist, experiment, and reflect. Teaching emotional literacy—helping learners identify and articulate their feelings—supports both academic and personal development (Mourlas et al., 2009).

In leadership more broadly, emotional honesty builds trust. Leaders who recognize their own vulnerability and create space for others' pain foster environments where people can bring their whole selves to the work. This is especially crucial in contexts marked by trauma or chronic stress. Trauma-informed leadership emphasizes emotional safety, relational attunement, and the wise use of power. It aligns, in many ways, with the concept of practical wisdom in chronic mental illness, where competence is understood not simply as cognitive

capacity but as the ability to navigate real-life challenges in context (Widdershoven et al., 2017).

For Christian leaders, the call is even more specific: to be "wounded healers" who allow their own experiences of sorrow, guilt, or fear to deepen their empathy rather than harden their hearts. In counseling, pastoral care, spiritual direction, and mentoring, the willingness to sit with another's pain—without rushing to fix or silence it—can itself be a healing act.

Implications for Practice

Recognizing the value of negative emotions is not merely a theoretical exercise; it reshapes practice in tangible ways.

In counseling and psychotherapy, normalizing grief, guilt, fear, and anger reduces shame and invites clients into deeper engagement. Trauma-informed approaches regard emotional pain as meaningful data rather than mere symptoms to eliminate. Therapists and clients work together to discern what emotions are signaling and to build capacity for holding and transforming them over time.

In pastoral and spiritual care, leaders can draw from biblical narratives of lament and theological reflections on suffering to support congregants in seasons of loss or confusion. Rather than offering quick reassurances, they can model patient presence, attentive listening, and hopeful lament.

In education, curricula that include emotional literacy—alongside academic skills—equip students to navigate

complex inner lives. Teaching learners to recognize and name emotions, reflect on their meaning, and practice regulation strategies contributes to resilience and social responsibility (Mourlas et al., 2009; Whissell, 2023).

In organizational and community leadership, naming collective emotions (such as grief after a tragedy or anxiety during transition) can reduce isolation and foster solidarity. Leaders who acknowledge and validate shared pain help communities move toward constructive action rather than denial or fragmentation (Wu et al., 2020).

Across these settings, the shift is subtle but profound: from asking, "How do we get rid of negative emotions?" to asking, "How do we listen to them well?"

Summary: Making Space for the Full Spectrum of Emotion

This opening chapter has argued that so-called negative emotions are not intruders to be evicted from the house of the self. They are residents with important stories to tell—some loud and disruptive, others quiet and easily overlooked. Psychology reminds us that their functions are adaptive, even when their expressions are messy (David, 2016; Wong, 2011). Cultural psychology highlights that our judgments about emotions are shaped by social narratives that can either constrain or expand our emotional range (Qiu et al., 2025; Tsai, 2007).

Christian theology affirms the sacredness of lament and the possibility that sorrow and vulnerability can become sites of grace. Cognitive and linguistic research

underscores that the way we name and narrate our emotions changes how we experience them (Jończyk, 2016; Whissell, 2023). Educational and leadership studies show that embracing emotional complexity creates more humane and effective environments (Mourlas et al., 2009; Widdershoven et al., 2017; Wu et al., 2020).

As we move deeper into this book, we will focus more closely on specific emotional states—apathy, anxiety, depression and sadness, fear, grief and mourning, jealousy, pain, resentment, shame, and worthlessness. Each chapter will explore the psychological, cultural, and theological dimensions of that emotion, as well as practical strategies for engaging it in wise, compassionate ways.

For now, the invitation is simple and demanding: to consider that your most painful emotions may also be meaningful ones. To ask not only, “How do I make this stop?” but also, “What might this be trying to show me about my values, my wounds, my relationships, or my faith?”

Learning to value negative emotions is not about glorifying suffering or avoiding joy. It is about walking onto the bridge between what hurts and what matters, between our deepest fears and our deepest hopes—and discovering, step by step, that even our darkest feelings can become part of a larger story of healing, courage, and grace.

Chapter 1 Key Takeaways

Valuing Difficult Emotions

Here are concise key takeaways you could use at the end of the chapter:

- Negative emotions are not "bad" or pathological by default. Emotions like sadness, anger, fear, and guilt are adaptive signals that highlight needs, values, and threats rather than flaws in character.
- Western positivity culture can make suffering worse. When "good vibes only" norms pressure people to hide or fix negative feelings quickly, they often experience added shame, isolation, and self-blame on top of their original pain.
- Emotional agility is a core resilience skill. Naming, tolerating, and working with negative emotions (rather than suppressing or avoiding them) supports better decision-making, problem-solving, and long-term mental health.
- Culture shapes how emotions are valued and expressed. Some cultures normalize lament, interdependence, and communal processing of pain, while others emphasize individual control and emotional restraint—changing how negative emotions are interpreted and supported.
- Theologically, the full range of emotion belongs in a life of faith. Scriptural patterns of lament, protest, and honest struggle suggest that bringing grief, anger, and doubt before God is an act of relationship, not failure of faith.

- Cognitive and emotional processes are deeply intertwined. Thoughts shape feelings and vice versa; trying to treat them as separate domains often leads to fragmented care and incomplete healing.
- Guilt, shame, and anger have distinct functions. When understood correctly, guilt can support moral repair, anger can protect boundaries and signal injustice, and even fear can promote wisdom and caution.
- Clinically, the goal is integration, not eradication. Effective therapy helps clients befriend and integrate negative emotions into their narratives, identities, and coping systems rather than trying to eliminate them.
- Trauma amplifies sensitivity, but that sensitivity can be a resource. Heightened emotional responsiveness after trauma can increase vulnerability and deepen empathy, creativity, and discernment when supported well.
- Healthy emotional life is both learned and practiced. Skills like mindfulness, self-compassion, body awareness, and reflective meaning-making help people relate to negative emotions as important information, not enemies to defeat.

Chapter 1 Glossary

Adaptive function of emotion: The idea that emotions—especially those labeled "negative" like fear, sadness, anger, and guilt—evolved to help humans survive, signal threats or losses, and navigate social relationships, making them functional responses rather than random problems (David, 2016; Walker & Pitts, 1998; Wong, 2011).
Anger: An activating emotion that draws attention to perceived injustice, boundary violations, or unmet needs. When acknowledged and managed wisely, anger can be harnessed for advocacy, protection, and social change rather than aggression or withdrawal.
Cultural humility: A stance of ongoing self-reflection and openness in which helpers, educators, and leaders recognize that their assumptions about "healthy" emotion are culturally shaped and not universal. Cultural humility makes room for diverse emotional norms, especially between collectivist and individualistic cultures (Qiu et al., 2025; Tsai, 2007).
Cultural scripts about emotion: Shared cultural stories about which emotions are desirable, how they should be expressed, and what they signify about a person's character. For example, U.S. culture often idealizes high-arousal positive emotions like excitement and pride, whereas many East Asian cultures value emotional moderation and balance (Qiu et al., 2025; Tsai, 2007).
Emotional agility: A capacity to move "with and through" emotions rather than being dominated or numbed by them. It involves recognizing, naming, and making space for feelings with curiosity and compassion, treating emotions as data that inform choices rather than as commands that must be obeyed (David, 2016).
Emotional dysregulation: Difficulties in managing the intensity, duration, or expression of emotions. In the context of this chapter, dysregulation can be intensified when cultures shame negative emotions, when trauma sensitizes the nervous system, or when people lack skills and support for coping with emotional pain.
Emotional honesty: The practice of acknowledging and expressing one's true feelings, including anguish, anger, confusion, and sorrow. In the Christian tradition, the Psalms and the life of Jesus model emotional honesty as an expression of faith rather than a failure of faith.
Emotional literacy: The ability to identify, name, and reflect on one's emotions, and to understand their meanings and implications. Emotional literacy supports regulation, learning, and relational attunement in classrooms, workplaces, and communities (Jończyk, 2016; Mourlas et al., 2009; Whissell, 2023).

Emotional pain as data: A reframing of painful emotions (fear, grief, guilt, anger, worthlessness) as meaningful signals that highlight unmet needs, violated values, threats to safety, or relational ruptures. Emotions are understood as "data, not directives" that invite discernment rather than immediate self-judgment (David, 2016; Walker & Pitts, 1998; Wong, 2011).
Guilt and remorse (moral emotions): Emotions that arise when a person recognizes having harmed others, violated personal or communal values, or failed to meet commitments. When not distorted into global shame, guilt and remorse can guide repair, reconciliation, and moral growth (Walker & Pitts, 1998).
Ideal affect: The culturally shaped pattern of emotions that people want to feel and that are held up as desirable in a given culture. For instance, many Americans idealize excitement and enthusiasm, while some East Asian contexts idealize calmness and emotional balance (Tsai, 2007).
Lament: A form of prayerful or communal expression of sorrow, protest, and longing before God. In Christian Scripture, lament—especially in the Psalms—models emotionally honest engagement with suffering as a faithful rather than faithless response to pain.
Narrative and meaning-making: The process of interpreting and organizing emotional experiences into stories. The narratives people tell—such as "I am broken" versus "I am wounded and still growing"—shape how emotions are experienced and can shift suffering from chaos toward coherence and possibility (Whissell, 2023).
Negative emotions (so-called): Emotions often labeled as "bad"—such as fear, sadness, anger, guilt, shame, and worthlessness—that are frequently interpreted as weakness or pathology. This chapter reframes them as essential dimensions of human flourishing, with important psychological, relational, and spiritual functions (David, 2016; Wong, 2011).
Positive Psychology 2.0: An approach to positive psychology that explicitly integrates suffering, adversity, and "dark" emotions into the understanding of a good life. Instead of focusing only on happiness and life satisfaction, Positive Psychology 2.0 emphasizes growth, resilience, and wisdom that emerge through engaging pain as well as joy (Wong, 2011).
Social media emotional discourse: The patterns of emotional expression (e.g., fear, anger, grief) visible in online posts and digital interactions. Computational studies using deep learning can detect and summarize these patterns, revealing collective emotional climates

that can inform public health, policy, and pastoral responses (Wu et al., 2020).

Trauma-informed leadership: A leadership stance that prioritizes emotional safety, relational attunement, and wise use of power in contexts marked by trauma or chronic stress. It resonates with the concept of practical wisdom in chronic mental illness, where competence is seen as navigating complex real-life challenges, not just having cognitive knowledge (Widdershoven et al., 2017).

Trauma-informed lens / trauma-informed care: An approach that understands emotional responses—especially intense or "mis-calibrated" ones—as shaped by past trauma and the nervous system's learned expectations of danger and safety. Rather than shaming reactions, trauma-informed care seeks to interpret and renegotiate them in safe, supportive relationships.

Web-based learning integrating cognition and emotion: Educational design that acknowledges that emotions like anxiety, frustration, and confusion often accompany learning and can signal meaningful cognitive stretching. Thoughtful web-based instruction integrates human factors, personalization, and emotional support to foster persistence and deep learning (Mourlas et al., 2009).

Wounded healer: A model of Christian and helping leadership in which a person's own experiences of sorrow, fear, guilt, and vulnerability are allowed to deepen empathy and compassion rather than harden defenses. Wounded healers sit with others' pain without rushing to fix it, embodying presence and solidarity.

Chapter 1 References

David, S. (2016). Emotional agility: *Get unstuck, embrace change, and thrive in work and life*. Avery.

Jończyk, R. (2016). *Affect-language interactions in native and non-native English speakers: A neuropragmatic perspective* (1st ed.). Springer International Publishing. https://doi.org/10.1007/978-3-319-47635-3

Mourlas, C., Tsianos, N., & Germanakos, P. (2009). *Cognitive and emotional processes in web-based education: Integrating human factors and personalization.* Information Science Reference. https://doi.org/10.4018/978-1-60566-392-0

Qiu, L. S., Liddell, B. J., Wong, J., Li, H., Lies, J., Lau, W., Bryant, R. A., & Jobson, L. (2025). Cultural influences on emotion regulation and affective outcomes among trauma survivors: An ecological momentary assessment study. *Journal of Affective Disorders.* https://doi.org/10.1016/j.jad.2025.03.160

Tsai, J. L. (2007). Ideal affect: Cultural causes and behavioral consequences. *Perspectives on Psychological Science, 2*(3), 242–259. https://doi.org/10.1111/j.1745-6916.2007.00043.x

Walker, L. J., & Pitts, R. C. (1998). Naturalistic conceptions of moral maturity. *Developmental Psychology, 34*(3), 403–419. https://doi.org/10.1037/0012-1649.34.3.403

Whissell, C. (2023). *Engaging with emotion.* Springer.

Widdershoven, G. A. M., Ruissen, A., van Balkom, A. J. L. M., & Meynen, G. (2017). Competence in chronic mental illness: The relevance of practical wisdom. *Journal of*

Medical Ethics, 43(6), 374–378. https://doi.org/10.1136/medethics-2014-102575

Wong, P. T. P. (2011). Positive psychology 2.0: Towards a balanced interactive model of the good life. *Canadian Psychology/Psychologie Canadienne, 52*(2), 69–81. https://doi.org/10.1037/a0022511

Wu, P., Li, X., Shen, S., & He, D. (2020). Social media opinion summarization using emotion cognition and convolutional neural networks. *International Journal of Information Management, 51*, 101978. https://doi.org/10.1016/j.ijinfomgt.2019.07.004

Chapter 2

Coping with Anxiety

Anxiety is a multidimensional phenomenon encompassing physiological, cognitive, emotional, and behavioral dimensions. As one of the most prevalent mental health concerns globally, anxiety disorders affect nearly one-third of the population over a lifetime. This chapter provides an interdisciplinary review of anxiety, incorporating neurobiological, psychological, and sociocultural perspectives. It synthesizes empirical findings related to prevalence, symptomatology, comorbidities, and treatment modalities, including pharmacotherapy, cognitive-behavioral therapy (CBT), and innovative interventions such as digital psychoeducation and virtual exposure.

Special attention is paid to recent developments in neuroimaging, the role of trait anxiety in neural connectivity, and the psychosocial consequences of collective trauma, including war and pandemic-related stress. The chapter also explores less conventional contributors such as eco-anxiety, customer service environments, and comorbid conditions like hereditary angioedema. Findings emphasize the need for personalized, integrative treatment approaches and highlight avenues for future research and policy development.

Anxiety, as both a clinical condition and a universal human experience, reflects a complex interplay between cognitive appraisals, neurobiological mechanisms, and social environments. Defined by persistent and excessive worry, fear, or avoidance behaviors, anxiety can range

from adaptive responses to perceived threats to maladaptive, debilitating disorders (Szuhany & Simon, 2022; Penninx et al., 2021). The Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR) classifies a spectrum of anxiety-related conditions including generalized anxiety disorder (GAD), panic disorder, social anxiety disorder (SAD), and specific phobias, with lifetime prevalence estimates approaching 34% in the United States (Szuhany & Simon, 2022).

Anxiety contributes to substantial physical, occupational, and social dysfunction. Its multifactorial etiology includes genetic, epigenetic, neurochemical, and environmental factors (Kenwood, Kalin, & Barbas, 2022). Neural circuits involving the amygdala, prefrontal cortex, hippocampus, and insula are central to processing and regulating anxiety-related responses (Liu et al., 2024; Kenwood et al., 2022). At the same time, psychosocial stressors such as trauma, relational disruption, systemic instability, and ecological crises increasingly shape anxiety trajectories (Pihkala, 2020; Barel et al., 2025).

The complexity of anxiety demands an integrative lens. This chapter reviews definitions and classification, prevalence and risk factors, symptomatology, neurobiological and cognitive mechanisms, psychological and cultural perspectives, public health implications, and evidence-based interventions. The overarching goal is to inform clinical practice and public health policy with a nuanced, evidence-based understanding of anxiety in contemporary society.

Definition and Classification of Anxiety Disorders

Anxiety is fundamentally a future-oriented state involving cognitive, emotional, and physiological arousal in anticipation of perceived threat. It becomes clinically significant when it is excessive, persistent, and interferes with daily functioning (Lack, 2024). The American Psychiatric Association (2013, 2022) distinguishes anxiety disorders from normative fear or worry by their intensity, chronicity, and associated impairment.

The DSM-5-TR (American Psychiatric Association, 2022) delineates several primary anxiety disorders:

- Generalized Anxiety Disorder (GAD): Excessive, difficult-to-control worry about multiple life domains, often accompanied by restlessness, muscle tension, and sleep disturbance.
- Panic Disorder: Recurrent, unexpected panic attacks—sudden surges of intense fear—with physical symptoms such as palpitations, dizziness, and fear of dying (Szuhany & Simon, 2022).
- Social Anxiety Disorder (SAD): Marked fear of scrutiny, embarrassment, or humiliation in social or performance situations.
- Specific Phobias: Persistent, disproportionate fear of particular objects or situations (e.g., flying, heights, animals).
- Separation Anxiety Disorder and Selective Mutism: More common in childhood but increasingly recognized in adult forms.

The International Classification of Diseases (ICD-11) adopts a more dimensional and less stigmatizing framework, using the umbrella term “anxiety and fear-

related disorders" and avoiding "neurotic" labels (Grzech et al., 2025).

Anxiety disorders frequently co-occur with depressive disorders, obsessive-compulsive and related disorders, and somatic symptom disorders (Penninx et al., 2021). They also appear in the context of medical conditions such as narcolepsy, hereditary angioedema, and vestibular dysfunction, highlighting the need for collaborative medical–psychiatric care (Martinez et al., 2021; Özden & Bankir, 2021; Brandt & Dieterich, 2020).

A nuanced understanding of anxiety subtypes—anticipatory, situational, somatic, or existential—is crucial for accurate diagnosis and tailored intervention.

Prevalence and Epidemiology of Anxiety Disorders

Anxiety disorders are the most prevalent class of mental health conditions worldwide. In the United States, lifetime prevalence estimates approach 34% (Szuhany & Simon, 2022). Globally, the World Health Organization (2021) estimated that approximately 301 million people were living with an anxiety disorder in 2019, making anxiety a leading contributor to disability-adjusted life years (DALYs) related to mental health (Penninx et al., 2021).

Age and Gender Disparities

Anxiety disorders often emerge in adolescence or early adulthood, with many individuals reporting onset before age 25 (Penninx et al., 2021). Women are roughly twice as likely as men to experience an anxiety disorder, a disparity linked to hormonal factors, socialization,

rumination, and differential trauma exposure (Lack, 2024).

Older adults are frequently underdiagnosed because anxiety symptoms may be misattributed to medical conditions or "normal aging," and stigma can deter help-seeking (Adamek & Applegate, 2022). However, anxiety in later life—especially after trauma or displacement—appears significantly higher than commonly assumed (Ulke et al., 2021).

Cultural and Sociopolitical Factors

Prevalence rates vary by cultural and geopolitical context. Studies in conflict zones such as Iraq, Israel, and the Turkish–Syrian border reveal markedly elevated rates of anxiety, PTSD, and panic symptoms following war, terror, and displacement (Chung & Freh, 2022; Ben-David et al., 2025; Şahpolat & Ayar, 2020). Global crises such as the COVID-19 pandemic further amplified anxiety across age groups, driven by health fears, isolation, economic disruption, and grief (Munk et al., 2020; Korkut & Altıntaş, 2024).

Populations at Risk

Certain groups show disproportionately high anxiety rates, including:

- First responders and military veterans exposed to mass trauma (Pijnenburg et al., 2024).
- College students, whose anxiety and comorbid depression have escalated sharply (Hoeflich et al., 2023).

- Healthcare professionals and caregivers facing chronic stress and secondary trauma.
- Individuals with chronic illness, neurodivergence, or reproductive transitions (e.g., postpartum anxiety).

The Healthy Minds Study documented rising anxiety diagnosis and treatment utilization among U.S. college students from 2013 to 2019, indicating both increased symptom burden and greater help-seeking (Hoeflich et al., 2023).

Etiology and Risk Factors of Anxiety Disorders

Anxiety arises from an interplay of biological, psychological, environmental, and sociocultural factors. No single cause is sufficient; instead, vulnerability factors interact with triggering events.

Biological and Neurophysiological Factors

Genetics and Heritability. Family and twin studies estimate heritability at 30–50% for GAD, panic disorder, and social anxiety disorder (Penninx et al., 2021). Genetic polymorphisms affecting serotonin, dopamine, and norepinephrine pathways have been implicated in anxiety vulnerability.

Brain Structures and Neurocircuitry. The amygdala, prefrontal cortex (PFC), hippocampus, and insula play central roles in anxiety regulation. The amygdala rapidly processes threat cues, while the PFC modulates emotional responses via top–down regulation. Dysregulated circuits—such as amygdala hyperactivity and medial PFC hypoactivity—are associated with

heightened anxiety (Kenwood et al., 2022). Liu et al. (2024) identified increased hippocampal–insula connectivity in GAD, with trait anxiety mediating symptom severity, suggesting neurofunctional abnormalities may drive clinical anxiety even without structural brain changes.

Neurochemistry and Autophagy

Abnormalities in GABA, serotonin (5-HT), and norepinephrine systems are robustly linked with anxiety disorders. The efficacy of SSRIs and SNRIs supports monoaminergic theories of anxiety (Bandelow et al., 2023).

More recent work implicates autophagy processes. Han et al. (2025) showed that inhibiting autophagy in the amygdala reduced morphine withdrawal–induced anxiety-like behaviors in male mice, identifying a novel neurobiological target with translational potential.

Psychological and Cognitive Factors

Trait Anxiety and Anxiety Sensitivity. Trait anxiety reflects a stable tendency to interpret ambiguous situations as threatening. High trait anxiety predicts later anxiety disorders (Knowles & Olatunji, 2020). Anxiety sensitivity—the fear of anxiety symptoms themselves—predicts panic and GAD and increases risk for anxious-depressive attacks (Schiele et al., 2021; Kaiya, 2024).

Cognitive Biases and Negative Affectivity. Individuals with anxiety often overestimate threat and underestimate coping resources. The State–Trait Anxiety Inventory (STAI) frequently reveals overlap with depressive traits,

supporting the view that anxiety is embedded within broader negative affectivity (Knowles & Olatunji, 2020).

Sociocultural and Environmental Factors

Early Adversity and Trauma. Childhood abuse, neglect, parental separation, and attachment disruptions increase later anxiety risk (Szuhany & Simon, 2022). Rejection sensitivity has emerged as a potent vulnerability factor, especially in anxious-depressive attacks and treatment-resistant depression (Kaiya, 2024; Noda et al., 2022).

Stressful Life Events and Displacement. War, displacement, pandemics, and natural disasters can trigger or exacerbate anxiety. Older adults displaced in East Germany, for example, showed higher anxiety and depressive symptoms than non-displaced peers (Ulke et al., 2021). Similar findings appear among Israeli civilians and first responders following terror attacks (Ben-David et al., 2025; Pijnenburg et al., 2024).

Technology and Social Isolation. Digital environments both buffer and exacerbate anxiety. Online CBT-style psychoeducation can reduce panic symptoms (Miqdadi et al., 2024), yet excessive screen time and social media use correlate with heightened anxiety in youth (Hoeflich et al., 2023).

Comorbid Conditions and Somatic Sensitivity

Anxiety frequently co-occurs with depression, tinnitus, chronic pain, autoimmune disorders, and rare conditions such as hereditary angioedema (Korkut & Altıntaş, 2024; Özden & Bankir, 2021). Vestibular dysfunction and vertigo are strongly linked to “excess anxiety,”

underscoring mind–body reciprocity (Brandt & Dieterich, 2020).

Symptomatology and Diagnostic Classification

Anxiety disorders encompass diverse symptoms and clinical presentations, making accurate classification essential.

Core Symptoms. Common symptoms include excessive worry, anticipatory dread, restlessness, irritability, concentration difficulties, muscle tension, sleep disturbance, and somatic complaints such as palpitations, shortness of breath, dizziness, or gastrointestinal discomfort. Avoidance behaviors are central and often maintain anxiety (Szuhany & Simon, 2022; Penninx et al., 2021).

DSM-5 and ICD-11 Frameworks

The DSM-5 specifies criteria for GAD, panic disorder, agoraphobia, social anxiety disorder, specific phobias, separation anxiety disorder, and selective mutism. OCD and PTSD, once categorized as anxiety disorders, now occupy separate clusters.

ICD-11 groups “anxiety and fear-related disorders” under a shared umbrella, emphasizing overlapping mechanisms and moving away from pejorative labels (Grzech et al., 2025).

Panic Attacks and Special Presentations

Panic attacks are defined as abrupt surges of intense fear or discomfort peaking within minutes and involving

symptoms such as chest pain, dyspnea, derealization, and fear of losing control or dying. They occur in panic disorder but also within SAD, PTSD, phobias, and depression (Lee & Bottomley, 2023; Miqdadi et al., 2024).

The concept of anxious-depressive attacks (ADA) has been proposed to describe episodes blending panic, agitation, and depressive rumination, often linked to rejection sensitivity and interpersonal trauma (Kaiya, 2024; Noda et al., 2022).

Modern contexts have given rise to specific anxiety forms such as eco-anxiety, health anxiety, technology-related anxiety, and performance anxiety in athletes or professionals, which can be clinically significant even if subthreshold for full DSM-5 diagnoses (Pihkala, 2020; Vu & Conant-Norville, 2021; Hidalgo-Muñoz et al., 2021).

Cultural norms shape symptom expression; somatic presentations predominate in some non-Western contexts, while cognitive symptoms are emphasized in many Western settings (Brandt & Dieterich, 2020; Korkut & Altıntaş, 2024). Gender differences persist, with women more likely to report anxiety and men more likely to externalize via irritability and avoidance (Penninx et al., 2021; Bandelow et al., 2023).

Epidemiology and Global Impact

Globally, anxiety ranks among the top causes of years lived with disability (YLDs) (Penninx et al., 2021).

Socioeconomic and Educational Impact. Anxiety impairs social functioning, academic performance, and workplace productivity. Students with anxiety disorders are more

likely to underperform or drop out (Hoeflich et al., 2023), while adults face absenteeism, presenteeism, and elevated healthcare utilization (Szuhany & Simon, 2022).

Comorbidity and Functional Impairment. Anxiety often co-occurs with MDD, substance use disorders, OCD, PTSD, and somatic symptom disorders. Comorbidity predicts higher severity, poorer prognosis, and greater suicide risk (Penninx et al., 2021; Lack, 2024). Treatment resistance is more likely when anxiety symptoms are underrecognized or untreated (Kenwood et al., 2022).

Vulnerable Populations. First responders, disaster survivors, and refugees are particularly vulnerable to chronic anxiety and PTSD. Perceived social support appears strongly protective across these groups (Pijnenburg et al., 2024; Barel et al., 2025; Şahpolat & Ayar, 2020).

COVID-19 and Anxiety Surge. The pandemic produced a global spike in anxiety, especially among individuals with chronic illness, tinnitus, hereditary angioedema, and college students (Munk et al., 2020; Korkut & Altıntaş, 2024; Manning et al., 2023; Hoeflich et al., 2023).

Neurobiological and Cognitive Mechanisms

Anxiety reflects dynamic interactions among brain circuits, neurotransmitters, and cognitive processes:

- *Brain Circuits*. The amygdala signals threat; the hippocampus encodes context; the insula integrates interoceptive signals; and the PFC exerts top–down regulation. Dysregulation—such as amygdala hyperreactivity and reduced PFC control—manifests

as hypervigilance and impaired emotion regulation (Kenwood et al., 2022; Schiele et al., 2021).

- *Neurochemical Factors.* Serotonin, GABA, norepinephrine, dopamine, and opioid systems each contribute to anxiety modulation. SSRIs and SNRIs enhance serotonin and norepinephrine, benzodiazepines potentiate GABA, and emerging research explores opioid and glutamatergic targets (Bandelow et al., 2023; Han et al., 2025).

- *Functional Neuroimaging.* fMRI and PET studies reveal increased amygdala reactivity, altered hippocampal–insula connectivity, and reduced PFC activation in anxiety disorders (Liu et al., 2024; Bas-Hoogendam et al., 2022). ENIGMA-Anxiety's large-scale neuroimaging work highlights both common and distinct patterns across anxiety subtypes.

- *Cognitive Mechanisms.* Attentional bias toward threat, intolerance of uncertainty, and catastrophic misinterpretation of bodily sensations are central features (Oussi et al., 2023). Avoidance and safety behaviors provide short-term relief but chronically maintain anxiety.

- *Emotion Regulation and Neuroplasticity.* High trait anxiety is associated with reduced cognitive reappraisal, greater reliance on suppression, and higher alexithymia (Oussi et al., 2023). Chronic anxiety can induce neuroplastic changes, including hippocampal atrophy and PFC thinning, further impairing cognition (Kenwood et al., 2022).

Psychological, Cultural, and Theological Perspectives

Anxiety is not only neurobiological but also psychological, cultural, and spiritual.

Psychological Models.

- *CBT* highlights distorted thinking, attentional biases, and avoidance as maintaining factors; treatment targets these patterns through restructuring and exposure (Szuhany & Simon, 2022; Oussi et al., 2023).

- *Psychodynamic* perspectives emphasize intrapsychic conflict and defense mechanisms.

- *Humanistic–existential* views frame anxiety as inherent to freedom, choice, and mortality (Pihkala, 2020).

- *Attachment theory* links insecure attachment with heightened interpersonal anxiety and rejection sensitivity (Kaiya, 2024).

- *Cultural Dimensions*. Culture shapes symptom expression, stigma, and help-seeking. Somatization, shame, and collectivist norms often influence how anxiety is experienced and reported (Korkut & Altıntaş, 2024; Khan & Nasreen, 2023). Chronic conflict, climate threat, and political instability can intensify death anxiety and existential distress (Ben-David et al., 2025; Pihkala, 2020).

- *Theological and Spiritual Perspectives*. Christian, Islamic, and Eastern traditions offer narratives and

practices—prayer, meditation, contemplative rituals—that can buffer anxiety and offer meaning. Anxiety may be framed as spiritual struggle, longing for safety, or "the dizziness of freedom" (Kierkegaard), inviting integration of faith-based coping into clinical care (Vu & Conant-Norville, 2021; Khan & Nasreen, 2023).

Intersectional and psychospiritual models increasingly recognize how trauma, culture, neurobiology, and belief systems intertwine, supporting trauma-informed and culturally humble approaches to care.

Public Health, Technology, and Anxiety in Contemporary Society

Anxiety has become a defining feature of 21st-century mental health, reflecting broader systemic stresses:

- *Anxiety as Public Health Crisis*. High prevalence, early onset, chronicity, and functional impairment position anxiety as a central public health concern (Penninx et al., 2021). Youth and college student populations show particularly steep increases (Hoeflich et al., 2023).

- *Technology, Social Media, and Digital Stress*. Telehealth and online CBT improve access (Miqdadi et al., 2024), but social media and self-service technologies can amplify anxiety via comparison, surveillance, and lack of human contact. Kinch and Buell (2025) found that enabling access to human representatives in high-anxiety customer service situations improved trust and satisfaction, underscoring the relational dimension of anxiety

even in commercial contexts. Privacy violations and surveillance capitalism further fuel consumer anxiety (Jones et al., 2020).

- *Inequality, Trauma, and Marginalization.* Displacement, conflict, and discrimination heighten anxiety risk (Şahpolat & Ayar, 2020; Ulke et al., 2021). Social support, resilience, and religiosity can buffer impacts (Pijnenburg et al., 2024; Khan & Nasreen, 2023).

- *Health Systems and Access.* Treatment gaps persist due to stigma, cost, provider shortages, and misalignment between available services and cultural preferences (Bandelow et al., 2023; Vu & Conant-Norville, 2021). Culturally adapted, integrative models are urgently needed.

Interventions and Treatment Modalities

Effective anxiety care is pluralistic and individualized:

- *Pharmacological Interventions.* SSRIs and SNRIs are first-line medications, with modest-to-moderate effect sizes (Szuhany & Simon, 2022; Bandelow et al., 2023). Side effects, delayed onset, adherence challenges, and treatment resistance are common. Novel treatments—such as EP107™, neuromodulation, and psychedelic-assisted therapies—offer emerging possibilities but require careful evaluation (Haller et al., 2025).

- *Cognitive Behavioral Therapy and Psychotherapy.* CBT remains the gold standard across anxiety disorders and age groups, outperforming

medication for some in long-term outcomes (Bandelow et al., 2023). Digital CBT and psychoeducation show efficacy and expand reach (Miqdadi et al., 2024). Other modalities—psychodynamic, acceptance and commitment therapy, and integrative approaches—address deeper meaning and relational patterns.

- *Emotion Regulation and Mind–Body Approaches*. Emotion regulation skills training, mindfulness, and somatic interventions target dysregulation at cognitive and physiological levels (Oussi et al., 2023). Progressive muscle relaxation, breathing exercises, and body-based practices reduce acute anxiety and support long-term resilience (Dewi et al., 2022).

- *Emerging Innovations and Community-Based Approaches.* VR exposure, CAST for anxiety sensitivity, and large-scale neuroimaging-informed interventions are reshaping the treatment landscape (Schiele et al., 2021; Freire et al., 2020; Bas-Hoogendam et al., 2022). Preventive strategies—including school-based programs, parental psychoeducation, and resilience-building in trauma-affected communities—are essential for reducing incidence and chronicity (Francis & Roemhild, 2021; Kimhi et al., 2020; Barel et al., 2025).

Implications, Future Directions, and Ethical Considerations

Clinicians and systems must bridge the treatment gap, especially for marginalized and high-risk groups. Early

screening, integrated primary care, and technology-assisted delivery can expand access (Patel et al., 2022; Szuhany & Simon, 2022; Miqdadi et al., 2024). Future research must advance precision psychiatry, identifying neurobiological and psychosocial markers that guide individualized interventions (Liu et al., 2024; Bas-Hoogendam et al., 2022). Gene–environment and epigenetic studies may clarify how trauma, socioeconomic adversity, and parenting shape anxiety risk.

Ethically, digital interventions raise questions about privacy, algorithmic bias, and informed consent. Novel biological interventions (e.g., psychedelics, neuromodulation) demand rigorous safety and equity considerations (Bandelow et al., 2023). Anti-stigma efforts, cultural humility, and respect for spiritual frameworks are necessary components of ethical, trauma-informed anxiety care.

The future of anxiety treatment lies in integration: blending neuroscience, psychotherapy, public health, technology, and community wisdom to support individuals and communities in moving from chronic fear to resilient, meaningful living.

Chapter 2

Key Takeaways: Coping with Anxiety

- Anxiety is both universal and clinical. It becomes a disorder when intensity, persistence, and impairment exceed normal worry, often reflecting interactions among biology, trauma, and environment.

- Anxiety disorders are highly prevalent and early-onset. They affect up to one-third of people over a lifetime, often beginning in adolescence or young adulthood and persisting if untreated.

- Brain, body, and beliefs all matter. Anxiety is shaped by neural circuitry (amygdala–PFC–hippocampus–insula), neurotransmitters, cognitive biases, early attachment, cultural norms, and spiritual frameworks.

- Trauma and inequality amplify risk. War, displacement, pandemics, climate crises, and systemic injustice significantly raise anxiety, especially in already vulnerable populations. Social support consistently buffers these effects.

- New forms of anxiety are emerging. Eco-anxiety, health anxiety, digital stress, and context-specific fears (e.g., performance, technology) reflect contemporary pressures and require updated clinical lenses.

- Coping with anxiety is not one-size-fits-all. Effective care often combines pharmacotherapy, CBT,

emotion regulation training, mind–body practices, digital tools, and community-based supports tailored to the individual.

- Emotion regulation is central. Learning to name, tolerate, and work with emotions—rather than suppress or avoid them—is a core skill for reducing anxiety and preventing relapse.

- Technology is both a risk and a resource. Social media and automation can heighten anxiety, while teletherapy and online CBT can increase access to care—highlighting the need for wise, ethical design.

- Public health approaches are essential. Anxiety is not just a private problem but a population-level issue, requiring prevention, early intervention, destigmatization, and attention to systemic stressors.

- **Hope is warranted**. Advances in neuroscience, psychotherapy, and digital health, combined with culturally and spiritually sensitive care, offer real possibilities for healing and for living well with—or beyond—anxiety.

Chapter 2 Glossary

Amygdala–Prefrontal Circuitry: Neural pathways linking the amygdala (rapid threat detection) with the prefrontal cortex (top–down regulation); hyperactive amygdala and hypoactive prefrontal regions are characteristic of pathological anxiety (Kenwood et al., 2022).

Anxiety and Fear-Related Disorders (ICD-11): ICD-11's dimensional umbrella category that groups anxiety and fear-related conditions together and avoids older "neurotic" labels, aiming to reduce stigma and emphasize shared mechanisms (Grzech et al., 2025).

Anxiety Disorders: A group of mental health conditions—including GAD, panic disorder, social anxiety disorder, specific phobias, separation anxiety disorder, and selective mutism—characterized by excessive fear, worry, and avoidance, with lifetime prevalence approaching one-third of the population (American Psychiatric Association, 2022; Szuhany & Simon, 2022).

Anxiety Sensitivity: Fear of anxiety sensations themselves (e.g., rapid heartbeat, dizziness) based on beliefs that these sensations are dangerous or catastrophic; strongly linked with panic and GAD and targeted in prevention programs such as CAST (Schiele et al., 2021; Kaiya, 2024).

Anxiety: A future-oriented state of heightened cognitive, emotional, and physiological arousal in anticipation of perceived threat; it becomes a disorder when worry, fear, or avoidance are excessive, persistent, and impair functioning (Lack, 2024; Szuhany & Simon, 2022).

Anxious–Depressive Attacks (ADA): Episodes characterized by a blend of panic-like anxiety, agitation, and intense depressive rumination, often associated with rejection sensitivity and treatment-resistant mood–anxiety presentations (Kaiya, 2024).

Autophagy in the Amygdala: Cellular "self-cleaning" processes in the amygdala that appear to modulate anxiety; inhibiting autophagy in animal models reduces withdrawal-induced anxiety-like behaviors, suggesting a novel biological target (Han et al., 2025).

CAST – Cognitive Anxiety Sensitivity Treatment: A targeted, often brief, intervention aimed at reducing anxiety sensitivity—especially fear of bodily sensations—by using psychoeducation and interoceptive exposure, with particular relevance for youth anxiety prevention (Schiele et al., 2021).

Cognitive-Behavioral Therapy (CBT) for Anxiety: A first-line, evidence-based psychotherapy that targets distorted thoughts,

avoidance behaviors, and safety behaviors through cognitive restructuring and exposure; effective across anxiety disorders and age groups (Szuhany & Simon, 2022; Bandelow et al., 2023).

Collective Trauma–Related Anxiety: Anxiety symptoms emerging in response to mass trauma such as war, terror attacks, or large-scale disasters, often co-occurring with PTSD and shaped by social support, self-compassion, and ongoing threat (Barel et al., 2025; Pijnenburg et al., 2024).

Comorbidity (Anxiety with Medical and Psychiatric Conditions): The frequent co-occurrence of anxiety disorders with depression, PTSD, OCD, substance use, and medical conditions such as vestibular dysfunction or hereditary angioedema, which increases severity, disability, and treatment complexity (Brandt & Dieterich, 2020; Penninx et al., 2021; Özden & Bankir, 2021).

Customer Service–Related Anxiety / Human Contact Buffer: Anxiety experienced by consumers when interacting with complex or automated service systems; allowing easy access to human representatives can reduce anxiety and improve trust and satisfaction, highlighting the relational dimension of anxiety in everyday contexts (Kench & Buell, 2025).

Digital Psychoeducation / Online CBT: Web-based or app-delivered programs that provide anxiety education and CBT skills training; shown to reduce panic symptoms and improve quality of life, while increasing access to care (Miqdadi et al., 2024; Szuhany & Simon, 2022).

Echinacea (EP107™) for Anxiety: A plant-based preparation studied as a potential anxiolytic; in randomized controlled trials, EP107™ has shown reductions in anxiety scores compared with placebo, though it remains an emerging, adjunctive option (Haller et al., 2025).

Eco-Anxiety / Climate Anxiety: Chronic or episodic anxiety related to climate change and ecological crisis, encompassing worry, grief, and existential dread about environmental destruction and future livability (Pihkala, 2020).

Eco-Anxiety Coping and Spiritual/Religious Buffers: Ways individuals use spirituality, resilience, and meaning-making to manage anxiety related to terrorism, death, and ecological crisis; religious beliefs and resilience can buffer death anxiety and broader anxious distress (Khan & Nasreen, 2023; Pihkala, 2020).

Emotion Regulation Difficulties in Anxiety: Problems using adaptive strategies like cognitive reappraisal and overreliance on suppression or avoidance, contributing to heightened anxiety, alexithymia, and impaired coping (Oussi et al., 2023).

ENIGMA–Anxiety Working Group: A large-scale international consortium conducting pooled neuroimaging analyses to map common and distinct brain patterns across anxiety disorders, advancing precision psychiatry (Bas-Hoogendam et al., 2022).
Exposure Therapy / Virtual Exposure: A CBT component where individuals systematically face feared situations or cues (in vivo, imaginal, interoceptive, or via virtual reality) without escape, to reduce avoidance and update threat beliefs (Szuhany & Simon, 2022; Schiele et al., 2021).
Generalized Anxiety Disorder (GAD): A disorder marked by excessive, hard-to-control worry about multiple life domains (e.g., health, work, family), accompanied by symptoms such as restlessness, fatigue, muscle tension, and sleep disturbance (American Psychiatric Association, 2022; Szuhany & Simon, 2022).
Hippocampal–Insula Functional Connectivity: Patterns of communication between the hippocampus (context and memory) and insula (interoception) that are altered in GAD; stronger connectivity has been associated with higher trait anxiety and more severe symptoms (Liu et al., 2024).
Panic Disorder / Panic Attacks: Panic disorder involves recurrent, unexpected panic attacks—sudden surges of intense fear reaching a peak within minutes, often with chest pain, dizziness, shortness of breath, and fear of dying or "going crazy" (Lee & Bottomley, 2023; Szuhany & Simon, 2022).
Parental Cognitions about Child Anxiety: Parents' beliefs and interpretations about their child's anxiety (e.g., viewing it as dangerous or shameful), which are associated with child anxiety severity and anxiety sensitivity, and are key targets for family-based interventions (Francis & Roemhild, 2021).
Perceived Social Support: An individual's sense of being cared for and supported by others; longitudinal studies of responders to mass trauma show that higher perceived social support predicts more favorable anxiety and depression trajectories (Pijnenburg et al., 2024).
Pharmacotherapy for Anxiety (SSRIs/SNRIs, etc.): Medication treatments—especially SSRIs and SNRIs—that act on serotonin and norepinephrine systems and are recommended as first-line pharmacologic options in major guidelines for anxiety, OCD, and PTSD (Bandelow et al., 2023; Szuhany & Simon, 2022).
Public Health Perspective on Anxiety: Viewing anxiety as a widespread, early-onset, and functionally impairing condition that requires population-level responses—screening, school-based prevention, integrated care, and policy aimed at reducing social

determinants of chronic anxiety (Penninx et al., 2021; Szuhany & Simon, 2022).

Social Anxiety Disorder (SAD): Marked fear and avoidance of social or performance situations due to worries about embarrassment, scrutiny, or humiliation, leading to significant distress and functional impairment (American Psychiatric Association, 2022; Szuhany & Simon, 2022).

Specific Phobias: Persistent, disproportionate fear of particular objects or situations (e.g., flying, animals, needles), often leading to avoidance that interferes with daily life (American Psychiatric Association, 2022).

Trait Anxiety: A relatively stable disposition to perceive a wide range of situations as threatening and to respond with elevated state anxiety; a risk factor for later anxiety disorders and a mediator between brain connectivity and symptom severity (Knowles & Olatunji, 2020; Liu et al., 2024).

Chapter 2 References

Adamek, M., & Applegate, J. S. (2022). Understanding emotions in the aging population: Clinical strategies and insights. *Gerontology & Geriatric Studies, 14*(2), 87–95. https://doi.org/10.1080/2348394.2022.1462134

Bandelow, B., Allgulander, C., Baldwin, D. S., Costa, D. L. da C., Denys, D., Dilbaz, N., … Zohar, J. (2023). World Federation of Societies of Biological Psychiatry (WFSBP) guidelines for treatment of anxiety, obsessive-compulsive and posttraumatic stress disorders - Version 3. The *World Journal of Biological Psychiatry, 24*(2), 79–117. https://doi.org/10.1080/15622975.2022.2086295

Barel, E., Tannous-Haddad, L., & Tzischinsky, O. (2025). Self-compassion, self-coldness, and social support and their relationship with depression, anxiety, and PTSD symptoms following a massive terror attack: A prospective study. *European Journal of Psychotraumatology, 16*(1), 2461948. https://doi.org/10.1080/20008066.2025.2461948

Bas-Hoogendam, J. M., Freitag, G. F., Harrewijn, A., Jahanshad, N., Thompson, P. M., Veltman, D. J., … Zwiebel, H. L. (2022). ENIGMA-anxiety working group: Rationale for and organization of large-scale neuroimaging studies of anxiety disorders. *Human Brain Mapping, 43*(1), 83–112. https://doi.org/10.1002/hbm.25100

Brandt, T., & Dieterich, M. (2020). 'Excess anxiety' and 'less anxiety': Both depend on vestibular function. *Current Opinion in Neurology, 33*(1), 136–141. https://doi.org/10.1097/wco.0000000000000771

Francis, S. E., & Roemhild, E. (2021). Assessing parental cognitions about child anxiety: Are parents' thoughts about child anxiety associated with child anxiety and anxiety sensitivity? *Journal of Anxiety Disorders, 80*, 102400. https://doi.org/10.1016/j.janxdis.2021.102400

Gillan, C. M., Vaghi, M. M., Hezemans, F. H., van Ghesel Grothe, S., Dafflon, J., Brühl, A. B., … Robbins, T. W. (2021).

Experimentally induced and real-world anxiety have no demonstrable effect on goal-directed behaviour. *Psychological Medicine, 51*(9), 1467–1478. https://doi.org/10.1017/S0033291720000203

Haller, J., Faludi, G., Kovacs, G., Purebl, G., Füzesi, Z., & Freund, T. F. (2025). The effects of Echinacea (EP107 TM) on anxiety: A comparison of anxiety measures in a randomized, double blind, placebo-controlled study. *Pharmaceuticals (Basel), 18*(2), 264. https://doi.org/10.3390/ph18020264

Han, S., Zhu, C., Min, D., & Li, Z. (2025). Inhibition of autophagy in the amygdala ameliorates anxiety-like behaviors induced by morphine-protracted withdrawal in male mice. *Neuroreport, 36*(9), 487–496. https://doi.org/10.1097/WNR.0000000000002166

Hoeflich, C. C., Nutley, S., Striley, C. W., Miller, L., Riba, M. B., & Morris, M. R. (2023). Current psychiatric treatment for college students with depression only, anxiety only, or comorbid depression & anxiety (2013–2019). *Journal of Affective Disorders, 320*, 348–352. https://doi.org/10.1016/j.jad.2022.09.133

Kench, M. A., & Buell, R. W. (2025). Mitigating the negative effects of customer anxiety by facilitating access to human contact. *Management Science.* https://doi.org/10.1287/mnsc.2022.01029

Kenwood, M. M., Kalin, N. H., & Barbas, H. (2022). The prefrontal cortex, pathological anxiety, and anxiety disorders. *Neuropsychopharmacology, 47*(1), 260–275. https://doi.org/10.1038/s41386-021-01109-z

Khan, A., & Nasreen, R. (2023). Investigating the relationship between perceived impact of terrorist attacks, resilience, and religious beliefs on death anxiety in students in Islamabad. Iranian *Journal of Psychiatry and Clinical Psychology, 29*(1), 94–117. https://doi.org/10.32598/ijpcp.28.2.4060.1

Lack, C. W. (2024). Anxiety disorders. *The Psychiatric Clinics of North America, 47*(4), 613–622. https://doi.org/10.1016/j.psc.2024.04.008

Lee, S. A., & Bottomley, J. S. (2023). Personality and grief-related panic attacks: Analysis of neuroticism, worry, and anxiety sensitivity. *Omega: Journal of Death and Dying, 86*(3), 849–861. https://doi.org/10.1177/0030222821992192

Liu, S., Cao, L., Li, H., Du, Y., Wang, M., Xiao, H., ... Gong, Q. (2024). Trait anxiety mediates the association between hippocampal–insula functional connectivity and anxiety symptom severity in adults with and without generalized anxiety disorder. *Journal of Affective Disorders, 344*, 1–7. https://doi.org/10.1016/j.jad.2023.10.006

Miqdadi, A. I., Chan, M. C., Tang, L. Y., Koh, O. H., Alhadidi, M., & Issa, M. (2024). Easing panic: The effect of an online psychoeducational program on panic symptoms, anxiety, and quality of life among people experiencing panic attacks. *Issues in Mental Health Nursing, 45*(10), 1022–1033. https://doi.org/10.1080/01612840.2024.2384412

Pihkala, P. (2020). Anxiety and the ecological crisis: An analysis of eco-anxiety and climate anxiety. *Sustainability, 12*(19), 7836. https://doi.org/10.3390/su12197836

Pijnenburg, L. J., Velikonja, T., Pietrzak, R. H., DePierro, J., de Haan, L., Todd, A. C., ... Velthorst, E. (2024). Perceived social support and longitudinal trajectories of depression and anxiety in World Trade Center responders. *Social Psychiatry and Psychiatric Epidemiology, 59*(8), 1413–1424. https://doi.org/10.1007/s00127-023-02569-y

Schiele, M. A., Vietz, M., Gajewska, A., Unterecker, S., Gottschalk, M. G., Deckert, J., ... Domschke, K. (2021). The cognitive anxiety sensitivity treatment (CAST) in anxiety prevention – Focus on separation anxiety and interoception. *European Neuropsychopharmacology, 53*, 104–113. https://doi.org/10.1016/j.euroneuro.2021.08.265

Szuhany, K. L., & Simon, N. M. (2022). Anxiety disorders: A review. *JAMA, 328*(24), 2431–2445. https://doi.org/10.1001/jama.2022.22744

Vu, V., & Conant-Norville, D. (2021). Anxiety. *The Psychiatric Clinics of North America, 44*(3), 373–380. https://doi.org/10.1016/j.psc.2021.04.005

Chapter 3

When Nothing Matters: Understanding Apathy

"I don't care."

Few phrases are as painful—for the person saying it and for those who love them. Apathy is one of the most misunderstood emotional states. On the surface, it looks like laziness, stubbornness, or not trying. Inside, it often feels like a heavy gray fog: no energy, no initiative, no sense that anything is worth the effort. Families frequently interpret it as "won't," when in fact it is much closer to "can't."

In clinical language, apathy is a neuropsychiatric syndrome marked by reduced motivation, reduced goal-directed behavior, and diminished emotional engagement (Mehak et al., 2023; Miller et al., 2021). It shows up frequently in neurodegenerative conditions like Alzheimer's and Parkinson's disease, but also in stroke, other medical illnesses, psychiatric disorders, and even in broader social and political life (Lanctôt et al., 2023; Nsor & Brown, 2024; Zhelnina, 2020).

This chapter translates that research into plain language. We will explore:

- What apathy is—and what it is not
- How it differs from depression
- What happens in the brain during apathy
- How clinicians assess it
- What we know about treatment

- How apathy affects families and society
- How to offer wise, compassionate care

At the heart of this chapter is a shift in perspective: apathy is not a character flaw. It is a complex syndrome with biological, psychological, and social roots—and understanding it can reduce shame and open pathways

Redefining Apathy: More Than "Not Caring"

In everyday language, "apathy" usually means "I don't care." Clinically, the picture is more precise. Apathy is defined as a persistent reduction in motivation and goal-directed behavior compared to a person's previous level of functioning. It typically shows up in three areas (Miller et al., 2021):

1. Diminished initiative

- Not starting tasks on their own
- Needing frequent prompting to begin even simple activities

2. Diminished interest

- Less curiosity about people, hobbies, or events that once mattered
- Reduced engagement in social, spiritual, or recreational activities

3. Diminished emotional expression

- Flattened facial expression or voice tone
- Less visible enthusiasm, joy, or distress

Crucially, these changes are relative to who the person used to be. Someone who has always been quiet and low-key is different from someone who used to be active, engaged, and expressive but has become increasingly withdrawn and inert over weeks or months. Apathy can occur:

In neurodegenerative conditions such as Alzheimer's disease, Parkinson's disease, and Huntington's disease (Mehak et al., 2023; Morris et al., 2023; Peelo et al., 2022):

- After stroke or other brain injuries (Pallucca et al., 2024; Tay et al., 2020)
- In the context of depression, anxiety, or other psychiatric disorders (Ma, 2020; Silva et al., 2021)
- As a response to chronic illness, medications, or overwhelming stress (Padala et al., 2020; Naguy et al., 2025)
- At a societal level, in the form of civic disengagement or "trained apathy" (Nooruddin & Rudra, 2025; Zhelnina, 2020; Wood & Schulman, 2021)

Understanding apathy as a syndrome—not a simple choice—can be profoundly relieving for clients and families (Manera et al., 2020; Silva et al., 2021).

Apathy vs. Depression: Why the Difference Matters

Apathy and depression often travel together, but they are not the same thing.

- Depression centers on painful feelings: sadness, hopelessness, guilt, self-criticism, despair, sometimes suicidality.
- Apathy centers on missing drive: lack of initiative, lack of interest, reduced emotional responsiveness—even when the person does not feel especially sad (Lanctôt et al., 2023; Ma, 2020).

Someone with depression might say:

"I feel terrible. I hate myself. I can't stop crying. Nothing will ever get better."

Someone with apathy might say:

"I don't really feel anything. I just don't see the point. I could do it, but… I don't care enough to start."

In dementia or Parkinson's disease, a person may stop bathing, lose interest in visitors, or sit in front of the TV for hours—not because they are consciously refusing, but because the internal machinery of motivation is malfunctioning (Lanctôt et al., 2023; Morris et al., 2023).

Clinically, this distinction matters because:

- Apathy often does not respond well to standard antidepressant treatment.

- Some antidepressants (particularly certain SSRIs) can worsen apathy, even as mood improves (Padala et al., 2020).
- Apathy may require different medications and different psychosocial strategies.

For families, this distinction can shift the story from "They're being lazy" to "Something in their motivational system isn't firing; we need support." That shift tends to reduce anger and blame and increases openness to help (Manera et al., 2020; Silva et al., 2021).

What's Happening in the Brain?

Behind the lived experience of "nothing matters" is a complex neural story. Apathy is strongly linked to disruptions in frontal–subcortical circuits—the brain networks that help us plan, initiate, value, and sustain action (Mehak et al., 2023; Nsor & Brown, 2024).

Key players include:

- Dorsolateral prefrontal cortex (DLPFC) – involved in planning, decision-making, and holding goals in mind.
- Anterior cingulate cortex (ACC) – central to effort, motivation, and monitoring whether an action is worth it.
- Orbitofrontal cortex (OFC) – helps evaluate rewards and punishments, guiding choices.
- Ventral striatum/nucleus accumbens – part of the brain's reward system, assigning "value" and

"wanting" to actions and outcomes (Morris et al., 2023).

Neuroimaging studies show that structural damage or functional disconnection in these circuits is associated with higher apathy scores across conditions like Alzheimer's disease, Parkinson's disease, and cerebrovascular disease (Mehak et al., 2023; Morris et al., 2023; Tay et al., 2020). In Parkinson's disease, changes in the functional connectivity of the nucleus accumbens can even precede observable apathy, suggesting apathy may act as an early warning sign for disease progression (Morris et al., 2023). From a neurotransmitter perspective:

- Dopamine is crucial for initiating and sustaining goal-directed behavior. Low dopamine states (as in Parkinson's disease) are strongly linked to apathy and reduced willingness to exert effort (Plant et al., 2024).
- Acetylcholine plays roles in attention and motivation; cholinergic deficits in Alzheimer's disease contribute to apathy and reduced engagement (Mehak et al., 2023).
- Serotonin is more complex; in some contexts, high serotonergic tone—especially from SSRIs—appears to contribute to "SSRI apathy syndrome," where motivation drops even if mood improves (Padala et al., 2020).

Advanced imaging (PET, fMRI) has begun to map apathy-related networks, including reduced connectivity in default mode and salience networks in cerebrovascular disease (Tay et al., 2020). Together, these findings reinforce a key point: apathy has identifiable neural correlates. It is not simply "not trying hard enough."

How Clinicians Assess Apathy

Because apathy overlaps with depression, fatigue, anhedonia, and social withdrawal, good assessment is essential.

Diagnostic Criteria

Miller et al. (2021) proposed formal diagnostic criteria for apathy in neurocognitive disorders. To meet criteria, a person must show:

- Persistent diminished initiative, interest, and/or emotional expression,
- Present for at least four weeks,
- Representing a change from previous functioning,
- Causing significant impairment in daily life,
- Not fully explained by another psychiatric or medical condition.

These criteria help clinicians distinguish:

- Apathy vs. anhedonia – Anhedonia is reduced capacity to feel pleasure; apathy is reduced initiation or interest, regardless of whether an activity might be pleasurable.

- Apathy vs. fatigue – Fatigue is about low energy; apathy is about low motivation. A person can feel physically tired yet still want to act, or have adequate energy but no internal push to start.
- Apathy vs. introversion or cultural norms – Some people or cultures value quiet, low-stimulation living. The question becomes: Has there been a change? Is functioning impaired?

Common Assessment Tools

Several scales help quantify apathy and its dimensions:

- Apathy Evaluation Scale (AES) – Self, informant, or clinician-rated.
- Neuropsychiatric Inventory (NPI) – Apathy Subscale – Often used in dementia research.
- Apathy-Motivation Index (AMI) – A brief self-report tool.
- Dimensional Apathy Scale (DAS) – Separately measures executive, emotional, and initiation apathy (Sankhe et al., 2025).

Sankhe et al. (2025) mapped these scales onto formal diagnostic criteria and found that the AES and DAS align well with the multidimensional nature of apathy, making them especially useful in both research and practice.

Apathy Across Disorders and Cultures

Apathy is common in:

- Post-stroke populations: Over 30% of stroke survivors experience apathy, which is associated with worse quality of life and disability (Pallucca et al., 2024).
- Alzheimer's disease: One of the most frequent behavioral symptoms, often emerging early and progressing with cognitive decline (Mehak et al., 2023).
- Huntington's disease: Often appears as three-dimensional apathy—emotional, cognitive, and behavioral (Peelo et al., 2022).

Cultural and social context matter. Declining civic engagement among younger generations may reflect societal apathy toward political and economic systems, more than individual pathology (Nooruddin & Rudra, 2025). In marginalized groups, "trained apathy" may emerge as an understandable response to repeated exclusion and powerlessness (Zhelnina, 2020).

Ethical assessment means asking: Is this a brain-based syndrome, an adaptive withdrawal from harm, or a mixture of both? (Stoliarov, 2023).

Treating Apathy: Medications and Beyond

Treating apathy is challenging—there is no single "apathy pill"—but there are emerging strategies.

Pharmacological Approaches

1. Dopaminergic agents and stimulants

- Medications like methylphenidate have shown modest improvement in apathy in Alzheimer's disease (ADMET 2 trial; Sankhe et al., 2025).
- Benefits must be weighed against potential side effects, especially in frail or older adults.

2. Cholinesterase inhibitors and NMDA antagonists

    - Drugs like donepezil and memantine may slightly improve motivation in some dementia patients, but effects are generally small and inconsistent (Lanctôt et al., 2023).

3. Antidepressants/SSRIs

    - While useful for depression, SSRIs can sometimes worsen apathy, particularly in older adults—an effect termed SSRI-associated apathy syndrome (Padala et al., 2020).

4. Emerging strategies

    - Novel agents targeting dopaminergic, serotonergic, and noradrenergic systems are under study (Lanctôt, 2023; Naguy et al., 2025).
    - Future pharmacology is likely to focus on specific motivational circuits, not just mood.

Nonpharmacological Interventions

Given the limitations of medication, nonpharmacologic approaches are essential—often as first-line options.

1. Behavioral activation and meaningful activity

- Manera et al. (2020) recommend structured, goal-directed activities tailored to the individual: art, music, gentle exercise, social visits, spiritual practices, or hobbies.
- The focus is on small, achievable steps that can gradually re-engage the person.

2. Cognitive-behavioral therapy (CBT) for apathy

- In Parkinson's disease, Plant et al. (2024) propose a CBT model that targets negative beliefs about one's abilities and expectations of failure.
- Therapy focuses on building self-efficacy, restructuring "why bother?" thoughts, and reinforcing even minor efforts.

3. Environmental supports and occupational therapy

- Clear routines, visual cueing, simplified choices, and supportive scheduling can reduce the effort needed to start tasks.
- Occupational therapy and physical activity programs in residential settings show promise in reducing apathy and improving engagement.

4. Technology-assisted approaches

- Gamified cognitive training, virtual reality environments, and reminder apps can scaffold initiation and provide immediate feedback.
- These tools must be carefully matched to cognitive level and cultural context.

Cultural and Ethical Considerations

Not all low-motivation states are pathological. Sometimes, stepping back is a sane response to chronic stress, injustice, or burnout (Stoliarov, 2023; Zhelnina, 2020). Ethical care requires:

- Not labeling legitimate protest or spiritual detachment as illness.
- Listening to personal and community narratives.
- Differentiating between "can't care" (clinical apathy) and "will not invest in a harmful system" (existential or moral choice).

Apathy in Families and Caregiving

Apathy can be heartbreaking for families:

> "He just sits there now. It's like he's not the same person."
>
> "She used to love the grandkids. Now she barely speaks when they visit."

These changes increase caregiver burden, often more than other behavioral symptoms, because they touch identity and relationship so deeply (Pallucca et al., 2024).

Helpful directions for families include:

- Psychoeducation – Learning that apathy is a syndrome, not laziness or stubbornness, can reduce blame (Silva et al., 2021).

- Skill-building – Training in prompting, structuring the day, and using positive reinforcement for even tiny steps (Manera et al., 2020).
- Support groups – Sharing experiences with other caregivers breaks isolation and normalizes emotional reactions.
- Realistic expectations – Understanding that improvement may be slow and partial helps families measure progress in inches, not miles.

Apathy Beyond the Clinic: Society and Soul

Apathy is not only a medical problem; it is also a social and spiritual concern. Political scientists describe dwindling enthusiasm for global institutions and political participation among younger generations—a shift "from enthusiasm to apathy" about globalization and public life (Nooruddin & Rudra, 2025).

Zhelnina (2020) writes about "apathy syndrome" in marginalized groups, where years of exclusion and broken promises train people not to care about politics as a form of self-protection. Wood and Schulman (2021) argue that vaccine disinterest is sometimes driven less by fear or misinformation and more by apathy: a sense that nothing one does really matters.

Philosophers and spiritual writers have long wrestled with apathy. Ancient Stoic discussions of apatheia point to a disciplined, thoughtful detachment from destructive passions—not the flat disengagement of clinical apathy but a kind of inner freedom (Ponthiere, 2023; Stoliarov, 2023). This reminds us again: not all reduced emotional

reactivity is unhealthy. Clinically, we must discern when apathy is:

- A brain-based syndrome needing treatment,
- A protective response to chronic harm,
- A spiritual or philosophical stance, or
- A complex mixture of all three.

Political and Civic Apathy

Zhelnina (2020) uses the phrase "apathy syndrome" to describe how individuals in certain political regimes are socialized to disengage from public life—learning that participation brings risk but little benefit. Similarly, Nooruddin and Rudra (2025) document declining support for globalization among younger generations, describing a shift from enthusiasm to apathy as economic insecurity and institutional distrust erode hope for meaningful influence.

Wood and Schulman (2021) apply the concept of apathy to vaccine attitudes, distinguishing vaccine apathy—a lack of interest or urgency—from active vaccine hesitancy or opposition. This distinction underscores the importance of understanding when disengagement reflects a motivational gap rather than ideological resistance.

Cultural Narratives and Philosophical Traditions

Cultural values and philosophical traditions shape how apathy is interpreted. In some contexts, withdrawal and emotional restraint are not signs of illness but expressions of maturity, spiritual practice, or self-protection (Stoliarov, 2023). Stoic notions of apatheia,

interpreted as rational freedom from destructive passion, further complicate the modern pathologization of all forms of detachment (Ponthiere, 2023).

For clinicians, this requires humility: behaviors that appear apathetic to an outside observer may represent adaptive coping, protest against injustice, or embedded cultural norms. Overpathologizing such responses risks obscuring legitimate suffering and silencing important moral or political critique.

Cultural and Ethical Considerations in Clinical Practice

Distinguishing between clinical apathy and culturally embedded or existential forms of disengagement is an ethical imperative. Nooruddin and Rudra (2025) and Zhelnina (2020) emphasize that in marginalized communities, apathy toward political or economic systems may signal accumulated frustration and learned futility rather than neuropsychiatric disorder. Ethically attuned assessment asks:

- What is this person withdrawing from—and why might withdrawal make sense in their context?
- Does disengagement reflect neural disruption, cumulative burnout, moral protest, or some combination?

Stoliarov (2023) argues that philosophical examinations of apathy can illuminate its double role as both symptom and stance. Clinicians must avoid equating all emotional distance with illness and must respect the meanings clients ascribe to their own disengagement. In practice, this means:

- Incorporating life history, social location, and cultural narratives into assessment.
- Collaborating with clients to determine whether engagement or protective distance is the more adaptive goal in a given season.
- Being cautious about imposing productivity-oriented norms on individuals whose disengagement arises from trauma, exploitation, or moral injury.

Psychoeducation, Caregiver Support, and Stigma Reduction

For clients and families, naming apathy accurately and compassionately can be deeply relieving. Instead of interpreting apathy as laziness, stubbornness, or lack of love, psychoeducation reframes it as a syndrome with identifiable causes and potential interventions (Silva et al., 2021).

Validating the Experience

Silva et al. (2021) emphasize that early recognition and validation of apathy can improve quality of life and adherence to treatment. Psychoeducation should:

- Explain the difference between apathy, depression, and fatigue.
- Clarify that apathy is common in many brain disorders and not a personal moral failure.
- Normalize caregiver frustration while reducing blame on both sides.

Manera et al. (2020) and Pallucca et al. (2024) highlight that caregiver burden often increases when apathy is present, as caregivers must provide more prompting, planning, and emotional energy for daily tasks.

Practical Strategies for Caregivers

Caregiver training can focus on:

- Using specific, simple prompts rather than vague requests (e.g., “Let’s walk to the mailbox now” instead of “You should get more exercise”).
- Establishing predictable routines to reduce the cognitive load of decision-making.
- Reinforcing small successes to rebuild confidence and positive expectancy.
- Collaborating with occupational therapists and other professionals to design meaningful, achievable activities.

These strategies help break cycles of withdrawal and conflict, replacing repeated confrontation (“You never do anything”) with structured support and realistic expectations (Manera et al., 2020; Pallucca et al., 2024).

Reducing Stigma and Enhancing Hope

Public and professional education campaigns can help shift narratives from blame to understanding. Emphasizing the neurobiological underpinnings of apathy, along with its modifiable aspects, may promote earlier recognition and more compassionate care (Silva et al., 2021; Nsor & Brown, 2024).

Importantly, hope does not require minimizing the challenges of apathy. It rests instead on honest acknowledgment of difficulty combined with practical, stepwise strategies and a recognition that even small gains in engagement can meaningfully improve quality of life.

Future Directions: Integration, Personalization, and Collective Healing

Apathy, as this chapter has argued, sits at the intersection of brain circuits, psychological processes, and social structures. Addressing it effectively will require several converging efforts.

Integration of Multidisciplinary Perspectives

Neurobiology, psychology, sociology, and philosophy each offer partial insights. Integrating these perspectives can improve diagnostic clarity, therapeutic creativity, and cultural sensitivity (Mehak et al., 2023; Zhelnina, 2020; Stoliarov, 2023).

Personalized, Contextualized Treatment

Future approaches will likely combine biomarker-informed pharmacotherapy (e.g., dopaminergic agents for specific apathy phenotypes) with individualized psychosocial interventions—such as CBT, behavioral activation, narrative work, and environmental design—tailored to each person's values, history, and cultural context (Naguy et al., 2025; Plant et al., 2024).

Community-Based and Preventive Strategies

Interventions within schools, workplaces, and community organizations that promote agency, meaningful participation, and social connection may help counter broader patterns of disengagement before they crystallize into clinical or societal apathy (Nooruddin & Rudra, 2025; Wood & Schulman, 2021).

Ethical Sensitivity and De-Stigmatization

Maintaining a clear distinction between apathy as illness and apathy as protest, burnout, or philosophical stance is crucial for ethical care (Ponthiere, 2023; Stoliarov, 2023). De-stigmatizing apathy involves respecting clients' narratives and resisting simplistic judgments about motivation or worth.

Longitudinal and Cross-Cultural Research

Much of the apathy literature focuses on Western, clinical populations. Expanding research across cultures and tracking individuals over time will help clarify which features of apathy are universal, which are context-dependent, and how sociopolitical environments shape motivational trajectories (Nooruddin & Rudra, 2025; Zhelnina, 2020).

Summary

Apathy is more than a lack of enthusiasm; it is a complex, multifaceted syndrome that shapes how individuals relate to themselves, others, and the world. At the neurobiological level, it reflects disruptions in fronto-subcortical circuits and neurotransmitter systems that govern motivation and reward (Mehak et al., 2023; Nsor & Brown, 2024). Clinically, apathy complicates the course of

neurodegenerative and cerebrovascular diseases, undermines rehabilitation, and burdens caregivers (Lanctôt et al., 2023; Pallucca et al., 2024).

Yet apathy also functions as a mirror, reflecting societal disillusionment, political disenfranchisement, and cultural narratives about what counts as a life worth caring about (Nooruddin & Rudra, 2025; Zhelnina, 2020). In marginalized communities and overstretched systems, apathy may signal not simply disorder but the limits of resilience and the need for systemic change.

To respond wisely, clinicians, researchers, and communities must move beyond narrow, deficit-based understandings. By listening deeply, designing more humane environments, and attending to both the brain and the broader stories in which people's lives are embedded, we can begin to transform apathy—from a silent, stigmatized problem into a catalyst for more compassionate, contextually grounded care and, ultimately, for collective healing and renewal.

Chapter 3 Key Takeaways

Apathy Is a Syndrome, Not a Character Flaw

Apathy involves reduced motivation, goal-directed behavior, and emotional engagement, often linked to identifiable brain changes (Miller et al., 2021; Mehak et al., 2023).

Apathy and depression are related but distinct.

Depression centers on emotional pain; apathy centers on lack of drive—even without sadness. This distinction is crucial for choosing effective treatments (Lanctôt et al., 2023; Ma, 2020).

Brain circuits and neurotransmitters matter.

Fronto–subcortical circuits and systems involving dopamine, acetylcholine, and serotonin are central to apathy, especially in neurodegenerative diseases (Mehak et al., 2023; Morris et al., 2023; Plant et al., 2024).

Assessment requires nuance.

Tools like the AES, DAS, and NPI apathy subscale help quantify apathy, but clinicians must also consider culture, history, and context (Miller et al., 2021; Sankhe et al., 2025).

Medication is only part of the picture.

Stimulants and dopaminergic agents can help some patients, but evidence is mixed, and SSRIs may worsen

apathy in some cases (Lanctôt, 2023; Padala et al., 2020; Naguy et al., 2025).

Nonpharmacological strategies are essential.

Behavioral activation, meaningful activity, CBT-bas
ed approaches, environmental supports, and technology-assisted interventions all contribute to re-engagement (Manera et al., 2020; Plant et al., 2024).

Context and ethics matter.

Not all "stepping back" is pathological; in some circumstances, apathy may represent protest, burnout, or spiritual detachment. Care must respect personal and cultural narratives (Nooruddin & Rudra, 2025; Stoliarov, 2023; Zhelnina, 2020).

Caregivers need support and validation.

Understanding apathy's neurobiological roots, learning practical strategies, and receiving emotional support can reduce burnout and improve care (Pallucca et al., 2024; Silva et al., 2021).

Apathy is both a clinical and societal concern.

It shapes the inner lives of individuals and the collective health of communities—calling for responses that address brains, relationships, systems, and stories.

Chapter 3 Glossary

ADMET 2 Trial (Methylphenidate for Apathy): The "Apathy in Dementia Methylphenidate Trial 2," which found that methylphenidate produced modest but clinically meaningful improvements in apathy among people with Alzheimer's disease, supporting dopaminergic/stimulant strategies in selected cases. (Sankhe et al., 2025)

Anhedonia (vs. Apathy): Anhedonia is a reduced capacity to experience pleasure; apathy is reduced initiation and interest in acting, regardless of whether an activity might still be pleasurable. The two can overlap but are conceptually distinct. (Lanctôt et al., 2023; Miller et al., 2021)

Apatheia (Stoic Detachment): In Stoic philosophy, a cultivated state of freedom from destructive passions achieved through rational discipline—conceptually different from clinical apathy, which reflects blunted motivation and emotional engagement rather than thoughtful, values-based detachment. (Ponthiere, 2023; Stoliarov, 2023)

Apathy in Alzheimer's and Other Neurodegenerative Diseases: One of the most common behavioral symptoms in Alzheimer's, Parkinson's, and Huntington's disease, often emerging early and reflecting degeneration in reward, executive, and salience networks. (Mehak et al., 2023; Peelo et al., 2022; Nsor & Brown, 2024)

Apathy Scales (AES, DAS, NPI Apathy Subscale): Validated tools used to quantify apathy: *Apathy Evaluation Scale* (AES) – self/informant/clinician rating of motivation and interest.

Apathy vs. Depression: A distinction between loss of drive (apathy) and presence of painful mood (depression). Depression emphasizes sadness, guilt, hopelessness, and self-criticism, while apathy centers on reduced motivation and emotional reactivity, which may occur with or without low mood. (Lanctôt et al., 2023; Ma, 2020)

Apathy: A neuropsychiatric syndrome marked by persistent reductions in motivation, goal-directed behavior, and emotional engagement compared to a person's prior level of functioning, often seen in neurodegenerative, cerebrovascular, psychiatric, and medical conditions. (Miller et al., 2021; Mehak et al., 2023; Lanctôt et al., 2023)

Civic or Political Apathy: Widespread disengagement from political participation, global institutions, or public life—especially among younger or marginalized groups—often driven by chronic mistrust, perceived powerlessness, or repeated exclusion rather than simple indifference. (Nooruddin & Rudra, 2025; Zhelnina, 2020)

Cognitive-Behavioral Model of Apathy in Parkinson's Disease: A framework suggesting that apathy is maintained by negative beliefs about one's capabilities and expectations of failure, where CBT can target "why bother?" thoughts, build self-efficacy, and reinforce small efforts. (Plant et al., 2024)

Diagnostic Criteria for Apathy in Neurocognitive Disorders: Standardized criteria requiring persistent diminishment in initiative, interest, and/or emotional expression for at least four weeks, representing a change from prior functioning and causing functional impairment, not fully explained by other conditions. (Miller et al., 2021)

Dimensional Apathy Scale (DAS) – separates executive, emotional, and initiation apathy.

Diminished Emotional Expression: Flattened or blunted outward emotional display—such as reduced facial expression, prosody, or visible joy/distress—despite the person being awake and responsive. (Miller et al., 2021; Peelo et al., 2022)

Diminished Initiative: Core apathy feature in which a person has difficulty initiating tasks or activities without prompting, even for basic or previously enjoyable actions. (Miller et al., 2021; Lanctôt et al., 2023)

Diminished Interest: Reduced curiosity or investment in people, hobbies, or events that previously mattered, reflected in withdrawal from social, recreational, or spiritual activities. (Miller et al., 2021; Silva et al., 2021)

Dopaminergic Dysfunction: Alterations in dopamine signaling that reduce willingness to exert effort and initiate goal-directed behavior; low dopamine states in conditions such as Parkinson's disease are closely tied to apathy. (Plant et al., 2024; Mehak et al., 2023)

Frontal–Subcortical Circuits: Networks linking frontal brain regions (e.g., dorsolateral prefrontal cortex, anterior cingulate, orbitofrontal cortex) with subcortical structures (e.g., basal ganglia, ventral striatum) that support planning, reward evaluation, and motivation. Disruption in these circuits is strongly associated with apathy. (Mehak et al., 2023; Nsor & Brown, 2024; Tay et al., 2020)

Neuropsychiatric Inventory (NPI) Apathy Subscale – commonly used in dementia.

Neuropsychiatric Syndrome : A cluster of behavioral and emotional symptoms (e.g., apathy, agitation, depression) that arise from brain dysfunction rather than purely "personality" or "willpower" problems. (Mehak et al., 2023; Nsor & Brown, 2024)

Nonpharmacological Treatment of Apathy: Structured, person-centered interventions including behavioral activation, meaningful

activities, environmental cueing, and caregiver training that aim to re-engage initiation and interest rather than simply "cheering up" mood. (Manera et al., 2020)

Nucleus Accumbens / Ventral Striatum: Key part of the brain's reward and "wanting" system that assigns value to actions and outcomes. Altered functional connectivity of the nucleus accumbens can precede and predict apathy in Parkinson's disease. (Morris et al., 2023)

Post-Stroke Apathy: A frequent sequela of stroke (affecting roughly one-third of survivors) associated with poorer quality of life, greater disability, and caregiver burden, often linked to cerebrovascular damage in motivation-related networks. (Pallucca et al., 2024; Tay et al., 2020)

SSRI-Associated Apathy Syndrome: A pattern in which selective serotonin reuptake inhibitors (SSRIs) improve mood but are associated with new or worsened apathy, particularly in older adults, highlighting that treating depression and treating apathy are not identical tasks. (Padala et al., 2020; Lanctôt et al., 2023)

These map well onto modern diagnostic criteria. (Sankhe et al., 2025)

Trained Apathy: A learned stance of "not caring" about politics or systems after repeated experiences of exclusion, broken promises, or lack of impact—functioning as a psychological defense in marginalized communities. (Zhelnina, 2020; Wood & Schulman, 2021)

Vaccine Apathy: Low motivation to pursue vaccination stemming from disinterest, low perceived personal relevance, or "nothing I do matters" attitudes, distinct from active vaccine hesitancy rooted in fear or mistrust. (Wood & Schulman, 2021)

Chapter 3 References

Lanctôt, K. (2023). Clinical trials for treatment of apathy. *Journal of the Neurological Sciences, 455*, 121025. https://doi.org/10.1016/j.jns.2023.121025

Lanctôt, K. L., Ismail, Z., Bawa, K. K., Cummings, J. L., Husain, M., Mortby, M. E., & Robert, P. (2023). Distinguishing apathy from depression: A review differentiating the behavioral, neuroanatomic, and treatment-related aspects of apathy from depression in neurocognitive disorders. *International Journal of Geriatric Psychiatry, 38*(2), e5882. https://doi.org/10.1002/gps.5882

Ma, L. (2020). Depression, anxiety, and apathy in mild cognitive impairment: Current perspectives. *Frontiers in Aging Neuroscience, 12*, 9. https://doi.org/10.3389/fnagi.2020.00009

Manera, V., Abrahams, S., Agüera-Ortiz, L., Bremond, F., David, R., Fairchild, K., Gros, A., Hanon, C., Husain, M., König, A., Lockwood, P. L., Pino, M., Radakovic, R., Robert, G., Slachevsky, A., Stella, F., Tribouillard, A., Trimarchi, P. D., Verhey, F., … Robert, P. (2020). Recommendations for the nonpharmacological treatment of apathy in brain disorders. *The American Journal of Geriatric Psychiatry, 28*(4), 410–420. https://doi.org/10.1016/j.jagp.2019.07.014

Mehak, S. F., Shivakumar, A. B., Saraf, V., Johansson, M., & Gangadharan, G. (2023). Apathy in Alzheimer's disease: A neurocircuitry based perspective. *Ageing Research Reviews, 87*, 101891. https://doi.org/10.1016/j.arr.2023.101891

Miller, D. S., Robert, P., Ereshefsky, L., Adler, L., Bateman, D., Cummings, J., DeKosky, S. T., Fischer, C. E., Husain, M., Ismail, Z., Jaeger, J., Lerner, A. J., Li, A., Lyketsos, C. G., Manera, V., Mintzer, J., Moebius, H. J., Mortby, M., Meulien, D., … Lanctôt, K. L. (2021). Diagnostic criteria for apathy in neurocognitive disorders. Alzheimer's & Dementia, 17(12), 1892–1904. https://doi.org/10.1002/alz.12358

Morris, L.-A., Harrison, S. J., Melzer, T. R., Dalrymple-Alford, J. C., Anderson, T. J., MacAskill, M. R., & Le Heron, C. J. (2023).

Altered nucleus accumbens functional connectivity precedes apathy in Parkinson's disease. *Brain, 146*(7), 2739–2752. https://doi.org/10.1093/brain/awad113

Naguy, A., Alablani, D. S., Alsalem, N. J., & Alamiri, B. (2025). Psychopharmacology of apathy. *American Journal of Therapeutics*. https://doi.org/10.1097/MJT.0000000000001860

Nooruddin, I., & Rudra, N. (2025). From enthusiasm to apathy: Dwindling support for globalization among future generations. *Journal of International Economic Law, 27*(4), 697–705. https://doi.org/10.1093/jiel/jgae053

Nsor, N., & Brown, C. (2024). Understanding apathy: Behavioral and neural correlates of apathy in neurodegenerative disorders. *Alzheimer's & Dementia, 20*(S8). https://doi.org/10.1002/alz.095685

Padala, P. R., Padala, K. P., Majagi, A. S., Garner, K. K., Dennis, R. A., & Sullivan, D. H. (2020). Selective serotonin reuptake inhibitors-associated apathy syndrome: A cross sectional study. *Medicine (Baltimore), 99*(33), e21497. https://doi.org/10.1097/MD.0000000000021497

Pallucca, C., Lisiecka-Ford, D. M., Wood, L., Abul, A., Jolly, A. A., Tozer, D. J., Bell, S., Forster, A., Morris, R. G., & Markus, H. S. (2024). Apathy after stroke: Incidence, symptom trajectory, and impact on quality of life and disability. *Neurology, 102*(3). https://doi.org/10.1212/WNL.0000000000208052

Peelo, C. G., Fallon, M., Campbell, D., Hammond, M., Hardiman, O., & Pender, N. (2022). F32 Apathy in three dimensions: Incidence and neuropsychological correlates of apathy in HD. *Journal of Neurology, Neurosurgery and Psychiatry, 93*(Suppl 1), A47. https://doi.org/10.1136/jnnp-2022-ehdn.123

Plant, O., Kienast, A., Drew, D. S., Slavkova, E. D., Muhammed, K., Kennerley, H., Husain, M., & Witt, K. (2024). A cognitive-behavioral model of apathy in Parkinson's Disease. *Parkinson's Disease, 2024*(1), 2820257. https://doi.org/10.1155/2024/2820257

Ponthiere, G. (2023). Epictetusian rationality. *Economic Theory*. https://doi.org/10.1007/s00199-023-01530-z

Sankhe, K., Bawa, K. K., Miller, D. S., Bateman, D., Cummings, J. L., Ereshefsky, L., Husain, M., Ismail, Z., Manera, V., Mintzer, J., Moebius, H. J., Mortby, M., Porsteinsson, A., Robert, P., & Lanctôt, K. L. (2025). Mapping of validated apathy scales onto the apathy diagnostic criteria for neurocognitive disorders. *International Psychogeriatrics*, 100074. https://doi.org/10.1016/j.inpsyc.2025.100074

Sankhe, K., Tumati, S., Perin, J., Rivet, L., Vieira, D., Rosenberg, P. B., Herrmann, N., Shade, D., Lerner, A. J., Padala, P. R., Brawman-Mintzer, O., van Dyck, C. H., Porsteinsson, A. P., Craft, S., Levey, A. I., Mintzer, J., & Lanctôt, K. L. (2025). Correlation between changes in apathy and cognition in Alzheimer's disease associated apathy: Analysis of the Apathy in Dementia Methylphenidate Trial 2 (ADMET 2). *International Psychogeriatrics, 37*(2), 100012. https://doi.org/10.1016/j.inpsyc.2024.100012

Silva, D., Martins, R., Polido, F., & Cruz, M. D. C. (2021). A closer look to apathy. *European Psychiatry, 64*(S1), S474. https://doi.org/10.1192/j.eurpsy.2021.1266

Stoliarov, A. (2023). Apathy. *Philosophical Anthropology, 9*(1), 177–190. https://doi.org/10.21146/2414-3715-2023-9-1-177-190

Tay, J., Lisiecka-Ford, D. M., Hollocks, M. J., Tuladhar, A. M., Barrick, T. R., Forster, A., O'Sullivan, M. J., Husain, M., de Leeuw, F.-E., Morris, R. G., & Markus, H. S. (2020). Network neuroscience of apathy in cerebrovascular disease. *Progress in Neurobiology, 188*, 101785. https://doi.org/10.1016/j.pneurobio.2020.101785

Wood, S., & Schulman, K. (2021). When vaccine apathy, not hesitancy, drives vaccine disinterest. *JAMA, 325*(24), 2435–2436. https://doi.org/10.1001/jama.2021.7707

Zhelnina, A. (2020). The apathy syndrome: How we are trained not to care about politics. *Social Problems, 67*(2), 358–378. https://doi.org/10.1093/socpro/spz019

Chapter 4

When Sadness Stays Too Long:

Understanding Depression and Sadness

Sadness is part of being human. It arrives after losses, disappointments, betrayals, and endings. It can deepen our empathy, slow us down long enough to reflect, and draw us toward others for comfort. Depression, however, is something different. When sadness hardens into a steady gray that will not lift—when hope shrinks, energy disappears, and life feels flat or unbearable—we are no longer talking about a passing emotion. We are talking about an illness.

In everyday conversation, the words sad and depressed are often used interchangeably. Clinically and spiritually, though, they are not the same. Confusing them can lead to two kinds of harm:

- Treating normal sadness as if it were pathology that must be eliminated
- Ignoring or minimizing depression because "everyone feels sad sometimes"

This chapter explores the difference and overlap between sadness and depression from multiple angles: historical, biological, cognitive, cultural, spiritual, and political. We will then turn toward how people actually heal—how individuals, families, churches, schools, and systems can respond when sadness becomes more than one heart can carry alone.

Sadness vs. Depression: Why the Distinction Matters

Sadness is a normal, often healthy response to an identifiable stressor—loss of a loved one, a breakup, a failure, a move, a frightening diagnosis. It tends to:

- Have a clear trigger
- Wax and wane over days or weeks
- Ease with time, support, or meaningful change
- Leave room for pleasure, connection, and hope alongside the pain

Sadness can even be spiritually meaningful. In some traditions, including Islamic teachings, sadness is described as multidimensional and spiritually significant—a feeling that can open the heart toward God, humility, and reflection (Khandani et al., 2020). Depression, particularly major depressive disorder (MDD), is different. Clinically, depression involves:

- Persistent low mood or emptiness
- Loss of interest or pleasure (anhedonia)
- Cognitive distortions (e.g., "I am worthless"; "nothing will ever change")
- Physical symptoms—sleep and appetite changes, fatigue, slowed movement
- Functional impairment in work, school, relationships, or self-care (Fries et al., 2022; Lokko & Stern, 2014)

Depression may arise without a clear external cause, or it may far outlast the original stressor. Even when life circumstances improve, the inner fog can stay. It is not just "feeling sad"—it is an alteration in how the brain, body, and mind are working together.

Culturally, sadness is often permitted or even honored—for example, in rituals of mourning or communal lament—while depression is more likely to be feared, stigmatized, or hidden. Yet people living with depression need more than comfort or exhortations to "pray more" or "think positive." They often require evidence-based treatment, social support, and systemic change. Getting this distinction right matters for at least three reasons:

- Accurate diagnosis and treatment – So that people receive appropriate care, not just encouragement when medication or structured therapy is needed.

- Reducing stigma – So people do not feel weak or faithless for needing help.

- Honoring normal grief – So we do not pathologize every painful emotion, but allow sadness its rightful place.

How Our Understanding of Depression Has Evolved

Our current language for depression is the product of centuries of wrestling with human sorrow.

In ancient medicine, Hippocrates and later Avicenna described melancholia as arising from an excess of "black bile." Treatment focused on balancing bodily humors.

In the Renaissance, Burton's Anatomy of Melancholy (1621) brought attention to lifestyle, relationships, and environment as contributors to mood.

Freud framed depression (then “melancholia”) as anger turned inward and rooted in early loss and unresolved conflict.

Existential thinkers like Viktor Frankl emphasized meaning, asking what happens when suffering seems pointless and life loses coherence (Frankl, 2000; Radden, 2003).

The 20th century introduced diagnostic manuals (like the DSM) and psychopharmacology, moving depression further into the realm of medical illness. The 21st century has layered on:

Neurobiology and Affective Neuroscience

Trauma-informed models that recognize the impact of chronic adversity. Narrative and culturally responsive care that honor people’s stories and contexts. In other words, we no longer see depression as just “bad chemicals,” “bad thinking,” or “bad character.” We understand it as a biopsychosocial-spiritual condition—a complex interaction of brain, body, history, relationships, culture, and systems.

What Depression Does in the Brain and Body

Biologically, depression is a systems-level disorder. It touches multiple brain regions, chemicals, and body systems:

- Hippocampus – Chronic stress and depression are associated with reduced hippocampal volume, which affects memory and learning (Pandya et al., 2012).

- Amygdala and prefrontal cortex – Overactive amygdala (threat center) and underactive prefrontal regions contribute to heightened emotional reactivity and impaired regulation (Tye, 2020).

- HPA axis – Dysregulation of the stress response system can lead to prolonged cortisol elevation, which damages neurons and further disrupts mood regulation (Poletti et al., 2024).

- Neuroplasticity – Lower levels of brain-derived neurotrophic factor (BDNF) and reduced neurogenesis have been observed, impacting the brain's capacity to adapt and heal (Fries et al., 2022).

- Emerging research also implicates inflammatory processes, autonomic dysregulation, and altered network connectivity:

- Elevated inflammatory markers like IL-6 and TNF-α appear in some people with depression.

- Heart rate variability (HRV) changes suggest disrupted autonomic balance, especially under emotional challenge (Ozden et al., 2024).

- Neuroimaging reveals altered connectivity in the default mode network, which may contribute to rumination and self-focused negative thinking (Kitch et al., 2024).

These findings don't reduce depression to mere biology; instead, they remind us that the emotional and spiritual

experience of depression is embodied. Faith, meaning, and therapy matter—but so do sleep, stress, inflammation, and the neural circuits that process emotion.

How Depression Changes Thinking and Attention

Aaron Beck's cognitive model remains foundational: depression often involves a negative triad—pessimistic views of self, world, and future (Beck, 1979). Research has expanded this model and shown that depression is associated with:

Attention bias toward negative information. People notice and remember more of what is threatening, sad, or self-critical (Beevers et al., 2021).

Memory bias and over general autobiographical memories—"My whole childhood was bad," rather than specific episodes, which can make problem-solving and meaning-making harder (Tutunji et al., 2024).

Language changes, including more first-person singular pronouns ("I," "me") and more sadness-related vocabulary, which show up in both speech and text-based analyses (Stade et al., 2023).

Maladaptive attributional styles, such as blaming oneself globally ("It's all my fault") or seeing difficulties as permanent and pervasive. This pattern ties into the concept of learned helplessness, where people come to believe their actions cannot change their outcomes (Abramson et al., 1978).

These biases do not mean people with depression are imagining their suffering. They mean depression tilts the mental lens so that pain and failure dominate the frame, while evidence of strength, love, or possibility falls out of view.

The hopeful side of this: attention and thinking styles are trainable. Interventions like cognitive therapy, attention bias modification, and narrative work can help people notice, challenge, and gently shift these patterns (Beck, 1979; Beevers et al., 2021).

Emotion Regulation and Relationships

Emotion regulation difficulties fuel depression and are also worsened by it:

- Rumination—repetitively turning over problems and painful feelings without moving toward solutions—keeps mood low and can predict the onset and persistence of depressive episodes (Visted et al., 2018).

- Suppression (pushing feelings down, keeping a "poker face") is linked with greater depressive severity and strain in relationships.

Adaptive strategies, such as reframing (cognitive reappraisal), mindfulness, and self-compassion, are often underused in depression.

These patterns begin early. Youth at high familial risk for depression show sex-based differences in how they handle sadness, with some girls and boys more likely to respond through rumination and withdrawal (Daches et

al., 2021). Children whose caregivers struggle with depression or cognitive fusion (being fused with painful thoughts) may develop more difficulty managing their own sadness (Eskandari et al., 2023).

Therapies like Dialectical Behavior Therapy (DBT), Acceptance and Commitment Therapy (ACT), and emotion-focused approaches directly target emotion regulation skills, helping people:

- Name and understand emotions
- Tolerate distress without harmful coping
- Move toward values and connection even while still feeling pain (Fitzpatrick et al., 2019; Zaid et al., 2025)

Depression often damages relationships—through withdrawal, irritability, or hopelessness—but those same relationships can become powerful sites of healing when loved ones learn to respond with validation, patience, and clear boundaries.

Culture, Art, and the Language of Sadness

Sadness and depression are not experienced in a vacuum; they are filtered through culture. In some settings, emotional distress is mostly expressed through the body—headaches, fatigue, stomach pain—because psychological language is stigmatized or unavailable (Barcellona, 2023). In others, religious or spiritual language shapes how sadness is understood—perhaps as a test, a purification, or a "dark night of the soul" (Underwood, 2022).

Art, story, and media become crucial alternative languages:

- Young people involved in artistic organizations report that creative activities provide spaces to process emotion, build identity, and connect with others (Gómez-Restrepo et al., 2022).

- Comics and visual metaphors (e.g., Depression Comix) can capture the "feel" of depression in ways simple descriptions cannot, helping people feel seen and less alone (Venkatesan & Suresh, 2021).

- Poetry, music, and film can serve as mirrors and companions, giving shape to feelings that are otherwise wordless.

Culturally responsive care takes these expressions seriously and does not insist that healing happen only in the language of Western psychiatry. It asks, How does your community talk about sadness? Who do you turn to first? What metaphors and rituals help you carry pain?

Placebo, Expectation, and the Power of Hope

One of the more surprising but encouraging research lines in depression is the placebo and expectation effect. Studies show that:

- When people believe they are receiving an effective treatment—even if it is inert—they often report real symptom reduction (Friehs et al., 2022).

- Expectation alone can produce measurable neurochemical changes, including dopamine release and reduced stress markers (Haas et al., 2020).

- The quality of the therapeutic relationship, the ritual of treatment, and the message of hope all contribute to these effects.

This doesn't mean depression is "all in your head" or that medications are meaningless. It means that meaning, trust, and ritual are part of what makes treatment work. Compassionate, collaborative care that explicitly protects and builds hope is not an "extra"; it is part of the active ingredient.

For faith communities, this dovetails with longstanding practices of blessing, anointing, prayer, and communal support. For clinicians, it underscores the importance of how we speak, not just what we prescribe.

Depression as a Public, Not Just Private, Problem

Depression is personal—but it is also political and structural. Large-scale sadness, anger, and disillusionment can:

- Shape voting patterns and fuel populist support, especially when people experience prolonged economic hardship and feel unheard (Ward et al., 2025).

- Increase social polarization as people turn their distress into blame and fear.

- Deepen mistrust in institutions when mental health systems are underfunded, inequitable, or inaccessible (American Psychiatric Association, n.d.).

- Policies that invest in collective mental wellness—through housing, living wages, trauma-informed schools, and accessible care—are not just "nice extras." They are part of maintaining a healthy society and resilient democracy.

Integrated care models, such as collaborative care, embed mental health treatment into primary care clinics, improving access and outcomes, particularly for people on Medicaid and in underserved communities (Unützer et al., 2013). These kinds of systemic solutions recognize that depression does not occur in a vacuum; it lives in bodies, families, neighborhoods, and laws.

Processing Depression and Sadness: What Healing Actually Looks Like

Healing from depression rarely happens through one single pathway. Research and clinical practice point to several overlapping processes (Fries et al., 2022; Zaid et al., 2025):

- Labeling emotions

- Moving from "I feel bad" to "I feel grief, shame, anger, numbness…" increases emotional granularity and often reduces distress.

- Journaling, therapy, and mindful awareness support this step.

- Accepting emotions without surrendering to them

- ACT and mindfulness-based therapies help people notice thoughts like “I’ll never feel happy again” without fully believing or obeying them (Fitzpatrick et al., 2019).

- Acceptance is not passivity; it’s dropping the war with sadness so energy can go toward values-based action.

Meaning Making

Spiritual reflection, narrative therapy, and the arts help people weave their suffering into a larger story—one that honors the pain but also allows for growth, wisdom, or new purpose (Gómez-Restrepo et al., 2022; Underwood, 2022).

Seeking Validation and Connection

Safe relationships—therapeutic, spiritual, communal—counteract isolation and shame. Support groups, trusted friends, or faith communities can offer “me too” spaces that are profoundly protective.

Engaging Treatment

Evidence-based therapies (CBT, DBT, ACT, interpersonal therapy), medication when indicated, and lifestyle changes (sleep, exercise, nutrition) all form a treatment scaffold (Caviness et al., 2023; Zaid et al., 2025).

Even a single bout of exercise can temporarily improve mood in some people with depression (Caviness et al., 2023).

Fostering Growth After Depression

Many people report that, on the other side of significant depressive episodes, they have greater empathy, clearer priorities, and deeper spiritual insight. This is not to romanticize suffering, but to acknowledge the real transformations that can occur.

The case of Jordan—the graduate student who moved from deep grief and withdrawal to renewed purpose through journaling, ACT, community support, spiritual reconnection, and physical activity—illustrates these processes in real life. His story reminds us that recovery is not a straight line but a multidimensional journey involving mind, body, spirit, and community.

Looking Forward: Opportunities for Care and Change

- If depression and sadness are shaped by biology, belief, behavior, and systems, then responses must be equally multidimensional. Policy recommendations arising from this synthesis include:

- Universal mental health education – Teaching emotional literacy and coping skills in schools normalizes feelings and builds resilience early.

- Integrated care models – Bringing mental health into primary care and community settings

increases access and coordination (Unützer et al., 2013).

- Stigma reduction campaigns – Honest public conversations that differentiate sadness from depression and emphasize treatability reduce shame (American Psychiatric Association, n.d.).

- Equity and access – Insurance parity, affordable medications, and culturally competent care are essential for justice.

- Trauma-informed systems – Schools, workplaces, and churches that prioritize safety, trust, collaboration, and empowerment reduce the risk and impact of depression.

Sadness will always be part of human life. Depression may always exist, too—but how many people are crushed by it, and how many find support and a path forward, depends on what we choose to build together.

Chapter 4 Key Takeaways

When Sadness Stays Too Long: Understanding Depression and Sadness

- Sadness and depression are not the same thing.
- Sadness is a normal, time-limited emotional response to loss or hardship.
- Depression is a persistent mental health disorder that affects mood, thinking, body, and functioning.
- Sadness can be adaptive and meaningful.
- It can deepen empathy, invite reflection, and draw us toward connection and spiritual growth.
- Many traditions, including Islamic and Christian thought, frame sadness as spiritually significant rather than pathological.
- Depression alters how the brain and body function.
- Involves changes in stress systems (HPA axis), hippocampus, amygdala, prefrontal cortex, and neuroplasticity.
- Inflammation, cortisol imbalance, and network connectivity (e.g., default mode network) can all be involved.
- Depression distorts thinking and attention.
- People often develop negative biases: seeing themselves, the world, and the future through a more hopeless lens.
- Attention, memory, and language get tilted toward loss, failure, and self-criticism.
- Emotion regulation is central.
- Rumination, suppression, and avoidance feed depression.
- Skills like mindfulness, cognitive reappraisal, and self-compassion are underused but highly protective.

- Early experiences and family patterns matter.
- Exposure to parental depression, trauma, or emotional invalidation increases vulnerability.
- Children often “learn” how to deal with sadness from what is modeled around them.
- Culture shapes how sadness and depression are expressed.
- In some cultures, distress is somatized (felt mostly in the body).
- Art, story, comics, music, and religious language often carry emotional truths that don’t show up in clinical labels.
- Hope and expectation have real therapeutic power.
- Placebo and expectancy research shows that belief, ritual, and relational trust can measurably reduce symptoms.
- How help is offered—the tone, relationship, and sense of hope—matters as much as what is offered.
- Depression is both personal and political.
- Widespread distress and disillusionment can influence voting, polarization, and trust in institutions.
- Mental health is a public health and justice issue, not only a private struggle.
- Healing is multidimensional, not a quick fix.
- Effective recovery usually involves some combination of:
- Emotion labeling and acceptance
- Meaning-making (spiritual, narrative, artistic)
- Connection and validation
- Evidence-based therapy and, when needed, medication
- Lifestyle supports (sleep, movement, structure)

- Stories like Jordan's show what real recovery looks like.
- Naming feelings, practicing ACT and mindfulness, reconnecting spiritually, seeking community, and moving the body can gradually transform despair into resilience and purpose.
- Systems must change too.
- School-based mental health education, integrated care models, stigma-reduction campaigns, trauma-informed environments, and equitable access to services are all part of responding to depression well.

Chapter 4 Glossary

Amygdala–Prefrontal Imbalance: A pattern in depression where heightened amygdala reactivity (threat and negative emotion) combines with reduced prefrontal regulation, contributing to emotional reactivity and difficulty modulating distress (Tye, 2020).
Artistic and Narrative Processing of Sadness: Use of arts, stories, and creative communities as spaces to explore emotion, build identity, and connect with others in ways that support mental health, especially among youth (Gómez-Restrepo et al., 2022; Venkatesan & Suresh, 2021).
Attention Bias Toward Negative Information: A tendency in depression to preferentially notice, process, and remember negative or self-critical material, which reinforces low mood and pessimistic thinking (Beevers et al., 2021; Cheeta et al., 2021).
Biopsychosocial-Spiritual Model of Depression: An integrative understanding of depression as arising from interacting biological (brain, stress, inflammation), psychological (cognition, emotion regulation), social (relationships, culture), and spiritual or meaning-related factors, rather than from "bad chemicals" or "bad character" alone (Fries et al., 2022; Underwood, 2022).
Cognitive Fusion (in Caregivers): Being entangled with one's thoughts (e.g., "If I think I'm a bad parent, it must be true"), which in depressed caregivers can be associated with children's difficulties managing sadness, especially in the context of learning disorders (Eskandari et al., 2023).
Cognitive Reappraisal: An emotion regulation strategy that involves reframing the meaning of a situation (e.g., "This setback is painful, but not the end of my story"), generally associated with lower depression and better adjustment (Zaid et al., 2025).
Collaborative Care Model: An integrated approach that embeds mental health services into primary care through team-based treatment (e.g., care managers, consulting psychiatrists), improving depression outcomes and access, particularly in Medicaid and underserved populations (Unützer et al., 2013).
"Dark Night of the Soul": A spiritual concept describing intense periods of inner desolation, doubt, or felt absence of God; used to differentiate deep spiritual struggle from medicalized views of sadness and depression (Underwood, 2022).
Default Mode Network (DMN) Alterations: Changes in connectivity within brain networks associated with self-referential thinking and

mind-wandering; in depression, such alterations may contribute to rumination and persistent negative self-focus (Kitch et al., 2024).

Depression / Major Depressive Disorder (MDD): A mood disorder characterized by persistent low mood or emptiness, loss of interest or pleasure (anhedonia), cognitive distortions ("I am worthless," "nothing will ever change"), physical symptoms (sleep/appetite changes, fatigue, psychomotor changes), and functional impairment in work, school, relationships, or self-care (Fries et al., 2022; Lokko & Stern, 2014).

Emotion Regulation Difficulties: Problems managing and responding to emotions—such as overreliance on suppression, limited use of reappraisal, and difficulty identifying feelings—that both increase risk for depression and interfere with recovery (Fitzpatrick et al., 2019; Zaid et al., 2025).

Emotion Regulation–Focused Therapies: Treatments such as DBT, ACT, and related approaches that explicitly build skills for identifying, tolerating, and modifying emotions while moving toward values and connection, shown to reduce depressive symptoms over time (Fitzpatrick et al., 2019; Zaid et al., 2025).

Heart Rate Variability (HRV) in Depression: Altered variability in heart rhythms—particularly reduced flexibility of LF components during emotional provocation—indicating autonomic imbalance and stress reactivity in major depression (Ozden et al., 2024).

Hippocampal Volume (in Depression): Reductions in hippocampal size associated with chronic stress and depression, which can impair memory and learning and reflect the impact of prolonged stress hormones on brain structure (Pandya et al., 2012).

HPA Axis Dysregulation: Disruption of the hypothalamic–pituitary–adrenal stress system in depression, often resulting in prolonged cortisol elevation that can damage neurons and further disturb mood regulation (Poletti et al., 2024).

Inflammatory Markers (IL-6, TNF-α): Immune system proteins often elevated in subsets of individuals with depression, supporting models that link mood disorders with systemic inflammation and bodily health (Fries et al., 2022).

Learned Helplessness / Maladaptive Attributional Style: A pattern in which individuals come to believe that their actions cannot influence outcomes, often attributing difficulties to global, stable, internal causes ("It's all my fault; it will always be this way"), increasing vulnerability to depression (Abramson et al., 1978).

Melancholia: A historical term for what we now call depression, originally framed in humoral medicine as excess "black bile," later reinterpreted psychodynamically as anger turned inward and

existentially as suffering linked to loss of meaning (Frankl, 2000; Radden, 2003).

Negative Cognitive Triad: Beck's classic model of depression: stable negative beliefs about the self ("I am defective"), the world ("everything is bad"), and the future ("nothing will ever improve"), which shape perception and maintain low mood (Beck, 1979).

Neuroplasticity and BDNF: Changes in the brain's capacity to adapt, including reduced neurogenesis and lower levels of brain-derived neurotrophic factor (BDNF) observed in some people with depression, which may hinder recovery and resilience (Fries et al., 2022).

Overgeneral Autobiographical Memory: Remembering past experiences in broad, nonspecific terms ("My whole childhood was bad") rather than detailed episodes, which can impair problem-solving and meaning-making in depression (Tutunji et al., 2024; Isham et al., 2022).

Pathologizing Normal Sadness: Treating ordinary, expected sadness as if it were a medical disorder, which risks over-medicalizing human emotion and undermining normal grief and lament (Radden, 2003; Underwood, 2022).

Placebo and Expectation Effects (in Depression): Symptom improvements driven by belief in treatment and therapeutic context rather than pharmacologic action alone—showing that expectation, hope, and clinician communication can produce measurable emotional and neurochemical changes (Haas et al., 2020; Friehs et al., 2022).

Post-Depressive Growth: Positive changes reported after recovery from significant depressive episodes—such as greater empathy, clearer priorities, or deeper spiritual insight—without romanticizing the suffering itself (Underwood, 2022; Gómez-Restrepo et al., 2022).

Rumination: Repetitive, passive focus on distress and its causes or consequences ("Why am I like this?") without moving toward solutions, strongly linked to the onset, severity, and persistence of depressive symptoms (Visted et al., 2018; Spyropoulou & Giovazolias, 2022).

Sadness: A normal, often healthy emotional response to identifiable stressors (e.g., loss, disappointment, diagnosis) that tends to fluctuate over time, allows moments of pleasure and connection, and can be spiritually meaningful rather than pathological (Khandani et al., 2020).

Somatization of Depression: The tendency to express emotional distress primarily through bodily symptoms (e.g., headaches, fatigue,

stomach pain) rather than psychological language, shaped by cultural norms and stigma around mental illness (Barcellona, 2023).

Stigma and Discrimination (Mental Illness): Negative stereotypes, prejudice, and discriminatory behaviors toward people with mental health conditions, which increase shame, reduce help-seeking, and represent a major barrier to care (American Psychiatric Association, n.d.).

Structural / Political Dimensions of Depression: Recognition that depression is shaped not only by individual factors but also by economic hardship, inequality, and social instability, which can influence political behavior and populist support, and highlight the need for policy-level mental health interventions (Ward et al., 2025; American Psychiatric Association, n.d.).

Suppression (Expressive Suppression): Attempting to hide or push down emotional expressions without changing inner experience; linked with higher depressive symptoms and strained interpersonal functioning (Fitzpatrick et al., 2019; Zaid et al., 2025).

Chapter 4 References

Abramson, L. Y., Seligman, M. E. P., & Teasdale, J. D. (1978). Learned helplessness in humans: Critique and reformulation. *Journal of Abnormal Psychology, 87*(1), 49–74. https://doi.org/10.1037/0021-843X.87.1.49

American Psychiatric Association. (n.d.). *Stigma, prejudice and discrimination against people with mental illness.* https://www.psychiatry.org/patients-families/stigma-and-discrimination

Barcellona, P. (2023). Cultural expression and the somatization of depression. Journal of Comparative Cultural Psychiatry, 29(3), 212–229.

Beck, A. T. (1979). *Cognitive therapy and the emotional disorders*. Penguin.

Beevers, C. G., Hsu, K. J., Schnyer, D. M., Smits, J. A. J., & Shumake, J. (2021). Change in negative attention bias mediates the association between attention bias modification training and depression symptom improvement. *Journal of Consulting and Clinical Psychology, 89*(10), 816–829. https://doi.org/10.1037/ccp0000683

Berg, S. S., Rosenau, P. S., & Prichard, J. R. (2022). Sleep quality mediates the relationship between traumatic events, psychological distress, and suicidality in college undergraduates. *Journal of American College Health, 70*(6), 1611–1614. https://doi.org/10.1080/07448481.2020.1826493

Caviness, C. M., Abrantes, A. M., O'Keeffe, J. B., Legasse, A. J., & Uebelacker, L. A. (2023). Effects of a bout of exercise on mood in people with depression with and without physical pain. *Psychology, Health & Medicine, 28*(4), 1068–1075. https://doi.org/10.1080/13548506.2022.2141276

Cheeta, S., Beevers, J., Chambers, S., Szameitat, A., & Chandler, C. (2021). Seeing sadness: Comorbid effects of loneliness and depression on emotional face processing. *Brain and Behavior, 11*(7), e02189. https://doi.org/10.1002/brb3.2189

Daches, S., Vine, V., George, C. J., & Kovacs, M. (2021). Age related sex differences in maladaptive regulatory responses to sadness: A study of youths at high and low familial risk for depression. *Journal of Affective Disorders, 294*, 574–579. https://doi.org/10.1016/j.jad.2021.07.086

Eskandari, L., Hooman, F., Asgari, P., & Alizadeh, M. (2023). Association between maternal cognitive fusion and depression and children's sadness management in students with specific learning disorders through an artificial neural network. *Women's Health Bulletin, 10*(4). https://doi.org/10.30476/whb.2024.100816.1259

Fitzpatrick, S., Bailey, K., & Rizvi, S. L. (2019). Changes in emotions over the course of dialectical behavior therapy and the moderating role of depression, anxiety, and posttraumatic stress disorder. *Behavior Therapy, 51*(6), 946–957. https://doi.org/10.1016/j.beth.2019.12.009

Friehs, T., Rief, W., Glombiewski, J. A., Haas, J., & Kube, T. (2022). Deceptive and non-deceptive placebos to reduce sadness: A five-armed experimental study.

Journal of Affective Disorders Reports, 9, 100349. https://doi.org/10.1016/j.jadr.2022.100349

Fu, G., Yu, Y., Ye, J., Zheng, Y., Li, W., Cui, N., & Wang, Q. (2022). A method for diagnosing depression: Facial expression mimicry is evaluated by facial expression recognition. *Journal of Affective Disorders, 323*, 809–818. https://doi.org/10.1016/j.jad.2022.12.029

Gómez-Restrepo, C., Casasbuenas, N. G., Ortiz-Hernández, N., Bird, V. J., Acosta, M. P. J., Restrepo, J. M. U., Sarmiento, B. A. M., Steffen, M., & Priebe, S. (2022). Role of the arts in the life and mental health of young people that participate in artistic organizations in Colombia: A qualitative study. *BMC Psychiatry, 22*(1), 757. https://doi.org/10.1186/s12888-022-04396-y

Gul, H., Torun, Y. T., Cakmak, F. H., & Gul, A. (2023). Facial emotion recognition in adolescent depression: The role of childhood traumas, emotion regulation difficulties, alexithymia and empathy. *Indian Journal of Psychiatry, 65*(4), 443–452. https://doi.org/10.4103/indianjpsychiatry.indianjpsychiatry_284_22

Haas, J. W., Rief, W., Glombiewski, J. A., Winkler, A., & Doering, B. K. (2020). Expectation-induced placebo effect on acute sadness in women with major depression: An experimental investigation. *Journal of Affective Disorders, 274*, 920–928. https://doi.org/10.1016/j.jad.2020.05.056

Isham, A. E., Watson, L. A., & Dritschel, B. (2022). Sad reflections of happy times: Depression vulnerability and experiences of sadness and happiness upon retrieval of positive autobiographical memories. *Memory, 30*(10), 1288–1301. https://doi.org/10.1080/09658211.2022.2105364

Khandani, E. K., Mohammadi Nia, M., & Akbarizadeh, M. (2020). Specifying the concept of sadness in the Holy Qur'an: A qualitative analysis. *Taḥqīqāt-i Kayfī Dar 'ulūm-i Salāmat, 9*(2), 91–100. https://doi.org/10.22062/JQR.2020.91456

Kitch, K., Zantopp, A., & Stevens, L. (2024). The depression network: A neuroimaging case study of acute stimulation. *NeuroRegulation, 11*(4), 405. https://neuroregulation.org/article/view/21331

Mizrahi Lakan, S., Millgram, Y., & Tamir, M. (2023). Desired sadness, happiness, fear and calmness in depression: The potential roles of valence and arousal. *Emotion, 23*(4), 1130–1140. https://doi.org/10.1037/emo0001120

Ozden, H. C., Gurel, S. C., Ozer, N., & Demir, B. (2024). Bidirectionality of LF when the movie makes you sad: Effects of negative emotions on heart rate variability among patients with major depression. *Journal of Psychosomatic Research, 184*, 111855. https://doi.org/10.1016/j.jpsychores.2024.111855

Shidhore, N., & Mangot, A. (2024). Sunshine and sadness: A case report on summer season depression. *Curēus, 16*(12), e75190. https://doi.org/10.7759/cureus.75190

Spyropoulou, E., & Giovazolias, T. (2022). The scarring effects of depression symptoms on sadness rumination and peer victimization in Greek early

adolescents. *The Journal of Early Adolescence, 42*(7), 845–884. https://doi.org/10.1177/02724316221078827

Stade, E. C., Ungar, L., Eichstaedt, J. C., Sherman, G., & Ruscio, A. M. (2023). Depression and anxiety have distinct and overlapping language patterns: Results from a clinical interview. *Journal of Psychopathology and Clinical Science, 132*(8), 972–983. https://doi.org/10.1037/abn0000850

Underwood, L. G. (2022). Review of Sadness, depression, and the dark night of the soul: Transcending the medicalization of sadness. *Journal of Disability & Religion, 26*(3), 316–318. https://doi.org/10.1080/23312521.2021.1895954

Unützer, J., Harbin, H., Schoenbaum, M., & Druss, B. (2013). *The collaborative care model: An approach for integrating physical and mental health care in Medicaid health homes.* Health Home Information Resource Center, Centers for Medicare & Medicaid Services. https://www.medicaid.gov

Venkatesan, S., & Suresh, A. (2021). Sequential sadness: Metaphors of depression in Clay Jonathan's Depression Comix. *Media Watch, 12*(1), 33–45. https://doi.org/10.15655/mw_2021_v12i1_205456

Ward, G., Schwartz, H. A., Giorgi, S., Menges, J. I., & Matz, S. C. (2025). The role of negative affect in shaping populist support: Converging field evidence from across the globe. *The American Psychologist, 80*(3), 323–344. https://doi.org/10.1037/amp0001326

Zaid, S. M., Hutagalung, F. D., Hamid, H. S. B. A., & Taresh, S. M. (2025). The power of emotion regulation: How managing sadness influences depression and anxiety? *BMC Psychology, 13*(1). https://doi.org/10.1186/s40359-025-02354-3

Chapter 5

Exploring Fear:
Interventions That Help or Hinder Fear

Fear is one of the most deeply wired human emotions. It mobilizes the body for survival—sharpening attention, activating the autonomic nervous system, and preparing us to fight, flee, or freeze in the face of threat (Gervaise, 2012). Yet the same mechanisms that keep us alive can also fuel anxiety disorders, phobias, and posttraumatic stress when fear learning becomes rigid, overgeneralized, or disconnected from current reality (Mineka & Sutton, 2007; Milosevic & McCabe, 2015).

This chapter explores how fear is learned, unlearned, and shaped by psychological interventions. Drawing from basic learning theory, clinical research, and models of emotion regulation, it highlights which interventions reliably reduce fear and which—often unintentionally—maintain or intensify it. Particular attention is given to fear conditioning and extinction, exposure-based therapies, cognitive-behavioral interventions, and the role of emotion regulation strategies such as reappraisal and suppression (Barad, 2007; Gross, 2007; Hermans et al., 2006).

Conceptualizing Fear: From Survival Signal to Clinical Problem

Fear can be understood as a rapid, high-intensity response to an immediately perceived threat, often accompanied by physiological arousal and a strong urge

to escape (Gervaise, 2012). In everyday life, fear is adaptive: it helps us avoid dangerous roads, react quickly to oncoming cars, or withdraw from genuinely threatening people or situations.

In anxiety disorders, however, fear responses become decoupled from realistic danger and instead attach themselves to benign stimuli (e.g., elevators, crowded spaces, physical sensations of arousal). Contemporary learning theories describe how such patterns develop when the brain overlearns associations between neutral cues and aversive outcomes, and then fails to update these associations when danger is no longer present (Mineka & Sutton, 2007). An important distinction emerges here:

- Acute fear is a short-lived response to immediate threat.
- Anxiety often involves anticipatory fear—worrying about what might happen in the future (Taylor, 1999).
- Psychological interventions for fear, therefore, must do more than simply "calm people down." They must modify the underlying learning, meaning, and regulation processes that keep fear active long after the threat has passed (Davey, 2007; Hermans et al., 2006).

Fear Conditioning: How Fear Is Learned

Fear conditioning has served as a central model for understanding how fears are acquired in both animals and humans. In this paradigm, a neutral cue (conditioned

stimulus; CS)—such as a tone or a light—is repeatedly paired with an aversive unconditioned stimulus (US), like a shock or loud noise. Over time, the CS alone elicits a fear response (Mineka & Sutton, 2007).

Classic work, such as the "Little Albert" study, demonstrated how quickly fears could be learned and generalized to similar stimuli (Watson & Rayner, 1920, as summarized in Mineka & Sutton, 2007). Although ethically unacceptable by modern standards, this and later research illustrate several key phenomena:

- *Rapid Acquisition*: Fear can develop after only a few pairings between CS and US.
- *Generalization*: Fear responses extend to stimuli that resemble the original CS.
- *Resistance to Change*: Once acquired, conditioned fear can persist even when the original threat is no longer present.

These processes help explain why an individual who experiences a panic attack in a grocery store may begin to fear not only that store but also other crowded or enclosed spaces, and why these fears persist even when repeated visits are objectively safe (Davey, 2007; Taylor, 1999).

Extinction: How Fear Is (Sometimes) Unlearned

Extinction occurs when the CS is repeatedly presented without the aversive outcome. Rather than erasing the original fear memory, extinction creates a new memory

that “this cue can also be safe” (Bouton et al., 2007). This distinction is crucial:

- The original fear learning (CS–US association) remains encoded.
- Extinction builds an additional, inhibitory learning that competes with the fear memory in guiding behavior (Barad, 2007).

Because extinction involves new learning, it is context-dependent and fragile. Research has documented several phenomena that illustrate this fragility (Bouton et al., 2007; Vansteenwegen et al., 2007):

- *Spontaneous recovery*: Fear returns after the passage of time, even without new threat.
- *Renewal*: Fear reappears when the CS is encountered in a different context from where extinction occurred.
- *Reinstatement*: Fear is rekindled after a new aversive event, even if it is unrelated to the original CS.

Animal studies point to the amygdala, hippocampus, and medial prefrontal cortex as key structures in both fear conditioning and extinction (Barad, 2007; Quinn & Fanselow, 2007). These systems help track environmental context and determine whether the “fear network” or the “safety network” is activated when a cue is encountered.

Clinically, these findings caution against viewing fear reduction as a simple matter of repeated exposure until fear decreases. Instead, therapists must deliberately

cultivate inhibitory learning that is durable across contexts and resilient to stress (Craske & Mystkowski, 2007; Hermans et al., 2006).

Exposure Therapy: Translating Extinction into Clinical Practice

Exposure therapy is the most direct translation of extinction principles into human treatment. In exposure-based work, individuals are systematically and repeatedly confronted with feared stimuli or situations without the expected negative outcome (Craske & Mystkowski, 2007). This can take several forms:

- *In vivo exposure*: Directly approaching feared objects or situations (e.g., dogs, bridges, public spaces).
- *Imaginal exposure*: Vividly recounting traumatic memories or feared future scenarios.
- *Interoceptive exposure*: Deliberately inducing feared physical sensations (e.g., dizziness, shortness of breath) in panic disorder.

Historically, exposure was often conceptualized through a habituation model, emphasizing fear reduction within sessions. Contemporary research, however, emphasizes inhibitory learning—the idea that the primary goal is to violate threat expectancies and encode new meanings about safety, even if fear does not fully habituate (Hermans et al., 2006; Milosevic & McCabe, 2015). Key principles that enhance exposure include (Bouton et al., 2007; Craske & Mystkowski, 2007; Milosevic & McCabe, 2015):

- *Maximizing mismatch with expectations*: Designing exposures that clearly disconfirm catastrophic predictions ("If I stay on this bridge, I will faint and fall").
- *Varying contexts*: Conducting exposure exercises in different places and conditions to reduce renewal.
- *Removing or minimizing safety behaviors*: Encouraging full contact with fear rather than partial or protected exposure.
- *Using retrieval cues*: Providing specific cues or strategies that can later help reactivate extinction learning in new settings.

When applied thoughtfully, exposure therapy is highly effective across a range of disorders, including specific phobia, social anxiety disorder, panic disorder, and PTSD (Craske & Mystkowski, 2007; Hermans et al., 2006).

When Exposure Fails: The Role of Avoidance and Safety Behaviors

Not all exposure is equal. When fear is confronted in ways that preserve avoidance, treatment gains can be greatly diminished. Avoidance and safety behaviors are strategies that help the individual feel safer in the short term but prevent the nervous system from fully updating its fear learning (Lovibond, 2007; Forsyth et al., 2007). Examples include:

- Staying near an exit during exposure to crowded places.

- Carrying “rescuer” objects (e.g., a specific water bottle or medication) perceived as necessary for survival.
- Mentally distracting during exposure rather than attending to feared cues.

From an expectancy perspective, these behaviors allow the person to attribute their survival to the safety behavior rather than to the absence of actual danger (Lovibond, 2007). As a result, fear learning is not fundamentally updated. In some cases, even well-meaning therapists inadvertently maintain avoidance by:

- Ending sessions whenever fear spikes rather than guiding the client through the peak.
- Reassuring excessively instead of inviting the client to observe what actually happens.
- Accepting clients’ constraints on exposure in ways that never fully activate their core fears.

Forsyth, Eifert, and Barrios (2007) argue that avoidance functions as a central regulatory strategy in many anxiety disorders: individuals are not simply afraid of external threats but also of their own emotional experiences. When treatment focuses only on external stimuli without addressing the fear of fear itself, change may be partial or short-lived.

Cognitive-Behavioral Therapy: Changing How We Think About Fear

Cognitive-behavioral therapy (CBT) integrates exposure with cognitive restructuring and behavioral experiments

to modify both fear responses and the beliefs that sustain them (Taylor, 1999). Whereas exposure directly targets the fear association ("Elevators = danger"), cognitive work addresses the interpretation of that association ("If my heart races, it means I am about to die"). Cognitive models emphasize several mechanisms that maintain fear (Davey, 2007; Mineka & Sutton, 2007; Taylor, 1999):

- *Catastrophic misinterpretations*: Interpreting benign sensations (e.g., dizziness) as signs of imminent catastrophe (e.g., heart attack).
- *Selective attention to threat cues*: Automatically scanning for danger and ignoring safety signals.
- *Inflated responsibility and overestimation of threat*: Believing one must control everything to prevent disaster.

In CBT, cognitive restructuring involves:

- Identifying automatic fear-related thoughts ("Everyone will laugh at me if I speak up").
- Evaluating evidence for and against these thoughts.
- Generating more balanced alternatives ("Some people might not notice; a mistake wouldn't mean total humiliation").

Behavioral experiments then put these new beliefs to the test in real life (Davey, 2007). For example, someone with panic disorder might deliberately induce heart palpitations through exercise and observe that they do not actually faint or die. This real-world disconfirmation strengthens new learning.

CBT is especially useful when fear is embedded in broader belief systems, such as core schemas about worth, control, or vulnerability, that exposure alone cannot fully shift (Hadwin & Field, 2010; Taylor, 1999). When cognitive elements are neglected, individuals may complete exposures yet continue to interpret their experiences through a catastrophizing lens, limiting long-term gains (Mineka & Sutton, 2007).

Emotion Regulation and Fear: Reappraisal Versus Suppression

How individuals regulate their emotions can either support or undermine fear treatment. Gross's (2007) emotion regulation framework differentiates strategies based on where they intervene in the emotion-generative process. Two strategies are especially relevant for fear:

- *Cognitive reappraisal*: Changing how one interprets a situation before or during an emotional response.
- *Expressive suppression*: Inhibiting outward signs of emotion without changing the internal experience.

Reappraisal tends to reduce negative affect, decrease physiological arousal, and promote more adaptive coping. When clients learn to reinterpret feared stimuli ("This is uncomfortable, but not dangerous"), they often engage exposure more willingly and experience less distress during it (Gross, 2007; Taylor, 1999).

Suppression, by contrast, often intensifies internal distress even as it reduces outward expression. People may appear calm while inwardly experiencing heightened

anxiety, shame, or fear (Forsyth et al., 2007; McAfee, 2019). Suppression can also:

- Increase physiological arousal.
- Narrow attention, making it harder to notice safety cues.
- Prevent emotional processing and integration.

When clients attempt to "white-knuckle" their way through exposure by suppressing emotional reactions, the nervous system may not truly update its prediction that the feared situation is survivable. Forsyth et al. (2007) propose that such experiential avoidance plays a central role in the development and maintenance of anxiety disorders, as individuals expend vast effort to not feel fear rather than learning to relate differently to fear itself.

Acceptance-based approaches—often integrated with CBT—encourage clients to allow fear sensations to arise and fall without struggle, while still moving toward valued actions (Forsyth et al., 2007; McAfee, 2019). When combined with reappraisal, this stance shifts the therapeutic question from "How do I get rid of fear?" to "How do I live meaningfully even when fear shows up?"

Interventions That Hinder Fear Recovery

Just as certain strategies reliably help fear diminish, others can unintentionally reinforce fear networks. These include:

- *Rigid avoidance-based coping*: Staying away from feared situations, internal states, or interpersonal

risks may provide short-term relief but prevents corrective learning (Lovibond, 2007; Forsyth et al., 2007).

- *Overuse of reassurance*: Seeking or providing constant reassurance about safety can undermine self-efficacy and keep catastrophic beliefs intact.
- *Exclusive reliance on suppression*: Encouraging clients to "stay strong," "not think about it," or "push it down" emphasizes control and avoidance rather than integration (Forsyth et al., 2007; McAfee, 2019).
- *Context-limited exposure*: Conducting exposure only in therapist offices or highly controlled environments, without generalization to everyday life, increases the risk of renewal when clients encounter triggers elsewhere (Bouton et al., 2007; Vansteenwegen et al., 2007).

At a broader level, McAfee (2019) notes that social and political narratives can institutionalize fear—constructing groups, events, or identities as inherently dangerous. When such narratives are internalized, they may counteract individual-level interventions by continuously reactivating fear schemas. Effective treatment, therefore, sometimes requires attention not only to intrapsychic processes but also to the cultural and relational contexts that shape fear.

Integrating Exposure, Cognition, and Regulation in Clinical Practice

The most effective fear interventions do not choose between exposure, cognitive work, or emotion regulation; they integrate these components in a coherent, individualized plan (Hermans et al., 2006; Taylor, 1999). An integrative protocol might include:

- *Psychoeducation*: Helping clients understand fear conditioning, extinction, and the logic of exposure.
- *Expectation mapping*: Clarifying what the client predicts will happen during exposure and using this as a target for expectancy violation (Bouton et al., 2007; Craske & Mystkowski, 2007).
- *Planned exposure exercises*: Conducted across varied contexts, with explicit reduction of safety behaviors and guided attention to feared cues.
- *Cognitive restructuring and behavioral experiments*: Targeting catastrophic misinterpretations and building more flexible, realistic appraisals (Davey, 2007; Mineka & Sutton, 2007).
- *Emotion regulation training*: Teaching reappraisal, mindfulness, and acceptance of internal experiences, while reducing reliance on suppression and experiential avoidance (Forsyth et al., 2007; Gross, 2007).

Across these components, the central therapeutic tasks are:

- Helping clients approach what they fear, rather than escape it.
- Updating the brain's predictions about threat and safety, rather than merely tolerating distress.

- Transforming the client's relationship with fear, such that fear becomes one piece of experience rather than an all-controlling force.

Summary

Fear is both a vital survival mechanism and a powerful driver of psychological distress. Learning theory, neurobiology, and clinical research converge on a central principle: fear diminishes when it is approached, examined, and reinterpreted—not when it is avoided, suppressed, or accommodated (Bouton et al., 2007; Craske & Mystkowski, 2007; Hermans et al., 2006).

Exposure therapy, CBT, and adaptive emotion regulation strategies such as cognitive reappraisal offer robust tools for reducing fear by fostering new inhibitory learning and reshaping maladaptive beliefs (Davey, 2007; Gross, 2007; Taylor, 1999). In contrast, safety behaviors, avoidance, and emotional suppression hinder these learning processes and can silently entrench fear over time (Forsyth et al., 2007; Lovibond, 2007; McAfee, 2019).

Future directions in fear treatment will likely expand on this integrative perspective—refining methods to strengthen extinction learning across contexts, tailoring interventions to developmental and cultural factors, and addressing societal narratives that feed chronic fear. As research continues to bridge basic and clinical science, practitioners are increasingly equipped to help individuals not simply manage fear, but to transform their relationship with it, reclaiming freedom and flexibility in the presence of a once-dominating emotion.

Chapter 5 Key Takeaways

Understanding Fear

- Fear is adaptive—but can become disordered. It's a survival signal that becomes problematic when it overgeneralizes, persists without real danger, or controls behavior.

- Fear is learned through conditioning. Neutral cues become threatening when paired with aversive events; these associations are sticky, generalize easily, and are resistant to change.

- Extinction is new learning, not erasure. Presenting feared cues without harm creates a safety memory that competes with the original fear memory—making fear reduction fragile, context-dependent, and prone to relapse.

- Exposure therapy works by violating expectations. Effective exposure:

    - Actively disconfirms feared predictions
    - Uses varied contexts
    - Minimizes safety behaviors
    - Aims for new learning, not just in-session fear reduction.

- Avoidance and safety behaviors hinder recovery. They protect in the short term but prevent the nervous system from updating its "this is dangerous" prediction, thereby maintaining fear.

- CBT deepens change by targeting beliefs. Cognitive restructuring and behavioral experiments modify catastrophic interpretations and core beliefs that drive and maintain fear.

- How we regulate emotion matters.

- Reappraisal (reframing meaning) reduces fear and supports exposure.

- Suppression (pushing feelings down) increases internal distress and undermines fear learning.

- Experiential avoidance keeps fear in charge. Efforts to not feel fear (numbing, distraction, emotional shut-down) often strengthen anxiety over time.

- Best practice is integrative. The strongest treatments combine exposure, cognitive change, and adaptive emotion regulation (reappraisal, acceptance, mindfulness) tailored to the person and their context.

- The goal is a new relationship with fear. Effective intervention doesn't just "turn off" fear; it helps people approach what they fear, update their sense of safety, and live meaningfully even when fear is present.

Chapter 5 Glossary

Acceptance-Based Approaches: Interventions that encourage individuals to allow fear and other internal experiences to arise without struggle, while continuing to move toward valued goals—shifting the focus from getting rid of fear to changing one's relationship with it (Forsyth et al., 2007; McAfee, 2019).

Acute Fear: Short-lived fear that arises in response to an immediate, identifiable danger (e.g., a speeding car) and subsides when the threat passes; typically adaptive and survival-oriented (Gervaise, 2012).

Anxiety / Anticipatory Fear: A future-oriented state characterized by worry and apprehension about what might happen, often without a clear immediate threat; in anxiety disorders, this anticipatory fear becomes excessive and impairing (Taylor, 1999; Mineka & Sutton, 2007).

Avoidance: Staying away from feared situations, cues, or internal states to reduce immediate fear; a central maintenance factor in anxiety disorders because it prevents exposure, extinction, and updated learning (Lovibond, 2007; Forsyth et al., 2007).

Behavioral Experiments: Planned activities used to test the accuracy of fear-based beliefs (e.g., inducing palpitations via exercise to see whether one actually faints), providing concrete disconfirmation that supports new learning (Davey, 2007).

Catastrophic Misinterpretations: Tendencies to interpret benign sensations or situations (e.g., heart racing, minor social mistake) as signs of impending disaster (e.g., heart attack, total humiliation), central to panic and other anxiety disorders (Taylor, 1999; Davey, 2007).

Cognitive Reappraisal: An emotion regulation strategy that involves reinterpreting the meaning of a situation (e.g., "This is uncomfortable but not dangerous"), generally associated with reduced negative affect and more adaptive coping in the context of fear (Gross, 2007; Taylor, 1999).

Cognitive Restructuring: A CBT technique involving identification, evaluation, and modification of fear-related thoughts and beliefs, moving from catastrophic interpretations toward more balanced appraisals that are then tested in real life (Davey, 2007; Taylor, 1999).

Cognitive-Behavioral Therapy (CBT) for Fear: An integrative approach that combines exposure with cognitive restructuring and behavioral experiments to change both fear responses and the

catastrophic beliefs that sustain them (Davey, 2007; Taylor, 1999; Mineka & Sutton, 2007).

Conditioned Stimulus (CS): A previously neutral cue (e.g., tone, place, bodily sensation) that, after being paired with an aversive unconditioned stimulus, elicits a learned fear response (Mineka & Sutton, 2007).

Context-Limited Exposure: Exposure conducted only in restricted or artificial settings (e.g., therapist's office) without sufficient variation, which increases the risk of renewal when the person encounters triggers in different real-world contexts (Bouton et al., 2007; Vansteenwegen et al., 2007).

Emotion Regulation: Processes by which individuals influence which emotions they have, when they have them, and how they experience and express them; certain strategies support fear treatment, while others hinder it (Gross, 2007; Forsyth et al., 2007).

Experiential Avoidance: A pattern of trying to control, escape, or suppress unwanted internal experiences (e.g., fear, thoughts, sensations), which often intensifies distress and keeps fear processes intact rather than allowing new learning (Forsyth et al., 2007; McAfee, 2019).

Exposure Therapy: A set of interventions in which individuals systematically and repeatedly confront feared stimuli, situations, or sensations without the expected catastrophe, with the goal of violating threat expectancies and building robust inhibitory learning (Craske & Mystkowski, 2007; Milosevic & McCabe, 2015).

Expressive Suppression: Inhibiting outward signs of emotion without changing internal experience; often increases physiological arousal and internal distress, and can interfere with emotional processing during exposure (Gross, 2007; Forsyth et al., 2007).

Extinction: A process in which the conditioned stimulus is repeatedly presented without the expected aversive outcome, leading to reduced fear responses; understood as new "safety" learning that inhibits, but does not erase, the original fear association (Barad, 2007; Bouton et al., 2007).

Fear Circuitry (Amygdala–Hippocampus–mPFC Network): Brain systems involved in fear conditioning and extinction: the amygdala encodes fear, the hippocampus tracks context, and medial prefrontal regions support regulation and extinction learning (Barad, 2007; Quinn & Fanselow, 2007).

Fear Conditioning: A learning process in which a neutral cue (conditioned stimulus) repeatedly paired with an aversive event (unconditioned stimulus) comes to elicit a fear response on its own,

forming the basic model for understanding how phobias and anxiety can develop (Mineka & Sutton, 2007).

Fear: A rapid, high-intensity emotional response to an immediately perceived threat, marked by physiological arousal and urges to fight, flee, or freeze; adaptive in real danger, but problematic when triggered by benign cues or maintained beyond actual threat (Gervaise, 2012; Mineka & Sutton, 2007).

Generalization (of Fear): The extension of fear from the original conditioned stimulus to other, similar stimuli (e.g., from one crowded store to all crowded places), helping explain the spread of fear across contexts in anxiety disorders (Mineka & Sutton, 2007; Davey, 2007).

Imaginal Exposure: Therapeutic revisiting of feared memories or anticipated scenarios in vivid detail (e.g., trauma narratives), used when direct exposure is not possible or would be unsafe (Craske & Mystkowski, 2007).

In Vivo Exposure: Real-life confrontation with feared objects or situations (e.g., riding an elevator, entering a crowded store) to disconfirm danger predictions and reduce avoidance (Craske & Mystkowski, 2007; Milosevic & McCabe, 2015).

Inhibitory Learning: The idea that extinction creates a new memory that "this cue can also be safe," which competes with the original fear memory; fear reduction depends on strengthening this inhibitory learning across contexts (Barad, 2007; Hermans et al., 2006).

Institutionalized / Cultural Fear: Broader social and political narratives that construct particular groups, identities, or situations as inherently dangerous, perpetuating fear at a societal level and sometimes undermining individual-level therapeutic work (McAfee, 2019).

Integrative Fear Treatment: A clinical approach that combines psychoeducation, expectation mapping, exposure across contexts, cognitive restructuring, and emotion regulation training to update threat predictions and help clients approach rather than avoid feared experiences (Hermans et al., 2006; Craske & Mystkowski, 2007; Taylor, 1999).

Interoceptive Exposure: Deliberate induction of feared bodily sensations (e.g., dizziness, shortness of breath) to demonstrate they are tolerable and not signs of impending catastrophe, particularly in panic disorder (Taylor, 1999; Milosevic & McCabe, 2015).

Reinstatement: The recurrence of fear after experiencing a new aversive event, even if it is unrelated to the original conditioned stimulus, suggesting that fear networks can be "re-activated" by later stressors (Bouton et al., 2007; Vansteenwegen et al., 2007).

Renewal: The return of fear when a conditioned stimulus is encountered in a context different from the extinction setting (e.g., feeling fine in session but anxious in a new environment), underscoring the context-dependence of extinction learning (Bouton et al., 2007; Vansteenwegen et al., 2007).
Safety Behaviors: Actions intended to prevent or minimize perceived danger (e.g., staying near exits, carrying "rescuer" objects, mentally distracting) that reduce distress short term but block full corrective learning, because survival is attributed to the safety behavior instead of the absence of real threat (Lovibond, 2007; Forsyth et al., 2007).
Spontaneous Recovery: The re-emergence of conditioned fear after the passage of time following extinction, reflecting the persistence of the original fear memory beneath newer safety learning (Bouton et al., 2007).
Unconditioned Stimulus (US): An inherently aversive event (e.g., shock, loud noise) that naturally elicits a fear or startle response without prior learning; in conditioning, it is paired with a neutral cue to create learned fear (Mineka & Sutton, 2007).

Chapter 5 References

Barad, M. (2007). *Anatomical, molecular, and cellular substrates of fear extinction*. In D. Hermans, D. Vansteenwegen, & M. G. Craske (Eds.), Fear and learning: From basic processes to clinical implications (pp. 157–173). American Psychological Association.

Bouton, M. E., Woods, A. M., Moody, E. W., Sunsay, C., & García-Gutiérrez, A. (2007). *Counteracting the context-dependence of extinction: Relapse and tests of some relapse prevention methods*. In D. Hermans, D. Vansteenwegen, & M. G. Craske (Eds.), Fear and learning: From basic processes to clinical implications (pp. 175–196). American Psychological Association.

Craske, M. G., & Mystkowski, J. L. (2007). *Exposure therapy and extinction: Clinical studies*. In D. Hermans, D. Vansteenwegen, & M. G. Craske (Eds.), Fear and learning: From basic processes to clinical implications (pp. 217–233). American Psychological Association.

Davey, G. C. L. (2007). *Cognitive mechanisms in fear acquisition and maintenance*. In D. Hermans, D. Vansteenwegen, & M. G. Craske (Eds.), Fear and learning: From basic processes to clinical implications (pp. 99–116). American Psychological Association.

Forsyth, J. P., Eifert, G. H., & Barrios, V. (2007). *Fear conditioning in an emotion regulation context: A fresh perspective on the origins of anxiety disorders*. In D. Hermans, D. Vansteenwegen, & M. G. Craske (Eds.), Fear and learning: From basic processes to clinical implications (pp. 133–153). American Psychological Association.

Gervaise, A. D. (2012). *Psychology of fear: New research* (1st ed.). Nova Science Publishers.

Gross, J. J. (2007). *Handbook of emotion regulation*. Guilford Press.

Hermans, D., Vansteenwegen, D., & Craske, M. G. (Eds.). (2006). *Fear and learning: From basic processes to clinical implications*. American Psychological Association.

Lovibond, P. (2007). *Fear and avoidance: An integrated expectancy model*. In D. Hermans, D. Vansteenwegen, & M. G. Craske (Eds.), Fear and learning: From basic processes to clinical implications (pp. 117–132). American Psychological Association.

McAfee, N. (2019). *Fear of breakdown: Politics and psychoanalysis.* Columbia University Press.

Milosevic, I., & McCabe, R. E. (2015). *Phobias: The psychology of irrational fear*. ABC-CLIO.

Mineka, S., & Sutton, J. (2007). *Contemporary learning theory perspectives on the etiology of fears and phobias.* In D. Hermans, D. Vansteenwegen, & M. G. Craske (Eds.), Fear and learning: From basic processes to clinical implications (pp. 75–97). American Psychological Association.

Taylor, S. (1999). *Anxiety sensitivity: Theory, research, and treatment of the fear of anxiety*. Lawrence Erlbaum Associates.

Vansteenwegen, D., Dirikx, T., Hermans, D., Vervliet, B., & Eelen, P. (2007). *Renewal and reinstatement of fear: Evidence from human conditioning research.* In D. Hermans, D. Vansteenwegen, & M. G. Craske (Eds.), Fear and learning: From basic processes to clinical implications (pp. 197–215). American Psychological Association.

Chapter 6

The Journey of Grief and Mourning

Grief is an unavoidable consequence of love. When someone or something deeply significant is lost, the psyche, body, and spirit reorganize themselves around a painful new reality. In this chapter, we explore grief and mourning as universal yet profoundly individualized experiences, integrating classic and contemporary theories, mind–body impacts, cultural and spiritual dimensions, special forms of grief, and evidence-based approaches to support healing.
Rather than treating grief as a problem to be solved, this chapter frames it as a natural—if often agonizing—process of adaptation and meaning-making. Mourning, in turn, is the relational and ritual space where that inner process is expressed and supported.

Grief and Mourning: Core Definitions

Grief refers to the internal experience of loss—the emotional, cognitive, and existential responses to a significant change or death. Mourning is the outward expression of that grief—rituals, behaviors, conversations, and communal practices through which loss is acknowledged and honored.

Grief may be triggered not only by death but also by the end of a relationship, loss of health or mobility, job loss, migration, or the shattering of a hoped-for future. Whatever the precipitant, grief is not a pass/fail test of strength but a testament to attachment: we hurt because we are wired to bond.

Major Theories of Grief

Grief theories are maps, not mandates. They offer language and structure, but they cannot dictate how any one person "should" grieve. Several influential frameworks help normalize diverse reactions and trajectories.

Kübler-Ross's Five Stages of Grief

Elisabeth Kübler-Ross (1969) originally described five emotional reactions among terminally ill patients: denial, anger, bargaining, depression, and acceptance. Over time, this model was generalized to bereaved survivors. The stages can be summarized as:

- *Denial* – "This can't be happening." A shock buffer that protects from overwhelming pain.
- *Anger* – "Why is this happening? Who is to blame?" Directed at self, others, God, or systems.
- *Bargaining* – "If only I had… Maybe if I…" Attempts to mentally negotiate with fate.
- *Depression* – Deep sadness, withdrawal, and recognition of the magnitude of the loss.
- *Acceptance* – Not "liking" the loss but acknowledging its reality and beginning to live within it.

Kübler-Ross did not intend these as rigid, sequential stages. People may skip, revisit, or oscillate among them. Many never experience a clear "acceptance" but instead

reach a more modest acknowledgement of the loss. When taken prescriptively ("you should be in stage X by now"), the model can pathologize normal variability (Tyrrell et al., 2023; Kübler-Ross, 1969).

Clinical implication: Use the stages as a shared vocabulary, not a checklist. If a client says, "I think I'm in the anger stage," that can open helpful exploration—as long as we emphasize that grief is not linear and there is no "right" order.

Worden's Tasks of Mourning

Worden (2009) reframed grief not as passive "stages" but as active tasks that mourners may work through over time:

- Accept the reality of the loss. Moving from intellectual knowledge to emotional recognition that the person or situation is truly gone.
- Process the pain of grief. Allowing oneself to feel and express grief rather than suppress or avoid it.
- Adjust to a world without the deceased (or what was lost).
- External adjustments: new roles, responsibilities, daily routines.
- Internal adjustments: shifts in identity ("spouse" to "widow").
- Spiritual adjustments: reworking beliefs about God, justice, or meaning.

Find an enduring connection with the deceased while moving forward. Maintaining a continuing bond without being immobilized by it.

These tasks are not linear and can be revisited repeatedly. They are clinically useful as a framework for assessing where someone may be struggling—for example, a client who functions well practically (Task 3) but has never processed the emotional pain (Task 2) (Worden, 2009).

Continuing Bonds Theory

Early psychoanalytic models framed "healthy" grief as withdrawing emotional energy from the deceased and reinvesting it elsewhere. Continuing bonds theorists challenged this idea, arguing that ongoing connection is both normal and adaptive (Klass et al., 1996). Continuing bonds may include:

- Talking to the deceased internally or in prayer.
- Keeping meaningful objects, photos, or clothing nearby.
- Marking birthdays or anniversaries.
- Living in ways that honor the loved one's values.

Across cultures, practices like ancestral altars, Día de los Muertos, or annual memorial rituals demonstrate that maintaining ties with the dead has long been normative. The key clinical question is not whether a bond continues but how—does it comfort and support functioning, or

does it anchor the mourner in denial or despair? (Klass et al., 1996; Worden, 2009).

The Dual Process Model

Stroebe and Schut's (1999) Dual Process Model describes healthy grieving as an oscillation between two modes:

- *Loss-oriented coping* – confronting the pain, yearning, crying, reminiscing, talking about the deceased.

- *Restoration-oriented coping* – dealing with secondary changes and rebuilding life: managing finances, returning to work, engaging in new roles or relationships, and sometimes deliberately taking breaks from grief.

Rather than viewing distraction or "getting on with life" as avoidance, the model emphasizes that alternating between loss and restoration is adaptive. Spending all one's energy in loss-oriented processing risks emotional overwhelm; staying only in restoration mode risks emotional numbness or delayed grief (Stroebe & Schut, 1999).

Worden (2009) describes similar "dosing": mourners engage with grief until it becomes too much, then retreat to everyday tasks or small pleasures to recover before re-engaging.

Evolving Perspectives: Meaning-Making and Narrative
More recent approaches highlight meaning reconstruction as central to adaptation. Loss can shatter core

assumptions about self, others, and the world. Grieving often involves:

- Reworking one's life story to integrate the loss.
- Finding meaning through legacy, advocacy, spiritual frameworks, or personal growth.
- Using narrative tools—journaling, storytelling, art—to "re-member" the deceased into one's ongoing story (Neimeyer, 2002).

These models underscore that grief is not only about feeling less pain but also about rebuilding a coherent sense of self and world after rupture.

The Impact of Grief on Mind and Body

Grief is not "just emotional." It is a full-body, whole-person stress response.

Emotional and Psychological Effects

Common emotional experiences include:

- Profound sadness, yearning, and loneliness.
- Anger (at self, others, God, systems, or even the deceased).
- Guilt and "if only" ruminations.
- Anxiety about the future and one's own mortality.

- Relief (especially after a long illness)—often followed by guilt for feeling relieved.

These emotions often come in waves, especially in early grief. Many describe "grief brain": difficulty concentrating, forgetfulness, feeling as if in a fog. Sleep disturbances, vivid dreams or nightmares, and appetite changes are widespread (Godman, 2019; Harvard Health Publishing, 2015).

Brief sensory experiences of the deceased—hearing their name, glimpsing their face in a crowd, momentarily reaching for the phone to call them—are common and generally not pathological, especially in acute grief. Grief may overlap with, or trigger, major depression. Key distinctions: in grief, self-esteem is typically preserved and affect is more wave-like; in depression, mood is more persistently low and marked by worthlessness. Still, many bereaved individuals meet criteria for depression in the first months, warranting monitoring and, at times, treatment (Godman, 2019).

Physical Effects and "Broken-Heart Syndrome"

- Physically, grief can manifest as:
- Fatigue and low energy.
- Sleep disruption (insomnia or hypersomnia).
- Appetite and weight changes.
- Headaches, muscle tension, gastrointestinal distress.

- Heightened vulnerability to infections due to immune suppression.

- Exacerbation of chronic conditions (e.g., hypertension, heart disease, diabetes).

Acute bereavement stress is associated with increased cardiovascular risk. In rare cases, intense emotional shock can precipitate stress-induced cardiomyopathy ("broken-heart syndrome"), mimicking a heart attack (Godman, 2019). Older widowed adults have elevated mortality in the first year after a spouse's death, partly reflecting this physiological burden.
These realities underscore that caring for the bereaved includes medical and behavioral health attention: sleep, nutrition, movement, and routine medical follow-up.

Cultural and Spiritual Dimensions of Mourning

Grief is universal; mourning is cultural. How people express and ritualize loss depends heavily on cultural norms, religious beliefs, and communal practices (Barnardos, n.d.).

Cultural Mourning Practices

Across cultures, mourning rituals tend to:

- *Honor the deceased* – funerals, wakes, memorial services.

- *Publicly mark bereaved status* – clothing colors (black, white, purple, etc.).

- *Provide communal care* – food, visits, shared storytelling.

- *Guide transition* – structured periods of more intense mourning followed by gradual re-entry to everyday life (e.g., shiva and shloshim in Judaism, Nine Nights in Caribbean contexts).

Some cultures encourage overt emotional expression (wailing, keening); others value composure and restraint. Both can be healthy when embedded in a supportive communal frame (Barnardos, n.d.).

For grieving individuals, cultural norms can be both containing and constraining. A person raised in a stoic context may need explicit permission to express more emotion; someone from a highly expressive tradition living in a more reserved culture may feel isolated or "too much."

Spiritual Beliefs and Grief

For many, bereavement is also a spiritual crisis or deepening. Faith traditions offer:

- *Rituals* (funeral liturgies, prayers, memorial masses, recitations like Kaddish or Janazah).

- *Beliefs about afterlife* (heaven, reincarnation, ancestral presence).

- *Communal support*, as congregations rally around the bereaved (Harvard Health Publishing, 2015).

Spirituality can buffer loneliness and provide a meaning framework ("They are at peace," "We will meet again"). At the same time, loss can trigger spiritual anger or doubt. Questioning God, wrestling with suffering, or reshaping beliefs is a normal part of many grief journeys (Ademiluka, 2025; Keenan, 2025).

Even outside organized religion, practices like mindfulness, time in nature, and personal rituals (lighting candles, home altars, symbolic acts) can be deeply grounding (Chemi, 2025).

Anticipatory and Disenfranchised Grief

Not all grief begins after death or is socially recognized.

Anticipatory Grief

Anticipatory grief arises before an expected loss—commonly in terminal illness, progressive neurocognitive disorders, or other prolonged, foreseen declines (Cleveland Clinic, 2024; Rodriguez et al., 2025). Family members (and sometimes patients) begin grieving:

- Loss of the person "as they were."
- Incremental losses of function, personality, or shared future plans.
- The looming death and their own life after it.

Symptoms mirror post-loss grief: sadness, anger, anxiety, guilt, and "rehearsal" of the death and its aftermath. This process can:

- Facilitate important conversations, goodbyes, and practical planning.

- Reduce some shock at the time of death.

- Still leave a fresh layer of grief when death occurs; anticipatory grief does not "use up" later mourning.

Clinically, normalizing anticipatory grief and supporting caregivers in "dosing" their engagement—being present with the dying person while also caring for themselves—is essential (Cleveland Clinic, 2024; Truman, 2025).

Disenfranchised Grief

Doka (1989) coined disenfranchised grief to describe losses that are not socially acknowledged, validated, or supported. This may occur when:

- The relationship is not recognized (e.g., extramarital partner, ex-spouse, LGBTQ+ partner in unsupportive contexts, close coworker).

- The loss type is minimized (miscarriage, stillbirth, pet loss, job loss, divorce, estrangement, loss of health).

- The cause of death is stigmatized (suicide, overdose, HIV/AIDS, deaths during criminal acts).

- The griever is marginalized (children, people with disabilities, caregivers without legal status, colleagues) (Doka, 1989; Drake, 2022).

Disenfranchised grievers often feel:

- They lack the "right" to mourn.
- Isolated, ashamed, or confused by the intensity of their feelings.
- Cut off from rituals and social support that might otherwise ease their pain.

This increases risk for depression and complicated grief (Drake, 2022). Support often begins with explicit validation: "Your grief makes sense," along with creation of personal rituals, seeking specialized support groups, and therapeutic spaces where all losses are enfranchised.

Contemporary Issues in Grief and Mourning

Grief in the Digital Age

Digital platforms have transformed how people mourn, creating what Sofka termed thana-technology—technology used in the context of death and grief (Counseling Today, 2023; Dula et al., 2025). Key features include:

- *Online memorials* – social media pages converted to memorial profiles; ongoing posts to the deceased; digital guestbooks.
- *Virtual support communities* – forums, Facebook groups, and subreddits for specific kinds of loss.

- *Public storytelling* – blogs, vlogs, podcasts documenting grief journeys.

- *Collective mourning* of public tragedies and celebrity deaths in real time.

Benefits:

- Reduced isolation; ability to find others with similar losses.

- Ongoing continuing bonds via images, posts, and shared memories.

- Accessibility for those without local support.

Challenges:

- Pressure to "perform" grief publicly.

- Exposure to insensitive comments or trolling.

- Algorithmic reminders (e.g., "memory" photos, automated birthday prompts).

Misinformation or unhelpful advice in unmoderated spaces (Counseling Today, 2023; Rodríguez-Dorans & Méndez Díaz, 2025). Clinically, helping clients use digital tools intentionally—as supplements to, not replacements for, embodied connection—is key.

COVID-19 and Collective Grief

The COVID-19 pandemic generated a global wave of bereavement and secondary losses. Unique features included:

- *Disrupted rituals* – restricted hospital visits, delayed or virtual funerals, inability to gather physically (Hartung, 2025; Gabay & Tarabeih, 2025).

- *Layered and cumulative losses* – multiple deaths in families and communities, plus job loss, disrupted education, and social isolation.

- *Stigma and politicization* – denial, minimization of COVID-19's seriousness, and blame around vaccination status contributing to disenfranchised grief.

Many survivors were left without opportunities for in-person goodbyes or communal ritual, increasing risk for prolonged grief and trauma reactions. At the same time, communities created innovative memorials—virtual services, national installations of flags or candles, and public days of remembrance that functioned as "the funeral they never had" (Hartung, 2025; Obradović et al., 2025). The pandemic highlighted the importance of public acknowledgment and flexible ritual for collective healing.

Trauma and Grief: When Loss is Traumatic

When deaths are sudden, violent, or horrifying (e.g., accidents, homicide, suicide, disasters, war), grief often intertwines with posttraumatic stress reactions (Coelho, 2022). Features of traumatic grief can include:

- Intrusive images or flashbacks of the death or circumstances.

- Hyperarousal, avoidance of reminders, and a sense of threat.

- Intense anger, guilt, and survivor guilt.

- Difficulty accessing comforting memories because trauma imagery dominates.

Children are especially vulnerable to childhood traumatic grief, in which trauma responses block the child's ability to process the reality of the death and associated emotions. Treatment often requires a dual focus:

- *Trauma-focused work* (e.g., TF-CBT, EMDR) to reduce PTSD symptoms.

- *Grief-focused work* to support mourning, continuing bonds, and meaning-making.

- *Peer groups* for specific types of traumatic loss (suicide survivors, parents of murdered children, etc.) can be particularly healing by reducing isolation and shame (Coelho, 2022).

Coping and Intervention Strategies

Grief cannot and should not be "cured." The goal of intervention is to help people carry their grief in ways that allow for functioning, connection, and eventual re-engagement with life.

Grief Counseling and Support Groups

Grief counseling offers:

- A safe, nonjudgmental place to tell and retell the story of the loss.
- Normalization of intense emotions and cognitive changes.
- Support for Worden's tasks: reality acceptance, emotional processing, adjustment, and continuing bonds (Worden, 2009).
- Identification and treatment of co-occurring depression, anxiety, substance use, or trauma.

Techniques may draw from CBT (challenging excessive guilt or catastrophic thoughts), expressive therapies (art, music, letter-writing), and relational approaches that emphasize companioning rather than "fixing."
Support groups provide peer validation: "I thought I was the only one who felt that way." Specialized groups (e.g., for parents, widows, LGBTQ+ losses, disenfranchised grief, pet loss) can be powerful antidotes to isolation (Silva et al., 2025; Toomey et al., 2025).

Narrative and Meaning-Making Approaches

- Narrative and meaning-focused interventions help the bereaved:
- Reconstruct a life story changed by loss (Neimeyer, 2002).
- Articulate the impact and legacy of the deceased.

- Identify threads of growth, values, and identity that persist beyond the loss.

Common practices:

- Journaling, including letters to the deceased.
- Creating memory books or digital stories.
- Guided imagery or "empty chair" conversations.
- Exploring questions like "How is this loss shaping who you are becoming?"
- Meaning-making may include activism, creative work, spiritual reframing, or quiet internal shifts. It is highly personal and should never be forced with platitudes ("everything happens for a reason").

Healing Rituals and Memorials

Rituals—formal or improvised—translate inner grief into embodied action:

- Funerals, wakes, memorial services, and anniversary gatherings.
- Candle lighting, visits to graves or special places, scattering ashes.
- Memory corners at home with photos and mementos.
- Acts of service or charity in the loved one's name.

- Creative memorials (quilts, art, music, performances) (Truman, 2025; Dula et al., 2025).

Such practices support Worden's tasks and continuing bonds: acknowledging reality, expressing emotion, adjusting roles, and maintaining an enduring connection in new form.

Building Resilience and Knowing When to Seek Help

Helpful coping strategies include:

- *Social support* – allowing others to help with practical tasks and emotional presence.
- *Physical self-care* – sleep, nutrition, hydration, gentle movement (Godman, 2019).
- *Emotional expression* – crying, talking, creative outlets; not pathologizing tears or waves of grief.
- *Realistic pacing* – setting small, manageable goals and allowing periods of rest.
- *Permission for joy* – recognizing that moments of laughter or enjoyment do not betray the deceased.

Professional help is recommended when:

- Intense grief symptoms persist beyond expected cultural norms and markedly impair functioning.
- There are persistent suicidal thoughts or self-harm behaviors.

- Trauma symptoms are overwhelming.

- The person feels “stuck” for a long time and unable to re-engage in life.

Evidence-based treatments for prolonged grief and traumatic grief can be highly effective when combined with compassionate support (Coelho, 2022; Worden, 2009).

Summary: Grief as Testimony to Love

Grief and mourning are not failures of faith, resilience, or mental health. They are the human response to the rupture of love and attachment. The theories and models reviewed—Kübler-Ross’s stages, Worden’s tasks, continuing bonds, the Dual Process Model, narrative and meaning-making—are different lenses on the same reality: grief is dynamic, non-linear, and deeply individual (Kübler-Ross, 1969; Klass et al., 1996; Stroebe & Schut, 1999; Worden, 2009; Neimeyer, 2002).

Grief affects mind and body, is shaped by culture and spirituality, and takes special forms in anticipatory, disenfranchised, traumatic, and pandemic-related losses (Doka, 1989; Cleveland Clinic, 2024; Hartung, 2025). Yet across these variations, certain constants emerge:

- People need permission—internally and socially—to grieve in their own way.

- They heal best when embedded in supportive relationships and communities.

- Rituals and narratives help transform raw loss into integrated memory and meaning.

- Continuing bonds allow love to persist without requiring the living to stop living.

Grief does not end; it changes shape. Over time, the sharp edges may soften into a bittersweet ache. Moments of joy and connection return, not because the deceased is forgotten, but because the mourner has learned to carry both love and loss.

In this sense, grief is not something to "get over" but something to live with—a long, evolving testament to the importance of what has been lost and the resilience of the human spirit.

Chapter 6 Key Takeaways

The Journey of Grief

1. Grief vs. Mourning

   - Grief = the inner experience of loss (emotional, cognitive, existential).
   - Mourning = the outward expression of grief (rituals, behaviors, communal practices).

2. Grief Is About Attachment, Not Weakness

   - Grief arises from love and bonding, not from a lack of strength or faith.
   - It is triggered by many losses, not just death (health, roles, dreams, relationships).

3. Theories Are Maps, Not Rules

   - Kübler-Ross's five stages (denial, anger, bargaining, depression, acceptance) offer language, not a required sequence.
   - They're most helpful as a shared vocabulary, not a timeline or checklist.

4. Worden's Tasks Emphasize Active Coping

   - Accept the reality of the loss.
   - Process the pain of grief.
   - Adjust to a world without what was lost (externally, internally, spiritually).
   - Find an enduring connection while moving forward.
   - These tasks can be revisited and are useful for clinical assessment.

5. Continuing Bonds Are Normal and Often Healthy

- Ongoing connection with the deceased (talking to them, rituals, anniversaries) is common and culturally grounded.
- The question is not if the bond continues, but how—does it support or hinder functioning?

6. Dual Process: Oscillating Between Loss and Life

Healthy grieving involves moving back and forth between:

- Loss-oriented coping (feeling, remembering, crying), and
- Restoration-oriented coping (rebuilding routines, roles, goals).
- Breaks from grief are not avoidance; they are part of adaptation.

7. Meaning-Making Is Central to Long-Term Adaptation

- Grief often requires reconstructing one's story, beliefs, and identity.
- Narrative tools (journaling, art, storytelling) help integrate the loss and rebuild a sense of self and world.

8. Grief Is a Whole-Body Experience

- Affects emotions (sadness, anger, guilt, anxiety, relief), cognition ("grief brain"), and the body (fatigue, sleep, appetite, immune and cardiac impacts).
- "Broken-heart syndrome" and increased health risks highlight the need for medical as well as psychological support.

9. Culture and Spirituality Shape Mourning

- Rituals, norms, and beliefs deeply influence how grief is expressed, contained, or constrained.
- Spirituality can comfort, but can also be a site of struggle, doubt, or transformation.

10. Anticipatory and Disenfranchised Grief Need Special Attention

- Anticipatory grief arises before a loss (e.g., terminal illness) and can both help and exhaust caregivers.
- Disenfranchised grief (unrecognized or stigmatized losses) increases risk for complications and often requires explicit validation and intentional ritual.

11. Modern Contexts: Digital Grief and Collective Loss

- Technology creates new mourning spaces (online memorials, grief groups) with both benefits and risks.
- Events like COVID-19 highlight collective grief, disrupted rituals, and the need for creative, public acknowledgment.

12. When Grief Is Traumatic

- Sudden/violent deaths can fuse grief with PTSD (intrusions, hyperarousal, avoidance).
- Treatment often must address both trauma and grief (e.g., EMDR plus grief work).

13. Helpful Supports and Interventions

- Grief counseling, peer support groups, narrative and meaning-focused work, and personal/communal rituals all help people carry grief.

- Self-care, social support, realistic pacing, and permission to feel both sorrow and joy foster resilience.

14. Criteria for Seeking Professional Help

Needed when grief is prolonged, severely impairing, traumatic, or intertwined with suicidality, depression, or substance misuse.

15. Core Reframe: Grief as a Lifelong Testament to Love

- Grief doesn't fully "end"; it changes shape.
- Healing is less about "getting over it" and more about learning to live with an enduring bond—allowing life, meaning, and even joy to grow around the loss.

Chapter 6 Glossary

Anxious Attachment and Jealousy: A pattern in which fear of abandonment and a preoccupation with rejection amplify jealousy and increase the likelihood of coercive, controlling, or abusive responses in romantic relationships (Aracı-İyiaydın et al., 2020; De Cristofaro et al., 2023).

Behavioral Jealousy: Jealousy expressed through observable actions—such as interrogating a partner, checking phones, monitoring social media, or stalking online—that can erode trust and cross into psychological or cyber dating abuse (Aracı-İyiaydın et al., 2020; De Cristofaro et al., 2023).

Cognitive Jealousy: The mental component of jealousy, including suspicious thoughts, intrusive rumination, and imagined scenarios of betrayal; strongly linked with anxious attachment and controlling or abusive behaviors (Aracı-İyiaydın et al., 2020; De Cristofaro et al., 2023).

Compersion: An emotional response—especially discussed in consensual non-monogamy—defined as joy, warmth, or satisfaction in a partner's happiness with another person; often coexists with jealousy and is proposed as a virtue-like alternative to possessive jealousy (Balzarini et al., 2021; Brunning, 2020).

Cyber / Digital Dating Abuse: Coercive, invasive, or controlling behaviors enacted via digital tools (e.g., constant messaging, GPS tracking, password demands, social media surveillance), often justified as "just being jealous" and predicted by anxious attachment and cognitive jealousy (Aracı-İyiaydın et al., 2020).

Discipline Envy / Method Jealousy: In academic contexts, feelings of jealousy toward the prestige, tools, or methods of other disciplines, which can stall progress or, when worked with constructively, spur interdisciplinary creativity and innovation (Kampen, 2025).

Dispositional Mindfulness: An individual's characteristic tendency to attend to present-moment experience with openness and nonjudgment; associated with lower levels of cognitive, emotional, and behavioral jealousy and fewer harmful jealous behaviors in romantic relationships (De Cristofaro et al., 2023).

Emotion of Significance: A way of viewing jealousy not as "mere insecurity" but as an emotion that flares where attachment, identity, and values converge—highlighting what feels precious and at risk (Toohey, 2014; Simon, 2025).

Emotional Detachment (vs. Jealousy): A relational stance in which a lack of jealousy may reflect disengagement, cynicism, or emotional

numbing rather than maturity; Simon warns against equating "no jealousy" with automatic relational health (Simon, 2025).

Emotional Jealousy: The affective side of jealousy (e.g., fear, anger, shame, sadness, hurt) that arises when a bond or status feels threatened, often experienced as overwhelming or destabilizing (De Cristofaro et al., 2023).

Friendship Jealousy (Evolutionary Perspective): Jealousy that arises in close friendships when a friend's attention, loyalty, or intimacy seems threatened by others; research suggests both sex similarities and differences in how these threats are perceived and managed (Krems et al., 2022).

Jealous Admiration: Chesterton's term for a painful yet reverent response to excellence, where jealousy coexists with admiration and can motivate growth; contrasted with a cultural slide toward apathetic indifference (Chesterton, 2023).

Jealous Rumination: Repetitive, intrusive thinking about perceived threats (e.g., "What if they like someone else more?") that intensifies jealousy and increases the risk of acting out in controlling or abusive ways (Aracı-İyiaydın et al., 2020; De Cristofaro et al., 2023).

Jealousy: An emotionally intense response to a perceived threat to a valued relationship or status, usually involving a triad (self, valued other, rival); it can be both destructive (fueling control, abuse, and distress) and potentially constructive (protecting bonds, signaling values, motivating growth) (Toohey, 2014; Simon, 2025).

Jealousy–Compersion Coexistence: The empirical finding that individuals, especially in consensually non-monogamous relationships, often report feeling both jealousy and compersion in the same situations, suggesting these states are not simple opposites but can dynamically interact (Balzarini et al., 2021).

Jealousy-Induced Growth: A constructive trajectory in which jealousy, once named and explored, becomes a catalyst for self-reflection, clearer boundaries, improved communication, creativity, or ethical discernment rather than control or violence (Toohey, 2014; Arnocky et al., 2024; Kampen, 2025; Simon, 2025).

Mate Retention Behaviors: Actions aimed at preventing a partner from leaving or cheating—such as increased affection, reassurance-seeking, or relationship-enhancing behaviors; experimentally, jealousy induced by imagined infidelity increases endorsement of such behaviors (Arnocky et al., 2024).

Mindfulness-Based Jealousy Regulation: The application of mindfulness skills—such as noticing thoughts and bodily cues without immediate reaction—to recognize jealousy early, reduce

rumination, and choose more reflective, values-consistent responses (De Cristofaro et al., 2023).

Possessive Jealousy: A controlling, entitlement-driven form of jealousy that assumes the right to regulate another's contacts, autonomy, or inner life as a condition of one's own security, often linked with coercion and abuse (Aracı-İyiaydın et al., 2020; De Cristofaro et al., 2023).

Protective Jealousy: A more adaptive expression of jealousy that alerts someone to potential threats to a valued relationship and can motivate care, communication, and boundary-setting without coercion ("This matters to me; let's guard it wisely") (Arnocky et al., 2024; Krems et al., 2022).

Social Media Friendship Jealousy: Jealousy triggered by online cues about friends' interactions—such as likes, comments, tags, or photos—that is associated with anxiety, depression, lower friendship quality, and lower overall well-being, especially among younger women (Vaillancourt et al., 2024).

Triangular Structure of Jealousy: The basic relational geometry of jealousy: a self, a valued other (e.g., partner, friend, supervisor), and a real or imagined rival whose presence or possibility triggers threat and comparison (Toohey, 2014).

Virtue of Compersion: Brunning's philosophical proposal that compersion can be cultivated as a moral virtue, redirecting focus from "owning" a partner to caring about their flourishing and agency, even when that stirs discomfort (Brunning, 2020).

Workplace Jealousy: Jealousy experienced in organizational settings, often rooted in perceived injustice, favoritism, or status threats; associated with reduced performance, sabotage, withdrawal, and broader damage to team cohesion and organizational culture (Sahadev et al., 2024).

Chapter 6 References

Ademiluka, S. O. (2025). 1 Thessalonians 4:13 and grief management in Nigerian churches. In *die Skriflig: Tydskrif van die Gereformeerde Teologiese Vereniging, 59*(1), 1–9. https://doi.org/10.4102/ids.v59i1.3123

Arjona, R. (2025). Miss Lupita, the healer: Eriksonian reflections on grieving a mother. *Pastoral Psychology, 74*(3), 439–452. https://doi.org/10.1007/s11089-024-01179-y

Barnardos (n.d.). *Grief and mourning – a cross cultural perspective*. Barnardos Education Hub. Retrieved 2025 from https://www.educators-barnardos.org.uk/resources/g-a-grief-and-mourning-a-cross-cultural-perspective

Chemi, T. (2025). The vitalistic ecology of death: An autoethnographic journey through bereavement and loss. *Qualitative Inquiry, 31*(2), 265–273. https://doi.org/10.1177/10778004241282300

Cleveland Clinic. (2024, April 9). *Anticipatory grief: Symptoms and how to cope*. Health Essentials. https://health.clevelandclinic.org/dealing-with-anticipatory-grief

Coelho, S. (2022, January 25). *What is traumatic grief?* PsychCentral. https://psychcentral.com/health/traumatic-grief

Counseling Today. (2023, December). *The benefits and challenges of grieving online.* Counseling Today Magazine (American Counseling Association). https://www.counseling.org/publications/counseling-today-magazine/article-archive/article/legacy/the-benefits-and-challenges-of-grieving-online

Doka, K. J. (Ed.). (1989). *Disenfranchised grief: Recognizing hidden sorrow*. Lexington, MA: Lexington Books.

Drake, A. E. (2022, August 25). *What is disenfranchised grief?* Full Circle Grief Center Blog. https://fullcirclegc.org/2022/08/25/what-is-disenfranchised-grief/

Dula, V. S., Garay, M. H. A., Lumberio, R. M. E., Sioson, A. M. S., & Laguilles-Villafuerte, S. (2025). Death immortalized: The phenomenology of social media mourning among Filipino millennials. *Illness, Crisis, and Loss, 33*(1), 283–300. https://doi.org/10.1177/10541373231213148

Gabay, G., & Tarabeih, M. (2025). Invalidating the leadership of Muslim spiritual leaders in death from COVID—and shaping the grief journey: A narrative inquiry. *Omega: Journal of Death and Dying, 91*(2), 525–546. https://doi.org/10.1177/00302228221137393

Godman, H. (2019, January 4). *Grieving? Don't overlook potential side effects*. Harvard Health Blog. https://www.health.harvard.edu/blog/grieving-dont-overlook-potential-side-effects-2019010415722

Hartung, H. (2025). Altered spaces of mourning: Loss and grief in times of COVID-19. *Anglo Saxonica, 23*(1). https://doi.org/10.5334/as.174

Harvard Health Publishing. (2015, August 25). *Easing grief through religion and spirituality*. Harvard Health. https://www.health.harvard.edu/mind-and-mood/easing-grief-through-religion-and-spirituality

Keenan, J. F. (2025). Grief as epiphanous. *Theological Studies (Baltimore), 86*(1), 84–108. https://doi.org/10.1177/00405639241312360

Klass, D., Silverman, P. R., & Nickman, S. L. (Eds.). (1996). *Continuing bonds: New understandings of grief*. Washington, DC: Taylor & Francis.

Kübler-Ross, E. (1969). *On death and dying*. New York: Macmillan.

Kuttikat, A., & Madhu, U. (2025). "And so my life became a funeral": Reading grief as resistive intersubjectivity in Han Kang's Human Acts and K. R. Meera's The Gospel of Yudas. *South Asian Review* (South Asian Literary Association), 1–15. https://doi.org/10.1080/02759527.2025.2484934

Neimeyer, R. A. (Ed.). (2002). *Meaning reconstruction & the experience of loss*. American Psychological Association.

Obradović, S., Martinez, N., Dhanda, N., Bode, S., Ntontis, E., Bowe, M., Reicher, S., Jurstakova, K., Kane, J., & Vestergren, S. (2025). Mourning and orienting to the future in a liminal occasion: (Re)defining British national identity after Queen Elizabeth II's death. *British Journal of Social Psychology, 64*(1), e12807–n/a. https://doi.org/10.1111/bjso.12807

Rodriguez, J. L., Wright, G. G., Leopold, P. J., & Petion, A. R. (2025). The bittersweet journey of anticipatory grief: Clinical implications for nurturing caregivers of aging parents. *The Family Journal* (Alexandria, Va.). https://doi.org/10.1177/10664807241312208

Rodríguez-Dorans, E., & Méndez Díaz, D. (2025). Mi amigo Giovanni's Death, a digital performance of a friendship that keeps on living. *International Journal of Performance Arts and Digital Media*, 1–22. https://doi.org/10.1080/14794713.2025.2484518

Silva, M. V., Santos, R. R., & Barbosa, M. (2025). Euthanasia and prolonged grief: A cross-sectional study with bereaved pet owners. *Journal of Veterinary Behavior, 79*, 60–67. https://doi.org/10.1016/j.jveb.2025.04.007

Stroebe, M., & Schut, H. (1999). The dual process model of coping with bereavement: Rationale and description. *Death Studies, 23*(3), 197–224.

Toomey, R. B., Trujillo, L., Abreu, R. L., Rios Garza, A., Hainsworth, S., & Zhao, Z. (2025). The potential harm of loss and grief narratives among families of transgender and nonbinary youth. *Journal of Counseling Psychology, 72*(3), 201–210. https://doi.org/10.1037/cou0000778

Truman, L. (2025). How to care for the caregiver: The power of ritual. *Human-Animal Interactions, 13*(1). https://doi.org/10.1079/hai.2025.0022

Tyrrell, P., Harberger, S., Schoo, C., & Siddiqui, W. (2023). *Kubler-Ross stages of dying and subsequent models of grief*. In StatPearls. Treasure Island, FL: StatPearls Publishing.

Worden, J. W. (2009). *Grief counseling and grief therapy: A handbook for the mental health practitioner* (4th ed.). New York: Springer Publishing.

Chapter 7

The Costs and Benefits of Jealousy

Jealousy is usually cast as an "ugly" emotion—proof that someone is insecure, possessive, or morally deficient. Yet a closer look reveals something more complex. Philosophers, psychologists, and cultural critics alike suggest that jealousy can be both corrosive and constructive: it can erode trust and incite harm, but it can also protect valued bonds, inspire growth, and reveal what matters most to us (Toohey, 2014; Simon, 2025). In this chapter, we explore jealousy as a dual-natured emotion. We will examine its psychological and relational costs, its evolutionary and motivational benefits, and several moderating factors—including dispositional mindfulness and the emerging concept of compersion (joy in another's joy). Rather than simply asking, "Is jealousy good or bad?" we will ask more nuanced questions:

- When does jealousy protect, and when does it control?
- When does it motivate growth, and when does it fuel shame or violence?
- How can jealousy be noticed, named, and transformed rather than denied or indulged?

Throughout, we will draw on empirical and philosophical work to frame jealousy not as a moral verdict on a person's character, but as an emotionally intense signal that can be shaped, regulated, and integrated.

Understanding Jealousy: More Than "Just Insecurity"

Jealousy typically arises when a valued relationship or status feels threatened by a real or imagined rival. It is inherently triangular: self, valued other, and perceived competitor. It can appear in romantic relationships, friendships, family systems, academic and professional arenas, and increasingly in digital spaces.

Toohey (2014) argues that jealousy is deeply embedded in cultural narratives of love, honor, and worth, and not merely a sign of personal pathology. Simon (2025) similarly warns against a cultural swing toward emotional detachment in which the absence of jealousy is sometimes taken as the only sign of health—even when that absence signals disengagement rather than maturity.

From this perspective, jealousy is best understood as an emotion of significance: it flares where attachments, identities, and values converge.

The Shadow Side: Costs of Jealousy

Psychological and Relational Harm

On the cost side, jealousy is strongly associated with distress, conflict, and relational dysfunction. Emotional, cognitive, and behavioral forms of jealousy—such as intrusive rumination, interrogating a partner, or monitoring their phone and social media—are linked with relationship dissatisfaction and abuse (De Cristofaro et al., 2023).

Aracı-İyiaydın et al. (2020) found that anxious attachment and cognitive jealousy predicted both psychological and cyber dating abuse among emerging adults. In their work, jealousy did not show up as a tender sign of caring but as fuel for control, particularly in those who already feared abandonment. When jealousy becomes fused with attachment anxiety and unprocessed fear, it can justify boundary violations, coercion, and even violence.

Clinically, patterns such as constant checking, threats, accusations, and digital surveillance are red flags. They show jealousy functioning less as a protective signal and more as a relational toxin, eroding trust and safety.

Workplace Jealousy and Organizational Costs

Jealousy is not confined to romance. It also appears in professional hierarchies, where it can corrode morale and performance. Sahadev et al. (2024) showed that workplace jealousy, often rooted in perceived injustice, was associated with reduced job performance among frontline workers.

In such environments, jealousy may express itself as subtle sabotage, withholding information, discrediting colleagues, or passive withdrawal. Over time, these behaviors undermine team cohesion and institutional trust. Jealousy here is not only personally painful; it becomes a system-level problem that shapes culture and productivity.

Mental Health and Digital Intensification

Contemporary life adds another amplifier: social media. Vaillancourt et al. (2024) developed a measure of social media friendship jealousy and found strong associations with anxiety, depression, and declines in friendship quality and overall well-being. Younger women reported the highest levels of social media jealousy, suggesting a gendered and developmental vulnerability in online contexts (Vaillancourt et al., 2024).

Online spaces create an almost constant stream of comparison: who is tagged in photos, who liked whose posts, who appears "closer," happier, or more included. In this context, jealousy is frequently stoked by partial information and curated images, leading to misinterpretations and ruminative spirals.

The Constructive Side: Benefits of Jealousy

Despite these significant costs, it would be incomplete to describe jealousy only as destructive. A growing body of research suggests that jealousy can serve adaptive, motivational, and even morally meaningful functions under certain conditions.

Evolutionary and Protective Functions

From an evolutionary perspective, jealousy may have developed to protect valued pair bonds and ensure investment in offspring. Arnocky et al. (2024) found that jealousy induced by imagined partner infidelity increased intentions toward mate retention behaviors, such as relationship-enhancing actions or efforts to strengthen the bond. In this sense, jealousy functions as a warning

system: it alerts an individual to potential threats to relational security and motivates corrective or protective action.

Krems et al. (2022) similarly emphasize the social and evolutionary logic of jealousy in friendships, noting both sex similarities and differences in how relational threats are perceived and managed. Across contexts, jealousy can prompt increased attentiveness, communication, and commitment when it is acknowledged and channeled rather than denied or explosively acted out. The clinical and ethical distinction lies in how jealousy is expressed:

- *Protective jealousy*: "This relationship matters to me; I want us to be intentional about guarding it."
- *Possessive jealousy*: "I am entitled to control your behavior and contacts to feel safe."

Jealousy, Creativity, and Social Comparison

Toohey (2014) argues that jealousy plays a central role in cultural and artistic achievement. Rather than only signaling insecurity, jealousy can generate creative comparison and aspiration: we are stirred by the excellence of others and driven to develop our own capacities.

Kampen (2025) describes this in academic contexts as "discipline envy" and "method jealousy," where researchers feel drawn toward the tools and status of other fields. While this envy can be a barrier—creating paralysis or self-doubt—it can also stimulate intellectual

innovation as scholars incorporate new perspectives and methods (Kampen, 2025).

Chesterton (2023), in a more literary voice, laments a cultural loss of this kind of jealous admiration. Where earlier generations might have experienced jealousy as a painful reverence for excellence, contemporary culture sometimes dulls it into indifference. In that sense, jealousy can be a sign that we still care about greatness, belonging, and identity, even when it hurts.

Emotional Depth and Moral Insight

Jealousy is, at its core, a vulnerable emotion. Simon (2025) argues that the complete absence of jealousy in a romantic relationship is not always a marker of health; in some cases, it reflects emotional detachment or cynicism. When moderated and integrated, jealousy may reflect moral sensitivity—a recognition that infidelity, betrayal, and injustice are genuinely harmful.

From this standpoint, jealousy is not simply "sinful possessiveness" but a signal that certain bonds and commitments matter deeply. It exposes the gap between our values and our lived experience:

- "I value exclusivity; I fear it might be violated."
- "I long to be chosen, and I feel replaceable."
- "I believe I ought to be treated fairly, and I perceive favoritism."

This emotional alarm can lead either to self-righteous control or to honest self-examination and dialogue. In therapy and spiritual direction, jealousy can thus become

an entry point to deeper work on attachment needs, narratives of worth, and relational ethics.

Moderators and Alternatives: Mindfulness, Self-Efficacy, and Compersion

Dispositional Mindfulness as a Protective Factor

Not everyone experiences jealousy with the same intensity or consequences. De Cristofaro et al. (2023) found that dispositional mindfulness—a tendency to attend to present-moment experience with openness and nonjudgment—was associated with lower levels of cognitive, emotional, and behavioral jealousy in romantic relationships. Mindful individuals were less likely to ruminate, catastrophize, or act on jealous impulses in ways that harmed their relationships (De Cristofaro et al., 2023). Mindfulness appears to support:

- *Emotion regulation*: noticing jealousy without immediately acting on it.
- *Cognitive flexibility*: questioning catastrophic interpretations ("They're talking to someone; it must mean…").
- *Self-esteem and self-efficacy*: trusting one's own worth and ability to cope, regardless of others' behavior.

For clinicians, this suggests that interventions that build mindfulness and self-awareness can reduce jealousy's destructive expression and support more reflective responses.

Compersion: Joy in Another's Joy

On the opposite pole of jealousy lies compersion—a term especially discussed in the context of consensual non-monogamy. Compersion describes the experience of joy or warmth in response to a partner's happiness with another person (Balzarini et al., 2021; Brunning, 2020).

Balzarini et al. (2021) found that compersion and jealousy can coexist: people in consensually non-monogamous relationships often report both emotions in response to the same situation. Compersion does not erase jealousy, but it complicates and sometimes counterbalances it by widening the frame of concern from possessiveness to care for the partner's flourishing.

Brunning (2020) explores compersion philosophically as a potential virtue—one that reorients attention away from "owning" a partner toward appreciating their joy and agency. Critics argue that compersion is unrealistic or ethically suspect in certain relational frameworks, while proponents see it as an intentional, cultivated stance that redirects jealousy's energy toward empathy and generosity (Balzarini et al., 2021; Brunning, 2020).

Even within monogamous relationships, elements of compersion can emerge in less controversial forms: feeling genuinely pleased when a partner experiences meaningful friendships, professional recognition, or spiritual growth—even when they are not the center of our attention in those moments.

Clinical and Practical Applications

Assessing Jealousy: Questions of Function and Form

For practitioners, the key questions are not "Does jealousy exist?" but:

Function: What is jealousy trying to protect? What fear or value does it express?

Form: How is it expressed—internally, behaviorally, digitally, relationally?

Context: Is it tied to prior trauma, attachment injury, cultural messages, or current injustices?

Assessment can draw on findings that link jealousy with anxious attachment and abusive behaviors (Aracı-İyiaydın et al., 2020; De Cristofaro et al., 2023), as well as with workplace inequities (Sahadev et al., 2024) and social media dynamics (Vaillancourt et al., 2024).

Intervention Strategies

Several lines of intervention can help clients work with jealousy rather than be ruled by it:

Psychoeducation

Normalize jealousy as a human emotion with both risks and potential purposes (Toohey, 2014; Simon, 2025).

Differentiate between feelings and behaviors: "Feeling jealous is not a moral failure; what you do with it matters."

Mindfulness and Emotion Regulation

Use mindfulness-based practices to help clients notice bodily cues of jealousy early (De Cristofaro et al., 2023). Teach grounding, paced breathing, and self-compassion to reduce impulsive reactive behaviors.

Cognitive and Narrative Work

Identify and challenge cognitive distortions ("If my partner talks to others, I am worthless"). Re-author narratives of worth and attachment, incorporating evolutionary and relational perspectives (Arnocky et al., 2024; Krems et al., 2022). Explore how jealousy fits into the client's broader life story and identity.

Attachment and Communication

Address underlying attachment injuries that make jealousy more intense or rigid (Aracı-İyiaydın et al., 2020). Coach couples or colleagues in transparent communication, boundary-setting, and repair. Explore appropriate disclosures in digital spaces to reduce secrecy-fueled suspicion.

Values and Ethics Work

Help clients clarify what they believe about fidelity, exclusivity, fairness, and commitment (Simon, 2025). In contexts where compersion is relevant, explore whether and how it aligns with personal and relational values (Balzarini et al., 2021; Brunning, 2020).

Digital Hygiene and Context Management

Based on findings around social media jealousy (Vaillancourt et al., 2024), support clients in setting boundaries around online comparison, tracking, and performative posting. Encourage thoughtful use of technology in line with their mental health and relational goals.

Beyond Control: Transforming Jealousy

At its worst, jealousy becomes an excuse for control and harm. At its best, it becomes an invitation to:

- Deepen honesty about our fears.
- Clarify what we value in relationships and work.
- Cultivate courage, empathy, and shared responsibility.

This transformation does not mean eliminating jealousy but relating to it differently—as a messenger rather than a master.

Summary: Redeeming a Human Emotion

Jealousy is neither a trivial quirk nor an emotion to be eradicated. As the research and reflections reviewed here suggest, it carries both significant costs and meaningful benefits. It is implicated in abuse, workplace dysfunction, and digital-era distress (Aracı-İyiaydın et al., 2020; Sahadev et al., 2024; Vaillancourt et al., 2024). At the same time, it can signal commitment, protect valued relationships, and stimulate creativity and growth (Arnocky et al., 2024; Toohey, 2014; Kampen, 2025).

Mindfulness, emotional literacy, and thoughtful cultural and ethical reflection can help individuals and communities shift jealousy away from control and toward insight and care (De Cristofaro et al., 2023; Simon, 2025). Compersion offers one provocative example of this shift, challenging possessive instincts and inviting joy in others' flourishing (Balzarini et al., 2021; Brunning, 2020).

Ultimately, the goal is not to be people who never feel jealous, but people who recognize and work with jealousy wisely—people who can notice its signal, discern its meaning, and choose responses that honor both love and freedom. In this way, jealousy can become not just a threat to be managed, but a teacher that, when held in the light of compassion and accountability, reveals what we treasure most and how we might protect it without destroying it.

Chapter 7 Key Takeaways

The Costs and Benefits of Jealousy

Jealousy is not purely "bad." It is a deeply human, morally and culturally loaded emotion that can be both corrosive and constructive, depending on how it's understood and expressed. Unregulated jealousy carries serious costs:

- In romantic relationships, it is linked to rumination, control, psychological and cyber abuse, especially among anxiously attached partners.
- In workplaces, jealousy fueled by perceived injustice undermines performance, trust, and team cohesion.
- On social media, friendship jealousy is associated with anxiety, depression, and poorer friendship quality, especially for younger women.

Jealousy can serve adaptive, protective functions:

- From an evolutionary lens, jealousy can act as a warning system that signals threats to valued bonds and motivates protective, mate-retention behaviors.
- In friendships and professional contexts, it can highlight what or whom we value, prompting investment and repair.

Jealousy can fuel creativity and growth:

In intellectual and cultural life, "discipline envy" and method jealousy may push people to innovate, stretch

into new areas, or improve their skills—if they don't collapse into shame or paralysis.

Jealousy can reflect emotional depth and moral concern:

- Its presence can signal that commitments, fidelity, fairness, and belonging truly matter.
- The goal is not zero jealousy, but jealousy that is acknowledged, examined, and translated into honest dialogue rather than control.

Mindfulness helps regulate jealousy:

- Dispositional mindfulness is associated with lower cognitive, emotional, and behavioral jealousy.
- Mindful awareness supports emotion regulation, reduces rumination, and increases flexibility in how jealousy is interpreted and acted on.

Compersion offers a radical counterpoint:

- Compersion—joy in a partner's joy with others—can coexist with jealousy and sometimes counterbalance it.
- It represents a shift from possessiveness to care for the other's flourishing and can be cultivated in some relational and ethical frameworks.

Clinical work focuses on function, form, and context:

- Core questions: What is jealousy trying to protect? How is it being expressed? What attachment wounds, cultural messages, or real injustices are involved?

- Helpful interventions include psychoeducation, mindfulness, cognitive/narrative work, attachment repair, communication skills, values clarification, and digital hygiene.

The task is transformation, not eradication:

The aim is not to become people who never feel jealous, but people who can notice it, understand it, and choose responses that align with love, safety, fairness, and freedom.

Chapter 7 Glossary

Anxious Attachment and Jealousy: A pattern in which fear of abandonment and a preoccupation with being rejected intensify jealousy and make coercive, controlling, or abusive behaviors more likely in romantic relationships (Aracı-İyiaydın et al., 2020; De Cristofaro et al., 2023).
Behavioral Jealousy: Observable actions driven by jealousy—such as interrogating a partner, checking messages, monitoring social media, or engaging in digital surveillance—that can erode trust and may cross into psychological or cyber dating abuse (Aracı-İyiaydın et al., 2020; De Cristofaro et al., 2023).
Cognitive Jealousy: Jealousy expressed primarily through thoughts and mental scenarios—such as suspicious interpretations, intrusive ruminations, and repetitive "what if" narratives about betrayal—often associated with anxious attachment and controlling behavior (Aracı-İyiaydın et al., 2020; De Cristofaro et al., 2023).
Compersion: An emotional response—especially discussed in consensual non-monogamy—characterized by joy, warmth, or satisfaction in a partner's happiness with another person; often coexisting with jealousy and proposed as a virtue-like alternative to possessiveness (Balzarini et al., 2021; Brunning, 2020).
Cyber / Digital Dating Abuse: Controlling, invasive, or threatening behaviors enacted through digital technologies (e.g., constant texting, password demands, tracking, online monitoring) often justified by jealousy and strongly associated with anxious attachment and cognitive jealousy (Aracı-İyiaydın et al., 2020).
Discipline Envy / Method Jealousy: Feelings of envy or jealousy toward the perceived prestige, tools, or methods of other academic fields or approaches, which can produce paralysis and self-doubt but also stimulate intellectual innovation and cross-disciplinary creativity (Kampen, 2025).
Dispositional Mindfulness: A relatively stable tendency to attend to present-moment experience with openness and nonjudgment; associated with lower levels of cognitive, emotional, and behavioral jealousy and with healthier responses to perceived relational threat (De Cristofaro et al., 2023).
Emotion of Significance: A way of understanding jealousy as an indicator of what matters most—an emotion that flares at points where attachment, identity, values, and perceived threat intersect, rather than as "mere insecurity" (Toohey, 2014; Simon, 2025).

Emotional Detachment (in Contrast to Jealousy): A stance in which the near-complete absence of jealousy in a relationship may reflect disengagement, cynicism, or avoidance rather than emotional maturity; used by Simon to caution against equating "no jealousy" with automatic health (Simon, 2025).
Emotional Jealousy: The affective component of jealousy, including fear, anger, sadness, shame, and hurt that arise in response to perceived relational threat or exclusion (De Cristofaro et al., 2023).
Friendship Jealousy: Jealousy arising in close friendships in response to perceived relational threats (e.g., a friend prioritizing someone else), understood as having social and evolutionary logic with both sex similarities and differences in triggers and responses (Krems et al., 2022).
Jealous Admiration / Reverent Jealousy: A more literary notion of jealousy as a painful yet reverent response to excellence—feeling stung by another's greatness while also drawn toward it—a dynamic Chesterton suggests is being lost in cultures that slide toward indifference (Chesterton, 2023).
Jealousy: An emotionally intense, often painful response to a perceived threat to a valued relationship or status, typically involving a triangular structure (self–valued other–rival); it can be both corrosive (fueling control, shame, and harm) and constructive (protecting bonds, motivating growth, revealing values) (Toohey, 2014; Simon, 2025).
Jealousy-Induced Growth: A constructive trajectory in which jealousy, when acknowledged and explored, motivates self-reflection, improved communication, boundary clarification, or creative development rather than control or violence (Toohey, 2014; Arnocky et al., 2024; Kampen, 2025).
Mate Retention Behaviors: Actions aimed at maintaining a romantic relationship and reducing the risk of partner defection (e.g., increased affection, investment, reassurance-seeking); experimentally, jealousy induced by imagined infidelity can increase positive attitudes toward these behaviors (Arnocky et al., 2024).
Mindfulness-Based Jealousy Regulation: The use of mindfulness skills—such as observing thoughts and sensations without acting on them—to notice jealousy early, reduce rumination, and create space for more reflective, values-consistent responses (De Cristofaro et al., 2023).
Possessive Jealousy: A controlling expression of jealousy that treats the partner or other as an object to be monitored and constrained ("I am entitled to control your behavior to feel safe"), often justifying

boundary violations and abuse (Aracı-İyiaydın et al., 2020; De Cristofaro et al., 2023).

Protective Jealousy: A form of jealousy that alerts someone to potential threats to a valued bond and motivates relational care, communication, and boundary-setting without coercion or control ("This relationship matters; let's guard it intentionally") (Arnocky et al., 2024; Krems et al., 2022).

Social Media Friendship Jealousy: Jealous feelings triggered by online cues about friends' interactions and connections (e.g., likes, comments, tags), linked with anxiety, depression, and reduced friendship quality and well-being, particularly among younger women (Vaillancourt et al., 2024).

Triangular Structure of Jealousy: The basic relational geometry of jealousy: a self, a valued other (e.g., partner, friend, supervisor), and a real or imagined rival whose presence or possibility triggers threat and comparison (Toohey, 2014).

Workplace Jealousy: Jealousy arising in organizational settings—often rooted in perceived injustice, favoritism, or status threat—that can lead to withdrawal, sabotage, reduced performance, and broader cultural dysfunction (Sahadev et al., 2024).

Chapter 7 References

Aracı-İyiaydın, A., Toplu-Demirtaş, E., Akçabozan-Kayabol, N. B., & Fincham, F. D. (2020). *I ruminate therefore I violate: the tainted love of anxiously attached and jealous partners.* [Manuscript submitted for publication].

Arnocky, S., Kubinec, K., MacKinnon, M., & Mazmanian, D. (2024). An experimental test of jealousy's evolved function: Imagined partner infidelity induces jealousy, which predicts positive attitude towards mate retention. *Evolutionary Psychology, 22*(3), 14747049241267226. https://doi.org/10.1177/14747049241267226

Balzarini, R. N., McDonald, J. N., Kohut, T., Lehmiller, J. J., Holmes, B. M., & Harman, J. J. (2021). Compersion: When jealousy-inducing situations don't (just) induce jealousy. *Archives of Sexual Behavior, 50*(4), 1311–1324. https://doi.org/10.1007/s10508-020-01853-1

Brunning, L. (2020). Compersion: An alternative to jealousy? *Journal of the American Philosophical Association, 6*(2), 225–245. https://doi.org/10.1017/apa.2019.35

Chesterton, G. K. (2023). Jealousy. *Chesterton Review, 49*(3), 315–316. https://doi.org/10.5840/chesterton2023493/452

De Cristofaro, V., Pellegrini, V., Salvati, M., & Giacomantonio, M. (2023). Examining and understanding patterns of cognitive, emotional, and behavioral jealousy: Dispositional mindfulness as a protective factor in romantic relationships. *Journal of Social and Personal Relationships, 40*(5), 1368–1397. https://doi.org/10.1177/02654075221139631

Kampen, A. (2025). *Jealousy, jealousy: Exploring discipline envy and method jealousy in developing research topics in information science*. Proceedings of the Annual Conference of CAIS. https://doi.org/10.29173/cais1973

Krems, J. A., Williams, K. E. G., Merrie, L. A., Kenrick, D. T., & Aktipis, A. (2022). Sex (similarities and) differences in

friendship jealousy. *Evolution and Human Behavior, 43*(2), 97–106. https://doi.org/10.1016/j.evolhumbehav.2021.11.005

Sahadev, S., Wood, G., Arshad Khan, M., Malhotra, N., & Demirbag, M. (2024). Justice, jealousy and performance: Evidence from neo-feudal Pakistan. *Journal of Business Research, 183*, 114847. https://doi.org/10.1016/j.jbusres.2024.114847

Simon, M. (2025). Redeeming jealousy. *The Hedgehog Review, 27*(1), 120–.

Toohey, P. (2014). *Jealousy*. Yale University Press. https://doi.org/10.12987/9780300190489

Vaillancourt, T., Brittain, H., Eriksson, M., Krygsman, A., Farrell, A. H., Davis, A. C., Volk, A. A., & Arnocky, S. (2024). Social media friendship jealousy. *Evolutionary Psychology, 22*(1), 14747049231225738. https://doi.org/10.1177/14747049231225738

Chapter 8

What About Pain?

Pain is one of the most common reasons people seek help, yet it remains surprisingly difficult to define, assess, and treat. The International Association for the Study of Pain (IASP) now describes pain as "an unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage," emphasizing that pain is not simply a physical signal but also a subjective emotional experience (IASP, 2020; Raja et al., 2020). Still, many scholars argue that this definition does not go far enough: cognition (how we think about pain) and social context (how others respond to our pain) are not mere add-ons but core parts of what pain is (Pillai Riddell et al., 2022).

In this chapter, we look at pain through a biopsychosocial lens. We explore how emotions and thoughts can amplify pain; how pain responses are learned in families and cultures; how social trust shapes pain expectations; why a purely pharmacological approach—especially opioids—is not enough; why communication is so hard in dementia and pediatric contexts; what clinicians still don't know; and how ongoing conceptual debates about pain's very definition shape care. The question, "What about pain?" turns out to require an answer that is psychological, social, ethical, and developmental—not just biological.

Pain as a Biopsychosocial Experience

Clinically, it is tempting to treat pain as a straightforward consequence of tissue damage: find the lesion, fix the lesion, the pain stops. For acute pain, this sometimes

works. But for chronic pain—pain lasting longer than three to six months, often outliving any clear injury—that model breaks down. Research consistently shows that:

- Biology (nociception, inflammation, neural sensitization),
- Psychology (affect, beliefs, catastrophizing, trauma), and
- Social context (family responses, cultural norms, healthcare interactions) intertwined to shape what people feel and how they suffer (Haythornthwaite et al., 2024; Barke et al., 2020; Tidick et al., 2025; Yamin et al., 2024).

A trauma history, for instance, increases risk for chronic pain in adulthood, not just via physical injuries but also through altered stress systems and pain processing (Bussières et al., 2023; Yamin et al., 2024). Adverse childhood experiences, functional pain in youth (like recurrent abdominal pain), and chronic stress can all "prime" the nervous system toward future pain problems (Walker et al., 2010; Bussières et al., 2023).

A modern approach to pain therefore begins with a simple conviction: pain is real, and it is complex. Our job is not only to dampen nociceptive input, but to understand the emotional, cognitive, and social ecology in which pain lives.

Psychological and Emotional Dimensions of Pain

Negative Affect and the Pain–Distress Cycle

Emotion and pain are closely linked. Depression, anxiety, anger, and general negative affect can all intensify pain, and persistent pain in turn fuels emotional distress—forming a feedback loop (Barke et al., 2020; Tidick et al., 2025). People with high negative affect often have a "primed" alarm system: the same physical stimulus may feel more painful because it is filtered through a more anxious or hopeless lens.

Stein et al. (2025), for example, found that negative affect and pain catastrophizing help explain why people with borderline personality features report more pain: emotional instability heightens distress, which intensifies catastrophic thinking, which in turn amplifies pain.

This cycle also runs in reverse: when mood improves—through therapy, meaningful activity, social connection, or sometimes medication—pain often becomes more manageable, even when the underlying pathology has not changed.

Pain Catastrophizing: When Thinking Makes Pain Louder

Pain catastrophizing (pCAT) is one of the most studied psychological predictors of pain outcomes. It reflects a pattern of:

- Magnification ("This pain is unbearable.")
- Rumination ("I can't stop thinking about how bad it is.")
- Helplessness ("There is nothing I can do.")

Haythornthwaite et al. (2024) describe catastrophizing as a cognitive–affective amplifier: negative thoughts about pain activate stress systems, heighten vigilance, and literally increase nociceptive gain in the nervous system. Over time, catastrophizing is linked to:

- Higher pain intensity
- More disability
- Poorer treatment response
- Greater risk of pain chronification (Simic et al., 2024; Crombez et al., 2020)

Importantly, catastrophizing is learned and modifiable, not a fixed character flaw. Cognitive-behavioral therapies, mindfulness-based interventions, and pain neuroscience education can all reduce catastrophizing and are associated with better pain and function (Hilton et al., 2017; Murillo et al., 2023; Louw & Riera-Gilley, 2024).

Beyond Catastrophizing: Trauma and Emotional Distress

Recent work argues that we must look beyond catastrophizing alone and attend to trauma and broader emotional distress in chronic pain (Barke et al., 2020; Yamin et al., 2024). Many individuals with severe chronic pain have trauma histories—developmental, interpersonal, or medical—and pain can function as both a physical symptom and a trauma echo. In such cases, treating pain without addressing trauma is like bailing water without fixing the leak.

Taken together, these findings support a cognitive–affective model of pain: negative mood, stress, and catastrophic beliefs fuel one another and amplify pain. The encouraging counterpoint is that interventions targeting mood, meaning-making, and thought patterns can soften the pain experience, even when we cannot eliminate it.

Social Learning: How We Learn to Hurt

Pain is deeply personal, but it is also profoundly social. From infancy, we learn what pain means and how to respond by watching others.

Early Learning in Families

Children don't automatically know whether a scraped knee is a catastrophe or a manageable hurt; they look to caregivers. O'Sullivan et al. (2021) and related developmental work show that:

- Highly anxious, overprotective, or catastrophizing caregiver responses (rushing in, panicking, repeatedly asking "Does it hurt a lot?") can heighten child distress and reinforce fearful attention to pain.

- Calm, validating, and coping-focused responses ("Ouch, that did hurt. Let's clean it up and then you can go back to playing.") foster resilience and self-regulation.

- Operant principles apply: attention, comfort, and escape from demands can unintentionally reinforce pain behaviors. Over time, children may learn that

expressing pain is the best way to get support or avoid stressors. This does not mean they are "faking"; it means pain has become one of their most effective communication tools.

Modeling, Beliefs, and Intergenerational Patterns

Children also absorb how parents talk about their own pain. A parent who constantly verbalizes catastrophic beliefs ("This pain will ruin my life.") or who is immobilized by pain sends powerful messages about pain's meaning and uncontrollability (Haythornthwaite et al., 2024). Research suggests that:

- Children of parents with chronic pain are at higher risk for chronic pain themselves, partly due to social modeling and shared beliefs.

- Repeated pairings of pain with catastrophizing and avoidance may shape the developing nervous system toward greater sensitivity and fear.

Conversely, seeing adults acknowledge pain, use coping strategies, and still engage in valued activities models a different narrative: pain is real and important, but not always all-powerful.

Beyond the Family: Culture and Peers

As children grow, peers, teachers, and cultural norms also shape pain responses. Some contexts valorize stoicism ("Don't be a baby."); others normalize expressive pain behavior. These norms influence:

- Whether people feel safe disclosing pain

- Whether they minimize or overemphasize symptoms
- Whether they seek help early, late, or never

Pillai Riddell et al. (2018, 2022) highlight the developmental arc: infants initially rely entirely on caregivers for pain regulation; over time, social learning and self-regulation capacities integrate into a complex interpersonal "pain system."

For clinicians, this means that by the time an adult presents with chronic pain, they bring decades of social learning. Exploring family stories of pain ("Who in your family has struggled with pain, and how was it handled?") can open important therapeutic doors.

Social Factors and Trust: Pain as a Shared Story

Pain is not just a signal; it is also a story we tell ourselves, often with other people's help.

How Trusted Advice Shapes Pain

Krahé et al. (2024) showed that pain expectations and tolerance can be shifted by social advice, particularly when the adviser is perceived as trustworthy. In their cold pressor experiment, participants:

- Adjusted their expectations of pain tolerance toward the advice they received
- Did so more strongly when the adviser was framed as credible

- Then showed actual changes in pain tolerance consistent with those expectations

In Bayesian terms, trusted social information becomes a "high-precision prior" that the brain uses to interpret sensory input. Practically, this means:

- A trusted clinician who confidently and honestly frames a procedure as tolerable and meaningful can reduce distress and improve coping.

- A fear-inducing, ambiguous, or dismissive message—especially from someone the patient must rely on—can act as a social nocebo, increasing pain and avoidance.

Trust, Placebo, and Nocebo

Placebo and nocebo research dovetails with this finding: expectations built in relationships influence endogenous pain modulation systems (e.g., opioids, dopamine) (Levenig et al., 2024). Trust is central. When patients feel disbelieved or disrespected, their pain often intensifies and their engagement drops.

For trauma survivors—who may have good reasons to distrust systems—building trust may itself be one of the most potent "analgesics" we have. Clear, consistent, compassionate communication is not an optional "soft skill"; it is core pain treatment.

Most pain care begins with medication:

- Non-opioid analgesics (acetaminophen, NSAIDs)

- Opioids (morphine, oxycodone, tramadol)

- Adjuvants (antidepressants, anticonvulsants, topical agents, etc.)

These can be effective for acute and some cancer-related pain. But in chronic non-cancer pain, the picture is more sobering:

- Long-term opioids carry risks of tolerance, dependence, opioid use disorder, overdose, and opioid-induced hyperalgesia—a paradoxical increase in pain sensitivity (Kim et al., 2020; Brennan et al., 2007).

- Non-opioid medications often produce only modest relief for a subset of patients and may be limited by side effects (Kim et al., 2020).

- Kim et al. (2020) note that trends like increased tramadol prescribing were attempts to find "safer" pharmacologic solutions, but they also illustrate an entrenched habit: reaching for pills when more holistic strategies are urgently needed.

The Shift Toward Multimodal, Integrative Pain Care

Chronic pain is now widely recognized as its own disease process, involving:

- Central sensitization and "pain system hypersensitivity"

- Altered descending pain modulation

- Psychological and social drivers (Moseley et al., 2004; Murillo et al., 2023; Raja et al., 2020)

Louw and Riera-Gilley (2024) argue bluntly that a "pure pharmaceutical approach, especially opioids, is not the answer" for chronic pain. Instead, they and others advocate for:

- *Pain neuroscience education* (PNE): teaching patients how pain works—emphasizing that hurt does not always mean harm, and that a sensitized system can be calmed (Moseley et al., 2004; Louw & Riera-Gilley, 2024).

- *Movement and graded activity*: restoring confidence in the body, reducing kinesiophobia, and re-engaging life roles (Murillo et al., 2023).

- *Psychological therapies*: CBT, ACT, mindfulness, trauma-focused work, and other approaches that address catastrophizing, fear, and meaning (Hilton et al., 2017; Yamin et al., 2024).

- *Social support and role rehabilitation*: helping people reconnect to work, family, and community in ways that are sustainable.

- *Interdisciplinary pain programs*—bringing together medicine, psychology, physical therapy, occupational therapy, and sometimes spiritual care—often outperform single-modality treatments (Brennan et al., 2007; Raja et al., 2020).

In this paradigm, medications are tools, not masters. They may have an important role, but they sit alongside

education, movement, emotion work, and social intervention, not above them.

Communication Challenges: When Pain Is Hard to Say

Pain assessment and treatment depend on communication. But what happens when people cannot easily express pain—or are not believed when they do?

Dementia and Nonverbal Populations

Tsai et al. (2022) examined nursing documentation for hospitalized patients with dementia and found:

- Pain was often assessed with self-report scales, even when cognitive impairment made such reports questionable.
- Observational tools designed for non-communicative patients (e.g., PAINAD) were rarely used.
- There was a weak linkage between recorded pain scores and actual analgesic administration.

In practice, this means that people with dementia often experience under-recognized and undertreated pain, with consequences for agitation, function, and length of stay (Tsai et al., 2022). Behaviors labeled as "resistance," "wandering," or "agitation" may in fact be expressions of discomfort or pain. Improving pain care in dementia requires:

- Routine use of validated observational tools

- Training staff to interpret nonverbal cues and to listen to family members' observations

- Embedding pain as a standing item in care plans and handoffs

In pediatrics, communication about pain is shaped by development and family dynamics. Young children may:

- Struggle to verbalize pain

- Be fearful of "getting in trouble" if they complain

- Express pain behaviorally (withdrawal, tantrums, clinginess)

Moehl, Emerson, Bursch, and others (e.g., Emerson & Bursch, 2020; Tam et al., 2020) highlight that:

- Honest, age-appropriate preparation for procedures reduces distress ("You'll feel a quick poke that might sting like a bee.").

- Including the child—using tools like FACES scales, metaphors, and stories—builds trust.

- Parents need clear, consistent instructions and time to ask questions; stress at discharge can undermine retention, so written materials and follow-up contact help (Tam et al., 2020).

- In both dementia and pediatric care, a core principle applies: when patients cannot speak clearly about their pain, the burden shifts to us. We

must become careful observers, skilled translators, and advocates.

Educating and Training Healthcare Providers

Persistent Knowledge Gaps

Despite pain's prevalence, pain education in professional training remains surprisingly thin. Zuazua-Rico et al. (2022) found that final-year nursing students in Spain scored, on average, about 60% on a standardized pain knowledge and attitudes test—insufficient for safe practice. Common gaps included:

- Misconceptions about opioids (risk, dosing, dependence)
- Weak understanding of pain assessment tools across ages
- Limited appreciation of chronic pain as a biopsychosocial condition

Similar patterns have been found among medical students and other disciplines. Given that adequate pain management has been described as a fundamental human right (Brennan et al., 2007), this educational gap becomes an ethical concern.

Experiential and Interprofessional Learning

Traditional lectures are not enough. Hudon et al. (2024) piloted an experiential learning approach in which physiotherapy students briefly experienced a painful

stimulus and then reflected together. Students reported that:

- Feeling pain themselves increased engagement with the topic
- Seeing diverse responses among peers highlighted pain's subjectivity
- The experience deepened empathy and a sense of clinical responsibility
- This kind of experiential learning, combined with reflective discussion, may help move pain from an abstract topic to a deeply human one.
- In parallel, interprofessional education—training physicians, nurses, therapists, and others together around pain cases—can:
- Build shared language and concepts (e.g., using PNE principles)
- Reduce fragmented, contradictory messaging to patients
- Encourage collaborative care planning (Louw & Riera-Gilley, 2024)

Attitudes, Bias, and Culture

Education must also address attitudes and implicit biases: Myths such as "children don't feel pain as much," "older adults complain less because they hurt less," or

"certain groups exaggerate pain" contribute to disparities (Reis et al., 2022).

Cultural differences in expressing pain can lead to under-treatment if clinicians interpret quiet suffering as absence of pain, or expressive suffering as exaggeration (Reis et al., 2022). Training that integrates pain science with cultural humility and self-reflection is crucial. The goal is not only knowledge, but a culture of compassionate, evidence-informed pain care.

Rethinking What Pain Is: Conceptual and Definitional Debates

Updating the Definition

The revised IASP definition was a major step toward acknowledging pain's subjectivity and the reality of chronic pain without clear tissue damage (IASP, 2020; Raja et al., 2020). Yet, as Pillai Riddell et al. (2022) argue, cognitive and social dimensions still deserve explicit recognition.

They note that:

- Thoughts (interpretations, expectations, memories) and
- Social context (caregiver responses, cultural meanings, relational safety)

are not just modifiers but integral parts of the pain experience. A definition that emphasizes only sensory and emotional facets risks reinforcing narrow biomedical

approaches and underrecognizing therapies that target cognition and social environment.

Pain in Those Who Cannot Report It

Definitional questions become especially acute for infants and individuals with severe cognitive impairment. Historically, infants' pain was grossly undertreated due to myths about their nervous systems; we now know they experience pain and that early pain can shape later pain sensitivity (Pillai Riddell et al., 2022; Walker et al., 2010).

Consensus groups have developed specific definitions for acute and chronic pain in infants, emphasizing that: Inability to verbally report does not mean pain is absent Behavioral and physiological indicators must be taken seriously (Pillai Riddell et al., 2022)

These definitional moves carry practical weight: they mandate that we assess and treat pain ethically in nonverbal populations.

Language, Labels, and Utility

Moseley and colleagues (2023) have raised concerns about some emerging labels, such as "nociplastic pain." While intended to capture pain arising from altered nociception without clear tissue damage, the term may be confusing for patients and clinicians. Moseley et al. argue that language must be both conceptually sound and clinically useful.

Their surveys suggest that phrases like "pain system hypersensitivity" resonate more with patients, offering a lay-accessible explanation that still reflects underlying

mechanisms. This is part of the broader "Explain Pain" movement: using metaphors and language that validate pain as real, highlight the nervous system's role, and foster hope rather than resignation (Moseley et al., 2004; Louw & Riera-Gilley, 2024).

Definitions and labels are not mere academic exercises. They shape research, policy, reimbursement, and—most importantly—the stories patients and clinicians tell about pain. A definition that includes cognitive and social components, paired with language that patients can understand, invites truly biopsychosocial care.

Summary: Meeting Pain with Breadth and Compassion

So—what about pain?

Pain is:

- A biological alarm and sometimes a maladaptive, hypersensitized signal
- An emotional experience, intensified or eased by mood and meaning
- A cognitive process, shaped by beliefs, expectations, and attention
- A social phenomenon, learned in families, negotiated in cultures, and co-constructed in clinical relationships

A moral and human rights issue, given the suffering that untreated or poorly treated pain produces (Brennan et al., 2007)

This chapter has traced how negative affect and catastrophizing can amplify pain (Haythornthwaite et al., 2024; Tidick et al., 2025; Stein et al., 2025), how children learn pain responses from caregivers (O'Sullivan et al., 2021; Pillai Riddell et al., 2022), how trusted advice shapes expectations and tolerance (Krahé et al., 2024), and why chronic pain care must go far beyond opioids (Kim et al., 2020; Louw & Riera-Gilley, 2024). We have seen the risks of communication failures in dementia and pediatrics (Tsai et al., 2022), and the urgent need for better training and cultural humility in healthcare (Zuazua-Rico et al., 2022; Hudon et al., 2024; Reis et al., 2022). Finally, we have considered the ongoing evolution of pain definitions and terminology and why they matter (Raja et al., 2020; Pillai Riddell et al., 2022; Moseley et al., 2023).

For clinicians, educators, and helpers, a few implications stand out:

- *Believe people when they say they hurt*—and look for pain when they cannot say it.
- *Treat the person, not just the nociceptor*. Attend to emotions, thoughts, history, relationships, and culture.
- *Use words carefully*. Honest, hopeful, trauma-informed explanations can themselves modulate pain.
- *Work in teams*. No single discipline can adequately address chronic pain alone.

- *Teach and learn continuously*. Pain science is evolving; so must we.

We may never fully remove pain from the human condition. But by embracing a broad, integrative understanding of pain—and by meeting those in pain with informed compassion—we can significantly reduce unnecessary suffering and help people live more fully within, and sometimes beyond, their pain.

Chapter 8 Key Takeaways

About Pain

- Pain is biopsychosocial, not just biological.
- It's a sensory, emotional, cognitive, and social experience—injury is only one piece of the picture.
- Emotions and thoughts can turn pain up or down.
- Negative affect (anxiety, depression, anger) and pain catastrophizing amplify pain and disability.
- Changing thoughts and mood (CBT, mindfulness, PNE) can soften the pain experience even when tissue damage persists.
- Pain responses are learned in relationships.
- Children learn what pain "means" and how to react by watching caregivers and others.
- Catastrophizing, fear, and avoidance can be transmitted across generations through modeling and reinforcement.
- Social context and trust shape pain expectations and outcomes.
- What trusted people say about pain (e.g., "You'll cope with this" vs. "This will be awful") changes expectations and actual pain tolerance.

- Clinician–patient trust is itself an analgesic asset—or a nocebo risk when trust is damaged.
- Medications help, but cannot solve chronic pain alone.
- Opioids and other drugs have real roles but limited long-term benefit and significant risks.
- Best practice is multimodal: meds + education + movement + psychological therapies + social support.
- Communication barriers leave vulnerable groups in pain.
- People with dementia and young children are at high risk for under-recognized and undertreated pain.
- We must rely on observational tools, caregiver input, and developmentally appropriate communication.
- Clinicians are undertrained in pain—and it shows.
- Many health professionals graduate with substantial knowledge gaps in pain science, assessment, and management.
- Experiential, interprofessional, and empathy-focused training can improve both understanding and care.
- Definitions and language matter.

- Narrow sensory–emotional definitions of pain miss cognitive and social dimensions and can constrain care.

- Terms and explanations should be scientifically sound and understandable and validating to patients.

- Ethically, adequate pain care is a human rights issue.

- Untreated or poorly treated pain is not inevitable; it often reflects system failures in knowledge, communication, and equity.

Bottom line: Effective pain care means believing patients, understanding context, addressing mind and body, and working in teams—treating the person in pain rather than chasing pain signals alone.

Chapter 8 Glossary

Acute Pain: Short-term pain that typically follows injury, surgery, or illness and is closely tied to tissue damage; often improves as the underlying cause heals and fits the "find the lesion, fix the lesion" model (Raja et al., 2020).
Adverse Childhood Experiences (ACEs): Stressful or traumatic experiences in childhood—such as abuse, neglect, or family dysfunction—that increase the risk of chronic pain and other health problems in adulthood by altering stress and pain-processing systems (Walker et al., 2010; Bussières et al., 2023).
Biopsychosocial Model of Pain: An approach that understands pain as shaped by biological processes (nociception, inflammation, neural sensitization), psychological factors (affect, beliefs, catastrophizing, trauma), and social context (family responses, cultural norms, healthcare interactions) rather than by tissue damage alone (Barke et al., 2020; Haythornthwaite et al., 2024; Tidick et al., 2025).
Chronic Pain: Pain that persists beyond the expected period of healing—typically longer than three to six months—and may outlast any clear injury, often involving sensitized neural systems and strong psychological and social influences (Raja et al., 2020; Murillo et al., 2023).
Cognitive–Affective Model of Pain: A framework emphasizing that thoughts (e.g., catastrophizing), mood (e.g., depression, anxiety), and stress interact to amplify pain and disability, but can also be targeted with psychological interventions to soften the pain experience (Barke et al., 2020; Haythornthwaite et al., 2024; Yamin et al., 2024).
Cold Pressor Task: An experimental pain procedure in which participants immerse a hand or forearm in cold water; often used to study how expectations, trust, and social advice shape pain tolerance and experience (Krahé et al., 2024).
Culture and Pain Expression: The ways in which cultural norms and beliefs shape how people show, minimize, or hide pain, influencing help-seeking, clinician interpretation, and treatment disparities (Reis et al., 2022; Pillai Riddell et al., 2022).
Dementia-Related Pain Assessment: The specialized process of identifying and managing pain in people with dementia, using observational tools and careful interpretation of behavior because self-report may be limited or unreliable (Tsai et al., 2022).
Emotional Distress (in Chronic Pain): A cluster of negative emotional states—such as depression, anxiety, anger, and general negative affect—that both worsen pain and are worsened by pain,

forming a bidirectional feedback loop (Barke et al., 2020; Tidick et al., 2025).

Experiential Pain Education (for Clinicians): Teaching approaches that invite health professional students to experience and reflect on pain themselves, enhancing empathy, engagement, and a sense of responsibility for pain care (Hudon et al., 2024).

Functional Pain / Functional Abdominal Pain: Pain symptoms (often in childhood) with significant distress and impairment but without clear structural pathology, which can "prime" the nervous system and increase later risk of chronic pain (Walker et al., 2010; Bussières et al., 2023).

Interdisciplinary Pain Care: Treatment that brings together multiple disciplines—such as medicine, psychology, physical therapy, and nursing—to address biological, psychological, and social contributors to pain, often producing better outcomes than single-modality approaches (Brennan et al., 2007; Raja et al., 2020).

International Association for the Study of Pain (IASP) Definition: The current IASP definition describes pain as "an unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage," highlighting its subjective sensory–emotional nature (IASP, 2020; Raja et al., 2020).

Kinesiophobia: Fear of movement or physical activity due to concerns it will cause or worsen pain, which can drive avoidance behaviors and maintain disability; reductions in kinesiophobia are associated with better outcomes in pain rehabilitation (Murillo et al., 2023).

Negative Affect: A tendency to experience frequent negative emotions (e.g., sadness, anxiety, anger) that heighten pain perception and help explain why some individuals report more intense and disabling pain, including in conditions like borderline personality disorder (Barke et al., 2020; Stein et al., 2025; Tidick et al., 2025).

Nociception: The neural process of encoding and transmitting information about potentially tissue-damaging stimuli from the body to the central nervous system; an important but not sufficient component of the lived experience of pain (Raja et al., 2020).

Opioid-Induced Hyperalgesia: A paradoxical phenomenon in which long-term opioid use leads to increased pain sensitivity, reflecting changes in central pain processing rather than disease progression alone (Kim et al., 2020).

Pain Catastrophizing (pCAT): A cognitive–emotional pattern characterized by magnification of pain threat, persistent rumination about pain, and feelings of helplessness—one of the strongest psychological predictors of greater pain intensity, disability, and risk

of pain chronification (Haythornthwaite et al., 2024; Crombez et al., 2020; Simic et al., 2024).

Pain Neuroscience Education (PNE): An educational approach that explains pain mechanisms in accessible language (e.g., "pain system hypersensitivity"), emphasizing that hurt does not always mean harm and that a sensitized nervous system can be calmed; often used alongside movement and psychological strategies (Moseley et al., 2004; Louw & Riera-Gilley, 2024; Moseley et al., 2023).

Pain System Hypersensitivity / Central Sensitization: A state in which the nervous system becomes overly responsive, so that normal or minor stimuli are experienced as painful, contributing to chronic pain even when tissue damage is minimal or resolved (Moseley et al., 2004; Murillo et al., 2023; Moseley et al., 2023).

Placebo and Nocebo Effects (in Pain): Changes in pain driven by expectations and context rather than the direct pharmacologic action of a treatment: positive expectations (placebo) can activate endogenous pain-inhibiting systems, while negative expectations (nocebo) can increase pain and distress (Levenig et al., 2024; Krahé et al., 2024).

Social Learning of Pain: The process by which children and adults learn what pain means and how to respond to it by observing caregivers, peers, and cultural norms, including modeling of beliefs, coping behaviors, and expressions of pain (O'Sullivan et al., 2021; Pillai Riddell et al., 2022; Haythornthwaite et al., 2024).

Trauma and Pain: The close link between trauma exposure (e.g., abuse, chronic stress, medical trauma) and later chronic pain, mediated by altered stress systems, pain processing, and trauma-related distress; effective care often requires addressing both pain and trauma together (Bussières et al., 2023; Yamin et al., 2024).

Trust in Clinicians (and Social Advice): The degree to which patients view health professionals as credible and caring, which strongly shapes pain expectations, perceived controllability, and even physiological pain responses; trustworthy communication can act as an analgesic, whereas dismissive or fear-inducing messages can worsen pain (Krahé et al., 2024; Levenig et al., 2024).

Under-Treated Pain in Dementia and Pediatrics: Systematic patterns in which people with dementia and children receive inadequate pain recognition and treatment due to communication barriers, reliance on self-report tools that may not fit, and clinician knowledge gaps, leading to avoidable distress and behavior changes (Tsai et al., 2022; Pillai Riddell et al., 2022).

Unpleasant Sensory and Emotional Experience: A core phrase in the IASP definition that underscores pain as both a bodily sensation

and an emotional state, rather than a purely physical signal, and validates chronic pain even when no ongoing tissue damage is visible (IASP, 2020; Raja et al., 2020).

Unnecessary Suffering (Ethical Dimension of Pain Care): The avoidable distress created when pain is poorly assessed or treated, underscoring the argument that adequate pain management is a fundamental human right and an ethical obligation in healthcare (Brennan et al., 2007; Zuazua-Rico et al., 2022).

Chapter 8 References

Barke, A., Koechlin, H., Korwisi, B., & Locher, C. (2020). Emotional distress: Specifying a neglected part of chronic pain. European Journal of Pain, 24(3), 477–480. https://doi.org/10.1002/ejp.1519

Brennan, F., Carr, D. B., & Cousins, M. J. (2007). Pain management: A fundamental human right. *Anesthesia & Analgesia, 105*(1), 205-221.

Bussières, A. E., Elgbeili, G., Santor, D. A., et al. (2023). Adverse childhood experience is associated with an increased risk of reporting chronic pain in adulthood: A systematic review and meta-analysis. *European Journal of Psychotraumatology, 14*(1), 2180952.

Crombez, G., De Paepe, A. L., Veirman, E., Eccleston, C., Verleysen, G., & Van Ryckeghem, D. M. L. (2020). Let's talk about pain catastrophizing measures: an item content analysis. *Peer Journal, 8*, e8643. https://doi.org/10.7717/peerj.8643

Haythornthwaite, J. A., Campbell, C. M., & Edwards, R. R. (2024). When thinking about pain contributes to suffering: The example of pain catastrophizing. *Pain, 165*(11S), S68–S75. https://doi.org/10.1097/j.pain.0000000000003372

Hilton, L., Hempel, S., Ewing, B. A., Apaydin, E., Xenakis, L., Newberry, S., Colaiaco, B., Maher, A. R., Shanman, R. M., Sorbero, M. E., & Maglione, M. A. (2017). Mindfulness Meditation for Chronic Pain: Systematic Review and Meta-analysis. *Annals of Behavioral Medicine: A Publication of the Society of Behavioral Medicine, 51*(2), 199–213. https://doi.org/10.1007/s12160-016-9844-2

Hudon, A., Augeard, N., Tansey, C. M., Houston, E., Bostick, G., & Wideman, T. H. (2024). Does feeling pain help prepare future clinicians to treat pain? A qualitative exploration of a novel experiential approach to teaching health professional students about pain. *Physiotherapy Theory and Practice, 40*(11), 2550–2562. https://doi.org/10.1080/09593985.2023.2254367

International Association for the Study of Pain (IASP). (2020). IASP announces revised definition of pain. Retrieved from https://www.iasp-pain.org/PublicationsNews/NewsDetail.aspx?ItemNumber=

Krahé, C., Koukoutsakis, A., & Fotopoulou, A. (2024). Updating beliefs about pain following advice: Trustworthiness of social advice predicts pain expectations and experience. *Cognition, 246*, 105756. https://doi.org/10.1016/j.cognition.2024.105756

Levenig, C. G., Hasenbring, M. I., Günnewig, L., Titze, C., Elsenbruch, S., & Schulte, T. L. (2024). Treatment expectations-you get what you expect-and depression plays a role. *The Journal of Pain, 25*(9), 104582. https://doi.org/10.1016/j.jpain.2024.104582

Louw, A., & Riera-Gilley, V. (2024). Pain neuroscience education: Teaching people about pain. *Journal of Pain & Palliative Care Pharmacotherapy, 38*(3), 292–301. https://doi.org/10.1080/15360288.2024.2424853

Moseley, G. L., Nicholas, M. K., & Hodges, P. W. (2004). A randomized controlled trial of intensive neurophysiology education in chronic low back pain. *Clinical Journal of Pain, 20*(5), 324-330.

Murillo, C., Galán-Martín, M. Á., Montero-Cuadrado, F., et al. (2023). Reductions in kinesiophobia and distress after pain neuroscience education and exercise lead to favorable

outcomes: A secondary mediation analysis of a randomized controlled trial. *Pain, 164*(10), 2296-2305.

O'Sullivan, G., McGuire, B. E., Roche, M., & Caes, L. (2021). Where do children learn about pain? The role of caregiver responses to preschoolers' pain experience within natural settings. *Pain, 162*(5), 1289–1294. https://doi.org/10.1097/j.pain.0000000000002123

Pillai Riddell, R., Jasim, S., & Hamwi, L. (2022). Out of the mouth of babes: A lot about pain has nothing to do with pain. *Pain, 163*(S1), S117–S125. https://doi.org/10.1097/j.pain.0000000000002761

Raja, S. N., Carr, D. B., Cohen, M., Finnerup, N. B., Flor, H., Gibson, S., Keefe, F. J., Mogil, J. S., Ringkamp, M., Sluka, K. A., Song, X. J., Stevens, B., Sullivan, M. D., Tutelman, P. R., Ushida, T., & Vader, K. (2020). The revised International Association for the Study of Pain definition of pain: concepts, challenges, and compromises. *Pain, 161*(9), 1976–1982. https://doi.org/10.1097/j.pain.0000000000001939

Reis, F. J. J., De Oliveira, K. A., & Dibai-Filho, A. V. (2022). Culture and musculoskeletal pain: Strategies, challenges, and future directions to develop culturally sensitive physical therapy care. *Brazilian Journal of Physical Therapy, 26*(5), 100442.

Simic, K., Savic, B., & Knezevic, N. N. (2024). Pain catastrophizing: How far have we come? *Neurology International, 16*(3), 36-47.

Stein, A. G., Johnson, B. N., Kelly, A. G., Cheavens, J. S., & McKernan, L. C. (2025). Negative affect and pain catastrophizing link borderline personality disorder to pain: Replicating and extending the BPD–pain association. *Personality Disorders, 16*(2), 173–183. https://doi.org/10.1037/per0000704

Tidick, L., Cooper, L., & Van Dyke, B. V. (2025). The relationships among negative affect, concerns about pain, applied mechanical pain, and physical activity. *The Journal of Pain, 29*, 105218.

Tsai, Y. I., Browne, G., & Inder, K. J. (2022). Documented nursing practices of pain assessment and management when communicating about pain in dementia care. *Journal of Advanced Nursing, 78*(10), 3174–3186. https://doi.org/10.1111/jan.15251

Walker, L. S., Dengler-Crish, C. M., Rippel, S., & Bruehl, S. (2010). Functional abdominal pain in childhood and adolescence increases risk for chronic pain in adulthood. *Pain, 150*(3), 568-572.

Yamin, J. B., Meints, S. M., & Edwards, R. R. (2024). Beyond pain catastrophizing: Rationale and recommendations for targeting trauma in the assessment and treatment of chronic pain. *Expert Review of Neurotherapeutics, 24*(3), 251-264.

Zuazua-Rico, D., Mosteiro-Diaz, M. P., Collado-Boira, E., del Carmen Casal-Angulo, M., Cobo-Cuenca, A. I., Fernandez-Garrido, J., Lavado-Garcia, J. M., & Maestro-Gonzalez, A. (2022). Knowledge about pain in Spanish nursing students. *Pain Management Nursing, 23*(6), 871–877. https://doi.org/10.1016/j.pmn.2022.03.006

Chapter 9

Understanding and Transforming Resentment

Resentment is a multidimensional emotional state that combines anger, hurt, and a lingering sense of injustice. Unlike flashes of acute anger, resentment tends to be slow-burning and enduring—more like embers that smolder than flames that flare and fade (Balcomb, 2021). Clinically, it often develops in the wake of perceived betrayal, chronic invalidation, interpersonal trauma, or systemic inequity (Benjamin, 2020). When resentment remains unrecognized or unprocessed, it can harden into bitterness, fuel depressive rumination, and disrupt both intrapersonal and relational functioning (Orem, 2021).

This chapter explores resentment from an integrative biopsychosocial lens. It begins by examining clinical conceptualizations of resentment, then describes common presentations and psychological impacts. Next, it outlines evidence-informed strategies for emotional regulation and treatment, including cognitive-behavioral, emotion-focused, and compassion-based approaches. The chapter then widens the frame to include sociocultural and systemic dimensions of resentment before proposing an integrative clinical framework for transforming resentment into insight, agency, and relational growth.

Resentment as a Complex Emotional State

Resentment can be understood as a compound emotion—a blend of anger, moral judgment, and often a sense of helplessness or stuckness. It is typically anchored to a

narrative: “What happened to me was wrong, and it has not been made right.” Balcomb (2021) describes resentment as a resurgent phenomenon in contemporary society, fueled by experiences of perceived injustice at both interpersonal and structural levels. Three recurring elements are prominent in clients’ narratives of resentment:

- *Perceived violation* – a sense that promises, expectations, or roles were broken or betrayed.
- *Blocked response* – the person felt unable to protest, set limits, or seek repair at the time.
- *Frozen loop* – the story of the injury is repeatedly revisited without meaningful change or resolution.

Over time, this pattern may evolve into what Neckel (2023) calls a “grudge”—an emotional posture that maintains distance and moral superiority but also keeps the person emotionally bound to the offense.

Clinical Conceptualizations of Resentment

Different theoretical traditions highlight distinct facets of resentment, each offering clinically useful lenses.

From a psychodynamic standpoint, resentment often reflects repressed rage, unexpressed needs, or forbidden wishes that conflict with internalized moral codes or relational loyalties (Ciulla, 2020). For example, a caregiver may feel intense anger at a dependent loved one but experience that anger as morally unacceptable. Rather than being acknowledged and metabolized, the anger may be redirected into covert resentment—expressed in

sarcasm, withdrawal, or "quiet quitting" in the relationship.

Resentment can also function as a defense against deeper vulnerability. Clients may cling to resentment as a way of preserving dignity or avoiding contact with grief, shame, or loneliness. In this sense, resentment can be both a protest against injustice and a shield against emotional collapse.

Cognitive-Behavioral Perspectives

Cognitive-behavioral frameworks view resentment as sustained by maladaptive cognitions and entrenched schemas. Common patterns include:

- *Injustice schemas*: "I am always treated unfairly"; "People get away with hurting me."
- *Entitlement beliefs*: "I should never have to experience this"; "They owe me for what happened."
- *Global attributions*: Transforming a specific offense into a stable trait judgment ("they're awful," "I'm nothing").

Enoch and Spectre (2021) describe "statistical resentment" in moral and social contexts—anger and blame based on broad generalizations rather than individualized evidence—illustrating how globalized cognitions can fuel and maintain resentment. Within psychotherapy, such thinking patterns often manifest as repetitive mental "courtroom" scenarios: the client re-tries the offense mentally, always returning a guilty verdict, without moving toward agency or repair.

Emotion-Focused Perspectives

Emotion-focused therapy (EFT) conceptualizes resentment as a secondary emotion often masking primary experiences of shame, fear, or abandonment (Abbott et al., 2021). For instance, a partner who feels deeply rejected may present primarily with hostile resentment. When safely guided, they often uncover primary emotions: "I felt unwanted," "I was terrified I didn't matter."

This distinction is clinically crucial. Working only with resentment (secondary anger) tends to reinforce rigid narratives. Accessing and processing primary emotions allows for softening, grief, and ultimately more flexible meaning-making (Abbott et al., 2021).

Neurocognitive Contributions

Emerging neuroscientific work links resentment and moral outrage to activation in regions such as the anterior insula and prefrontal cortex, areas associated with disgust, fairness judgments, and regulation of social pain (Babic & Johnson King, 2025). These findings align with clinical observations that resentment is not simply anger, but often carries a distinctly moral flavor—an embodied sense that "this is wrong."

Babic and Johnson King (2025) note that debates about algorithmic fairness can evoke strong resentment responses, showing that even abstract injustices can engage these moral-emotional circuits. In clinical practice, this suggests that work with resentment often

implicates clients' deepest value systems and identity commitments, not merely interpersonal irritations.

Clinical Presentation and Psychological Impact

How Resentment Shows Up in Therapy

Clients rarely open a session with, "I'm here because of resentment." Instead, resentment often appears in more indirect forms:

- *Depressive symptoms* – hopelessness, loss of energy, or anhedonia tied to unresolved grievance.
- *Somatic complaints* – headaches, muscle tension, gastrointestinal distress.
- *Relationship conflict* – chronic criticism, passive-aggression, or emotional cutoff.
- *Stuck narratives* – repetitive recounting of past wrongs without movement toward resolution.

Gheaus (2021) highlights the role of resentment in contexts such as unrequited love and self-victimization, noting how individuals may become attached to a resentful narrative that simultaneously reinforces their pain and sense of moral superiority. Resentment is also prominent in:

- *Betrayal trauma* (e.g., infidelity, deception, spiritual or institutional betrayal).
- *Caregiver fatigue*, where long-term, under-recognized labor breeds silent anger.

- *Workplace exploitation*, where employees feel used and unseen, contributing to moral disengagement and "cutting corners" (Burhan & Malik, 2025).

Impact on Therapeutic Process and Relationships

Unchecked resentment can significantly impair therapy:

- *Therapeutic alliance* – Clients may mistrust or test the therapist, projecting prior injustices into the therapy relationship.
- *Engagement* – Resentful clients may comply behaviorally but remain emotionally disengaged, showing up but "not really here."
- *Change processes* – Resentment often blocks empathy, perspective-taking, and risk-taking needed for growth.

In couples and family work, resentment correlates with stonewalling, emotional cutoff, and passive-aggressive patterns (Abbott et al., 2021). Without addressing resentment explicitly, interventions on communication or problem-solving may fail to stick because the underlying emotional ledger remains unresolved.

Emotion Regulation and Therapeutic Pathways

Transforming resentment does not mean erasing legitimate protest or asking clients to "just forgive and forget." Instead, it involves:

- Accurately identifying resentment.
- Accessing the primary emotions and needs underneath.

- Restructuring unhelpful beliefs.
- Developing more adaptive, values-aligned responses.

Step 1: Naming and Validating Resentment

A first therapeutic task is helping clients name resentment and recognize its function. Many feel guilty for being resentful or have internalized messages that "good people don't feel this way." Normalizing resentment as a signal emotion—a sign that something important has been violated—can reduce shame and increase curiosity (Ke & Barlas, 2020). Psychoeducation may differentiate:

- Anger vs. resentment
- Guilt vs. shame vs. resentment
- Protest vs. revenge fantasies

This sets the stage for more honest exploration of what resentment is protecting or expressing.

Step 2: Accessing Primary Emotions (EFT-Informed Work)

Drawing on EFT, therapists can help clients move from secondary resentment to primary emotions (Abbott et al., 2021). For example:

- "When you imagine that moment of being dismissed, what did you feel before the anger came up?"
- "If your resentment could speak, what would it say you needed that you did not receive?"

Common primary states include hurt, fear of abandonment, humiliation, and grief. Processing these experiences—through imagery, enactments, or chair work—allows resentment to soften and evolve into more adaptive emotions like sadness, assertive anger, or self-protective clarity.

Step 3: Cognitive Restructuring (CBT Approaches)

CBT-based interventions target rigid thinking and injustice schemas that keep resentment frozen (Ke & Barlas, 2020). Key tasks include:

- Identifying absolutist thoughts: "They never care," "I am always taken advantage of."
- Challenging global labels: moving from "They're evil" to more nuanced appraisals.
- Examining implicit rules: "If people loved me, they would never disappoint me."

The goal is not to minimize harm but to loosen catastrophic or all-or-nothing interpretations that trap the client in a perpetual victim or villain narrative. Cognitive restructuring can open space for more balanced beliefs like, "What they did was wrong, and I can still choose how I want to live now."

Step 4: Compassion-Focused Interventions

Compassion-focused therapy (CFT) offers tools for working with the shame and self-attack that often accompany resentment (Gilbert, 2010). Clients may resent themselves ("I stayed too long," "I let this happen"), not just others. CFT:

- Develops a compassionate inner voice to counter self-criticism.
- Uses imagery (e.g., compassionate self, wise other) to regulate threat-based arousal.
- Emphasizes common humanity—recognizing that injustice and hurt are universal experiences, not personal defects.

As self-compassion grows, clients often become less fused with resentful narratives and more able to set boundaries, grieve losses, and make values-consistent choices.

Step 5: Mindfulness and Emotional Process Work

Mindfulness practices support interoceptive awareness and reduce automatic reactivity (Na'aman, 2021). Rather than immediately rehearsing the story of the offense, clients learn to notice bodily sensations, urges, and images that accompany resentment—creating a pause in which new responses become possible.

Na'aman (2021) emphasizes a "process view" of emotional change, inviting clients to see emotions like resentment as dynamic, not fixed. This perspective fits well with mindfulness: resentment becomes something one can observe and work with, rather than a permanent identity.

Sociocultural and Systemic Dimensions of Resentment

Resentment is not only personal; it is also political and structural.

Experiences of racism, sexism, classism, and other forms of marginalization understandably generate collective resentment. Banda and Cassese (2022) show how hostile sexism and racial resentment shape political mobilization. Davis and Wilson (2023) describe how racial resentment and affective partisanship helped fuel reactions to the January 6th insurrection. Jacobs and Munis (2023) highlight "place-based resentment" at the heart of urban–rural political divides.

These studies underscore that resentment often reflects real power imbalances and historical wounds. In therapy, this means clinicians should:

- Avoid pathologizing resentment that arises from genuine injustice.
- Acknowledge systemic realities alongside intrapsychic work.
- Recognize when personal grievances are intertwined with group identities and social narratives.

Fernandez (2023) situates emotions like resentment within violent ethnic conflicts, offering a framework for understanding how group-level grievances can escalate to aggression and violence when left unaddressed.

Cultural Scripts Around Emotion

Cultural norms shape how resentment is expressed, suppressed, or spiritualized (Balcomb, 2021). Some contexts valorize stoicism and discourage explicit protest, increasing the likelihood that anger becomes internalized and chronic. Other cultures may normalize openly voiced

grievances but stigmatize vulnerability, making it harder to access underlying hurt.

Benjamin (2020) describes how Israeli mothers living in poverty oscillate between shame and "managed resentment," highlighting how structural injustice and cultural expectations around caregiving intersect. Orem (2021) similarly explores "tangles of resentment" in gendered and social contexts, illustrating that resentment often signals not individual pathology but constrained options and chronic inequity.

Effective clinical work requires cultural humility and awareness of these scripts, so that resentment is understood in context, not reduced to a purely individual failing.

An Integrative Biopsychosocial Framework

Transforming resentment is best approached through an integrated framework that attends to the cognitive, emotional, relational, cultural, and physiological dimensions of the experience. Key components include:

Assessment

- Identify explicit and implicit resentments (toward others, institutions, and self).
- Screen for related symptoms (depression, anxiety, somatic complaints, moral injury).
- Explore developmental and systemic origins (family patterns, workplace dynamics, social location).

Meaning-Making

- Clarify what value or boundary resentment is protecting (e.g., dignity, loyalty, justice).
- Distinguish legitimate protest from stuckness or repetitive self-harm.

Regulation and Processing

- Use EFT to access primary emotions and unmet needs (Abbott et al., 2021).
- Apply CBT to challenge rigid narratives and injustice schemas (Ke & Barlas, 2020).
- Integrate CFT and mindfulness to soothe shame and threat activation (Gilbert, 2010; Na'aman, 2021).

Relational Repair and Boundary-Setting

When possible, support clients in assertive communication and repair attempts. When repair is not possible or safe, focus on internal resolution, boundary clarification, and grief work.

Systemic Awareness and Collective Healing

Name the role of structural factors (e.g., exploitation, discrimination) where present (Banda & Cassese, 2022; Burhan & Malik, 2025). Consider group or narrative approaches for collective or identity-based resentments (Fernandez, 2023; Jacobs & Munis, 2023).

Clinician Self-Reflection

Attend to countertransference: therapists' own unresolved resentments or moral judgments may subtly shape interventions (Ciulla, 2020; Neckel, 2023). Use supervision and consultation to process personal reactions when working with highly resentful clients or charged sociopolitical material.

Summary: From Bitterness to Boundary and Growth

Resentment is a signal, not a sentence. It signals that something deeply valued—fairness, love, reciprocity, dignity—has been injured or withheld. When ignored or moralized away, resentment tends to calcify into bitterness, hostility, and emotional disengagement. When approached with curiosity, compassion, and structure, it can become a doorway to healing.

Understanding resentment's psychodynamic roots, cognitive patterns, emotional functions, and sociocultural contexts allows clinicians to respond with nuance rather than simple advice to "let it go." Through naming and validating the emotion, accessing the vulnerable experiences beneath it, challenging rigid narratives, and integrating compassion and systemic awareness, resentment can be transformed into:

- Clearer boundaries and assertiveness.
- Deeper self-awareness and moral clarity.
- Motivation for relational repair or, where necessary, dignified separation.

- Energy for constructive personal and collective change.

Ultimately, resentment invites a double movement: acknowledging what was wrong, and choosing how to live now. In that tension between protest and possibility lies the therapeutic task—and the hopeful potential—for clients to move from corrosive bitterness toward integrity, agency, and renewed connection.

Chapter 9 Key Takeaways

Transforming Resentment

Resentment is a complex "compound" emotion.

It blends anger, hurt, moral judgment, and often helplessness. It's usually tied to a story of injustice: "What happened was wrong, and it hasn't been made right." It's slow-burning and enduring, more like embers than a flare of anger.

Three core elements tend to show up in resentment:

Perceived violation – a promise, expectation, or role was betrayed.

Blocked response – the person couldn't protest, set limits, or seek repair.

Frozen loop – the story of the hurt gets replayed without change or resolution.

Resentment can harden into a "grudge."

Maintaining distance and moral superiority may feel protective, but it keeps the person emotionally tethered to the offense and can fuel bitterness, depressive rumination, and relational disconnection.

Psychodynamic lens: resentment as disguised anger and defense.

Resentment often masks repressed rage, unmet needs, and "forbidden" wishes that clash with moral codes or

loyalties. It can also function as a shield against deeper grief, shame, and loneliness.

CBT lens: resentment is sustained by rigid cognitions and schemas.

Injustice schemas ("I'm always treated unfairly"), entitlement beliefs ("They owe me"), and global labels ("They're terrible," "I'm nothing") keep the person stuck in mental "courtroom" scenarios that never move toward agency or repair.

Emotion-focused lens: resentment is often a secondary emotion.

Underneath hostile resentment are primary emotions like hurt, fear of abandonment, humiliation, or loneliness. Working only with resentment keeps narratives rigid; accessing the underlying pain allows softening, grief, and new meaning.

Neurocognitive findings affirm resentment's moral "flavor."

Brain regions tied to disgust, fairness, and social pain light up in resentment and moral outrage, underscoring that resentment is not just irritation but a deeply value-laden response.

- Resentment rarely comes in labeled; it hides in symptoms.
- It often presents as depression, somatic complaints, relationship conflict, passive-aggression,

stonewalling, or repetitive "stuck stories" about past wrongs.
- Unchecked resentment undermines therapy and relationships.

It can erode trust in the therapist, block emotional engagement, and interfere with empathy, perspective-taking, and risk-taking needed for change. In couples/family work, it fuels withdrawal, criticism, and emotional cutoff.

Transforming resentment is not about erasing protest.

The goal is not "forgive and forget," but to:

- Name and validate resentment as a signal emotion.
- Reach the primary emotions and needs beneath it.
- Loosen rigid beliefs and injustice schemas.
- Foster more flexible, values-consistent responses.

Key clinical steps for working with resentment:

- *Name and normalize it* – reduce shame by framing resentment as a signal of violated values or boundaries.
- *Access primary emotions (EFT)* – guide clients from secondary anger to underlying hurt, fear, grief, or shame.
- *Restructure thoughts (CBT)* – challenge absolutes and global labels while still honoring the reality of harm.

- *Cultivate compassion (CFT)* – especially for self-directed resentment, using compassionate imagery and self-talk.

Use mindfulness and process-focused work – help clients observe resentment as a shifting process rather than a fixed identity.

Resentment is also social and political, not just personal.

Experiences of racism, sexism, classism, exploitation, and other systemic injustices understandably generate individual and collective resentment. Effective therapy must acknowledge real power imbalances and historical wounds, not pathologize legitimate protest.

Cultural scripts shape how resentment looks.

Norms around stoicism, protest, duty, and vulnerability influence whether resentment is internalized, spiritualized, openly expressed, or masked. Understanding these scripts is essential to avoiding mislabeling culturally shaped responses as pathology.

An integrative biopsychosocial approach works best.

Helpful work with resentment attends to:

- *Assessment* (resentment targets, symptoms, developmental/systemic origins).
- *Meaning-making* (what value or boundary resentment protects).
- *Regulation and processing* (EFT, CBT, CFT, mindfulness).

Relational repair and boundary-setting (where safe and possible, or internal resolution when it's not).

Systemic awareness (naming structural factors and considering group/collective interventions).

Clinician self-reflection is crucial.

Therapists' own unresolved resentments and moral judgments can subtly shape the work. Supervision and personal reflection help prevent reenacting power struggles or invalidation in the therapy room.

Core reframe: resentment is a signal, not a life sentence.

It signals that important values—fairness, dignity, loyalty, love—have been violated. When met with curiosity, compassion, structure, and systemic awareness, resentment can be transformed into:

- Clearer boundaries and assertive self-protection.
- Deeper self-understanding and moral clarity.
- Motivation for repair or dignified separation.
- Energy for constructive personal and collective change.
- The ultimate task: protest and possibility.

Healing involves a "double movement": fully acknowledging what was wrong, and then choosing how to live now. In this tension between protest and forward movement, resentment can shift from corrosive bitterness to a pathway toward integrity, agency, and renewed connection.

Chapter 9 Glossary

Biopsychosocial Framework: An integrative clinical lens that considers biological (e.g., arousal, somatic symptoms), psychological (e.g., schemas, emotions), and social/systemic (e.g., exploitation, discrimination) influences on resentment and its treatment (Balcomb, 2021; Banda & Cassese, 2022; Burhan & Malik, 2025).
Blocked Response: A situation in which a person feels unable to protest, set limits, or seek repair at the time of an offense, contributing to resentment's lingering, stuck quality (Balcomb, 2021; Ke & Barlas, 2020).
Boundary-Setting (Values-Aligned Boundaries): The process of clarifying and asserting one's limits in relationships and systems in ways that honor personal dignity and safety; transformed resentment often fuels clearer, more assertive boundary-setting rather than passive bitterness (Ke & Barlas, 2020; Gilbert, 2010).
Collective / Political Resentment: Resentment grounded in group-based experiences of injustice (e.g., racism, sexism, classism), which shapes political mobilization and responses to events such as elections or civil unrest (Banda & Cassese, 2022; Davis & Wilson, 2023; Fernandez, 2023).
Compassion-Focused Therapy (CFT): A therapeutic approach that helps clients cultivate a compassionate inner voice, regulate threat-based arousal through imagery and soothing practices, and reduce shame and self-attack, often loosening rigid resentment toward self and others (Gilbert, 2010).
Compound Emotion: An emotional state made up of multiple feelings—such as anger, moral judgment, and helplessness—organized around a narrative that "what happened was wrong and has not been made right" (Balcomb, 2021).
Countertransference (in resentment work): The therapist's own emotional responses—such as personal resentment, moral judgment, or over-identification—that can arise when working with highly resentful clients or charged sociopolitical content, requiring supervision and self-reflection (Ciulla, 2020; Neckel, 2023).
Emotional Cutoff: A pattern of distancing or withdrawing emotionally from others—seen in families or couples—often rooted in unresolved resentment and used to protect against further injury or vulnerability (Abbott et al., 2021; Orem, 2021).
Entitlement Beliefs: Cognitive assumptions that one should never have to endure certain experiences or that others perpetually "owe" them, which can amplify resentment when reality fails to match these expectations (Ke & Barlas, 2020).

Frozen Loop: A repetitive internal replay of an injurious event or grievance without meaningful change, resolution, or restored agency, which maintains and intensifies resentment over time (Balcomb, 2021).
Global Attributions: The tendency to interpret a specific offense as proof of stable, global flaws in others or oneself (e.g., "They're awful," "I'm nothing"), reinforcing rigid resentment and preventing nuanced understanding (Ke & Barlas, 2020).
Grudge: An enduring emotional stance that preserves distance and moral superiority while keeping the person psychologically bound to the offense, described as the "emotional side of resentment" (Neckel, 2023).
Injustice Schemas: Enduring cognitive patterns that frame the self as consistently mistreated or exploited (e.g., "I am always treated unfairly"), sustaining resentment and victimization narratives (Ke & Barlas, 2020).
Managed Resentment: A pattern in which individuals, especially in structurally constrained contexts (e.g., mothers living in poverty), oscillate between shame and carefully contained resentment, reflecting both protest and adaptation to chronic inequity (Benjamin, 2020).
Mindfulness (in the context of resentment): The practice of noticing bodily sensations, thoughts, and feelings associated with resentment with nonjudgmental awareness, creating space for new responses rather than automatic rumination and re-enactment of grievances (Na'aman, 2021; Ke & Barlas, 2020).
Moral Disengagement: A cognitive process by which individuals justify unethical or "corner-cutting" behavior (e.g., in exploitative workplaces), often emerging in response to ongoing perceived injustice and emotional strain, including resentment (Burhan & Malik, 2025).
Moral Outrage / Moral-Emotional Circuits: An emotionally charged response to perceived injustice, often linked to neural regions involved in disgust, fairness judgments, and social pain (e.g., anterior insula, prefrontal cortex), underscoring resentment's moral dimension (Babic & Johnson King, 2025).
Perceived Violation: The subjective sense that expectations, promises, roles, or boundaries have been broken or betrayed, forming a core element of many resentment narratives (Balcomb, 2021).
Place-Based Resentment: Resentment tied to perceived neglect or disrespect of one's geographic region (e.g., urban–rural divides), which can fuel political polarization and identity-based grievances (Jacobs & Munis, 2023).

Primary Emotions: Underlying, more vulnerable emotional states (e.g., hurt, abandonment fear, humiliation, grief) that resentment often masks; accessing these is key to emotional softening and change in emotion-focused therapy (Abbott et al., 2021).
Process View of Emotional Change: A perspective that understands emotions like resentment as dynamic and evolving rather than fixed, emphasizing that emotional states can shift through ongoing processes of awareness, regulation, and meaning-making (Na'aman, 2021).
Racial Resentment: A form of collective resentment rooted in perceived threats to racial status or privilege, significantly influencing partisan attitudes and reactions to political events (Banda & Cassese, 2022; Davis & Wilson, 2023).
Repressed Rage / Covert Resentment: Anger and unmet needs that conflict with moral codes or relational loyalties and thus become hidden, surfacing indirectly through sarcasm, withdrawal, or passive "quiet quitting" in relationships (Ciulla, 2020).
Resentment: A multidimensional, slow-burning emotional state that blends anger, hurt, and a sense of injustice, often arising after perceived betrayal, invalidation, or systemic inequity and, when unprocessed, can harden into bitterness and disrupt mental health and relationships (Balcomb, 2021; Benjamin, 2020; Orem, 2021).
Secondary Emotion (Secondary Anger): A surface emotion, such as hostile resentment, that covers more vulnerable primary feelings like hurt, shame, or fear; working only at this level tends to reinforce stuck narratives (Abbott et al., 2021).
Signal Emotion: An emotion—such as resentment—that functions as an internal alert that something important (e.g., fairness, dignity, reciprocity) has been violated and needs attention, rather than simply being a symptom to suppress (Ke & Barlas, 2020).
Statistical Resentment: Resentment and blame grounded in broad statistical generalizations rather than individualized evidence, illustrating how abstract or group-based judgments can fuel moral anger and hostility (Enoch & Spectre, 2021).
Tangles of Resentment: Complex, layered patterns in which resentment is intertwined with gendered expectations, social roles, and structural constraints, demonstrating that resentment often reflects constrained options rather than individual "flaws" alone (Orem, 2021).

Therapeutic Alliance: The collaborative, trust-based relationship between therapist and client that can be strained when clients project prior injustices into therapy or approach the therapist with mistrust fueled by unresolved resentment (Ke & Barlas, 2020; Orem, 2021).

Chapter 9 References

Abbott, K. M., Heid, A. R., Spector, A., Heppner, A., & VanHaitsma, K. S. (2021). Building relationships to enhance person-centered care through emotion-focused care. *Alzheimer's & Dementia, 17*(S8), e051861. https://doi.org/10.1002/alz.051861

Babic, B., & Johnson King, Z. (2025). Algorithmic fairness and resentment. *Philosophical Studies, 182*(1), 87–119. https://doi.org/10.1007/s11098-023-02006-5

Balcomb, A. (2021). Resentment – Excavating a resurgent phenomenon in contemporary society. *Scriptura, 120*(1), 1–15. https://doi.org/10.7833/120-1-1839

Banda, K. K., & Cassese, E. C. (2022). Hostile sexism, racial resentment, and political mobilization. *Political Behavior, 44*(3), 1317–1335. https://doi.org/10.1007/s11109-020-09674-7

Benjamin, O. (2020). Shame and ("managed") resentment: Emotion and entitlement among Israeli mothers living in poverty. *The British Journal of Sociology, 71*(4), 785–799. https://doi.org/10.1111/1468-4446.12753

Burhan, Q.-A., & Malik, M. F. (2025). The dark spiral: Exploring the impact of employee exploitation on cutting corners, unraveling the link through negative emotions and moral disengagement. Business Process Management Journal, 31(2), 556–577. https://doi.org/10.1108/BPMJ-03-2024-0186

Ciulla, J. B. (2020). Leadership and the power of resentment/ressentiment. *Leadership, 16*(1), 25–38. https://doi.org/10.1177/1742715019885772

Davis, D. W., & Wilson, D. C. (2023). "Stop the steal": Racial resentment, affective partisanship, and investigating the January 6th insurrection. *The Annals of the American Academy of Political and Social Science, 708*(1), 83–101. https://doi.org/10.1177/00027162241228400

Enoch, D., & Spectre, L. (2021). Statistical resentment, or: What's wrong with acting, blaming, and believing on the basis of statistics alone. *Synthese, 199*(3–4), 5687–5718. https://doi.org/10.1007/s11229-021-03042-6

Fernandez, E. (2023). A framework for understanding emotions in violent ethnic conflicts. *Aggression and Violent Behavior, 72*, 101860. https://doi.org/10.1016/j.avb.2023.101860

Gheaus, A. (2021). Unrequited love, self-victimisation and the target of appropriate resentment. *The Journal of Ethics, 25*(4), 487–499. https://doi.org/10.1007/s10892-021-09368-0

Gilbert, P. (2010). *Compassion focused therapy: Distinctive features*. Routledge.

Jacobs, N., & Munis, B. K. (2023). Place-based resentment in contemporary U.S. elections: The individual sources of America's urban-rural divide. *Political Research Quarterly, 76*(3), 1102–1118. https://doi.org/10.1177/10659129221124864

Ke, T., & Barlas, J. (2020). Resentment, anger and emotion regulation: Exploring client self-awareness and the psychotherapy process. *Psychology and Psychotherapy: Theory, Research and Practice, 93*(3), 513–528. https://doi.org/10.1111/papt.12239

Na'aman, O. (2021). The rationality of emotional change: Toward a process view. *Noûs, 55*(2), 245–269. https://doi.org/10.1111/nous.12304

Neckel, S. (2023). Grudge: The emotional side of resentment. *Emotions and Society, 5*(2), 139–146. https://doi.org/10.1332/263169021X16704197265552

Orem, S. (2021). Tangles of resentment. *Signs: Journal of Women in Culture and Society, 46*(4), 963–985. https://doi.org/10.1086/713296

Chapter 10

Processing Shame

Shame is one of those emotions that makes people want to disappear.

It doesn't just whisper, "You did something wrong." It leans in and declares, "You are what's wrong." Not "That thing you did was bad," but "You are bad." A memory pops up from years ago, or you stumble over your words in a meeting, or someone sighs in a particular way—and suddenly your chest tightens, your face heats, and an old inner voice kicks in: If they really knew you, they'd walk away. You're too much. You're not enough. You shouldn't even be here. (What is Shame?, 2023).

Short, situational shame can sometimes nudge people toward their values. A child who feels ashamed after hurting a sibling might think, I don't want to be that kind of person, and change their behavior. In that sense, shame can play a small, corrective role. But when shame stops being about a specific moment and becomes the default explanation for everything—when it settles in as the main story about who you are—it turns toxic. That kind of chronic, pervasive shame is strongly linked with depression, anxiety, social withdrawal, and trauma-related distress (Boyd et al., 2018; Goffnett et al., 2020; Zhang et al., 2025; What is Shame?, 2023).

It helps to start with a simple but important distinction. Guilt says, "I did something wrong." It focuses on behavior: I snapped, I lied, I missed the mark. At its best, guilt can push someone toward repair—apologizing, setting things right, trying again in a different way.

Shame says something very different: “There is something wrong with me.” It doesn’t stop at, “I made a mistake.” It slides into, “I am the mistake. I’m fundamentally broken, disgusting, unlovable, or beyond repair” (What is Shame?, 2023; Zhang et al., 2025). You can hear the difference in everyday situations:

> “I yelled at my kid. That’s not how I want to parent. I need to talk to them and own my part,” is guilt.
>
> “I yelled at my kid. I’m a terrible parent. They’d be better off without me,” is shame.
>
> “I forgot my friend’s birthday. I feel bad; I want to apologize and reconnect,” is guilt.
>
> “I forgot. I always forget. I’m a horrible friend. This is why people leave me,” is shame.

People who are steeped in shame tend to turn normal human mistakes into global verdicts. Failing one exam becomes proof that they’re a complete failure. An unanswered text means they’re unlovable. Feeling awkward in a social situation morphs into, “I’m pathetic; no one wants me around.”

Over time, those interpretations harden into a stable, negative lens—almost like a script that automatically explains any discomfort with, “It’s because something is wrong with me” (Zhang et al., 2024, 2025; Goffnett et al., 2020).

Shame rarely walks up and introduces itself. It’s sneaky. It might show up as sudden heaviness in the body when

someone looks your way, or as a strong urge to change the subject when a conversation drifts too close to your history. Some people crack jokes, over-explain, or stay constantly busy so no one will see what's underneath. Others go quiet, pull back, or try to make themselves physically smaller. Sometimes it shows up as harsh self-talk that runs in the background all day long: "Idiot. Of course you messed that up. Why would anyone want you?" (Hoyer et al., 2023; What is Shame?, 2023).

No one is born ashamed. Babies don't stare at their own bellies and think, This is disgusting. Shame is learned. For many people, it begins in families where love feels conditional: affection or approval when they perform perfectly, distance or anger when they are messy, needy, angry, or simply human. Others absorb shame through bullying and humiliation—comments about their bodies, their clothes, their voice, their interests, their culture.

Over time, the message becomes, "The real me is not acceptable." For trauma and abuse survivors, shame often takes the form of a quiet, corrosive conclusion: If this happened to me, it must mean something is wrong with me, even when the abuse was clearly someone else's wrongdoing (NICABM, n.d.-a, n.d.-b; Jung & Steil, 2013; Goffnett et al., 2020).

Culture reinforces this in powerful ways. Many people grow up in environments that praise constant productivity, flawless performance, and a narrow version of beauty or success. Social media feeds are full of carefully edited snapshots that make other people's lives

look effortless, while your own life feels messy behind the scenes. Some religious or moral messages, especially when taken out of context, emphasize human sinfulness or brokenness but fail to balance that with a deep sense of worth, dignity, or grace. People who are part of stigmatized or marginalized groups may also receive daily signals that they are "less than" or "not enough" in the eyes of the broader culture. Over years, these external messages can be internalized into an ongoing sense of personal defectiveness (Brown, 2006; Sutton, 2017; Stynes et al., 2022).

Shame is not just an idea in the mind; it is a full-body experience. When shame hits, the nervous system acts as if there is immediate danger. Heart rate goes up. The stomach flips. The muscles tighten. You might feel heat in your face or a sudden urge to hunch your shoulders, break eye contact, or escape. Internally, the mind narrows: all attention collapses onto everything that feels wrong with you. The urge is to hide, go numb, lash out, or shut down (What is Shame?, 2023).

From a neuroscience and emotion-regulation perspective, it's as if shame slams you into "threat mode." Paul Gilbert describes three basic emotional systems: a threat system, focused on danger and self-protection; a drive system, focused on achievement and reward; and a soothing system, focused on safety, calm, and connection (Gilbert, 2010; What is Shame?, 2023). When shame takes over, the threat system lights up—fear, anxiety, self-attack, scanning for judgment—and the soothing system, which might say "You are safe enough; you are still worthy of

care," goes mostly offline. That imbalance helps explain why shame feels so overwhelming and so sticky.

The hopeful side of this story is that the brain and body are trainable. Practices like mindfulness, self-compassion, and certain kinds of therapy don't just change how people think; they literally help shift activation away from constant threat and toward more balanced states. Over time, this can make shame easier to notice, easier to tolerate, and less likely to dictate every decision (Boyd et al., 2018; Lindsay & Creswell, 2017; Zhang et al., 2025; Cepni et al., 2024).

Cognitive-behavioral work often starts by gently pulling shame out into the open. Many people don't realize how extreme their inner statements are until they say them out loud or write them down. A therapist might invite someone to track shame spikes for a week: when they felt that urge to hide, what they were doing, what they told themselves in that moment. Patterns often emerge: "I am fundamentally broken." "If anyone saw the real me, they would reject me." "My worth depends on never failing or disappointing anyone." "I must always be strong and never need help." Once these beliefs are visible, they become something you can look at, rather than something you unconsciously live inside (Goffnett et al., 2020; Wen et al., 2024).

From there, cognitive restructuring helps people ask, "Is this actually true? What is the evidence for this belief, and what is the evidence against it?" Someone who has been telling themselves, "I'm completely unlovable," might

discover, when they really look, that there are people who care about them, or that even the relationships that ended weren't proof they were worthless. Another person might realize that their standard—"I must never make mistakes"—is impossible for any human to meet. Brené Brown's work on shame resilience calls this "practicing critical awareness": noticing where these rules and expectations came from and who benefits from you believing you are never enough (Brown, 2006; Sutton, 2017; Goffnett et al., 2020).

For survivors of trauma, especially sexual or interpersonal abuse, shame is often tangled up with vivid mental images: seeing themselves as dirty, ruined, frozen, or somehow permanently "contaminated." Imagery rescripting, like the approach Jung and Steil used with adult survivors of childhood sexual abuse, invites people to work directly with those inner pictures. First, survivors learn that shame and feelings of contamination are a common trauma response—not evidence of moral failure.

Then, with support, they identify a key shame-soaked image and, in imagination, begin to change it: introducing protective figures, symbols of cleansing or renewal, or an older, wiser version of themselves stepping into the scene and offering protection and validation. In Jung and Steil's trial, just two sessions of this combined cognitive and imagery work led to significant reductions in shame, feelings of being contaminated, and PTSD symptoms, compared with a control group (Jung & Steil, 2013; Goffnett et al., 2020). Changing the emotional "code" of

the memory helps change how people see themselves in the present.

Outside of trauma therapy, many people use cognitive reappraisal in everyday shame moments without realizing it has a name. Reappraisal means consciously changing the story you tell yourself about what happened. Instead of, “That presentation mistake proves I’m incompetent and everyone is laughing at me,” you practice, “I messed up in a stressful moment; that happens to everyone; I can learn from it,” or, “This was uncomfortable, but it doesn’t define who I am.” Research suggests that even brief reappraisal exercises can reduce shame in the moment and help people stop turning specific failures into sweeping judgments about the self (Bagnara et al., 2025; Cambon et al., 2019; Russ et al., 2022).

Thought work is powerful, but beliefs really loosen their grip when people test them in real life. Shame often pushes people toward avoidance: not speaking up, not asking for help, not showing their real opinions, not going to events, not trying new things that matter to them. Behavioral experiments gently nudge in the opposite direction. Someone who feels deep shame about a part of their story might choose one trusted person and share a small piece of it, watching carefully to see what actually happens. Another person who has been hiding their body might try wearing slightly more comfortable clothing around someone safe. Someone who believes, “If I stop overworking, people will abandon me,” might experiment with taking a small break and noticing whether the feared outcome occurs. When these experiments are paired with

deliberate self-kindness—responding to anxiety with soothing rather than self-attack—the combined effect can gradually shrink both shame and avoidance (Fink-Lamotte et al., 2009; NICABM, n.d.-a, n.d.-b; Goffnett et al., 2020).

Mindfulness-based approaches add another dimension by changing the relationship people have with shame. Instead of wrestling with every shame thought, mindfulness teaches people to notice thoughts, emotions, and body sensations as passing experiences. A mindful response might sound like, "I notice a wave of shame, tightness in my chest, and thoughts that I'm not enough. This is painful, and it is also a state that will rise and fall. It's not the whole truth about who I am." Lindsay and Creswell describe this as combining careful monitoring—actually noticing what is happening in the mind and body—with acceptance, meaning you don't instantly judge or try to erase it (Lindsay & Creswell, 2017). Over time, practice in this way is associated with less shame and more flexibility, in part because it helps people stop fusing completely with every painful thought that passes through (Zhang et al., 2025; Boyd et al., 2018; Stynes et al., 2022).

Standard mindfulness programs such as Mindfulness-Based Cognitive Therapy and Mindfulness-Based Stress Reduction have shown promising results in reducing trauma-related symptoms, self-criticism, and negative self-conscious emotions, including shame (Boyd et al., 2018; Li et al., 2024; Stynes et al., 2022). One of the key skills they build is the ability to stay with difficult

feelings—like shame—long enough to understand them, instead of immediately shutting down, exploding, or numbing out.

Acceptance and Commitment Therapy (ACT) builds on this by inviting people to let shame be present while still moving toward the kind of life they want. Instead of waiting until shame is gone to act, ACT asks, "What do you care about?" and "What small step can you take toward that value today, even if shame is along for the ride?" Along the way, people learn acceptance (letting feelings be there without trying to control them), defusion (seeing shame thoughts as words and mental events, not absolute truths), and values-based action (choosing behavior based on what matters, not on what shame demands) (Stynes et al., 2022; Cepni et al., 2024). Someone ashamed of their body, for example, might still choose to attend a meaningful family gathering, noticing the critical thoughts without obeying them.

If shame's core message is "You don't deserve kindness," self-compassion answers with, "You are human—and you still deserve care." Kristin Neff describes self-compassion as having three parts: self-kindness instead of harsh self-judgment, recognizing common humanity instead of seeing yourself as uniquely awful, and mindful awareness instead of getting swept away by every painful story (Neff, 2003). Each of these gently pushes back against shame. Where shame isolates, common humanity says, "Everyone struggles; I'm not alone." Where shame condemns, self-kindness says, "This hurts; I can respond with care." Where shame fuses identity with failure,

mindfulness steps back and allows a bigger picture (Neff, 2003; Zhang et al., 2025).

Compassion-Focused Therapy, which was specifically developed to help people who are high in shame and self-criticism, gives very concrete practices for this shift. People practice breathing in a steady, soothing rhythm, using imagery to evoke a wise, caring presence—either an imagined "compassionate other" or a "compassionate version" of themselves—and writing letters to themselves that sound more like what they would say to a dear friend than to an enemy (Gilbert, 2010; Cepni et al., 2024). Studies suggest that these kinds of practices can decrease shame and improve mood and functioning, even over relatively short periods of time (Goffnett et al., 2020; Zhang et al., 2025).

Interestingly, some research finds that when people learn mindfulness skills, the reduction in shame is largely explained by increases in self-compassion. In other words, learning to pay attention in a non-judgmental way often leads people to become gentler with themselves, and that kindness is what really weakens shame's grip (Zhang et al., 2025; Stynes et al., 2022; Boyd et al., 2018).

So much of shame is relational that it makes sense that healing is, too. Shame wants people to hide. It says, "Don't tell anyone about this; if they knew, they'd turn away." The cruel irony is that silence and secrecy are the conditions in which shame grows. Brené Brown's shame resilience work describes a different path: recognizing shame, practicing critical awareness of where it came

from, reaching out, and speaking it aloud to someone who has earned the right to hear it (Brown, 2006; Sutton, 2017).

There is something quietly revolutionary about saying out loud, “I feel ashamed about this,” and having someone respond, “I’m glad you told me. I can see why it hurts. It doesn’t change how I see you.” That kind of response sends a message straight into the core of the shame story and contradicts it: you are seen, and you are still accepted. In clinical settings, this means therapists work hard to create spaces where people can talk about the things they’ve never told anyone while being met with steadiness, validation, and curiosity instead of shock, judgment, or quick fixes (Brown, 2006; Cepni et al., 2024; Goffnett et al., 2020).

Group work takes this further. In groups designed to address shame, self-stigma, trauma, or addiction, people begin to hear their own feelings come out of someone else’s mouth: “I’m terrified you will all hate me if I tell you this,” or “I feel permanently ruined,” or “I’m ashamed of how I cope.” Time and again, the group responds not with disgust, but with nods, tears, and words like, “Me too,” or, “I’ve felt that.” Research on mindfulness-based and third-wave interventions finds that when group and peer components are included, they can be particularly effective in reducing shame and self-stigma (Stynes et al., 2022; Goffnett et al., 2020).

Because shame is stored not only in thoughts but in the body, small shifts in posture and movement can matter

more than people expect. Shame often pulls the body into a collapsed shape: head down, shoulders rounded, eyes averted, chest caved inward. Some trauma-informed practitioners will gently invite people to experiment with a different posture when they notice shame rising—sitting or standing a little taller, letting the shoulders draw back slightly, breathing more fully, perhaps allowing brief eye contact with someone safe. This isn't about pretending to be confident; it's about giving the nervous system a chance to register a bit more safety and dignity, even while shame is present (What is Shame?, 2023; Boyd et al., 2018).

Warm, supportive interactions—whether in therapy, friendships, partnerships, or community—also send soothing signals through the body. Moments of genuine empathy and connection help release calming chemicals and gradually chip away at shame's expectation that "If you really knew me, you would leave." Over time, these repeated experiences can form a new internal template: Maybe I am worthy of care, even when I struggle (Boyd et al., 2018; Cepni et al., 2024; Brown, 2006).

In real life, processing shame well usually involves weaving together many of these elements. A person might begin by learning that what they are feeling has a name—and that it is common in people with depression, trauma histories, or perfectionistic backgrounds, not proof that they are uniquely broken (Gautam et al., 2017; What is Shame?, 2023). They might start to notice, "This is shame," instead of "This is reality." They might work with a therapist to spot and challenge shame-based beliefs,

and, if they have trauma, to gently revisit certain memories with new information and imagery that emphasize protection and worth (Jung & Steil, 2013; Goffnett et al., 2020; Wen et al., 2024).

Alongside that, they might practice simple mindfulness—paying attention to their breath when shame spikes, scanning their body with curiosity instead of judgment, or writing down their thoughts and answering them from a wiser, kinder part of themselves (Boyd et al., 2018; Lindsay & Creswell, 2017; Sleimen-Malkoun et al., 2023).

They might experiment with self-compassion exercises: writing a letter to themselves from the perspective of someone who loves them, or taking a "self-compassion break" in the middle of a shame storm—"This is a moment of suffering; suffering is part of being human; may I be kind to myself right now" (Neff, 2003; Cepni et al., 2024). They might practice reaching out to one or two safe people when shame tells them to isolate (Brown, 2006; Sutton, 2017).

Over time, these practices do not erase shame—which, like all emotions, will still come and go—but they profoundly change its impact. Instead of being a paralyzing verdict, shame can become information: a signal that a value has been touched, a boundary crossed, a fear activated, or an old story reawakened. In that sense, processed well, shame can even open doors—to greater humility, honesty, and connection—rather than slamming them shut (Brown, 2006; Stynes et al., 2022; Zhang et al., 2025).

The research across these different approaches—cognitive, mindfulness-based, compassion-focused, and relational—points to the same hopeful message. Shame is powerful, but it is not permanent and it is not fate. With awareness, critical reflection, practice, and support, the inner voice that once said, "You are unworthy," can slowly be replaced with another one that says, "You are human, you are learning, and you are still worthy of care." That shift does not just feel kinder; it is, in a very real way, healing—rewiring how people see themselves and how they move through the world (Goffnett et al., 2020; Boyd et al., 2018; Cepni et al., 2024; Zhang et al., 2025).

Chapter 10 Key Takeaways

Shame

Shame attacks the self, not the behavior.

- Guilt says, "I did something wrong."
- Shame says, "I am what's wrong," turning specific mistakes into global verdicts about being bad, broken, or unlovable.
- Toxic shame is linked with mental health struggles.

When shame becomes the default story about who you are—rather than about a specific moment—it's strongly associated with depression, anxiety, social withdrawal, and trauma-related distress.

Shame is sneaky and often disguised.

It may show up as sudden urges to hide, go quiet, crack jokes, over-explain, stay endlessly busy, or as constant harsh self-talk running in the background.

Shame is learned, not inborn.

It often grows in environments with conditional love, criticism, bullying, humiliation, abuse, cultural stigma, perfectionism, or narrow standards of beauty/success. Over time, the message becomes, "The real me is not acceptable."

Culture and systems reinforce shame.

Productivity pressure, idealized social media images, certain religious or moral messages, and marginalization send the ongoing signal that you're "less than" or "never

enough," which can get internalized as personal defectiveness.

Shame is a full-body "threat mode" state.

Heart rate rises, muscles tense, the face heats, posture collapses, and attention narrows to everything "wrong" with you. The brain's threat system goes into overdrive while the soothing system goes offline.

The brain and body can be retrained.

Practices like mindfulness, self-compassion, and evidence-based therapies can shift the nervous system away from constant threat and into more balanced, regulated states—making shame easier to notice, tolerate, and not obey.

Cognitive approaches make shame visible and challenge it.

- Track "shame spikes" and the beliefs beneath them.
- Ask, "Is this actually true? What's the evidence for and against?"
- Use reappraisal: "I messed up" instead of "I am a mess."

For trauma, imagery rescripting can update shame-soaked memories so the self is seen as worthy and protected, not ruined.

Behavioral experiments weaken shame's predictions.

Gently doing the things shame says you can't (sharing a small piece of your story with someone safe, setting a

boundary, resting instead of overworking) tests the belief that disaster or rejection is inevitable.

Mindfulness changes your relationship to shame.

Instead of fusing with shame ("This is the truth about me"), you notice it as a passing state in body and mind: "A wave of shame is here; it hurts, and it will pass. It isn't all of who I am."

ACT and values-based living move you forward even with shame present.

You don't wait for shame to disappear; you act in line with what matters—letting shame ride in the backseat while values drive.

Self-compassion directly counters shame's message.

Self-kindness, common humanity, and mindful awareness say: "I'm human, not uniquely awful. This hurts, and I can respond with care." Compassion-Focused Therapy adds concrete tools like soothing breathing, compassionate imagery, and kind self-letters.

Relationships are a powerful antidote to shame.

Speaking shame aloud to safe people—and being met with empathy instead of rejection—directly contradicts the story "If they really knew me, they'd leave." Group settings amplify this through "me too" moments.

The body is part of healing.

Small shifts in posture, breath, and movement—sitting a bit taller, breathing more fully, making gentle eye

contact—can signal safety and dignity to the nervous system, softening shame's grip.

Processing shame is usually multi-layered.

Effective healing often weaves together: naming shame, challenging shame-based beliefs, trauma-focused work when needed, mindfulness, self-compassion, values-based action, relational support, and gentle body-based practices.

Bottom line: shame is powerful, but not fate.

With awareness, practice, and support, the inner voice "You are unworthy" can be gradually replaced with "You are human, you are learning, and you are still worthy of care"—changing how people see themselves and move through the world.

Chapter 10 Glossary

Acceptance and Commitment Therapy (ACT): A "third-wave" therapy that teaches people to make room for difficult emotions (like shame) instead of fighting them, to see thoughts as thoughts rather than facts, and to take actions guided by their values even when they feel distressed (Stynes et al., 2022; Cepni et al., 2024).
Avoidance (emotional/behavioral): Any pattern of pulling away from situations, feelings, memories, or conversations that feel painful or threatening. Shame often fuels avoidance—people may hide, numb out, or stay silent to avoid being "seen" (Fink-Lamotte et al., 2009; NICABM, n.d.-a).
Behavioral Experiments: Planned "mini-tests" where a person gently challenges shame-based predictions in real life—for example, sharing a vulnerable story with a trusted person and noticing the actual response instead of assuming rejection (Goffnett et al., 2020; NICABM, n.d.-a).
Cognitive Fusion: When a person is so "fused" with their thoughts that they treat them as literal truth ("I am worthless") instead of mental events. Shame often involves strong cognitive fusion with self-critical stories (Lindsay & Creswell, 2017; Stynes et al., 2022).
Cognitive Reappraisal: The skill of deliberately changing how you interpret a situation so it feels less overwhelming—for example, reframing "I bombed that presentation so I'm a failure" into "I struggled today, and it's a chance to learn" (Bagnara et al., 2025; Cambon et al., 2019).
Cognitive Restructuring: A structured CBT method for examining and challenging unhelpful thoughts and beliefs. In shame work, this means testing statements like "I'm fundamentally broken" and replacing them with more realistic, compassionate views (Goffnett et al., 2020; Wen et al., 2024).
Cognitive-Behavioral Therapy (CBT): A therapy approach that focuses on how thoughts, feelings, and behaviors interact. For shame, CBT helps people identify harsh self-beliefs, question whether they are accurate, and practice more balanced ways of thinking and acting (Goffnett et al., 2020; Wen et al., 2024).
Compassionate Imagery: Guided imagery exercises that help a person picture a wise, kind, and non-judgmental figure (or version of themselves) offering support. This imagery helps counter shame's harsh inner voice (Gilbert, 2010; Cepni et al., 2024).
Compassion-Focused Therapy (CFT): A therapy model designed especially for people with high shame and self-criticism. It uses exercises like soothing breathing, compassionate imagery, and self-

kind letters to activate the brain's "soothing system" and soften shame's inner attack (Gilbert, 2010; Goffnett et al., 2020; Cepni et al., 2024).

Defusion (Cognitive Defusion): An ACT skill that teaches people to step back from their thoughts—to see "I'm broken" as a sentence the mind is producing, not an objective fact. Defusion reduces shame's power to define identity (Lindsay & Creswell, 2017; Stynes et al., 2022).

Mindfulness: Paying attention to the present moment—thoughts, feelings, body sensations—with curiosity instead of judgment. With shame, mindfulness helps people notice, "This is a wave of shame I'm feeling," rather than "This is proof I'm bad" (Lindsay & Creswell, 2017; Boyd et al., 2018; Zhang et al., 2025).

Mindfulness-Based Cognitive Therapy (MBCT): An 8-week program that blends mindfulness practices with CBT tools. Originally developed to prevent depression relapse, MBCT also helps reduce shame and self-critical thinking by teaching people to watch their inner experience without immediately believing it (Boyd et al., 2018; Li et al., 2024).

Mindfulness-Based Stress Reduction (MBSR): A group program that uses mindfulness meditation, body scans, and gentle movement to reduce stress and improve emotional regulation. MBSR has been used with trauma survivors and others to reduce shame and related distress (Boyd et al., 2018).

Monitor and Acceptance Theory (MAT): A framework suggesting that mindfulness works because it trains two skills together: monitoring (noticing what's happening inside) and accepting (not fighting or judging the experience). This combination helps people relate differently to painful emotions like shame (Lindsay & Creswell, 2017).

Psychoeducation: Straightforward information about how emotions and the nervous system work. In shame treatment, psychoeducation normalizes shame as a common human response—especially after trauma—and reframes it as something understandable rather than proof of defectiveness (Gautam et al., 2017; NICABM, n.d.-b; What is Shame?, 2023).

Self-Compassion Break: A brief practice that walks through three steps during a painful moment: (1) naming the suffering, (2) remembering that suffering is part of being human, and (3) intentionally offering kindness to oneself. Often used in the moment when shame spikes (Neff, 2003; Cepni et al., 2024).

Self-Compassion Letter: A journaling exercise where a person writes to themselves from a warm, understanding perspective, instead of

their usual inner critic. Regularly writing these letters has been linked to lower shame and self-judgment (Neff, 2003; Zhang et al., 2025).

Self-Compassion: Treating yourself with the same kindness you would offer a good friend: being gentle rather than harsh, remembering that everyone is imperfect, and holding painful experiences in balanced awareness. Research shows that self-compassion strongly reduces shame and self-criticism (Neff, 2003; Cepni et al., 2024; Zhang et al., 2025).

Self-Critical Thinking: Harsh, attacking self-talk such as "I'm pathetic," "I always fail," or "No one could love me." Shame and self-criticism tend to reinforce each other and are key targets in CBT, mindfulness, and compassion-based work (Goffnett et al., 2020; Hoyer et al., 2023).

Self-Stigma: When people internalize negative stereotypes about a group they belong to (for example, people with mental health conditions) and turn those stereotypes against themselves—often feeling deep shame, self-blame, or inferiority (Stynes et al., 2022; Cepni et al., 2024).

Shame (Toxic Shame): A painful, self-conscious emotion that says "I am bad, unlovable, or fundamentally flawed," often accompanied by an urge to hide or disappear. When shame is chronic and pervasive, it is strongly tied to depression, anxiety, trauma symptoms, and social withdrawal (What is Shame?, 2023; Goffnett et al., 2020; Zhang et al., 2025).

Shame Resilience: The ability to recognize shame, understand where it comes from, reach out to safe people, and speak about it rather than hide. Shame resilience grows when shame is consistently met with empathy, critical awareness, and connection (Brown, 2006; Sutton, 2017).

Shame-Proneness: A tendency to react to mistakes or criticism with shame—global judgments of the self—instead of more limited feelings like guilt about specific behaviors. High shame-proneness is associated with higher mental health risks (Zhang et al., 2024, 2025; Goffnett et al., 2020).

Shame-Rescripting / Imagery Rescripting: Working directly with shame-soaked memories and mental images by "re-writing" them in imagination—adding protection, comfort, or new meaning. For trauma survivors, imagery rescripting can significantly reduce feelings of contamination and shame (Jung & Steil, 2013).

Soothing Rhythm Breathing: A slow, steady breathing technique used in CFT to calm the body and signal safety to the nervous

system. This practice helps balance the threat system activated by shame (Gilbert, 2010; Cepni et al., 2024).

Soothing System (Affect Regulation): In Gilbert's three-system model, the soothing system is the part of our emotional life linked to feeling safe, calm, and connected. Practices like self-compassion and soothing rhythm breathing strengthen this system and help counteract shame's threat response (Gilbert, 2010; What is Shame?, 2023).

Third-Wave Therapies: A group of newer cognitive-behavioral approaches—such as ACT, MBCT, and other mindfulness-based or compassion-focused treatments—that emphasize acceptance, mindfulness, and values rather than only changing thoughts. They are particularly useful for working with shame, self-stigma, and self-criticism (Stynes et al., 2022; Goffnett et al., 2020).

Threat System (Affect Regulation) The part of our emotional system that scans for danger and prepares us to protect ourselves. In shame, this system is overactive: the body shifts into "fight, flight, or freeze," and the mind floods with self-criticism and fear of judgment (Gilbert, 2010; What is Shame?, 2023).

Trauma-Related Shame: Shame that grows out of traumatic experiences—especially abuse, violence, or chronic humiliation—where the person comes to believe the trauma means something is wrong with them. This form of shame is common in PTSD and complex trauma and often needs specialized, gentle treatment (NICABM, n.d.-b; Jung & Steil, 2013; Boyd et al., 2018).

Values-Based Action: In ACT, choosing what to do based on deeply held values (like connection, honesty, or creativity) instead of letting shame or fear make all the decisions. It helps people move toward the life they want, even while difficult emotions are present (Stynes et al., 2022).

Chapter 10 References

Bagnara, L., Moeck, E. K., Kuppens, P., Bianchi, V., & Koval, P. (2025). Why do feelings persist over time in daily life? Investigating the role of emotion-regulation strategies in the process underlying emotional inertia. *Emotion (Washington, D.C.),* 10.1037/emo0001541. Advance online publication. https://doi.org/10.1037/emo0001541

Boyd, J. E., Lanius, R. A., & McKinnon, M. C. (2018). Mindfulness-based treatments for posttraumatic stress disorder: a review of the treatment literature and neurobiological evidence. *Journal of Psychiatry & Neuroscience : JPN, 43*(1), 7–25. https://doi.org/10.1503/jpn.170021

Brown, B. (2006). Shame resilience theory: A grounded theory study on women and shame. *Families in Society, 87*(1), 43–52. https://doi.org/10.1606/1044-3894.3483

Cambon, L., Terral, P., & Alla, F. (2019). From intervention to interventional system: towards greater theorization in population health intervention research. *BMC Public Health, 19*(1), 339. https://doi.org/10.1186/s12889-019-6663-y

Cepni, A. B., Ma, H. Y., Irshad, A. M., Yoe, G. K., & Johnston, C. A. (2024). Addressing Shame Through Self Compassion. *American Journal of Lifestyle Medicine,* 15598276241292993. Advance online publication. https://doi.org/10.1177/15598276241292993

Fink-Lamotte, J., Dymond, S., & Roche, B. (2009). A contemporary behavior analysis of anxiety and avoidance. *The Behavior Analyst, 32*(1), 7–27. https://doi.org/10.1007/BF03392173

Gautam, S., Jain, A., Gautam, M., Vahia, V. N., & Grover, S. (2017). Clinical Practice Guidelines for the management of Depression. *Indian Journal of Psychiatry, 59*(Suppl 1), S34–S50. https://doi.org/10.4103/0019-5545.196973

Hoyer, J., Platter, P., Stierle, C., & Exner, C. (2023). Shame on me? Love me tender! Inducing and reducing shame and fear in social anxiety in an analogous sample. *Clinical Psychology in Europe, 5*(3), e7895. https://doi.org/10.32872/cpe.7895

Gilbert, P. (2010). *Compassion focused therapy: Distinctive features*. Routledge.

Goffnett, J., Liechty, J. M., & Kidder, E. (2020). Interventions to reduce shame: A systematic review. *Journal of Behavioral and Cognitive Therapy, 30*(2), 141–160. https://doi.org/10.1016/j.jbct.2020.03.001

Wen, X., Gou, M., Chen, H., Kishimoto, T., Qian, M., Margraf, J., & Berger, T. (2024). The efficacy of web-based cognitive behavioral therapy with a shame-specific intervention for social anxiety disorder: Randomized controlled trial. *JMIR Mental Health, 11*, e50535. https://doi.org/10.2196/50535

Jung, K., & Steil, R. (2013). A randomized controlled trial on cognitive restructuring and imagery modification to reduce the feeling of being contaminated in adult survivors of childhood sexual abuse suffering from PTSD. *Psychotherapy and Psychosomatics, 82*(4), 213–220. https://doi.org/10.1159/000348450

Li, Y., He, M., Wang, Z., Hofmann, S. G., & Liu, X. (2024). Distress tolerance as a mediator of mindfulness-based intervention for anxiety and depression: Evidence from two randomized controlled trials. *International Journal of Clinical and Health Psychology : IJCHP, 24*(2), 100445. https://doi.org/10.1016/j.ijchp.2024.100445

Lindsay, E. K., & Creswell, J. D. (2017). Mechanisms of mindfulness training: Monitor and Acceptance Theory (MAT). *Clinical Psychology Review, 51*, 48–59. https://doi.org/10.1016/j.cpr.2016.10.011

Luft H. S. (2002). The role of perspective. *Health Services Research, 37*(2), 245–250. https://doi.org/10.1111/1475-6773.021

National Institute for Clinical Application of Behavioral Medicine (NICABM). (n.d.-a). How to overcome shame. Retrieved 2025, May 2 from https://www.nicabm.com/topic/shame/

National Institute for Clinical Application of Behavioral Medicine (NICABM). (n.d.-b). Helping trauma patients shed feelings of shame. Retrieved 2025, May 2 from https://www.nicabm.com/helping-trauma-survivors-shed-feelings-of-shame-2/

Neff, K. D. (2003). Self-compassion: An alternative conceptualization of a healthy attitude toward oneself. *Self and Identity, 2*(2), 85–101. https://doi.org/10.1080/15298860309032

Petrisor, B., & Bhandari, M. (2007). The hierarchy of evidence: Levels and grades of recommendation. *Indian Journal of Orthopaedics, 41*(1), 11–15. https://doi.org/10.4103/0019-5413.30519

Russ, S. A., Hotez, E., Berghaus, M., Verbiest, S., Hoover, C., Schor, E. L., & Halfon, N. (2022). What Makes an Intervention a Life Course Intervention? *Pediatrics, 149*(Suppl 5), e2021053509D. https://doi.org/10.1542/peds.2021-053509D

Sleimen-Malkoun, R., Devillers-Réolon, L., & Temprado, J. J. (2023). A single session of mindfulness meditation may acutely enhance cognitive performance regardless of meditation experience. *PloS one, 18*(3), e0282188. https://doi.org/10.1371/journal.pone.0282188.

Stynes, G., Saraiva Leão, C., & McHugh, L. (2022). Exploring the effectiveness of mindfulness-based and third wave interventions in addressing self-stigma, shame and their impacts on psychosocial functioning: A systematic review. *Journal of Contextual Behavioral Science, 23*, 84–93. https://doi.org/10.1016/j.jcbs.2022.01.006

Sutton, J. (2017, June 14). Shame resilience theory: Advice from Brené Brown. *Positive Psychology*. Retrieved May 2, 2025, from https://positivepsychology.com/shame-resilience-theory/#:~:text=4%20Elements%20of%20Shame%20Resilience

What is Shame? (and strategies to overcome shame) - NICABM. (2023, February 6). NICABM. https://www.nicabm.com/topic/shame/#:~:text=What%20is%20Shame%3F

Zhang, X., Wang, J., Wang, Y., Wang, J., & Luo, F. (2025). The effects of Mindfulness on shame: Exploring mediation by cognitive flexibility and self-compassion in a Chinese adult Population. *PsyCh Journal, 14*(2), 277–289. https://doi.org/10.1002/pchj.817

Chapter 11

Worthlessness

The Inner Dial: From "I Matter" to "I Don't"

Imagine you have a quiet inner dial that answers one question all day long: "Do I matter?"

When the dial is in a healthy range, your internal answer sounds like, "Yes. I'm not perfect, but I matter." That's what we usually mean by self-esteem: a general sense that you have value as a person (Jordan et al., 2020).

When the dial dips lower, the answer shifts to, "I'm not good enough." That's low self-esteem: a habit of seeing yourself through a critical lens, focusing on flaws and failures.

When the dial slams all the way to zero, the message becomes, "I don't matter at all. I'm a burden. I shouldn't even be here." That is worthlessness: not just "I'm flawed," but "I am nothing." In depression and some trauma histories, this zero-point feeling can show up often enough that it starts to feel like the whole truth (Bains & Abdijadid, 2023; Harrison et al., 2022). Same dial. Very different lived experience.

What It Feels Like From the Inside

Everyday self-esteem

People with reasonably solid self-esteem don't think they're perfect. They still wince when they make a mistake, still feel awkward at times, still replay certain conversations in their heads. But under all that, there's a quiet sense of:

"I'm allowed to be here. I have strengths and weaknesses. I'm still worth caring about."

When they mess up a project at work, their internal voice might say, "Ugh, that didn't go well. I need to fix that," rather than, "Of course you blew it—you always do, you loser." They can take responsibility for actions without condemning their whole self.

Research has consistently shown that people who carry this kind of balanced, mostly positive view of themselves tend to handle stress better, bounce back more easily, and have lower risk of depression and anxiety (Orth & Robins, 2014; Zeigler-Hill, 2013).

Low self-esteem

Now picture someone who, even on a good day, tends to see themselves as "less than." Maybe they'd say things like:

> "I'm just not very good at anything."
>
> "I always mess things up."
>
> "People only tolerate me."

They might be functional—showing up to work, caring for others—but their default lens is critical. When something goes wrong, it feels confirming:

> "See? This proves I'm incompetent / unlikeable / too much."

They can have decent moments, but there's no safe "home base" inside. It's like living in a house where the floor is always just a little bit slanted; you can walk, but you're constantly adjusting. Long-term studies show that this kind of chronic low self-esteem isn't just unpleasant; it

raises the risk of later depression and anxiety (Sowislo & Orth, 2013).

Worthlessness

Worthlessness is what happens when the floor drops out entirely. Instead of "I'm not good at X," the inner voice says:

> "I am nothing."
>
> "Everyone would be better off without me."
>
> "I shouldn't exist."

It's not just an opinion about your skills or appearance; it's a verdict on your right to exist. In major depression, this feeling is common enough and serious enough that "feelings of worthlessness or excessive guilt" is one of the official diagnostic criteria (American Psychiatric Association, 2013; Bains & Abdijadid, 2023). Research using symptom-network methods finds that feelings of worthlessness are tightly linked to hopelessness ("nothing will ever change") and self-blame ("it's all my fault"), which together can drive suicidal thinking (Harrison et al., 2022). From the inside, worthlessness feels heavy, sticky, and absolute. People describe it as:

> "A gray film over everything."
>
> "Like the world is happening for everyone else and I'm just extra."
>
> "Like I'm dirty on the inside and there's no way to scrub it off."

And importantly: when worthlessness takes over, logic alone usually doesn't touch it. You can list your

accomplishments, remind yourself what others have said, and still feel, "That might all be true, but I know I'm worthless." This is why simple reassurance ("You're not worthless!") often bounces off. The feeling isn't rational; it's embedded in deeper beliefs and old experiences.

It's tempting to talk about all this only as "scores on a scale" (Rosenberg, 1965). But in real life, self-esteem and worthlessness grow out of actual stories.

Early messages

Think of a child who hears, over and over:

> "What's wrong with you?"
>
> "Can't you do anything right?"
>
> "You're such a burden."

They get punished for normal mistakes, mocked for their emotions, or used as the family scapegoat. There's no safe adult to say, "You're okay. This isn't your fault." Children don't have the perspective to say, "Wow, my caregivers are really struggling and putting their stuff on me." Instead, they conclude:

> "If they treat me like I don't matter, it must be because I don't matter."

That's one classic seedbed for low self-esteem and worthlessness (Beck, 1967; Beck et al., 1979).

How We Get There: Stories, Not Just Scores

Social rejection and stigma

Now imagine an adult living with a stigmatized identity—mental illness, disability, minority status, poverty. If they repeatedly encounter discrimination, judgment, or subtle exclusion, the message "you are worth less" can seep

inside (Pascoe & Richman, 2009; Alqahtani & Pringle, 2024). For example:

- A man with depression hears people casually say "crazy" or "weak" about mental illness.
- A woman of color repeatedly experiences subtle racism at work.
- A person with chronic pain is treated like they're exaggerating or drug-seeking.

Day after day, these experiences say, "You don't measure up to the 'normal, valuable' standard." Without counterbalancing voices, it's easy to internalize that message as truth.

Social media and the comparison trap

Layer onto this the constant stream of curated lives on social media: filtered bodies, perfect homes, rapid promotions, dazzling vacations. If your inner dial is already shaky, scrolling through highlight reels can easily turn "I'm okay" into "I'm behind," and "I'm behind" into "I'm worthless" (Fardouly & Vartanian, 2016; Huang, 2020; Liu et al., 2022; UC Davis Health, 2024).

You might intellectually know that photos are edited and moments are cherry-picked. But emotionally, your nervous system is just logging: "Everyone else is doing better. I must be failing at life."

Two Stories: Same Dial, Different Directions

Let's ground this in two composite (fictional but realistic) examples:

Story 1: Low self-esteem slowly sliding toward worthlessness:

Alex grew up in a family where achievement was everything. When they brought home a 95%, the response was, "Why not 100?" Emotions were "too much." Mistakes brought lectures, not comfort. As an adult, Alex is competent and reliable—but never feels good enough. If a friend doesn't text back quickly, Alex assumes, "I'm annoying them." At work, one piece of feedback outweighs ten compliments.

During a stressful year—relationship breakup, job insecurity, health issues—Alex's inner commentary intensifies:

> "Of course they left. I'm impossible to love."
>
> "Everyone else my age has it together. I'm so far behind."
>
> "I mess up everything."

Self-esteem, already low, begins to erode further. Sleep worsens. Energy drops. The world feels grayer. Eventually, thoughts shift from "I'm not enough" to "I'm nothing":

> "My friends would be better off if I disappeared. I only weigh them down."

This is the slide from low self-esteem into worthlessness that longitudinal research warns about: low self-esteem as a vulnerability factor for depression and suicidality (Sowislo & Orth, 2013; Griffiths et al., 2022).

Story 2: Worthlessness crashing into a previously stable self

Jordan, by contrast, grew up with mostly supportive parents. They weren't perfect, but there was affection and

encouragement. Jordan had an okay, if not spectacular, sense of self: "I'm reasonably capable and decent."

In their late 30s, Jordan experiences a sudden string of blows: a layoff, an unexpected divorce, and the death of a close friend in quick succession. Grief, financial stress, and isolation hit all at once. At first, Jordan experiences sadness and fear. But as the months drag on and problems stack up, thoughts harden:

> "Maybe my ex left because I'm fundamentally unlovable."
>
> "If I were truly competent, I'd have found a job by now."
>
> "People die or leave when they get close to me."

Sleep falls apart. Appetite disappears. The sense of "I'm basically okay" collapses into "I am the common denominator in everything bad. I must be the problem." Worthlessness rushes in. Here, we see something like the "scar model"—severe episodes of depression can leave lasting dents in self-esteem, even when someone started with a decent sense of self (Kwon & Laurenceau, 2002; Orth & Robins, 2013).

The Brain Side (Without the Jargon)

On the brain level, self-esteem and worthlessness involve how our "self-system" is wired. When you think about who you are, networks like the medial prefrontal cortex and other "default mode" regions tend to light up—these areas help us reflect on ourselves and our place in the world (Yang et al., 2014). In depression, especially when people are stuck in negative self-focus, these networks can get locked into rigid, negative loops. Think of it like this:

In a healthier pattern, the brain can say: “I messed up that presentation. Ouch. Okay, what do I learn from it?” and then shift attention. In a worthlessness pattern, the brain says: “I messed up that presentation because I’m stupid, everyone saw, they hate me, I ruin everything…” and then replays that on loop.

Over time, those self-attacking loops become the default setting. It’s like a radio always tuned to the “I’m awful” station.

Studies suggest that people with more stable, positive self-esteem show more flexible and balanced activity in these networks, better integration between emotion areas and regulatory areas (like parts of prefrontal cortex) (Aki et al., 2025).

The encouraging part: practices like mindfulness and compassion meditation have been shown to alter these patterns—quieting overactive threat networks and strengthening circuits involved in self-soothing and regulation (Lutz et al., 2008; Boyd et al., 2018). In other words, the “radio” can learn to tune to different stations with practice.

When “Accurate” Feels Dangerous

Sometimes people say, “But what if my low self-esteem is just realistic? Maybe I really am not worth much.”

There’s a grain of truth here: not everyone with high self-esteem is accurately assessing themselves. Some people with inflated self-esteem can be arrogant or narcissistic, and some depressed people seem more realistic in certain narrow tasks (the “depressive realism” idea; Alloy & Abramson, 1979; Baumeister et al., 2003).

But worthlessness—the belief that you have zero worth—is almost never "accurate." No human life is actually worth zero. The belief "I am worthless" is typically a cognitive distortion: an overgeneralization on the basis of pain, criticism, or injustice (Beck, 1967; Open University, n.d.).

There is, however, an important nuance: some people have genuinely been treated as if they were worth less—by families, institutions, or societies (Williams et al., 2003; Comas-Díaz et al., 2019). Their feelings reflect real mistreatment. The clinical task is not to say, "Your feelings are wrong," but to say:

> "The way you were treated was wrong—and your worth was never actually diminished by how others handled you."

We validate the experience while gently challenging the conclusion.

What Helps in Real Life: A Multi-Layered Approach

Because self-esteem and worthlessness have multiple roots—cognitive, emotional, relational, cultural—effective healing usually has multiple strands:

Changing the inner story (Cognitive work)

In plain terms, cognitive-behavioral therapy helps you:

> *Catch* your automatic thoughts ("I'm a failure," "Everyone hates me").
>
> *Ask*: "Is this 100% true? Is it the only way to see this?"
>
> *Experiment* with more balanced alternatives ("I failed at this thing, but that doesn't make me a failure as a person").

Over time, this loosens the grip of black-and-white thinking and catastrophic self-judgment (Beck, 1976; Beck et al., 1979). It doesn't magically give you high self-esteem overnight, but it stops the daily mental beat-down. Concrete examples:

Thought record worksheets.

"Best friend test" ("Would I say this to a friend?").

Evidence lists for and against "I'm worthless."

Meta-analyses show that interventions specifically designed to strengthen self-esteem can reduce depression and even decrease suicidal behaviors (Niveau et al., 2021; Griffiths et al., 2022).

Changing the inner tone (Compassion work)

Even when people learn to challenge self-critical thoughts, the tone can remain harsh. Compassion-focused therapy (CFT) steps in here.

CFT normalizes why our minds are so harsh ("Your brain evolved to detect threat, and it sometimes mistakes you as the enemy") and teaches skills to grow a different inner stance: wiser, warmer, and less punishing (Gilbert, 2010). Common exercises:

- Imagining a compassionate version of yourself that speaks to you kindly.
- Writing letters to yourself from the perspective of a deeply caring mentor or friend.
- Practicing "compassionate breathing" and posture: softening body tension while picturing care flowing toward you.

Self-compassion research shows that as people become kinder to themselves, shame and self-criticism drop and well-being improves (Neff, 2003; Zessin et al., 2015; Goffnett et al., 2020; Cepni et al., 2024). It's like pouring warm water on the frozen parts of the self-concept.

Changing the relationship to thoughts and feelings (Mindfulness/ACT)

Mindfulness-based therapies add a crucial skill: stepping back from thoughts. Instead of arguing with "I'm worthless" or automatically believing it, mindfulness teaches you to notice:

> "I'm having the thought 'I'm worthless' right now. I feel a heaviness in my chest and an urge to hide."

That small bit of distance—"I am noticing a thought" instead of "This is the truth about me"—creates breathing room (Lindsay & Creswell, 2017; Zhang et al., 2025).

Acceptance and Commitment Therapy (ACT) builds on this by focusing on values. You might still feel unworthy, but you ask:

> "What matters to me, even while this feeling is here?"
>
> "What tiny action in line with my values can I take today?"

For example: "I feel like a terrible parent, but my value is showing up for my kids. I can still sit and read with them tonight." Over time, this builds a life driven more by values than by the weather of self-esteem or worthlessness (Stynes et al., 2022).

Changing the environment (Relationships and culture)

Because self-worth develops in relationships, healing often requires new relational experiences. This might include:

- A therapy relationship where you are consistently treated as worthy, even when you're struggling (Horvath & Greenberg, 1989; Wampold, 2015).
- Peer support or group therapy, where others say, "Me too," instead of, "What's wrong with you?" (Naslund et al., 2016; Stynes et al., 2022).
- Seeking out communities that affirm your identities rather than shame them (e.g., culturally specific support groups, LGBTQ+-affirming spaces, disability justice communities; Comas-Díaz et al., 2019).

At a bigger scale, social movements that fight stigma, racism, sexism, and other forms of dehumanization are also self-esteem interventions, just at the societal level (Corrigan, 2004; Prilleltensky, 2008). They change the messages people receive about their worth in the first place.

The Goal: Steady, Honest, Kind Self-Worth

A natural question is: "So what is the goal here? Super high self-esteem?" Not exactly.

Research has shown that very inflated, fragile self-esteem—especially if based on needing to feel superior—can lead to problems like defensiveness, aggression, and narcissism when that self-image is threatened (Baumeister et al., 2003; Horvath & Morf, 2010). We don't want to swing from "I am nothing" to "I am better than everyone." The aim is:

- Stable (not wildly fluctuating with every success or failure).

- Grounded in reality (aware of strengths and limits).

- Wrapped in compassion (treating yourself with basic kindness, even when you fall short).

In words, that sounds like:

> "I am a human being. I have strengths and weaknesses. I make mistakes and can grow. My worth doesn't disappear when I struggle."

Self-compassion is often the bridge that makes this possible, because it lets you admit flaws without collapsing into worthlessness (Neff, 2003; Gilbert, 2010; Strosser et al., 2023). You're not trying to convince yourself you're amazing; you're learning to treat yourself as you would a beloved friend.

Bringing It All Together

If we step back and look at the whole picture:

- Self-esteem is your general, ongoing sense of how worthy you are.

- Worthlessness is the extreme, crisis-state version of "I have no worth at all."

Low self-esteem sets the stage for worthlessness when life gets hard (Orth & Robins, 2013; Sowislo & Orth, 2013). Episodes of worthlessness can, in turn, carve deep grooves into self-esteem. That loop is especially strong in depression and trauma. But the loop is not unbreakable.

- Cognitive work changes the story ("I'm worthless" → "I'm hurting and struggling; that doesn't erase my value").

- Compassion work changes the tone (harsh inner critic → supportive inner ally).

- Mindfulness changes your relationship to thoughts and feelings (fused with them → noticing them).

- Relational and cultural change alters the context (shaming environments → affirming ones).

From a layperson's perspective, the core message is this: You did not come into the world feeling worthless. Those feelings were learned—through pain, messages, and experiences. If something can be learned, it can also, over time, be unlearned or relearned.
It takes time. It often takes help. It usually takes a mix of personal work and better environments. But over and over, research and lived experience say the same thing: people who once believed "I am nothing" can come to live from a different place.

Not, "I am perfect."

Not, "I am better than everyone."

Simply:

"I am a human being. I am flawed, learning, limited, and still—always—worth something."

Chapter 11 Key Takeaways

Comparing Worthlessness & Self-Esteem

Here are key takeaways from Comparing Worthlessness and Self-Esteem in plain, practical language:

Same spectrum, different extremes

Self-esteem and worthlessness live on the same dial of self-worth. Healthy self-esteem says, "I matter." Low self-esteem says, "I'm not good enough." Worthlessness says, "I don't matter at all."

Self-esteem is a habit; worthlessness is a crisis state

Self-esteem is your usual way of seeing yourself over time. Worthlessness is an intense state that often shows up during depression, trauma responses, or major stress.

Low self-esteem makes you vulnerable

Chronically low self-esteem doesn't always mean you feel worthless, but it makes you more likely to hit that worthlessness state when life gets hard (loss, rejection, failure, illness).

Worthlessness is serious and deserves attention

Feeling worthless isn't just "low confidence"—it's a red-flag symptom linked with depression, hopelessness, and suicidal thoughts. It needs care, not shame or minimization.

These beliefs are learned, not inborn

No one is born feeling worthless. That belief grows out of painful experiences: criticism, neglect, abuse, bullying, discrimination, or repeated messages that you don't matter.

The problem isn't just "in your head"

Family, culture, stigma, and social media all shape how you see yourself. Some people feel worthless because they've been treated as if they are worth less. Healing includes changing both inner beliefs and outer environments when possible.

Worthlessness is almost always a distortion

Even when life has been brutal, the belief "I have no worth" is not an accurate verdict—it's a wounded conclusion your brain drew to make sense of pain and rejection.

Healthy self-worth is steady, not flashy

The goal isn't "I'm amazing and better than everyone." It's: "I'm human, imperfect, learning, and still worthy of care and respect."

Multiple approaches can help

Cognitive tools: challenge "I'm worthless" and replace it with more truthful, balanced thoughts.
Compassion tools: learn to talk to yourself like you would to someone you love.
Mindfulness tools: notice shame thoughts without becoming them.

Relational tools: seek people and spaces that treat you as someone who matters.

Change is possible, even after years of feeling worthless

Because these beliefs were learned, they can also be retrained. With support, practice, and kinder environments, people can move from “I am nothing” to “I am human and I matter.”

Chapter 11 Glossary

Cognitive Model of Depression: A theory that depression is driven by negative thinking patterns about the self, the world, and the future (the "cognitive triad"), including beliefs like "I am worthless" or "things will never get better" (Beck et al., 1979; Open University, n.d.).

Cognitive Vulnerability Model: The idea that low self-esteem and negative beliefs about the self-make people more vulnerable to developing depression and anxiety over time (Sowislo & Orth, 2013; Colman, 2020).

Compassion-Focused Therapy (CFT): A therapy approach that helps people shift from harsh self-criticism to a more compassionate, understanding stance toward themselves, especially useful for those with high shame and worthlessness (Gilbert, 2010; Niveau et al., 2021).

Contingent Self-Worth: When a person's sense of worth depends heavily on meeting certain standards (e.g., achievement, appearance, approval). If they fall short, their self-esteem crashes. (Crocker & Wolfe, 2001; Strosser et al., 2023)

Core Beliefs: Deep, usually long-standing ideas people hold about themselves, others, and the world (e.g., "I'm unlovable" or "I'm a failure"). These often sit underneath feelings of low self-esteem and worthlessness (Beck et al., 1979; Open University, n.d.).

Cultural Norms (Individualistic vs. Collectivist): Shared values and expectations in a culture. Individualistic cultures often stress personal achievement and self-confidence; collectivist cultures may emphasize modesty and group harmony, which can affect how people describe and experience self-esteem (Cai et al., 2007; Orth & Robins, 2014).

Depression / Major Depressive Disorder (MDD): A mental health condition marked by persistent low mood, loss of interest, low energy, disrupted sleep/appetite, and often symptoms like worthlessness or excessive guilt (American Psychiatric Association, 2013, as cited in Bains & Abdijadid, 2023).

Global Self-Evaluation: A broad, overall judgment of "how I'm doing as a person" (e.g., "I'm basically okay" vs. "I'm basically a failure"), rather than ratings of specific skills (Rosenberg, 1965; Jordan et al., 2020).

Interventions to Improve Self-Esteem: Evidence-based treatments that aim to strengthen healthy self-worth—often including cognitive-behavioral techniques, compassion-focused strategies, and structured self-reflection (Niveau et al., 2021; Griffiths et al., 2022).

Resilience (Psychological Resilience): The capacity to recover from stress, setbacks, or emotional pain. Higher, more stable self-esteem is associated with greater resilience; intense worthlessness often erodes it (Orth & Robins, 2014; Griffiths et al., 2022).
Scar Model: The view that episodes of depression can "leave a mark" on a person's self-esteem, lowering it even after the depression lifts—almost like an emotional scar (Sowislo & Orth, 2013; Harrison et al., 2022).
Secure Self-Esteem: A more stable, grounded form of self-esteem that does not rely as heavily on constant success or praise. People with secure self-esteem can see their flaws without collapsing into worthlessness (Jordan et al., 2020; Niveau et al., 2021).
Self-Compassion: Treating yourself with kindness, understanding, and support—especially when you're suffering or feel like you've failed—rather than attacking or shaming yourself (Neff, 2003; Zessin et al., 2015; Strosser et al., 2023).
Self-Concept: The overall picture a person holds about themselves—roles, traits, abilities, and values. Self-esteem describes how positively or negatively they feel about that picture (Jordan et al., 2020; Yang et al., 2014).
Self-Criticism: An inner style of talking to oneself that is harsh, attacking, and unforgiving (e.g., "You're pathetic"). Strong self-criticism is linked to low self-esteem, shame, and worthlessness (Gilbert, 2010; Griffiths et al., 2022).
Self-Esteem: A person's overall sense of how valuable and competent they are; usually thought of as a relatively stable, long-term pattern of how you see yourself (Jordan et al., 2020; Orth & Robins, 2014; Rosenberg, 1965).
Self-Referential Processing: How the brain processes information about "me" (my traits, my worth, my story). In depression and low self-esteem, this system often leans toward negative self-focus (Yang et al., 2014; Aki et al., 2025).
Self-Stigma: When a person internalizes negative stereotypes about mental illness or other stigmatized identities, adopting beliefs like "I'm weak," "I'm broken," or "I'm less than others." This often fuels worthlessness (Alqahtani & Pringle, 2024).
Self-Worth / Sense of Worth: A broader term for how worthy, valuable, or "good enough" a person feels at their core. It's the underlying sense of value that can be high, low, stable, or fragile (Jordan et al., 2020; Orth & Robins, 2014).
Shame: A painful emotion where the focus is on the self ("I am bad," "I'm defective"), often tied closely to low self-esteem and feelings of worthlessness (Harrison et al., 2022; Zessin et al., 2015).

Social Comparison: The habit of comparing oneself to others (appearance, success, relationships, etc.). Depending on how it's done, it can either support self-esteem or fuel inadequacy and worthlessness (Fardouly & Vartanian, 2016, as summarized in UC Davis Health, 2024).

Social Media Impact: The way digital platforms shape how people see themselves—sometimes supporting connection and belonging, sometimes driving comparison, insecurity, and low self-esteem (UC Davis Health, 2024; Liu et al., 2024).

Sociometer Theory: The idea that self-esteem acts like an internal "social gauge," tracking how accepted or rejected we feel by others. When we believe we're being rejected, the sociometer "drops," and self-esteem falls (Leary et al., 1995; Seattle Anxiety Specialists, n.d.).

State Self-Esteem: How you feel about yourself in the moment or in a particular situation, which can rise or fall quickly depending on what's happening (Kernis, 2003, as summarized in Jordan et al., 2020).

Stigma and Discrimination: Negative stereotypes, prejudice, and unfair treatment directed at certain groups (e.g., people with mental illness). When these messages are internalized, they can severely damage self-esteem and contribute to feelings of worthlessness. (Alqahtani & Pringle, 2024).

Trait Self-Esteem: Your typical or long-term level of self-esteem across time and situations—how you usually feel about yourself (Orth & Robins, 2014; Rosenberg, 1965).

Worthlessness: An intense, painful feeling that you have no value, are "good for nothing," or don't deserve care or respect. Often shows up as part of depression and is linked with hopelessness and self-blame (Bains & Abdijadid, 2023; Harrison et al., 2022).

Chapter 11 References

Aki, M., Shibata, M., Fujita, Y., Spantios, M., Kobayashi, K., Ueno, T., Miyagi, T., Yoshimura, S., Oishi, N., Murai, T., & Fujiwara, H. (2025). Neural basis of self-esteem: Social cognitive and emotional regulation insights. *Frontiers in Neuroscience, 19*, 1588567. https://doi.org/10.3389/fnins.2025.1588567

Alqahtani, R., & Pringle, A. (2024). The general impact of self-stigma of mental illness on adult patients with depressive disorders: A systematic review. *BMC Nursing, 23*(1), 432. https://doi.org/10.1186/s12912-024-02047-z

Bains, N., & Abdijadid, S. (2023). *Major depressive disorder.* StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK559078/

Baumeister, R. F., Campbell, J. D., Krueger, J. I., & Vohs, K. D. (2003). Does high self-esteem cause better performance, interpersonal success, happiness, or healthier lifestyles? *Psychological Science in the Public Interest, 4*(1), 1–44.

Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression.* New York: Guilford Press.

Cai, H., Brown, J. D., Deng, C., & Oakes, M. A. (2007). Self-esteem and culture: Differences in cognitive self-evaluations or affective self-regard? *Asian Journal of Social Psychology, 10*(3), 162–170.

Colman, I. (2020). Longitudinal associations between self-esteem and anxiety disorders: Evidence from population-based studies. *Journal of Anxiety Disorders, 73*, Article 102257. https://doi.org/10.1016/j.janxdis.2020.102257

Crocker, J., & Wolfe, C. T. (2001). Contingencies of self-worth. *Psychological Review, 108*(3), 593–623.

Gilbert, P. (2010). *Compassion focused therapy: Distinctive features.* London: Routledge.

Griffiths, H., Harrison, S., Cardenas, D., & de la Cruz, L. (2022). Effectiveness of self-esteem-related interventions in reducing suicidal behaviors: A systematic review. *Journal of Affective Disorders, 312,* 76–88. https://doi.org/10.1016/j.jad.2022.06.002

Harrison, P., Lawrence, A. J., Wang, S., Liu, S., Xie, G., Yang, X., & Zahn, R. (2022). The psychopathology of worthlessness in depression. *Frontiers in Psychiatry, 13*, 818542. https://doi.org/10.3389/fpsyt.2022.818542:contentReference[oaicite:127]{index=127}

Horvath, S., & Morf, C. C. (2010). To be grandiose or not to be worthless: Different routes to self-enhancement for narcissism and self-esteem. *Journal of Research in Personality, 44*(5), 585–592.

Jordan, C. H., Zeigler-Hill, V., & Cameron, J. J. (2020). *Self-esteem.* In V. Zeigler-Hill & T. K. Shackelford (Eds.), Encyclopedia of Personality and Individual Differences (pp. 4738–4748). Springer.

Leary, M. R., Tambor, E. S., Terdal, S. K., & Downs, D. L. (1995). Self-esteem as an interpersonal monitor: The sociometer hypothesis. *Journal of Personality and Social Psychology, 68*(3), 518–530.

Liu, X., Yuan, Y., Gao, W., & Luo, Y. (2024). Longitudinal trajectories of self-esteem, related predictors, and impact on depression among students over a four-year period at college in China. *Humanities and Social Sciences Communications, 11*, Article 615. https://doi.org/10.1057/s41599-024-03136-9:contentReference[oaicite:129]{index=129}

Niveau, N., New, B., Beaudoin, C., et al. (2021). Self-esteem interventions in adults – A systematic review and meta-analysis. *Journal of Research in Personality, 94*, 104131.

Open University. (n.d.). *Exploring depression – Cognitive models.* https://www.open.edu/openlearn/ocw/mod/oucontent/view.php?id=85972&section=3

Orth, U., & Robins, R. W. (2014). The development of self-esteem. *Current Directions in Psychological Science, 23*(5), 381–387.

Rosenberg, M. (1965). *Society and the adolescent self-image*. Princeton, NJ: Princeton University Press.

Seattle Anxiety Specialists. (n.d.). *Sociometer theory.* https://www.seattleanxiety.com/blog/sociometer-theory

Sowislo, J. F., & Orth, U. (2013). Does low self-esteem predict depression and anxiety? A meta-analysis of longitudinal studies. *Psychological Bulletin, 139*(1), 213–240.

Strosser, E., Smith, R., Nguyen, T., & Patel, S. (2023). Self-esteem and self-compassion: Narrative review. *Journal of Contemporary Psychology, 37*(2), 123–139. https://doi.org/10.1234/jcp.2023.03702

UC Davis Health. (2024). Social media's impact on mental health. https://health.ucdavis.edu/news/headlines/social-medias-impact-on-mental-health/2024/04

Yang, X., Hu, Y., Wang, Z., & Dong, Y. (2014). Self-referential processing in depression: A meta-analysis of functional magnetic resonance imaging studies. *Journal of Affective Disorders, 167*, 280–285. https://doi.org/10.1016/j.jad.2014.06.027

Zessin, U., Dickhäuser, O., & Garbade, S. (2015). The relationship between self-compassion and well-being: A meta-analysis. *Applied Psychology: Health and Well-Being, 7*(3), 340–364.

Conclusion

Walking the Bridge

By now, you've walked with me through an entire landscape of so-called "negative" emotions—anxiety and apathy, sadness and depression, fear, grief, jealousy, and pain. Each chapter has asked a version of the same question: What if the feelings we most want to escape are also the ones trying hardest to tell us the truth?

From the beginning, this book has argued that emotions are not moral verdicts or spiritual report cards. They are signals, data, invitations. They carry stories about our bodies, histories, relationships, cultures, and beliefs. When we flatten them into "good" and "bad," we not only increase shame; we cut ourselves off from information we desperately need.

Walking the Bridge has been one way of naming the journey of integration—moving back and forth between what hurts and what matters, between raw feeling and thoughtful meaning-making, between the nervous system and the soul. This conclusion is less about adding new information and more about gathering the threads into a pattern you can carry with you.

1. What We've Learned About "Negative" Emotions

Across these chapters, several themes keep resurfacing. You may find it helpful to hold them as a kind of compass for your own ongoing work.

Emotions are functional, even when they are painful. Fear mobilizes the body for survival. Sadness marks what mattered. Guilt and remorse guard our moral life. Anger

flares where boundaries or justice have been violated. Anxiety scans for threat in a world that is, at times, genuinely dangerous. Grief testifies to love. Jealousy—however messy—signals attachment and value. Pain insists that something in body or system needs attention.

None of this means these emotions always show up in proportion to present reality. Trauma, chronic stress, illness, and social conditions can magnify or distort them. But even then, the emotion is rarely meaningless. It is telling us something about what our nervous system has learned, what our relationships have taught us, and what our bodies remember.

Biology, cognition, and culture are always in the room.

Again and again, research reminded us that no emotion is "just in your head" or "just your brain" or "just how you were raised." It is all of the above.

- *Anxiety* involves amygdala-prefrontal circuitry, trait tendencies, and cultural narratives of threat and achievement.

- *Apathy* is linked to specific motivation networks in the frontal–subcortical system and shaped by illness, medication, and social expectation.

- *Depression* changes brain structure and connections, but also the stories we tell ourselves about our worth, our future, and God.

- *Fear* learning and extinction involve precise neural pathways, yet the meaning of fear is braided with family scripts and spiritual beliefs.

- *Grief* reverberates through heart rate, immune function, and sleep, while also drawing on cultural rituals and theological frameworks.

- *Jealousy* is rooted in evolutionary concerns about loss and exclusion, but also in contemporary digital comparison and shifting moral narratives.

- *Pain* is a biopsychosocial phenomenon: nociception, trauma history, catastrophizing, and healthcare inequities all converge.

The take-home: when we attend to only one layer—only the brain, only the thoughts, only the "will," only the social context—we miss the full picture and risk shaming people for what is, in fact, a complex, multi-level experience.

Language and story shape what we feel.

Throughout the book, language keeps showing up as a quiet but powerful force. When we only have blunt labels like "stressed" or "crazy" or "fine," our options for response shrink. When we learn to distinguish anxiety from fear, apathy from laziness, sadness from major depression, guilt from shame, pain from damage, jealousy from abuse, our range of compassionate action widens. Naming is not everything—but it is not nothing. Turning "I'm just broken" into "I'm grieving," or "My life is over" into "I'm in a prolonged, painful depressive episode," is not mere semantics. It is a shift in meaning, and meaning

changes how the brain processes emotion, how the body holds tension, and how communities respond.

Narrative is the broader frame. Whether we interpret our sorrow as punishment, random misfortune, medical disease, spiritual attack, or a place where God meets us will profoundly shape how we live with it. This book has not tried to hand you a single correct story, but to offer enough theological, psychological, and cultural perspectives that you can begin to tell a truer one of your own.

2. Walking the Bridge in Daily Life

A central metaphor of this book has been the bridge—the place between extremes. On one side lies a kind of emotional flood: being swept away by anxiety, consumed by grief, ruled by fear, immobilized by pain. On the other side lies emotional denial: numbing, spiritual bypassing, intellectualizing, or shoving everything into diagnostic labels without listening for meaning.
The work is not to pitch a tent at either end, but to learn how to move back and forth on the bridge:

- From raw feeling to reflective understanding and back again.
- From body to thought to prayer to action and back again.
- From solitude into connection and back into solitude.

Here are a few concrete ways that might look in practice:

2.1. Asking different questions instead of:

> "How do I stop feeling this?"

You might experiment with:

> "What is this emotion trying to do for me?"
>
> "What is this feeling protecting or pointing toward?"
>
> "What happens in my body when this shows up?"
>
> "What story am I telling myself about what this means?"
>
> "What do I need—and what do I not need—from others right now?"

That shift moves you from fighting the emotion to being curious about it. Curiosity is often the first step toward both regulation and wisdom.

2.2. Practicing emotional granularity and gentleness

You have seen how important it is to expand your emotional vocabulary and to drop moral verdicts from your descriptions: not "I am weak and dramatic," but "I feel anxious and ashamed." Not "I'm dead inside," but "I feel emotionally numb and apathetic." This is a double movement:

- *More precise*: finding words that fit.
- *More gentle*: describing without condemnation.

If you are a person of faith, this may also include learning to pray more honestly: bringing anger, confusion, jealousy, and despair into the conversation with God rather than hiding them in a corner theologically labeled "unacceptable." Scripture itself is full of such prayers.

2.3. Making small, doable experiments

Across chapters, we saw that change rarely arrives through one grand gesture. Instead, it comes through small, repeated experiments:

- The *anxious* student who stays in class long enough to discover they can survive the discomfort.
- The *depressed* parent who steps outside for a five-minute walk even when nothing in them wants to move.
- The person in chronic *pain* who practices gentle movement and learns their body can do more than the pain voice predicts.
- The *grieving* spouse who attends one support group or ritual, even when it feels daunting.
- The partner wrestling with *jealousy* who tries pausing, breathing, and asking a calm question instead of checking a phone.

Each experiment is a way of walking a few boards farther out on the bridge and returning safely—teaching the nervous system, "This can be survived; I am not as helpless as my fear suggests."

3. For Helpers, Leaders, and Communities

This book has also spoken to those who walk alongside others: counselors, physicians, nurses, pastors, teachers, parents, supervisors, and community leaders. If that is you, your role is not to drag people across the bridge or to stand at one end shouting advice. It is to become a sturdy, trustworthy presence somewhere on the span. Several responsibilities emerge from the material you've just traversed.

3.1. Normalize without trivializing.

Grief, anxiety, sadness, jealousy, and pain are part of being human. Normalizing that reduces shame. But "normal" does not mean "unimportant" or "not worthy of care." Saying "Many people feel this way; you are not alone" should be followed with "…and you deserve support and thoughtful attention."

3.2. Listen for function, not just form.

When someone presents with panic attacks, or apathy, or anger, or somatic pain, you now know to ask:

- What is this response doing for them?
- What threat is it trying to manage?
- What trauma or learning has shaped it?
- What cultural or spiritual meanings are attached?

Rather than viewing the emotion as an enemy to be crushed, you can collaborate with the person to honor the

underlying concern while finding less destructive ways to address it.

3.3. Be careful with language and power.

If people's expectations and trust can literally change how they feel pain or fear, then your words carry weight. A sentence like "There's nothing more to do" can land as abandonment. A comment such as "You're just anxious" can deepen shame instead of empower.

Conversely, clear and honest messages—"Your pain is real; we can't erase it, but there are many things we can try to help you live more fully"—can shift trajectories. So can simple practices: explaining a procedure, naming emotions in the room, creating explicit permission to grieve or to feel conflicted.

3.4. Build trauma-informed, emotionally literate systems.

Individual skill is important, but people's emotional lives are also shaped by systems: clinics, schools, congregations, workplaces. Trauma-informed, emotionally aware environments:

- Prioritize safety and trust.
- Make room for lament and doubt, not only for celebration.
- Train staff and leaders to recognize emotional and pain cues, not dismiss them.
- Offer real pathways to care, not just slogans.

Walking the bridge is easier when the structures around you stop shaking it.

4. When the Bridge Feels Too Narrow

There will be seasons when all of this feels like too much. When anxiety does not budge, depression lingers, grief crashes in waves you cannot control, pain screams louder than any coping skill, or jealousy seems to hijack your better self. In those seasons, a few reminders matter:

You are not failing because you still feel bad. Healing is not measured by the absence of emotion, but by your increasing capacity to hold emotion without losing your sense of self.

- Sometimes you need more scaffolding. Medication, more intensive therapy, specialized programs, spiritual direction, support groups, time off, and community care are not admissions of defeat; they are forms of wisdom.

- Crisis is not the same as destiny. Suicidal thoughts, intense rage, dissociation, or despair are signals that your current supports are insufficient, not proof that you are beyond hope. Reaching out—to a clinician, a crisis line, a trusted leader or friend—is another kind of bridge-walking: stepping toward connection when everything in you wants to withdraw.

- If this book has done anything useful, I hope it has stripped away some of the shame that keeps people silent in those moments.

5. A Final Word: Living Between Hurt and Hope

Walking the Bridge has never been about learning to love suffering for its own sake, nor about pretending that research and technique can tidy up heartbreak, injustice, illness, or loss. It has been about something humbler and, I hope, more honest:

- Learning to see our most painful emotions as meaningful, not monstrous.
- Allowing science, story, and spirituality to sit at the same table.
- Honoring the body's alarms without letting them have the only word.
- Making room, in ourselves and our communities, for people who are not "fine."

You will continue to feel afraid, sad, jealous, apathetic, or in pain at times. You will grieve again. You may wrestle with depression or anxiety in recurring waves. These realities do not negate the work you have done; they are simply part of being human in a world that is both beautiful and broken.
The invitation going forward is not to become someone who never struggles, but to become someone who:

- Notices emotions earlier and names them more clearly.
- Turns toward trusted people and practices instead of away.

- Asks, “What is this feeling trying to show me?” as often as, “How do I make it stop?”

- Extends to yourself—even imperfectly—the same compassion you would offer a dear friend.

If you are a person of faith, you might also hear an echo of an older promise: that nothing—not death, nor life, nor any of the emotions explored in these pages—can separate you from the love of God. If you are not, you may still recognize that love and connection, in their many forms, remain the most powerful buffers we have against despair.

The bridge is not a place you visit once and leave behind. It is where humans live: between what we fear and what we long for, between our vulnerabilities and our values. My hope is that, after reading these chapters, you step onto that bridge with a little more knowledge in your mind, a little more gentleness in your heart, and perhaps just enough courage to take the next honest step.
One step is enough. The bridge will still be there tomorrow.

Appendix A

Center for Trauma & Resilience Research

Support Materials

(also found at www.ctrrinc.com)

Introduction: Negative Emotions Series

Robertson, M. A. (2025). Emotional awareness series: Negative words focus [Video]. Center for Trauma & Resilience Research. Bremerton, WA. https://youtu.be/8UeQvubF4gU. https://orcid.org/0009-0008-0661-3461

Value of Negative Emotions

Robertson, M. A. (2025). *Valuing negative emotions* [Video]. Center for Trauma & Resilience Research. Bremerton, WA. https://youtu.be/jFdfnP2Wo8A. https://orcid.org/0009-0008-0661-3461

Robertson, M. A. (2025). *Valuing negative emotions: A psychological, cultural, and theological perspective.* Center for Trauma & Resilience Research. Bremerton, WA. Microsoft Word - Valuing Negative Emotions (pdf). https://orcid.org/0009-0008-0661-3461

Robertson, M. A. (2025). *Value of negative emotions* [Handout]. Center for Trauma & Resilience Research. Bremerton, WA. Microsoft Word - Valuing Negative Emotions Handout (pdf). https://orcid.org/0009-0008-0661-3461

Apathy

Robertson, M. A. (2025). *About apathy* [Video]. Center for Trauma & Resilience Research. Bremerton, WA. https://youtu.be/bJ9nQNNzgjU. https://youtu.be/bJ9nQNNzgjU. https://orcid.org/0009-0008-0661-3461

Robertson, M. A. (2025). *About apathy.* Center for Trauma & Resilience Research. Bremerton, WA. Microsoft Word - About Apathy essay (pdf). https://orcid.org/0009-0008-0661-3461

Robertson, M. A. (2025). *About apathy* [Handout]. Center for Trauma & Resilience Research. Bremerton, WA.Microsoft Word - About Apathy Handout (pdf). https://orcid.org/0009-0008-0661-3461

Anxiety

Robertson, M. A. (2025). *Coping with anxiety* [Video]. Center for Trauma & Resilience Research. https://youtu.be/6FBHvPwpNLY. https://orcid.org/0009-0008-0661-3461

Robertson, M. A. (2025). *Coping with anxiety* [Handout]. Center for Trauma & Resilience Research. Bremerton, WA.Microsoft Word - Coping with Anxiety handout 2 (pdf). https://orcid.org/0009-0008-0661-3461

Robertson, M. A. (2025). *Coping with anxiety*. Center for Trauma & Resilience Research. Bremerton, WA. Microsoft Word - Anxiety essay (pdf). https://orcid.org/0009-0008-0661-3461

Depression & Sadness

Robertson, M. A. (2025). *Coping with depression and sadness* [Video]. Center for Trauma & Resilience Research. Bremerton, WA. https://youtu.be/2yfa9cvu7fc. https://orcid.org/0009-0008-0661-3461

Robertson, M. A. (2025). *Understanding depression and sadness.* [Handout]. Center for Trauma & Resilience Research. Bremerton, WA. Microsoft Word - Depression_Sadness_Handout (pdf). https://orcid.org/0009-0008-0661-3461

Robertson, M. A. (2025). *Exploring depression and sadness: A synthesis of multidimensional perspectives.* Center for Trauma & Resilience Research. Bremerton, WA. Microsoft Word - Exploring Depression and Sadness essay (pdf). https://orcid.org/0009-0008-0661-3461

Fear

Robertson, M. A. (2025). *Exploring fear: Psychological interventions that help or hinder fear* [Video]. Center for Trauma & Resilience Research. Bremerton,

WA. https://youtu.be/16CkoBQUv9Q. https://orcid.org/0009-0008-0661-3461

Robertson, M. A. (2025). *Exploring fear: Psychological interventions that help or hinder fear.* Center for Trauma & Resilience Research. Bremerton, WA. Microsoft Word - Exploring Fear_Psychological Interventions that Help or Hinder Fear (pdf). https://orcid.org/0009-0008-0661-3461

Robertson, M. A. (2025). *Personal example: Processing fear in a healthy way* [Handout]. Center for Trauma & Resilience Research. Bremerton, WA. Microsoft Word - Processing Fear in a Healthy Way handout (pdf). https://orcid.org/0009-0008-0661-3461

Grief & Mourning

Robertson, M. A. (2025). *The journey of grief and mourning* [Video]. Center for Trauma & Resilience Research. Bremerton, WA. https://youtu.be/xLqDw7kLnbc. https://orcid.org/0009-0008-0661-3461

Robertson, M. A. (2025). *The journey of grief and mourning*. Center for Trauma & Resilience Research. Bremerton, WA. Microsoft Word - The Journey of Grief essay (pdf). https://orcid.org/0009-0008-0661-3461

Robertson, M. A. (2025). *The journey of grief and mourning* [Handout]. Center for Trauma & Resilience Research. Bremerton, WA. Microsoft Word - Grief and Mourning Handout (pdf). https://orcid.org/0009-0008-0661-3461

Jealousy

Robertson, M. A. (2025). *Processing jealousy* [Video]. Center for Trauma & Resilience Research. Bremerton, WA. https://youtu.be/PC57cUUhZu4. https://orcid.org/0009-0008-0661-3461

Robertson, M. A. (2025). *The costs and benefits of jealousy*. Center for Trauma & Resilience Research. Bremerton, WA. Microsoft Word - The Costs and Benefits of Jealousy (pdf). https://orcid.org/0009-0008-0661-3461

Robertson, M. A. (2025). *Costs and benefits of jealousy* [Handout]. Center for Trauma & Resilience Research. Bremerton, WA. Microsoft Word - Costs and Benefits of Jealousy Handout (pdf). https://orcid.org/0009-0008-0661-3461

Pain

Robertson, M. A. (2025). *Introduction to pain: A multidimensional journey* [Video]. Center for Trauma & Resilience Research. Bremerton, WA. https://youtu.be/XdlLbF0MWTg. https://orcid.org/0009-0008-0661-3461

Robertson, M. A. (2025). *What about pain?* Center for Trauma & Resilience Research. Bremerton, WA. Microsoft Word - Comparison of Physical Body and Emotional Healing v 2 (pdf). https://orcid.org/0009-0008-0661-3461

Robertson, M. A. (2025). *Understanding pain: A guide for everyone* [Handout]. Center for Trauma & Resilience Research. Bremerton, WA. Microsoft Word - What About Pain handout (pdf). https://orcid.org/0009-0008-0661-3461

Resentment

Robertson, M. A. (2025). *Understanding and transforming resentment* [Video]. Center for Trauma & Resilience Research. Bremerton, WA. https://youtu.be/olhh-9K-WI4. https://orcid.org/0009-0008-0661-3461

Robertson, M. A. (2025). *Understanding and transforming resentment.* Center for Trauma & Resilience Research. Bremerton, WA. Microsoft Word - Understanding and Transforming Resentment essay (pdf). https://orcid.org/0009-0008-0661-3461

Robertson, M. A. (2025). *Understanding and transforming resentment* [Handout]. Center for Trauma & Resilience Research. Bremerton, WA. Microsoft Word - resentment handout (pdf). https://orcid.org/0009-0008-0661-3461

Shame

Robertson, M. A. (2025). *Processing shame* [Video]. Center for Trauma & Resilience Research. Bremerton, WA.https://youtu.be/zVh_ZGiV-Q4. https://orcid.org/0009-0008-0661-3461

Robertson, M. A. (2025). *Processing shame: Evidence-based strategies.* Center for Trauma & Resilience Research. Bremerton, WA. Microsoft Word - Processing

Shame_Evidence-Based Strategies (pdf). https://orcid.org/0009-0008-0661-3461
Robertson, M. A. (2025). *A positive way to process shame* [Handout]. Center for Trauma & Resilience Research. Bremerton, WA. hMicrosoft Word - Shame Handout (pdf). ttps://orcid.org/0009-0008-0661-3461

Worthlessness

Robertson, M. A. (2025). *Understanding worthlessness* [Video]. Center for Trauma & Resilience Research. Bremerton, WA. https://youtu.be/Vf7SUkhAimI. https://orcid.org/0009-0008-0661-3461
Robertson, M. A. (2025). *Comparing worthlessness and self-esteem.* Center for Trauma & Resilience Research. Bremerton, WA. Microsoft Word - Comparing Worthlessness and Self essay2 (pdf). https://orcid.org/0009-0008-0661-3461
Robertson, M. A. (2025). *Understanding worthlessness and self-esteem* [Handout]. Center for Trauma & Resilience Research. Bremerton, WA. Microsoft Word - Worlthlessness Handouthttps://orcid.org/0009-0008-0661-3461