Inside the Revolutionary Treatment That Could Change Psychotherapy Forever

IFS therapy is upending the thinking around schizophrenia, depression, OCD, and more

In May 2014, three days before graduating from college in Massachusetts, Ross Calvert (name changed for privacy), a quiet, artsy guy whose hopeful eyes and side-parted mop lend him some of the cherubic quirkiness of a Wes Anderson protagonist, had a bad acid trip from which his brain somehow failed to come back. His best friend's face kept looking weird and sinister. Passing strangers seemed to be whispering about his appearance, his mannerisms, his thoughts. Ross managed to keep it more or less together when his family arrived for his graduation, but for the next several months, voices came in and out of his head in a constant swell. One evening, Ross locked himself in the bathroom of the house he shared with friends just outside Boston and refused to come out. After exhausting all other avenues, his friends finally called the police, who broke down the door, hauled Ross out to a squad car, and delivered him to the hospital, where he was stripped of his clothes and belongings, forcibly administered antipsychotic medication, and confined to the psych ward.

The conventional view of psychosis in modern Western medicine is that it is essentially biological in nature. The focus is on rapid diagnosis and medication. Involuntary hospitalization remains common, despite evidence that it can often be avoided through early intervention involving families and psychotherapy. In one small but suggestive study, involuntary hospitalization induced post-traumatic stress disorder in 31% of patients.

"When I first saw Ross, it was almost as if there were a pane of glass between us," says David Medeiros, the therapist who Ross's parents brought him to after he got out. "His speech was

delayed. And then every time there was another hospitalization, it felt like another glass was put in place."

In March 2016, two days after yet another hospital release, Ross spiraled into another crisis. Again the police delivered him to the hospital. Again he was confined to the psych ward and forcibly medicated. This time he received a diagnosis of schizophrenia.

It was a devastating blow for Ross, his family, and his therapist. Between 85% and 90% of schizophrenic patients are unemployed in the United States, one of the most difficult places on Earth to live with the diagnosis. In a 1992 World Health Organization study of schizophrenia that continues to spark controversy in the field, patients in developing countries healed and went into remission at significantly higher rates than their counterparts in developed countries like the United States.

The problem is much bigger than schizophrenia. All too often, patients in today's U.S. mental health system fall into a downward spiral of increasing diagnoses and increasing medication. As journalist Robert Whitaker reported in his controversial classic *Anatomy of an Epidemic,* the number of people on government disability for mental illness has actually increased since the introduction of Xanax, Prozac, and other drugs that were once billed by pharmaceutical companies as a panacea for mental health. Though psychiatric medications have brought relief to millions of patients, the impact of long-term use of many drugs is only starting to become clear: chemical dependency, mounting side effects, and fundamental changes in the neurochemistry of the brain. For patients with a diagnosis of schizophrenia, the effect is particularly severe. Numerous studies have found that schizophrenics fare worse on long-term antipsychotics, though it remains the standard of care. Ross was teetering on the edge of a long, steep hill that ended in near-total dependency: on daily meds to manage symptoms, on hospitals

to arrest full-blown psychotic episodes, and likely on disability checks to provide for a living. (He had already begun the process of applying.)

Medeiros, Ross's therapist, didn't want that to happen. He had known Ross since age 11, when his parents had first brought him in for germophobia, and couldn't help believing that the warm, quirky kid he remembered lay somewhere inside the shell-shocked guy who now showed up each week in his office. But nothing Medeiros had tried seemed to be getting through. Ross kept ending up back in the hospital and coming out even more wary and cut off.

On the day after the 2016 presidential election, terrified by what it meant for the country, Ross slipped into psychosis yet again, wandering into the courthouse downtown and making a scene before the police finally hauled him off to the hospital. This was the fourth hospitalization in two years, and Medeiros was running out of options. At a loss for what else to do, he decided to try something radical: a novel therapeutic model called internal family systems therapy (IFS).

IFS had recently been the subject of a lot of chatter in the psychotherapy community. It was based on a novel theory of the mind so profoundly at odds with the biomedical model of mental illness that, if true, called decades of clinical orthodoxy into question. In IFS, mental health symptoms like anxiety, depression, paranoia, and even psychosis were regarded not as impassive biochemical phenomena but as emotional events under the control of unconscious "parts" of the patient — which they could learn to interact with directly.

Medeiros had only been undergoing IFS training for a year and didn't feel ready to do more than some preliminary exploratory work with Ross. But he had some idea who could help: Richard C. Schwartz, PhD, the developer of the therapy, whom Medeiros had had the good fortune to meet in person back in June 2016. When Schwartz appeared on the lineup for a trauma conference in Chicago, Medeiros signed up with the hope of speaking to him again. Nearly holding his breath

with anxiety, Medeiros found an opportune moment to seek Schwartz out and explain Ross's case. Schwartz listened intently.

"Why don't you bring him to Boston to see me?" Schwartz said.

Richard C. Schwartz, who goes by Dick with friends and colleagues, is an unlikely revolutionary. Modest and short-statured with a salt-and-pepper goatee, he has the gentle, close-set eyes of a slightly sleepy teddy bear. Though he is not widely known outside professional circles, those in the upper echelons of psychotherapy have been quietly spreading the word about him for some time. Bessel van der Kolk, the world-renowned trauma guru, has written that it was through Schwartz's work that the metaphor of the mind as an internal family "truly came to life for me and offered a systematic way to work with the split-off parts that result from trauma." Gabor Maté, a celebrated expert on addiction, has called IFS "a profound psychotherapy model" and directed his own followers to Schwartz's lectures. In 2016, Schwartz was invited into dialogue with the Dalai Lama as part of Europe's Mind & Life Conference in Brussels. Other influential figures in psychotherapy speak of Schwartz in language just shy of incantatory.

"Dick is a true visionary," says Deany Laliotis, director of training for the EMDR (Eye Movement Desensitization and Reprocessing) Institute, a central hub for one of the most widely respected and empirically grounded trauma therapies. "He's made a huge difference in the profession and in the world."

Terrence Real, bestselling author, expert on male depression, and co-founder of Harvard's Gender Research Project, agrees. "Dick is the St. Francis of Assisi of our generation," he says.

The son of a renowned endocrinologist, Schwartz went into practice as a therapist in the 1980s, beginning his career as part of a burgeoning movement of "family systems" therapists who

believed that mental illness arose not from individual pathology but from family dynamics. Schwartz specialized in bulimia and other eating disorders. He would ask the parents of his largely teenage clients to come to his office so he could explain the way a child could become a zone of proxy warfare, absorbing the familial pathology into themselves. When parents followed Schwartz's directives, the emotional health of the family tended to improve, but the patient's eating disorder would often persist.

"The patients kept refusing to see that they were cured," Schwartz dryly recalls.

It took a long time for Schwartz to break out of family systems orthodoxy and ask his patients about their interior lives. What he noticed in their responses was a surprising echo of the conflicted interpersonal relationships he had been trained for: They tended to talk colloquially about warring "parts" of them. One part of them wanted to be skinny; another part didn't care what people thought. One part felt shy and introverted; another part liked parties. One part sometimes seized control and ate and ate in a numb haze; a colder, more punitive part then took over and made them purge.

Schwartz found that one after another of his patients were able to identify regular voices in their heads that got into repetitive arguments with each other, often just below the level of language. At first, Schwartz was alarmed. He almost wondered if he was seeing undiagnosed dissociative identity disorder. But the symptoms didn't quite add up. For those with DID, the switch between "alters" meant a discontinuity in consciousness and memory, but switches between "parts" were usually more subtle than that. As one early patient put it, "In the course of 10 minutes I go from being a professional who has it all together, to a scared, insecure child, to a raging bitch, to an unfeeling, single-minded eating machine." Was it possible that parts were just a normal part of conscious experience — that everyone had parts?

Schwartz spent a while looking inside himself. Sure enough, his own inner conflicts separated out into distinct perspectives which voiced coherent points of view. In stressful situations, one or another of them would often hijack his consciousness to impose its own distorted perspective on the world, a process Schwartz came to call "blending." It seemed that Schwartz himself, like his patients, had parts. He considered coining a technical name for them, but eventually decided "parts" worked just fine.

For a while, drawing on his family systems training, Schwartz tried thinking of parts as internalized parents. The trick, he assumed, was to learn how to stand up to them, take back control. Then he had an encounter with a patient that changed his understanding forever.

Roxanne (name changed for privacy) was a deeply traumatized young woman who had been sexually abused as a girl and now cut her forearms with razor blades. For most of an hour-long session, Schwartz demanded that Roxanne's cutting part agree not to cut Roxanne's arms this week. He was firm, insistent, scolding — all the qualities he believed Roxanne needed to learn in order to control this part of herself. At last, looking beleaguered and exhausted, Roxanne relented and said she wouldn't cut her arms.

The next week, she walked into Schwartz's office with a long gash down her face.

"I just collapsed," Schwartz recalls. "I come from this 'first, do no harm' background with my medical father and family, and I could just see that I was doing harm to her, and that was a horrible feeling for me. A part of me literally wanted to give up, and I said that to her: 'I give up. I can't beat you at this.'"

It was an extraordinary admission from a therapist, puncturing the conventional patriarchal frame of the relationship. In an instant, the combative tension of the previous week drained out of the room. Roxanne looked at Schwartz curiously and said, “I don’t want to beat *you*.”

With that, her cutting part began to open up. As Schwartz listened with growing astonishment, it explained that it felt it needed to cut Roxanne to distract her from surges of rage and fear that it believed would be terribly dangerous to succumb to, a strategy it had first learned while she was being abused.

“The story made more and more sense to me,” Schwartz says. “I could, in my own mind, shift my view of the part from some kind of enemy or antagonist to a hero. It was a hero in her life, but it was also stuck in time.”

It was the beginning of Schwartz’s years-long investigation into the strange, often phantasmagoric world of parts. He soon learned that, like Roxanne’s cutting part, parts tended to be trapped in desperate situations they had encountered years before, using strategies to cope which had long since ceased to be adaptive. Schwartz got to know anxious achiever parts and depressed caregiver parts, super-efficient manager parts and flirtatious social butterfly parts, five-year-old parts which covered up pain with temper tantrums and 40-year-old parts which covered it up with drinking, parts which had never gotten over a small playground slight from a friend and parts which were trapped in horrifying scenes of child abuse or of war.

It would have been tempting to fit all this into a baroque theoretical framework, but Schwartz took his humbling experience with Roxanne to heart. Rather than impose his own ideas, he tried to approach parts with open curiosity, asking them to explain their roles and relationships with each other in their own words. To this day, when a young therapist attending one of Schwartz’s workshops comes up to the mic to ask whether a suicidal part is just seeking attention or a

comedic part is covering for shame, the answer Schwartz generally gives is, “You’d have to ask it,” invariably provoking a wave of nervous laughter from the room at his failure yet again to act like a guru.

Eventually, Schwartz did come up with names for the most common roles he saw parts taking on in their relationships with each other. Parts that he called protectors used a vast array of coping strategies, sometimes very extreme ones, to manage the emotional pain of deeply buried parts that Schwartz called exiles. Exiles were often very young and lived in a nightmarish limbo, interpreting even minor adult pain through the lens of the childhood memories they were trapped in. Because they were so vulnerable, exiles were hard to access. You had to go through protectors to get to them, and protectors could be tough customers. To speak to a seven-year-old exile carrying the pain of a father’s abusive criticism, for example, you might have to reckon with a blustering 40-year-old protector of a different exile who thought the seven-year-old was just as much of a pussy as his father used to call him — and that you were too, for taking his concerns seriously.

Luckily, it turned out there was an easier way of negotiating with protectors than having patients blend with them. If a patient simply closed their eyes and asked a part to “step back” a pace, they could often get enough emotional distance from it to speak for the part rather than from the part: “My defensive part is jumping up and down with rage that you would say something like that,” rather than “fuck you.” In this unblended state, the patient could ask questions of the part, listen to it, even bargain with it. If the part felt that its concerns were being taken seriously, it was often willing to step aside completely for a while, entering a visualized “waiting room” with the door closed behind it so that the patient could begin work on whatever part came up next.

If a patient got all their parts to step aside, protectors and exiles alike, something curious happened. They entered a state of mind far clearer and more joyful than any they seemed able to maintain in day-to-day life: calm, confident, curious, compassionate.

"What part is *this*?" Schwartz asked, amazed, the first few times it happened. He always got the same answer: "This doesn't feel like a part. It just feels like myself."

So Schwartz decided to call it Self*:* a unified mode of consciousness that seemed to lie just beneath all the sound and fury of parts, surprisingly reminiscent of the clear mental waters that Buddhists sought with mindfulness meditation. When a patient went into Self and visualized approaching an exile with total openness and compassion, something extraordinary happened: They began spontaneously to do the kind of work with their exiles that Schwartz himself would have done, far more effectively than Schwartz had been able to do from outside. With relief and gratitude, exiles opened up to Self about pain that they had held inside for decades. Patients sobbed, shook, screamed. Some reported seeing images of the exile opening its arms out for a hug or crawling into their laps, its long wait for rescue finally over. It almost felt to Schwartz as if he had hacked into the mind's built-in system for psychological self-repair.

Schwartz decided to call the process "unburdening," since his patients found it natural to visualize the exile's pain as a physical burden that was being burned away, dissolved into the ocean, or released into a great beam of light. Once an exile was unburdened, Schwartz found, the protectors that had been managing its pain — for instance, by eating mass quantities of ice cream every time the exile got triggered — tended to be more than happy to abandon their stressful old roles and find more fulfilling new ones. The transformations were powerful and lasting. Schwartz's bulimic patients finally stopped bingeing and purging.

Schwartz began giving talks at conferences about what he was doing. But his colleagues were far from convinced. Family systems therapists balked at the internalization of problems they were still convinced were located in families rather than individuals. Cognitive behavioral therapists thought distorted beliefs and attitudes had to be corrected, not coddled. Psychiatrists favored biochemical explanations that could be addressed with psychiatric medications, not nebulous internal dramas surrounding a mystical-sounding "Self." Even Schwartz's family wasn't convinced. According to Schwartz, his first wife and kids suffered from his obsessive early efforts to evangelize what he had decided to call internal family systems therapy. To this day his adult daughters rib him for all his strange talk of "parts."

Though Schwartz would end up consigned to the margins of psychotherapy for the better part of two decades, he never gave up on IFS. He felt sure that he was onto something.

Ona chilly winter's day in 2017, David Medeiros met Ross Calvert at his office in Newton, Massachusetts, and from there drove through 45 minutes of traffic to meet with Dick Schwartz in Boston. Ross was wary and quiet. Once in Schwartz's office, he took off his thick jacket and lay back stiffly into the depths of the couch as if dropped there from a great height, his eyes blank and distant behind his thick-framed glasses. Seeing him in this new context brought home to Medeiros just how sick Ross was. Medeiros hoped that Schwartz would be able to get through to him, but it wasn't looking good.

"It was taking Ross 10 seconds to answer simple questions," Medeiros recalls.

Schwartz began by asking Ross to report what he was feeling, to notice where it came up in his body. For a time he helped Ross get to know an inner critic part that attacked him for small social mistakes. Finally Schwartz took the plunge into the heart of it all: the paranoid part responsible for the wild outbursts which had landed Ross in the hospital.

“I’m really interested in that part,” Schwartz said. “Are you ready for that? How do you feel towards it?”

There was a long pause.

“I feel a bit afraid of it,” Ross said in a faltering monotone.

Medeiros knew enough about IFS by now to recognize this as the telltale sign of another part of Ross coming in. Ross’s hospital stays had been traumatic battles between different parts of him, the paranoid part wrestling for control with other parts and wreaking havoc when it won out. No wonder Ross was afraid of it.

“Let’s see if those scared parts can go into a waiting room,” Schwartz said.

Medeiros recognized the common IFS “waiting room” technique that he had been learning about in training. It could be surprisingly effective.

Schwartz asked how Ross felt toward the paranoid part now.

“I sort of feel like it’s kind of… silly,” Ross said. “Or… pointless.”

It was a step in the right direction, but even these gentler judgments were a sign of another part interfering. Schwartz chuckled.

“Okay,” he said. “Let’s get that part to step back, too. We just want to be open and curious with it, if that’s possible.”

There was another pause as Ross asked the judgmental part who had just spoken to step aside and returned his attention to the paranoid part.

“I sort of feel bad for it,” Ross said.

“Yeah, so let it know that,” said Schwartz, obviously pleased.

It was the first glimmer of Self, the built-in mental healing mode that Ross would need to tap into to heal his paranoid part. But it turned out that the paranoid part was wary of being contacted, fearing the critical parts which had attacked it so often before. For the next 45 minutes, Schwartz helped Ross strengthen his connection to Self, extending enough sympathy and compassion to the paranoid part that it began to trust Ross to help. By the end, Ross was describing himself sitting side by side with his paranoid part in the dorm room where he’d experienced that nightmarish LSD trip just before graduation. The part talked about its intense fear of the end of college, about the way Ross’s best friend’s face had started looking increasingly scary, about how a number of little incidents over the past few days had seemed to add up to a plot among his friends to betray him.

Schwartz asked if the part was ready to leave that place behind. Ross said that it was. He imagined driving the part around in the passenger seat of his old car.

“See if he’s interested in unloading any of the thoughts or beliefs or emotions he got back there,” Schwartz said.

Ross’s eyes closed behind his glasses. His shoulders slumped. Three whole minutes passed in silence on the clock before his eyes opened again.

“Um,” he said. “I think I was able to release a lot of what it was holding onto. Pretty much all of it.”

One by one, he explained, he and the paranoid part had walked through all the distorted beliefs from the psychotic break and given them up into a great beam of light.

“How do you feel?” Schwartz asked.

A tentative smile cracked Ross’s face.

“I feel unburdened in a literal sense,” he said. “I feel a lot lighter. I feel good. I feel hopeful.”

And with that, Medeiros couldn’t restrain himself from jumping out of his chair and giving a little cheer.

The idea of internal multiplicity is at least as old as Plato, who argued in *The Republic* that just like a city is divided into different social classes, the soul too is divided into parts with different characters, thriving only when justice and harmony reign among them. Many evolutionary psychologists subscribe to the “modularity of mind” hypothesis, which holds that the mind is built up of semi-independent evolutionary modules with different functions and goals. Famed neuroscientist Michael Gazzaniga discovered in a series of landmark experiments beginning in the 1960s that “split-brain” patients who have had their brain hemispheres surgically disconnected possess, in effect, two minds in one body. Gazzaniga posited that even fully connected brains were best understood as communities of semiautonomous agents.

It remains a significant conceptual leap from theories like these to the clinical phenomenon of “parts,” but Schwartz is not the first to have stumbled upon it. The Italian Freudian analyst

Roberto Assagioli called them “subpersonalities” and developed a psychoanalytic school of thought known as psychosynthesis at the beginning of the 20th century that sought to integrate them into a harmonious whole. Half a century later, husband-and-wife team John and Helen Watkins developed ego-state therapy in the United States with different terminology but much the same goal.

What sets IFS apart is the radically open and de-pathologizing stance it takes toward even the most extreme parts, which are presumed by default to be protecting exiles, and the calm, compassionate Self that seems to emerge in response. Schwartz credits the value so many have found in IFS’s map of internal multiplicity to the fact that, as a family therapist, he was largely ignorant of what had come before.

“I was forced to come to the phenomenon without any presumptions or preconceptions,” Schwartz says. “There’s no map that’s an exact replica of the territory, but I think [IFS] is closer than many others simply because I was so much in what the Buddhists call the beginner’s mind — total naive openness.”

Through the 1980s and ’90s, Schwartz managed to build a devoted cult following and earn a few high-profile champions, most notably trauma pioneer Bessel van der Kolk, who would first introduce many readers to IFS in his bestselling book *The Body Keeps the Score*. But initially, Schwartz failed to reach a larger audience. He attributes the upswing in IFS’s fortunes that followed in part to using IFS on himself: His crusading, moralizing attacks on mental health orthodoxy had come, he realized, from a protective part, defending against his fear of presenting such radical ideas. Schwartz came to the view that IFS was not a replacement for but a complement to other modalities. Different parts responded best to different kinds of treatment — including, in some cases, medication. For therapists with broad training, IFS could serve as a kind of umbrella framework that gave patients a simple conceptual language for tracking their

issues. For instance, a patient might have a suicidal part, a self-harming part, a bingeing part, and a socially anxious part, each requiring different kinds of care.

Slowly the tide began to turn. The increasing popularity of mindfulness meditation brought wider openness to the idea that we all might have inside us a compassionate state of mind like the one that Schwartz calls Self. The 2015 Pixar hit *Inside Out* offered perhaps the first positive view of internal multiplicity ever to hit the big screen, depicting five endearingly personified emotions wrestling for control inside an ordinary 11-year-old girl's head. According to Schwartz, from barely a few hundred IFS-trained therapists throughout the 1980s and '90s, the rapidly expanding IFS Institute (formerly the Center for Self Leadership) has now trained nearly 10,000 in 20 countries. Between 2016 and 2019, new Level 1 trainings more than doubled, from 14 courses per year to 35. Even with these much-expanded offerings, the Institute is struggling to keep up with demand, with long waitlists in many regions.

"So many people I know are in IFS therapy," says Rich Simon, editor in chief for 40 years of *Psychotherapy Networker*, one of the field's most widely read trade publications. "A lot of senior therapists who have been exposed to all kinds of other different models have found this very helpful. They themselves have availed themselves of IFS therapy."

Some of the demand comes from mental health professionals disillusioned with mainstream mental health treatment in America, with its relentless focus on diagnosis and medication. In IFS they have found what they see as a desperately needed alternative.

"The public mental health system is so fucked up," says Sascha Altman DuBrul, co-founder of influential mental health support network The Icarus Project (since reorganized as Fireweed Collective) and former recovery specialist and trainer at the New York State Psychiatric Institute. "Fundamentally, the way that we look at people is we see them as having illnesses, and diseases,

and disorders. That immediately, in and of itself, ends up taking away agency from people. Young people who are diagnosed with psychotic disorders who are coming in are thought to have a disease of the brain."

More than 20 years ago, DuBrul himself was diagnosed with bipolar disorder and hospitalized repeatedly with psychotic symptoms. He has since devoted his life to helping other patients navigate the mental health system. After three years at the Psychiatric Institute, he has recently left to open a private practice incorporating IFS.

"The beauty of IFS is that it shifts the frame," he says. "If I'm someone with a psychotic disorder, let's say, then all of a sudden my identity very easily can get wrapped up in this idea of 'I'm bipolar' or 'I'm schizophrenic.' Whereas IFS understands we have a bunch of different parts, and we can have parts that have a lot of work to do. We can have these exile parts that are full of pain and trauma and we can have these protector parts that are just trying to help us. That can end up looking like what's considered mental illness. If I'm sitting with someone who has what's considered a serious diagnosis, I don't have to see them as ill. I can see them as someone who has a bunch of stuff going on, and we can kind of isolate it and tease apart the different pieces."

Patients have found it equally liberating. In the last few years, IFS has begun popping up everywhere, from the bestselling new memoir by *Queer Eye*'s Jonathan Van Ness to an essay on Oprah.com by Elizabeth Gilbert of *Eat Pray Love* fame to podcasts by Alanis Morissette and Van Ness to Gwyneth Paltrow's lifestyle site Goop. British cartoonist Mardou is publishing an ongoing series of comics about it. Pioneering neuroscientist Ed Boyden recently revealed that although he has devoted his professional life to studying the brain using optogenetics (genetically modifying animals so their neurons can be controlled with light), he studies his own mind using IFS therapy. An enthusiastic online community has begun sharing stories of ongoing IFS work and tips for working with recalcitrant parts.

“I bring it up as much as I can because it’s really changed my life for the better,” says Nancy-Lee Mauger, an artist and French hornist in Boston, who first encountered IFS after receiving a diagnosis of dissociative identity disorder in 2010. “There’s an old idea of [DID patients] being shattered or fractured from a single entity, and then to bring something new to the table, to say, ‘No, no, everybody’s built this way, and they have parts that have different roles,’ it has been life-changing and life-saving.”

In the IFS view, DID represents the extreme point of a spectrum we all lie on, typically developing in response to severe childhood trauma. Mauger was abused by a houseguest as a child and suffered further sexual trauma in adulthood. IFS therapy has helped her develop a positive relationship with an alter ego named Sally who used to engage in various destructive behaviors. It has also helped her get in touch with parts she hadn’t been aware of.

“For me, the most amazing thing was learning about a part of me that was suicidal and knowing that that was just a single part of me. It wasn’t my entire being. That changed my world. I try to share that with a lot of people because I know a lot of people who get very depressed and sometimes feel suicidal. If you can step back from that feeling and realize that it’s just a part of you that’s trying to take away your pain and suffering, then you can move through it and find a different way to deal with it, to help that part.”

If there is indeed a spectrum of internal multiplicity, Maya Bourdeau, founder and co-CEO of a neuroscience-based market research and strategy firm in San Francisco, lies at the opposite end of it from Mauger. She had no sense at all of being anything but a unified personality when her therapist first suggested IFS.

“I was resistant to it,” she recalls. “I just thought it was strange. I’m such a rational person — I’m not a woo-woo person at all. I do spreadsheets.”

A Harvard Business School graduate with an undergraduate Harvard degree in psychology and an illustrious business record, Bourdeau was presenting global market research reports to major multinationals in her twenties despite being so depressed she could barely get out of bed.

“I was kind of like the textbook definition of a successful career woman, and yet on the inside, I was a complete mess,” she says.

After two years of work on her depression, her therapist brought up IFS again. Bourdeau finally trusted her enough to try it.

“I think once the trust is there and you’re able to let go, our minds naturally do this,” she says. “All of a sudden, I saw in my mind such vivid, vivid things.”

In her first sessions, she worked with a despairing part that thought there was no reason to go on and a crusading part she calls “Joan of Arc” that rushed in to try to help others, often doing more harm than good. Describing the way she came to love and understand them and the transformations they underwent in response still brings tears to her eyes. IFS no longer seems so strange to her; she has even managed to reconcile it with her neuroscience training.

“We naturally think in stories and metaphors,” she says. “It’s how we encode memory, so in a way, going through metaphor to access the subconscious is the most natural way to do it.”

She also credits IFS with helping her connect with and heal an angry part that came near to destroying her marriage.

“[IFS] absolutely changed my life,” she says. “If more people knew how effective it was, how wonderful that would be.”

Robert Fox, a therapist in Woburn, Massachusetts, also wishes more people knew about IFS. Diagnosed with obsessive-compulsive disorder at age 21 after a lifetime of unusual compulsions, he spent 23 years receiving the standard care: cognitive behavioral therapy (CBT) and exposure response prevention (ERP). Neither had much effect, especially ERP, which involved repeatedly exposing himself to things he was anxious about in the hopes of gradually habituating to them.

“When you think about it, it’s a very painful method of therapy,” he says.

Fox discovered IFS in 2008. Before, he had always been encouraged to think of his compulsions as meaningless pathologies. Now, for the first time, they began making sense to him as the behavior of protectors who were trying to manage the underlying shame and fear of exiles.

After two particularly powerful unburdenings, his symptoms abated by 95% and stayed that way.

“[OCD] used to be almost like kryptonite around my neck when I would have serious flare-ups,” he says. “I feel a lot of freedom and peace and I really owe it to Dick [Schwartz] and the model.”

Fox now practices IFS with his own OCD patients. He is haunted by a memory of a germophobic woman with OCD whom he met once while she was hospitalized. As part of her ERP therapy, the therapists took her into the bathroom and had her wipe her hands over the toilet and sink and then rub them through her hair. She wasn’t permitted to shower until the next morning.

“I would love to see a study on IFS and OCD,” Fox says, “because if we were to march over to your local hospital, they would still be doing ERP in the unit with their clients, and it just doesn’t need to be that way. There is this other model of therapy that I think works wonders.”

Not everyone is so enthused about IFS. It has its skeptics and critics, too, some emerging from a scandal at a St. Louis eating disorder clinic called Castlewood. In 2011 and 2012, former Castlewood patients filed suit alleging that they had been pressured into recovering memories of childhood abuse that had not in fact occurred. Richard Schwartz had spent a year and a half at Castlewood training its staff in IFS therapy at the invitation of the clinic's directors, Lori Galperin and Mark Schwartz (no relation). Though Schwartz did not himself treat patients at Castlewood, IFS played a role in patients' negative experiences there.

Schwartz is dismayed by what happened at Castlewood, which he calls a misuse of IFS. He says he has no present relationship with Mark Schwartz and Lori Galperin.

"In what I teach and what I do myself," Schwartz says, "when [a patient] comes up with memories that they didn't have before, I take the position that we can't know whether they're true or not without corroboration."

The other issue that IFS skeptics tend to point to is a dearth of empirical support. Despite growing anecdotal evidence about IFS's effectiveness for OCD, DID, depression, and a host of other disorders, few clinical studies have yet been done. Less easily reduced to repeatable techniques than competing modalities like cognitive behavioral therapy and eye movement desensitization and reprocessing, IFS has attracted little academic attention.

That may be starting to change. Frank Anderson, a former clinical instructor at Harvard Medical School, was working as a staff psychiatrist at Bessel van der Kolk's renowned Trauma Center in Brookline, Massachusetts, when he first encountered Schwartz and IFS. It flipped his world upside down.

“I had been working with severe trauma for a long time at the Trauma Center, and I was one of the many people who go, ‘Oh wow,’” Anderson recalls. “Within the mental health world, it’s a huge paradigm shift. IFS is very non-pathologizing. Every part, every symptom has a positive intention. That kind of blows therapists away. ‘What do you mean, shooting heroin has a positive intention? What do you mean, cutting yourself or bingeing has a positive intention?’”

In 2013, Anderson became chair and later executive director of the Foundation for Self Leadership, IFS’s research arm, with the aim of finding academic partners willing to try IFS in clinical tests. The first opportunity was with rheumatoid arthritis patients. IFS proved not just to significantly lower their depressive symptoms but to diminish pain and improve physical function as well. The study earned IFS official designation as an evidence-based treatment in 2015. More recently, a complex PTSD trial (currently under submission to journals) confirmed, Anderson says, the longstanding belief and clinical experience of IFS therapists that IFS is a very effective trauma treatment. After 16 sessions of IFS therapy, 12 of 13 trial subjects no longer qualified for the diagnosis.

Though promising, these results are preliminary. Even some of Schwartz’s biggest fans worry that he may be overselling what IFS can accomplish.

Deany Laliotis, the EMDR therapist and trainer, is among them. She is a big proponent of IFS, viewing it as complementary to EMDR and including IFS concepts in her own EMDR trainings, but she has reservations about the scope of the paradigm shift Schwartz is hoping to achieve.

“I appreciate that de-pathologizing people’s emotional struggles and challenges is important,” she says, “but it’s not just about our parts; it can be about other things, like biochemical changes, too.”

Schwartz says he has heard this concern many times in the course of his career but maintains that IFS respects the place of biochemical issues and medication's role in addressing them.

"If you're talking about things like schizophrenia and intense depression and so on, my position is that we all have genetic predispositions for certain conditions," he says. "I have one for asthma. I've just been getting over a bit of an asthma attack, and migraine headaches. Those are physiological, biomedical things. They're real. But our parts get wind of those things and begin to use them when they don't feel like they can get through otherwise."

In a workshop at last year's IFS conference in Denver, Schwartz and bestselling author Dr. Lissa Rankin discussed the success many therapists have found in using IFS to alleviate physical symptoms by healing the parts that trigger them. From an IFS perspective, Schwartz says, Ross's psychotic symptoms likely came about in much the same way that a part-induced asthma attack might come about: through a genetic proclivity for delusions that a part made use of to get Ross's attention.

"That was, from my point of view, a biochemical reaction," Schwartz says. "He had the gene to make him hear voices that way. Once the part realizes it doesn't have to do that anymore, the biochemical thing stops."

This is a radically unorthodox view of schizophrenia, but it appears to be working for Ross. Three years after his first IFS unburdening, with vastly diminished paranoia and no further hospitalizations, he points to that first session with Schwartz as the turning point in his recovery.

"Once I had that experience doing an unburdening," he tells me, "feeling the major change that happened, it really opened things up for me. It changed everything. I can't tell you it immediately

cured me, that one session, but it was such a dramatic shift that it really opened up the path to the eventual work. It made me feel like my goal of getting better was really possible."

Ross's voice today is lively and articulate, a far cry from the halting monotone that stymied Medeiros. He says that while antipsychotic medication calmed him and made the voices in his head less terrifying, it didn't actually help him heal.

"To be honest, I really was always hearing voices," he says. "It was something I felt I had to deny when I saw psychiatrists because I very much didn't want to have a higher dose of medication, and I was concerned about being hospitalized, too. But I think as I am now, where I hear so little of the voices that they just don't even register, it's kind of like — I don't think that's the medication suddenly kicking in. I think that's all IFS."

When I first spoke to Ross in August 2019, he had just been hired for his first job, an extraordinary step away from the downward spiral of dependency that our mental health system sends so many patients down. Though he told me that he had parts that still required attention — an inner critic, a numbing part which muted his feelings, an "unacceptable part" that carried childhood shame — they had calmed down significantly since he had built positive relationships with them using IFS and relieved them of some of their burdens. When one of them or his "voice-hearing part" got activated, he practiced what Schwartz calls "Self-leadership," taking a step back from the part ("unblending" in IFS parlance) and hearing out its concerns. He told me he planned to taper off his antipsychotic medication in consultation with an IFS-trained psychiatrist as soon as he had proved to himself that he could live independently.

"There are certain conditions I want to meet," he said then. "I want to work full time — I'm only working 20 hours per week, and that's not quite enough to support myself. Then I want to move out of my mom's house, take a little time, and then start the tapering process."

By the time I checked in again a few months later, Ross was up to 40 hours per week, had begun driving himself to work each morning in his own car, and had moved into an apartment with a roommate. He was continuing to make progress on healing his parts, both in sessions with Medeiros and in work on his own.

The most powerful thing about IFS, Ross says, is the way it has restored his sense of agency.

"It wasn't just like I needed to be fixed by some external force," Ross says. "It was like, 'Yeah, *I* can make these changes.' That was huge."

With passionate advocates like Ross and an expanding community of IFS therapists committed to affecting Schwartz's paradigm shift, IFS is beginning more and more to feel like a movement, one which has already evolved the culture of psychotherapy toward de-pathologization and an acceptance of inner multiplicity. Patients can find IFS therapists in all 50 U.S. states through the IFS Institute's online directory or on *Psychology Today*. Many have also done "parts work" on their own using psychologist Jay Earley's popular guide *Self-Therapy*.

Schwartz likes to joke in talks that he is planning to rewrite the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), psychiatry's bible, to explain the basis of each disorder in non-pathologizing terms of protectors and exiles, thereby challenging the dominant "chemical imbalance" view. But for all the humor, his real ambitions are even greater than that. Experts in conflict resolution, anti-racist education, high school guidance counseling, mediation, 12-step addiction recovery, and a growing list of other fields have begun adopting IFS techniques and developing pilot programs based around its principles. Just as important, Schwartz wants IFS to transform the way we connect to each other one-to-one.