Trauma: What is it and how it impacts our daily lives?

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Heart to Heart Counseling

Welcome to our free e-book which is dimension five in our six-part Multidimensional Relational Model of Psychotherapy (MDRT), and is centered around the concept of Trauma.

Based on our clinical work and research experiences, we have learned that trauma is central in that it reflects a critical role when addressing all psychological and relational issues (van der Kolk, 2014). Over our sixty plus combined years of experience with clients, we now know that nearly everyone encounters some form of trauma by adulthood, influencing their mental health, relationships, and overall well-being.

The narrative of our clients suggests that their traumas vary in severity from minor to significant impacts on their lives. Each individual brings with them their own unique perspective which is shaped by many factors including heredity, age, gender, culture, and individual resilience (Herman, 2015).

Trauma disrupts a person's feelings of safety and can leave lasting emotional scars when left unaddressed. For instance, a child, when physically, mentally, emotionally or sexually abused, may carry those deep-seated negative experiences into adulthood, affecting all aspects of both their personal and professional life.

In this e-book, we will explore the pervasive nature of trauma, illuminate its mechanisms and effects to help with both recognizing and healing, which are essential for restoring well-being and relational harmony.

What is trauma?

We have learned that all traumas incorporate the physical, emotional, psychological, and social impacts stemming from distressing events which make one feel unsafe.

This may include severe accidents, violence, emotional, physical or sexual abuse, and neglect (Levine, 2010). It disrupts individuals' feelings of security and well-being, often manifesting in symptoms that affect their thoughts, emotions, behaviors, and relationships.

Trauma can present itself in various forms such as acute stress reactions, like those experienced after a near-miss accident, and complex trauma, which may result from prolonged exposure to adverse situations. These situations can culminate in the development of Post-Traumatic Stress Disorder (PTSD) (Brewin et al., 2010).

PTSD is a psychological condition characterized by intrusive memories, nightmares and emotional distress, when reminders of the trauma arise, making it difficult for individuals to function normally (Friedman et al., 2007). These reminders can trigger powerful emotional responses, leading individuals to project their unresolved traumatic symptoms onto close relationships, which can create chaos.

For instance, some of our clients who reported experiencing childhood abuse, have been struggling as adults with intimacy and trust. In addition to relationship challenges, some have experienced physical symptoms that constantly interfere with their daily lives and functioning.

These physical effects of trauma can be extensive, including chronic pain, cardiovascular issues, and gastrointestinal problems, which according to our experience and research reduces overall quality of life (Sinha & Jastreboff, 2013)

Emotionally, trauma often manifests heightened anxiety, depression and/or guilt, and shame, particularly in cases of complex trauma. These intense feelings create layers of emotional complexity that individuals may find challenging to navigate.

For example, prolonged exposure to child abuse might lead a survivor to experience pervasive fear and hyper-vigilance always scanning the environment for danger and affecting their ability to engage with the world as an adult.

Psychologically, trauma disrupts cognitive functions, leading to difficulties in concentration and decision-making (Nolen-Hoeksema, 2004). In the case of acute trauma, individuals might initially experience shock and confusion, which, if left unaddressed, can evolve into chronic stress reactions and PTSD. Socially, trauma can lead to isolation, due to trust issues and fear of vulnerability, further impacting interpersonal relationships by creating barriers that prevent any kind of emotional connection.

Vicarious trauma impacts those close to trauma survivors, such as therapists and caregivers, who may exhibit trauma-like symptoms despite not directly experiencing the traumatic events (Figley, 1995). The nuances of trauma's effects vary greatly between individuals and highlight the need for tailored healing approaches that consider individual experiences, cultural contexts, and the relational aspects of trauma. Our MDRT model of psychotherapy does not have a generic approach as each person's trauma(s) need to be addressed based on their own unique perspective and strengths.

Ultimately, trauma and its repercussions are profound, stretching across physical, emotional, psychological, and social domains. Unresolved trauma is typically manifested in three ways, which include physical ailments (the body), self-sabotage, and negative projections toward others. Recognizing the multifaceted nature of trauma is necessary for effective healing and recovery. By addressing trauma within our MDRT therapeutic framework, we assist our clients to build resilience and enable them to reclaim their sense of safety, agency, and quality of life.

Examples of trauma in real life

Lisa was a young woman who had survived a severe car accident that resulted in multiple injuries. The acute trauma she experienced triggered intense flashbacks and anxiety, particularly when she was in a car. Over time, these symptoms evolved into PTSD, affecting her ability to drive and travel. Lisa became increasingly anxious and reluctant to engage in activities outside her home, leading to social isolation and strained relationships with friends who could not understand her sudden withdrawal.

Michael was a veteran who recently returned from combat. He experienced complex trauma due to repeated exposure to violence and loss during his service. Upon returning home, he struggled with hyper-vigilance, irritability, and difficulty relating to his family and friends. Michael often found himself feeling detached and unable to enjoy activities he once loved. He avoided discussions about his experiences, fearing judgment and misunderstanding, which led to a growing rift between him and his loved ones, plunging him deeper into isolation and depression.

Disconnection from the Authentic True-Self

Each person comes into this world in a body, which gives them important information about themselves, others, and their environment. When we are born, we arrive physically and emotionally present, meaning that we occupy the now moment.

Our primitive thoughts, emotions and physical sensations are available for us beginning at day one, and allow us to express our authentic needs, desires, and awarenesses which, we can call our authentic true-self. As we get older, we show our parents and others who we are, and when our parents enjoy and approve of who we are our authentic true-self becomes stronger. If, contrarily we learn that our thoughts, feelings, observations, and expressions are met with disapproval through blame and judgement, our authentic true-self goes into hiding, and we begin to lose our connection to who we really are. This is the beginning of what may develop into a pervasive lifetime trauma, experienced by the person as overwhelming distress.

Trauma(s) often triggers dissociation, which is an emotional defense mechanism where the mind distances itself from painful events in order to shield itself against overwhelming distress. Dissociation can take place on a scale that ranges from emotional numbness to severe conditions like Dissociative Identity Disorder (DID), where individuals may exhibit alternate identities controlling their behaviors. For instance, a child facing severe bullying might dissociate during those experiences, later carrying this dissociation into adulthood, as difficulty connecting with themselves or others during stressful situations.

Furthermore, past bullying can become dissociated from their core identity and take on a life of its own, resulting in them displaying bullying behaviors toward others. Another common outcome of trauma is distorted self-perception, where individuals internalize negative beliefs which they formed during traumatic experiences. For example, those who have suffered emotional abuse might unjustly view themselves as inadequate or unworthy, despite objective evidence to the contrary,

Types of traumas: Small 't' trauma vs. large 'T' trauma

We have learned that trauma may be categorized into two main types: small 't' trauma and large 'T' trauma (Kolk, 2014).
Both significantly affect mental health, relationships, and personal well-being. Small 't' traumas include everyday experiences which are often common within society, and as such are not recognized as traumatic.

This may include persistent criticism, verbal abuse, or ongoing stress, which may appear non-catastrophic, but can lead to cumulative psychological pain. For example, a child bullied at school may develop chronic anxiety and low self-esteem. Similarly, continuous microaggressions in the workplace can make individuals feel undervalued and affect their health. In contrast, large 'T' traumas involve deeply distressing events perceived as life-threatening, such as natural disasters or sexual assault, often resulting in PTSD (Brewin et al., 2010).

The aftermath of both small 't' and large 'T' traumas can lead to psychological struggles such as anxiety, depression, and relational difficulties (Kolk, 2014). Maladaptive coping mechanisms, including avoidance and substance abuse may develop as individuals attempt to manage distressing emotions. For example, a person who experiences verbal abuse (small 't' trauma) might isolate themselves and exhibit trust issues.

Conversely, survivors of war (large 'T' trauma) often experience severe PTSD symptoms, like hypervigilance and flashbacks, complicating their reintegration into daily life (Brewin et al., 2010). Unaddressed traumas can distort self-perception, leading to negative self-talk and difficulties in forming meaningful relationships. In our therapy work with couples, we have witnessed how couples often blame each other for their own emotional pain, exacerbating distance and negativity between them (Johnson, 2008).

Post-Traumatic Stress Disorder (PTSD)

In cases of Post-Traumatic Stress Disorder (PTSD), feelings of fear, shame, and guilt often emerge (Friedman et al., 2007). Fear typically arises from a perceived loss of something valuable, which may include health, safety, or relationships. Guilt stems from a belief that one has caused harm, potentially motivating reparative actions.

In contrast, shame conveys a sense of deficiency and worthlessness, discouraging individuals from seeking connection and repair (Brown, 2012). When these feelings are stored in the subconscious, they can be triggered by various circumstances, resulting in intense reactions. This misattribution of blame complicates healing, as individuals often turn their distress toward others instead of addressing their underlying emotions (Herman, 2015).

Trauma and the Creation of Ego Defenses

In our work with thousands of couples and individuals, we have first-hand experienced their use of many subconsciouses defense mechanisms. Each defense mechanism employed is used as a coping style to deal with their own unique trauma experience. These coping or defense mechanisms impact their lives in many ways, which include lifestyle choices they made, as well as who they selected as friends and lovers to be in relationship with.

To cope with trauma, individuals frequently use defense mechanisms such as denial (i.e., believing the trauma did not occur…), avoidance (i.e., not thinking or talking about it…), and dissociation (Vaillant, 1992). Other common defenses include repression (i.e., pretending the trauma was unimportant…), rationalization (i.e., giving a logical explanation without emotions attached…), displacement (i.e., making up a false reason for what occurred…), and isolation (i.e., staying away from others to avoid feeling the effects of the trauma…).

While these mechanisms offer temporary relief from emotional pain, they can impede emotional growth and impair communication in relationships. For instance, denial allows individuals to avoid acknowledging their traumatic experiences, preventing them from processing and integrating their emotions (Friedman et al., 2007).

This can lead to ongoing psychological distress and physical symptoms. Often, clients enter therapy unaware of their past traumas, having idealized their childhood to protect themselves from negative emotions, and also to maintain the illusion that their parents did not hurt them. Prolonged denial may obstruct healing, making it difficult to address current challenges that stem from unresolved issues (Herman, 2015). Ultimately, through therapy, recognizing and slowly dismantling these defenses can open the door for healing, deeper relationships with others and overall emotional recovery.

Projection is a one of the most common defense mechanisms where individuals attribute their own unwanted thoughts, feelings, and motives onto others, thereby avoiding uncomfortable internal conflicts (Freud, 1937). For instance, someone feeling guilty or shame might accuse others of being judgmental, deflecting attention away from their own emotions.
This behavior can create misunderstandings and conflicts in relationships.

A person fearing abandonment may project this anxiety onto their partner by making unfounded accusations of infidelity. Such dynamics erode trust and intimacy, potentially resulting in a self-fulfilling prophecy, where the projected fears lead the partner to distance themselves (Whitfield, 2006). Projection effectively places the projector in a judgmental position where they criticize others, often making themselves appear better and righteous.

Trauma and Addictions to Looking Elsewhere.

A number of our clients come to treatment with issues related to addiction(s). These addictions often represent the psyche's attempt to self-regulate following dysregulation due to small or large T traumas (Van der Kolk, 2014). This dysregulation results in a persistent state of distress, leaving individuals feeling anxious and uneasy. Mood-altering substances may provide temporary relief from this discomfort, leading to habitual use and ultimately addiction.

The brain can also self-regulate through activities like gambling or sex, which releases dopamine and endorphins, forming addictions similar to drugs or alcohol (Leeman & Potenza, 2013). Early traumatic experiences, particularly during childhood, can cause individuals to hide their authentic true-selves and gravitate towards addictions for relief. In our practice, we have observed how many couples have expressed trauma rooted in developmental dysregulation, which can lead to problematic defense mechanisms being employed in their relationships.

Trauma and the ego-based codependent-self: A disease of lost selfhood

Trauma profoundly impacts various aspects of an individual's personality, leading to a disconnection from the authentic true-self, which may include some or all of their behaviors, thoughts, and feelings (Whitfield, 1991). Excessive focus on others can cause individuals to overlook their inner life, essential for self-awareness and balance.

Often, the true-self becomes hidden to conform to external expectations imposed by parental figures, leading to the development of a false-self or co-dependent self.

This codependent-self urges individuals to seek validation outside themselves, creating an addiction to external approval. In contrast, recognizing and expressing one's authentic true-self is necessary for a person to experience peacefulness and safety in their own body. Suppressing difficult emotions can prevent self-understanding, leading to confusion and detachment from one's life purpose and journey. Embracing emotions is essential for reclaiming one's true identity and meaning in life (Kolk, 2014).

Awareness of being culturally traumatized

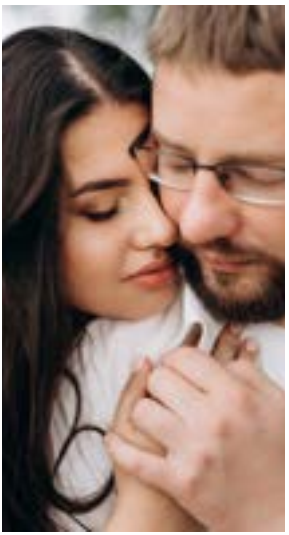
Our clients come from different walks of life which include their diverse cultures. These cultural influences significantly shape the developmental experiences that individuals later recognize as traumatic (Rashidian et al., 2014). For instance, gender-specific play items in childhood convey messages about capabilities, contributing to small 't' traumas that limit self-perception. These subtle messages, prevalent across various cultural domains, often perpetuate discrimination and remain unexamined due to their normalization.

Societal norms that discourage emotional vulnerability can prevent individuals from expressing needs or seeking support, complicating emotional regulation and healing (Herman, 2015).

Moreover, the societal pressure to suppress emotions can complicate recovery from trauma, as individuals may dismiss their suffering or avoid acknowledging these experiences (Van der Kolk, 2014). Our model of MDRT psychotherapy both recognizes and addresses these nuances, to provide culturally sensitive interventions and help create inclusive support systems that promote healing.

Trauma and its impact on Intimate Relationships

Our subconscious minds communicate through nonverbal cues such as body language, facial expressions, and tone of voice, conveying thousands of messages in each interaction (Goleman, 2006).



These subtle yet powerful actions occur instantly and can reflect deeper emotional needs, such as a desire to be rescued or protected.

For instance, a girl raised in a violent household may subconsciously seek partners who replicate that abusive behavior, believing it reflects love. Or, in the alternative, she may seek someone to rescue her, who ends up controlling her. These patterns are known as following a **"love map."** While individuals can consciously break away from these patterns, true freedom of choice relies on self-awareness.

Left unexplored, subconscious dynamics can lead to confusion in relationships, prompting the question, **"Why did I choose this partner?"** Our MDRT model of psychotherapy assists couples to eliminate blame and encourages each partner to recognize their traumas both small **'t'** and large **'T'**, and how these influence their relationship dynamics (Yalom, 2002).

As that occurs, it becomes easier for the couple to recognize when they are triggered by each other, take responsibility for the feelings that arise, and even allow their partners to show them love and affection.

Trauma response in and out of intimate relationships

Trauma impacts individuals profoundly, influencing their sense of power and resilience (van der Kolk, 2014). All traumas, whether small or large, are a loss of personal power and can affect relationships, leading to co-dependency. In healthy relationships, partners support each other's independence, however, they are there to help their partner in times of pain and weakness. Unresolved trauma often fosters dependency, where one partner relies excessively on the other for emotional stability.

For instance, individuals exposed to neglect may seek constant validation from their partners, creating an imbalanced dynamic. Mistrust also emerges as a significant consequence, often preventing healthy attachments.

Trauma can negatively impact effective communication, as survivors may fear vulnerability, leading to misunderstandings and intimacy issues. Recognizing, understanding and detoxifying these dynamics is crucial for healing. As this occurs, partners can acknowledge past traumas and cocreate healthier interdependent relationships (Herman, 2015; Whitfield, 1991).

Healing from Trauma

Healing from trauma involves a deep understanding by the client of its effects on their beliefs, thoughts, feelings, and behaviors (van der Kolk, 2014). Traumatic experiences can distort a person's perception of themselves. For instance, repeated rejection may lead individuals to internalize and hold feelings of unworthiness. These negative beliefs can create schemas, such as "*I will always be alone,*" or "*No one will ever truly love me*", which over time facilitates loneliness and fear of intimacy.

Additionally, trauma can result in psychosomatic illnesses, where psychosocial stress influences physical symptoms like headaches or gastrointestinal issues (Henningsen et al., 2003).

In our MDRT model of psychotherapy, we address these negative schemas and beliefs and their origins to help our clients recognize why they are there and how they can be readjusted.

Conclusion

Understanding and addressing the complex nature of trauma is necessary for healing, as well as creating and maintaining healthy relationships. Our Multidimensional Relational Therapy (MDRT) model uniquely emphasizes the relationship between the ego and the spirit, helping clients recognize ego-driven defenses that arise from trauma such as dissociation, projection, and distorted self-image (Kolk, 2014).

This newfound self-awareness allows for dismantling maladaptive behaviors like denial and avoidance, facilitating genuine exploration of deeper emotions. Our MDRT model also examines how trauma negatively affects intimacy, creates addiction and co-dependency, guiding clients to initiate self-healing and rebuilding valuable connections with others. By providing tailored interventions and promoting emotional resilience, we empower our clients to reconnect with their authentic true-selves. This transformative process not only enhances personal growth, but also strengthens relationships, ultimately leading to greater self-efficacy, increased intimacy and an overall more fulfilling life (Herman, 2015).

References

Brewin, C. R., Andrews, B., & Valentine, J. D. (2010). Meta-analysis of risk factors for posttraumatic stress disorder in trauma-exposed adults. Journal of Consulting and Clinical Psychology, 78(4), 748-758.
Figley, C. R. (1995). Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized. Brunner/Mazel.
Brewin, C. R., Andrews, B., & Valentine, J. D. (2010). Meta-analysis of risk factors for posttraumatic stress disorder in trauma-exposed adults. Journal of Consulting and Clinical Psychology, 78(4), 748-758.
Kolk, B. A. van der. (2014). The body keeps the score: Mind, brain, and body in the healing of trauma. Viking.

Brewin, C. R., Andrews, B., & Valentine, J. D. (2010). Meta-analysis of risk factors for posttraumatic stress disorder in trauma-exposed adults. Journal of Consulting and Clinical Psychology, 78(4), 748-758.

Johnson, S. M. (2008). Hold me tight: Seven conversations for a lifetime of love. Little, Brown and Company.

Kolk, B. A. van der. (2014). The body keeps the score: Mind, brain, and body in the healing of trauma. Viking.

Brown, B. (2012). Daring greatly: How the courage to be vulnerable transforms the way we live, love, parent, and lead. Gotham Books.

References

Friedman, M. J., Keane, T. M., & Resick, P. A. (2007). Handbook of PTSD: Science and practice. Guilford Press.

Herman, J. L. (2015). Trauma and recovery: The aftermath of violence—from domestic abuse to political terror. Basic Books.

Friedman, M. J., Keane, T. M., & Resick, P. A. (2007). Handbook of PTSD: Science and practice. Guilford Press.

Herman, J. L. (2015). Trauma and recovery: The aftermath of violence—from domestic abuse to political terror. Basic Books.

Vaillant, G. E. (1992). The wisdom of ego. Harvard University Press.

Freud, S. (1937). The ego and the mechanisms of defense. Grune & Stratton.

Whitfield, C. L. (2006). Healing the child within: Discovery and recovery for adult children of dysfunctional families. Health Communications.

Leeman, R. F., & Potenza, M. N. (2013). The intersection of impulse control disorders and addiction: A review. Psychological Medicine, 43(2), 337-346.

Van der Kolk, B. A. (2014). The body keeps the score: Mind, brain, and body in the healing of trauma. Viking.

Kolk, B. A. van der. (2014). The body keeps the score: Mind, brain, and body in the healing of trauma. Viking.

Whitfield, C. L. (1991). Healing the child within: Discovery and recovery for adult children of dysfunctional families. Health Communications.

References

Herman, J. L. (2015). Trauma and recovery: The aftermath of violence—from domestic abuse to political terror. Basic Books.

Rashidian, A., Moshiri, F., & Yavari, D. (2014). The role of culture in trauma experience: A historical and thematic analysis. Journal of Cultural Psychology, 2(3), 351-364.

Van der Kolk, B. A. (2014). The body keeps the score: Mind, brain, and body in the healing of trauma. Viking.

Goleman, D. (2006). Social intelligence: The new science of human relationships. Bantam Books.

Yalom, I. D. (2002). The gift of therapy: An open letter to a new generation of therapists and their patients. HarperCollins.
Herman, J. L. (2015). Trauma and recovery: The aftermath of violence—from domestic abuse to political terror. Basic Books.

van der Kolk, B. A. (2014). The body keeps the score: Mind, brain, and body in the healing of trauma. Viking.

Whitfield, C. L. (1991). Healing the child within: Discovery and recovery for adult children of dysfunctional families. Health Communications.

Duman, R. S., & Aghajanian, G. K. (2013). Synaptic dysfunction in depression: potential therapeutic targets. Nature Genetics.

Henningsen, P., Van Dulmen, S., & Klose, P. (2003). Psychosomatic symptoms: A brief overview. Journal of Psychosomatic Research, 54(5), 441-447.

References

McEwen, B. S. (2000). The neurobiology of stress: implications for health. Annals of the New York Academy of Sciences, 907, 1-24.

van der Kolk, B. A. (2014). The body keeps the score: Mind, brain, and body in the healing of trauma. Viking.

Herman, J. L. (2015). Trauma and recovery: The aftermath of violence—from domestic abuse to political terror. Basic Books.

Kolk, B. A. van der. (2014). The body keeps the score: Mind, brain, and body in the healing of trauma. Viking.

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Dr. Rashidian earned her Ph.D. in Counseling at the University of New England (UNE), School of Health, in Armidale, Australia. She then completed a two-year post-Doctoral fellowship position at UNE with the focus on sexual healthcare and inclusion. She received a Master of Science degree in Counseling – Option: Marriage and Family Therapy from California State University, Northridge – Northridge, California. She has presented her research topic and findings locally and abroad, at various conferences, and lectured at workshops throughout Europe, and the United States. Further, she has written and published articles and book chapters in numerous scientific journals.

Committed to sexual healthcare and mental well-being research, Dr. Rashidian has focused on the enhancement of relationships and sexual enrichment over the past 25 years. Her passion is to help all people achieve and experience joy and fulfillment with their partners. "We all want everlasting happiness in our lives, and I believe that this is achievable."

In addition to her clinical and research pursuits, she possesses a remarkable talent in the culinary arts, an enduring passion for painting, a fervent dedication to gardening, and a strong commitment to maintaining a healthy lifestyle through mindful eating and regular exercise habits.

Further information about her clinical work and focus can be obtained at Psychology Today, trfsq.com, and ResearchGate.

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