Pre-TSD: The Weight of What We See Coming

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On the dread that comes not from what has already broken you, but from seeing — with terrible clarity — what is breaking everyone else, what is coming, and knowing that hope alone will never be enough to stop it.

There is a particular kind of suffering that does not yet have a billing code. It arrives not as a memory of something terrible that happened, but as a clear-eyed recognition that something terrible is actively, continuously happening, and that the systems claiming to prevent it are accelerating it.

Call it Pre-Traumatic Stress. Call it anticipatory dread with functional precision. Whatever name you give it, the people who feel it most acutely are often the ones paying the closest attention.

This is not anxiety disordered thinking. This is not catastrophizing. For those of us who work within a framework of Functional Contextualism, the distinction matters enormously, because how we label a behavior, including the behavior of worrying, grieving, or sounding an alarm, determines how the world responds to it.

Label the concern as pathology, and we have made the witness into a patient. We have, in one clinical stroke, removed their credibility and placed the locus of the problem inside their skull rather than in the systems they are watching fail.

> *"The organism that responds accurately to a deteriorating environment is not disordered. The environment is."— Functional Contextualism, on the unit of analysis*

What Pre-TSD Actually Is

Pre-Traumatic Stress Syndrome — Pre-TSD, as a functional description — refers to the cumulative psychological load carried by individuals who perceive, track, and respond to systemic harm in real time, before that harm reaches its full expression.

It is the weight of watching healthcare systems dispense diagnoses the way vending machines dispense snacks, each one feeding a pharmaceutical revenue cycle that has very little to do with the lived context of the human sitting across the desk. It is the grinding awareness of an educational apparatus that measures children against standardized outputs while their interior lives go unaddressed. It is the visceral recognition that social media platforms are not neutral tools but environments specifically engineered to fragment attention, colonize identity, and monetize dysregulation.

It is the knowledge that the food most readily available to the most economically vulnerable people has been engineered not for nourishment but for shelf life, shipping distances and compulsive consumption, quietly rewiring gut chemistry and neurological reward systems in ways the clinical world is only beginning to confront honestly.

It is watching microplastics turn up in human blood, in breast milk, in the placentas of newborns, in arterial plaque — while regulatory systems move at the pace of consensus-building institutions whose incentive structures were never designed for this kind of problem.

It is the specific, heavy awareness of a climate system under measurable, accelerating stress that no previous generation has ever had to carry as present-tense reality rather than distant forecast.

It is, for a growing number of people, the unease that arrives with each wave of artificial intelligence deployment — not science fiction dread, but the practical, grounded recognition that entire occupational categories are being restructured or eliminated faster than any social safety net has ever been designed to absorb. The people most likely to be displaced are those who can least afford it and the velocity of that displacement does not pause for retraining programs or policy debates.

In the language of Relational Frame Theory, Pre-TSD is a derived relational network — a web of if-then relations, analogical frames, causal histories, and temporal projections — constructed from genuine contact with genuine contingencies.

The person experiencing Pre-TSD is not imagining the cliff. They have read the map. They have tracked the trajectory. They have watched, sector by sector, as the logic of extraction rewrites the grammar of care, of nourishment, of vocation, of planetary stability.

Signal One
Behavioral health systems optimized for throughput over therapeutic depth, producing iatrogenic harm at scale while calling it care.

Signal Two
Ultra-processed foods degrading gut-brain function and reward architecture across entire populations, disproportionately in those with fewest alternatives.

Signal Three
Microplastics accumulating in human tissue with endocrine, neurological, and immune implications still being mapped as exposure continues.

Signal Four
Climate destabilization producing measurable psychological load — eco-grief, anticipatory loss, chronic low-level threat activation in those paying attention.

Signal Five
AI-driven displacement restructuring identity, economic security, and purpose for millions of working people faster than adaptive social infrastructure can respond.

Signal Six
Agriculture and education trading long-term human and ecological resilience for short-term measurable outputs, compounding across generations.

> *"We have built systems so large, so interlocking, and so resistant to correction that the clearest sign of psychological health may be the refusal to feel comfortable inside them."*

Iatrogenic Weight: When the Cure Is Part of the Wound

The concept of iatrogenesis — harm caused by the very act of treatment — is one of the most important and least examined ideas in behavioral health.

When a child receives a diagnosis that recasts every future behavior through a pathological lens, something iatrogenic has occurred. When a trauma survivor is placed in a protocol requiring them to describe their most shattering experiences to a rotating cast of clinicians who will never follow up, something iatrogenic has occurred. When a depressed adult is handed a prescription and a handout and scheduled for a follow-up in six weeks, something iatrogenic has occurred.

In each case, the harm is delivered inside the form of help, which is precisely what makes it so difficult to name and so easy to defend.

Pre-TSD is, in part, the cumulative experience of witnessing iatrogenesis at scale. It is what a clinician feels after the tenth intake where the person across from them has already been through four treatment programs, accumulated three diagnoses, and lost confidence in the possibility that anything will actually change. Check your experience. I have witnessed this more often than I would like.

The harm is not always dramatic. Often it is quiet, incremental, and dressed in the language of evidence-based practice, a clinical sleight of hand in which the absence of improvement becomes the patient's failure rather than the system's.

Functional Contextualism insists on asking: working for what, for whom, and under what conditions? That question is a scalpel. Aimed at the dominant models shaping behavioral health, food systems, environmental policy, and the economy of technological deployment, it cuts quickly to the truth that most of our largest systems are not optimized for human flourishing. They are optimized for their own continuation.

On Idiographic Awareness

The idiographic lens — the insistence on understanding each individual in their own specific context rather than through nomothetic averages — is not only a clinical tool. It is a moral stance.

It says: this person's life, this person's history, this person's reinforcement context, this person's suffering cannot be adequately described by population-level statistics. When we apply that lens to whole communities, we begin to see not a collection of disordered individuals, but a population responding predictably to disordered environments.

Pre-TSD, understood idiographically, is not the same in a rural farmer watching their neighbors' topsoil diminish as it is in a school counselor watching their caseload double each year, or in a mid-career professional watching automation eliminate half of what gives their work meaning.

The functional topography differs. The relational networks differ. The specific histories that give the dread its particular color differ. What does not differ is the structure: accurate perception of harm trajectory, insufficient systemic response, and the compounding weight of that gap over time.

The Body as the First Battleground

Pre-TSD does not only live in the mind. For any clinician working from a Functional Contextualist perspective, the separation of psychological experience from biological context is already a conceptual problem. Several of the signals being tracked by those who carry Pre-TSD are signals about the body itself, about what is being introduced into it, what is accumulating inside it, and what the downstream consequences are for cognition, mood, regulation, and the very architecture of the nervous system that behavioral health is tasked with supporting.

Ultra-Processed Foods and the Reengineered Gut

The evidence linking ultra-processed food consumption to mental health outcomes has moved, in the last decade, from suggestive to substantial. The gut-brain axis is not a metaphor. The microbiome that populates the human gastrointestinal tract communicates bidirectionally with the central nervous system, influencing inflammation, neurotransmitter production, stress reactivity, and mood regulation in ways that are clinically meaningful and experimentally demonstrable. This is something important to us as clinicians since it IS in the treatment room with us.

Ultra-processed foods, engineered for palatability, stripped of fiber, saturated with additives designed to extend shelf life and override satiety signals, do not support that microbiome. They degrade it. They do so efficiently, profitably, and at a scale that has restructured the dietary baseline of entire populations within a single generation.

The behavioral health clinician who does not ask about food, who treats mood and regulation as purely psychological phenomena while ignoring the substrate on which mood and regulation depend, is operating with a model of the person that is, at a basic biological level, incomplete. The functional clinician who introduces food environment as a relevant variable in assessment is not practicing nutrition. They are practicing contextual integrity.

The person carrying Pre-TSD who watches a client describe a diet composed almost entirely of processed food, not from ignorance but from economic constraint and the deliberate engineering of food environments, is watching something iatrogenic in slow motion — a harm structured into

the landscape of daily life and rendered nearly invisible by its ubiquity.

Microplastics: The Invisible Accumulation

The discovery of microplastics in human blood, in lung tissue, in placental material, in testicular tissue, and in arterial plaque has moved this issue from environmental abstraction to clinical fact. The behavioral health implications are not yet fully mapped, and that is precisely the point — the person tracking this signal is not operating in the territory of settled certainty. They are operating in the territory of precaution, watching evidence accumulate in real time while the regulatory and public health apparatus moves at the pace of institutions designed for slower-moving problems.

The psychological weight of knowing that a contaminant is inside you — inside everyone — and that you cannot see it, cannot feel it, and cannot readily remove it, is a particular kind of aversive stimulus. It activates relational frames around contamination, helplessness, and temporal uncertainty that have no clean behavioral resolution.

The clinician who understands RFT recognizes this as a context in which defusion from catastrophic derivations is genuinely difficult, precisely because the derivations are grounded in real data. The clinical work here is not to talk someone out of accurate perception. It is to help them remain functional in the presence of what they accurately perceive — to hold the knowledge without being immobilized by it, and to locate, within that knowledge, the next values-directed action available to them.

Climate Change and the Psychology of Slow Emergency

Climate grief has entered the clinical literature, but the framing remains uncomfortably close to pathology, as though the appropriate response to observable ecological loss is a disorder requiring treatment rather than a signal requiring action.

The person who grieves the loss of species, who feels dread at each successive report of accelerating ice loss, who cannot watch their children play outside on a smoke-heavy summer day without a particular quality of sorrow, that person is not disordered. They are in contact with something real.

The question a Functional Contextualist must ask is not how to reduce their distress to a manageable level, but how to help them remain in motion toward what they value while carrying distress that is, given the circumstances, entirely proportionate.

The behavioral health system is one of the few institutions positioned to reframe this. Not by offering reassurance and certainly not by pathologizing the witness, but by building the clinical language and the therapeutic containers in which accurate perception of large-scale harm can coexist with personal agency, relational connection, and committed action. That is a specific and trainable set of skills. It is also, presently, an underdeveloped one and one of the main reasons I am so active in my writing and training. I am asking the same of you if you are not already as motivated.

Artificial Intelligence and the Displacement of Purpose

The psychological consequences of AI-driven job displacement are not primarily economic. They are existential in the functional sense, the reorganization of the contingency structures through which people derive meaning, identity, social connection, and a sense of efficacy in the world.

Work is not merely income. For most people, work is a primary context in which behavior contacts reinforcement, in which relational frames around competence and contribution are built and maintained, in which the day has shape and the self has a legible role. When that context is disrupted rapidly and without clear alternative, the behavioral consequences are predictable and serious.

What makes AI displacement distinctively difficult from a clinical perspective is its velocity and its selectivity. Previous technological disruptions unfolded over generations, allowing adaptive responses to emerge across time. The current wave is operating within years, sometimes months, and it is reaching into occupational categories — writing, legal analysis, radiological reading, accounting, software development, graphic design, customer service — that were previously considered relatively insulated from automation. The relational frames that many people carry around their vocational identity are being invalidated at a pace that has no precedent, and the verbal community around them has not yet developed adequate language for what that loss actually is.

The clinician who recognizes this as a behavioral and contextual problem, rather than an individual adjustment problem, is already practicing something different from what the dominant model offers. They are asking: what contingencies have changed, what reinforcers have been lost, what values remain intact, and what committed actions are possible within the new context? Those are functional questions. They open different doors than the question of how to help someone feel better about a situation that is, functionally, genuinely difficult.

Relational Frames and the Architecture of Dread

Relational Frame Theory gives us a way to understand why Pre-TSD is cognitively exhausting in ways that are difficult to articulate. The mind that has learned to track causal relations across time — if this, then that — and has derived those relations across domains — this system behaves like that system, which behaved like this other system before it failed — carries a constant low-level processing load that others may not share.

The person has, through their learning history, developed a dense and frequently activated relational network connecting present observations to projected futures, many of them bleak.

This is not a malfunction. Derived relational responding is among the most adaptive capabilities a human mind possesses. The problem arises when the network is accurate, when the projections are grounded in genuine contingencies, and when the verbal community around that person continues to respond as though things are basically fine.

The result is a profound form of contextual isolation — the individual whose functional analysis aligns with the available data finds themselves relationally stranded in a social world organized around a very different narrative. I put this all in writing so that we do not become complacent and dismissive.

In ACT terms, this is a context where both fusion and avoidance are particularly seductive. Fusing with catastrophe becomes the mind's way of insisting on its own accuracy. Avoidance, on the other hand, offers temporary relief from the weight of knowing. Neither serves values-based action.

The clinically relevant question is how to hold the accuracy of the perception, to neither deny it nor be consumed by it, while remaining in contact with what actually matters and what can actually be done. This is not a question that hope, as conventionally understood, can answer.

Hope Is Not Enough and Never Was

Hope is one of the most overused and least examined words in the clinical vocabulary. It is offered as though it were itself a therapeutic mechanism, as though the person who hopes hard enough will somehow find the distress more bearable, the future more open, the present more navigable. This is not only insufficient, but in the context of Pre-TSD and the converging pressures described here, it is functionally irresponsible.

Hope, as passive orientation toward an unspecified better future, is a behavior. Like any behavior, it can be assessed for what it actually does in context. How it functions. What passive hope most reliably does is reduce the urgency of action. It provides enough emotional relief to quiet the alarm without generating the behavioral output the alarm was designed to produce.

The distinction that matters here is precise. Passive hope says: things may get better if conditions change. Values-driven committed action says: I know what I care about, I can see what is happening, and I am going to move in the direction of what matters regardless of whether the outcome is certain. These are not the same psychological event. They do not produce the same behavioral results. They do not carry the same long-term consequences for the person, for the people they serve, or for the systems they are positioned to influence.

Passive Hope
Waits for conditions to improve before acting with full commitment.

Reduces short-term distress by softening urgency and diffusing the pressure to move.

Generates no specific behavioral output. The future it imagines is unconnected to present action.

When conditions do not improve — and the trajectory suggests they will not, without intervention — passive hope converts into despair. The long-term cost is significant and compounding.

Values-Driven Committed Action
Moves toward what matters now, with full awareness that the outcome is uncertain.

Accepts short-term distress as the functional cost of contact with values. Does not require comfort as a precondition for action.

Generates specific behavioral output: clinical practice changes, advocacy, community building, honest conversations, structural refusal of iatrogenic defaults.

The long-term consequence of values-directed action, even when outcomes are uncertain, is the preservation of psychological integrity and the expansion of behavioral flexibility over time.

Implications

This distinction has a direct clinical implication. When a person carrying Pre-TSD comes into contact with a practitioner who offers hope — even genuine, warmly intended hope — without also offering a values clarification process and a committed action framework, the practitioner has provided comfort without traction.

The person leaves feeling marginally better and behaviorally unchanged. Over time, that pattern compounds. The gap between what they perceive and what they are able to do about it widens. The distress does not resolve. It accumulates. What began as Pre-TSD risks calcifying into something closer to chronic demoralization, the functional collapse of the relationship between perception, values, and action.

The ACT model is explicit on this point, and it is worth stating plainly: the willingness to experience distress in the service of values is not a side effect of psychological health. It is a defining feature of it. The person who can feel the weight of what they see coming, remain in contact with what they care about, and take the next available action in that direction — even when the action is small, even when the outcome is uncertain, even when the short-term cost is real — is not a person who has learned to hope more effectively. They are a person who has learned to act from values in the presence of difficulty. That is a trainable capacity. It is also the most clinically honest thing we can offer anyone carrying this particular kind of weight.

> *"The choice is not between distress now and distress later. It is between short-term distress in the service of values, and long-term distress in the service of nothing."*

Behavioral Health as the Lever Point

Of all the systems implicated in the converging pressures described in this article, behavioral health is unique in one critical respect:

it is the system in which the unit of change is the individual therapeutic relationship, and in which the practitioner has direct, ongoing, contextually informed contact with the human consequences of every other failing system.

The behavioral health clinician sits at the intersection of food insecurity and mood dysregulation, of climate grief and panic presentations, of job displacement and identity fragmentation, of iatrogenic diagnosis histories and the learned helplessness they produce. No other professional is positioned quite this way.

This positioning is not incidental. It is the argument for why behavioral health, practiced from a Functional Contextualist framework, represents one of the most consequential levers available for producing genuine change — not only in individual lives, but in the broader cultural and systemic context those lives inhabit.

I am not asking you to become an advocate while within a session. That would be unethical. That would become more about you and not about who is in front of you. What I am asking you to do is to become well versed in functional contextualism and relational frame theory in order to enhance your presence while in session in order to act as a safe guard against everything I have described so far.

Transform the function of the stimuli that you can see in the act-in-context occurring right in front of you. Get them to see the system so that they are liberated from it and can move on their values and find ways of bringing them into their lives.

When enough clinicians refuse the iatrogenic defaults, when enough practitioners ask the contextual questions that the dominant model systematically avoids, when enough therapeutic relationships become spaces in which accurate perception is validated and values-directed action is developed rather than managed, something structural begins to shift.

This is not optimism. It is a functional analysis of how systems change. Systems do not change because enough people hope for something different. They change because enough people behave differently in the contexts where change is possible and for behavioral health practitioners, the therapeutic relationship is exactly that context. It is where the lever meets the load.

What Clinicians Can Actually Do — Starting Now

Ask contextual questions that the dominant model avoids. What does this person eat, and what shapes that? What is happening to their work, their sense of purpose, their relationship to the future? What are they tracking in the world around them, and is their perception accurate? These questions are not scope violations. They are functional assessments.

Refuse the move that pathologizes the witness. When a person presents with distress that is proportionate to genuine systemic harm, the clinical task is not symptom reduction. It is values clarification and committed action development. Name the difference explicitly, in the room, with the person in front of you.

Introduce the hope-versus-action distinction as a therapeutic tool (think creative hopelessness, it is already in your toolbox). Help clients identify where they are waiting for conditions to improve

versus where they are moving toward what matters. The former feels safer in the short term and costs more in the long term. Make that contingency visible.

Build your own committed action framework. The clinician who is carrying Pre-TSD without a values-anchored response structure cannot offer what they do not have. Your own psychological flexibility is not separate from your clinical effectiveness. It is inseparable from it.

Functional Contextualism as Liberation, Not Just Framework

Functional Contextualism, at its deepest level, is a philosophy of liberation — not in any romanticized sense, but in the hard, practical sense of freeing the analysis, and the person, from the constraints of inherited categories that no longer serve accurate understanding or effective action.

When we stop asking what is wrong with this person and start asking what this person's behavior is doing, in this context, given this history, toward what end — we open a fundamentally different space. We are no longer matching symptoms to diagnostic labels and labels to treatment protocols designed for the average patient who does not actually exist. We are doing the harder and more honest work of understanding this person, here, now, in the actual conditions of their actual life.

Applied to Pre-TSD, this means refusing the clinical move that would pathologize the witness. It means taking seriously the functional content of the distress: the specific systems being tracked, the specific harms being perceived, the specific values that make those harms feel intolerable. It means helping the person who carries this particular weight to carry it in ways that do not destroy them, not by convincing them the weight is imaginary, but by helping them locate their footing and their direction of movement.

That footing is values-based committed action. Not the performance of optimism. Not passive hope dressed in clinical language. The willingness to stay in contact with what matters, to accept the short-term distress that contact with genuine values in a genuinely difficult environment will always produce, and to move in that direction anyway — in the company of others who are similarly grounded, similarly honest, and similarly unwilling to pretend that business as usual is good enough.

The Path Through Is Not the Path Around

There is no functional shortcut through Pre-TSD. The mind that has derived the relational network connecting present trajectories to probable futures cannot simply unlearn those relations, nor would it be useful to try. The work, instead, is in building the psychological flexibility to remain present in contact with those relations without being governed entirely by them, to hold the dread in one hand and the next committed action in the other, and to keep moving.

Acceptance, in the ACT sense, is not resignation. It is the active refusal to spend behavioral resources on a fight with your own nervous system that you cannot win and do not need to win.

The person who can feel the weight of what they see coming without either fusing with catastrophe or retreating into avoidance is, in functional terms, in the strongest possible position to act. Not because the action will certainly succeed, but because the action will be in contact with something real, with actual contingencies, actual values, actual human stakes.

The systems we have inherited — in healthcare, in food production, in environmental stewardship, in the design of technological deployment, in the architecture of digital life — are not neutral. They have histories, contingencies, and beneficiaries. Seeing them clearly is the beginning of something, not the end.

The particular question that Pre-TSD poses, beneath all the dread and the grief and the urgency, is whether enough people can stay in contact with what they are seeing, refuse the sedative of passive hope, clarify what they actually value, and commit to moving in that direction — behavior by behavior, session by session, conversation by conversation, for as long as it takes.

That is not a small ask. In the context of everything described here, it may be the most important ask there is. Behavioral health, practiced with functional integrity and genuine contextual honesty, is not peripheral to that project. It is among its most powerful instruments.

To the Person Reading This Who Recognizes Themselves

Your distress in the face of what you are seeing is not a malfunction. The accuracy of your perception is not evidence of pathology. The grief you feel watching systems that should be healing, nourishing, and sustaining people instead harm them, that grief is appropriate. It is proportionate. It is, in a functional sense, a form of love: the behavioral evidence that you have not lost contact with what human life is actually for.

The question is not whether your perception is accurate. The question is what you do with it — how you carry it, who you carry it with, and whether you can remain in motion toward what actually matters even while holding it. Passive hope is not the answer. Knowing what you value and taking the next available action in that direction, even when it costs something, especially when it costs something, is the only response that does not compound over time into something worse.

That is not a small ask. It is the work of this particular moment in history. It is also, by every functional measure available, the only work worth doing.

Grounded in Functional Contextualism, Relational Frame Theory, and ACT as applied extension.

Written for clinicians, educators, practitioners, and anyone carrying the weight of accurate perception.

Pre-TSD, Functional Contextualism, RFT, ACT, Iatrogenesis, Idiographic Practice, Committed Action, Values Clarification, Microplastics, Ultra-Processed Foods, Climate Grief, AI Displacement, Psychological Flexibility,

Systemic Harm