SECOND EDITION

Becoming A THERAPIST

What Do I Say, and Why?

Suzanne Bender
Edward Messner

GUILFORD PRESS
e-book

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Foreword by Nhi-Ha Trinh

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Suzanne Bender, MD, is a Staff Psychiatrist in the Division of Child and Adolescent Psychiatry at Massachusetts General Hospital (MGH) and Assistant Professor in Psychiatry, part-time, at Harvard Medical School. Within the Department of Pediatric Gastroenterology (GI) and Nutrition Department at MGH for Children (MGHfC), she is the Co-Director of the MGHfC Pediatric GI Psychiatry program. Dr. Bender teaches a weekly year-long course on child and adolescent psychodynamic psychotherapy in the MGH/McLean Child and Adolescent Psychiatry Fellowship Program. She has received five departmental teaching awards and three departmental mentoring awards from the graduating classes of the Child Psychiatry Fellowship. Dr. Bender has a private practice in Newton, Massachusetts, specializing in psychotherapy and psychopharmacology with children, adolescents, and adults.

Edward Messner, MD, until his death in 2006, was a Senior Psychiatrist at MGH and Associate Clinical Professor of Psychiatry at Harvard Medical School. Dr. Messner trained as a psychiatrist at the Boston VA Hospital, at Boston's Thom Clinic, and at MGH. He also graduated from the Boston Psychoanalytic Institute as a certified psychoanalyst. Dr. Messner received the Teacher of the Year award from the MGH Department of Psychiatry eight times. To honor him and his qualities of "kindness, compassion, understanding, insightfulness, humility, and selflessness in his daily work with patients and as an untiring teacher and supervisor of residents," the MGH/McLean Adult Psychiatry Residency Program created the Edward Messner Faculty and Resident Awards in 2008. These awards annually recognize outstanding and committed teaching in Adult Psychiatry by both a faculty member and a graduating resident.

Foreword

One of the most exciting and also terrifying processes of becoming a psychiatrist is sitting down for the first time with a new patient for therapy. In 2003, when I arrived to my outpatient resident clinic orientation, our program director handed me a copy of *Becoming a Therapist,* a new volume written by a psychiatrist, Suzanne Bender, and her senior supervisor, Edward Messner. "This looks like a good read," she said. She was right—*Becoming a Therapist* quickly became a well-thumbed, worn copy sitting in my work bag as a security blanket of sorts. Down-to-earth, and written with a combination of academic rigor, practicality, as well as a refreshing humble vulnerability, *Becoming a Therapist* has become a classic read for the novice clinician. Throughout residency, I thought of Drs. Bender and Messner as my "supervisors on call" and found myself reading through sections in preparation for, or in reaction to, sticky patient situations. I slowly gained confidence knowing that I wasn't the only resident in history who had fumbled through the first encounter, or later on, waded through the intricacies of starting a private practice. Although I have moved offices five times since I completed residency and discarded numerous outdated books and curricula through the years, I have hung on to *Becoming a Therapist* and recommended it to my supervisees. Just seeing the book spine on my bookshelf is comforting.

Over the last 20 years, throughout my career as a clinical researcher, clinical administrator, and educator, I've continued to hone my clinical skills, both as a psychopharmacologist and as a therapist. My clinical practice has evolved along with the technological and cultural zeitgeist of the 21st century. No longer do many of us pen progress notes on paper, letters

to our patients, or even prescriptions; most have transitioned to an electronic medical system. Many of my colleagues email or text to communicate with their patients; lengthy voicemails from patients are largely a thing of the past. Knowing what the underlying communication of these electronic missives may symbolize can feel dizzying at times. As new forms of communication emerge, such as social media, we clinicians can feel like we're "making it up" as we go along, eagerly comparing our notes and thought process with peers in supervision to find our way. Clearly, we need some sensible grounding, and this second edition of *Becoming a Therapist* addresses such new dilemmas, as well as giving much-needed, thoughtful guidance on vacations, family leave, and ongoing professional development—for the clinician at all stages: from trainee, midcareer, to senior practitioner.

With regard to the cultural zeitgeist, in my role as Director of the Massachusetts General Hospital (MGH)/McLean Sociocultural Series for psychiatry residents since 2008 and as Director of the MGH Psychiatry Center for Diversity since 2014, I have watched the field of cultural psychiatry evolve, from a simplistic, knowledge-based *cultural competency* model to one that is attitudinally based in *cultural humility,* a framework that encourages clinicians to maintain an interpersonal stance that is open in relation to aspects of cultural identity most important to the patient. Cultural identity is no longer a shorthand for race and ethnicity; rather, clinicians are encouraged to view their patients (and themselves) as the product of a multitude of cultural experiences, and to acknowledge explicitly these currents in the therapeutic work. More recently, in the wake of the growing movement for Black lives over the last 5 years, and Ibram Kendi's groundbreaking volume *How to Be an Antiracist* in 2019, we have all been challenged to self-reflect on our unconscious socialization and participation in the racial hierarchy within the United States.

Dr. Bender approached me in the summer of 2020 at the height of the racial uprisings in the United States and shared with me how she was working on a second edition, with a mind to incorporate the newer concepts of *cultural humility* and *antiracism*. She mentioned how a video presentation I had made in 2019 for faculty focusing on cultural humility had made an impression on her. She shared with me her writing process, which included consulting experienced Black, Indigenous, People of Color (BIPOC) clinicians we both know, learning from and with them as she revised her book. She also invited me to review a draft of her chapter focusing on cultural identity and repeatedly emphasized how she wanted it to be an introduction to these concepts for her readers, to raise their awareness and inspire them to learn more. I was struck by how her process truly reflected the deep values of both therapy and cultural humility, with a focus on continual self-reflection, humble curiosity, and acknowledgment of our own growth edge.

Indeed, in her new chapter on professional development, Dr. Bender writes, "It is much more complex work to actively engage in the process with every new person, carefully noticing what makes their story unique."

In this pivotal cultural moment, a new edition of *Becoming a Therapist* is needed now more than ever for therapists, no matter how many years of experience they may have—to give tried-and-true advice, to offer wisdom and reflections from a seasoned therapist who herself has grown so much in the last 20 years, and to provide a roadmap ahead for future generations of healers. Ultimately, *Becoming a Therapist* acknowledges that we are indeed always becoming and always evolving with the times. We are called to always grow as clinicians, with our patients, and with the communities we serve.

Nhi-Ha Trinh, MD MPH
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Assistant Professor in Psychiatry, Harvard Medical School
Associate Director, Harvard Medical School William Augustus Hinton Society

Preface

I smiled at the empty chair, hoping my facial expression conveyed empathy and wisdom. In 15 minutes, my first psychotherapy patient would inhabit this seat, and as a solid believer in site-dependent learning, I hoped these final rehearsals would prepare me for the initial moments of the upcoming session.

One more time, I ran through the details of my scripted introduction. I tried to assume an assortment of "empathic postures." I moved the box of tissues next to the unoccupied chair. I offered my outstretched hand to the empty space. "I'm Dr. Bender," I said in the most sensitive, professional tone I could muster. *Pause. Pause.* After the first hello, I was tongue-tied.

Before psychotherapy training, I never had trouble talking with patients. During a year of medical internship, communicating with the seriously ill seemed to be one of my strengths. Maybe my acute onset of wordlessness as a psychotherapy trainee was connected to my high personal expectations. I wanted to be very good. Well, to be honest, I wanted to be incredible. Instead, my first year as a psychiatrist became my year to sweat as I listened intently to my first patients. I half expected (hoped? prayed?) that healing words would magically emerge from within me, heralding the first spontaneous psychiatric cure. You know, the patient enters the office in anguish and leaves 50 minutes later with renewed hope and faith in the human condition.

I majored in psychology in college and have some relatives who are therapists, so I hoped I would have a knack for this work. Needless to say, I was disappointed and had to learn the art of psychotherapy at the same painstakingly slow rate as everybody else.

During my first few years of training, I started my personal search for words: words that would calm, words that would gently confront, and words that would comfort. Many of my supervisors gently teased me when I wrote down their advice verbatim for presession reference. Personally, I still think this approach makes perfect sense. In psychotherapy, words and sentences are the tools of intervention. A small modification in sentence structure changes a comment from judgmental to curious and empathic. For example, the sentence "Your relationship with your husband seems complicated" is much less disparaging than the comment "You certainly have trouble dealing with your husband."

Despite this intensive preparation, I didn't coast through my first year as a psychotherapist. I endured patients who never showed for the first session and others who came to a few meetings and then vanished. I worried that I was inadvertently causing the recurrent flight reactions.

I fantasized about a sophisticated walkie-talkie system that would fit discreetly inside my ear and connect me to my supervisor's office. With this system, I could obtain the guidance I needed instantly during a difficult session. I could whisper into my hidden microphone while the patient blew her nose. "Dr. Messner, are you in? She's not talking at all. What should I do next?"

"10-4, Suzanne, why don't you ask her more about her relationship with her brother?"

"Gotcha. Thanks. Signing off for now. I'll keep you posted."

"What do you really *do* in there?" became my persistent question during my first years as a psychiatrist. I was taught almost nothing about the process of psychotherapy in medical school or internship. When I was in training, a mental review of psychotherapists in film was not helpful. Many therapists were featured as comic relief, quirky, and somewhat odd. At worst, they were sleeping with their patients or their patients' family members. Even Robin Williams's warm, empathic therapist in *Good Will Hunting* had poor boundaries and some questionable therapeutic tactics best left on the silver screen. Except for Judd Hirsch's portrayal of a sensitive therapist in the movie *Ordinary People* (and how many comforting comments can you glean from a few thoughtful scenes?), portrayals of sensitive, intelligent, and ethical therapists were scarce on the big screen. More often than not, Hollywood provided a clear outline of what *not* to do.[1]

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[1]Since the publication of the first edition of *Becoming a Therapist*, many new series and movies have portrayed psychotherapists in action. For example, HBO's series *In Treatment* (with the first version running from 2008 to 2010) offers a thoughtful depiction of the psychotherapy process; each show is a condensed version of one meeting. In the original version of the show, the therapist, Dr. Paul Weston, struggled with significant, and sometimes dangerous, boundary violations. In the series *Big Little*

While my beginning theory/technique courses and supervision provided some useful guidance, my questions emerged more quickly than they could be answered. From my novice's perspective, most books for the beginning therapist weren't very useful. One book advised me to create "a holding environment" for an agitated patient in crisis. Another stated that it was useful to "explore the resistance" for a patient who didn't want to talk. With only weeks of experience under my belt, I had no idea how to follow these recommendations.

To make matters worse, the patients in these texts were entirely too well behaved. They came on time; they understood complex interpretations; and they talked openly about their transference to the therapist. I didn't feel I could apply the interventions created for such extraordinarily sophisticated exemplars to my practice of ordinary patients without prior psychotherapy experience. Meanwhile, my clinic was growing, and I found myself embroiled in many complex clinical situations. What I needed were explicit directions telling me what to do, what to say, and why.

The roots of *Becoming a Therapist: What Do I Say, and Why?* took hold in the midst of my training, during an innocent conversation at the Massachusetts General Hospital (MGH) cafeteria with Dr. Edward Messner, a primary mentor and teacher at MGH with a special ability to explain arcane psychotherapeutic concepts in a clear and concise manner. On a whim, I told Dr. Messner of my hope to write a book someday that would explain how to practice psychotherapy to the interested but confused beginner. I figured I'd be able to advise others once I had more experience, maybe when I was about 50. Instead of waiting 20 years, Dr. Messner proposed we write the book together. For me, it was one of those "aha" moments: our collaboration was the perfect way to organize a book geared for the novice psychotherapist. I was still in touch with all the gnawing questions that bother a beginner, and Dr. Messner could explain what to do clearly and concisely, based on more than 40 years of clinical experience.

Our conversation over coffee was the seed for the text before you—a book developed specifically for psychotherapy trainees (including psychiatrists, clinical psychologists, mental health counselors, psychiatric mental health nurses and social workers); all new therapists share the quandary

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Lies (2017–2019), Dr. Amanda Reisman is the featured therapist for a number of characters; while she helps one character recognize the emotional and physical abuse in her marriage, her approach has also been critiqued as oversimplified and intermittently shaming. While the new version of *In Treatment* or other shows about the therapeutic encounter may avoid some of these outlined pitfalls, I stand by the perspective that these shows should not be used as an optimal model for clinical formulation, theory, and technique. They are excellent resources for inspiring conversation, inquiry, and interest in psychotherapy, while also decreasing the stigma of mental health treatment.

of how to talk to a patient from a psychotherapeutic perspective. Writing from the physician perspective, we refer to the person seeking therapy as a patient, though some therapists may prefer the term *client*.

Although the original intention was to produce an instructive book for clinicians only, I was delighted when a number of friends, ranging from writers to lawyers, were intrigued by our project. It turns out that psychotherapists aren't the only ones with questions about the process of psychotherapy. People are curious about what goes on during talking treatment, including how therapists think or feel, and what they say—and why. The writing attempts to avoid jargon and aims instead for clear explanations that are accessible to all interested readers. A glossary is included to define technical terms.

Fast forward over a decade since the first edition was published, and so much has changed. It was a great loss when Dr. Messner passed away in 2006, but his wisdom continues to inform all my patient encounters. I am grateful *Becoming a Therapist* preserves his guidance and thoughtfulness for those of us who knew him as well as for future generations of novice therapists. Personally, I have passed the 50th birthday I mentioned to Dr. Messner decades ago. Now, I am an experienced clinician, supervisor, and mentor. Following in Dr. Messner's footsteps, I teach a weekly psychotherapy course to MGH psychiatry trainees (in the Child Psychiatry Department). I feel confident in my clinical skills, but I continue to believe in self-reflection and curiosity as a critical aspect of professional development, at any career stage. For this second edition, I write alone, adding my current perspective as a seasoned teacher and psychotherapist. While Dr. Messner isn't by my side, his input remains, both from his sage insights and knowledge drawn from the first edition, and from the sense of him looking over my shoulder, providing thoughtful commentary and direction.

The second edition has additional information on some notable clinical topics. Chapter 1 provides guidance on how to communicate with patients by email or text. Chapter 5 contains a new discourse on cultural identity, cultural humility, and racism. Chapter 12 addresses the complexities of navigating social media as a clinician and discusses how to document psychotherapy in electronic medical records. Chapter 13 on substance use disorders has been thoroughly updated. Chapter 18 discusses the pros and cons of telehealth virtual visits, informed by a personal crash course in the medium during the COVID-19 global pandemic. Useful resources (Therapist Tools) to help a therapist's treatment planning are included throughout the book at the end of their respective chapters; they are also available for downloading at the book's companion website (see the box at the end of the table of contents).

Whereas in the first edition, the first-person plural point of view reflected our writing process, the revised second edition is from a first-person

singular perspective, except when describing a specific interaction between Dr. Messner and myself. While the first edition preferentially used the pronouns *she, her, hers* when referring to patients, the second edition uses the option *they* as a singular pronoun when referring to an unspecified person; this is also the most inclusive approach by referencing those with male, female, and nonbinary pronouns simultaneously.

In order to illustrate how to approach many basic issues that commonly emerge in a psychotherapy, Dr. Messner and I invented our virtual patient, Sallie Gane, a 21-year-old college junior. With Sallie Gane, it's possible for the reader to be the fly on the wall, listening in to Sallie's psychotherapy with me, her hypothetical therapist. Her story will unfold over time, just as it would in a typical treatment. Notations describing Sallie's tone of voice, facial expressions, gestures, and postures will describe some of her nonverbal communications. Similar notations for the therapist are also included, as a therapist's body language complements the spoken word and is a vital part of any effective treatment.

As I experience typical psychotherapeutic dilemmas in my interactions with Sallie, the book will illustrate a variety of possible responses. The title of each dialogue informs the reader whether the example is an illustration of a clinically effective strategy or an illustration of one worth avoiding.

Sallie's treatment illustrates the basics of therapy in a cohesive framework, but her psychological conflicts are simpler than those of many patients. She does not struggle with economic hardship. She has not faced interpersonal or systemic racism, and she has benefited from this privilege. It is easier to navigate the world as a cisgender straight woman. Her physical health is intact, and she is able-bodied. She doesn't currently have a substance use disorder. She has not experienced physical, sexual, or emotional abuse.

For teaching purposes, the therapy centers on Sallie's difficulties with her college friend Gwen and on Sallie's conflicts with her mother. While some treatments may spend more time focusing on the relationship with just one parent, it would be unusual for the focus to be this exclusive, as most patients have been influenced by numerous people, including both parents. Still, I hope the strategies and words offered in response to Sallie's difficulties will be transferable to your work with your patients.

Throughout the book, I introduce additional fictitious patients to discuss topics not included in Sallie's treatment. Candice Jones, a patient who has some trouble differentiating what is real from what is fantasy when she is under stress, appears intermittently (in Chapters 5, 12, 17, and 18), illustrating a specialized treatment approach for patients with this type of difficulty. Anthony Lee in Chapter 13 struggles with problematic alcohol use. His story describes how the therapist's strategy must change when dealing with a patient who has a substance use disorder. Chapter

14 introduces another patient, Elaine Barber, to highlight the therapeutic issues that emerge when treating a patient with psychotherapy and psychotropic medications. I have also used references to actual patients to supplement the dialogues. In these cases, multiple clinical details and identifying features have been changed to make the patient unrecognizable. The patient's privacy is wholly protected, but the critical teaching points are preserved.

The first part of the book, "The Consultation," outlines how to approach the first few sessions with a new patient. It begins with the first phone call or email to set up an appointment and ends with an explanation of psychotherapy for a patient unfamiliar with the process.

Part II, "Frame and Variations," explains how talking with a therapist is different from talking to a friend. This section explains the importance of the ground rules of the therapy (such as starting and ending at a particular time) that may seem arbitrary or capricious to the beginning clinician. This section also illustrates how to handle situations if treatment boundaries are breached. A new chapter for the second edition discusses the impact of therapist's life events (such as a vacation, maternity leave, or illness) on the psychotherapeutic process.

Part III, "Chemistry," focuses on harmful and helpful drugs relevant to psychotherapeutic practice. Chapter 13 presents ways to recognize and to treat patients with substance use difficulties. Chapter 14 offers suggestions on how to coordinate psychotropic medication treatment with psychotherapy.

Part IV, "Therapeutic Dilemmas," discusses how to approach more complex issues that may emerge within a therapy, such as dreams, interpretations, and transference. Overall, this section focuses on the intricate process of therapy, rather than the basic rules that create the treatment's foundation.

Part V, "Being a Therapist," is new to the second edition. In Chapter 19, I share my thoughts on being a therapist after taking you through my journey of becoming one. I review clinical tenets I have found useful over the years as well as the details of memorable psychotherapy encounters (with identifying details changed), including some that didn't go well, and what I have learned from them. As a therapist, I am a firm believer in continued self-critique; clinical skill development doesn't conclude with the end of training. Innumerable hours of supervision, with colleagues and mentors, have helped me to formulate my questions and to find my own answers, and I gratefully recognize these clinicians in the acknowledgments.

I don't pretend to have the answers to every situation that you will encounter with your patients; the process of psychotherapy is as complex and variable as the patients and the therapists who engage in it. Instead,

I hope that the outlined concepts and approaches will guide you as you develop your own voice.

This book will lead you through the basics of psychotherapy: how to start seeing a patient, how to continue through the inevitable difficulties inherent in the process, how to understand what you are doing and why, and finally, how to terminate a treatment. My greatest hope is that this book will provide for you what I was looking for when I was a trainee.

Acknowledgments

I am forever indebted to Ed Messner for his mentorship and supervision in helping create the first edition of this book. I also want to recognize my patients, who have taught me a great deal. I am grateful for the opportunity and privilege to work with them so closely.

The second edition required the same incubation period as the first (6 years!); as I learned to write on my own, I was incredibly fortunate to have the support and guidance of so many.

Kitty Moore and Jim Nageotte were the esteemed Guilford Press editors who helped Dr. Messner and me create our first edition. I am beyond grateful that Jim stuck around and patiently encouraged me and provided wise counsel as the second edition slowly evolved. As the new edition was created, Jane Keislar joined his efforts and her input has also been invaluable. Every Tuesday and Friday, when I sat down during my writing time, they were both available to help me on any and all topics. With Jim in the United Kingdom and Jane on the West Coast, there was always someone awake during my work hours to help me with questions. Throughout the process, I was highly aware how lucky I am to have devoted, thoughtful, experienced editors with such sound judgment. I also want to thank Bill Messner, who represented the Messner family and was supportive of the second edition from the get-go.

For the first edition, Dr. Messner and I had the help of Senior Production Editor Laura Patchkofsky; Art Director Paul Gordon; Marketing Director Marian Robinson; and copy editor Jeanne Ford. For this second edition, I would like to acknowledge the necessary help and efforts of Senior Production Editor Anna Nelson and copy editor Patti Brecht, along with Paul and Marian.

For the second edition, I am so grateful for the help of the Privacy Office at Massachusetts General Hospital. Paula Moran and Samantha

Ciarocco were helpful early on in the process, and Christine Griffin, JD, MGH Director and Privacy Officer of Health Information Management, was incredibly generous with her time and expertise with multiple conversations and emails on many different topics, including the use of email and texting within a psychotherapy, as well as up-to-date information on electronic medical records. This book is a more comprehensive and thoughtful resource because of her input. I am also indebted to Lauren O'Connor, JD, the MGH Director of Risk Management; she freely gave of her expertise regarding questions about patient risk management, especially when a patient moves out of state (when it isn't in the middle of a once-in-100-years pandemic).

For this edition, I benefited greatly from the specific expert guidance of several esteemed colleagues who were all committed, patient, and wise readers. Dr. Amy Yule's thoughtful, knowledgeable input and willingness to answer my numerous questions made all the difference as I updated the section on substance use disorders. Dr. Paula Rauch's expertise, gleaned from decades working with severely ill children and parents, was so helpful when I had some questions in Chapter 11 on the psychological impact of medical illness. Drs. Deborah Kadish and Janet Wozniak were endlessly patient, encouraging, and willing to read through multiple chapter sections. They were always available to answer questions and to provide critically helpful feedback. I have benefited greatly from their support of this project.

I could not have developed the sections on cultural identity, cultural humility, and antiracism without the expert critique and wise thoughtful direction from Drs. Juliana Chen, Tanishia Choice, Christine Crawford, Maria Jose Lisotto, and Nhi-Ha Trinh. Their careful and thorough reading, direct and useful input, and knowledgeable insightful guidance have made me a better clinician. I also want to thank Drs. Katia Canenguez, Aisha James, and Nhi-Ha Trinh, a leadership team on the MGH Anti-Racism Toolkit project, who recommended the phrasing for clinicians asking patients about their experience with racism and discrimination. Dr. Trinh also deserves one more special mention, as I am so appreciative to have her beautifully written, discerning foreword open the second edition.

It takes a village to cultivate a professional. After training, I continue to be so aware and thankful for the community that has supported my ongoing growth as a clinician. I am incredibly fortunate to have the priceless gift of over 20 years of wise guidance via monthly peer supervision with Drs. Deborah Kadish and Jennifer Rathbun. The Boston psychiatric community has been my home now for decades, and there are too many dear colleagues to mention by name. A special shout-out (and an apology for anyone I might have missed) to the group of colleagues not mentioned above who have supported my career, and provided invaluable input and guidance over the years, including Drs. Annah Abrams, Gene Beresin, Joe Biederman, Abigail Donovan, Stephen Durant, Anne Fishel, Eric Hazen, Lindy

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After over 10 years of teaching psychotherapy within the MGH Child Psychiatry Department, I am a better clinician, teacher, and writer because of the MGH/McLean Child and Adolescent Psychiatry Fellowship trainees who then become my esteemed colleagues. They inspire me as I teach them, and then as they launch, making the world a better place for the great work that they do. I am reminded of this statement by Anna Freud: "Teaching is learning twice: first one learns as one prepares for one's students, and then one learns from them, as one works with them." To each and every one of you: your work inspires me, and I am proud to have been part of your education. My hope is that I have paid it forward, with the generosity of time, attention, and care that was given to me during my training.

Last, but not least, I am so grateful for my family, as none of this would have existed without your belief and support of me. Now, with this second edition, I am bolstered by the input and counsel of three generations, from my parents, my husband and sisters, and my children. Thank you all for cheering me on and providing insightful suggestions as the second edition of the book evolved. My mother has served as an example of an inspired working mother. She bolstered my creativity when I couldn't find it. Karen taught me the power of storytelling, and paved the way. Aimee's unrelenting encouragement, courageous example, and willingness to share her writing expertise in response to any question anchored me throughout this process. Sarah and Ethan enrich my life, bring me such joy, and broaden my vision and understanding of the world. My father, my first mentor in this field, provided me with the inspiration to become a psychiatrist and has continued to provide gentle and wise oversight throughout the years. Last, and so crucial, my husband, Randy. His insight, strength, and character inspire me. He also has been endlessly patient as I asked him for input whenever I faced an obstacle. At every twist and turn, he was there; I wouldn't be who I am today without his support and love.

Suzanne Bender

Contents

Introduction

As a trainee, I was intrigued when my teachers compared psychotherapy to an impromptu dance between two partners. While it is possible to plan the first "hello" and the "thank you" at the end of the set, what happens between the greetings is unpredictable. Accomplished dancers can capably improvise with a new partner because they are most familiar with the basic and common dance steps. Psychotherapy is similar. Advanced therapists have an expansive repertoire of "steps" at their disposal. They are comfortable with psychotherapy basics, and they tailor each treatment to meet the unique needs of a patient.

This book's purpose is to teach you the basic steps one needs to know fluently to practice psychotherapy. It is not a cookbook or script to follow, but a guidebook to help the beginner understand and resolve common clinical dilemmas. Predicaments that emerge in treatment frequently are outlined, and then a variety of responses are evaluated.

THE BASICS

What is psychotherapy supposed to do? Psychotherapy can help patients cope with traumas, crises, losses, and developmental crises. It can enable people to bring out the best in themselves by recognizing and then discarding ineffective approaches to life's challenges and by discovering talents, capacities, and strengths that were previously buried. The psychotherapeutic relationship itself is involved in the healing process. It can provide a model for mature and empathic interactions and can foster the development of problem-solving skills in emotionally laden situations. By removing the obstacles to personal maturation, psychotherapy can help a patient discover inner complexity, richness, beauty, and worth.

For psychotherapy to occur, the patient must make it to the therapist's office. This is no little achievement. By calling for an appointment, the patient is acknowledging that they have an emotional conflict or difficulty that has not improved despite their best efforts. Often, the trip to the therapist is the patient's last resort. Since psychotherapy is poorly understood by many people, it is often shunned and considered only after other remedies (e.g., exercise, relaxation, friendly advice, vitamin supplements) have failed.

Interestingly, as a treatment evolves, it may focus on a conflict very different from the one that first brought the patient to the office. For example, a patient may start therapy complaining about their self-centered partner who is unresponsive to their many thoughtful gestures. Although the beginning of treatment may concentrate on the patient's relationship, eventually the focus may shift. Why is the patient drawn to such an unfulfilling partner in the first place? After some discussion of present and past difficulties, it may become clear that the patient has a maladaptive behavior pattern, pulling them toward self-absorbed companions.

Here's where the work in psychotherapy becomes difficult. If it were easy to act differently or to feel better, the patient wouldn't need therapy in the first place. Underneath an emotional conflict that doesn't seem to make sense (e.g., why is this person always attracted to unsupportive partners?), there may lurk multiple intrapsychic forces and overlearned responses that oppose more adaptive behavior. The potent influences of early experience also need to be understood for the patient to improve. Many inner conflicts, fears, and motivations originate outside the conscious awareness of the patient. All of these forces are powerful. They have to be; they've repeatedly interfered with the patient's ability to act in a way that would promote their own happiness or productivity.

As therapists, it is our duty and responsibility to recognize these forces, to respect them, and then to learn about them in careful detail. Looking at one's emotional blemishes isn't easy; to be effective, the treatment must explore the patient's difficulties in a nonpejorative and compassionate manner. The goal of therapy is to understand the powerful grip of these beliefs, emotions, and patterns of behavior. They wouldn't exist unless they had been useful once, but by the time a person finds their way to therapy, they tend to be obsolete and harmful.

When the patient is able to understand and to integrate both the thinking and feeling parts of their unconscious motivations, emotional growth and change become possible. Learning this information unaccompanied by the emotions that travel with it, or feeling hurt and angry without grasping its source, isn't therapeutic. For emotional change to occur, both the feelings and thoughts involved in a conflict need to be understood. Only then can the patient recognize that they have choices; before this realization, their maladaptive behavior had appeared to be automatic and the only option available. As treatment progresses, the patient may view life's

conflicts and dilemmas with more insight and flexibility, with increased ability to choose more adaptive courses.

I also believe the well-prepared therapist needs to have a variety of potential interventions available in their repertoire. Cognitive-behavioral therapy focuses predominately on beliefs, attitudes, and overlearned behaviors. Psychodynamic therapy focuses on free association (rather than a predefined treatment plan), self-reflection, and the transference to discover and to understand the multiple intrapsychic forces fueling emotional distress. Psychopharmacological treatment uses medication to change the patient's neurochemical milieu. This book includes elements of all these approaches as the well-prepared therapist needs to have a variety of potential interventions readily available. For this reason, the book's approach could be called "integrative."

So, there you have it. Read on, and the therapy with the fictional patient Sallie begins, starting with her first message on my answering machine. How should I respond to her phone call? This is the type of question that used to plague me. My hope is that this text will provide answers to these types of basic questions, explaining the "what," "why," and, most crucial for the beginner, the "how" of psychotherapy.

PART I
THE CONSULTATION

CHAPTER 1

First Contact

The initial interaction with a new patient may be a challenge for the novice therapist. It is the first opportunity to set the stage for future treatment. All communications should be approached with the patient's privacy and concerns in mind.

THE PHONE CALL

"Hi, my name is Sally Gane and my primary care doctor gave me your number. I think I am interested in therapy. Could you call me back? My number is 555-2121."

Before I pick up the phone to return Sally's call, I want to acknowledge how anxious I felt with my first psychotherapy referral. It was difficult to embrace a professional identity that had been in place only 48 hours. I reacted with an acute bout of indigestion.

My friends with similar psychosomatic tendencies reported feeling flushed and then concerned that they may have suddenly acquired high blood pressure. Some colleagues coped by skimming large psychotherapy texts during occasional spare moments between patient care and seminars. One classmate seemed unnaturally calm and overconfident, and spouted comments like, "Psychotherapy is all intuition anyway. I trust my instincts, so I know I am ready to treat just about anybody."

Basically, all of these reactions demonstrate the varied ways of managing the intense and normal anxiety that most psychotherapy trainees experience. Your supervisors probably had similar worries when they began training, but they may have successfully submerged these memories as they gained expertise. On the bright side, anxiety can be advantageous when it's

motivating but not overwhelming. My recommendation is to acknowledge that you are worried and to share your experience with sensitive colleagues for support. Anxiety usually increases if you fight it, or pretend it's not there.

Psychotherapy trainees who can acknowledge that they have a lot to learn are in the best position to help their patients. The process of psychotherapy is all about *not knowing* and having patients teach you about their experience. The more questions you ask your patients, the more the two of you will learn together. The more questions you ask your supervisor, the more you will learn about the case you are discussing. A grandiose "I know everything" or "Here's the answer" approach does not serve your patients well, especially if you hesitate to seek the guidance you will undoubtedly need.

When I started learning psychotherapy, I felt guilty that my patients would be stuck with me as their therapist, rather than a more experienced clinician in the community. Many of my novice colleagues shared this concern. Dr. Messner taught the residents in a weekly seminar and shared his perspective during our first days of training: beginning therapists have something very special to offer. A quote: "The first patients of a psychotherapy trainee are lucky." Yes, lucky.

Under a trainee's care, patients will receive enthusiastic, concerned, and attentive treatment from an interested and compassionate psychotherapist. Via supervision, the patient will also benefit from clinical expertise. This combination can provide for a thoughtful and helpful treatment that may have advantages over a treatment received in the community where energy, idealism, and optimism might have subsided. I've even heard patients brag about being their therapist's first patient and about how proud they were to be in this unique position.

Although it may seem obvious to some, I want to share a common and effective coping mechanism that can mitigate first-session jitters. Whatever your current state during the consultation with a new patient, the patient is bound to be the more anxious individual in the room. They have decided to confide in a stranger because of persistent emotional difficulties. Setting up the first appointment may have been a formidable task that took weeks or months. Whenever a psychotherapy becomes complicated or anxiety-provoking for the therapist, it can revitalize compassion and calm to remember how the patient must feel.

For the skeptics in the audience, I want to review why I am spending a chapter discussing how to navigate the first contact with a new patient, a seemingly uncomplicated event. A therapist's response to a phone message or an email from a potential psychotherapy patient counts as the first clinical interaction. It is the therapist's first opportunity to demonstrate the unique attributes of the therapeutic relationship. The therapist's focus is on the patient, but the interaction is professional with specific and strict

limitations. With this in mind, even the words the therapist chooses to leave on Sally's voicemail or email are relevant in setting the stage and tone for a potential therapeutic relationship and for future communications.

So, how to respond?

If I receive a phone call to set up an initial appointment, my return phone message cannot assume that the patient's voicemail is set up to protect their privacy. Some individuals still use a shared home answering machine. While it is much less likely that a cell phone voicemail will be intercepted, leaving a more discrete first message for a new patient is preferred until I confirm that the phone number is not shared with others.

To protect confidentiality, I use words that do not scream "psychotherapy" when returning a message. The upcoming session can be referred to as an "appointment" or "meeting." Since I have not met Sally yet, I may choose to address her in a more formal manner—"Sally Gane" or "Ms. Sally Gane."

I feel most comfortable referring to myself in a first phone message as Suzanne Bender, not Dr. Suzanne Bender. Other clinicians may disagree with this approach, arguing it is important to use one's professional title consistently. There are pros and cons to both points of view. On the one hand, if I address my future patient in a more formal manner on the phone, it may be more consistent to use my title as well. Yet, until I have confirmed that this voicemail is only accessible to Sally, I err on the side of protecting her privacy and the fact she is interested in starting psychotherapy.

While returning a message may seem like a simple communication, some messages facilitate future interactions better than others. Here's an example of a message that could lead to a mishap:

EXAMPLE 1.1

The therapist's vague phone message in response to the patient's first call

THERAPIST: Hello, this is Suzanne Bender returning a message from Sally Gane. You can call me at my voicemail, 555-0001, or I'll call back later so we can set up a meeting time.

While this message seems relatively straightforward, its vague directions set the stage for future "phone tag." First, I don't clarify when I'll be available to pick up the phone; Sally may contact me while I'm in session with another patient, or commuting home and inaccessible for many minutes. If Sally doesn't answer when I return her call, I'm left in the uncomfortable position of chasing my new patient to set up a meeting time.

Some possible solutions:

First, I try to answer initial phone calls in the early evening hours, when I am more likely to reach the potential patient. If it is still difficult to get in touch with the patient, the following message is an effective option.

EXAMPLE 1.2

The therapist's clear phone message in response to the patient's first call

THERAPIST: Hello, this is Suzanne Bender, returning the call from Sally Gane. I'm hoping we can find a time over the next few days to talk by phone and review some more details. Tomorrow I am free to talk between 10 and 11 A.M., and Wednesday I am available between 2 and 3 P.M.; you can reach me at 555-0001. If we are unable to connect today or tomorrow, please leave me a message with some good times that I can reach you.

By sharing the times when I can promptly answer Sally's call, I have decreased the likelihood of future phone tag. If my outreach doesn't work, the next move is Sally's; I don't need to repeatedly call her but can wait for her message, listing upcoming times when she is available to talk.

WIRELESS COMMUNICATION WITH PATIENTS: EMAILING AND TEXTING[1]

Over the last decade, new technologies have transformed how therapists interact with their patients outside of the office. Emailing and texting are efficient and easily accessible modes of communication that many therapists utilize. (Remote telehealth, providing treatment via virtual visits, has also transformed psychotherapy, and is covered in detail in Chapter 18.) Once provided the opportunity, patients will email and text with their therapists about topics ranging from schedule changes and late arrivals to medication refills or even urgent clinical issues. Unfortunately, these communications may not be completely secure and confidential; without special protections, they may be hacked or intercepted, and they may be accessible to the email or text carrier. For these reasons, electronic communication with patients requires special forethought and discussion.

For psychotherapy to work, a patient needs to know, first and foremost, that their privacy is protected by the therapist. My new recommendations in this section were developed after several hours in consultation with health information privacy experts who have guided the development and adoption of organization policies and procedures relating to the use of Internet and wireless communication technologies. As I received guidance on the many recommended restrictions (reviewed below) necessary to protect confidentiality while emailing or texting, it took some time to digest the supervision.

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[1] Conversations with Christine Griffin, JD, MGH Director and Privacy Officer in Health Information Management, were critically helpful in the development of this section.

At first, I found myself squirming and pushing back in response to this information, similar to my novice self, learning some of psychotherapy's unique privacy rules. Was this consistent caution regarding wireless communication truly necessary? The answer was a resounding "yes." While it's so easy to get caught up in the moment and to want to respond to a patient quickly and efficiently by email or by text, protecting confidentiality must be my first priority; I cannot ignore the security risks of interacting with patients on an insecure network. Thankfully, just as I experienced with other communication practices required of therapists, what felt annoyingly restrictive at first, slowly became more comfortable and, eventually, second nature.

The Health Insurance Portability and Accountability Act (HIPAA) holds health care providers accountable for securing Protected Health Information (PHI) that is shared or transmitted electronically. At this time, encrypting email via a communication portal is considered the standard for protecting a patient's sensitive information. With this approach, the email carrier doesn't have copies of the communications and the messages are secure.

A 2013 HIPAA addendum known as the 2013 *Omnibus Final Rule* suggests that clinicians should also consider patient preference in electronic communication. If a patient states (preferably in writing) a clear preference for unencrypted email after being informed of potential confidentiality risks, a therapist may use the more easily accessible, less secure modality for future communications.

Let's imagine Sally and I continue to play phone tag, so I leave her my email address in a voicemail: *"Hi, this is Suzanne Bender calling back. Since we are playing phone tag, if you would prefer, please email me (address provided) some times you are free to talk during the next few days, and I will try to catch you then. In order to be respectful of your privacy, I want to add that some people prefer not to communicate via standard email because the setup isn't a secure method of communication or completely confidential. There is a way for us to securely communicate by email via a sign-in portal; I can tell you more about this when we connect. If you would prefer to communicate by phone only, please call me back with some upcoming times you are available to take a call."* From the get-go, I introduce email as a method of communication that lacks adequate privacy protections but is also easily accessible.

If Sally follows up via email, my first response should inform her of the security risks associated with using unencrypted email, and ask her preference regarding more or less secure email, before further communication proceeds. I will start to share scheduling information only after I have secured her messaging preferences. With assistance from experts in health information privacy, I have created two templates, Therapist Tool 1.1 and Therapist Tool 1.2, to guide the first email exchange. The first template is

for therapists who have access to encrypted email via a protected portal for patient communication, and the second template is for therapists who do not. A caveat: legal regulations regarding the use of technology for clinical care are in a state of constant evolution. Before using these templates, the therapist should check with the appropriate professional organization and review the latest guidelines regarding HIPAA confidentiality. HIPAA's website (*www.hhs.gove/hipaa/index.html*) is an excellent resource.

It is important that the patient has a full understanding of the privacy risks when using a standard personal email. It is so easy to think of email as a private communication rather than a conversation that can be intercepted, hacked, viewed, or disclosed by the email carrier. If a patient prefers to use standard email (instead of a secured email via a portal system) after learning the risks, I will accept and read the messages sent to me, but my reply should not add any new private information to the thread. For instance, if a patient brings up an emotionally complex topic via email, I don't respond with additional clinically sensitive information; my reply will be to schedule a telehealth or in-person visit or a time to check in by phone.

Once I have Sally's permission, email is well suited for straightforward uncomplicated communications that don't share much confidential information. As I do not regularly check my email over the weekend, I inform patients to expect replies on weekdays only. I clarify that email should not be used to contact me during an emergency and review my emergency contact information for use in a crisis.

Sally and I could use email to find a mutually agreeable time to answer her questions about my practice and psychotherapy in general. I could also use email for future scheduling changes. For simplicity's sake, patients in ongoing treatment sometimes prefer to email me for a medication refill, even if they prefer the unsecured standard email. As a medication refill request contains confidential information, I recommend that the patients using unsecured email provide me with just the first letter of the needed medication; using my medical notes, it is fairly easy for me to understand their request. If I have further questions, I can call for clarification.

Some information should never be shared by email. Personal identifying information is especially vulnerable on wireless networks and, according to health information experts, it should always remain off email (unless working with a specific encrypted network designated for this task) and/or texts (see item 4 in Table 1.1). If I need specific insurance information for a patient, I should obtain this information over the phone, or during a telehealth or in-person visit. In Massachusetts, there is a specific law restricting the transmission of personal identifying data (such as a Social Security number or driver's license number) via unsecured wireless networks; many other states are likely to have a similar protective statute.

Some clinical practices have responded to the need for secure email by embedding encrypted, secure wireless portals into the electronic medical record (EMR) system; patients can then communicate directly with their

TABLE 1.1 Patient Information That Should Never Be Shared in Text Messages

1. Patient orders or prescription refills
2. Information about the diagnosis of a patient or family member
3. Lengthy clinical discussion or counseling[a]
4. Personal identifying information such as Social Security numbers, driver's license numbers, state-issued identification card numbers, financial account numbers, credit card numbers, debit card numbers, or any other identifier that exposes financial risk to individuals

[a]Some specific clinical programs may be designed to include counseling by text, but these would require specific and separate authorization.

clinicians, but every discussion is logged directly into the medical chart. (Therapist Tools 1.1 and 1.2 do not address this type of email option; if it is available, the health care institution or clinic will provide education to patients about this mode of communication.) While this approach addresses many of the confidentiality concerns inherent in wireless communications, many patients have expressed concerns to me about using patient portals in an EMR system. Will the portal be efficient enough to deliver the message that the patient is running late? Is the portal easy to navigate on a handheld device? Some patients have also felt less comfortable using the portal because all messages sent between providers and patients (including therapists and patients) may be logged into the medical record, and sometimes, these private communications may be accessed or reviewed by all health care providers for the patient, not just the therapist.

My take-home: a perfect version of efficient confidential electronic communication with patients doesn't currently exist, but it will likely emerge soon. In the meantime, our job is to thoughtfully discuss and consider all the options for email use with our patients, reviewing the risks and benefits of each approach at the beginning of every treatment.

What to Consider If You Wish to Text With Your Patient

HIPAA mandates that providers protect confidential information from unauthorized access, use, and disclosure (see Table 1.1). Texting platforms that meet industry security and HIPAA encryption standards do exist; if a clinician wants to text with their patients, they need to carefully vet their texting platform to make sure it is legally sound and following all HIPAA standards and rules. Texting through the use of one's cell phone texting app does not meet these specific security criteria.

While I know many attentive clinicians who regularly text with their patients, texting without an encrypted platform is not adequately privacy protected; in addition, providers must also consider rules (reviewed below)

imposed by the Telephone Consumer Protection Act (TCPA). Even with an encrypted platform, the decision to text with patients needs to be thoughtfully considered, weighing potential risks and benefits.

As texts may be viewed, fairly easily, by unintended snoopers, texting should be used sparingly and only in unique clinical scenarios. Texting with a patient to confirm or cancel a scheduled appointment, or if either party is running late, may be useful. Even the fact that the patient is in psychotherapy treatment should be treated as a piece of confidential information, so the therapist's text to the patient should include only the basics of office address and session time: "Confirming appointment with Suzanne Bender at 4:30 on 11/18 at office address." The text would not include the reason for the visit or the name of the clinic.

While I have decided not to text with patients (reasons why, listed below), I consulted with health care information security experts to learn the latest thinking on this issue, to inform those clinicians who do want to text with patients. They specifically advised against texting prescription refill information, information about a patient or family member's diagnosis, counseling interventions, or identifying information (to protect from potential identity theft).[2] (See Table 1.1.) In addition, before texting with a patient, the therapist needs to confirm the mobile number with the patient to decrease the possibility of sending a message to the wrong individual. The therapist can double check that the number is keyed in correctly by sending a test-text during a psychotherapy session. A side note: sending group texts to patients is never appropriate because phone numbers, which are considered unique patient identifiers, will be revealed to the larger group.

The TCPA of 1991 also requires ongoing consumer consent for all forms of telephone and texting communication, specifically, when technology has the capacity to autodial. For instance, any system that can send automated, system-generated messages to patients must comply with the TCPA. The TCPA provides that any patient must be allowed to opt out of text communications with their therapist at any time. As the use of this tool within psychotherapy is still evolving, I recommend checking with one's professional organization on a regular basis to stay up to date on new regulations and safety measures.

If a therapist chooses to text for scheduling purposes, the patient should sign a release that reviews the confidentiality limits of texting, permits this specific type of communication for certain specific circumstances,

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[2]In addition, texting clinical orders to an inpatient clinical service is specifically prohibited by the Joint Commission, Center for Medicare and Medicaid Services, as texted orders lack ordering provider authentication and signature. While this is important information, outpatient psychotherapists generally aren't in a position to text orders to other health care providers.

such as scheduling, and clarifies that texting should not be used to discuss clinical concerns or in the event of a clinical emergency. While it is useful to delineate how texting should be used within a treatment, I am concerned that these limits may be difficult to implement in practice.

Ideally, the therapist would have an encrypted HIPAA-approved platform with a unique number for texting and phone calls, but many therapists use their cell phone as their office contact number. In this case, would the therapist have a designated HIPAA-approved texting number specifically for scheduling issues, while phone calls would focus on confidential clinical concerns? If the office number is also a cell phone and texting is accepted as a communication modality within the treatment, would patients eventually try to text you directly at the office cell phone number rather than using the designated encrypted platform? Will it work to create this artificial boundary with different topics allowed for phone calls and texts?

I would be concerned that patients facing an emotional crisis may not remember the limits of a contract signed months before and may text me in desperation. From my perspective, I bear an ethical, and possibly legal, responsibility to respond to an urgent text even if I have specified in my consent form at the start of treatment that texting is not appropriate in the event of an emergency and that I only answer texts between 9 A.M. and 5 P.M.

Here's another imagined scenario that concerns me: What if my patient texts me while I am on vacation, reaching out directly and bypassing my coverage? If I have a separate cell phone designated for clinical use only, I will leave my work cell phone at home and I won't receive the message. If I am texting using a HIPAA-approved platform, I may be able to create an easily accessible HIPAA-approved autoreply, which would respond to any incoming text, similar to the email autoreply that directs patients to my coverage when I am unavailable. On the other hand, if I have not used these privacy protections, and have been using my personal cell phone for texting patients, my patient may have unmitigated access to me during my break. Bypassing my voicemail and email that outline my coverage while away, my patient may not know or may ignore that I am officially unavailable. I can easily imagine needing to take time away from my holiday to text my coverage details in response to any incoming query. If the text is urgent, I cannot ethically ignore the emergency; at the least, I would need to contact my coverage to facilitate a crisis intervention.

My personal take is that inviting a patient to text me is a confusing offer. While texting may be introduced as a way to communicate about mundane topics quickly and easily (i.e., scheduling), it provides a sense of immediate clinical access more akin to a beeper. I understand why a patient in crisis may forget any texting limitations when faced with an urgent situation, but then my patient has unrestricted access to me at all times, leading to unexpected emergency communications.

As I mentioned earlier, after a careful review of the pros and cons, I have decided not to text with my patients. To avoid patients inadvertently accessing my cell phone number, I block my number when I return calls from my cell. With a separate secure voicemail on a different number, an email, and a pager, my patients have plenty of access to me and the boundaries of the treatment are preserved. This is not the only optimal setup, but it works well for me; part of becoming a therapist is developing one's own personal system for communicating with patients outside of the office. Whatever the final choice, it is critically important to prioritize a patient's confidentiality in every encounter, and to obtain the consent of a patient regarding the risks and benefits of any electronic communication technology employed.

THE FIRST PHONE CALL

Ideally, the therapist and patient discuss the details of the first appointment by phone, as the conversation involves more than just choosing a time and a place to meet.

EXAMPLE 1.3

The first phone conversation: In her excitement, the therapist agrees to meet at an inopportune time

THERAPIST: Hi, is this Sally Gane?

SALLY: Yes.

THERAPIST: Hi, this is Dr. Suzanne Bender; I got your message.

SALLY: Oh, hi. I got your name from Dr. Newman, my doctor at school.

THERAPIST: You mentioned in your message that you might be interested in therapy. Can you tell me a little bit about what you are looking for?

SALLY: Umm, well, I don't know. . . . Do you do therapy?

THERAPIST: I do. I have my schedule book open. Would you like to set up a time to meet?

SALLY: Okay.

THERAPIST: What days are possible for you?

SALLY: Well, I am working part time and going to school, so my schedule is a bit tight. But I could meet at Tuesday at 7:00 P.M. or Friday at 6:00 P.M.?

THERAPIST: (*Feels stomach sink at thought of meeting so late in the day, but doesn't know what else to do but to agree.*) Okay, I think Tuesday at 7:00 would be fine.

SCHEDULING

With my first psychotherapy patients, I agreed to almost any meeting time, no matter how awful, because I didn't want to lose the potential patient by being less accessible. With more experience, my strategy changed. Now, before I return a call to set up a first appointment, I outline the hours I have available for new patients. During the initial phone call, I only offer these session times, and avoid scheduling people during protected times that feel too late or too early.

While the time of the first consultation does not commit the therapist to that time for future therapy, the patient might develop that expectation. If Friday evening at 6:00 is a one-time event, the therapist needs to review their time restrictions when scheduling future meetings.

During my first year as a therapist, I spent my Wednesday mornings commuting at an ungodly hour to meet one patient at 6:30 A.M. At first, I really didn't mind. I was so excited to have any patient interested in working with me. We started meeting during the summer when the sun had already risen before my 30-minute commute. My patient's attendance was perfect, and the session with him was the highlight of my day.

By December, I was no longer so excited by our arrangement. The absurdity of the schedule hit home the day I spent 15 minutes inching down an icy hill toward my subway stop before sunrise. Then my patient didn't show up. When I called to find out what had happened, he said it was too cold to come to such an early appointment.

This missed session was just the first of his many wintertime no-shows. I tried to reschedule his weekly time, but he insisted that this was the only hour he could meet with me during the entire week. I was caught in a frequent beginner's quandary: I was more invested in his therapy than he was, and I didn't feel comfortable setting limits. (Words I could have used: "Unfortunately, I can no longer continue meeting at 6:30 A.M. Let's look at our schedules together and come up with a solution.") Meanwhile, my patient continued to attend only every second or third session, and I continued to spend many Wednesday mornings waiting alone in a fury. Ultimately, the therapy suffered. I was not as sensitive or engaged as I might have been. How could I be when I was fuming inside?

I hope to protect you from this type of mistake. Safeguarding your own time is a crucial part of being an effective therapist. Scheduling an awkward meeting time may eventually backfire if the therapy suffers due to increasing resentment. Nowadays, a telehealth option may have improved my patient's therapy attendance during the winter months, but even so, the take-home guidance is the same: it is important to recognize your own needs, not only the patient's, when scheduling therapy sessions.

Patients who work are ordinarily available mornings and evenings. To make room for these patients and simultaneously to heed your own needs,

you can schedule patients with full work schedules at early or late hours, depending on your own working style. Before I had my first child, I preferred to start working early in the morning, but when I became a working mother, a weekly Wednesday evening and Saturday morning clinic worked best for my family and for my hard-to-schedule patients. In addition, telehealth provides increased flexibility and may be offered as an option when rigid schedules or bad weather affect a patient's ability to attend psychotherapy sessions. (For more information on telehealth, see Chapter 18.)

When I end up in a scheduling nightmare that I didn't anticipate and don't want to tolerate, I've tried to view the situation as an educational experience. As a trainee, I used supervision to examine what made it so difficult to set limits. Once the dilemma was discussed and understood, my irate feelings dispelled; the next step was learning how to sensitively broach a schedule change with the patient.

Let's play back the first phone conversation, illustrating how I could protect my schedule by offering a number of reasonable appointment times.

EXAMPLE 1.4

The first phone conversation: The therapist sets up a viable appointment time

THERAPIST: Hi, is this Sally Gane?

SALLY: Yes.

THERAPIST: Hi, this is Dr. Suzanne Bender; am I catching you at a good time to talk?

SALLY: Oh, sure. Thanks for calling back. I got your name from my internist Dr. Newman; she told me that she has referred patients to you in the past.

THERAPIST: You mentioned in your message that you might be interested in therapy. Can you tell me a little bit more? What kind of treatment are you interested in?

SALLY: Umm, well, I don't know . . . college has been stressful, so I thought it might be helpful to talk to someone. Do you do that kind of therapy?

THERAPIST: Yes, I do and I would be glad to meet with you for a consultation. I have my schedule book open. Would you like to set up a time to meet?

SALLY: Okay.

THERAPIST: What days are possible for you?

SALLY: Well, I am working part-time and going to school, so my schedule is a bit tight. But I could meet on Tuesday at 7:00 P.M. or Friday at 6:00 P.M.?

THERAPIST: Let's see . . . I don't have either of those times available as my latest meeting time during the week is 6:00 P.M. on Tuesday. I do

have some morning times available as well as some lunch hours. What about 8:00 A.M. on Thursday?

SALLY: Oh, I can't meet on Thursdays, but I just remembered, I do have Monday afternoons open.

THERAPIST: What about this Monday, March 20th, at 2:00 P.M.?

SALLY: Oh, sure. I can do that.

THERAPIST: Good. I'm glad we found a time. Would you like to discuss my fee now, or during the first visit?

SALLY: Um, can we discuss it during the meeting? Is that okay?

THERAPIST: Sure. Now let me give you directions to my office.

Example 1.4 also illustrates how I bring up my fee during the first phone call. The question ("Would you like to discuss my fee now, or during the first visit?") broaches the topic of money in a respectful yet open manner. An alternative approach would be to ask, "What type of health insurance do you have?" and then discuss whether the insurance covers your services.

Since most novice psychotherapists train in a clinic where the administrative staff handles the billing, I have not included an in-depth discussion of financial and insurance issues in this chapter. Once I opened my own private practice, I did need to know how to discuss fees and payments with new patients, and I review these topics in detail in Chapter 8.

As my phone call with Sally draws to a close, it is useful to obtain some basic information.

THERAPIST: Before we stop for now, for my records, may I have the correct spelling of your name and your address?

SALLIE: Oh, sure. I spell my first name with an *ie*—so it is *S-a-l-l-i-e*. My last name is *Gane, G-a-n-e*. My address is 1111 Central Street in Boston.

THERAPIST: What is the ZIP code?

SALLIE: Um, it is 02114.

THERAPIST: Thanks so much. Is this the best number to reach you at?

SALLIE: Umm, no, actually I'm home for spring break, and this is my parents' home number. It makes more sense for you to have my cell phone number; it's 617-555-6666.

THERAPIST: Thanks very much. So, is it okay to leave messages at this number?

SALLIE: Yeah—it's fine to leave a message. I have my cell with me almost all the time. You can also text me.

THERAPIST: Thanks so much. I don't text because it isn't as protected or private, but I'm glad I know I can call and leave a message at this number if I need to get in contact with you.

Spelling a patient's name correctly conveys respect and consideration. I ask for this information during the consultation because it may become awkward to insert this simple question into an ongoing treatment. I try never to assume how to spell a patient's name since I've been wrong before. Even simple names may have unusual spellings, as in this case, as Sallie spells her name with an *ie* rather than the traditional *y*.

I never know when I might need a patient's address during a therapy, so I also collect this information during the first phone call or meeting. In a psychiatric emergency, an address can be lifesaving. If Sallie leaves treatment abruptly, I might need to send her a letter or bill by mail. Problems in confidentiality can also be avoided by having a precise address. My use of the phrase *for my records* emphasizes the professional nature of the contract and reinforces the privacy that is protected in therapy.

Sallie may have some questions before the conversation ends.

SALLIE: Um, I was just wondering, before we meet, what is your psychological orientation?

THERAPIST: What do you mean?

SALLIE: Well, I am taking a psychology course, and they are discussing self psychology versus cognitive-behavioral psychology versus a psychoanalytic approach to therapy. What's your approach?

THERAPIST: Well, I use an eclectic approach that integrates teachings from many of the schools but emphasizes psychodynamic psychotherapy.

SALLIE: What about cognitive-behavioral techniques?

THERAPIST: Can you tell me what you are looking for?

SALLIE: I don't know really. I just want to know more about what to expect.

THERAPIST: I do incorporate some cognitive-behavioral therapy strategies into treatment, but rather than discussing this now, I would like to give these questions the time they deserve. I hope we can talk more about them when we meet, and you can let me know your concerns or preferences.

SALLIE: Okay, I'll see you then.

THERAPIST: I look forward to meeting you on Monday, the 20th, at 2:00.

When setting up a first meeting, I try to keep the conversation simple and clear by validating the patient's concerns but avoiding a lengthy discussion that could be prone to misunderstandings.

It isn't unusual for a patient to express concerns about the therapeutic process as early as the first phone call. Sometimes these questions may reflect the patient's ambivalence regarding treatment. If they express significant hesitation about psychodynamic psychotherapy or a definite

preference for another genre of treatment, I may provide alternative referral options.

FRAMING THE FIRST VISITS AS A CONSULTATION

I view the first few sessions with a patient as a consultation, not the beginning of treatment. The consultation consists of a few meetings during which I will obtain a history, make a diagnosis, and recommend a treatment plan. The package does not include a guarantee that I will become the patient's individual psychotherapist. In fact, until the consultation is complete, I cannot assume that individual psychotherapy is even the treatment of choice.

Framing the meeting as the first session of a consultation has a number of advantages. Before committing to treatment, the patient can test whether they feel comfortable talking to me, and I can ascertain whether I feel capable of treating them. Both of us are given the freedom to view the first meeting as an introduction without an obligation to continue.

The consultation approach allows each person to see whether the two individuals are a *good match*, a term commonly used in psychological circles. A good match means that the patient feels understood and willing to work with the clinician, and the clinician feels hopeful about their ability to work with the patient effectively.

Now and then, a patient may feel misunderstood by a therapist from the moment they step into the office. Sometimes the clinician can turn this situation to therapeutic advantage by understanding why the patient is so uncomfortable (see Chapter 16). However, bad matches also exist. Sometimes the patient and therapist just don't "click." Certain people may work together more easily, depending on whether the patient is searching for a therapist with a style similar to or different than their own. A shy, withdrawn woman may find a charismatic and interactive male therapist either overwhelming or energizing. Alternatively, a dramatic person may prefer a therapist with a similar disposition, or one with a more low-key, soft-spoken approach.

I've found it's best to explain the consultation process early on to reduce the likelihood of future misunderstanding. Some therapists choose to review this information over the phone while setting up the first appointment, so the arrangement is clear before the patient enters the office. In Sallie's treatment, I mention that the initial meeting is a consultation during our phone conversation and explain the process in detail during our first session, as explored in Chapters 2 and 3. I recommend that trainees try multiple approaches in order to weigh the pros and cons of each firsthand.

THERAPIST TOOL 1.1

Sample Email If the Therapist Has Access to Encrypted Email for Patient Communication

Hello, thank you so much for your email.

Before I write back with some possible times to meet for a consultation, I need to let you know about the current protective legal regulations for emails between therapists and patients.

Email sent over the Internet is not secure unless both parties are using an encryption technology with a portal. Without encryption, it is possible for other individuals (beyond the intended recipient of the email) to access and to read the email, and this could result in the unauthorized use or disclosure of your information. Some email carriers note that they already encrypt communications, but without a secure portal, the email carriers may also access, retain, and control copies of communications. Unsecured email should be restricted to simple topics, such as scheduling, and not used to share important confidential information.

My clinic has an encryption system that uses a portal to protect patient information. When using this secure system, you will need to sign in to read my responses to your emails. Encrypted emails using a portal are a little more cumbersome to access than basic email, but communications received and sent within this system are safe and secure.

If you prefer, we can also communicate by unencrypted email, although it does contain some risk, as outlined above.

Please let me know your preference for email communication (encrypted via portal or unencrypted) in your email response to this message. If you prefer more secure communications, my next email will outline how to access the encrypted portal system to send and receive messages. If you would rather opt out of the more secure system, please let me know this as well and I will email you back directly. Of course, you always have the option to change formats in the future if you would like.

I look forward to hearing from you and setting up a time to meet in the near future.

Sincerely,

_____

THERAPIST TOOL 1.2

Sample Email If the Therapist Does Not Have Access to Encrypted Email for Patient Communication

Hello, thank you so much for your email.

Before I write back with some possible times to meet for a consultation, I need to let you know about the current protective legal regulations for emails between therapists and patients.

Email sent over the Internet is not secure unless both parties are using an encryption technology via a portal. Without encryption, it is possible for other individuals (beyond the intended recipient of the email) to access and read the email, and this could result in the unauthorized use or disclosure of your information. With encryption without a portal, email carriers may still access, retain, and control copies of the information. For these reasons, unsecured emails should be restricted to simple topics, such as scheduling, and not used to share important confidential information.

Unfortunately, I do not have access to an encrypted email system that uses a private portal at this time. Please let me know if you feel comfortable proceeding with email communication by responding to this email, although it does have some risk, as outlined above.

If you do not feel comfortable communicating without an encryption option via a portal, please call me back at my voicemail (list voicemail number here) and we will communicate only by phone in the future.

Throughout treatment, you always have the option to change your preferences.

I look forward to hearing from you and setting up a time to meet in the near future.

Sincerely,

CHAPTER 2

The First Moments

First impressions during the initial visit of a psychotherapy consultation are important. The therapist should greet the new patient in a manner that will protect their confidentiality. The session begins with an open question that facilitates conversation.

INTRODUCTIONS

Sallie Gane checks herself into the clinic and sits down in the public waiting area. She is 20 minutes early. She nervously picks up a news magazine and flips through it quickly. I start my internal countdown: 10 minutes to 2:00 P.M., 5 minutes to 2:00. . . .

I felt more like a fraud than a clinician with my first patients. I agonized over the fact that I couldn't prepare beforehand for the first meetings. I could orchestrate my greeting, but it was impossible to choreograph the rest of the session before hearing what the patient had to say. As a novice, I reviewed my first session plan with Dr. Messner.

To be honest, I hadn't expected to have such a long discussion with him about it. "Dr. Messner," I'd started, "I'll call out my patient's name in the waiting room, and we'll walk into the office together, but then what do I do?" He paused and didn't answer my question right away. Instead, we discussed whether my current plan of action adequately protected my patient's confidentiality. I hadn't considered that privacy was a therapeutic issue before the patient even entered the office.

As Dr. Messner explained, protecting a patient's confidentiality must be a priority. By calling my patient's name in a common waiting area, I

would have failed to safeguard their identity. For psychotherapy to be successful, the therapist must earn the patient's trust by respecting and protecting their privacy from the moment that the treatment begins.

Dr. Messner knew of a priest who had been struggling with his vow of celibacy and had come to psychotherapy for help in clarifying his future role in the church. The priest was wearing layman's clothes and was holding hands with a woman while he waited for his appointment. His psychotherapist entered the public waiting room and greeted him with "Hello, Father." The low-level buzz in the waiting room ceased; people stared and whispered. The therapist's seemingly innocent greeting was embarrassing at best, humiliating at worst: not the best way to instill trust in a new relationship.

To avoid making a similar mistake when I met my patient, Dr. Messner recommended that I identify myself without calling out their name. With this strategy, I could protect their identity just in case they were indirectly connected with someone in the waiting area. Sallie's decision to seek psychiatric consultation would remain private. (For more discussion of confidentiality, see Chapter 11.)

EXAMPLE 2.1

A method of introduction that preserves the patient's confidentiality

Sallie Gane now waits expectantly in the waiting room. There are four other people waiting for other clinicians.

I ask the secretary who checked Sallie in to point her out to me. I approach her cautiously since I have not confirmed that she is my new patient.

THERAPIST: Excuse me, who are you waiting to see?

SALLIE: Dr. Bender?

THERAPIST: Hello, I'm Dr. Bender. Let me show you to my office.

SALLIE: Thanks. I'm Sallie.

If Sallie didn't offer her name spontaneously after my introduction, I could confirm her identity once back in the office with a prompt: "And your name is . . . " or "I'm sorry, I didn't catch your name. . . . "

On first impression, I thought Example 2.1 seemed like introduction gymnastics. I didn't feel grateful for Dr. Messner's clear and sensitive explanation. In fact, I felt resentful of the advice that felt too intricate and restrictive. I checked with a few other supervisors to see whether they agreed with his approach. Interestingly, they were all completely unanimous on this issue. Privacy first . . . and always, they said.

I still felt upset. With these new rules, I felt bound in a social straitjacket. I felt sure that Sallie would think my specially concocted introduction was extremely strange. I also imagined many awkward moments standing by a full waiting room, asking if anyone was here to see me and getting no response. It didn't feel natural to act in such a ritualistic manner. One other worry: if I couldn't even figure out how to say hello without supervision, what damage might I do in an entire session? It took a few deep breaths and some cathartic complaining sessions with my fellow trainees before I was ready to accept this unfamiliar approach.

It helped to think about learning psychotherapy as similar to learning a new sport. When you start to play a new game, such as basketball, it initially feels very strange to dribble and shoot the ball. The moves don't feel natural, because they aren't, but they are necessary in order to play the game well. The moves in psychotherapy, such as the introduction to a patient, involve using everyday language in unique ways. Initially, these procedures feel constraining and maybe even a bit bizarre, but, within the realm of psychotherapy, they are appropriate.

I followed Dr. Messner's advice and was surprised that my real patients didn't react to my new greeting with raised eyebrows and "Who are you?" looks. In fact, I have a definite sense that certain treatments would have been in trouble if I hadn't carefully protected patient confidentiality from the first moment. Over time, what initially felt like an odd greeting ritual began to feel natural and normal. Many interventions in psychotherapy are like this, uncomfortable and stiff at first, but useful and easier with time.

HOW DO I ADDRESS MY PATIENT?

Since I don't call my patient's name in the waiting room, the question of whether to address my patient by their first or last name is not immediately relevant in a psychotherapy. That said, it is still helpful to be thoughtful about this question, even from the first hello.

Do I refer to Mr. Jim Smith, who is my age, by his first or last name? Is my patient who is a physician and 10 years my senior, Dr. Powell or Julie? How should I address Sallie, who is an adult but much younger than me? What are the pros and cons to each approach? While it seems a simple question, the answer is surprisingly multifaceted. While there is no right answer, whatever one decides should be a thoughtful considered choice.

As a psychotherapist, I am privy to a patient's innermost secrets, yet I am not a family member or a close friend. While my interactions with the patient are purely professional, I learn detailed private information about a patient's struggles; for therapy to work, I maneuver carefully between this dichotomy of boundaries and intimacy.

How I choose to address a patient has clinical ramifications. First names may blur the important boundaries within a psychotherapy. Last names may leave the patient feeling disengaged and detached or, in contrast, positively highlight the special attributes of the relationship. (How the patient addresses the clinician will naturally follow, and differs based on training, title, and personal preference.) As therapists, our ultimate goal is to address the patient in the manner that most supports an open comfortable therapeutic environment with intact boundaries.

My preferences as a therapist have changed over the years. For example, as a younger woman, it felt important to me to call most patients by their last name. The added formality reinforced the professional boundary within the treatment relationship, which felt especially important with male patients. As I've aged, I feel more comfortable calling younger patients by their first name; now in my 50s, I bring a cloak of age and experience to the treatment frame that I didn't carry in my 30s.

Some therapists may ask their patients at the first meeting what they would prefer to be called. This approach has the advantage of being straightforward and clear, but it also assumes that the patient's boundaries are good, and that the therapist will not wish, in the future, for a more formal style of interaction. For instance, a male patient "Tom Baker" might develop an intense erotic transference to his female therapist, at which point, his clinician might wish that she could be addressing him as "Mr. Baker" instead of "Tom" to underscore the professional nature of their relationship.

As another option, the therapist may assume a more reserved stance at the treatment's beginning, with the option to pivot to a more relaxed approach as the relationship evolves. I like this practice as it feels easier to transition to a more casual stance than reclaim formality.

I can take my time deciding how to address each patient as there aren't many moments that require me to identify a patient by name. When I call a patient on the phone, I might use first and last names and avoid prefixes (Mr., Ms., or Mx.) until I know their preferred pronouns. Emails are trickier. I have colleagues who dodge the issue by starting the email with a simple "Hi" without noting the patient's name. While I might also start with a simple salutation if I am truly conflicted on how to address a patient, I generally follow my gut on this one, addressing younger patients by their first name, and older patients in a more formal manner. Some older patients may appreciate the added denotation of respect. Younger patients are generally less formal, so a more restrained approach may leave them ill at ease within the psychotherapy.

Each region also has its cultural norms. In a more conservative community, it may feel most natural to address a patient in a more formal manner. In a more progressive area, using last names may feel awkward and out of touch, and first names may be the more comfortable choice.

If a patient specifically requests that I call them by their first name, I am happy to comply in the grand majority of cases. (Of note: this is just one perspective. A colleague I greatly respect recently shared with me that she calls all patients of all ages by their last names and explains to new patients that she feels this approach is most respectful to the treatment.) If the patient refers to themself with a nickname ("Sam" instead of "Samantha"), I will clarify which first name they prefer for me to use. Generally, my take is that a person has a right to be called what they would like to be called, with rare exceptions. For patients with an erotic transference or very poor boundaries, I might politely refuse to call them by their first name and explain, "Therapy works best with a more formal approach."

Now back to Sallie in the waiting room. . . .

Sallie Gane stands up. I smile and she smiles back. She extends her hand. Should I take it?

Some traditional psychotherapists question whether even minimal physical contact, such as an introductory handshake, is appropriate between therapist and patient. Because a handshake is such an accepted greeting in American culture, avoiding a handshake may feel rejecting. The handshake will also give you nonverbal information. Does the patient extend their hand comfortably, or are they more cautious? Is their grip firm or loose? An interesting note: as therapy does try to minimize all types of physical contact, this may be the last time you touch your patient, unless you shake their hand good-bye at the end of the treatment.

Would I extend my hand first? While I don't think a correct answer exists, I've personally decided not to initiate handshakes. During these first moments, I don't know anything about my new patient and if they might prefer to avoid a handshake, a preference that is more common since the COVID-19 pandemic. Setting the stage for future therapy interactions, I follow the patient's lead, even with the basic hello.

I lead Sallie into my office. She moves toward the chair that I usually sit in; my bookbag clearly propped against the chair's leg. What should I do?

After I received detailed and unexpected advice about how to choreograph introductions, I worried about other unanticipated clinical situations. Maybe there was a special rule that the patient sits in the office chair they prefer no matter what the therapist's previous plans. Luckily, clinical situations that don't involve confidentiality are best approached with straightforward common sense. In this case, it is important that *you,* as the therapist, feel comfortable in *your* chair with easy access to your desk, telephone, notepad, computer, or other items. If I were stuck in the situation

just outlined, I could point to the appropriate chair and redirect Sallie with a quick comment: "Could you take this chair, please?" or "Please sit here."

SETTING UP THE OFFICE

Psychotherapists have minimal overhead. To practice this type of treatment, all I really need is four walls, a couple of chairs, and a phone.

Therapists arrange the chairs in their office at various distances, depending on their own culture and style. If the patient and I might kick each other's feet by accident, we're too close. Depending on the population I am working with, I might set up the room so that I am closer to the door, allowing for a quick exit in case a patient becomes physically threatening. I hope I never have to escape from my office, but in case of an emergency, this setup would facilitate an easy departure.

Talking across a desk can be overly formal and not conducive to intimate conversation; my patient may feel like an employee reporting to a superior. I may use a desk to my advantage if the patient sits at the end of the desk, and I talk to them across the desk's corner. This setup is relaxed, and for some it may feel less threatening than sitting face-to-face across open space.

In contrast to many other health professionals who display pictures of their families at their desks, psychotherapists tend to avoid placing personal photos in public view. Personal mementos draw attention away from the patient's intimate concerns and may make it more difficult for the patient to focus on their own experience and to talk about issues that may be shaming or painful. Family pictures also pique a patient's curiosity, communicating an inconsistent message when the therapist refuses to share further personal information.

Many psychotherapists practice psychotherapy in a home office, but do not decorate the professional space with personal items. Nevertheless, interested patients will pay detailed attention to the home environment, noting the type of cars in the driveway, the noises in the other rooms, and any kitchen odors. Although an office at home provides convenience and tax benefits, it is a challenge for a beginner.

How to decorate your office is your call. For obvious reasons, it's preferable to avoid pictures with violent, sexual, or distressing themes. More neutral art is less distracting. Therapists' offices are all unique. Decor varies widely depending on the therapist's interests and background. I have seen offices that display drawings of European landmarks, enlarged personal photos of local wildlife sanctuaries, or collections of folk and ethnic art, to name just a few. I know one therapist who does not decorate the wall across from his patient's chair to minimize distraction. Clearly, there

is more than one way to create an office; and creating a space in which you feel comfortable is important.

THE FIRST FEW MOMENTS OF THE INITIAL SESSION

Sallie Gane settles into her chair and sneezes. She looks expectantly at me to start.

While later in therapy, the patient will start talking about whatever is on their mind, it is my responsibility to start the first session if the patient does not know how to begin. My opening question will set the tone for the initial first meeting. While none of the beginnings that follow are "bad," some facilitate a discussion better than others.

EXAMPLE 2.2

Starting the session with a statement that may set the stage for a paternalistic relationship rather than a collaboration

THERAPIST: How can I help you?

SALLIE: I don't know actually. My friend told me I should be in therapy, but nothing is really wrong, I guess.

THERAPIST: Oh, why are you here then?

At first glance, the introductory question "How can I help you?" seems neutral and unassuming, but this opening may subtly promise quick relief of long-standing symptoms, a service that the therapist may not be able to provide. By suggesting a relationship based on dependence or paternalism—or maternalism—the question may set the stage for an undesirable regression if the patient expects a different type of process than the one that will actually occur.

Psychotherapy is not effective because the clinician administers a healing elixir to a passive patient. Instead, the power of the treatment lies in the collaboration between therapist and patient, with the patient acting as expert on the subject at hand.

Unlike many other medical treatments, psychotherapy tends to be a slow process that doesn't follow a "Take two and call me in the morning" model. There is no potion that will rapidly alleviate emotional pain, provide a stable romantic relationship, or supply career motivation. Even most psychotropic medications, if indicated, do not work immediately. Understandably, most patients hope for a quick cure, but since this is usually not possible, a more neutral opening may be more appropriate.

Here's another opener that might lead to some trouble.

EXAMPLE 2.3

Starting the session with a statement that may make the patient defensive

THERAPIST: Can you tell me what is troubling you?

SALLIE: Well, I don't know. I feel okay. I'm not that bad, really. I've had a bit of trouble at school lately, but maybe it isn't even out of the ordinary.

When asked "What is troubling you?" or its equivalent ("Can you tell me what's wrong?"), a patient is likely to respond by minimizing their concerns. For patients sensitive to the stigma of mental health treatment, this innocuous question may have a humiliating sting. An opening question without an affective slant is preferable.

EXAMPLE 2.4

Starting the session with a statement that may facilitate discussion

THERAPIST: Can you tell me what brings you in?

SALLIE: My mother! She just keeps bugging me to get some professional help.

THERAPIST: That could be uncomfortable. What does she keep bugging you about?

Although many patients will respond favorably when asked, "What brings you in?" some, like Sallie in Example 2.4, may use this query as an opportunity to externalize, for example, "I don't have a problem. I'm here because my mother wants me to be in treatment." For other patients, this opener may feel too threatening as it might suggest the therapist's need to get right down to business before even saying hello. In Example 2.4, I respond empathically to Sallie's statement and follow her lead. If it is easier for Sallie to talk about her mother's concerns rather than her own, this is also where I will initially focus.

Here's a tried-and-true opener that should avoid defensiveness.

EXAMPLE 2.5

Starting the session with a statement that should avoid defensiveness

THERAPIST: How would you like to start?

SALLIE: Umm, you mean, why am I here?

THERAPIST: Sure. What would you like to tell me?

SALLIE: Well, I don't know. . . . I guess my life has been kind of a mess lately.

THERAPIST: (*concerned look*) How so?

SALLIE: Well, this guy broke up with me 6 months ago, and instead of feeling better, little by little, I just feel worse. I just can't stop thinking about him. I thought the relationship was going really well when he broke it off. I still don't know what happened.

THERAPIST: The breakup was unexpected?

SALLIE: Completely! There was no warning at all.

Example 2.5's opener is the least directive of the outlined choices, but, for a novice, it may also feel the most awkward. Like other "moves" unique to psychotherapy, it is likely to feel more comfortable after a little practice. It can also be used as a backup if "What brings you in?" results in a defensive stance.

Congratulations! You are ready to meet your first patient and to start the consultation process. Balancing the four goals of the next three sessions—responding empathically, creating an alliance with the patient, evaluating patient safety, and obtaining basic background information—is the focus of the next three chapters.

CHAPTER 3

Initiating an Alliance and Assessing Safety

During a consultation, the therapist does not only gather the relevant information needed for diagnosis and treatment planning. Throughout the process, the therapist responds empathically to the patient's distress, initiates a therapeutic alliance, assesses the patient's safety, and explains the consultative procedure. In this chapter, I focus on establishing the working alliance and addressing the patient's safety.

THE PURPOSE AND PROCEDURE OF THE CONSULTATION

Sallie began the first session by telling me about her recent breakup with her boyfriend Charlie. Then she paused for a moment. "I've never felt this bad before in my whole life. So what do you I think I should do?"

I hate it when my patients ask me for advice. It's too tempting to take the bait and respond: "Well, Sallie, I think you should keep busy and be nice to yourself." It isn't a bad answer. It's certainly well meaning. It's just unlikely to help.

By the time a patient makes their way to your office, they have undoubtedly received loads of suggestions. They're in your office because the suggestions didn't work. Psychodynamic psychotherapy is different because the work attempts to help a person from the inside out rather than from the outside in. The process is understandably slow, so now when a new patient asks me for a quick solution, I take the opportunity to discuss the process of the next three or four sessions.

I use the first few sessions with a new patient to learn more about their primary concern, to gather some history, and to develop and organize a preliminary formulation and treatment plan. Since I do not know what

type of psychological treatment is appropriate for a new patient, I consider these early sessions as "consultation" visits, not the beginning of psychotherapy. I use the word *consultation* to describe these meetings, rather than *evaluation*, because the former term sounds less judgmental and still implies that the interaction is time-limited.

EXAMPLE 3.1

Framing the first three visits

SALLIE: I've never felt this bad before in my life. So what do you I think I should do?

THERAPIST: I realize that you feel distressed, but at this point, I need to know much more before I can offer a responsible recommendation. For example, what have you already tried to help you feel better during this difficult time?

SALLIE: I don't know. I've tried a lot of things, but obviously they didn't work or I wouldn't be here in the first place! I assumed you would know how to make me feel better.

THERAPIST: Perhaps you feel disappointed that I need to learn more before we can find a course of action that will help. Deeper healing does take time, but before we finish today's meeting, we will review some stress management techniques that may be useful in the short term.

SALLIE: Okay, I would like to learn some stress management techniques, but I am disappointed that there isn't a quick solution here. I am sick of feeling so terrible. What do you want to know?

THERAPIST: Feeling terrible for a long time is very upsetting. At this point, I think I can be most helpful to you if I hear more about your experience with Charlie and also learn a bit about your background.

SALLIE: Then what?

THERAPIST: I usually view these first few meetings as a consultation. It is an opportunity for me to learn more about you and to see if I can help. You can also decide whether you feel comfortable working with me. Together, by the end of the three or four visits, we should be able to come up with a preliminary treatment plan for this difficult situation. How does that sound to you?

SALLIE: Okay, I guess.

THERAPIST: Would it be okay if I jot down a few notes while you talk?

SALLIE: Sure. The last few months have been the worst of my life.

THERAPIST: If it isn't too painful, could you tell more about how they have been the worst in your life [*using Sallie's words to facilitate her associations*]?

SALLIE: Well, I haven't been sleeping or eating very well. I just feel mopey. I'm studying economics at college; I'm a junior now. Usually, I can focus really well, but for weeks now, my concentration has been shot.

Once the first few sessions are labeled as a consultation, they acquire a structure and a purpose. Patients may also be reassured when they learn that attendance at one therapy meeting does not commit them to a lengthy treatment course. While the three- to four-visit consultation format is ideal, therapists in many clinics are required to complete a new consultation in one 90-minute session. Even without the flexibility of the multisession method, many of the therapeutic approaches outlined here may be employed.

Although I don't take notes during an ongoing psychotherapy, I write down pertinent information from the current presentation and the patient's past history as well as names and dates (rather than a record of what the patient says verbatim) during the consultation. These pieces of information help me organize the patient's story into a cohesive written summary. I will keep a copy for my records and, with permission, will forward a copy at the end of the consultation if I refer Sallie to another clinician.

The consultation format also outlines an exit for both parties in case the therapist and patient are a poor match. (See Chapter 1 for a more detailed discussion of the patient–therapist match.) If the patient feels seriously uncomfortable with the clinician, they are encouraged to find another one, with the therapist's blessing. It is my responsibility as the consultant to provide treatment recommendations and referrals after three to four visits, but I am not obligated to continue as a patient's therapist once the consultation is completed.

As I mentioned earlier, although most patients cooperate with the consultation format, many patients, like Sallie Gane, will request faster relief than psychotherapy can promise. At these moments, the therapist walks a tightrope—acknowledging the patient's acute distress, providing some coping guidance to help a patient who feels overwhelmed and unmoored (see Example 3.5 for specifics), while also educating the patient that a deeper sense of understanding and contentment cannot be rushed. In response to patients' impatience, I have learned innumerable ways to say, "It is hard to tolerate delay and to keep working on this problem, but it takes time to truly understand complex concerns. Together as a team, as our insight increases, we will be able to come up with a reasonable course of action."

As a novice, I found it difficult to have confidence in my work and to convince my patients of therapy's efficacy when I had just recently entered the field. A positive personal experience with my own treatment didn't translate into trust in my ability to heal others. I used my skepticism to guide my learning in supervision. With time, as I saw my patients improve, it became easier to feel more secure in my clinical abilities. Clinical research and experience have shown that patients improve when therapy is practiced

well. Just as patients need patience while they grapple with their problems in therapy, it is equally important that trainees are patient with themselves as they learn to practice this difficult but rewarding profession.

DIRECTING THE FIRST INTERVIEW

After mapping out the consultation process to a new patient, it is the therapist's responsibility to direct the first interview. After experimenting with many approaches, I think the first meeting works best with a focus on establishing a therapeutic alliance with the patient and completing a suicide assessment, if that seems necessary. Experienced supervisors often say that a major point of a first session is to set the stage for a second session. If my patient doesn't feel understood and heard during the first meeting, they might never return. Even if the therapist works in a clinic and is expected to gather relevant current and past history during an extended initial meeting (see Chapters 4 and 5 on how to collect necessary information during the consultation), *the essential objectives of the first session remain the same: connect with the patient and make sure they are safe*.

It is easy enough to state how important it is to establish a therapeutic alliance during the beginning of a psychotherapy, but as a novice, I bristled at this sort of statement because it seemed too vague and theoretical. To avoid making this mistake, I will outline some specific strategies later in this chapter that you can use to create a therapeutic alliance. First, I'll offer some examples of how the process can go awry.

To foster a therapeutic alliance, the therapist needs to be responsive but not overbearing, although this is always easier said than done. When you are a a beginner, it is easy to under- or overdirect the first session. I'll offer an example of each.

EXAMPLE 3.2

The therapist takes an overly passive stance during the first interview

SALLIE: Well, I haven't been sleeping or eating very well. . . . My concentration has been shot.

THERAPIST: So, you haven't been eating very well?

SALLIE: Yeah. I'm not hungry at all. I have to force myself to eat, but all food tastes like sawdust to me. Half the time I just feel sick to my stomach. The only thing that tastes good to me is ice cream.

THERAPIST: Hmm. . . .

SALLIE: Last night, I spent the evening watching TV for 3 hours, and eating a pint of chocolate chip cookie dough ice cream for dinner. Gross, isn't it? I just feel like crap most of the day.

THERAPIST: Yes. . . .

SALLIE: Last week, I sat at home and cried all day long. That's been happening every now and then. I realized that I had to do something, so I made this appointment.

Example 3.2 illustrates a traditional psychoanalytic approach to the first session. I avoid directing the interview in any way as I listen to Sallie's associations. Years ago, many first sessions were conducted with this approach. While the psychotherapist may have asked a few questions of the patient, in general, they would intrude as little as possible. The patient would associate freely, saying whatever came to mind. According to theory, the less the therapist hindered the patient's train of thought, the more likely the patient would reach important repressed material.

From this traditional perspective, questions by the psychoanalytic psychotherapist were not seen as useful, but as unwanted influences that would taint the psychotherapeutic process. The goal for the therapist was to be as neutral as possible, and the metaphor of therapist as a blank slate was introduced. As a result, in worst instances, a therapist could treat a patient for years and not know if they had experienced self-injurious impulses, had a serious head injury, had recovered from leukemia as a child, and so on, unless the patient chose to volunteer this information.

Spontaneous association continues to be a powerful source of information that therapists should employ, especially after the consultation is completed and the psychodynamic psychotherapy begins (see Chapters 6 and 15), but I do not recommend a pervasively nondirective approach during diagnostic sessions. Moreover, the free association strategy is also not as neutral as it may have once seemed. It is impossible to attain a true "blank slate" status. In fact, a therapist who does not ask questions or respond to their patient in a human way is often perceived as odd or withholding rather than as neutrally listening.

In an attempt to avoid the "blank slate" approach, a beginner might over-organize the first session around a list of predetermined questions. It is understandably easy to overshoot and to become more directive than necessary with this strategy.

EXAMPLE 3.3

An overstructured approach for the first interview

SALLIE: Well, I haven't been sleeping or eating very well. . . . My concentration has been shot.

THERAPIST: So, your eating, sleeping, and concentration have all been affected? Is it sometimes hard to motivate as well?

SALLIE: Yes.

THERAPIST: It sounds as though this has been a difficult time. Have you been feeling hopeless at all?

SALLIE: Sometimes.

THERAPIST: Hmm (*sympathetically*). Some people who feel hopeless start thinking a lot about dying or wishing that they were dead? Has this been part of your experience?

SALLIE: Oh, no. I'm Catholic. I could never do anything to hurt myself.

THERAPIST: So, you haven't thought of hurting yourself at all?

SALLIE: Nah.

THERAPIST: Have you ever felt this bad before?

In Example 3.3, the approach to the first psychotherapeutic interview is modeled after a first visit with an internist or family physician. Symptoms are identified, their severity is clarified, and data are gathered with the intent of making a diagnosis. Many of the questions require only short, one-word answers. The therapist is able to make a possible diagnosis of a major depression by identifying five neurovegetative symptoms in less than 5 minutes.

While this approach has a number of disadvantages for relatively stable patients, for some individuals this interview style is the structure of choice. If the patient lacks some internal structure due to psychosis, mania, substance use, or comparable conditions, a structured interview will compensate for the deficiency. The increased organization will provide comfort for the out-of-control patient. By acting as a diagnostician, the therapist can effectively begin to clarify the problem and to plan an emergency treatment strategy. In a sense, this interview follows the format of an emergency room psychiatric interview or a psychopharmacological consultation. (For more information on how to respond to a psychiatric emergency, see Chapter 9.)

A more structured interviewing style may also come in handy if my new patient becomes tongue-tied during the first interview. With an empathic statement such as "Perhaps you find it hard to think of what to say because it's such a troubling and complicated topic. Let's take a breather, and I'll fill in some other information I need," I can use the first session to gather as much history as I would like.

I have included a sample questionnaire at the end of Chapter 4 that may help collect the clinical information I would like to learn. I have used the questionnaire in two ways. If my patient is at a loss for words during the consultation, I may use the questionnaire to guide my interview. I've also given a patient a copy of the questionnaire at the end of the first session to fill out and to return to me at or before the second session.

It is important to know how to employ a structured interview for disorganized patients or for those who feel uncomfortable talking spontaneously

during the first session. That said, for psychotherapy specifically, an intensive history taking can hinder the development of a therapeutic alliance. Ideally, an interested approach that balances an ability to listen, a capacity to follow the patient's associations, and the foresight to assess suicidality is most likely to preserve safety while also fostering a therapeutic alliance.

EXAMPLE 3.4

Balancing the need for information and the need to create a therapeutic alliance during the first consultation session

SALLIE: Well, I haven't been sleeping or eating very well. . . . My concentration has been shot.

THERAPIST: Can you tell me more about what has been going on?

SALLIE: Well, I usually am so full of energy. Now I just don't care. This Saturday, for instance, I just stayed in my room and listened to music. I'm such a loser lately. I mean, the weather has been so perfect, and I'm listening to love songs crying my eyes out. What a mess!

THERAPIST: A lot of sadness and distress. Do you have an understanding of what has made it so hard?

SALLIE: For starters, I still can't believe that Charlie broke up with me. BOOM! It seemed out of nowhere. I didn't anticipate it at all, and he didn't really give me a reason. Well, he did talk about one thing that bothered him. . . .

THERAPIST: What was that?

SALLIE: I don't know—maybe something about my tone of voice. Sometimes, he would complain that I was bossing him around when I was just telling him my opinion. It just doesn't make any sense to me. I'm a very sensitive person, and with Charlie I was always on my best behavior. And it's the first time I've ever really liked a guy this much. Usually, I am the one to break it off. (*Reaches for a tissue.*)

THERAPIST: It has been a very painful breakup. When did this happen?

SALLIE: About 6 months ago.

THERAPIST: Six months of grief: I can see that Charlie really meant a lot to you. Can you tell me more about the relationship and breakup?

SALLIE: I thought he was "it." He seemed perfect from the first moment I laid eyes on him. Our first 4 weeks together were awesome. He had it all—cute, smart, funny, nice. After the first few weeks, though, it was never the same. He is majoring in music, and there really isn't any future in that, so I tried to convince him to change to an economics major, like me. He seemed interested at first, but then he started to withdraw and not answer my texts.

I don't understand it, because I was just trying to help him out, and he knew it. I don't know if that was the beginning of the end. I have no idea why he was so sensitive about my suggestions. We were together a few months, and then he said he wasn't interested anymore. It was so cruel, because just weeks before, he said he was in love with me. I don't know what I did wrong, but obviously, I'm a total failure.

THERAPIST: That sounds harsh. It is very painful when a relationship that seems so promising doesn't work out. Somehow it feels to you that you are a failure because of the breakup? What do you mean?

SALLIE: If I were really capable, I could have made this work. And it feels so strange to be the one who was rejected. See, like I said, I am the person who ends relationships. I've had two serious relationships before Charlie. They were nice guys, but maybe too nice. I don't know, they just seemed so young. They did whatever I wanted them to do, then I'd get bored and break it off. Charlie was different; he was independent. He had his own ideas, and somehow I messed it up, and I don't know how. I was just trying to help him when I gave him career advice. I feel like I can't do anything right. How did I manage to ruin such a good thing?

THERAPIST: It feels to you that it is all your fault?

SALLIE: Yes, completely. Sometimes I want to curl up and sleep all day just to avoid the pain.

THERAPIST: It does sound as though you have been in a lot of pain. Sometimes when a person feels so hopeless, they might think about dying or wishing they were dead. Has that been a part of your experience?

SALLIE: Oh, I'm Catholic. I could never do anything to hurt myself.

THERAPIST: Had it crossed your mind?

SALLIE: A couple of times. Well, not exactly. I don't care if my plane flying home from vacation drops from the sky or if I don't wake up in the morning, but I would never purposely hurt myself.

THERAPIST: To be thorough, I also want to ask about any self-injurious behavior. Have you ever cut yourself or hurt yourself on purpose when you have been in a lot of distress?

SALLIE: Nah. I haven't done that and I don't plan to, although I know some people at college who do this when they are really upset.

THERAPIST: So, if I'm understanding correctly, your safety has been protected, but your suffering has been very significant. Does this sound right to you?

SALLIE: Yeah, that fits.

In Example 3.4, I use a balanced approach: following Sallie's narrative, empathizing with her situation, and inserting a suicide assessment in

response to Sallie's hopelessness. Example 3.4 follows the patient's lead, in contrast to Example 3.3, which leads the patient. The question regarding suicide fits easily within the context of the conversation, rather than within a predetermined review of the neurovegetative signs and symptoms of depression. With the approach used in Example 3.4, I may not complete the full psychiatric review of systems within the first session, but by helping Sallie describe her experience, I can empathize with her most urgent concerns.

HOW TO LISTEN AND CULTIVATE A THERAPEUTIC ALLIANCE

Over time, I've learned a few specific techniques that help cultivate a therapeutic alliance. First, I ask detailed questions about the patient's main concern. If the patient tells me a few facts and then stops short (i.e., "I am upset about my breakup with my boyfriend"), I flesh out the story with questions like "Could you tell me more?" or statements such as "Please go on."

Second, I ask every patient why they decided to come into treatment at this particular time. In Sallie's case, she has been suffering for 6 months. What led her to come in now, rather than last week or next week? I am almost guaranteed to learn more about a patient's present conflicts and concerns with this inquiry.

Third, if it doesn't feel right to follow a patient's emotional statement with a question, I respond with a validating comment that reframes what the patient is sharing without diminishing its intensity. For example, when Sallie says, "I don't know what I did wrong. . . . I'm a total failure!" I tune into her emotional state by naming it: "That sounds harsh. It is very painful when a relationship that seems so promising doesn't work out. Somehow it feels to you that you are a failure because of the breakup? What do you mean?"

The ability to listen empathically is one of the most powerful tools of an effective therapist. Even so, I spent my training years missing empathic opportunities and fighting against an internal pull toward "fix it" statements. Again and again, I'd hear paragraphs flow out of my mouth full of well-intentioned advice and cheerful pick-me-ups: "It wasn't your fault that it didn't work out. Charlie didn't sound that nice anyway. I'm sure there are plenty more guys out there whom you could date."

I would have been a master therapist in record time if fix it statements were helpful. They aren't. Minimizing emotional pain and distracting people from their discomfort may actually exacerbate emotional distress. As a therapist, I am most useful if I tune into my patient's unique experience and don't assume I know how to fix their crisis. I now think of empathic listening that avoids minimization as a genuine way to alleviate distress. With this tool, my patient will feel understood, a powerful experience with healing power.

The therapeutic alliance is also nurtured by reminding the patient that they are working together with the therapist toward a common goal: the patient's health, recovery, or resolution of problems. This is accomplished by using first-person plural pronouns such as *we, us,* or *our* when referring to the work, task, or goals of therapy. (Example: "Our work together is to find out what would be the best course of action for you.")

This strategy is further reinforced by explaining my questions to the patient. For example, "I'm asking these questions about your family history because it helps me put your current difficulties in context, and because a vulnerability to depression may continue from generation to generation."

Finally, as Sallie also asks for help with feeling overwhelmed in the "here and now," it is useful if I provide some stress management techniques to help her cope in the short term. In Example 3.5, I illustrate how to introduce these strategies while also recognizing that deeper understanding and healing take more time.

With these tools in my back pocket—asking questions about the material important to the patient; inquiring "why now?"; validating affect; framing the consultation as "our work together"; explaining the consultation procedure as it unfolds, and responding to Sallie's request for some crisis coping strategies—I can cultivate a therapeutic alliance within the first few sessions.

ASSESSING SUICIDALITY

Whatever style you choose to employ during the consultation, you must complete a suicide assessment during the first interview if your patient seems to be at any risk for self-harm. In Sallie's case, I screen early for suicidality because she has many symptoms of depression. Other risk factors for self-harm include substance use, psychosis, bereavement, HIV positive status or other illness, trauma, loss of employment, borderline personality disorder, mania, panic disorder with agoraphobia, perceived abandonment, or divorce.

If a new patient doesn't have any risk factors for self-harm and they have a clear focus on their future, asking about suicidality may be in response to the clinician's needs rather than the patient's. However, if I am at all unsure about the patient's self-destructive impulses, I will ask. Many suicidal patients will discuss their self-destructive impulses honestly when asked directly, but few will spontaneously offer this information. (For more details on how to complete a suicide assessment for a patient who is currently at risk, see Chapter 9.)

A suicide assessment is the only part of the psychiatric consultation that cannot be postponed to future meetings if the patient has any risk factors. A large proportion of successful suicides are preceded by contacts

with a health care provider. Quiet calls for help are often not heard. In addition, the diagnosis of depression, a major antecedent to suicide, is frequently overlooked by many medical professionals who aren't schooled in mental health screenings. Despite all these reasons supporting the inclusion of a suicide assessment in the first meeting, it is easy for therapists to "forget" to complete this portion of the evaluation, because it is understandably discomforting to ask about this topic. However, ignoring it may prove fatal.

COLLECTING BASIC INFORMATION AT THE END OF THE FIRST SESSION

About 20 minutes before my first consultation session with Sallie draws to a close, I review some stress management techniques, collect some administrative information, and then shift the subject back to Sallie's main concern before the hour ends.

EXAMPLE 3.5

Offering coping strategies and collecting some basic information at the end of the first session

THERAPIST: The situation with Charlie has clearly been a tough one.

SALLIE: It's been horrible. You said you had some suggestions that might help me to feel a little better before our next meeting?

THERAPIST: I'm glad you reminded me. I want to review these coping strategies with you, but also clarify that they won't have the power to take away all the pain. If it were easy to feel better, you wouldn't be here in my office. It will take us some time to understand your concerns in a deeper manner, which is connected to more profound healing.

That said, I recommended these interventions during the COVID-19 pandemic, which was a global situational crisis; the individuals who incorporated these recommendations into their daily routine found them to be helpful.

First, many people find meditation helpful during a time of great stress. There are a number of helpful meditation apps available, and I can share some specific suggestions if you are interested. YouTube also has a number of meditation options that are free.

SALLIE: I don't know much about meditation.

THERAPIST: Consider meditation as a guided relaxation that is a reboot for your brain. The guided meditation tells you what to do—so you don't need prior experience to benefit. If you commit to 15 minutes a day, it will help you manage the overwhelmed out-of-control feeling.

Practicing yoga at home, even just 15 minutes a day, is another option. Yoga for beginners is available on numerous apps or YouTube. Some schools also provide yoga classes for students.

SALLIE: But what if I'm feeling overwhelmed during class? I can't really pull out my YouTube video and start meditating or doing yoga.

THERAPIST: Then, I would recommend box breathing to help you reset if you are feeling unmoored; it has been used by many under extraordinary stress, even U.S. Navy Seals.

SALLIE: What is box breathing?

THERAPIST: For box breathing, you inhale for four slow deep breaths, hold for a count of 4, exhale for a count of 4, and hold for a count of 4. You could practice this throughout the day or just use it during really tough moments. Would you like to practice it together?

SALLIE: No, that's okay. I'll think about trying some of these things, but I agree with you, they aren't going to bring me back to my normal happy self.

THERAPIST: I agree. They may help provide some needed coping support during a tremendously difficult time, but 6 months of significant emotional distress takes time to understand and to alleviate. Over time, we will learn more to help you feel better on a deeper level.

Now, before we finish today, I need to collect some information for my records.

SALLIE: Okay. What do you need to know?

THERAPIST: Well, for starters, what is your address? [*I need to collect this information in the first session if it was not gathered during the previous phone contacts.*]

SALLIE: I live at 1111 Central Street in Boston.

THERAPIST: What is the zip code?

SALLIE: Oh, it is 02114.

THERAPIST: If I ever needed to call you about scheduling changes, should I call the number you left on my office line last week?

SALLIE: Actually, my cell number is probably the best way to reach me. 617-555-6666.

THERAPIST: If I call the cell or need to leave a message, is it better if I don't identify myself as a doctor?

SALLIE: Nah, it's fine. No one listens to my cell messages other than me. But if you need to call me at the other number, it would be better if you didn't identify yourself as a doctor. Is that okay?

THERAPIST: It's no problem at all. Many people feel that way, which is why

I ask. I also like to have the phone number of someone to contact in case of an emergency.

SALLIE: What do you mean?

THERAPIST: Well, overall, I take the confidentiality of my patients very seriously. If anyone ever called me and asked if you were seeing me, I wouldn't divulge this information without your written permission. But in case of an unforeseen emergency, I would like to have an emergency contact.

SALLIE: Oh, I don't think you'll ever need to call anyone, but I can give you my parents' number. Their names are Jane and Anthony Gane. They live in Providence, Rhode Island.

THERAPIST: I don't expect emergencies either, but I want you to know the procedures I follow if one should arise. Also, I want to tell you about my training and my supervision.

As you know, this is a teaching hospital, and I'll be in training here for the next 2 years. One of the advantages of receiving your care here is that trainees like me receive advice regularly from experienced, fully trained clinicians. To obtain that guidance, I'll have to give my supervisor information about you.

It's not unusual to have some questions about this process. How does it sound to you?

SALLIE: I don't know. I don't really want anyone else to know what we talk about.

THERAPIST: Can you tell me what you are concerned about?

SALLIE: What will they think of me? I don't want anyone to know my business.

THERAPIST: I understand your wish for privacy. It's important that you know that my supervisors are required by law to keep any patient information completely confidential.

Their presence will benefit both of us. With their help, I will be able to provide you with the most comprehensive treatment.

SALLIE: They don't tell anyone else?

THERAPIST: That's right. The discussions I have with my supervisor are protected and private.

SALLIE: I don't know. I've never really heard of anything like this, but I guess it makes sense if I think about it. Whatever. I don't love it, but I guess it's okay.

THERAPIST: If you have any further questions about it, please don't hesitate to ask me.

Let's see, I also want to let you know how to get in touch with me if you need to contact me between sessions. I have a voicemail

answering system, and I am also available by email. If we communicate by email, I use an encrypted email system via a secure portal that provides an extra layer of security for our correspondence. That said, if there is anything complex to discuss, I have found it works best to set up a time to talk by phone instead of emailing.

Sometimes, patients request that I don't use the encrypted email system because the added layer of security makes it cumbersome to access messages via the portal. General email is much easier to access, but it isn't as protected because it can be hacked and the servers preserve copies of all correspondence. What email system sounds best to you?

SALLIE: I think encrypted email is a good idea actually, but I'll let you know if I change my mind.

THERAPIST: Sounds good. I check my messages and emails many times a day on weekdays. During the week, I'll always try to answer a message within 24 hours. Nonurgent weekend messages are answered on Monday, so the best time to send them is on Monday morning so they are at the front of the line. For urgent weekend issues, I would want you to page me.

With all new patients, I also review how to contact me in an emergency. In case of an emergency, please use my pager, rather than email or voicemail. My pager is on 24 hours a day. I can't always answer right away, and there may be a delay of an hour or two, but I'll answer as soon as I am in a quiet private place. If the emergency can't wait for my return phone call, it would be important to go straight to your nearest emergency room for treatment.

SALLIE: Oh, okay. But, like I said, I don't expect any real emergencies.

THERAPIST: That's good to hear, but I always share this information with all new patients, just in case. Let's see if we can find a time to meet these next few weeks. Are you free Wednesdays at 4:00?

SALLIE: Let me look at my schedule book. Yeah, I think I can do that.

THERAPIST: You may already know this, but therapy differs from other medical visits because you can depend on it to start and end on time. Each session will last 50 minutes.

SALLIE: (*Nods.*) Okay.

THERAPIST: Okay. I think that is all the administrative information I need to cover. We need to stop in a few minutes, but I was wondering how has this meeting felt to you? What has it felt like to talk about these concerns with me?

SALLIE: I don't know really. It feels weird. I am more a listener than a talker usually, and 50 minutes can seem a bit long.

THERAPIST: It makes sense then that therapy may feel unusual. Did you feel uncomfortable during our meeting?

SALLIE: A little.

THERAPIST: It may feel uncomfortable telling a stranger about private concerns, and it takes some courage to do so. Was the discomfort enough to keep you from coming back?

SALLIE: I don't think so. I really need help with this, and it hasn't been getting better on its own.

THERAPIST: I am glad you could share this with me. Consultation sessions are different from a discussion with a caring friend or relative because our goal is to focus completely on your concerns. It can feel different at first. You may have more feelings about this session before our next one, and I would be interested in hearing what your thoughts are next time.

SALLIE: Okay.

THERAPIST: Before you leave, I want to give you a questionnaire to help gather information rapidly. You can fill it out and mail it to me or bring it to our next appointment. How does that sound to you?

SALLIE: That's fine.

THERAPIST: I know that you're more concerned about what happened with Charlie than you are about any of these background matters. Let's use the remaining time to talk about him.

In this chapter, I present Sallie as a clinic patient to demonstrate how to talk about supervision with a patient. As the clinic handles the finances, I do not need to discuss fees and payment. In Chapter 8, Sallie is my private patient, and I illustrate how to discuss financial matters at the start of treatment.

It is useful to provide a supportive intervention during this meeting. Sallie can immediately implement the coping strategies reviewed (meditation, yoga, and box breathing) over the following week. While these recommendations will not fully alleviate her suffering, they may help her manage her current dysphoria and anxiety. (Please see Additional Readings and Resources for references that focus on adaptive coping skills that may alleviate acute distress.)

As shown in Example 3.5, I use this session to educate Sallie about the 50-minute session. Some therapists work in 45-minute blocks, which is an acceptable alternative. I've found it's easiest to specify the session's length early in the process. Without this discussion, Sallie may not understand why I stop the session 10 minutes before the hour.

The first consultation meeting must also include a discussion on how to contact the therapist between sessions (voicemail, email, and emergency

contact information). Nowadays, many therapists use their designated work cell phone number as an emergency contact number, following the same safety parameters outlined for the pager in Example 3.5.

During this first visit, I could also include a discussion on texting within a psychotherapy if Sallie broaches the topic (see Chapter 1 for more information on texting in psychotherapy). For emailing, I can document her preferences in the chart, while also confirming them in our first email exchange. I could also have her sign a treatment contract, reviewing email risks and noting her email preferences. (Chapter 1 includes a more extensive discussion on the use of email with patients, and Therapist Tools 1.1 and 1.2 provide templates on how to approach a first email with a patient if the therapist is emailing with the patient before the first meeting.) Therapist Tools 3.1 and 3.2 differ slightly; they are templates for a treatment contract regarding the use of email that may be presented to the patient during the first consultation meeting.

Near the end the session, I also check how Sallie has experienced the meeting. Sometimes a new patient will use this opportunity to share their ambivalence about therapy, as Sallie did. Interestingly enough, once a patient has voiced their uncertainty, they may actually be more likely to return for the second session. I praise Sallie's ability to talk openly about our interaction to encourage future discourse on the topic. She is likely to experience more feelings about our meeting, and now she might feel comfortable sharing them with me.

In summary, I try to accomplish four major tasks for a successful first session. If I respond to the patient's distress empathically, explain the consultation process, assess suicidality if necessary, and concentrate on forming an alliance with the patient, the consultation is well on its way.

THERAPIST TOOL 3.1

Email Treatment Contract If the Therapist Has Access to Encrypted Email via a Portal

Email sent over the Internet is not secure unless both parties are using an encryption technology with a portal. Without encryption, it is possible for other individuals (beyond the intended recipient of the email) to access and to read the email, and this could result in the unauthorized use or disclosure of your information. With encryption, but without a secure portal, the email carriers may still access, retain, and control copies of communications. Unsecured email should be restricted to simple topics such as scheduling and not used to share important confidential information.

My clinic has an encryption system that uses a portal to protect patient information. When using this secure system, patients will need to sign in to read my responses to emails. Encrypted emails using a portal are a little more cumbersome to access than basic email, but communications received and sent within this system are safe and secure.

Unencrypted email is also an option, although it does contain some risk, as outlined above.

If one starts with unencrypted email, there is always the option to change to a more encrypted format in the future and vice versa.

Emails will be answered Monday through Friday. Emails sent over the weekend will be reviewed and responded to on Monday (or Tuesday if Monday is a holiday).

Emails should not be used to share urgent information. For urgent clinical needs, please contact me at _____.

____ I have had the chance to ask questions about emailing with the aforementioned therapist's practice.

____ I understand the risks and other information covered above and wish to communicate with my therapist via email.

Prefer encrypted email: _____ Date: _____
Signature

OR

Prefer unencrypted email: _____ Date: _____
Signature

Printed name: _____ Email: _____

I have provided this form to the patient and answered any questions.

Therapist's printed name and signature:

_____

_____

THERAPIST TOOL 3.2

Email Treatment Contract If the Therapist Does Not Have Access to Encrypted Email via a Portal

Email sent over the Internet is not secure unless both parties are using an encryption technology with a portal. Without encryption, it is possible for other individuals (beyond the intended recipient of the email) to access and to read the email, and this could result in the unauthorized use or disclosure of your information. With encryption without a portal, email carriers may still access, retain, and control copies of the information. For these reasons, unsecured emails should be restricted to simple topics such as scheduling and not used to share important confidential information.

Unfortunately, I do not have access to an encrypted email system that uses a private portal at this time.

In my practice, emails are answered Monday through Friday. Emails sent over the weekend will be reviewed and responded to on Monday (or Tuesday if Monday is a holiday).

Emails should not be used to share urgent information. For urgent clinical needs, please contact me at _____.

If at any point you do not feel comfortable communicating via email without an encryption option with a portal, we will use the phone to communicate between sessions.

____ I have had the chance to ask questions about emailing with the aforementioned therapist/practice.

____ I understand the risks and other information covered above and wish to communicate with my therapist via email.

I can change my mind and opt out of email at any time.

_____ Date: _____
Signature

Printed name: _____ Email: _____

I have provided this form to the patient and answered any questions.

Therapist's printed name and signature:

_____

CHAPTER 4

Enhancing the Therapeutic Alliance and Eliciting History

During the second session, the therapist may encourage the patient to share their experience of the consultative process. By explaining the relevance of psychiatric and medical history while collecting the needed information, the clinician reinforces the therapeutic alliance. While data collection is important, session time must also be reserved to talk about the patient's primary concern.

THE BEGINNING OF THE SECOND SESSION

When Sallie returns for her second session, I start to feel a little more confident. With the knowledge that our therapeutic alliance is off to a good start, it's easier for me to be more directive during our second session. I'll use the time to outline Sallie's medical and psychiatric history, but before I start the data collection, I ask Sallie about her week and her experience of our first meeting.

EXAMPLE 4.1

Opening the second session

Sallie walks briskly into the room and sits down. She looks at me expectantly.

SALLIE: How are you, Dr. Bender?

THERAPIST: I'm all right, thanks. How are you doing?

SALLIE: Okay, I guess.

THERAPIST: Any thoughts about our last meeting? How did it feel to you?

SALLIE: It was fine, I guess. Well, to be honest, I don't love the idea of coming in to talk to a stranger about my personal problems, but I can't stand to feel this way anymore, so I'm willing to try anything. I did hear from Charlie this week—that was a highlight (*sarcastically*). He needed a book that he'd left at my dorm. We talked for about 30 seconds. Nothing about missing me or about wondering if breaking up was the right decision. He's doing fine, and I'm so messed up that I need to see a shrink to get over him.

THERAPIST: It's clear that the breakup with Charlie has been a very painful experience. Can you tell me more about how you feel "messed up"?

SALLIE: I don't know. At the beginning of last week, I actually felt a little better. Maybe talking to you did help a tiny bit. I also tried the box breathing you recommended, and it decreased the free-floating anxious feeling a little bit. But then, after Charlie's call, I was back to square one. I didn't sleep that night, and my stomach has been in knots ever since. I've always looked down on women who get all riled up after a breakup, and now look at me. I'm so pathetic.

THERAPIST: Aren't you overly harsh with yourself?

SALLIE: I don't think so. I am pathetic.

THERAPIST: From my perspective, being upset doesn't make you pathetic. When you start feeling upset about Charlie, how do you take the edge off the pain?

SALLIE: I call my friend Gwen a lot. She's been helpful, mainly because she keeps me busy. It helps a little bit, I guess. But, Dr. Bender (*in a slightly irritated tone*), I've been trying to feel better for weeks, doing a million different activities, and nothing really works. Like I said, I'm here because I don't feel better, no matter what I do.

THERAPIST: [*reflecting Sallie's emotional experience with more specific descriptive words*] I imagine it could be a frustrating experience—trying so hard to feel better but then continuing to feel so upset?

SALLIE: (*Relaxes into her seat.*) Yes, it is!

THERAPIST: I think it's a wise idea to consider therapy at this time to understand more about the situation with Charlie and to understand why it has been so hard to move on. In the next couple of sessions, I'll need to get to know you better in order to come up with a treatment plan that feels reasonable to both of us. I'd like to use part of this meeting to learn about your medical and psychiatric history.

SALLIE: (*aggravated*) With all due respect, Dr. Bender, I need to get better as fast as possible. Do we have to spend time talking about stuff that isn't bothering me right now?

THERAPIST: It makes sense that you want to get better as quickly as possible.

I need to know your medical history because some medical conditions intensify emotional distress and interfere with recovery.

SALLIE: (*Interrupts*.) Well, I'm not here to be analyzed. I just need to get over this stupid guy. I don't think it will be that helpful to talk about my past and my first memory and all those Freudian things I learned about in my freshman psych class.

THERAPIST: Our goals aren't so different—I want to help you feel better also, but I need more information to help me put together a suitable treatment plan. To begin to understand your pain with Charlie, I need to know more about you as an individual.

SALLIE: Okay, whatever (*sighs*), how long do you think this will take?

THERAPIST: Let's see how it goes, but the consultation usually takes three or four sessions.

SALLIE: Well, what do you want to know?

THERAPIST: Well, for starters, I want to clarify how this breakup has affected your ability to function in school. Have you been able to keep up with your classwork despite feeling so poorly?

Before I focus on information collection during the second session, I model and encourage direct and honest communication by asking Sallie how she experienced our first meeting. The wording of my questions ("Any *thoughts* about our last meeting? How did it *feel* to you?") purposively pulls for both cognition and affect. In general, it is less challenging to share one's thoughts than one's underlying emotions. As treatment progresses, the focus on affect will become more intense, but early in the consultation, my line of questioning offers Sallie a choice.

As Sallie starts to relate the events of her week, I strategically ask specific details of her experience. Sometimes the questions themselves use words from Sallie's previous statements. For instance, when Sallie mentions that she feels so "messed up," I respond, "Can you tell me more about how you feel 'messed up'?"

Sallie becomes irritated when I focus, even for a moment, on her coping mechanisms rather than her distress. Her response is a cue to change tactics. When I validate how frustrated she has felt, she visibly relaxes and becomes more agreeable.

Fortunately, most patients aren't as ornery as Sallie, so the second interview is rarely this emotionally taxing. But, as a novice, I was most worried about patients who would question my judgment and leave me tongue-tied. Surprisingly, while Dr. Messner and I wrote this book and I grappled with Sallie's feisty nature, my confidence increased. My experience with my virtual patient helped me feel more competent with the flesh and blood variety. Basically, if you are ready for a "Salliesque" patient, many other patients will feel easy by comparison.

A MORE DIRECTIVE APPROACH

In order to gather the necessary medical and psychiatric information for a comprehensive consultation, I am more directive during the second session. Nowadays I don't have trouble switching gears (following the patient's lead in Session 1 and leading the patient in Session 2), but this change in approach was not easy for me to master. Early on, I worried that I was squelching the patient's self-expression every time I directed the questioning away from the present complaint and toward the pertinent history. In my attempt to be the ultimate empathic therapist, I often completed the consultation without obtaining essential historical data.

My inability to redirect also led to a few embarrassing moments in supervision when I didn't know fundamental facts about patients I had seen for months. Supervisors would encourage me to acquire this information as soon as possible, but if I was bad at interrupting a new patient during the first few visits, I was even worse at interrupting my patient in ongoing therapy. As I gained clinical experience, the treatment benefit of a comprehensive consultation became increasingly clear, and only then did I feel empowered to direct the interview during the first few sessions.

To formulate the most informed treatment plan, a clinician needs to obtain a medical and psychiatric history from every new patient *whether or not the therapist has medical training*. Unrecognized physical disease may first present as psychological distress, and physical illness can have a profound emotional effect on a patient's life.

For medical questions about the patient's current symptoms, I refer the patient to an internist. Dr. Messner once treated a 45-year-old lawyer, whom we will call Mr. Martinez, who started psychotherapy because of generalized anxiety with intermittent panic attacks following an unexpected promotion. As psychotherapists, it's easy to formulate a whole bunch of different hypotheses as to why success might feel overwhelming to a man in his 40s, but during the consultation interview, Dr. Messner also learned that the patient had a family history of heart disease. The patient's father had died of a heart attack at 46. While this fact may have psychodynamic importance in the treatment of a 45-year-old man, the medical implications are more urgent. Had Mr. Martinez seen his internist in the last year? "No." Did his panic attacks include symptoms of chest pain and shortness of breath? "Yes." A possibly lifesaving intervention at the beginning of psychiatric treatment was a referral to an internist for a physical exam and cardiac workup. Happily, Mr. Martinez's cardiac condition was deemed non-life-threatening. However, especially in light of his family history, it was reassuring that a cardiologist would continue to follow him as needed. If Dr. Messner had taken a "free-floating" approach to the consultation sessions, the necessary medical intervention would not have occurred. While physicians will be understandably more comfortable talking to their

patients about health issues, nonphysicians can be very effective if they refer psychotherapy patients for a medical consultation whenever a patient is suffering from a bothersome physical symptom that hasn't been evaluated by a medical doctor.

Our consultation questionnaire (discussed below) screens for medical symptoms that may require follow-up. For positive answers noted in the "Brief Review of Symptoms" section, the therapist should refer the patient to their primary care physician for further investigation.

STRATEGY FOR THE SECOND SESSION

During this session, I focus on the details of the psychiatric and medical history and only ask about other historical information if extra time is available. To help focus my time, I may ask a new patient to fill out my consultation questionnaire (Therapist Tool 4.1) between Sessions 1 and 2, or I may use my questionnaire as a crib sheet to guide the interview

Every now and then, a new patient feels their current concerns are so urgent that they are unable to focus exclusively on their history during the second session. When this occurs, I quickly scan the completed questionnaire during our meeting, and then review the answers in more detail during the third and fourth session. Or, if I plan to continue to work with the patient after the consultation, I may use 15–20 minutes of several sessions to collect the necessary historical information.

EXAMPLE 4.2

Clarifying the patient's current psychiatric symptoms—a more directive approach during the second consultation session

THERAPIST: For starters, I wanted to clarify how this breakup has affected your ability to function in school. Have you been able to keep up with your classwork despite feeling so poorly?

SALLIE: Well, even though I have felt crappy most of the time, I haven't fallen behind in my classes. School is the only thing I am successful at nowadays.

THERAPIST: It is impressive that despite your distress you have been able to continue your work. Have you been able to spend time with friends as well? You mentioned a friend, Gwen. . . .

SALLIE: Yes, Gwen has been great. She calls me every day to check on me, and we go see a lot of movies together. It gets my mind off things.

THERAPIST: She has been an important source of support.

SALLIE: Yes.

THERAPIST: Has anyone else been helpful during this difficult time?

SALLIE: My family, I guess. They are supportive of me, but I don't usually tell them details about my love life, you know.

THERAPIST: I want to get a good sense of how the breakup has affected your life in many areas. Last week we talked briefly about your sleep and appetite, but I wanted to touch base on this again. How well have you slept the last few weeks?

SALLIE: It's erratic. Sometimes I have a lot of trouble falling asleep, but I would say I generally sleep about 8 hours a night.

THERAPIST: And your appetite?

SALLIE: It's bad. I just don't feel like eating most of the time.

THERAPIST: Have you lost any weight?

SALLIE: No, I haven't actually. Too bad . . . that would be a little bonus. You know, get dumped and get skinny. (*Grins.*)

THERAPIST: [*I note that Sallie's weight seems normal for her height. My next questions screen for an eating disorder.*] Do you have any worries about eating?

SALLIE: Maybe a little. I'd like to be one size smaller at least.

THERAPIST: Have you ever put yourself on a very strict diet and tried to lose a lot of weight, although everyone else thought you looked okay?

SALLIE: Nah. I've never been that disciplined. I had a friend in high school who got obsessed with her weight and became way too skinny, but I could never do that. I'd get too hungry.

THERAPIST: Some students your age will eat a lot of food when they are very upset, but then they'll regret it afterward and try to lose weight with vomiting, overexercising, or laxatives that cause diarrhea. Sometimes they use a dangerous medication called ipecac to induce vomiting. Have you ever struggled with bingeing or purging?

SALLIE: No, I have never made myself throw up and I don't overexercise, but I don't really like to talk to people about this stuff.

THERAPIST: [*I am wondering if there is more to learn because of Sallie's reluctance to talk about this particular topic.*] You'd be surprised how many people have trouble with food.

SALLIE: Well, I did take laxatives for a bit in high school because I felt really bloated.

THERAPIST: What else was going on then?

SALLIE: Nothing really important. I was stressed about going to college, but mainly I felt fat and wanted to fit into this slinky dress for the prom.

THERAPIST: Sometimes people find it hard to stop taking laxatives once they start. How was it for you?

SALLIE: I don't think it was that big a deal. I did it for a little while—maybe a few weeks—but then I stopped.

THERAPIST: How did you manage to stop?

SALLIE: I don't know. I got weak, and then I stopped, okay? (*defensively*)

THERAPIST: I imagine it may have been a difficult time for you if you were using laxatives. All medications for weight loss can be addicting, so it can take a lot of internal motivation to be able to stop.

SALLIE: (*slightly calmer*) Yeah, it did.

THERAPIST: Because these products can affect a person's health, I do need to know about them. Have you ever used diet pills or diuretics to lose weight?

SALLIE: What are diuretics?

THERAPIST: Good question. They are medications that make a person urinate a lot and are used to treat high blood pressure, but sometimes people use them secretly to try to lose weight.

SALLIE: No, I never did that.

THERAPIST: I ask these questions because a lot of women your age have some difficulty with eating. It sounds like you have struggled with this some in the past. How about now?

SALLIE: I'm better now, I think. Even though I have felt sort of sick to my stomach lately because I've been so upset, I'm not doing anything unhealthy to lose weight.

THERAPIST: Has your energy been affected as well?

SALLIE: Oh, I don't have much energy, especially when I don't eat much that day.

THERAPIST: These last few months certainly sound tough. Have you ever felt this bad before?

SALLIE: No, this is the worst I have ever felt.

THERAPIST: Overall, there are some symptoms that are making it difficult to function day to day, but somehow you have managed to keep up with school and friends?

SALLIE: Yes, I guess that is right.

THERAPIST: Can you correct me? What part doesn't feel right?

SALLIE: Well, even though I can still be sociable and still do well in school, I'm not doing well at all.

THERAPIST: It is important that I understand how much you have been struggling. Someone just watching you from outside may not know how much you are suffering inside.

SALLIE: Yeah, that's true actually.

When a new patient reports significant dysphoria, I determine early on whether their current symptoms are consistent with a diagnosis of major depressive disorder, as outlined in the DSM. A useful mnemonic can organize your review: SIGECAPS. (This abbreviation could either stand for the name *Sigmund E Caps* or the abbreviated prescription for E capsules. It was devised by Cary Gross, MD, and over the years, has become part of the psychological lexicon.) Each letter stands for a neurovegetative symptom of depression that may accompany significant dysphoria or irritability: *S*, a change in *s*leep; *I*, a decrease in *i*nterest and pleasure; *G*, an increase in *g*uilt or worthlessness; *E*, a decrease in *e*nergy; *C*, a decrease in *c*oncentration; *A*, a change in *a*ppetite; *P*, *p*sychomotor retardation or agitation; and *S*, *s*uicidal thoughts, intentions, plans, or actions.

A person has major depressive disorder if they experience a depressed mood, or significant loss of interest or pleasure in addition to five neurovegetative symptoms for longer than 2 weeks. Sallie has some symptoms of depression, although her interest, concentration, and sleep are basically intact.

For Sallie, a trial of psychotherapy without medications is reasonable, but if her symptoms worsen during treatment, a medication evaluation might be indicated. In general, if my new patient has any psychiatric symptom that significantly affects their daily functioning, I include a psychopharmacological evaluation as part of their consultation. Although it is beyond the scope of this book to review how to complete a psychopharmacological evaluation, excellent resources are included in the Additional Readings and Resources list available at the end of the book.

In Example 4.2, I also fold a number of questions about eating disorders into my SIGECAPS review. Eating disorders are especially prevalent in young women, but patients rarely offer information about food restriction or bulimia spontaneously. These disorders also deserve some special attention because they place a patient at medical risk. Among many other complications, anorexia nervosa can lead to osteoporosis and bone fractures, and bulimia nervosa can lead to cardiac dysrhythmias. Both conditions have significant mortality rates when they go untreated. If a patient is restricting food intake and appears significantly below a normal body weight or is actively bingeing or purging, they are best served by a treatment team that includes a therapist, internist, and nutritionist. For my complicated eating-disordered patients, I also intermittently review their treatment with an expert experienced in this specialty.

Ultimately, there is no way to be ready for every clinical situation. Over time, I've come to accept that I will never know everything. However, if I recognize what I don't know and when I need consultation, I will be able to provide excellent, ethical care.

As I continue to ask questions about Sallie's psychiatric history, I might fall for Sallie's nonchalant and somewhat defensive attitude and make some erroneous nonempathic assumptions about her past.

EXAMPLE 4.3

The therapist assumes incorrect information about the patient

THERAPIST: So, let me review some past psychiatric history. You probably haven't seen a psychiatrist before, have you?

SALLIE: Actually, I have.

THERAPIST: As a child?

SALLIE: No, actually it was just a few years ago, but I didn't want to go.

When faced with a question that assumes a particular response—such as "You probably haven't seen a psychiatrist before, have you?"—a self-conscious patient may minimize or edit their history in order to present a good impression. For a patient to feel safe sharing private and potentially shaming information, the clinician needs to create a nonjudgmental atmosphere and avoid "leading the witness."

Clinical experience with a wide range of patients has helped me to avoid erroneous clinical assumptions. When I started my residency, my tendency was to minimize psychopathology in college students like Sallie Gane. After a few years, my clinic assessments became more accurate, but I proceeded to make the same mistakes all over again in my private practice. If the patient was the least bit intimidating (a lawyer, another mental health professional, a wealthy and/or attractive patient), I was at risk for overdirecting the interview or assuming clinical information, as I did in Example 4.3. Again, over time, clinical experience decreased my anxiety, and in turn, my therapeutic acumen improved.

Here's Take 2 with an approach that helps Sallie share her experience.

EXAMPLE 4.4

Collecting a personal and family psychiatric history, Part I

THERAPIST: So, have you ever seen a therapist before?

SALLIE: Well, when I was in high school, I saw someone for several months.

THERAPIST: How did you experience the treatment?

SALLIE: Actually, even though I didn't want to go at first, I ended up liking Dr. Mehta. He was a nice guy, and I always felt better after talking to him. It was a good experience.

THERAPIST: Can you tell me why you started seeing Dr. Mehta?

SALLIE: Well, actually, it was around the time that I was using the laxatives.

THERAPIST: What was going on?

SALLIE: Well, I was really stressed out. I was trying to decide which college to go to, and my parents were totally invested in my attending their

alma mater. I don't know. I just got overwhelmed with the whole idea, so I started to focus on the prom to keep my mind off of graduation and moving on. You know, the whole growing up thing. Dr. Mehta helped me figure this out.

I had this great black dress to wear to the prom, but it was a little too tight when I bought it. Then my friend Mara offered me laxatives, so I could lose a couple of pounds really quickly, and I hate to admit it, but I jumped at the chance.

I know I shouldn't say this, but the laxatives were amazing, at least at first. I never felt bloated any more, and the dress fit perfectly at the prom. I just got hooked kind of fast. I'd take the stuff before I went to bed, and I'd only feel uncomfortable for a short time each morning. I felt great all day. And totally skinny.

After a few weeks, my parents found about five boxes of laxative tablets in my room, and they had a fit. First, I had to see my pediatrician, and then she recommended this guy, Dr. Mehta.

THERAPIST: Was the therapy helpful?

SALLIE: Overall, it was okay, I guess. We talked a lot about college and the end of high school. I did feel better having someone to talk to.

THERAPIST: How did the therapy end?

SALLIE: After a while, I just felt better, and then we met a few more times before we stopped. Dr. Mehta said I could always call him in the future if I wanted to talk. I didn't need to . . . until now, I guess.

THERAPIST: Did you think about calling him after the breakup with Charlie?

SALLIE: I did call him twice a couple of weeks ago. He was the one who recommended that I find a person to see up here. After we talked and I wasn't feeling better, he thought I should find someone to see locally. Knowing me, he thought in-person treatment would be preferable to telehealth. He also isn't licensed in this state, so he can't treat me this time. I was crying so hard when we talked; I think I freaked him out a little bit.

THERAPIST: Hmm, how did you feel when he recommended you find a therapist locally?

SALLIE: (*Becomes tearful.*) I felt pretty upset. I understand the legal rules, but I was surprised when he thought I was so messed up that I needed to see a new therapist. I mean, he really knows me!

THERAPIST: Do you miss him?

SALLIE: I really do. No offense, Dr. Bender, but I don't know you at all. I have to tell you all this history that he is already familiar with.

THERAPIST: No offense taken. It is doubly hard to start with someone new

and to miss Dr. Mehta at the same time [*validating Sallie's experience rather than taking offense*].

SALLIE: Yep . . . it is. Whatever . . . what other questions do you need to ask?

THERAPIST: Let's see . . . well, have you ever been on any psychiatric medications?

SALLIE: No. Talking alone did the trick, at least in high school. Like I said, until now I've been doing really well. My eating habits have been really healthy for years now. The idea of taking laxatives again is repulsive. At least, that's progress.

Even though I was scared of leaving home at first, I think it's been helpful to go to school in another state. I'm the oldest, so maybe it was extra hard to leave, but the independence has been good for me.

THERAPIST: It is important progress that your eating has improved and that you no longer take laxatives. You mentioned you are the oldest. How many siblings do you have?

SALLIE: Just one. Tom is 6 years younger than me. He's 15.

THERAPIST: What is your relationship with him like?

SALLIE: Oh, good I guess. It's really fine.

THERAPIST: I definitely want to know more about Tom and your family, but I want to make sure that I get a chance to ask a bit more about your psychiatric and medical history. Have you ever been in a psychiatric hospital?

SALLIE: Actually, yes. Umm, I guess I forgot to mention that.

THERAPIST: When was that?

SALLIE: Well, after the prom when my parents found the laxatives, my pediatrician said that my lab data were dangerous. She sent me to the emergency room to get IV's and stuff, and the shrink that saw me at the hospital sent me to a psychiatric hospital because he didn't trust I could stop the laxatives safely on my own. Maybe he was right, but I'll never forgive him. It felt humiliating to be placed in a program that I didn't want to go to.

Well, maybe it helped a tiny bit because I didn't use the laxatives ever again after I got out, but it's totally humiliating that I had to be locked up in a loony bin for about a week when I was in high school. I don't tell many people.

THERAPIST: Humiliated is how you feel, but it isn't the word that comes to mind for me. While there may still be a stigma around psychiatric care, I don't believe it is any different than any other type of clinical care that a person might need to decrease suffering. It sounds as though you were really struggling. What was the hospital's name?

SALLIE: Something-or-other Lodge.

THERAPIST: Were you in the hospital any other times?

SALLIE: No, just that once. I am not that much of a kook.

THERAPIST: Is it uncomfortable to talk about this sensitive time?

SALLIE: Sort of. I mean it's not something that I'm proud of.

THERAPIST: I am glad you feel comfortable enough to tell me about it. It sounds as though it was a difficult time, but you were able to take advantage of the help from the hospital and from Dr. Mehta. You overcame the crisis in high school. The resilience you showed then, and the ability to use psychotherapy to feel better, can benefit you during this hard time as well. [*Offering justifiable hope is reassuring and bolsters the therapeutic alliance.*]

Thank you for sharing this information with me; it will help me help you. Now, during this time in high school, did you have any thoughts of wishing you were dead or harming yourself?

SALLIE: Now and then. . . .

THERAPIST: Could you share with me what you were thinking about?

SALLIE: Sometimes I thought about what my funeral would be like and how many people would come. Actually, I would get depressed thinking about it because I didn't think any of my high school friends would even show up. I knew I would never do anything, though. My parents would have been too devastated.

THERAPIST: Did you ever think about how you might hurt yourself?

SALLIE: No, not specifically.

THERAPIST: Is there any other time in your life when you thought about suicide? Have you thought about it recently?

SALLIE: No, suicide has never really been an issue for me. Nowadays I sometimes feel I just don't care about a lot of things, but I don't think I would go that far.

THERAPIST: Some people, under stressful circumstances, will attempt to relieve the emotional pain by cutting or burning themselves. Have you ever done this?

SALLIE: Oh, I just read an article about that for psych class. Nah, I'd never do that. Well, to be honest, last week I was sort of curious and I pricked myself once with scissors when I felt really angry. I didn't even draw blood, though. It hurt, then I stopped.

THERAPIST: What stopped you?

SALLIE: I just imagined my family freaking out. Plus, I don't like pain. I think I was just curious. I don't plan on doing it again.

THERAPIST: How does it feel talking about this?

SALLIE: Okay, I guess. A little easier than I expected it would be, to be honest.

THERAPIST: I appreciate your honesty. You are doing a good job of giving me a detailed history. Has anyone else in your family ever been in a psychiatric hospital?

SALLIE: No.

THERAPIST: Does anyone in your family struggle with psychiatric difficulties, like anxiety, depression, or an alcohol or substance use disorder? Eating disorders?

SALLIE: My mother's brother used to have a problem with alcohol, but he is okay now. He's been sober a number of years. My mother sometimes says she had the "baby blues" after I was born, but I don't really know what that means. She never went to a therapist.

THERAPIST: Anyone in the family try to hurt themselves in any way?

SALLIE: No, not as far as I know.

It's easy to swerve off course during the second session while I collect the past medical and psychiatric history. During Example 4.4, Sallie introduces a number of new topics that pique my interest (moving away to college, her brother Tom), but I stay focused, concentrating on Sallie's past outpatient and inpatient treatment, past trials of psychopharmacological medications, past suicidal behavior, and her family's psychiatric history. I mentally "bookmark" the other topics for future discussion.

For patients who have been in therapy before, I learn how long the prior treatment lasted and how the patient felt about the experience. I try to pay special attention to how my new patient terminated with their previous therapist. Were they able to tolerate a planned good-bye, or did they disengage abruptly and without warning? People tend to replay their past. How my patient dealt with a former therapist may provide a clue for our future together.

If the previous therapy was a good experience, I acknowledge how difficult it is to start with someone new. Polite patients are unlikely to tell me this directly, but they may feel relieved and understood when I mention that switching therapists may be a difficult process.

As a psychiatrist, I collect a psychopharmacological history during this part of the consultation. In addition to learning which medications have been tried in the past, I ask how long each trial occurred, the maximum dose reached for each medication, as well as medication efficacy and side effects.

Even for therapists who do not prescribe medication, it is important to know whether your patient has ever taken any psychotropic drugs, such as antidepressants, mood stabilizers, antianxiety medications, or others. Learn which drugs have been tried and which were successful. Are they taking any medication currently? Who prescribes them? Do not assume

the patient isn't taking psychotropic medications if they aren't seeing a psychiatrist. Many primary care doctors will prescribe antidepressants, such as fluoxetine or sertraline.

For past psychiatric hospitalizations, I learn the basic details about the admissions (when and where they occurred, how long they lasted, whether any medications were tried during the admissions, and the details after discharge). At this time, Sallie remains vague about the details of her psychiatric admission during high school. As we continue to work together and Sallie begins to trust me, I hope to learn more about this stressful time. With a signed release, I could also obtain her inpatient psychiatric records for my files. This early in the consultation it is normal to have only an outline of the patient's history, similar to a coloring book that hasn't been filled in yet.

As prior suicidal behavior and self-mutilation are some of the strongest predictors of future suicidal attempts, it is essential to clarify the past history of self-harm with special attention to specific thoughts and actions the patient has had throughout their life. For any suicidal thoughts, I ask for a detailed account of any actions that occurred as well. For instance, if the patient had a fleeting plan of overdosing when they were a teenager, did they just think about it, or did they collect pills, count them out, and hold them in their hand?

Questions about self-mutilatory behavior can follow the questions about suicide. For any repetitive self-injurious behavior, it is important to elicit details about the symptom. For example, for cutting, I ask where and how deeply the patient cuts, how often they do it, and what triggers the activity. For medical reasons, it is useful to know what instrument they use and if they have ever required medical attention for this behavior. If the patient is using unclean implements, I ask about their most recent tetanus booster, as it needs to be updated every 10 years. (For more guidance on how to respond to self-destructive behavior and to an actively suicidal patient, see Chapter 9.)

I also gather information on medical history, medications, and allergies during this second session.

EXAMPLE 4.5

Collecting a personal and family medical history, Part II

THERAPIST: We need to review your medical history. Do you have any major medical conditions I should know about?

SALLIE: No.

THERAPIST: Have you ever been in a medical hospital overnight for any reason?

SALLIE: Oh, yeah, when I was 10 I had an infection in my hand, and I needed to be hospitalized for IV antibiotics.

THERAPIST: How did it feel to be hospitalized overnight at such a young age?

SALLIE: It was scary, but it was only a few days, so it wasn't too horrible.

THERAPIST: Do you have any residual problems with your hand?

SALLIE: No, it is okay, luckily.

THERAPIST: I am glad to hear that. Any other medical problems as a child? Any other major infections, surgeries, broken bones?

SALLIE: Let me think. No other infections. No surgeries. Only a broken wrist once. Oh, yes, I had tubes in my ear when I was baby because I had so many ear infections, but I don't remember much about that, obviously. I do remember my mother saying that I was a trouper and never complained about all my doctor's visits. [*Sallie is beginning to follow my lead, not only stating the facts, but also trying to remember how the incident affected her.*]

THERAPIST: Any other recurrent chronic medical problems with any part of your body? Any problems with asthma? Any stomach problems?

SALLIE: No. No.

THERAPIST: Any concussions or head trauma with loss of consciousness?

SALLIE: I don't think so, but I fainted once when I was really tired and standing up too long on a really hot day.

THERAPIST: Did you hit your head?

SALLIE: No. My dad caught me as I went down. He has quick reflexes.

THERAPIST: Good reflexes definitely come in handy. Ever have any seizures?

SALLIE: Umm, I don't think so, I'd know if I had that, right?

THERAPIST: (*Nods.*) When is the last time you had a physical exam? Do you have any current physical symptoms that are bothering you?

SALLIE: Oh, I had a physical about 6 months ago. Everything was fine.

THERAPIST: Who is your primary care physician?

SALLIE: Well, I got my physical at school from a doctor at the student health services. Her name was Dr. Newman, but at home my doctor is Dr. Rodriguez.

THERAPIST: Do you have any current physical symptoms that are bothering you? [*Repeating the question because Sallie did not answer it the first time around.*]

SALLIE: I have been feeling very tired lately. But I figured that it was just because I am overwhelmed with this whole Charlie incident.

THERAPIST: Did the tiredness start before or after you had your physical 6 months ago?

SALLIE: Oh, it's relatively recent; I've only had it about 2 months now.

THERAPIST: The tiredness may be related to the breakup with Charlie, but there are also a number of medical conditions that can cause fatigue. It may be worth making an appointment with Dr. Newman to make sure that you don't have any other medical reason to be so tired.

SALLIE: Okay.

THERAPIST: Have you been taking any medications, prescribed or over-the-counter?

SALLIE: I take ibuprofen every month with my period, and vitamins, but that's it.

THERAPIST: Which vitamins?

SALLIE: Umm, I take a vitamin D supplement and a multivitamin.

THERAPIST: Are you allergic to any medicines?

SALLIE: Maybe penicillin. I think I get a rash from that.

THERAPIST: Are you currently sexually active?

SALLIE: Umm, yes . . . at least I was before Charlie and I broke up.

THERAPIST: What did you use for contraception?

SALLIE: Oh, yeah, I'm also on the pill.

THERAPIST: Oh, okay. Did you know Charlie's HIV status or if he had any other sexually transmitted disease?

SALLIE: Umm, no. But I'm sure he's fine.

THERAPIST: Hmmm . . . I wouldn't be doing my job if I didn't ask how you were protecting yourself from sexually transmitted diseases or STDs. The pill will protect you from pregnancy but not from STDs.

SALLIE: Oh, I think Charlie was safe. He didn't sleep around a lot.

THERAPIST: Safe sex precautions aren't easy, but they are the best way to prevent being exposed to anything. How would you feel about getting medically checked for HIV or other sexually transmitted diseases?

SALLIE: Oh, I don't think that's necessary. Charlie hasn't had many other sexual partners. He's clean.

THERAPIST: I am glad you did think about it. I feel a bit in a bind, because I think your health is awfully important, but I also don't think it is my role as your therapist to act as the sex police. [*I make a mental note to bring this up again if the opportunity presents itself, for instance, if Sallie starts a new relationship.*]

SALLIE: Yeah, I hear your point, but I really think I was safe enough here.

THERAPIST: Do your parents have any medical problems?

SALLIE: No. They are pretty healthy overall. My dad has some arthritis

from some old sports injuries, but otherwise they're doing pretty well. They do a lot of outdoor activities together.

THERAPIST: And your brother?

SALLIE: Umm, he has a history of stomach problems, but he's better now.

THERAPIST: What kind of stomach problems?

SALLIE: He used to have a lot of trouble with chronic stomach pain and diarrhea, but he's doing better currently.

THERAPIST: I'm glad to hear he is doing better. I've asked you a lot of questions today, and I am beginning to get a good overview. How has it felt for you?

SALLIE: It is weird to think about my psych hospitalization during high school. I don't usually talk about that, but the rest was okay.

THERAPIST: Well, I appreciate you being so open with me about your experience. Next week, we'll cover some more of my questions, and we'll be closer to making a treatment plan.

SALLIE: Oh, good. I really want to get back to talking about Charlie.

THERAPIST: We still have some time. I also want to hear about Charlie. Could you fill me in? What would you like to tell me?

A thorough medical history should cover Sallie's current physical health as well as her personal and family medical history. During this part of the consultation, I always ask specifically about a history of significant or repeated head trauma with loss of consciousness. With significant head injury, a patient is at risk for cognitive impairment, seizures, and emotional lability. Repeated concussions increase the lifetime chance of depression. A history of such events combined with any current neurological issues may warrant further evaluation by a neurologist or by a psychiatrist who is familiar with the behavioral manifestations of brain damage.

It's often not easy to gather a sexual history. At the start of a treatment, I may not know my patient's sexual orientation, and to be an effective therapist, I will eventually need to know this information. During medical school at the University of California, San Francisco, I was taught to ask about sexuality with two questions: "Are you sexually active?" followed by "With men, women, or both?" While this approach may feel expected and comfortable for some younger, open-minded patients, it may feel embarrassing for those who are older and more conservative. For patients who are more comfortable talking openly at the start of the treatment, I may follow the more direct approach; for others, I follow the patient's lead in terms of topic and wait to gather a more thorough sexual history after building up trust. For both populations, until I hear otherwise, I don't assume that a patient's partner will be of the opposite sex until I hear this fact explicitly.

Chapter 5 reviews how I can embed queries about gender identity and sexual orientation within a question on cultural identity: *"Is there anything you think I should know about your cultural identity or background? Each person determines their own cultural identity, and generally it consists of the groups that you identify with, or feel a part of. It can include all sorts of groups—one's ethnic group, religion, languages you speak, sexual orientation, gender identity, areas you feel close to, or special interest groups. If you feel a sense of belonging to a group, it is part of your cultural identity."* If the patient feels comfortable sharing their sexual orientation with me, my question on cultural identity provides an easy opening. If they would rather not address this topic, they can answer the cultural identity question by focusing on other aspects of their background.

A therapist is often in the unenviable position of hearing about a patient's poor judgment that puts them at physical or emotional risk. In Sallie's case, her unsafe sex with Charlie may have exposed her to an STD. As a health practitioner, it would not be responsible for me to ignore my patient's risky behavior, but a righteous directive stance is unlikely to promote change. During my first months as a psychotherapist, I didn't know how to approach these sensitive issues in a therapeutic way. I spent many uncomfortable sessions inwardly screaming "STOP!" while I listened to patients describe their numerous sexual escapades without a condom, their experimentation with multiple illicit substances, or their driving recklessly 60 miles an hour down a side street without wearing a seatbelt.

If preaching worked, I'd use it, but the last thing any patient needs is another directive, un-empathic person in their life. While it can be terrifying to worry about my patients' safety, the only way they will ultimately change their behavior is by overcoming their inner resistance to protecting themselves. Usually, this process takes time and occurs as the therapy slowly evolves. Meanwhile, my job is to acknowledge that the behavior is dangerous but to avoid becoming a nag. The strategy outlined in Example 4.5 is balanced, because it provides education and understanding without a domineering attitude. Our goal as therapists is to guide deftly but not to pretend that we have control.

Even if the patient doesn't protest about spending the majority of the session relating their medical and psychiatric history, I reserve at least 10–15 minutes at the end of the session to focus on the primary difficulty that brought them to treatment. The patient will appreciate that I haven't forgotten their main concerns, and this will also be my opportunity to arrange for the third session.

EXAMPLE 4.6

Closing the second session

THERAPIST: Well, I appreciate your being so open with me about your experience. Next week I'll gather a little more history, and then we'll be closer to making a treatment plan.

SALLIE: Oh, good. I really want to get back to talking about Charlie.

THERAPIST: We still have about 15 minutes today. Could you fill me in? What would you like to tell me?

SALLIE: Umm, I don't know. Does this breakup make any sense to you? I just don't get what happened.

THERAPIST: I think it will also take some time for me to understand the relationship and what happened. You have mentioned a couple of ideas that I hope we can delve into more deeply in future meetings. I remember you saying that Charlie experienced some of your suggestions and opinions as bossing him around, but you didn't think that these interactions were problematic. Is that fair to say? [*reflecting back information that Sallie has shared during the consultation*]

SALLIE: That's right. I appreciate when people give me feedback. My mom gives me direction all the time, and I think it is very helpful. I just don't get it.

THERAPIST: Over time, as we talk about this in more detail, I think we will understand more together. I wish I could say some words that could take away all your pain, but unfortunately it isn't that simple. If it were easy to fix, you wouldn't even be seeing me in the first place. You would have figured this out by yourself long ago. We will both keep working on this together, and with understanding, I am very hopeful that you will feel better over time.

SALLIE: Oh, okay. I wish it could be faster, too, but if this is the way it has to be, I'll just manage as best I can. I'll just keep distracting myself; I think that works best when I'm feeling low.

THERAPIST: Which distractions work best?

SALLIE: Movies, running—even studying sometimes. (*Laughs.*)

THERAPIST: Sounds good. Until next week . . .

SALLIE: Yeah, I'll see you then.

The consultation is well on its way. Sallie is beginning to trust me, and I am slowly getting an outline of her story, both present and past.

Review of mnemonic for depression: SIGECAPS—sleep, interest, guilt, energy, concentration, appetite, psychomotor changes (agitation or retardation), suicide.

THERAPIST TOOL 4.1

Sample Patient Consultation Questionnaire

The information in this questionnaire will help me understand your situation. When added to our meetings, it will help us find an effective approach to the problems that we will be working on together. Your replies will be held in confidence as required by law.

Please add any information that you believe might be relevant, using the reverse sides of pages if necessary.

Name: _____ **Date:** _____

Preferred pronoun: she/her/hers he/him/his they/them/theirs other

Date of birth: _____

Address: _____

Contact information:

Home phone: _____

Work phone: _____

Cell phone: _____

Email: _____

Please note which number I should call if I need to reach you.

Occupation: _____

Who referred you to me? _____

Health insurance: _____ Group: _____

Policy: _____

Emergency contact information:

Name: _____

Address: _____

Phone number: _____

What is the main concern that led you to consult me? _____

_____

_____

_____

_____

(continued)

MEDICAL HISTORY

Allergies

Are you allergic to any medicines? Yes _____ No _____

If "yes," please list: _____

Are you allergic to other substances? Yes _____ No _____

If "yes," which ones? _____

_____

What types of allergic reactions have you had? _____

Medical Illnesses

Have you had any illnesses in the past? Yes _____ No _____

If "yes," which ones? _____

_____

Do you have any illnesses at present? Yes _____ No _____

If "yes," which are they? _____

_____

Are you in any current pain? If so, where? How would you rate it on a scale of 1 to 10?

_____

Date of your most recent physical examination: _____

Name of your Primary Care Physician (PCP): _____

Address: _____

Phone number: _____

Do you authorize me to communicate with your physician? Yes _____ No _____

If "yes," we will discuss when, how, and what information I might share with your PCP.

Surgical Conditions

Have you had surgical operations or injuries? Yes _____ No _____

If "yes," what were they and when did you have them? _____

Date of your most recent tetanus booster: _____

Have you ever had a head injury? Yes _____ No _____

Did you lose consciousness? Yes _____ No _____

When did this happen? _____

How did it occur? _____

Have you ever had seizures? Yes _____ No _____

If so, what are they like? _____

(continued)

PSYCHIATRIC HISTORY

Hospitalizations

Have you ever been hospitalized for a psychiatric disorder? Yes _____ No _____

If "yes," what was the disorder, which hospital(s), and what were the dates? _____

_____

_____

_____

Outpatient Psychiatric Treatment

Have you ever had out-of-hospital treatment for a psychiatric condition?

Yes _____ No _____

If "yes," what was the condition? _____

When and where did you receive the treatment? _____

What type of treatment was it (e.g., psychotherapy, medication, behavior therapy, others)?

_____

Name of your former therapist: _____

Address: _____

Phone number: _____

Do you authorize me to communicate with your former therapist? Yes _____ No _____

If "yes," I will have you sign a release of information form.

MEDICATION HISTORY/HEALTH OVERVIEW

Which medications are you taking now (medical or psychiatric)?

Drug	Dose	Frequency	Prescribing Physician

Which medications have you taken in the past?

Drug	Date	Reason for Discontinuing

Do you use nonprescription medications? Yes _____ No _____

If "yes," which ones/how much/how often? _____

_____

(continued)

Do you or have you used recreational or illegal drugs? Yes _____ No _____

If "yes," which drugs/how much/how often? _____

_____

Do you drink alcohol? Yes _____ No _____

How often did you have a drink containing alcohol in the past year? _____

How many drinks containing alcohol did you have on a typical day when you were drinking in the past year? _____

How often did you have six or more drinks on one occasion in the past year? _____

Do you smoke/use e-cigarettes (vaping)? Yes _____ No _____

If "yes," how much do you smoke per day? _____

Any uses of nonsmoking forms of tobacco? Yes _____ No _____

If "yes," which ones? _____

Beverages with caffeine:
(Circle those that apply.)

Coffee or tea _____ cups per day

Colas _____ cans/bottles per day

Do you engage in safe sex? _____ Always _____ Sometimes _____Never

Do you have any sexual concerns? Yes _____ No _____

Which form(s) of birth control do you use? _____

Do you own a gun? If so, is it in your home? If so, how is it stored? _____

_____

FAMILY PSYCHIATRIC HISTORY

Has anyone in your family ever had a psychiatric disorder? Yes _____ No _____

Have any of the following family members had psychiatric disorders (including depression, mania, bipolar disorder, schizophrenia, alcohol or substance use disorder, eating disorders, attention-deficit disorders, obsessive–compulsive disorder, panic disorder, phobias, suicide)? Please indicate diagnosis and the name of the individual.

Children: _____

Father: _____

Mother: _____

Siblings: _____

Maternal grandparents: _____

Paternal grandparents: _____

Uncles/aunts/cousins: _____

(continued)

MARITAL STATUS

Single ____ Living with partner ____ Married ____ Widowed ____ Divorced ____

If living with someone, for how long? _____

If married, for how long? _____

Occupation of husband/wife: _____

If widowed, date of spouse's death: _____

Cause of death: _____

If separated/divorced, date: _____

Reason: _____

CHILDREN

Name Date of Birth

_____

_____

_____

_____

Your current living situation: _____

_____

Those living in your household and their relationship to you:

Name Relationship

_____

_____

_____

_____

FAMILY MEDICAL HISTORY

Mother's name: _____ Age: _____

If deceased, date and cause of death: _____

Serious illnesses: _____

Father's name: _____ Age: _____

If deceased, date and cause of death: _____

Serious illnesses: _____

(continued)

Siblings:

Name Serious Illnesses

_____

_____

_____

_____

BRIEF REVIEW OF SYSTEMS

Symptom or Problem: Circle all that apply. If circled, please describe in more detail and make a note of the date it began.

- Decreased vision/eye pain

  _____

- Wear eyeglasses/contacts

  _____

- Dizziness/vertigo

  _____

- Earaches/buzzing or other sounds

  _____

- Decreased hearing

  _____

- Difficulty swallowing

  _____

- Chest pain

  _____

- Shortness of breath

  _____

- Decreased energy

  _____

- Difficulty concentrating/distractibility

  _____

- Difficulties with organization

  _____

- Impulsivity

  _____

(continued)

- Cough/asthma

_____

- Abdominal pain

_____

- Menstrual/reproductive problems or infections

_____

- Eating difficulties

_____

- Decreased appetite

_____

- Using laxatives, diuretics, or diet pills to lose weight

_____

- Nausea/vomiting/diarrhea

_____

- Weight loss/gain

_____

- Bloody or black stools

_____

- Blood in urine

_____

- Frequent or severe headaches

_____

- Convulsions or seizures

_____

- Self-induced vomiting with or without ipecac

_____

- Depression

_____

- Anxiety/panic attacks

_____

- Avoidance of public places in order to avoid panic attacks

_____

- Sleep difficulty

_____

(continued)

- Decreased motivation

_____

- Racing thoughts

_____

- Suicidal thoughts/fears

_____

- Suicidal wishes/plans/attempts

_____

- Homicidal thoughts/wishes

_____

- Homicidal plans/violent acts

_____

- Seeing things that other people don't see

_____

- Hearing things that other people don't hear

_____

- Legal history—trouble with the law

_____

- Loneliness/isolation

_____

- Repetitive unwanted thoughts or actions

_____

- Hopelessness/guilt

_____

- Checking things multiple times to make sure they are in place

_____

- Washing things multiple times to make sure they are clean

_____

- Nightmares

_____

- Flashbacks

_____

- Distress about any aspect of your appearance

_____

(continued)

Does your PCP know about the symptoms you have circled?

Yes _____ No _____

REVIEW OF TRAUMA SYMPTOMS

If you feel comfortable, please add any details you would like me to know at this time.

Have you had a traumatic experience? Yes _____ No _____

_____

_____

Have you been exposed to abuse? Yes _____ No _____

_____

_____

If "yes," check those that apply.

Physical _____

Sexual _____

Emotional _____

If you feel comfortable noting this information, who was involved? _____

_____

_____

Have you been impacted by discrimination or racism? Yes _____ No _____

Has discrimination or racism caused anxiety, increased your stress level, or lowered your mood? Yes _____ No _____

EDUCATIONAL HISTORY

	Name of School/Location	Dates
Elementary:		
Secondary:		
College:		
Postgraduate:		

Have you had any history of difficulties at school? Yes _____ No _____

If "yes," please describe: _____

_____

(continued)

OCCUPATIONAL HISTORY

Dates	Job Titles	Exposure to Dangerous Substances

Military Service Yes _____ No _____

Please fill in some details on your military service. _____

_____

_____

Have you had any history of difficulties at work? Yes _____ No _____

If "yes," please explain. _____

_____

_____

Have you had any problems with the law? Yes _____ No _____

If "yes," please explain. _____

_____

_____

DEVELOPMENTAL HISTORY

Was your mother exposed to stresses, drugs, or dangerous substances while pregnant with you? Yes _____ No _____

If "yes," what were they? _____

_____

Were there any difficulties with your birth? Yes _____ No _____

If "yes," what were they? _____

_____

Did you have any difficulties in your physical development? Yes _____ No _____

If "yes," what were they? _____

_____

Have you had any recent stresses or relevant stresses in the past? Yes _____ No _____

If "yes," please list them. _____

_____

(continued)

ADAPTIVE HISTORY

Your cultural identity is determined by you and generally consists of groups that you identify with or feel a part of. It can include all sorts of groups including one's ethnic group or race, religion, languages you speak, sexual orientation, gender identity, areas in the world you feel close to, special interest groups, and so on. If you feel a sense of belonging to a group, that group is part of your cultural identity. I am interested to know about your unique cultural identity:

_____

_____

_____

Which stresses have you overcome in the past? _____

_____

How did you do it? _____

_____

What was the best period of your life? _____

_____

What are your personal strengths? _____

_____

Please sign this questionnaire below.

_____

CHAPTER 5

Collecting a Psychosocial History and Screening for Common Psychological Disorders

To facilitate arrival at an accurate diagnosis and to formulate an effective treatment plan, it is important to collect relevant history concerning the patient's childhood, cultural identity, and later development as well as information about substance use, anxiety disorders, trauma, psychosis, and mania.

THE BEGINNING OF THE THIRD SESSION

I don't especially like psychiatric consultations. Ongoing treatment is a different story. It's a special privilege to work over time with a patient on their most pressing and private concerns. Consultations, in contrast, are a bit of a slog because I need to collect so much information in a short amount of time. Part of me has always wanted to skip the consultation process altogether, but I'm now resigned that a thorough evaluation is actually the best way to start an effective psychotherapy. Thankfully, once I've finished asking the questions reviewed in this chapter, I'm more than halfway done.

A quick review of Sallie's first and second visits: During Session 1, I focused on Sallie's main concern and only directed the interview to assess suicidality and safety, the most urgent parts of the mental status examination—unless the patient is homicidal or is openly psychotic. During Session 2, I used a more structured approach and asked Sallie about her current depressive symptoms and her past psychiatric and medical history.

In my private practice, I have the flexibility to offer this type of prolonged assessment. It is my preference as it best balances the need to

establish a therapeutic alliance with the need to gather pertinent clinical information. In my clinic setting, I do not have the luxury of a three-session assessment, but I follow a similar approach as I collect information during one 90-minute evaluation session. (See Figure 6.1 in Chapter 6 for Sallie's consultation summary and mental status examination.)

During Session 3, my first round of questions will focus on Sallie's developmental history. Before the meeting, I review the information I already have and make a special notation of the questions I still need to cover. Using the strategy outlined in Example 4.1, I gently interrupt Sallie after she talks freely for the first 10 minutes of the session, leading with an empathic statement as I redirect the conversation. (For example, "This has really been a tough time. While I also want to hear how you have been feeling during the last week, I would like to use this session and the next one, if necessary, to finish collecting the information I need to plan an effective treatment.")

COLLECTING A DEVELOPMENTAL HISTORY

When eliciting a developmental history, I am guided by Freud's basic adage that a person is emotionally stable when they have succeeded in both love and work. For a child, immediate family and school serve as the first love and work experiences. Over time, I'll learn about each member of the Gane family and paint a mental picture of Sallie interacting with her parents and brother. As children mature, they form significant relationships with their peers, so I'll also focus on Sallie's past and current friendships and romantic relationships.

I will not be able to gather all the overview information I would like to know during an evaluation, but I will eventually learn more about Sallie's childhood as the treatment progresses. I am interested in her experiences at all ages, starting with preschool, and moving through latency (elementary school), adolescence, and beyond. Persistent significant difficulties in school may signal an unrecognized diagnosis of attention-deficit/hyperactivity disorder (ADHD) or a learning disorder.

As I construct an impression of Sallie's life, I'll listen for significant childhood life events, especially those that can have a profound impact on a child: a relative's or friend's death, a mother's miscarriage, a move across the country or even to another school district, a divorce, or an illness suffered either by the patient or by someone close to her. The patient's age at the time of the event is important. A 4-year-old, for instance, will process a family crisis differently than a 10-year-old.

Positive memories are equally important. To have a clear picture of Sallie's development, I'll eventually want to know some joyful family

memories, some of her favorite activities as a child, her natural talents, and her childhood aspirations.

As I gather all of this information, I'll be trying to understand why Sallie is currently having trouble finding contentment in her life. Interestingly enough, difficulties in work and love may be intertwined.

There are two main strategies a therapist can use to collect a developmental history, each with its own set of pros and cons. With a sequential approach, the therapist asks about the patient's past slowly, starting with their birth and then gradually advancing up the developmental ladder until the present.

With the sequential approach, my knowledge of Sallie's upbringing would be extraordinarily detailed, but there may be a therapeutic cost. In order to gather so much information, I'll have to be fairly directive, and I may miss opportunities to discuss any emotionally pertinent topics in more detail. If the process becomes prolonged, Sallie may also feel frustrated that her primary concern, Charlie, is not being addressed.

I prefer to collect a developmental history by asking questions about Sallie's past that specifically relate to her present concern. This method is illustrated in Example 5.1.

EXAMPLE 5.1

Obtaining a developmental history by following the patient's lead

SALLIE: I just feel so punk about Charlie and the breakup. (*Sniffles.*)

THERAPIST: (*Waits in concerned silence for Sallie to continue.*)

SALLIE: I don't even know what to say anymore.

THERAPIST: You mentioned before that the relationship with Charlie felt very different from your relationships with other boyfriends. Could you tell me more about that?

SALLIE: Yeah, sure. Well, my first boyfriend's name was Larry. We went out for 3 months during my freshman year of college. He was very sweet, just very boring.

THERAPIST: What made him boring?

SALLIE: It's weird. The features that attracted me to him in the first place were also the reasons I couldn't stand him by the end.

THERAPIST: What were those features?

SALLIE: Well, at first I just thought he was the best. He brought me flowers all the time. I think he looked up to me. I mean, he had me on—What do you call it?—oh, yeah, a pedestal. Basically, Larry thought I was perfect, and who was I to disagree? (*Grins.*) But he let me boss him around. That wasn't so good, I think.

THERAPIST: Can you give me some examples?

SALLIE: I don't know. . . .

THERAPIST: (*Waits quietly with an interested look.*)

SALLIE: Well, for instance, if I wanted to go out to dinner, we went out to dinner. If I wanted to go shopping, we went shopping. At first, I loved the fact that I always got my way, but then (I hate to say this, but I think it's true) . . . I started taking advantage. I think I was sort of pushy, and he never stood up for himself. This sounds horrible, but I think I got bored.

THERAPIST: How did the relationship end?

SALLIE: Umm, well, I sort of lied to break it off. I told Larry that I needed to devote time to my studies, and I couldn't afford to be distracted with a boyfriend. Then, I stopped answering his calls. Eventually, he got the message.

THERAPIST: What was that like for you?

SALLIE: I feel guilty that I didn't feel more upset. Maybe I am a hard-hearted person, I don't know. But, after I broke it off, I felt 10 pounds lighter. Even though Larry was *so* nice to me, he made me feel squished.

THERAPIST: You have taken some time to really understand what worked and didn't work with Larry. What happened with the second boyfriend?

SALLIE: Oh, Alec . . . well, he was a premed student. When we first met, he was majoring in biochemistry. It looked like he had goals other than focusing on me, and I liked that.

But the strangest thing happened. After we went out for a few months, he started acting just like Larry. It was bizarre. He had been so independent, and then, all of a sudden, he was constantly catering to me. I don't really know how it happened, but once I knew I had the upper hand, I lost interest again.

See, this is why Charlie is such a find. He's interesting and always has an opinion that he is willing to defend, even if I disagree with it. Life with him was never boring. I sometimes fantasized about marrying him. . . . (*Looks down abruptly and eyes well up with tears.*)

THERAPIST: This breakup was so painful because you felt that you had found someone very special?

SALLIE: That's true.

THERAPIST: What do you think it would have been like to be married to Charlie?

SALLIE: Fun. New adventures together all the time. Taking chances. Not like my parents' marriage.

THERAPIST: Could you tell me more about your parents' relationship?

SALLIE: Why? There is nothing wrong with them. (*Looks annoyed.*)

THERAPIST: [*I reword the question to correct Sallie's impression that I was criticizing her parents' relationship.*] Well, when searching for a partner, it is impossible not to be affected by your experience of your parents' relationship. What is their marriage like?

SALLIE: Oh, it's fine.

THERAPIST: Can you tell me a bit more?

SALLIE: Well, they basically get along. But they are very different.

THERAPIST: How are they different?

SALLIE: Well, my mom has always reminded me of a hummingbird. She never stops moving; she has so much energy. When I was growing up, all my friends would always want to come over to my house because my mom was the most fun. She's very cutting edge. We both have an interest in fashion. Did I tell you? I won "best dressed" in high school, but she was the one that really deserved the award; she took the time to take me shopping, so I could create the look I had in mind.

THERAPIST: Does she work outside of the home as well?

SALLIE: She's a real estate agent part-time. She likes it, but it isn't her dream job. She talks a lot about starting her own business, but she wants to wait until my brother is healthier and in college.

She is really supportive of me though. She loves that I'm studying economics. She always says it will prepare me to do whatever I want when I graduate.

THERAPIST: You mentioned that she is very different from your dad. Can you tell me more? [*I make a mental note to ask more details later about Sallie's brother's health.*]

SALLIE: Well, my dad is sort of quiet. He makes a lot of jokes, but he was always the calm influence at home. My mom flits around nonstop, and my dad is happy to sit in one place and read or watch TV. I think they are good for each other, but they are very different.

THERAPIST: What does your dad do for a living?

SALLIE: He's the manager of an electronics store. He likes gadgets, and he's good with people, but once he's home, he just wants to be with us. He's my reading buddy, because we'll read the same stuff and then talk it over. I love that.

THERAPIST: What are your parents like together?

SALLIE: Cute, I guess. But they bicker a lot, too. My mom always wants things a certain way, so they tend to get into arguments.

THERAPIST: What happens during a typical argument? [*I mirror Sallie's words, by using "argument" to describe the interaction.*]

SALLIE: If my mother wants to have a dinner party and my dad just wants a quiet evening at home, they yell about it for at least half an hour, sometimes longer. It's amazing how these little disagreements can blow out of proportion.

THERAPIST: How do you feel when you listen to the arguing?

SALLIE: Annoyed. It's stupid, but it's just the way they do things.

THERAPIST: How does it usually end?

SALLIE: Oh, it usually ends the same way. My dad gets sick of fighting, and my mom gets her way. I think it's strange that he doesn't get resentful. I would, if I were giving in as much as he does, but he tells us, "I didn't realize how important this was to your mother, so we will do it her way." Then, they are all lovey-dovey—until the next fight, that is.

THERAPIST: How long has this type of fighting been part of their relationship?

SALLIE: Umm, as long as I can remember, but maybe it has gotten more frequent over the last few years.

When I follow Sallie's associations and ask detailed questions, our discussion about her submissive former boyfriends leads naturally into a conversation about her parents. She describes situations and scenes with specifics and emotions, and her stories are inherently interesting. While I privately notice a potential similarity between Sallie's upper hand with some of her past boyfriends and her mother's interactions with her father, I don't comment on this. This early on, I don't have enough information to draw a clear connection; more importantly, it is likely to feel intrusive if I share these thoughts during the consultation, as Sallie slowly builds trust in me and the therapeutic process.

Example 5.1 also illustrates some techniques that help Sallie talk more specifically when she starts speaking in generalities and vague statements. When Sallie worries that my interest in her parent's marriage is a surreptitious dig for psychopathology, I openly describe the intent behind my line of questioning: "When searching for a partner, it is impossible not to be affected by your experience of your parents' relationship. What is their marriage like?" When she describes her parents' marriage as "fine," I ask for more details.

In this interview, I use the question "What was that like for you?" after Sallie describes her breakup with Larry. For a patient who has a difficult time describing their emotions, this query may feel less threatening than the ubiquitous "How did that feel"? With "What was that like for you?" or the similar "How did this affect you?," Sallie can choose to answer with either

cognition or emotion, whichever feels more accessible. As the therapy progresses and she is more comfortable expressing her emotions, I might focus more exclusively on feelings, but at this point my main goal is to facilitate the conversation and the therapeutic alliance.

Since this preferred history-taking approach requires that I follow the patient's associations, rather than direct the collection of data, it takes more time to learn about Sallie's early childhood. Some topics (grade school, best friend, more details about her brother, puberty) may not be covered until the therapy is well underway. After Sallie leaves the office, I may jot down some of the subjects that still need to be fleshed out during future sessions. Another option is to present Sallie with the questionnaire (provided at the end of Chapter 4) at the conclusion of the first session to obtain some additional background; then, I may use the method illustrated in Example 5.1 to fill in the details over time.

ASKING ABOUT CULTURAL IDENTITY[1]

Learning about a patient's cultural identity deepens the therapist's understanding of the patient. The definition of a cultural identity, the feeling of belonging to any group, is inclusive and is determined by the patient. A person's cultural identity may be multidetermined and may or may not include ethnicity, race, religion, nationality (or nationality of their parents or grandparents), social class, generation, sexual or gender identity, languages spoken, or locality, to name a few. (See Figure 5.1 for more examples.)

When I have asked patients about their cultural identity and whether it impacts their current struggles in any way, my understanding of their personal experience expands: a 40-year-old high school music teacher reflects on his Catholic faith, which had been a source of solace and support but now is causing internal strife as he has fallen in love with another man; a 31-year-old Black computer scientist mentions a strong connection to his Black church and the group of college friends with whom he plays online video games once a week; a young woman of Asian heritage adopted at birth by an observant Jewish family struggles with feeling both connected and somewhat out of place in both communities; and a 35-year-old single mother mentions she is a diehard Boston Red Sox fan, with the team's games providing great comfort during tough times. I am respectfully curious about all facets of patients' identity. Patients may feel a cultural and community connection to several different groups, and one's cultural identity may be

[1]I am grateful for the wise input and guidance provided by Drs. Juliana Chen, Tanishia Choice, Christine Crawford, Maria Jose Lisotto, and Nhi-Ha Trinh while creating this new section on cultural identity as well as the section "Talking to Your Patient about Systemic Racism" on page 93.

Race	Neighborhood/region
Ethnicity	Interests
Religion	Nationality (personal and/or family)
Languages spoken	Regional sports team
Generation	Social class
Sexual identity	Career
Gender identity	Interests/hobbies
Heritage	Political affiliation

FIGURE 5.1. Potential elements (not comprehensive) within a cultural identity.

an important source of pride and resilience. An open discussion of cultural identity signals an interest in the patient's unique perspective and a valuing of the strengths and coping strategies developed.

The open-ended query about cultural identity is also my favorite way to ask about sexual orientation and gender identity. If the patient is ready to disclose this information to me, the question on cultural identity (see Example 5.2 for a model dialogue) provides an easy opening. I may also choose this moment to ask a patient about their preferred pronouns (*she/her/hers*, *he/him/his*, *they/them/theirs*, or another alternative).

After asking about cultural identity (as illustrated in Example 5.2), my next questions will start to clarify what each community means to the patient. For instance, if I learn that a patient is part of the LGBTQIA+ (a common abbreviation for lesbian, gay, bisexual, transgender, queer, intersex, agender, asexual, and ally) community, I will ask for more details about the patient's personal experience and relationships; the family support received or denied; interactions with the LGBTQIA+ community; and any discrimination the patient faced growing up, in school, and at the workplace. If I am unfamiliar with a patient reference, or have questions about any parts of the patient's story, I make sure to ask for clarification rather than pretend to be knowledgeable when I lack expertise in a specific area. As I learn about the unique cultural values, beliefs, and attitudes of each patient, I aim to avoid stereotyping or overgeneralizing any particular group. The goal is to create an environment where the patient can be fully themselves, so I can tune into the breadth and depth of their experience.

As with any aspect of psychotherapy, it is easy to assume inaccurate information if one doesn't ask. Two individuals who seem to have a similar cultural identity from the outside may have a very different take on the same question. Jesse and Rafael are both graduate students in Boston, with fathers who immigrated to the United States from Mexico and White

mothers who grew up in the Midwest, but the two men may answer questions about their cultural identity very differently. Jesse may talk with pride about his ties to his Mexican family and culture, the advantages of being bilingual, and then add that his family has had minimal exposure to the purpose or efficacy of psychotherapy. While Rafael's family history seems to be similar, when he is asked to describe his cultural identity, he mentions his long-standing affection for the Minnesota Vikings, and that until he turned 18 years old, the best months of every year were the summers spent working on his grandparents' farm in Minnesota. He finds urban life stressful, and wonders if living and working in the rural Midwest might be a better fit.

What if the therapist and patient share a cultural identity? As a Jewish White woman originally from Los Angeles, I cannot assume that my experience is the same as my Jewish patients. While I am aware and knowledgeable about many aspects of Jewish life, I do not assume that I understand the meaning of Judaism for each new patient without asking. I freely ask to be educated when a patient mentions a part of Judaism that I am not familiar with. While it may feel easier for me to talk spontaneously about this topic since my patient and I are often both aware that we share this common background, it is critically important that I don't take shortcuts and assume I know the details of a patient's personal experience because we share this heritage. My goal is to learn the details of each patient's unique story and to avoid making any assumptions. This approach may also be applied more generally to therapists of the same race, ethnicity, or sexual orientation as their patients.

Research on the racial/ethnic matching of patients and therapists is evolving, and a complex picture is emerging. Myriad factors, beyond sharing a similar background, impact treatment outcome, such as experience, accessibility, ability to create a strong therapeutic alliance, capacity to ask questions in a manner that is curious but not shaming, an openness to learning, and so on. It makes sense that a patient may feel more comfortable at the start of treatment with a therapist who shares a similar background, but over time, the therapist of a different background may gain a patient's trust if they listen carefully and sensitively, while working to understand the patient's unique experience. Sharing a similar background may give a therapist a head start with a new patient, but this doesn't mean that therapists of different backgrounds can't catch up (Cabral & Smith, 2011).

While asking about cultural identity may feel uncomfortable to the novice clinician, the questions become easier to ask with practice. Like any other topic in psychotherapy, I just learn the basics during the first discussion. Once the topic is established, it is likely that the patient's story will evolve in complexity, and our understanding will slowly expand over time. The Cultural Formulation Interview (CFI), a 16-question semistructured

interview available in DSM-5 (available by searching for "CFI" at *psychiatry.org*) provides a deeper dive into the impact of culture on a patient's experience. The CFI and its accompanying online supplemental modules support positive clinical outcomes by bolstering patient–therapist communication on cultural issues (American Psychiatric Association, 2013b).

EXAMPLE 5.2

Asking a patient about their cultural identity

THERAPIST: As I learn about your family, it helps me understand your experience if I also know a bit more about your background and cultural identity.

SALLIE: What do you mean exactly?

THERAPIST: Each person determines their own cultural identity, and generally it consists of the groups that you identify with, or feel a part of. It can include all sorts of groups—one's ethnic group or race, religion, languages you speak, sexual orientation, gender identity, areas you feel close to, or special interest groups. If you feel a sense of belonging to a group, it is part of your cultural identity. For example, I haven't asked you yet what pronouns you prefer. Could you share that with me?

SALLIE: Oh, I like she/her/hers; that is pretty straightforward and I'm straight. I mentioned I was Catholic before but I'm not really practicing.

THERAPIST: Can you tell me more about how your religion fits within your life?

SALLIE: I think Catholicism is valued within my family—from both sides actually. My dad's mom is Filipina, and she is a devout Catholic; my mother's side of the family is Irish Catholic. Religion was part of my upbringing for sure; my family always attended church and celebrated holidays together. While I'm not going to church these days, my faith is definitely still an important part of my identity.

THERAPIST: Did you turn to your faith during this most recent difficult time?

SALLIE: That's an interesting question. I didn't actually, maybe because I'm away from home. Maybe I would have thought about attending church or contacting my pastor if I was home, but since I've been living at school the last few years, I'm not as connected to my home parish. Here at school, I didn't really click with the students in the Catholic Student Organization.

THERAPIST: I'm definitely interested in learning more about how your faith

is important to you as we meet together. Could you tell me now a bit more about both sides of the family?

SALLIE: Unfortunately, I don't get to see my father's family too often; they live across the country, but they are really sweet. My grandfather is more quiet, like my father; he is White and his family is from the Bay area. It's a little interesting when I think about it; just like my dad, he married a really extroverted woman who immigrated to the United States. My grandmother is a go-getter like my mom, and she is so easy to talk to. She is also an amazing cook. There is an incredible Filipino noodle dish called "pancit," and she always makes it for me when I visit. I don't speak any Tagalog, but I can recognize when other people are speaking it. I hope someday I have a chance to visit the Philippines to learn more about this part of my heritage.

THERAPIST: Your Filipino heritage is an important part of your cultural identity; thank you for sharing it with me. With your Southeast Asian heritage, have you or anyone on your father's side of the family been impacted by discrimination or racism?

SALLIE: My father doesn't talk about it too much actually. He's mentioned a few stories here and there from when he was growing up, but it isn't something that I have thought a lot about because it hasn't affected me directly. I would probably know more details if I saw my grandparents more often. Should I tell you about my mother's side of the family next?

THERAPIST: Yes. I'm interested to hear.

SALLIE: So, my mom is originally from Ireland, but she moved to the United States when she was in her early 20s. We visit my aunts and uncle in Dublin every summer. I love my Irish cousins; they are so fun. I wish they lived in America and I saw them more than once a year. So, I also feel connected to my Irish roots, for sure.

THERAPIST: Can you tell me a little more?

SALLIE: Well, my cousins are the best; during my summer visit, we are inseparable from the moment I arrive to the day I leave, but the visit is only about 2 weeks. We try to stay in touch over the year, but we all get so busy. My family stands out in comparison to my Irish relatives; my mother is a bit of a trailblazer because she moved to America, is more career-focused, and only has two children.

THERAPIST: Your mother has a unique life trajectory when compared to her siblings. How does your family's story affect your current struggles?

SALLIE: Umm, I don't know. My extended family is a positive part of my life, but they don't provide much support during the school year.

Maybe the fact that my mom is a trailblazer in her family affects how I approach college in general.

THERAPIST: Can you say more? How do you experience this—that your mother is a bit of a trailblazer as compared to her siblings?

SALLIE: Oh, I'm so proud of her. And she is an important mentor for me. There are also some expectations for my future career, but I appreciate that. So, maybe it adds a little stress, but overall it is a positive.

THERAPIST: Thank you for sharing this with me. It is important information that will help me understand more about your current situation at school. Is there any other aspect of your cultural identity that you think I should know about?

SALLIE: On campus, I'm a member of a marketing club at school. I've been a member for a few years . . . does that count?

THERAPIST: Yes, everything counts. Any group you belong to, that is important to you, counts as part of your cultural identity.

Sallie's answers to my questions about her cultural identity deepen my knowledge of her unique experience. Since adding this question to my intake consultation during the last several years, my knowledge of my patients' backgrounds and what identity groups are important to them has expanded significantly. Once this topic has been opened, patients may also feel comfortable sharing details of cultural celebrations that are meaningful to them, including the personal significance behind certain traditional dishes, rituals, and holidays. My understanding of a patient expands as their world opens up to me.

Also, by asking about cultural identity, I avoid assumptions about the patient's lived experience. Without asking, I wouldn't know that Sallie is a quarter Filipina, and that her mother is from Ireland. As a therapist, I may only learn about a patient's cultural identity if I ask the question; otherwise, based on my own internal biases, I may make simplifications or assumptions about a patient based on name, looks, or actions.

Asking about cultural identity opens up the topic for exploration; a multicultural counseling and therapy (MCT) approach is one way to expand the journey further. MCT embeds a patient's cultural strengths into the treatment planning, as a patient's background affects their experience of psychotherapy and what interventions may be most effective. MCT specifically promotes cultural humility. It requires therapists to learn about their own internal biases and prejudices, and how they might affect therapeutic interactions; the process of learning is continuous and specific to each patient (Sue, Arredondo, & McDavis, 1992). Research has shown that a therapeutic stance that incorporates cultural humility, a lack of superiority, and a respectful sensitive curiosity supports a strong working alliance

with positive therapeutic outcomes (Hook, Davis, Owen, Worthington, & Utsey, 2013). While it is beyond the scope of this book to delve deeply into this important topic, I encourage you to take a look at the Additional Readings and Resources list for recommended sources focused on MCT.

Talking to Your Patient about Systemic Racism[2]

During my training many years ago, discussions on how to talk to patients about sexuality, gender, money, and family secrets were embedded in the curriculum. It was clear to me, early on, that a therapist superpower was the willingness and capacity to discuss difficult topics with sensitivity. I reveled in learning the words to open and propagate discussions. Guidance was also provided on how to promote conversations about cultural identity and differences, but, in my experience, one topic remained a third rail: racism. I wondered, how does a therapist talk sensitively to a patient about their experiences with racism and prejudice, especially if the therapist's race is different from the patient's? As a White psychiatrist, is addressing that difference within the psychotherapy a thoughtful approach, or could it interfere with creating a connection and an alliance? Direction about how to talk to patients about racism was available if I searched for it, but this information was not regularly integrated into my training.

I spent a fair amount of time thinking about how to address bias, racism, and social justice issues within this book, wanting to highlight their importance while also recognizing that I am not an authority on these issues. As an introduction to this topic, I will raise questions, provide some preliminary guidance, amplify the voices of experts, and then offer more extensive guidance within the Additional Readings and Resources list available at the end of the book.

For readers with less lived experience thinking about or discussing this issue, I encourage you to lean in even if this discussion causes some uneasiness. The path to clinical excellence requires therapists to learn about complex subjects, which may not be easy to talk about and might cause some discomfort. This is an opportunity to deepen your understanding of the human experience.

Being an Antiracist

As a therapist, my goal is to understand my patient's story and promote healing; it fits within this mandate that a therapist must strive to be an antiracist. As Ibram X. Kendi (2019) notes in his book *How to Be an Antiracist,*

> What's the problem with being 'not racist'? It is a claim that signifies neutrality: 'I am not a racist but neither am I aggressively against racism.' But there is no

[2]See footnote 1 on page 87.

> neutrality in the racism struggle. The opposite of 'racist' isn't 'not racist.' It is 'antiracist.' What's the difference? One endorses either the idea of a racial hierarchy as a racist or racial equality as an antiracist. One either believes problems are rooted in groups of people, as a racist, or locates the roots of problems in power and policies, as an antiracist. One either allows racial inequities to persevere, as a racist, or confronts racial inequities, as an antiracist. There is no in-between safe space of 'not racist.' (p. 9)

The Smithsonian Museum of African American History and Culture expands on these points: "Being antiracist results from a conscious decision to make frequent, consistent, equitable choices daily. These choices require ongoing self-awareness and self-reflection as we move through life. In the absence of making antiracist choices, we (un)consciously uphold aspects of white supremacy, white-dominant culture, and unequal institutions and society. Being racist or antiracist is not about who you are; it is about what you do" (National Museum of African American History and Culture/Smithsonian Institute, 2014).

It is an antiracist action to be able to talk to patients about racism and how it has affected them. Charles R. Ridley, author of *Overcoming Unintentional Racism in Counseling and Therapy* (2005), addresses how racism may affect the therapeutic interaction: "Therapist inaction—behaviors of omission—is an important element in the victimization of minority clients. Some mental health care professionals are so frightened of doing the wrong thing that they refuse to do or say anything when issues of race arise" (p. 39).

Defining Racism

Being familiar with a comprehensive definition of racism is a necessary first step for a therapist preparing to discuss this topic in the office. Dr. Camara Phyllis Jones, president of the American Public Health Association (APHA) from 2015 to 2016, defines racism as "a system of structuring opportunity and assigning value based on the social interpretation of how one looks (which is what we call 'race'), that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources" (Jones, 2018, p. 231). Interpersonal racism (conscious or unconscious discriminatory changes in behavior when interacting with individuals from a different racial background) and systemic racism (historical, social, cultural stereotypes and norms, as well as public policies and institutions, that advantage Whites and disadvantage People of Color) have had a profound impact on communities of color.

While some therapists may profess to be "color blind," I maintain that this approach is a disservice to patients. Being color blind effectively erases an appreciation for diversity and interferes with my capacity to recognize ongoing racial bias and discrimination. As Ridley (2005) notes, "Color-blind counselors attempt to relate to minority clients as though race is unimportant.

In so doing, they disregard the central importance of race to these clients' psychological experience. These counselors tend to overlook the influence of racism and discrimination on the attitudes, feelings, behaviors and personality development of minority clients" (p. 67).

While race and ethnicity constitute only a portion of a complex person's experience, they affect one's identity and day-to-day experience of the world, and to ignore them is to ignore critical parts of a patient's internal and external experience. A person of color may reflect on the impact of discrimination on a daily basis; one aspect of White privilege is not needing to consider one's race as a contributing factor to a strenuous day.

Racism as a Chronic Stressor

It is important that I, as a therapist, recognize that managing interpersonal and systemic racism is a chronic stress. The list that follows doesn't intend to be comprehensive but outlines just some of the many ways that racism and discrimination can negatively affect a person's daily experience. Interpersonal microaggressions exist in the form of subtle put-downs; cultural racism rewards one type of look as all-American, and structural racism is embedded in all levels of our society, within housing, education, and work opportunities, among others. Black and Brown Americans may worry about the basic safety of their family; they may need to give extra thought to how they look and behave when they enter a store or a restaurant; they may have to make an extra effort to keep their own emotions hidden when in the presence of police officers or other authority figures. While the murder of George Floyd triggered the international Black Lives Matter protests during the summer of 2020, he is only one of many Black Americans murdered while going about their daily activities: Trayvon Martin while walking home with a bag of Skittles, Tamir Rice while in a recreation center, Breonna Taylor while asleep in her own bed, and Ahmaud Arbery while out for a run—to name only a few.

Some more examples: U.S. Immigration and Customs Enforcement (ICE) has a history of raiding immigrant households and tearing apart law-abiding families by deporting undocumented individuals, some who have lived in America for decades. Families with undocumented members may live in fear of the government taking away their loved ones. The profound emotional loss of a parent through an abrupt deportation is highly traumatic and fundamentally undermines a child's sense of security and well-being, increasing a child's risk of anxiety, depression, and posttraumatic stress disorder (PTSD; American Academy of Child and Adolescent Psychiatry, 2018). The COVID-19 virus that led to a worldwide pandemic has been referred to as the "Chinese virus" or even "Kung flu" by some news outlets and politicians. The derogatory terms drummed up racism and targeted physical violence against Asian Americans and Pacific Islanders (AAPI) and their businesses, fueling xenophobic accusations that Asian American families did not belong in the United States.

Racism Negatively Affects Health and Well-Being

As a therapist, I need to recognize that the ongoing stress and anxiety of maneuvering in a world with systemic racism may contribute to deleterious health outcomes. Repeated experiences of racial discrimination have been associated with mental distress, including depression, anxiety, and hypervigilance, in wondering when and how the next experience will occur (Pieterse, Todd, Neville, & Carter, 2012). Black women who report more racial discrimination with accompanying anxiety also report more diagnosed chronic medical illness (Carter, Walker, Cutrona, Simons, & Beach, 2016). Multiracial individuals may experience the unique stress of racial discrimination from one's own family members, which may contribute to their documented increased rate of substance use disorders (Franco & Carter, 2019). Acculturative stress (the stress that is associated with cultural adaptation) has been associated with depression and suicidal ideation in immigrants as well as adolescents and young adults of color (Walker, Wingate, Obasi, & Joiner, 2008; Sirin, Ryce, Gupta, & Rogers-Sirin, 2013; Hovey & King, 1996; Cho & Haslam, 2010). Meanwhile, those facing psychological harm from ongoing discrimination may also confront more barriers when trying to access mental health services (financial limitations, insurance difficulties, lack of nearby locations, lack of linguistic support, etc.) (Pumariega et al., 2013). The continual strain is a form of ongoing trauma; there is discussion about adding oppression-based trauma to the DSM-5, which would recognize that these experiences have a profound impact on an individual's physical and mental health (McSilver Institute for Poverty Policy and Research, 2015).

Recognizing the emotional effect of systemic oppression deepens the therapist's understanding of the patient's experience. As noted in *Counseling the Culturally Diverse* (Sue, Sue, Neville, & Smith, 2019), "Many problems encountered by marginalized clients actually reside externally to them (such as bias, discrimination and prejudice). Such clients should not be faulted for encountering these obstacles, nor the emotions that they experience as a consequence" (pp. 99, 100). The patient experiencing ongoing discrimination should be understood as facing problems, which is distinct from having a problem; minimization or invalidation may be experienced as retraumatizing. As Dr. Christine Crawford reflects in her excellent talk "The Impact of Racism and Trauma on Black Mental Health" for the National Alliance on Mental Illness (NAMI): "[If] people who are in the mental healthcare field . . . are working towards improving the emotional wellness of other people, . . . there is harm if you aren't taking into consideration the impact of trauma from racism" (NAMI, 2020).

Talking about Race, Ethnicity, and Racism

Step 1 in encouraging open conversations about race and ethnicity is for the therapist to avoid making assumptions about the patient's background. A discussion of a patient's racial and ethnic identity may naturally follow

the questioning about cultural identity, outlined in the previous section. If it does not come up at this time, the therapist may ask the patient directly. The thoughtful article by Esteban Cardemil and Cynthia Battle, "Guess Who's Coming to Therapy?," provides some sample wording: "Often, I ask my clients about their racial and ethnic background because it helps me have a better understanding of who they are. Is that something you'd feel comfortable talking about?" (Cardemil & Battle, 2003–2006, p. 279).

In my patient survey (Therapist Tool 4.1), I have added similar questions to my trauma review of systems: "Have you been impacted by discrimination or racism?" "Has discrimination or racism increased your stress or anxiety or lowered your mood?" I also recognize that a patient may not feel comfortable sharing these experiences with me until trust is built between the two of us. Survey questions are not intrusive, and the patient can leave them blank if they don't want to share information on this topic, but the inclusion of these questions communicates that I consider discrimination and racism to be a real and ongoing stressor. When talking to my patient directly, I will craft my questions with the recognition that some patients may not want to discuss this subject: "Have you been impacted by discrimination or racism? In what ways has it impacted your mood and anxiety? I'm interested in hearing how this has affected you, if you would like to share this with me."[3]

The questioning can feel especially awkward if the patient and the therapist are of different races or ethnicities. Rather than ignoring the situation in an attempt to smooth over the awkwardness and create an artificial environment of "sameness," the therapist best serves the patient who is part of a marginalized community by demonstrating a willingness to talk openly about race. Ridley (2005) provides some sample wording on how to open up the topic within a therapy:

> Many . . . who come to counseling for the first time do not know exactly what to expect . . . the fact that you and I are of different races may make you even more uncomfortable or make you question whether I can really help you. If you have these feelings, let's try to get them out in the open. We can make better progress that way. (p. 110)

Cardemil and Battle (2003–2006) offer another sample opening to consider:

> I know that this can sometimes be a difficult topic to discuss, but I was wondering how you feel about working with someone who is from a different racial/ethnic background? I ask because although it is certainly my goal to be as helpful to you as I possibly can, I also know that there may be times when I cannot fully appreciate your experiences. I want you to know that I am always open to talking about these topics whenever they are relevant. (p. 281)

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[3]Thank you to Drs. Katia Canenguez, Aisha James, and Nhi-Ha Trinh for allowing me to amplify their thoughtful wording and expertise gleaned from our work on the Clinician Anti-Racism Toolkit.

A patient must feel secure in the therapeutic relationship to share their encounters with racism and discrimination. While racism will continue to impact the patient's world, acknowledging their lived experience may ease distress. These conversations should not focus on the intention of the perpetrator. During the discussion, the therapist may thank the patient for trusting them with their lived experience, while also validating both the difficulties the patient has endured and the painful emotional responses that follow. For therapists searching for the right words, one could start by saying, "I know it's hard to talk about these experiences, and I thank you for entrusting me with your experience. I'm so sorry this happened to you. You deserve to be treated with respect and dignity. Racism is never okay."[4] Further discussion may focus on both the immediate impact of a particular event on the patient, and how this experience fits within the construct of the patient's daily life as a member of the Black, Indigenous, and People of Color (BIPOC) community (Lingras, 2021).

After the topic is welcomed into the therapy, the therapist may revisit it intermittently; for instance, when learning about a patient's job, a therapist may ask directly if the patient has experienced racism or race-related issues at the workplace. By showing a capacity to explore race and its effect on a person's daily experience, the therapist recognizes this topic as relevant and important. Within this discussion, that therapist could add: "I will be listening carefully and asking questions to make sure I understand your experience, but if I do misunderstand something, please let me know. I welcome and value your input."

A version of this same query may be used to open up a discussion of discrimination when a therapist of color is treating a patient of color. While both the therapist and patient have faced discrimination and racism, it is important that the therapist avoid assuming details of the patient's experience; addressing the differences in background directly may allow for a more honest direct conversation: "While I am also a therapist of color [the therapist may choose to share their cultural background], I don't want to assume I know and understand the racism and discrimination you have faced. Could you share with me more what it has been like at work?" Curious, respectful, and interested questions acknowledge the individuality of each patient's experience (see Figure 5.2).

Finally, while the advice is to promote open conversations, every patient will be different in how much time and attention they will want to pay to this topic. If a patient is upset at a therapist broaching the topic of racial and ethnic issues, Cardemil and Battle (2003–2006) recommend this response:

> My intention was not to offend you when I brought up the topic of race and ethnicity. As we've discussed before, I want therapy to be a place where you can talk about anything that might be relevant to your life. In this case, I wondered

[4]See footnote 3 on page 97.

> whether anything related to our racial/ethnic differences might be affecting our therapy process. If this is not relevant, or if it's not something you wish to talk about here, I certainly respect that decision. (p. 283)

My aim as a therapist is to create an environment where my patients feel comfortable letting me know if I misunderstood them. It is inevitable that I will intermittently make empathic errors. As Laura S. Brown (2020) writes:

> As one grows in this domain, one grows in self-awareness of one's ignorance and how one might stretch intellectual, experiential, spiritual and emotional edges to better develop empathy. Deepening cultural competence leads the therapist, paradoxically, to make more errors of commission at first, in place of the errors of omission and avoidance that are more common. (pp. 186–187)

While this idea may feel unnerving to the novice therapist in particular, it is a therapeutic win if I have created a safe enough environment for a patient to tell me directly if my comment was upsetting or even offensive. (See Chapter 16 on empathic lapses for more details.) Given a second chance to understand what went wrong, my job is twofold. First, I need to listen carefully and to remain open without defensiveness. Then, I need to appreciate the patient's perspective and to take responsibility for any errors I may have made. As my understanding increases, I can facilitate a reconnection after a disconnection.

Learn about Your Unconscious Biases

While it isn't comfortable to admit, every individual (and that includes every therapist) comes to the table with unconscious biases. I recommend that my readers take the Implicit Association Test to provide a self-audit of your unconscious biases (Project Implicit, 2011). As my colleague Tanishia Choice, MD, comments, "We all have biases, but we can choose to learn about our unconscious biases and override our first impulses. Unrecognized biases have the potential to drive racist actions. To improve, we all must learn to tolerate these uncomfortable conversations on this topic" (personal communication, July 2020). Clinicians paying attention to these issues will provide better clinical care, as noted in *Counseling the Culturally Diverse* (Sue et al., 2019):

> Recognize that no one style of counseling or therapy will be appropriate for all populations and situations. A . . . therapist who is able to engage in a variety of helping styles and roles is most likely to be effective in working with a diverse population. . . . [R]espect, unconditional *positive regard*, warmth, and empathy are most effective in the *therapeutic alliance* when they are communicated in a culturally consistent manner. (pp. 184, 207, italics in original)

I hope you will be inspired to read some of the expert sources listed in the Additional Readings and Resources list to increase your personal understanding of a critical topic that is often underdiscussed.

1. Often, I ask my clients about their racial and ethnic background because it helps me have a better understanding of who they are. Is that something you'd feel comfortable talking about?*
2. Have you been impacted by discrimination or racism? In what ways has it impacted your mood and anxiety? I'm interested in hearing how this has affected you, if you would like to share this with me.‡
3. Many . . . who come to counseling for the first time do not know exactly what to expect . . . the fact that you and I are of different races may make you even more uncomfortable or make you question whether I can really help you. If you have these feelings, let's try to get them out in the open. We can make better progress that way.†
4. I know that this can sometimes be a difficult topic to discuss, but I was wondering how you feel about working with someone who is from a different racial/ethnic background? I ask because although it is certainly my goal to be as helpful to you as I possibly can, I also know that there may be times when I cannot fully appreciate your experiences. I want you to know that I am always open to talking about these topics whenever they are relevant.*
5. Has racism been part of your experience at work?
6. I know it's hard to talk about these experiences, and I thank you for entrusting me with your experience. You deserve to be treated with respect and dignity. Racism is never okay.‡
7. I will be listening carefully and asking questions to make sure I understand your experience, but if I do misunderstand something, please let me know. I welcome and value your input.
8. While I am also a therapist of color (the therapist may choose to share their cultural background), I don't want to assume I know and understand the racism and discrimination you have faced. Could you share with me more what it has been like for you?
9. My intention was not to offend you when I brought up the topic of race and ethnicity. As we've discussed before, I want therapy to be a place where you can talk about anything that might be relevant to your life. In this case, I wondered whether anything related to our racial/ethnic differences might be affecting our therapy process. If this is not relevant, or if it's not something you wish to talk about here, I certainly respect that decision.*

*Cardemil and Battle (2003–2006).

†Ridley (2005).

‡Created with the help and expertise of Drs. Katia Canenguez, Aisha James, and Nhi-Ha Trinh.

FIGURE 5.2. Sample questions: Talking to your patient about race and discrimination. As noted in the text, many of these questions were gleaned from expert sources.

FILLING IN THE GAPS: COMPLETING A REVIEW OF SYMPTOMS

Before the consultation concludes, I need to make sure that I have a comprehensive understanding of Sallie's difficulties. In medicine, internists run through a list of questions related to the main physiological systems in the body (such as cardiovascular and gastrointestinal) to see if their patients have any symptoms that they did not mention spontaneously. This is known as a *medical review of systems*. In psychotherapy, a clinician needs to complete a similar review to uncover pertinent psychological symptoms.

Screening for Substance Use Disorders

When considering a patient for psychotherapy, it is critical to evaluate their alcohol and substance use during the consultation process, especially as most patients with a substance use disorder rarely disclose their addictive behavior spontaneously during the first few interviews. If my new patient has a substance use disorder, my treatment approach needs to be modified, as outlined in Chapter 13, or the therapy has the potential to be destructive.

Psychodynamic therapy has the potential to exacerbate a patient's addiction. The normal process of insight-oriented dynamic work, uncovering and discussing emotionally laden topics, may trigger increased substance use if the affect experienced during treatment becomes overwhelming. With this knowledge, some therapists won't even treat patients with substance use disorders with insight-oriented psychotherapy until the patients have a number of months of sobriety under their belt.

For these reasons, I start my psychological review of systems with some questions about substance use. Over the last 10 years, new screening tools have replaced the CAGE questionnaire (Bradley, Bush, McDonell, Malone, & Fihn, 1998),[5] which I recommended in the first edition. My current recommended approach utilizes the Alcohol Use Disorders Identification Test-Concise (AUDIT-C; U.S. Department of Veterans Affairs, 2014; World Health Organization, 2001) combined with two questions derived from the National Institute on Drug Abuse (NIDA) Drug Screening Tool, Quick Screen (NIDA, 2012; NIDA Drug Screening Tool, 2005). The AUDIT-C investigates adult alcohol use and dependence with just three questions; it is a very sensitive brief screening tool for risky drinking. The two additional questions from NIDA scan for current drug use. All reported drug use should be followed by more detailed questioning to assess the need for

[5]**C:** Have you ever in your life tried to CUT down on your alcohol (or drug use)? **A:** Have people ever ANNOYED you by criticizing your drinking (or drug use)? **G:** Have you ever felt bad or GUILTY about your drinking (or drug use)? What have you done under the influence? **E:** Have you ever had a drink (or drug) first thing in the morning to steady your nerves or to get rid of a hangover? (EYE-OPENER) Concern for a substance use disorder increases with two positive answers.

further clinical attention. (See Therapist Tools 5.1 and 13.1 for questionnaires you can use with your patients.)

The interview in Example 5.3 includes questions (highlighted in **bold**) derived from the AUDIT-C and NIDA Screening Tool (see Therapist Tool 5.1). I fold the validated screening tool questions into a lengthier assessment of Sallie's substance use history. How I ask these sensitive questions will affect the truthfulness of her responses.

EXAMPLE 5.3

Multiple strategies used to assess substance use during the consultation

THERAPIST: Now, in order to plan the best treatment approach, I need to know a bit more about your medical history, including your experience with alcohol, cigarettes, and drugs. Currently, when you drink socially, what is your drink of choice?

SALLIE: I actually like cider the best. Mainly on weekends.

THERAPIST: **How often do you have a cider or another drink containing alcohol?**

SALLIE: I don't know. . . . I'm in college—you know, people do drink during college. . . .

THERAPIST: Students often drink during college, but the frequency can really vary. **Do you drink four or more times a week? Two to three times per week?**

SALLIE: Nah, less than that. Maybe one weekend day, usually on Saturday with friends. But I used to drink a lot more. During high school, around the time I was using the laxatives, I liked to go to parties. I mostly drank beer during high school—during party games especially. Everybody was doing it, senior spring, you know. By the end of senior year, I could drink as much as my guy friends without a problem!

THERAPIST: Could you hold down more than a six-pack of beer?

SALLIE: Nah, but almost.

THERAPIST: **Over the past year, on a typical drinking day, how many drinks do you have? Five or six? Three or four?**

SALLIE: Now I'm a total lightweight. I feel dizzy after just one or two ciders. I usually stop at one—sometimes I have two. (*Chuckles.*)

THERAPIST: **How often have you had six drinks or more?**

SALLIE: I can't even remember the last time when I drank that much. I've really cut down now that I think about it.

THERAPIST: **In the past year, how often have you used tobacco products?** Smoking and vaping are the most common ways people use tobacco.

SALLIE: Actually, I don't smoke or vape at all. I avoid tobacco. I think it is kind of gross.

THERAPIST: **How often have you used any illegal or recreational drugs?**

SALLIE: I don't use anything often—maybe just weed now and then. You know, weed is everywhere nowadays.

THERAPIST: **How many times have you used in the past year? Daily? Weekly?**

SALLIE: Nah, I never seek it out or buy it, but maybe I'll use it at a party.

THERAPIST: How do you use it? These days, there are many ways to use weed. [*mirroring Sallie's word choice*]

SALLIE: I'll take a nibble of an edible if it's offered, but I always take just a little bit.

THERAPIST: **How often do you ingest an edible?**

SALLIE: Oh, not often. Maybe every few months or so. I think the last time was 2 months ago.

THERAPIST: Thanks for reviewing this information with me. Next, I have a fairly long list of drugs that I want to review with you. Please bear with me as I go through the list with you; I know you said you have only experimented with marijuana, but sometimes it is easy to forget a drug previously tried. All of these drugs can affect mood, so it is useful information to review. Have you ever used cocaine, heroin, or any type of opioid?

SALLIE: No, I never tried those.

THERAPIST: Anything called an "upper," such as methamphetamine or speed?

SALLIE: Too scary. No way.

THERAPIST: Or a "downer," which could also be known as a sedative or sleeping pill?

SALLIE: Not that I can think of.

THERAPIST: **Have you ever used any prescription medication prescribed for you or someone else for a nonmedical reason?**

SALLIE: Well, once last week, I guess I did. I didn't buy it from a drug dealer, though—or anything sketchy like that. My roommate takes Klonopin for panic attacks, and she gave me one last week when I was so upset and anxious, but I didn't like the way it made me feel. I made me too tired, and I couldn't think straight all day.

THERAPIST: Some college students try stimulants when they feel overwhelmed with academic work. While these medications may be prescribed, usually by psychiatrists, for individuals with diagnosed

attention disorders, some students buy them off the street. Have you ever done this?

SALLIE: Nah. I had a friend that tried Adderall once when she needed to finish a paper in one night. She bought one pill from this guy—and she finished the paper, but she was really different on the drug. She talked really fast—maybe she took too much, but it was uncomfortable to be around her. I was kind of freaked out. Thankfully, doing schoolwork hasn't been too big of an issue for me, so I never considered taking a drug to help me out.

THERAPIST: You have paid careful attention to how these drugs affected you and your friends. Just a few more to ask you about. Have you ever tried hallucinogens like LSD or mushrooms, or newer drugs that are sometimes offered at parties or dance clubs such as Ecstasy or Molly, or any other drug I haven't mentioned?

SALLIE: Once I was offered some scary party drug when I was at a club, but I said "no." I don't even remember which one it was. . . . I'm pretty conservative actually, compared to some people I know. I'm really not into this stuff.

THERAPIST: I appreciate you bearing with me as I run through all these questions. They are important because a lot of people your age may experiment with substances or use them to distract from emotional pain when they are having a tough time. Has that been part of your experience after this tough breakup?

SALLIE: No, I'm more of an ice cream-oholic. Give me a pint of cookies and cream anytime. If I'm really upset, I'll eat three or four scoops.

Taking an accurate substance use history requires some clinical finesse because a patient is likely to report minimal use no matter what their actual intake. For this reason, we recommend asking about alcohol and drug use in several ways, while inserting the screening questions (noted in the examples in bold) into the discussion, as illustrated in Example 5.2.

First, I assume that my patient does drink socially, as most adults do, and I ask about her "drink of choice." Patients who drink heavily may minimize their use, but they are unlikely to deny all intake. With this question, I also identify the true teetotalers who avoid any alcohol intake no matter what the occasion. While patients who abstain from alcohol completely are unlikely to have a current substance use issue, further questioning may reveal either a past personal or family history of addiction.

Second, after asking about the drink of choice, I learn about my patient's alcohol tolerance. A higher guesstimate of alcohol use is strategic. I ask, "**Do you drink four or more times a week? Two to three times per week?**" in hopes of creating an accepting environment, so Sallie will feel

comfortable reporting her use honestly. AUDIT-C's second and third questions use a similar approach: "**Over the past year, on a typical drinking day, how many drinks do you have? How often did you have six or more drinks on one occasion in the past year?**"

While Sallie's current alcohol intake is not concerning, her drinking in high school did sound worrisome. Any woman of average height and weight who can manage more than two or three beers at a sitting has a higher than normal tolerance, which often reflects a sign of more frequent alcohol intake. In fact, the National Institute on Alcohol Abuse and Alcoholism defines heavy alcohol use as five or more drinks per occasion for men and four or more drinks per occasion for women on 5 or more days in the past month (National Institute on Alcohol Abuse and Alcoholism, 2020, October).

I use my questions about alcohol to transition to a substance use history. Even though Sallie only reports intermittent use of marijuana, sometimes a patient might forget about other past drug experimentation unless asked directly. Options include an overarching question asking about all other drug use, or screening for each drug type, as illustrated in Example 5.3.

In Example 5.3, I use the NIDA approach to ask about tobacco and drug use. These questions share a similar strategic approach to the AUDIT-C as the interviewer does not ask "if" the patient has used any substances, but "how often," an approach that may lead to more honest reporting. When Sallie denies any drug use other than marijuana, I modify the NIDA wording as I scan for any past experimental drug use. When obtaining a substance use history, I try to delineate details of the use: how long the patient has been using the drug, how much, and how often. For certain drugs such as cocaine and opioids, the method of use (snorted, smoked, or injected) is also relevant. (For more discussion on starting treatment with a patient struggling with alcohol or a substance use disorder, see Chapter 13.)

Finally, at the end of our discussion, I attempt to unmask surreptitious addiction as I wonder about substance use as a coping mechanism for emotional pain. For Sallie, I ask specifically if she has used substances to manage her emotional distress after the breakup. Avoiding judgment and understanding that substance use may be my patient's last-ditch effort to cope with a difficult situation might facilitate a more honest intake report.

For simplicity's sake, we've spared Sallie a current substance use issue. Her therapy won't require a modified approach for patients struggling with an addiction. To illustrate the use of the AUDIT-C with the two NIDA screening questions in a patient with concerning substance use, Example 5.4 will introduce a new fictional patient, Jon Sellers, a 35-year-old owner of a local restaurant. I'll place Jon in a state that has legalized recreational marijuana use.

EXAMPLE 5.4

Assessing substance use using the AUDIT-C and NIDA Screening Tool

Midway through the third session of the consultation with Jon, I start to ask my questions about substance use. (Once again, questions derived from the screening tools are in ***bold****.)*

THERAPIST: **I'm going to ask you a little bit more about your alcohol use during the last year as alcohol use can affect many areas of health. First, how often do you drink alcohol?**

JON: I only drink on weekends—so most Friday and Saturday nights with my work buddies. I don't ever drink during the work week. [*Two to three times per week = 3 points on the AUDIT-C*]

THERAPIST: **What is your drink of choice?**

JON: Oh, I'm a beer drinker. Not picky about brand, though.

THERAPIST: **How many beers do you have on a typical weekend day?**

JON: I don't know. When the guys and I are partying, we have fun. I might have six beers. It hasn't been a problem. My family has a high tolerance for alcohol, and I'm a big guy. At the restaurant, we work hard and we party hard. It is just part of the culture. [*Five to six drinks per event = 2 points on the AUDIT-C*]

THERAPIST: **How often did you have six or more drinks on one occasion in the past year?**

JON: Well, like I said, I have about six drinks when I go out, so probably at least once every weekend, but my buddies are doing the same thing. [*Six drinks per event weekly = 3 points on the AUDIT-C*]

THERAPIST: Sometimes, when friends are partying [*using Jon's words*], they may use drugs as well. Do you use marijuana?

JON: Well, when we drink, we often smoke weed together. Yeah, we usually use both.

THERAPIST: How do you use marijuana? Do you vape, smoke, use edibles, or another method?

JON: We go the old-fashioned route. Just a joint.

THERAPIST: **About how often are you smoking weed would you say? Daily? Weekly?** [*again mirroring Jon's words*]

JON: Probably about once a week. No more than that.

THERAPIST: **How about tobacco products? How often have you used during this past year?**

JON: Actually, very rarely. I can't remember the last time I smoked a cigarette, to be honest.

THERAPIST: I appreciate you running down this list with me as it has many sections. **In the past year, how often have you used any illegal drugs?** [*In this example, I don't ask about every category of drug, but instead just ask this overarching question.*]

JON: One buddy of mine likes to snort coke as well, but I've only done that a few times.

THERAPIST: **A few times may have different meanings for different people. Do you use weekly? Monthly?**

JON: I guess I snort about once a month. Maybe a little bit more—every other week or so, but it isn't my drug of choice.

THERAPIST: **How often have you used any other drugs or prescription drugs for nonmedical reasons?**

JON: I don't use any other drugs. My drugs of choice are booze, weed, and coke, now and then, but you understand that I'm generally sober during the week and doing really well at work. I don't think my partying is a problem for me in any way.

Per AUDIT-C scoring, men with more than 4 points (and women with more than 3 points) require a more thorough evaluation of their alcohol use. The higher the score, the higher the likelihood that alcohol is causing physical and emotional difficulties for a patient, whether or not the patient has identified drinking as a potential problem. Jon's relatively high score of 8 is notable, and his alcohol use should be considered when formulating a treatment plan for him. His ongoing use of marijuana and cocaine also deserves further inquiry.

Jon may not have offered this information spontaneously if I hadn't asked about it directly. As heavy drinking and drug use are part of his work culture, he would not have identified them as a potential issue during his therapy consultation. With the help of the screening tools, a new perspective on his difficulties emerges. He is much more likely to improve with therapy if his alcohol and substance use is addressed as part of his treatment. In Chapter 13, we review a more detailed assessment of a patient struggling with substance use, and how to start treatment even if the patient currently denies that their alcohol and substance intake is a problem.

Screening for Anxiety, Obsessive–Compulsive Disorder, and Trauma

Returning to my consultation with Sallie, I still need to screen for panic symptoms, obsessive–compulsive disorder (OCD), and a history of trauma before deciding on a treatment recommendation. This screening is not meant to be completely comprehensive as I don't ask specifically about all anxiety disorders (such as social anxiety disorder) or other disorders

related to OCD (such as hoarding disorder or trichotillomania). It is a good first pass as I complete a basic psychiatric review of systems.

EXAMPLE 5.5

Screening for anxiety disorders during the consultation

THERAPIST: I have a few more questions to go. Have you ever had a panic attack? [*screening for panic attacks and panic disorder*]

SALLIE: I think so. You mean, those times when a person feels really panicky?

THERAPIST: During a panic attack, a person may definitely feel panicky but may also feel some physical symptoms, such as shortness of breath, nausea, chest pain, or dizziness. Have you felt any symptoms like these?

SALLIE: Yes, I did have a panic attack like that about a month ago before an economics test. It was horrible.

THERAPIST: Panic attacks can feel horrible. Can you tell me what yours was like?

SALLIE: Well, the professor was passing out the test, and all of a sudden, I felt light-headed and couldn't really breathe. I had no idea what was going on. Then, my hands started to tingle, and I was convinced I was going to pass out until I settled down because I realized I actually knew the answers. I felt like I was working through a fog. Honestly though, it was one of the scariest things I have ever experienced. Is this what you are asking about?

THERAPIST: Yes, it is. Panic attacks, by definition, are very scary. Sometimes, during an attack, a person may not know it is a panic attack and might worry that they are dying or going crazy. Did that happen to you?

SALLIE: Umm, yeah. I wasn't going to mention that part because it's sort of embarrassing. I thought maybe I had some kind of mini-heart attack, so I went to the student health center after the exam, but they said I was completely fine.

THERAPIST: I think it was a smart move to visit the health center if you were worried. Especially for new panic attacks, it is a good idea to have an internist weigh in, to make sure there isn't a medical condition causing the symptoms.

[*screening for agoraphobia*] Sometimes, the panic attack can be so bad that a person might avoid the places that provide a reminder of the attack to try to prevent another one. Have you avoided the area where you took the economics test?

SALLIE: No, thank goodness, because most of my tests are in that building!

THERAPIST: [*screening for anxiety symptoms, obsessive–compulsive and related disorders, and trauma disorders*] Have you struggled with anxiety in any other form?

SALLIE: Well, I get anxious now and then, but mainly I've been feeling more hopeless and bummed.

THERAPIST: The breakup has definitely caused some depressive symptoms that sound truly distressing. I want to screen for a few more anxiety symptoms just in case they are relevant to your experience. Do you ever notice that you have a thought in your head that really bothers you, so you perform an activity to try to make it go away?

SALLIE: What do you mean?

THERAPIST: Well, some people check things over and over again in their home in order to make sure everything is secure, such as checking to make sure that the door is locked at night or that the stove is turned off. Sometimes these behaviors increase in response to a worry or fear.

SALLIE: Oh, I check my front door to make sure it is locked before I go to bed at night.

THERAPIST: How many times do you check it?

SALLIE: Just once.

THERAPIST: Have you ever checked something so many times that you are late to an appointment, or has your checking interfered with your daily routine because you are busy making absolutely sure that the object is secure?

SALLIE: Umm, no. I don't think so.

THERAPIST: Have you ever felt compelled to wash or clean anything, including yourself, multiple times to make sure that it is clean?

SALLIE: Well, I am a neat person. I like to make sure that my room is clean.

THERAPIST: What I am asking about is a symptom that is beyond basic cleanliness. With this condition, an individual might feel convinced that something is dirty and needs recleaning even after it has just been washed. This might include washing your hands or your hair.

SALLIE: Nope, I am not that obsessive.

THERAPIST: [*screening for posttraumatic stress disorder*] Thank you for this information. It may feel random to have me ask all these unrelated questions, but it helps me screen for any ongoing distress that you are experiencing, but maybe forgot to mention. Have you ever had a traumatic experience that then led to distressing memories or nightmares?

SALLIE: Not really. When I was really stressed in high school, I had a bunch of nightmares around the time I saw Dr. Mehta. I kept dreaming I was

locked up in a burning house and couldn't get out, but my house has never been on fire; it was just a really bad dream. I haven't had one of those dreams for a while, though.

I don't think I've ever had a real trauma. What would the nightmares be like if I did?

THERAPIST: Sometimes with a significant trauma, a person may have nightmares reminding them of the event or has flashbacks during the day even if it happened a long time ago.

SALLIE: What do you mean . . . flashbacks? Like in the movies when a character remembers the past?

THERAPIST: Yes, that is a good example. When flashbacks happen in real life, the person having them might also reexperience the feelings they had during the original episode.

SALLIE: No, I've never had that.

THERAPIST: Have you ever avoided any place because it reminds you of painful memories?

SALLIE: I don't think so.

Example 5.3 screens briefly for common psychiatric disorders: panic disorder, agoraphobia, OCD, and PTSD, respectively, based on the symptom criteria presented in the latest version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), the diagnostic manual for psychiatric disorders. Of note, I am not screening for eating disorders because I already discussed restrictive eating as well as bingeing and purging during my discussion with Sallie in Chapter 4, Example 4.2.

Many times, a patient may be bothered by a few of the symptoms reviewed in Example 5.3 without an impairment in daily functioning. In such a case, psychodynamic psychotherapy alone may be sufficient treatment. For more severe symptoms, such as recurrent panic attacks, obsessions, or compulsions that interfere with daily activities for hours at a time, or frightening symptoms consistent with active PTSD (nightmares, flashbacks, or avoidance), a patient deserves psychopharmacological and cognitive-behavioral therapy consultations.

While some clinicians include questions about past physical, emotional, or sexual trauma in the psychological review of systems, others believe that this information is so emotionally charged that the patient should be the first to bring up the topic. One moderate approach would be to ask, "Would you feel comfortable telling me about the trauma that caused these symptoms?" for patients reporting a number of PTSD symptoms without a specified cause. Another effective and relatively nonintrusive approach would be to ask about trauma and categories of abuse in a questionnaire, as illustrated in our sample patient consultation questionnaire (Therapist Tool

4.1) at the end of Chapter 4. If the patient is ready and willing to share the details of the trauma, they can document their history in writing. If they are not interested in sharing the information with a relative stranger, it is easier to skip over a written question than an oral one.

Screening for Learning Disorders

Learning difficulties add persistent stress to everyday life and may increase an individual's risk for an anxiety or mood disorder. For simplicity's sake, we've spared Sallie, but if a patient has a history of struggling academically, a clinician may scan for signs and symptoms of a learning disorder (affecting a patient's ability to read, write, manage visual spatial tasks, or complete mathematical calculations) during the review of systems. In addition, if a patient describes a persistent history of distractibility, poor grades, and disorganization, they deserve a more thorough neurocognitive evaluation to assess whether they have ADHD.

When learning disorders or ADHD go unrecognized, they may continue to wreak emotional havoc into adulthood. With the right medication and/or learning support, a patient's performance at school and/or at work may improve tremendously. Relationships may also benefit as the patient's focus and self-esteem improve.

Screening for Psychosis or Bipolar Illness

At this point, I am nearly finished with Sallie's review of systems because her psychiatric history is not very extensive. My screening continues if I am considering psychopharmacologic treatment, or if a patient seems particularly depressed, withdrawn, hard to talk to, or unusual in a way that is hard to pinpoint. To illustrate how to screen for bipolar illness, and if necessary, psychosis as well, we'll introduce our third fictional patient, Candice Jones. Candice is a depressed, single 45-year-old paralegal who presents with a 2-month history of neurovegetative symptoms so debilitating that she has missed many days of work by the time of our consultation. Before this depression, she had a long history of unstable relationships and some self-injurious behavior during her 20s and 30s. When she is under stress, she has difficulty distinguishing between fantasy and reality. In Example 5.6, I screen for psychosis and mania in Candice's consultation interview.

EXAMPLE 5.6

Screening for psychosis and mania during the consultation interview

I learn about Candice's current depression during the first session. She talks extensively and coherently about all her stressors at work. She is not currently suicidal. At the beginning of the second session, she seems

much worse. She is easily agitated and has poor eye contact. We start the dialogue below after the first 10 minutes of the session.

CANDICE: (*slumping in chair with eyes focused past me and on a painting on the wall behind me*) I don't know what else to say, Dr. Bender. . . . (*Eyes dart around the room.*)

THERAPIST: I hear from what you have been telling me that this last month has felt unbearable to you. Sometimes when a person has such a severe depression, as you have, their mind plays tricks on them, but it is too scary to tell anyone because it is so unusual. I don't know if this has happened to you.

CANDICE: (*suspiciously*) What do you mean . . . exactly?

THERAPIST: Well, during a severe depression some people hear voices that only they can hear. Others see things that only they can see. . . .

CANDICE: I do hear voices sometimes. I don't see anything unusual. (*Voice trails off.*)

THERAPIST: What kind of voices do you hear? (*curious, calm tone*)

CANDICE: Well, I hear two actually. These two men yelling at me . . . telling me that I am nothing, that I am useless. . . . (*Starts to cry.*)

THERAPIST: It sounds very scary.

CANDICE: It is. (*Crying increases in intensity.*)

THERAPIST: (*I wait quietly. After a minute or so*) Do you want to take a break, or may I ask more questions?

CANDICE: (*Wipes her eyes and nose with tissues and takes a few deep breaths.*) It's okay. What else do you want to know?

THERAPIST: During this very difficult time, have you ever felt that you are receiving any special messages from the TV, radio, or anything else?

CANDICE: No, I don't think so. Well, maybe once. . . . I felt like the newscaster on the 7 o'clock news was mocking me. Is that what you mean?

THERAPIST: Yes, it is. Can you tell me more about your experience?

CANDICE: Well, it was last week. I was watching the news, and worried that I might get fired if I don't feel better soon, and then I could see the anchorman looking right at me. When he said, "We'll be right back. . . . ," I knew he was referring to my voices . . . and then, just as he had predicted, they started screaming at me. (*Looks at me worriedly.*)

THERAPIST: What a day that must have been. I imagine it was very frightening.

CANDICE: It was one of the worst days of my life.

THERAPIST: Sometimes, with these unusual experiences, a person may also feel an unusual sense or a special power. Has this happened to you?

CANDICE: Like ESP? Sometimes I feel I might have a little bit of that.

THERAPIST: Can you tell me more?

CANDICE: Sometimes I think I can tell what people are thinking about me.

THERAPIST: What are they thinking?

CANDICE: Well, they are wondering what's changed about me. I have a very good reputation at the law firm, Dr. Bender. You see, I've worked there for almost 10 years. They must notice that I'm different. I'm obviously out of it; I don't shower or wash my hair very often. I know I don't look good.

THERAPIST: It took courage to seek treatment, and this consultation is the first step toward developing a treatment plan to help you. I have a few other questions to help me understand what you are going through. Do you ever feel as if your coworkers are watching you or following you?

CANDICE: I do think I must be the current subject of most of the office gossip. I just know it.

THERAPIST: What do you think they are saying?

CANDICE: I don't really know, but people seem to be staying away from me at work, or they treat me so gingerly. They must know something is up, and something is different.

THERAPIST: If they know you well, they may have a sense that you aren't feeling like yourself. I do have one more question about the special power. Do you ever feel that you can control people's thoughts or that others can exert power over your thoughts?

CANDICE: Not my coworkers, of course, but these two men I hear yelling at me are torturing me. They want me to lose it.

THERAPIST: Does anyone else know about them?

CANDICE: No, of course I haven't told anyone about this. I don't want people to think I am crazy. I know this sounds strange, Dr. Bender, but this is truly happening to me. . . .

THERAPIST: How does it feel to tell me these things?

CANDICE: I'm not sure . . . strange. Maybe . . . maybe a little bit better, although I'm scared of what you think. I hope you can help me.

THERAPIST: I realize this information is difficult to talk about, but your honesty will definitely help me design the best treatment plan for you. I understand a bit more why it has been so hard to go to work.

In order to recommend the best treatment plan, I also need to know if you have ever experienced what we, as therapists, call "hypomania"

or "mania." In some ways, mania is the opposite of depression. It is an unusual state that can last 4 days or more during which a person needs very little sleep or doesn't need to sleep, but still has energy. The mood during the episode can range from very positive, associated with lots of productivity, to more irritable and agitated.

CANDICE: Well, I felt really happy last year for a few days. I felt wonderful, on top of the world.

THERAPIST: What was happening at that time?

CANDICE: Last May, I met a man named Eric, and in the first weeks of our romance, I felt incredible.

THERAPIST: What was your sleep pattern at that time?

CANDICE: Oh, fine.

THERAPIST: How many hours were you sleeping a night?

CANDICE: Maybe 6 or 7.

THERAPIST: Has there ever been a time in your life when you felt this good, and you had so much energy that, for consecutive days, you only required minimal sleep—maybe just 3 hours a night—all without the help of drugs or medications?

CANDICE: Oh, no. I've never had that happen to me. I don't do well with sleep deprivation.

When Candice's affect becomes more withdrawn at the beginning of Session 2, I screen for common psychotic symptoms, including, in this order, auditory and visual hallucinations, ideas of reference (receiving special messages), paranoia, thought insertion and thought broadcasting (the patient experiences that their thoughts are being controlled, or that they can broadcast their thoughts to others, respectively). If Candice's decompensation had emerged during our first session, I wouldn't hesitate to screen for psychosis even earlier in the consultation process.

During this interview, it becomes clear that Candice has auditory hallucinations with hostile content. Her delusion that the TV anchorman was addressing her personally is an example of an idea of reference, a psychotic perspective in which the patient believes general experiences contain unique personal significance. At first blush, her clinical presentation, including the affectively laden psychotic symptoms, is most consistent with a mood disorder, such as depression with mood-congruent psychotic features. Whatever the final diagnosis, Candice's distress is severe, and she deserves a psychopharmacological consultation as soon as possible.

Candice does not have true paranoia. Her perception of her coworkers is not unreasonable considering the circumstances. Her "special powers" may be intuition about her professional colleagues' reactions to her illness.

Any patient with a severe depression, with or without concurrent psychosis, should be asked about past episodes of hypomania or mania. As a psychopharmacologist, I also complete this screening any time I am starting a patient on an antidepressant for the first time. Since antidepressants alone can flip a bipolar patient from depression to a manic state, they are not recommended in patients with histories of mania unless a mood stabilizer is prescribed concurrently.

Candice misinterprets my question about mania when she identifies a very happy time in her life as a manic episode. This is a common misunderstanding for patients first learning about manic symptoms. If Candice had experienced a true manic or hypomanic episode, the specific symptoms could be delineated, according to DSM criteria, by using the mnemonic DIGFAST (devised by William Falk, MD; personal communication, 1984): *D*, *d*istractability; *I*, *i*njudicious behavior and/or *i*mpulsivity; *G*, *g*randiosity; *F*, *f*light of ideas; *A*, increased *a*ctivity; *S*, *s*leep loss; and *T*, increased *t*alkativeness. Further information on the identification and treatment of bipolar illness is available in the Additional Readings and Resources section at the end of the book.

As a beginner, I was worried that my new patients would be offended if I included questions about psychosis in my review of systems. I do skip the review of systems for psychosis if a patient is high-functioning and without any current risk factors, but, if I have *any* concern that a patient might have some psychotic symptoms lurking behind their chief complaint, I bite the bullet and ask away. Interestingly enough, the majority of patients, whether or not they are currently psychotic, are relieved that I can talk openly about such frightening symptoms.

As I mentioned at the beginning of this chapter, gathering the developmental history and completing a review of systems have never been my favorite part of this work. However, they convey information I need to obtain to make educated treatment recommendations, as I do for Sallie in Chapter 6.

Review of mnemonic for mania: DIGFAST—distractibility, injudicious behavior and/or impulsivity, grandiosity, flight of ideas, increased activity, sleep loss, increased talkativeness.

THERAPIST TOOL 5.1

AUDIT-C (Questions 1–3) with NIDA Drug Screening Tool (Questions 4–6)

With three questions, AUDIT-C screens for patients who have risky unhealthy drinking. A score of 0 is for patients who have not had an alcoholic drink in the last year. Men with more than 4 points and women with more than 3 points are flagged for further evaluation and counseling regarding their alcohol use. The higher the score, the more likely that alcohol is causing physical and emotional difficulties for the patient (Babor, de la Fuente, Saunders, & Grant, 1989; World Health Organization, 2001).

The U.S. Department of Veterans Affairs (2014) recommends the introduction below before administering the screening. "Now I am going to ask you some questions about your use of alcohol during the past year. Alcohol use can affect many areas of health and may interfere with certain medications, so it is important for us to know how much you usually drink."

Question 1: How often did you have a drink containing alcohol?

- ☐ Never (0 points)
- ☐ Monthly or less (1 point)
- ☐ Two to four times a month (2 points)
- ☐ Two to three times per week (3 points)
- ☐ Four or more times a week (4 points)

Question 2: How many standard drinks containing alcohol do you have on a typical day?

- ☐ 0 drinks (0 points)
- ☐ 1 or 2 (0 points)
- ☐ 3 or 4 (1 point)
- ☐ 5 or 6 (2 points)
- ☐ 7 to 9 (3 points)
- ☐ 10 or more (4 points)

Question 3: How often do you have six or more drinks on one occasion?

- ☐ Never (0 points)
- ☐ Less than monthly (1 point)
- ☐ Monthly (2 points)
- ☐ Weekly (3 points)
- ☐ Daily or almost daily (4 points)

(continued)

Source. Questions 1–3 from U.S. Department of Veterans Affairs.

Questions derived from the NIDA Drug Screening Tool (National Institute on Drug Abuse, 2012; NIDA Drug Screening Tool, 2005)

Question 4: In the past year, how often have you used tobacco products?

- ☐ Never
- ☐ Once or twice
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or almost daily

Question 5: In the past year, how often have you used a prescription drug for a nonmedical purpose?

- ☐ Never
- ☐ Once or twice
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or almost daily

Question 6: In the past year, how often have you used illegal or recreational drugs?

- ☐ Never
- ☐ Once or twice
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or almost daily

CHAPTER 6

Creating a Formulation and a Treatment Plan

After collecting an adequate history, the patient and I work together to identify the elements and circumstances, from psychodynamic conflicts and educational struggles to medical illness and family difficulties, that are contributing to their current distress. The developing construct that explores the evolution of a patient's symptoms is often referred to as a "formulation." The formulation will guide the patient and me as we design a treatment plan together.

CREATING A FORMULATION

Before recommending the appropriate treatment for any new patient, I create a preliminary formulation; early on in treatment, the formulation is a first stab at identifying the relevant forces—biological, psychological, and social—that are contributing to the patient's suffering.

A formulation evolves over the course of a treatment; at the beginning of a therapy, the hypotheses are more embryonic. The clinical constructs developed in the earliest stages of therapy are never as accurate as those developed over time. As a novice therapist, I felt pressure to rush my formulations, as if I were in a race. With experience, I realize it is much more of a slow cooker process, and for the best and most accurate results, it cannot be rushed.

The best formulations maintain an equilibrium between the approaches of deduction and induction. With deduction, I guide the interview and ask targeted questions about specific symptoms; I am assessing if my patient's

clinical presentation meets criteria for a particular disorder. I am using deductive reasoning when evaluating a patient for a DSM or medical diagnosis.

In contrast, when switching to an inductive process, I spend time collecting information without a predefined agenda. Instead, I work to develop a narrative that will explain a patient's unique struggles. The psychodynamic process employs more inductive reasoning with the therapist and patient focusing on specific details of the patient's story. Early on, this section of the formulation may include more questions than answers. The patient and I will identify important topics to explore further—such as Sallie's confusion after the breakup with Charlie.

The risk of diagnostic error decreases if I rely on both deduction and induction in the treatment of a patient, as illustrated in this case presentation of a 60-year-old male patient, "Mr. Toth." Mr. Toth comes to my office for evaluation of increased irritability and anxiety over the last 6 months. When reviewing his medical history, Mr. Toth shares that he has been taking levothyroxine for thyroid hormone replacement therapy since he was diagnosed with hypothyroidism during his 40s.

Filling out some checklists during the deductive portion of my consultation, I evaluate whether Mr. Toth meets criteria for a DSM disorder. I learn that Mr. Toth hasn't been sleeping well as he feels restless and on edge. His energy is low, and his focus is suboptimal. While he is intermittently irritable, he is more anxious than dysphoric. He is not hopeless or suicidal, and he continues to be motivated at work. His symptoms are most consistent with a generalized anxiety disorder.

I also consider whether any medical issues could be contributing to Mr. Toth's distress.

Thyroid hormone abnormalities may alter mood, increase fatigue, and affect weight and sleep patterns. I make sure to ask if Mr. Toth's thyroid hormone levels have been checked recently and if his primary care provider has confirmed that his current supplementation is adequate to support normal thyroid function.

The inductive portion of my evaluation focuses on the unique details of Mr. Toth's story, so my questions will require more detailed answers: Have there been any recent stressors that may be fueling these symptoms? I learn that Mr. Toth has been married to his husband for several years and that the relationship is stable and supportive. I also learn that Mr. Toth's twin brother died 2 years ago in a motor vehicle accident, and this profound loss continues to haunt Mr. Toth on a daily basis. Most days he feels worried that he will also meet an untimely death, and this anxiety peaks at bedtime. Although Mr. Toth's remaining sibling, his older sister Gail, had been a critical source of local emotional support, she recently moved to Japan for several months. While the siblings have been trying to find regular times

to talk by phone or by videochat, the time difference has made scheduling difficult. Mr. Toth adds that he feels most comfortable expressing complex feelings in person.

The deeper dive into the details of Mr. Toth's personal narrative significantly expands my understanding of his struggles. I hope to learn much more about his marriage, family, job, and community as the therapy progresses. Meanwhile, my deductive portion of the interview, collecting specific data on psychiatric and medical symptoms, ensures I don't miss diagnostic data that requires more immediate follow-up. Therapy works best if both the comprehensive assessment and ongoing therapy use an inductive and deductive approach. It is the best way to avoid premature conclusions or an oversimplification of a complex human being.

SALLIE'S DIAGNOSIS, PRELIMINARY FORMULATION, AND TREATMENT RECOMMENDATION

To create the best treatment plan for Sallie, I need to generate a preliminary formulation that reflects the complexity of her struggles. With my deductive approach, I determine that Sallie meets criteria for a mild case of major depressive disorder. She also has an unspecified eating disorder, in remission. My consultation summary that becomes part of Sallie's medical record preferentially focuses on the deductive portion of my evaluation. Especially now, in the era of electronic medical records (EMRs) that may allow Sallie's other clinicians to access my notes, my documentation focuses on medically relevant information and diagnoses needed for insurance billing, but intentionally leaves out sensitive confidential details of her story. (For a further discussion of documentation in EMR, see Chapter 12.) By translating Sallie's difficulties into DSM-ese, I can also summarize her condition in supervision and immediately be understood. (See Figure 6.1 for Sallie's consultation summary and Therapist Tool 6.1 for a Consultation Summary template.)

After labeling Sallie's condition with the terms and codes of DSM, we feel the need to add a disclaimer. While a diagnosis is a necessary part of her treatment, just as with Mr. Toth in the earlier example, it doesn't even start to capture the complexity of her situation or her unique strengths, traits, and yearnings. While DSM diagnoses are relevant to a patient's treatment, they are always a simplification.

With my inductive approach, I focus on Sallie's relationships and school (as Freud famously said "Love and work . . . work and love, that's all there is"). At the beginning of a treatment, I focus on outlining areas of future inquiry; there is no way for me to fully understand Sallie's motivations and relationships this early on. I would like to know more about

Chief complaint (CC):

Preferred pronouns: she/her/hers

Sallie Gane is a 21-year-old single female college student in her junior year whose chief complaint is "My life has been kind of a mess."

Referral source:

The patient's primary care physician at college:

Miranda Newman, MD
617-111-3333

Information sources:

The patient: reliable

History of present illness (HPI):

About 6 months prior to her first visit (PTV), the patient was rejected by her boyfriend. Since then, she has felt "mopey," her appetite has declined, and her ability to concentrate has decreased. Gradually, her symptoms worsened despite her efforts at exercise, socializing, and study. She denies any current eating-disordered issues.

One week prior to visit (PTV), she had an "all-day" crying spell and decided she needed professional help.

Past psychiatric history:

During her final months in high school (about 3 years PTV), she purged with and became dependent on laxatives. She was hospitalized for about a week at a psychiatric facility near her home. Following that, she had several months of outpatient psychotherapy with Dr. Mehta prior to starting college; treatment was helpful. She reported no other psychiatric treatment.

Substance use:

In addition to laxative misuse, as reported above, she had relatively high alcohol tolerance during high school. Currently, she reports drinking alcohol once a week, usually one drink (rarely two) per occasion and denies laxative use. She does not smoke or use any tobacco products. She reports very occasional use of small amounts of marijuana edibles. She tried her roommate's Klonopin once when very anxious but didn't like how fatigued it made her feel, and she doesn't intend to try it again. She denies any other substance use.

Past medical history (PMH):

Ear infections bilaterally in childhood.

Hand infection at age 10 with hospitalization for IV antibiotics.

(continued)

FIGURE 6.1. Consultation summary.

No head injuries and no loss of consciousness or seizures.

A complete physical examination 6 months ago was entirely within normal limits, per patient report. Over the past 2 months, SG has been feeling very tired, but this symptom has not been worked up medically.

She was medically cleared by the student health services after a panic attack on campus.

Primary care physician at college: Miranda Newman, MD

Current medications:

Ibuprofen for menstrual discomfort
Daily multivitamins
Oral contraceptive pill

Allergies:

Rash associated with penicillin

Family history:

Psychiatric:

Sallie's mother experienced "blues" following her daughter's birth. No psychiatric treatment.

A maternal uncle had alcohol problems but is now sober.

Medical:

Sallie's brother has suffered from gastrointestinal pain and diarrhea; no specific diagnosis noted.

Social/cultural history:

The patient's mother is a part-time real estate agent, and her father manages an electronics store. Catholic, currently not practicing while at college. Close relationships with extended family, although none are local: paternal grandmother is Filipina, married to her paternal grandfather who is White; they live in California. Mother's family from Ireland, and they visit every summer. Her only sibling, Tom, is 6 years younger and is currently in high school.

Mental Status Examination (MSE), including a suicide risk assessment:

Sallie Gane is a neatly and casually dressed young woman who appears to be her stated age and seems to be of roughly normal weight for her height. She is cooperative and engaged throughout the interview, although at times she seems tense and nervous. She has good eye contact. Her speech is normal rate, tone, and volume without any pressure. A review of the neurovegetative symptoms of depression finds that her sleep is normal (7–8 hours nightly), but her interest, motivation, energy, concentration, and appetite are decreased. Her feelings of

(continued)

FIGURE 6.1. *(continued)*

guilt and self-blame are high; her self-esteem is low. She has no psychomotor agitation or retardation. She occasionally wishes that she would die in an airplane crash, but she has had no current suicidal intention, plan, or actions. She has no self-harm thoughts or expression of violent/destructive or homicidal thoughts. Static risk factors for suicide include new onset depression and recent loss with the end of a meaningful romantic relationship. Modifiable risk factors include her current depressed mood, anxiety, and hopelessness as well as limited coping skills. Protective factors include help seeking behaviors, no active suicidality or self-harm, interest in treatment, social supports, and a personal belief against suicide. Current overall acute risk of harm to self and/or others is minimal.*
Her thought content is appropriate. She shows no evidence of delusions or hallucinations. Her thought form is well ordered and logical. Her cognition is grossly intact. Her insight and judgment are fair.

Assessment and plan (A/P):

Sallie Gane is a 21-year-old single female college student in her junior year referred to me by Dr. Newman in primary care for evaluation of Sallie's ongoing symptoms of depression.

She meets the criteria for major depressive disorder, but she has been able to function well in her college studies and does not pose a suicidal threat at this time. Her present concerns revolve around her relationship with her former boyfriend.

At this time, I recommend a trial of psychotherapy to alleviate her distress. If symptoms and functioning worsen, antidepressant medication can be considered. As her psychotherapist, I will remain alert for possible recurrences of her eating disorder or for symptoms of a substance use disorder. I also referred Sallie back to her primary care physician for evaluation of her ongoing fatigue over the past 2 months.

Diagnoses:

Major depressive disorder, single episode, mild. (DSM-5: F32.0)

Eating disorder in remission. (DSM-5: F50.9)

Return to office: 1 week.

*Over the last several years, the standard of care for suicidal risk documentation has expanded to include a list of risk and protective factors in addition to the standard evaluation of a patient's thoughts, plan, intent, and actions. Documentation requirements regarding patient safety also vary by region and institution.

FIGURE 6.1. *(continued)*

Sallie's experience of her parents' relationship, with her mother seeming, at first blush, to have more power regarding some choices within the marriage. I privately wonder if Sallie identifies with her mother's role when she is in a romantic relationship and hope to gather more information about this hypothesis during future sessions. I would like to learn more details about Sallie's experience dating Charlie, who seemed to assert himself more freely than any of her prior boyfriends. I'm curious to learn more details of the stressors during high school, especially around the time of her laxative abuse and inpatient and outpatient treatment. I'm interested to learn more details about Sallie's current friendships and what traits she considers important in a good friend. Sallie alludes to her brother's illness. I currently don't know what illness her brother has, and I wonder how his medical issues have impacted her, in the past, and now, as a young adult.

I would also like to know more about Sallie's academic college experience and how she chose to be an economics major. How and when did this area become interesting to her? It is likely that, as a young woman, Sallie will identify with her mother. I wonder how Sallie feels about her mother's dissatisfaction with her own career choice. Sallie also mentions that her mother has some expectations for Sallie's future career; I want to hear more about this in future sessions. Over time, I will learn more about Sallie's story and her dreams and struggles; there is no way to rush this process without oversimplifying or jumping to conclusions.

I will recommend to Sallie that she start weekly individual psychotherapy because she is intensely distressed, is grieving a loss, and has a history of interpersonal problems. While she is in crisis, I also think she would benefit most from the one-on-one attention of individual psychotherapy. While I may embed numerous therapeutic approaches into Sallie's treatment, her therapy will be anchored by psychodynamic principles. Over time, if individual psychotherapy does not provide enough emotional support, or if Sallie wishes to understand more about how she interacts with others in a therapeutic environment, I might consider an additional referral to a long-term psychotherapy group that focuses on relationship issues.

As a psychodynamic therapist who integrates cognitive-behavioral techniques within the treatment, I would not refer for outside specialized cognitive-behavioral therapy. Medication isn't currently indicated because Sallie's daily functioning is not severely impaired, and she is not at risk for suicide. A medication evaluation is mandatory in a few instances: (1) when a patient's symptoms of depression and/or anxiety are significantly interfering with their daily functioning, (2) when the patient has a history of mania or psychosis, and (3) when the patient has current manic symptoms, significant agitation, or psychosis. A medication consultation may also be very helpful for the patient who continues to suffer with significant symptoms despite an investment of time and energy in psychotherapy.

DIAGNOSES THAT PREFERENTIALLY RESPOND TO PSYCHODYNAMIC PSYCHOTHERAPY

Psychodynamic psychotherapy is an especially helpful treatment approach if a patient's difficulties revolve around relationships or involve problems of self-esteem. Some of the other common diagnoses that benefit from psychodynamic psychotherapy include adjustment disorders; personality disorders; problems related to trauma, abuse, or neglect; and maturational crises and associated problems. DSM also lists a number of V codes (conditions that are not considered to be mental illnesses but may be a focus of clinical attention) that often respond to psychodynamic psychotherapy, such as bereavement, academic problems, occupational problems, relationship distress, social exclusion, religious or spiritual problems, acculturation problems, or phase of life problems.

As I make my treatment recommendation, I explain the process of psychodynamic psychotherapy to Sallie.

EXAMPLE 6.1

Explaining the process of psychotherapy to a new patient

THERAPIST: How has it felt talking to me over these last few meetings?

SALLIE: It has been okay, I guess.

THERAPIST: As I think about what we have talked about, I believe psychodynamic psychotherapy will be able to help you. I think the distress you are feeling about Charlie would improve through talking to me weekly about your concerns.

SALLIE: You really think so?

THERAPIST: Yes, but there are also alternatives: cognitive-behavioral therapy, group therapy, and medications, to name a few. You could even consider no treatment at all. I'll be glad to explain the other treatments if you wish.

SALLIE: But, you think psychotherapy would be the best type of treatment for me?

THERAPIST: Yes, as I see it, if you could have figured out this situation with Charlie intellectually, you would have by now. I think the way for you to feel better is to learn more about your inner experience, learning with your heart, not only with your head. Psychotherapy can help you do this.

SALLIE: You're right that it has been a problem of the heart. My heart was definitely broken. But I don't really understand what I have to do to feel better.

THERAPIST: Psychotherapy will allow you to get closer to inner feelings by using a format similar to what we have been using, but with some differences. First, I think it would be good to continue to meet once a week for 50 minutes, but I won't be directing the meeting with a list of questions as I have done during the consultation, and I won't be taking as many notes. Instead, I'll want to hear about your current concerns. When I think it will help, I'll try to add my observations and will probably ask an occasional question. Your task will be to talk about whatever is on your mind, trying not to edit. [*I introduce the concept of free association.*]

SALLIE: Yeah, but what good is that going to do?

THERAPIST: It can be helpful to confide in someone in detail about your experience with Charlie. You may also start to feel better as you gain some perspective and learn from what happened.

SALLIE: But, I talk to my friend, Gwen, about Charlie all the time. No offense, Dr. Bender, but I don't really understand how this is supposed to be different.

THERAPIST: No offense taken. I'm glad you feel comfortable asking these questions.

A psychotherapist can provide more objectivity than a friend as well as specific knowledge and training for healing emotional wounds after difficult life events. When Gwen hears about the situation with Charlie, she might relate it to her own dating experiences, and her input will be influenced by her personal relationship with you. As a therapist, I can be more objective, and my training has centered on helping people with relationship difficulties.

SALLIE: Yeah, but all that training won't bring Charlie back!

THERAPIST: Well, that's true, but it might help you to discover ways to calm and to soothe your feelings and to prevent a tormenting breakup like this from happening again.

SALLIE: Oh. . . .

THERAPIST: During our work together, you might have feelings about things I say, including a feeling that I may not have understood something. If this happens, I hope that you will tell me.

SALLIE: How will that help? I don't want to offend you.

THERAPIST: Actually, I welcome your input, and I won't be offended. Together, we can learn a lot if we are open to talking about our relationship. Psychotherapy is a process that deals with three sets of relationships: present, past, and the one between you and me. By sharing with me any feelings you have about our relationship, we might learn

more about the other relationships in your life. Any feelings about what goes on in this room can be an important part of our work together. [*This is an adapted explanation of transference.*]

SALLIE: I can try, but I am pretty shy about being direct about things like that.

THERAPIST: That's natural. I'll try to help. This is why I am telling you now that I welcome more openness. Other paths to learn about one's inner life are through mental images, daydreams, and night dreams. If any occur to you, feel free to bring them in.

SALLIE: You have got to be kidding! Now this is starting to feel a little like psychobabble.

THERAPIST: (*calmly, and not defensively*) Dreams and other forms of imagination can sometimes be helpful in learning about inner parts of life that are difficult to think about otherwise. The ideas and feelings they bring up can be useful in psychotherapy. I just wanted you to know they are welcome here.

SALLIE: So, how long does this take? When will I feel better?

THERAPIST: It's difficult to predict. One of our goals is to enable you to feel better as soon as possible. How are you feeling now compared to when we first met?

SALLIE: About the same. It's just hard being patient. I want to feel better immediately.

THERAPIST: I can understand that. Usually, it takes a little time to feel better, and it is hard to be patient.

In about 10 minutes, and without using any psychological jargon, I've taught Sallie Gane about free association, transference, and the usefulness of dreams in psychotherapy. The psychoeducation provides a useful bridge between the consultation and the upcoming psychotherapy. Now, Sallie will understand that the apparent lack of structure in the sessions that follow is a deliberate choice, with a specific purpose. My change in style from the last session of the consultation to the first session of the psychotherapy will be understood and expected.

Sallie also requests immediate relief, a common request from a new patient in crisis. Although I can't promise rapid improvement, cognitive or behavioral interventions that maximize coping skills can be integrated within the psychodynamic treatment to provide a measure of early relief. Some examples of these techniques are outlined in Example 3.5 and Chapter 9, which focuses on crisis intervention. (The Additional Readings and Resources list also provides some resources on this topic.) There is also great comforting power in feeling understood. Often, with an empathic

therapist who listens carefully, new patients may start to feel a little better after the first few meetings.

IF YOU DON'T WANT TO TREAT THE PATIENT AFTER YOU HAVE COMPLETED THE CONSULTATION

As a trainee, my supervisors recommended that I work with numerous patients with a range of psychiatric disorders in order to gain experience. With this advice in mind, I sometimes hesitated to continue treating a patient after the consultation was completed. For instance, I might want to hold my open session slot for a male psychotherapy patient if my entire caseload was female.

Early on, I also referred patients to other providers if I was too frightened to treat them. During my first year as a therapist, I refused to treat any actively suicidal outpatient because I was scared that my inexperience would be fatal. Experience has helped me feel more and more comfortable treating a wide range of patients, but in the beginning, I was more anxious.

Rarely, the reason I didn't want to treat a patient was much more personal and much more embarrassing. What if I had an aversion to talking to Sallie and felt little empathy for her troubles? What if she reminded me of a bully from grade school or a snotty girl from seventh-grade dance class? My first stop would be supervision to try to understand and to work through my difficulty. But sometimes, even with the best of intentions, I wasn't able to shake the "emotional block." (For more discussion of how a therapist's reaction to a patient can affect the treatment, see Chapter 17 on transference and countertransference.)

If I had persistent or profound trouble connecting with a patient from the get-go, it wasn't in anyone's best interest for me to continue as the therapist after the consultation was completed. While I would try to learn from the experience, I would also trust my instincts. A good rapport is needed for a successful therapy. The patient would be best served with a referral to a clinician who could be an eager and engaged collaborator.

Unfortunately, while it is often easy for a therapist to refer a patient to another clinician, it can be upsetting to be on the receiving end of a transfer. As a guilt-ridden beginning therapist, it's easy to complicate the already loaded situation by minimizing or denying the patient's hurt feelings to alleviate one's own distress ("I know you expected to work with me, but I think you'll like Dr. Smith even better anyway") or by delaying the news until the consultation's final session.

In general, patients are rarely delighted to learn that they will be passed off to another clinician after the consultation is completed. They digest the information more easily if they learn about the transfer during

the first or second consultation meeting and have time to process their disappointment.

EXAMPLE 6.2

The therapist sensitively refers the new patient to another clinician early in the consultation

At the Beginning of the Second Session

THERAPIST: Before we start the second session today, I wanted to know if you had any thoughts about our last session.

SALLIE: No, not really.

THERAPIST: I learned enough during our first session to recognize that I am able to complete the consultation, but I'm unable to take you on as a therapy patient once the consultation is completed. At the end of the consultation, after we decide on a treatment plan, I'll access my professional network to refer you to an excellent clinician who can provide you with the care you need.

SALLIE: Why can't you see me?

THERAPIST: It is a matter of professional judgment about what's best for you. As my schedule has evolved over the last few weeks, I have realized that it is more restricted than I anticipated. I realize it isn't ideal to complete a consultation with one person, and then be transferred to another. [*I am deliberately vague to avoid an in-depth discussion about this issue.*]

SALLIE: Oh, I was hoping I could continue with you.

THERAPIST: I appreciate your saying that. How do you feel hearing this news?

SALLIE: Crappy and bummed. I must be hitting a new low to be rejected by a therapist!

THERAPIST: It is unfortunate timing to hear this right after a breakup, and I understand how this can feel like a rejection. In fact, I am transferring you because I truly want what's best for you, and in this situation, it isn't me. After finishing up today, I will work hard to match you with a colleague who has the time and expertise available to provide what you need.

SALLIE: Someone you know?

THERAPIST: Yes, I will try to refer you to someone whose work I know well.

During a transfer, my patient doesn't need to know the reasoning behind my decision to seek a transfer; a comment that my schedule is unable

to accommodate them is adequate and protective. As I've gained experience as a psychiatrist, referrals to other therapists have become a relatively easy process. I refer to my professional network honed first during training, and then expanded during subsequent years working in my private practice and as an academic psychiatrist at MGH. If I cannot take on a new patient after a first session, it is ethical professional practice to help find the patient another provider; I refer with confidence to my colleagues, because I know their work well and trust their abilities.

NOTE TAKING

Once psychotherapy starts, I generally don't take notes during the session, except to jot down the names of important people in the patient's life. I complete any necessary clinical documentation after the session has ended and the patient has left. I always regret when I don't tell new patients about this change in format, postconsultation. When I'm taking copious notes during the evaluation process, the patient may feel their story is noteworthy (excuse the pun). If I don't explain my abrupt decrease in writing once the psychotherapy officially starts, they may easily misinterpret the change as a reduction in my attention and a waning of interest.

Some therapists have an uncanny ability to listen, to maintain eye contact, and to jot legible words simultaneously, and they may continue to take notes as a therapy progresses. Even if you are one of these talented few, this procedure also travels with its own potential difficulties. A former patient of mine, whom I'll call Anne, once described how she scrutinized her previous therapist's note taking. She watched her therapist's hands carefully, noticing when they picked up their pen or put it down. Over time, Anne began to feel upset when the therapist didn't take notes after she had related an especially sensitive story. A simple action had become replete with emotional meaning. It was unfortunate that Anne never shared her feelings about this issue with her therapist. The therapy would have benefited from an open discussion of her concerns.

PSYCHOTHERAPY "PROCESS" NOTES

While clinical documentation is legally required after a psychotherapy visit (and reviewed with more detail in Chapter 12), psychodynamic psychotherapists may also keep a separate set of notes for some patients, referred to by HIPAA as "psychotherapy notes." Historically, these notes have often been referred to as "process notes"; to keep things simple, I will refer to them moving forward using the HIPAA term: psychotherapy notes.

My psychotherapy notes are not included within any official medical record, and they are for my eyes only; when they are not in use, they are kept in a locked cabinet. The documentation helps me to remember and to analyze the contents of a therapy session. When I first started keeping these records, it took several minutes for me to write down the content from a 50-minute session, even in a shorthand form. Luckily, with more practice, the process of writing psychotherapy notes became more expeditious. I don't try to record the session verbatim, but only note the key moments and details. If I complete a psychotherapy note for a patient, I write it during the 10 minutes between patients when my recall for the material is most vivid. Psychotherapy notes are considered especially privileged and may be protected from others, including the patient, payer, other MDs, and so on. (For more information on the confidentiality protections for psychotherapy notes, see Chapter 12.)

During training, I used another version of psychotherapy notes—and even though it takes a bit more time, I still use this method if I am struggling with a clinical situation. With this second type of psychotherapy note, I try to re-create the session with Sallie in an "I said, she said" format. I organize these notes by dividing a plain sheet of paper in half with a vertical line (or fold) down the center. On the left side of the paper, I write down as much as I can remember of the session's most meaningful moments (including first names of important people in the patient's life for future reference). I try to remember how the conversation evolved, and write down each topic in the order discussed. Then, on the right side of the paper, I write any questions, ideas, or feelings I had during the hour. I identify the patient only by their initials. During training, I used these notes in supervision to formulate my questions and to guide the discussion. I kept the notes in a composition book in a locked cabinet, or I might dispose of them after supervision, in a manner that recognized their confidential nature (such as shredding).

EXAMPLE 6.3

An excerpt from a session followed by a typical psychotherapy note that abbreviates the action and formulates the therapist's questions

Sallie rushes in 15 minutes late.

SALLIE: I am so, so sorry. Traffic was terrible. I don't know why it is so hard to get here. My job makes it hard to get here on time. Did I tell you? I have a work-study position at the library. I am REALLY sorry. I just can't leave early to make it on time.

THERAPIST: It was difficult to leave enough time to get here?

SALLIE: Yes. My boss is difficult; she likes me and we get along, but I still

don't want to annoy her. I've worked at the library about 6 months and right now, I'm on her good side. Maybe I could have made it if I had left the library 10 minutes earlier, but I didn't want to ask for any special favors.

THERAPIST: So, leaving 10 minutes early one afternoon a week doesn't feel right?

SALLIE: My boss is tough, but she also seems fair. She says that she would be flexible with our schedules because she knows that we have other commitments. I just don't want to push it.

THERAPIST: It doesn't feel comfortable to ask for the favor.

SALLIE: I just don't want to jeopardize anything.

THERAPIST: I can understand why you might be careful asking for favors at work, but it also sounds like your relationship with her feels somewhat fragile—that one minor wrong step might jeopardize your position at work?

SALLIE: Yes, that's it.

THERAPIST: Can you tell me more about how that feels?

SALLIE: I don't know. I just get so scared. People can like you one minute and ignore you the next for no apparent reason.

THERAPIST: Have you had other experiences in which people liked you one minute but ignored you the next?

SALLIE: Well, didn't that happen with Charlie? It seemed to be going great from my point of view, but then we broke up and I still don't totally get it.

THERAPIST: The breakup with Charlie was so upsetting because you had invested so much in the relationship, and it was unclear, at least at first, why it didn't work out.

SALLIE: I still don't get it. Do you?

THERAPIST: I don't, but I think we will learn more as we continue to work together. Had you ever experienced such an unanticipated change in a relationship before Charlie?

SALLIE: I guess it has happened before, but usually with girlfriends, but they don't break up with me. They just disappear. Amanda, my best friend in elementary school, moved away when I was in ninth grade. Even though we promised to write every day, we lost touch almost immediately. I felt so upset because she was my number one best friend, and then she basically disappeared from my life after she moved.

In 10th grade, I became good friends with a girl named Dawn, and the same sort of thing happened when we went to different colleges. This time it didn't hurt as much because I sort of expected it.

But, I still don't get it. Other people manage to keep their friends even if they switch schools. (*Sniffles and looks upset.*)

THERAPIST: Some of the important female relationships in your life have not worked out the way you hoped.

SALLIE: That's true, I guess.

THERAPIST: It would make sense that you might also have some concerns about our relationship, and whether I will be stable or leave you as the others have.

SALLIE: I don't know. That sounds strange. I've just met you, and this is your job.

THERAPIST: It might feel strange the first time we talk openly about our working relationship. You are right; it is different because we have just started working together, but often talking about the therapeutic relationship can be a useful part of a psychotherapy. I hope over time that we can learn more about it together.

Psychotherapy Note for SG, January 2

SALLIE: Sorry. Traffic. Work-study position. Couldn't leave early.	*15 minutes late.*
SB [my initials]: Difficult to get here?	*Is there any other reason she can't get here on time? When should I bring this up?*
SALLIE: Can't ask boss to leave early.	*I feel nervous. Will SG quit treatment?*
SB: So, even leaving 10 minutes early once a week doesn't feel right . . . ?	*Ask supervisor what they would have said here. My comment didn't seem like the best choice—feels a little judgmental.*
SALLIE: Don't want to jeopardize the relationship.	*Does SG worry that if she takes one misstep, that our relationship would also suffer? When should I bring this up directly?*
SB: Relationships are fragile?	*Is this too direct too early on?*
SALLIE: Can't depend on good relationships.	
SB: Ever happened before?	*What else could I have said here?*
SALLIE: Charlie.	
SB: Ever happened before?	*Did I move off of Charlie too quickly?*

SALLIE: Friend Sarah—up till ninth grade—lost touch; Dawn—high school, same story.	*SG looked very upset. Should I push for more information? What would be the right thing to say here?*
SB: Female relationships don't work out as you would hope.	*Should I have asked more about her mom instead? Is it too early and/or too intense to talk about the therapeutic relationship so directly? Asked about her relationship with me?*
SALLIE: Too strange to talk about that.	*I finish my training in 3 years. Already I feel guilty about leaving SG. How does one talk about this with a patient?*

My prowess as a psychotherapist improved dramatically when taking psychotherapy notes became part of my training routine, for my own benefit and for supervision. The repeated act of jotting down these notes for several patients, over several months, had an additional unforeseen benefit: the more times I recreated a session's content on paper, the easier it was to remember details of any particular discussion—a very useful psychotherapeutic skill that continues to be beneficial to this day.

Psychotherapy notes also helped me identify the clinical situations I was most nervous about as a beginning therapist. What should I do if a patient is late? How do I talk to a patient about vacations? A list of complicated, interesting, and anxiety-provoking clinical scenarios emerged. In response, I developed the next several chapters, focusing on common clinical predicaments and providing strategies for the clinician.

THERAPIST TOOL 6.1

Template for the Consultation Summary

Chief complaint (CC):

Referral source:

Information sources:

History of present illness (HPI):

Past psychiatric history:

Substance use:

Past medical history (PMHx):

(continued)

Current medications:

Allergies:

Family history:

Social/cultural history:

Mental Status Examination (MSE) with suicide risk assessment:

Assessment and plan:

Diagnoses:

Return to office:

PART II
FRAME AND VARIATIONS

CHAPTER 7

The Frame

Psychotherapy can seethe with emotional intensity. Therapists follow practice guidelines collectively known as *the frame* to create a safe environment that maintains the therapist's relative objectivity and contains the patient's emotional overflows. While at first the novice patient and therapist may find these standards of practice random and unnecessary, they are indispensable because they protect the integrity of the therapeutic relationship. Limits around scheduling, the beginning and ending of sessions, personal self-disclosures by the therapist, and outside contacts need to be explained clearly and sensitively. In addition, protecting the frame has become a more complex process during the digital age.

The "frame" refers to a set of behavioral guidelines that define the patient's and the therapist's roles within the confidential therapeutic environment. The term *the frame* is shorthand for "the frame of reference" that defines the differences between a psychotherapeutic relationship and a personal relationship.

From the first meeting, features of the frame pervade a psychotherapy. A stable meeting time is established as soon as possible. The session begins and ends at predetermined times. Fees are negotiated as necessary. Any changes in these arrangements that affect the treatment, such as a vacation, are discussed ahead of time. The therapist divulges relatively little personal information, and the patient and therapist do not interact socially. With a few exceptions defined by law, information about the treatment is never disclosed to anyone without the patient's express permission unless the patient's safety or the safety of another individual is at risk.

WHY A THERAPIST CANNOT BE FRIENDS WITH A PATIENT

Some rules provided by the frame make obvious sense. It's clear to most why a romantic relationship between a patient and their therapist is unethical and emotionally harmful. (See Additional Readings and Resources for more information on boundary violations.)

Other guidelines may seem more obscure, and many beginning therapists harbor covert questions about these aspects of the frame. For instance, while many new therapists secretly wonder why a therapist and a patient can't be friends, many trainees are too embarrassed to ask a teacher why this rule exists.

Let's consider the possible ramifications of a social relationship between a therapist and their patient. I'll make myself the fall guy with a new hypothetical patient we'll call Zoe. To complicate matters, let's make Zoe a reasonably stable person. She starts psychotherapy seeking help with career concerns. She is also an avid tennis player. In our virtual scenario, I'm a tennis player also, and both Zoe and I are in need of a tennis partner. This information slips out during a therapy session, and Zoe asks me if I would like to play tennis with her this weekend. Against my better judgment, I agree. How will the psychotherapy be affected?

From the moment I play tennis with Zoe, our relationship's dynamic is irrevocably altered. As a friendship naturally moves toward the social norm of give-and-take, it cannot coexist with the previous one-sided therapeutic relationship that focused on Zoe.

To play devil's advocate, it's always possible that our tennis game will be the beginning of a great unambivalent, uncomplicated friendship that lasts a lifetime. Meanwhile, Zoe will have to find a new therapist, but it's worth it because our friendship is so lasting and enriching.

Actually, this lovely outcome is about as likely as winning a lottery. A relationship born out of a betrayal (in this case, my betrayal of my professional role) will not flourish. As patient and therapist, Zoe and I had agreed on a set of goals for her treatment. Losing me as a therapist but gaining me as a friend may seem like a plum opportunity from afar, but by losing me as an objective listener, Zoe has just sustained an emotional loss.

I shouldn't assume that Zoe doesn't really need or want therapy. While "career concerns" may seem like a vanilla topic, discussions in therapy about her future aspirations may be complicated by a host of complex emotions—emotions she might confide in a therapist but never tell a new friend.

Zoe may also be using career concerns as a ticket to enter treatment and to talk about a number of relationship difficulties that are troubling her. What if my friendship with Zoe runs into the same complicated problems

that she has experienced in other close relationships? Once again, Zoe gets hurt, but since I'm involved, I'm no longer available as an objective listener. Due to an understandable mistrust of the profession, she may avoid seeking out future therapists to process her experience with me.

It would be different if Zoe ever felt rejected by me within the confines of our professional relationship. Within a therapeutic relationship, I can be relatively objective. We could talk about her experience and attain a deeper emotional understanding of the process. (For more about this sort of event, see Chapter 16.) But, as a tennis partner, I've lost my unique perspective and my credibility in relation to Zoe. She doesn't get help with her relationship problems, and the friendship fails—not a good treatment outcome.

Many patients are tempted to draw their therapists into personal relationships to satisfy unfulfilled needs in their own lives. If a therapist tries to fulfill the patient's wishes rather than to help the patient understand their yearnings for closeness, good intentions may lead to a slippery slope. Any decrease in boundaries tends to accelerate once it starts, to the detriment of all involved. Ultimately, my role as a therapist is not to become the friend or partner that is missing, but to help the patient develop the internal capacity to enrich their own life.

THE FRAME AND THE INTERNET

With the advent of the Internet, the frame has changed. Public domain information is now accessible in seconds with a few computer clicks, and any posted data create a digital footprint that may exist indefinitely. My patient may arrive to their session armed with information about me that I would have preferred to keep private. For therapists who have grown up in the digital age, a patient's quick Web search may pull up information from high school or college, wedding announcements, past job descriptions, or even obituaries of family members.

Faced with this awkward situation, my job is still to protect the frame; I don't provide additional information, but redirect the conversation to understand the patient's interest. (*"Yes, I did participate in California's Academic Decathlon in high school, but I'm more interested in your thoughts and feelings about learning this information. What was it like for you to learn this about me?"*)

Intermittently, I carry out a self-audit on the Internet to see what pops up if I search my name. Professional organizations also provide guidance on how to navigate the digital age as a psychotherapist. As the technology continues to evolve, new and improved methods will inevitably emerge to control one's online presence.

SOCIAL MEDIA

Becoming a therapist reached a new level of complexity with the addition of social media. Many 21st-century novice therapists will enter training with years of use on personal accounts such as Facebook, Instagram, and Twitter. It also isn't unusual for an individual born in the digital age to have hundreds of online friends or followers. Out of curiosity, I expect that many new patients might try to access a therapist's personal social media accounts.

What if Zoe, my hypothetical tennis partner, peruses my Facebook page, through a connection via a distant mutual acquaintance? Learning personal information and reviewing private photos of one's therapist are fairly compelling; it may be hard for Zoe to resist a thorough and repeated search of my comments, postings, and photos. As she explores, she may learn how and where our personal lives intersect. As a result, the therapeutic frame starts to blur.

Ideally, patients should not have this much access to my personal information; details of my social life need to remain outside the office, to protect my privacy and the integrity of the psychotherapy. In her treatment, Zoe needs to focus on her own emotional struggles with minimal distraction. If she learns a lot of personal information about me, she may feel curious and preoccupied about what she discovered, self-conscious or ashamed about her personal concerns, and/or competitive with my successes. I may feel exposed and disturbed when she brings up several private details of my personal life during her session. In addition, the development of transference (discussed in more detail in Chapter 17) is an important part of a psychodynamic treatment; it will be hindered if Zoe is distracted by my life details. Suffice to say, it is counterproductive, even countertherapeutic, for my psychotherapy patient to know a significant amount about my personal life; as a psychotherapist, the line between professional and private life needs to be especially reinforced.

Being a psychotherapist doesn't mean I'm not allowed to have social media accounts, but it does mean that I need to be especially thoughtful about public versus private interactions on the Web. I may create a professional media presence with the specific purpose of educating the public about my work, but my private social media platforms need to be securely locked, with restricted access only for my family and friends, and with minimal public information posted in case of curious Internet cruisers. To the best of my ability, I keep personal photos inaccessible to strangers. I try to be aware of the media platform's most current policies to make sure that the privacy settings aren't loosened without my knowledge.

If a patient asks to follow me on any personal social media account (as opposed to a professional platform meant to interact with the public), the answer will always be a polite "no," followed by a thoughtful sensitive

discussion examining the yearnings behind the request. In addition, I do not follow any patient on any social media platform. Therapy works best if the information gathered about a patient's struggles is obtained within their session, not by perusing the Web on my own.

Over the last 10 years, many institutions have instituted social media guidelines for employees. While these rules change over time as the technology evolves quickly, the main take-home is that anything posted on the Internet that is attached to my name, even on my own personal site, is ultimately public information and cannot be erased easily once it is posted. An error in professional judgment could reach hundreds with an inadvertent click, and then it isn't easily retracted. If I would feel uncomfortable with one of my superiors, colleagues, or patients seeing a post, then I shouldn't post it. Even though I am not at work while I am active on personal social media, I still represent the profession of psychotherapy as a whole.

To new therapists who grew up in the age of open information sharing, these limitations might feel restrictive. Yet, while social media has complicated the discussion, the tenets of psychotherapy privacy protection have not changed for decades. When I started out years ago, I was also taught that the details of my personal life should not leak into a patient's treatment. I remember learning the many new rules and regulations for professional behavior on and off the job and feeling uncomfortable and anxious about my new professional role. These career growing pains, adopting the ethical code of the clinician, feel funny at first but become second nature over time.

MINOR FRAME ALTERATIONS WITHIN A THERAPY

The patient benefits by the predictable beginning and end of each meeting. The clearly defined session exit may help the patient to bear the expression of painful and upsetting feelings. The scheduled future session can pick up any matters not fully settled.

If both the therapist and the patient know the specific rules that define the psychotherapeutic relationship, it is meaningful when the patient (or therapist!) bends or breaks the frame. For instance, the frame is affected when a patient is repeatedly 10–15 minutes late to their session. Even if they repeatedly blame traffic for their tardiness, I'd wonder (silently at first and then aloud) what prevents them from attending a session in its entirety.

If psychotherapy didn't follow clearly outlined starting and stopping times, I might never notice that a patient repeatedly misses the first third of their session. It wouldn't be reasonable or even fair to wonder whether the recurrent tardiness was some kind of emotional indicator. On the other hand, if both my patient and I know the rules, it *is* meaningful if they repeatedly miss a significant chunk of our time together. In psychotherapy,

we often discover that recurrent events are rarely random. Over time, the patient and I may learn that there is an underlying, maybe unconscious, reason for the pattern of tardiness. (Chapter 10 focuses on how to address a patient's recurrent late arrivals.)

In therapy, every attempt needs to be made to translate action into spoken feelings and thoughts. If a patient is recurrently late, eventually I'll try to discuss this with them in a noncritical and open manner. If a patient wants to change the parameters of our meetings by having a 30- or 90-minute session or by seeing me twice a week, we will talk about the issue thoughtfully and deliberately before doing anything that changes our initial therapeutic contract. Talking after a change has been actualized isn't nearly as effective. Once a treatment's structure is modified to suit my patient's desires, they might lack sufficient internal motivation to delve into the emotional meaning behind their request.

Beginning therapists may be tempted to alter the frame in subtle ways as "errors of kindness," but even these frame violations may increase the risk of a poor treatment outcome. For instance, a beginning therapist may be tempted to shield a needy patient from treatment fees by "forgetting" to fill out the appropriate clinic paperwork. While this action may seem altruistic, ultimately, this type of frame violation might impair the therapeutic process. When the patient realizes they aren't being billed, they may feel thrilled at first, but feelings of obligation toward the therapist, doubts about the therapist's honesty and loyalty to their clinic or institution, and even concerns about the therapist's passive–aggressive behavior may follow. A seemingly benevolent procedure will have become countertherapeutic.

This section of the book will illustrate how a therapist can use alterations in the frame as opportunities for exploration and discussion. The topics covered reflect the ones that gave me the most anxiety as a novice clinician: how to set the fee and to bill, handle telephone calls and crises, respond to patients who arrive late, and manage confidentiality. This second edition includes a new chapter discussing the clinical ramifications of a therapist-driven frame change, such as a vacation, maternity leave, or illness.

Since most people don't talk about these issues outside of psychotherapy, it is easy for a therapist in training to become wordless when faced with a frame issue that requires frank discussion. With guidance and practice, it will become easier to broach these topics with your patients. Then, an open, thoughtful, and therapeutically beneficial dialogue can follow.

CHAPTER 8

Setting the Fee and Billing

The exchange of money for services is an intrinsic part of every psychotherapy. At first, many altruistic therapists are uncomfortable accepting money for their services. Even some experienced therapists may have difficulty talking to patients directly about money.

Guidelines are provided to help you navigate the monetary aspect of the therapeutic relationship, whether the patient is paying out of pocket, their insurance company is footing the bill, or the care is subsidized by a clinic. The therapist's goal is to provide a clear expectation regarding fees and then to talk sensitively with the patient about any reactions to the payment policies.

When I was a novice therapist, talking to patients about money was more uncomfortable for me than talking to them about sex. While I felt a little nervous the first time I listened to a patient's intimate sexual concerns, I considered it a privilege when a patient could trust me enough to share such sensitive information. In contrast, discussions about insurance coverage, fees, and payment felt self-serving in a treatment that deals in the currency of empathy and emotions. Monetary discussions in a psychotherapy are unique because the focus is on the therapist's agenda rather than the patient's needs.

As a novice, I wished there was a way I could practice therapy without having to discuss payment with my patients. A generation ago, my wish would have been fulfilled—at least sometimes. Generous insurance companies often provided years of psychotherapy reimbursement with minimal pushback. With today's health care management, these types of insurance plans are practically nonexistent. Although mental health care insurance coverage has improved since the first edition of this book, many insurance

plans still restrict the number of psychotherapy sessions a patient is allotted per year. For additional treatment, the patient and therapist may independently negotiate a fee and payment method, or insurance companies may authorize some amount of additional therapy if the provider discloses confidential information that supports the need for ongoing clinical care. (See Example 8.3 for more details on how to navigate this aspect of treatment.)

During my first 2 years as a trainee, I treated only clinic patients, and the MGH department of financial services took care of most monetary issues, setting fees, accepting most insurance plans, and collecting payment for service. Several years ago, before Massachusetts comprehensive health reform provided near-universal health coverage, the hospital would provide free psychotherapy care to a subset of patients without insurance coverage. As a trainee, I viewed these recipients as very desirable patients. I didn't have to report confidential information about them to an insurance company. The therapy was completely subsidized as long as the patient's financial situation didn't improve substantially. Patients received therapy, I received my paycheck for working with clinic patients, and money was never an issue. What could be better?

Then, a few unexpected treatment issues emerged. Some of my free-care patients had a difficult time taking advantage of the therapy when they felt guilty about getting something for nothing. Others would treat the free service as expendable by forgetting to show or arriving late for scheduled appointments. When I finished my adult psychiatry residency and offered to continue privately with some of these patients for a substantially reduced fee, many of them declined. Although they were satisfied with my care, they chose to receive therapy for no charge with a new clinic provider, rather than to pay for treatment with me.

Slowly, I began to understand the clinical advantages of paying for psychotherapy, using insurance or with private pay. As my experience with the free-care patients demonstrated, it's easy to devalue a process that is free. In addition, the fee reinforces the limitations and possibilities of the therapeutic relationship. While the collaboration between a therapist and a patient is one of mutual regard and respect, with the focus exclusively on a patient's private emotional concerns, it is still a fee-for-service enterprise. The payment, through insurance or direct compensation, defines the relationship as a working entity, rather than as a substitute for other sustaining relationships.

SETTING THE FEE

During my residency, I could wax poetic on money's necessary role in psychotherapy, but the clinic continued to manage all monetary issues for my patients. When I started a small private practice before graduation, I

realized I didn't know how to discuss this topic thoughtfully; my motivation to master this area intensified overnight.

Of note, this issue is not so relevant if the therapist is a preferred provider on a patient's insurance plan, which predetermines the therapist's reimbursement for treatment. As long as the insurance is covering the psychotherapy, the patient only needs to cover a co-pay (which is typically small) with each visit. That said, if the patient prefers to see a therapist who isn't on their insurance panel or would rather self-pay, treatment will require a greater out-of-pocket expense.

Early on in my career, I felt uncomfortable talking openly about my fee and a therapy payment plan when an out-of-pocket expense was required by the patient. A new patient would rarely ask details about my fee, so it was easy for me to make mistakes of omission and delay a discussion about monetary issues until later in treatment.

EXAMPLE 8.1

The therapist does not review her fee with the private practice patient early in treatment and then ends up accepting a much lower fee

During my comprehensive consultation with Sallie Gane, I "forget" to discuss my fee, and she does not ask about it. We decide to continue working together after the consultation is completed. At the month's end, I hand her a bill for my services.

THERAPIST: This covers our two consultation sessions during March. Here is how my billing works. In the future, I will mail you a bill at the beginning of each month and expect payment by the end of the month. Since we haven't talked about billing before now, I printed out this month's bill to review together in case you have any questions. (*I hand Sallie a bill for two sessions totaling $___.* [*Since fees vary so widely, you can fill in the fee you are using here.*][1])

SALLIE: Oh . . . okay. (*Looks at the bill.*) $___!

THERAPIST: You were expecting a different amount?

SALLIE: Ummm, well . . . yes! You didn't tell me you were charging $___ per session!

THERAPIST: Well, I thought you were aware that this is the average fee in this area. Didn't your primary care doctor tell you this when she referred you to me?

SALLIE: No, I thought my insurance would pay for this. Can I give this bill to my insurance? Are you an EntropyMedical provider?

[1]Since fees vary widely based on training, degrees, experience, and local market forces, I have used "$_____" to designate the fee(s) for psychotherapy in the chapter examples.

THERAPIST: Actually, I am not part of that insurance plan. [*I feel guilty and uncomfortable*.] Let's think together how we can approach this in a way that will feel fair to you.

SALLIE: Well, I think I could afford half of your usual fee.

THERAPIST: Okay, that's fine.

In Example 8.1, I feel so uncomfortable and guilty about charging for my services that I don't discuss monetary issues during the first consultation sessions, and then immediately agree to a 50% reduction of payment when Sallie balks at her bill. I'm not independently wealthy, so by agreeing to accept a reduced fee, I'll have to work an extra hour at full fee every other week to make up the lost income.

Sallie doesn't broach the subject of my fee during our first meetings. When I don't mention the cost of the treatment, she assumes her insurance carrier will cover the sessions; possibly, she also may have a surreptitious wish that the therapy fee is so low that I don't think it is worth discussing. My reluctance to talk openly about my fee during the consultation visits is countertherapeutic; a payment for service discussion clarifies the structure of the treatment relationship.

It's best to talk openly about fees and payment early in the treatment. Often, I'll ask the patient during the first phone call if they intend to use their health insurance to pay for treatment, or if they would like to discuss my fee on the phone or wait until the first visit. This procedure prevents any future misunderstanding or disappointment if the patient expects to use their insurance to subsidize their treatment, only to discover that I am not a provider on their insurance plan after meeting me.

Whether on the phone or in my office, the first conversation about fees can follow a somewhat standardized format.

EXAMPLE 8.2

The therapist discusses her fee and insurance issues during the first phone call

Midway through My First Phone Call with Sallie

THERAPIST: Do you have health insurance that you are planning to use for your psychotherapy?

SALLIE: I have EntropyMedical insurance through school. I think it pays for therapy.

THERAPIST: Unfortunately, I am not an EntropyMedical provider, so the insurance will not be able to offset my fee if you want to work with me.

SALLIE: My primary doctor thought you would be a good therapist for me. Is there any way to work it out?

THERAPIST: My fee per session is $___ if you are willing to pay out of

pocket. You could also check if EntropyMedical has an out-of-network benefit that provides reimbursement for treatment with an out-of-network provider. If this benefit exists, my bill will include the information your insurance company may need to reimburse you.[2]

SALLIE: Oh, gosh, I didn't know you would cost this much.

THERAPIST: What were you expecting?

SALLIE: I don't know. I thought you wouldn't charge so much since you see students. I think $___ is too expensive for me. Umm, what should I do now?

THERAPIST: We have a number of options. If you obtain a list of EntropyMedical providers from your insurance company, I would be happy to review the list with you on the phone. If I know any of the therapists, I can help you choose one from the list. I can also refer you to a clinician who may be able to slide their payment scale, although it still may not be as low as you might like. Also, I have the numbers of the community clinics and local hospitals in your area that will accept EntropyMedical or provide therapy at a lower rate. What sounds good to you?

SALLIE: I don't know.

THERAPIST: [*I wait patiently in silence. I sense Sallie's unspoken wish that I make a special exception to treat her at a below market rate, but I do not make this a treatment option.*]

SALLIE: Well, you were highly recommended, so I guess maybe I could ask my parents to help me out so I could at least see you for a few visits, and then see if I want to continue.

THERAPIST: Sure, that is another option.

SALLIE: What do we do next?

THERAPIST: Well, we've scheduled the first session of the consultation for next Monday. Would you like to discuss my fee with your parents before we meet?

SALLIE: Okay, that makes sense.

THERAPIST: After talking to your parents, if it looks like some of the other treatment options I mentioned are a better fit for you, please call me to cancel our next appointment at least 48 hours ahead of time. At that time, we can review more details of the other therapeutic options if that would be helpful to you. I'm happy to try to help you find care somewhere else if we aren't able to work together.

SALLIE: Okay. Thanks.

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[2]Generally, insurance companies request that the bill includes patient's name and address, diagnoses, dates of service, fees, therapy procedure codes, the provider state license number, NPI (National Provider Identifier) number, and Tax ID number, although some companies may require additional information as well.

If a new patient prefers to discuss monetary issues during their first session, rather than during the initial phone call, I bring up the topic midway through the meeting, so I am able to return to the patient's primary concerns before our session ends. Around 20 minutes in, I review administrative information about the treatment including a discussion of my fee, my cancellation policy, privacy protections, and any other logistical matter that the patient needs to know at the outset of treatment.

The scenario changes if I am a provider under the patient's insurance plan. (We will refer to EntropyMedical as our prototypical managed care insurance plan.) Unlike the insurance plans of the past, some current health plans require psychotherapists to intermittently divulge patients' personal information before approving insurance coverage of more psychotherapy sessions. While the complex issues of managed health care may sometimes feel overwhelming, I try to discuss them openly with my patients so they can make an informed decision about their treatment.

EXAMPLE 8.3

Discussing managed care as payment for psychotherapy and how to set a reduced fee

SALLIE: I have EntropyMedical insurance through school. Can I use it to see you?

THERAPIST: I think you should be able to. I am an EntropyMedical provider. Are you familiar with how the insurance works?

SALLIE: Not really.

THERAPIST: The insurance provides automatic payment for 24 sessions each year. Then, if we think it might be useful to continue treatment, I'll either fill out a prior authorization form or talk to an insurance coordinator to provide an update on our work together. The insurance company will use this information to decide whether it will pay for additional sessions.

SALLIE: Do you tell them a lot about me? I don't feel comfortable with them knowing my business.

THERAPIST: It is important for you to know that while the insurance company is also concerned with confidentiality, some or all of the information will be entered into EntropyMedical's system.

The information isn't quite as protected as if we were working without the input of the company. The benefit, of course, is that your treatment will be supported by your insurance.

When I talk to insurance providers, I try to be as general as possible, but sometimes they won't authorize further visits without specific information. If there is paperwork to fill out, we can fill it out together during your session, so you know exactly what I'm sharing with them.

SALLIE: Does the information stay private?

THERAPIST: Health insurance companies are bound by HIPAA to keep patient information confidential. That said, I don't know the details of who will have access to any information we share with them. For your particular situation with EntropyMedical, you may want to call to learn details of their protocol.

SALLIE: What if I don't want you to talk to anyone?

THERAPIST: In that case, you have your first 24 sessions covered, and I will only need to provide them with a diagnosis.

SALLIE: What's my diagnosis?

THERAPIST: It's difficult to say after just our first session, but it may be adjustment disorder with depressed mood, or major depression. Both diagnoses reflect the distress you have suffered after your breakup with Charlie.

SALLIE: This is so complicated!

THERAPIST: I agree that it can feel overwhelming to learn how a health care system works, but we will work together to find the approach that feels best to you.

SALLIE: What happens if I don't want to use my insurance anymore after we meet 24 times?

THERAPIST: At that point, I will charge you my regular fee per session, which is $___.

SALLIE: Since I'm a student, is there any way that you could reduce your fee for me?

THERAPIST: What portion of $___ would you be able to pay?

SALLIE: Umm. Maybe two-thirds of that?

THERAPIST: Could you tell me more how you came up with that number?

SALLIE: I could earn two-thirds of $___ a week working extra hours at the library or tutoring.

THERAPIST: Based on my own financial obligations, I can't lower my fee by that much, but I could agree to a reduced fee of $___ per session (cites a reduced fee that is manageable within the therapist's budget); could that work for you?

SALLIE: I'm not sure, but I think I could probably manage that. I feel uncomfortable with my insurance knowing such private information about me, but I also think I'll want to keep working with you after my 24 sessions are up. Now that I'm finally in treatment, I want to stay until I really feel better.

THERAPIST: I agree that it often takes time to truly understand a complicated emotional event like your breakup with Charlie. We'll consider $___(reduced price per session that is manageable within the

therapist's budget) to be your fee once your insurance stops supporting the treatment, and if your financial situation changes, we can reconsider the fee at that time.

You should also know how I do my billing. Unless you would prefer to pay me at each visit, I'll mail you a bill at the beginning of each month; you'll have until the end of the month to pay me.

SALLIE: Oh, okay. Thank you so much for reducing the fee. That really helps, and I am glad that I can continue to see you.

THERAPIST: I am glad that we were able to work something out as well.

Before discussing out-of-pocket treatment, I try to converse openly with the patient about managed care's simultaneous support of and interference with psychotherapy. Due to financial limitations, not all patients have the choice to pay for treatment out of pocket. Moreover, some patients may prefer to exclusively use their mental health care benefits through their insurance. The treater's responsibility is to explain the issues involved, so the patient can weigh the advantages and disadvantages of the available options and make an informed decision.

I try not to rush when I'm negotiating a reduced fee with a new patient, so I don't agree to something I might regret or resent in the future. At the beginning of each year, I estimate my required earnings for the following 12 months, and use these figures to calculate how much care I can reasonably provide at a reduced rate. I need to think carefully before agreeing to slide my fee for a new patient; I am most flexible when sliding my fee for long-term patients who hit financial difficulties and then need a fee decrease to continue ongoing treatment. When my sliding fee slots are filled, I'll refer new patients in need of subsidized treatment to other providers or to community clinics.

When and if a patient's financial situation changes, I'll renegotiate the fee at that time. Example 8.4 illustrates what I might do if I learn that a patient with a reduced fee could, in fact, pay the full fee if they used financial assets reserved for "other expenses."

EXAMPLE 8.4

The therapist confronts a private practice patient receiving a reduced fee who has monetary resources that were kept secret

SALLIE: So, I just can't stand living in the dorm anymore. I think I might try to move into an apartment this summer. Maybe I'll live alone. I think the change would really decrease my stress level.

THERAPIST: When did you start to think about this?

SALLIE: Well, when I turned 21, I was able to access a trust fund from my grandparents for school and other stuff. I was thinking about it this week. I can actually afford to move out of student housing this year.

THERAPIST: What does the trust fund provide for you?

SALLIE: Well, it is for college expenses, and maybe a trip after graduation. I want to spend it carefully, so maybe it can help me with a down payment on a house someday.

THERAPIST: It must be such a relief to have some increased financial resources.

SALLIE: Yes, it is!

THERAPIST: It is great news that the trust fund allows you some financial flexibility. This information also does affect our treatment contract. Since your financial situation has changed from when we originally set your reduced fee, I would like to increase your fee back to my standard session fee.

SALLIE: Oh, please don't do that. This money isn't supposed to be used for psychotherapy.

THERAPIST: When I agreed to the reduced fee, I indicated that we would renegotiate if your financial status improved.

SALLIE: Well, my financial situation hasn't changed at all. Like I said, this money isn't for therapy but for living expenses.

THERAPIST: I understand that, but I also reserve my reduced fees for people who do not have adequate monetary resources. I am glad this money allows you some flexibility, but starting next month, I will raise your fee to my standard rate of $_____.

SALLIE: I don't know. That doesn't feel very fair to me, Dr. Bender.

THERAPIST: If I raised the fee to $_____, how much of the money in the trust fund would you be using?

SALLIE: Not much, I guess. Just supplementing the money that I save each week to see you with money from the trust fund. But, it just doesn't seem right.

THERAPIST: What if you were to spend the trust fund difference on school expenses and pay the remainder for the therapy from other funds?

SALLIE: I never really thought of that and it would work, but I still think it feels really wrong.

THERAPIST: In what way?

SALLIE: I just worry what my parents would think about me using my trust fund for psychotherapy. Everyone—both sets of grandparents and my parents—saved years and years to give me this money.

THERAPIST: I can see that the trust fund carries a lot of feelings with it.

SALLIE: It really does. I feel so guilty about it.

THERAPIST: Guilty?

SALLIE: Well, my parents keep telling me how lucky I am to have a trust

fund. It's supposed to help me pay for extra opportunities that they didn't have. I don't want to use it for therapy!

THERAPIST: How does your family view psychotherapy?

SALLIE: Even though I saw Dr. Mehta in high school, they don't really understand what psychotherapy is. No one else has needed to see a shrink. And I've needed to talk to two therapists already, and I'm only 21! Once should have been enough.

THERAPIST: I think we should talk about this topic in more detail. I will hold your fee at its lower rate this month, so we can discuss your concerns in more depth. If I decide to go ahead with a fee change, I'll let you know at the end of this month before the next billing period begins.

SALLIE: Okay. But, I feel really upset about this. Maybe I'll just need to stop therapy altogether.

THERAPIST: You are explaining to me why it feels so upsetting if I raise my fee back to my standard rate, but why would you consider stopping altogether?

SALLIE: Well, like I said, if you increased my fee, I would have to use some of my trust fund money and I don't want to do that!

THERAPIST: To you, mixing the two—therapy and the trust fund—doesn't seem possible. Let's try to understand this a little more together.

SALLIE: What's to understand? Like I told you, the trust fund was given to me under certain terms. It is supposed to be used for certain things, and therapy is not on the list!

THERAPIST: [*I notice a growing feeling of annoyance toward Sallie, so I stay quiet and only nod.*]

SALLIE: I don't know; this is just the way I feel.

THERAPIST: (*Regains composure.*) It is a very strong feeling?

SALLIE: Yes, it is. So what are we going to do about it?

THERAPIST: For now, we will just keep talking about it.

In the next few sessions, Sallie continues to express her ambivalence about using her trust fund to subsidize her therapy. I wonder if I should keep her fee at the reduced rate, but I also know that I will feel resentful treating Sallie at a reduced fee when she has the resources to pay my full fee. I consult with a trusted supervisor who wonders why my spouse, my children, and I should subsidize Sallie's therapy, and I decide to raise Sallie's session fee during the next month of treatment. I tell Sallie about my decision during the last session of the month in our current billing cycle.

Sallie starts the session by reviewing her week. Then, 10–15 minutes into the session, I announce my decision about her fee.

THERAPIST: I want to hear more about your week, but I also wanted to let you know my decision about the fee today.

SALLIE: Oh, no. What did you decide to do?

THERAPIST: Well, I did think very carefully about your comments to me while also reviewing my finances carefully before coming to a final decision. As I had mentioned earlier, this month will be at the previously decided lower fee. But, starting next month, I will be raising your fee to $___.

SALLIE: You are going to raise it? (*incredulous*)

THERAPIST: I am. This is not what you hoped I would say.

SALLIE: Umm . . . no, it is not!

THERAPIST: Can you tell me more?

SALLIE: Well, I thought you understood. You must not understand me at all if you are going to raise my fee.

THERAPIST: I know there is a lot of emotion surrounding this issue. By raising your fee, which part don't I understand?

SALLIE: That my parents would be so upset if they knew about this, and my trust fund is an incredibly special gift. I can't use the money for something my parents wouldn't approve of!

THERAPIST: You feel certain they wouldn't approve of using the fund to support your medical care?

SALLIE: I don't know. I bet they'll think I'm so messed up that I need to spend this money on stupid therapy! (*Tears up and grabs a few tissues out of the box.*) I don't really talk to them very much about coming here, you know.

[*This illustrates how limit setting—holding to the frame—helps bring the underlying issues to the surface. Sallie may be more fearful of her parents' disapproving attitude than she is about the vague conditions of the trust fund.*]

THERAPIST: I hope you can say more. I think I'm beginning to understand why this is so upsetting to you. If you spend some money monthly on psychotherapy, you worry your parents will think you are messed up? [*using Sallie's words to describe her concern*]

SALLIE: I'm incurable. I know they already think I'm nuts that I have to see a shrink to help me recover after a breakup with a boyfriend!

THERAPIST: Seeking help during a difficult time isn't seen as a strength?

SALLIE: No, it's not. And the fact that I tell you how I feel and you still increase my fee makes me really upset.

THERAPIST: Yes, I can see that the increase in fee is very upsetting to you.

SALLIE: So, why did you have to do it?

THERAPIST: Because you are not as limited financially as I had previously believed, and I'm not independently wealthy and able to slide a fee when resources are available to pay the full amount.

SALLIE: Maybe I'll just stop therapy altogether.

THERAPIST: I would hope that wouldn't happen because of the fee increase, but it is always your choice. We have a lot to discuss about this loaded topic, and there is probably much to learn from it.

SALLIE: Yeah, but you aren't the one who is disappointing her parents.

THERAPIST: I'm beginning to understand how uncomfortable it would feel for you to disappoint your parents. Can you tell me more?

SALLIE: I think there was only one time that I spent money on something that they disapproved of. When I was a senior in high school, I saved and saved my money for the newest version of my smartphone. For whatever reason, they thought it was a stupid thing to buy. My mother said I was indulgent. She didn't understand why I wasn't happy with my older phone. But, the new phone could do so many more things than my old one; even the camera was so much better. From my perspective, a really good phone isn't a luxury item.

I don't know. Sometimes my parents are strange about money.

THERAPIST: How do you feel now about your decision to buy this particular phone during high school?

SALLIE: Umm, at the time I felt guilty, but now I feel that it was one of the best independent decisions I have ever made.

THERAPIST: What allowed you to separate your own feelings from those of your parents?

SALLIE: I'm not sure. (*Pauses.*) I just knew I really needed it. My old phone was too slow, the camera was awful and it had really limited capabilities. It was a good investment to get a new one. But, I don't know if I feel as strongly about therapy.

THERAPIST: That's important to figure out. Perhaps it will help if you think about how you might feel if you continue or stop psychotherapy, and how you might feel if you change providers.

SALLIE: I'm not sure. I'm willing to give it some more thought, but are you still going to raise my fee?

THERAPIST: Yes, I am, for the reasons I explained, but I appreciate that you are really working hard here. By having these conversations, I think we will learn more about what money means to you and how your parents may influence your decision making.

FEE CHANGE

For any significant fee change, it is useful to follow the steps demonstrated in Example 8.4: (1) The therapist lets the patient know they are considering raising the fee weeks ahead of time, in order to get the patient's input. (2) The therapist reminds the patient of the fee increase before the next bill. (3) Even after the decision to increase the fee has been made, the therapist remains open to talking empathically, and not defensively, about the patient's monetary concerns.

I have a different approach for small fee increases. Every 2 years, I generally increase my session fee by about 5–7%. For a patient with financial limitations, or a family anxious about new expenditures (a new baby, a child off to college), I may delay the increase until the financial situation seems more stable. I announce the fee increase a few months ahead of time at the bottom of my bill with a small notice: "*As of MM/DD/YY, my 50-minute session rate will increase to $_____. Please contact me if you have any questions or concerns.*" (See the sample bill in Figure 8.1 for an example of this notation.) Generally, patients view this small fee increase as reasonable and fair, and pay the increase without any discussion, preferring to spend session time on other topics.

BILLING

For most patients, a straightforward and clear discussion about monetary issues early in the treatment sets the stage for an unencumbered collection process. I require new patients in my private practice to sign a treatment contract that outlines my billing procedures and their financial responsibilities. This type of contract differs depending on region and by specialty, but generally it may include the decided fee, the expectation of timely payment if the patient is paying out of pocket, or the planned approach, when the patient is using insurance, if the insurance company denies payment. Some therapists may also accept credit cards, keep a credit card "on file," charge interest for unpaid balances, or document the plan to use an agency that specializes in medical collections for unpaid balances (Hill-Spaine, 2012). By explicitly outlining the method for money transfer from the get-go, it is also easier to delve into any emotional reaction to the billing process.

There are multiple ways to approaching treatment billing. Unless a patient prefers to pay at each visit, I bill for my services at the start of each month and expect payment by month's end. A money exchange at every meeting can be distracting, so I only insist on session-to-session payment when a patient has repeatedly fallen behind on their account. In this book's first edition, I described handing each patient their bill at the beginning of the month, to promote an immediate discussion of the bill if there are

[Letterhead here]

Sallie Gane
1111 Central Street
Boston, MA 02114
(h) 617-555-3333
(cp) 617-555-8882

For Professional Services:
ICD-10: F32, F50.9

Date	Description	Credits	Charges
9/8/YY	50-minute individual outpatient psychotherapy		
	CPT code -90834		$_____
9/15/YY	50-minute individual outpatient psychotherapy		
	CPT code -90834		$_____
9/22/YY	50-minute individual outpatient psychotherapy		
	CPT code -90834		$_____
9/29/YY	50-minute individual outpatient psychotherapy		
	CPT code -90834		$_____
		Balance due:	$_____

Billing date: October 1, 20____

Balance due at month's end

State License Number:

NPI:

TAX ID:

Please pay the overdue August balance of $_____ upon receipt of this invoice, if you have not done so already. Please contact me with any questions or concerns.

As of December 1, 20____, my 50-minute session rate will increase to $_____. For any questions or concerns, please contact me to discuss.

FIGURE 8.1. Sample bill for ongoing treatment.

any problems or questions. Now, I recommend sending the bill through the mail, especially as there are a number of patients whom I don't see weekly, or whose parents are paying for their treatment. If payment is a problem, I feel comfortable bringing up any billing issue directly with the party responsible for the treatment. With mailing, monetary issues do not interrupt the treatment unless payment isn't received.

LATE PAYMENTS

Every now and then patients don't pay their bill, and the overdue balance becomes an issue within the psychotherapy. If Sallie did not pay her bill and then took a break from therapy, I would send her duplicate bills over the next few months. Most often, a lack of payment is an innocent oversight: the patient was busy and they forgot to pay the bill. For a first late payment, I give patients the benefit of the doubt and just add a note to the bottom of the next month's bill noting the overdue portion: "*Please pay the overdue July balance of $_____ during the first week of September if you have not done so already. Please contact me with any questions or concerns.*" Often, this note is all that is necessary to procure payment. If I don't receive payment within a week or two, I reach out to the patient and ask if they have any questions or concerns about the bill, or if they are struggling financially. Most often, the lack of payment is an oversight, and payment quickly follows our discussion.

In some instances, a patient doesn't pay their bill because of financial difficulties. My response to the patient's needs will depend on my financial limitations. If I am able, I help facilitate further treatment by reducing the patient's fee temporarily, or even permanently. During the COVID pandemic, I decreased the fee of patients facing financial strain with the understanding that I would increase their fee back to its prior rate when their financial situation stabilized. I may also set up a payment plan if a patient has an outstanding balance. As long as a patient works with me in good faith, I don't mind if a bill is paid off slowly. If paying for therapy becomes an undue burden that negatively affects the process, I may refer a patient to lower-fee treatment options.

The situation is complicated for the patient without financial limitations who continues to come for appointments without paying their bill. The first time I was faced with a patient who didn't pay their bill, I didn't initiate any discussion about the unpaid balance and just hoped silently that the situation would spontaneously resolve. This strategy didn't work, and it even jeopardized the therapy as I became more and more resentful of working without compensation. Nowadays, I discuss this issue with a patient early and often, if it isn't resolved quickly. (Please see Example 8.5 for more details how to approach this situation.) I am more empathic at

exploring the patient's feelings about monetary issues when the amount owed is not prohibitive.

In my years of experience, I have found most patients to be honest and thoughtful when paying off an outstanding balance. As a final last resort, a therapist can consult a reputable and ethical agency that specializes in medical collection to obtain an overdue payment. Ideally, the goal is to avoid this type of antagonistic situation. A proactive approach that favors clear, open, and frequent communication about payment generally prevents the need for a more adversarial approach.

In Example 8.5, Sallie has the financial resources to pay her bill, but her ambivalence about the therapeutic process impedes the payment process. The best approach combines business finesse with some psychotherapeutic principles.

EXAMPLE 8.5

Discussing payment with the patient who hasn't paid

It is December 29th, and Sallie has not paid for her November sessions. The bill is due December 31.

THERAPIST: (*Interrupts flow of conversation about 15 minutes into the session.*) I definitely want to hear more about what has been going on, but we do need to take a few minutes to iron out a few administrative details.

SALLIE: Oh, like what?

THERAPIST: I just wanted to remind you that the November bill is due in 2 days. Do you have any questions about the bill?

SALLIE: Oops. I guess it's due really soon, huh? I don't think I'll be able to get you the check in 2 days, but I'll definitely pay you the first week in January. I just forgot. Thanks for reminding me.

By the next session, the bill is about a week overdue. I interrupt Sallie at approximately the 15-minute mark. I also might send an email reminder a few days prior to the session requesting the overdue payment during this meeting.

THERAPIST: I wanted to make sure to ask you about the bill this session because it is overdue. Are you able to pay it today?

SALLIE: Oh, no! Did I forget again? I planned to pay today, especially after you sent the email reminder on Monday. I don't know what is wrong with me! I'm so sorry, Dr. Bender.

THERAPIST: I appreciate you planning to pay it today. Could you mail it to me, so I receive payment before next week?

SALLIE: Oh, I feel so guilty that you have to keep reminding me, but then I keep forgetting to write the check before I leave home. I am really sorry. I'll try to remember to mail you the check.

THERAPIST: Hmm, what do you think would work to help you remember?

SALLIE: I'm just disorganized; if I don't mail it, I'll definitely make sure to bring the check next time.

Next Session

I bring up the subject of money at the beginning of the session to check in regarding the outstanding payment. When a payment is late, regular check-ins are protective of my finances and the therapy. It is easier to be thoughtful during this discussion if the overdue balance is not sizeable.

THERAPIST: Let's start the session by touching base about the bill.

SALLIE: Umm, oh my goodness, I forgot my checkbook again. I don't know what is wrong with me. I am so embarrassed.

THERAPIST: Let's also take some time to try to understand why the bill has been so difficult to pay. Are you in any financial trouble?

SALLIE: Well, things aren't great, but they aren't incredibly tight either. I just need to review my expenses to make sure I can pay you. I think I should be able to do it.

THERAPIST: How do you understand this—that you keep forgetting to write me a check?

SALLIE: I don't know. I always try to remember after I leave here and then I forget.

THERAPIST: When you think about payment and money in therapy, what feelings come up?

SALLIE: I don't know. Money is hard for me.

THERAPIST: Hard for you in what way?

SALLIE: It just feels weird paying you to talk to me.

THERAPIST: I'm glad you could share this with me. Could you tell me any more about this weird feeling?

SALLIE: I'm not sure what it is exactly. It feels uncomfortable to pay you to listen to me.

THERAPIST: Can you tell me more about how it is uncomfortable?

SALLIE: I just feel that therapy is such a strange concept. We sit here and talk about all these very private things, and then I get a bill weeks later. Why can't I make friends that would listen to me for free? Why am I so screwed up that I need to do this?

THERAPIST: Our work is definitely unique. We talk about private topics, which may feel similar to a friendship, and the collaboration is meaningful and connected, like a friendship. Psychotherapy is also different from a friendship because the rules of therapy confine our relationship to these meetings, and my purpose is solely to understand your struggle, using my training to guide us. Does it feel complicated to get a bill reminding you about the working rules for psychotherapy and how our work is different from a friendship?

SALLIE: Sort of . . .

THERAPIST: (*Nods encouragingly.*) Can you tell me more?

SALLIE: Well, first, I just wonder how you view this whole thing.

THERAPIST: For the sake of the therapy, can you tell me what you imagine?

SALLIE: I don't know. I just sometimes wonder if you only care about the money. Therapy is pretty expensive. Maybe that is the only reason you do this.

THERAPIST: Can you tell me more?

SALLIE: I just worry that all your concern is fake. Maybe it is so hard for me to pay because that makes it crystal clear that you are not a friend. And you are the nicest person I know at college right now. It feels so weird. Maybe if I don't pay you, I can sort of pretend that we have a connection that is more real.

THERAPIST: It doesn't feel real because it is a therapeutic relationship?

SALLIE: Yes, the money clouds it all.

THERAPIST: The special connection between a therapist and patient is real, but it makes sense that it can feel strange because it is unique. While payment provides a frame for the professional nature of the relationship, that doesn't mean that it isn't meaningful for me to work with you as we try to understand your struggles with Charlie and Gwen. I am invested in helping you understand what happened and moving forward. I hope we can continue working together, but to do so, I do need to get paid.

The Bill Payment Is 1 Month Late

SALLIE: Dr. Bender, I have your check! I am sorry it was so late. I'll pay for this session now, too. It feels so good to be caught up.

THERAPIST: Thank you so much. What enabled you to bring this check now?

SALLIE: I'm not sure really. I got a little worried that you might stop seeing me if I didn't manage to pay up soon.

A pattern emerges. Sallie eventually pays her monthly bill, but it is always several weeks late, requiring me to chase her for payment every time.

THERAPIST: (*Brings up topic midsession.*) Let's take a few minutes to review the money situation. Your bill has been late several times now, and to avoid a similar situation in the future, I think it would be reasonable for you to pay for each session at the time of the meeting—starting next week. What would be better for you—to pay at the beginning or at the end of each session? [*I provide two choices that are acceptable to me.*]

SALLIE: Oh, the end, I think. It might be hard to get started if I'm sitting here writing a check before the session starts.

THERAPIST: How do you feel about this arrangement?

SALLIE: I guess it's fine, but I can't start today. I'll pay for two sessions and last month's bill next week. Is that okay?

THERAPIST: That would be fine, but then I think it will be useful for us to follow the new payment plan during each session.

SALLIE: You're probably right. I'll see you next week.

At the End of the Next Session

THERAPIST: We'll need to stop a couple of minutes early to catch up on payment for this session and your current overdue balance.

SALLIE: Oh, yes. I am supposed to pay up today. I don't know how to say this, but I don't have my checkbook again.[3] Now what should we do? I'm really sorry.

THERAPIST: I know that paying for therapy feels very complicated to you, but to continue working together, I do need to get paid. We need to figure out a way for billing to work within your treatment; that is our first priority now. Once the bill is paid in full, I hope we will have the opportunity to understand why it is difficult for you to pay me on a regular basis.

SALLIE: Dr. Bender, you know that I intend to pay the bill and, eventually, I always do. I'm not trying to cheat you. I'll pay you next week.

THERAPIST: I'm glad that you intend to pay me next time, but as I had mentioned before, I would like for us to have a dependable payment plan so you don't regularly have an outstanding bill. Meanwhile, I think

[3]There are alternate forms of payment rather than a check. Therapists need to check that their preferred method of payment is HIPAA-approved. Of note, if the patient is ambivalent about paying for treatment, payment may be avoided no matter how many payment options are available.

that it is time for you pay me before each session. If you don't have your payment at the beginning of our next session, we'll reschedule the appointment. Does that sound reasonable to you?

SALLIE: No, I don't think that's fair.

THERAPIST: Considering what's been going on, what do you think is fair?

SALLIE: In another month, my finances will be in great shape, and it will be no problem to pay my balance, but right now I'm pinching pennies.

THERAPIST: I'm not willing to wait a month, but I am willing to extend your credit 1 week more. [*In other circumstances, I might be more willing to set up a payment plan when I hear a patient is struggling with their finances. In Sallie's case, I know she has access to her trust fund to pay me and she has not been responsible about her outstanding balance, so I only offer limited flexibility.*]

At the Beginning of the Next Session

THERAPIST: Before we begin, here is the outstanding bill that includes today's meeting.

SALLIE: (*Searching anxiously through her backpack*) Oh no, oh, please don't be mad at me. Dr. Bender, I messed up again. I didn't bring my checkbook. What happens now? (*Begins to tear up.*)

THERAPIST: I am sorry, but without payment today I need to end our session now, and reschedule after you have paid off your balance. We can reschedule for another session, but in order to have that meeting, it will be necessary for you to pay your balance. [*Sallie had reviewed her finances with me at a prior session including plans for a few expensive vacations. My sense is that she is able to afford the treatment, but for complicated reasons, she has not protected funds to cover the psychotherapy.*]

SALLIE: But Dr. Bender, what happens if there is an emergency and I need to talk to you?

THERAPIST: I hope we can continue to work together after the bill is paid. We can talk briefly by phone if you need to check in, but I will need to send you for evaluation at your local clinic or emergency room if you need more intensive treatment.

Another option would be to transfer treatment now to a local clinic that provides therapy at a much lower fee. I don't want you to ration care with me because of the expense of treatment. It may make more sense to find treatment that doesn't create additional financial stress.

I end the meeting and charge Sallie for the adjourned session. When she pays the outstanding bill, we resume psychotherapy, with payment at the start of every session.

When Sallie repeatedly forgets her checkbook, we can assume the action is multidetermined and emotionally meaningful. She is acting in a passive–aggressive manner when she repeatedly denies me payment but does not acknowledge the hostility driving this behavior. As the therapy deepens, Sallie and I may learn more about her use of delay and withholding in multiple personal relationships. As relationships rarely flourish in such an environment, Sallie's interactions with others might improve substantially when she is ready to learn about this part of herself.

When I have to withhold Sallie's treatment because of an unpaid bill, I also make sure to inform her of the services available at her local emergency facilities in case of an emotional crisis. During this transition phase, I am still her designated clinical provider; if she is in crisis, we will touch base so I can direct her to appropriate care. My role does change from one of treatment to one of triage; I am concerned about her welfare, but I don't want to provide free treatment, which would support Sallie's wish that I treat her as a friend and without charge.

Now and then, a patient's parents refuse to pay the bill in a timely manner, after they have promised to fund the treatment. In Example 8.6, Sallie's parents offer to subsidize her treatment, but then they do not pay for the sessions as promised; the example illustrates some tactics I use when faced with this predicament.

EXAMPLE 8.6

How to react when a patient's relative refuses to subsidize the therapy as previously promised

In early December, I mail Sallie a bill for her November sessions. I know she will be forwarding it to her parents as they have been mailing me payments for her treatment. The bill is still unpaid and is now more than a week overdue.

Midsession, January 10th

THERAPIST: I wanted to mention to you that I haven't received payment from your parents for the last bill that I sent to you. Are there any problems with the payment that you know about?

SALLIE: Umm, I'm really sorry they haven't paid it yet. I mailed your bill to my parents right after I received it.

THERAPIST: Any ideas why they haven't paid the bill yet?

SALLIE: I don't know really. I *sometimes* wonder what they think about the fact that I am in therapy again.

THERAPIST: What have you wondered about?

SALLIE: Oh, when they learned I was back in treatment, they made a couple of stupid wisecracks about it. They couldn't understand why I needed

a therapist to talk about a boy. According to my mom, I might as well call "rent-a-friend." But, after all the jokes, they did say that they would pay for the sessions.

THERAPIST: How did you feel when they referred to me as your "rent-a-friend"?

SALLIE: Horrible. Wouldn't you?

THERAPIST: I can understand why it bothered you. Why would they say such a hurtful statement?

SALLIE: I don't know. I'm probably being oversensitive.

THERAPIST: It may be difficult to find the words to respond to your parents' comment if they don't realize the significance of your current distress or how hard you are working in psychotherapy. Have you discussed this late bill with them?

SALLIE: Not really. I let them know I mailed the bill, and I expected they would mail you a check before January 1st. I don't know what's wrong.

THERAPIST: Do you feel comfortable asking them about it?

SALLIE: No, not really.

THERAPIST: Could I have your permission to call them about the bill?

SALLIE: Oh, I don't know. They'll pry for details about my life.

THERAPIST: I can understand your concern. I promise to only talk finances with them, but I would like to approach this in a way that feels thoughtful to you. How should we approach this so both the therapy and your privacy can be protected?

SALLIE: I guess I'll talk to my parents. I'll tell them the payment is overdue, and they need to mail you a check right away.

THERAPIST: Okay, that sounds fine.

Sallie comes to the next meeting in tears.

THERAPIST: (*Waits for Sallie to start talking.*)

SALLIE: My parents are acting so weird. They have all these excuses why they can't mail the check this week. I don't get it. They promised to support the therapy, and I know money isn't the issue. I don't know what to do.

THERAPIST: What was the conversation like?

SALLIE: When I asked about the check, they were very vague. I don't know if they plan to mail it anytime soon.

THERAPIST: Have they ever done something like this before?

SALLIE: Once when I asked them for some money to fund a school retreat

to Vermont for the weekend, they said "yes" at first, but never came through with the money.

THERAPIST: Then what happened?

SALLIE: Well, eventually, they paid, but only after I talked to them about the project in more detail.

THERAPIST: Could that be what they are looking for here? Maybe if they felt more included in your treatment, they would be more willing to pay. We could do this without sharing private information about your psychotherapy, but giving them an overview of the process. How would it feel to you if I gave them a call to try to clear things up?

SALLIE: (*sniffling*) Okay, but what are you going to tell them?

THERAPIST: That is an important question. What would feel comfortable to you?

SALLIE: You can tell them that I sometimes feel depressed.

THERAPIST: You met criteria for a major depression when we first started meeting. And may I fill them in on some of the symptoms of depression that you have experienced, like loss of sleep and appetite?

SALLIE: Yeah, that would be okay, I guess.

THERAPIST: Anything that you would like me to avoid mentioning?

SALLIE: Don't tell them any details about Charlie and the whole problem with him. Are you going to tell them a lot about me?

THERAPIST: No, but I do think a bare-bones outline of what we are doing may help them understand the therapy a little better. Would you be willing to sign a form authorizing me to talk to them?[4]

SALLIE: Okay.

THERAPIST: I will also fill you in on our conversation at our next meeting.

SALLIE: That sounds good.

Phone Call to Mr. and Ms. Gane

THERAPIST: May I talk to Mr. or Ms. Gane, please?

MS. GANE: This is Ms. Gane.

THERAPIST: Hello, this is Dr. Bender, I am the psychiatrist treating your daughter, Sallie. Am I catching you at a time when you are free to talk?

MS. GANE: Oh, yes. Is Sallie okay?

THERAPIST: Yes, this isn't an emergency call, but I have some concerns I wanted to share with you. Sallie has some difficulties, but I think the treatment is helping her to feel better. I am calling to clarify whether you are willing to finance her therapy. Her current bill is overdue.

MS. GANE: Of course, we will provide whatever Sallie needs, but do you

think she really needs therapy? Breakups are a normal part of growing up.

THERAPIST: I think the therapy has been helpful for Sallie, especially as she has suffered from symptoms of depression as a result of the tough breakup.

MS. GANE: Oh, I don't know. Sallie was already in therapy once during high school. I don't think she really needs any more.

She was doing just fine before the breakup with Charlie. She'll survive. I'm sure she'll be fine in a couple of months.

THERAPIST: There may be a misunderstanding. Your daughter has been struggling with a depression, which is different from just having an unhappy mood. She has been improving with treatment, but if her mood disorder isn't treated, it can lead to other problems, some of them serious.

MS. GANE: What kind of serious problems?

THERAPIST: When symptoms of a depression are untreated, a person can lose sleep and appetite, which was already happening to Sallie when I met her. With untreated depression, an individual is at risk of becoming profoundly hopeless and, in about 15% of cases, become suicidal. If depression is treated, these problems are usually avoided.

MS. GANE: Oh, no! Is Sallie suicidal? Is that why you are calling?

THERAPIST: While I don't want to reveal the details of the therapy with Sallie, I can promise you that if I thought her condition was an emergency and she was at high risk for hurting herself, I would let you know.

MS. GANE: Oh, that's a relief. Our main issue is that you don't take our insurance. Couldn't Sallie see someone through our insurance?

THERAPIST: If you would prefer, I can absolutely help Sallie find someone local who takes her insurance. It is possible there will be a bit of a wait until a clinician has an opening. While it can be difficult to start treatment with a new therapist if you have already started working closely with someone else, my first priority is to help Sallie access treatment, even if that isn't with me

MS. GANE: Dr. Bender, my son has some medical problems, and we seek second opinions all the time. It has never been an issue. He's been fine with switching doctors or seeing new people. Sallie might be upset at first, but I'm sure she would adjust to seeing someone at a clinic. At least she could just meet a second therapist and see how it feels to talk to someone else.

THERAPIST: I would be glad to cooperate if she wishes to obtain a second opinion, but it is more complicated with psychotherapy than with other health professionals. It takes time to build trust to talk about emotionally intense issues. To start over is possible but not simple.

Ms. Gane: I am sorry, Dr. Bender, you do sound very concerned about my daughter, but I need to talk to my husband before I commit to paying for Sallie's treatment with you.

Therapist: Could you call me back by 5:00 P.M. tomorrow? If the decision is to transfer providers, I will need time to find Sallie another clinician and will want to get started right away.

Ms. Gane: Sure, that shouldn't be a problem. I'll leave you a message.

Therapist: Okay, that would be very helpful.

Sallie's treatment is turning into a monetary morass. It isn't easy to figure out how to proceed. It would be difficult for her to switch providers at this point. For simplicity's sake, we'll say that her parents decide to support her treatment with me. In real life, it is equally possible that they might insist that she transfer her care to a clinic.

I would have several options if the Ganes refused to pay for Sallie's treatment. After talking with the Ganes, I may have an increased understanding of the family's financial constraints. If they have the capacity to pay my bill without difficulty but prefer not to, I would not consider lowering my fee and would refer Sallie to treatment the family is willing to support. If it becomes clear during our conversation that the family is financially struggling, I can review my finances to decide whether I can afford to accept a reduced fee or a partially deferred fee from Sallie. If neither possibility is financially feasible, I could refer Sallie to a clinic or provider who accepts her insurance.

With a few preventive measures at the beginning of treatment, I might be able to avoid a situation like the one outlined in Example 8.6. Some therapists provide a patient with an outpatient service contract that outlines billing procedures and expectations for payment, including a payment plan if parents are responsible for the bill. Figure 8.1 provides an example of a bill for professional service; this bill also models how to follow up on a late payment and how to increase one's fee.

Money is a complicated topic. At first, setting the fee, billing, and then collecting payment may seem graceless and embarrassing to the beginning therapist. With experience, talking openly about monetary issues might be enlightening to the therapist and to the patient. Both individuals will benefit as they learn to grapple with these issues and their underpinnings in everyday life.

CHAPTER 9

Telephone Calls and Emails

From Dependencies to Emergencies

Phone calls and emails during the course of a psychotherapy can range from ordinary scheduling communications, to repeated unnecessary contacts that may herald a regressive dependency, to emergencies that require a rapid assessment and definitive response. As reviewed in Chapter 1, texting with patients is generally not recommended. The therapist's responsibility is to discern the nature of the communication and to respond appropriately. When responding to a phone call from a patient in crisis, the therapist needs to keep calm and listen with empathy and respect. The goal is to help the patient access effective coping skills.

Every time I examined a patient in medical school, my work was checked and double-checked by physicians with more experience. I had a little more autonomy as a medical intern the year after graduation, but not much. As the physician on the inpatient team with the least amount of experience, I was responsible for the patient care tasks that required the most time and the least skill. My beeper was my constantly intruding nemesis. Every time I received a new page, I knew my job list for the day had just lengthened.

Internship does have some hidden perks that I didn't appreciate at the time. Because I didn't have primary responsibility for the patients on the ward, my patient care responsibilities ended when I exited the hospital at the end of the day. While at work, I was at everyone's beck and call, but when I was off, I was unreachable and free.

After my internship, I began 3 years of residency training in adult psychiatry at Massachusetts General Hospital (MGH). I was ready to discard

my role as the medical team's peon and to assume my new identity as a novice psychiatrist, but I expected to be coddled as the ignorant newcomer.

I wasn't.

Instead, the 1994 MGH Adult Psychiatry training program highly valued early independence. While the entire staff, from the chief of psychiatry down, was always available for questions and for teaching, I was expected to grow out of my underling's mentality and to assume primary responsibility for my outpatients.

Within the first weeks of my residency, I became the designated psychiatrist for a small group of outpatients from the psychotherapy and psychopharmacology clinic. In case of an emergency, these patients (*my* patients!) could have me paged through the hospital operator at any time. During my training, now decades ago, I was expected to keep my beeper on (unless I had signed out to a coverage clinician during a vacation), from the moment I signed my employment papers until the day I graduated.[1]

At first, I hated this arrangement. To be honest, I spent my first week at MGH trying to drum up support for an alternate emergency coverage system. At neighboring psychiatric programs, the residents signed their beepers out to the psychiatrist-on-call after 6:00 P.M. I expected that my colleagues would also want to adopt a less demanding coverage approach, but I was outvoted.

As I slowly adapted to the idea that my beeper was a new constant in my life, my next response, and my next mistake, was to romanticize my new appendage. Early on, I had only a few patients, so I didn't expect that I would be called frequently after hours. I made sure the pager was on my nightstand every evening so I could respond immediately to any alert. The arrangement became problematic as I began to view my beeper as a type of baby monitor. I was poised for the first "cry," ready to comfort and to help if my patient needed me.

While my attitude was steeped in empathic good intentions, it wasn't therapeutic. Patients aren't babies, and thinking and treating them as such are infantilizing.

It's a delicate issue. My patients should be able to reach me in a timely manner for questions and concerns. On the other hand, if I respond immediately and eagerly to nonemergency pages after hours, I might encourage these types of interactions and even promote a patient's regression.

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[1]Fast forward a few decades, and requirements from the national Accreditation Council for Graduate Medical Education (ACGME) continue to evolve and often are more protective of trainee time off. In 2019, training programs were mandated to provide trainees a monthly average of one 24-hour period a week without emergency coverage responsibility. In addition, for many psychiatry training programs, an evening sign-out program for residents' pagers has become the norm. While I wholeheartedly support trainee-protected time off, I also believe training is the ideal time to learn how to manage emergency coverage for one's outpatients.

Patients first learn about a therapist's emergency availability at the beginning of a treatment. The verbal and nonverbal cues during this discussion can set the tone for the entire therapy. Early in my career, I unwittingly encouraged increased dependency by presenting the beeper (or the message center) as a conduit for unlimited after-hours contact. The same potential pitfalls exist for those who use a cell phone number for emergency coverage.

EXAMPLE 9.1

The therapist sets herself up for abuse of her emergency services

End of First Consultation Session

THERAPIST: Let me tell you how to reach me in case you need to reschedule or in case of an emergency.

SALLIE: Okay.

THERAPIST: (*somewhat proudly*) I have my voicemail number listed on the card if you want to leave me a message. I also have my beeper on 24 hours a day in case of emergencies.

SALLIE: (*Nods.*)

THERAPIST: If you have an emergency, please page me immediately, and I will get back to you right away.

My statement without clear limits, "If you have an emergency, please page me immediately, and I will get back to you right away," offers my pager (or nowadays, often a cell phone) as a patient's lifeline. Putting aside the fact that this statement may detrimentally affect my private life, acting as a personal 911 service can lead to disastrous consequences if modern technology fails, with impaired transmission or reception. It would be tragic to miss the emergency page or call from a suicidal patient who is poised to act.

Example 3.5 reviews how to talk to a new patient about the appropriate use of an emergency contact system. Whether I use a beeper, a cell phone, an answering service, or a voicemail system for emergency coverage, the basic rules are the same. I don't promise that I will be able to answer a message immediately, but I will return the call as soon as I am able. A patient also needs to know that it is their responsibility to go to the nearest emergency room for acute intervention if they can't wait for my reply. From the get-go, the patient and I share the responsibility of reacting to a crisis.

Some therapists work in group practices or community clinics in which a designated person or a designated emergency facility takes calls after hours. For these patients, emergency care is provided by the clinician on call, who may or may not be the patient's primary provider. To provide

the most seamless coverage, therapists in a group practice may want to inform colleagues about their more fragile or higher-risk patients. If a patient expresses disappointment that you, their personal therapist, won't be available after hours, their feelings should be thoroughly discussed within the treatment. But, usually the coverage system should not—and often cannot—be altered.

Surprisingly, although I graduated from my residency decades ago, I've continued with the beeper coverage system that I used during training. In retrospect, I appreciate that my training program didn't let me off the hook after hours. I've learned how to respond effectively to emergency pages and to set limits when a patient pages me excessively and inappropriately. There are advantages to this system that I hadn't recognized when it was first introduced to me. Since I am only answering pages of my patients and not covering a larger group (unless I am covering for a colleague on vacation), I am best prepared to answer questions and to respond to concerns because I know my patients so well. Since I am familiar with the personality style of each patient I treat, I am less likely to over- or to underreact to an emergency call.

These skills emerged slowly with experience. The following examples document some of the clinical scenarios that helped me learn to set limits with the patients in my practice.

DEPENDENCY PHONE CALLS

Early on, it was easy to let a phone call develop into an unscheduled therapy mini-session.

EXAMPLE 9.2

The therapist allows and then encourages extended phone calls outside the session

On Wednesday, Sallie Gane cancelled an appointment for the first time on the morning of the appointment. She said she was ill and unable to come to our session.

On Saturday evening while I am at the local movie theater with my husband, my beeper goes off. The beeper reads, "Sallie—" and is followed by her cell phone number. She has never paged me before so I feel worried, leave the film, and head to a private area to call her back on my cell phone. If I am answering using my personal cell phone, I block my number before calling back.

THERAPIST: May I talk to Sallie Gane, please?

SALLIE: It's me. (*Sniffles.*) Dr. Bender, I just feel horrible, so I called you.

THERAPIST: What's wrong?

SALLIE: Well, remember I told you that one of the ways I have coped with the breakup with Charlie is to talk to my friend Gwen? Well, I just got into a terrible fight with her, and she is one of my only friends here at school. We were arguing about what to do tonight, and then, in the middle of the discussion, she got up and walked right out of my apartment. She even slammed the door. I don't know what to do. I'm sure she hates me now.

THERAPIST: I understand why this was upsetting; I know Gwen has been such a support for you. How are you managing?

SALLIE: I just feel overwhelmed. I didn't know what to do, so I called you.

THERAPIST: Could you tell me what happened?

SALLIE: Well, it started over breakfast yesterday. (*Starts describing the details of the fight. Sallie and I talk for 30 minutes.*) [*I miss the end of the movie. She receives a free psychotherapy mini-session.*]

SALLIE: Oh, Dr. Bender, I feel so much better. I really appreciate that you called me back. You are the best doctor I have ever had!

THERAPIST: I'm so glad you feel better. Feel free to call me back if I can be of further help. [*I feel proud and accomplished that Sallie's crisis has passed due to my therapeutic intervention.*]

As an insecure novice practitioner, flush with the power of being a therapist rather than a medical intern, I believed that Example 9.2 modeled the ultimate empathic response. Sallie had felt abandoned and bereft, and I was available, approachable, and comforting. But Sallie's call was not truly an emergency clinical situation. She called for reassurance, and I sacrificed a substantial amount of my free time to take care of her. The question is whether this type of behavior should be encouraged.

There are many hazards to providing extensive psychotherapeutic discussions outside the scheduled session. If Sallie realizes she can obtain an unscheduled evening mini-session after an emotionally difficult day, this sort of phone call may be just the first in an upcoming series. Weekend or evening calls, especially after a missed weekly appointment, may become more frequent. Sallie might even try to substitute telephone calls for regular office visits. Complex payment problems might arise. If I'm really unlucky, the behavior might be contagious, with the patient's relatives or friends starting to call me to partake of my cost-free and—for them—"risk-free" therapy.

I might also become resentful of Sallie if she phones frequently. Without noticing, I might emotionally withdraw from her during our normally scheduled time, and the therapy itself might suffer. (Such a withdrawal would be an example of a countertransference enactment.)

Finally, by missing a significant amount of my planned evening entertainment in order to untangle Sallie's tiff with Gwen, I may convey the subtle message that I don't believe Sallie can cope with her troubles independently. If Sallie is treated as though she is incapable of handling emotional distress without extensive intervention, she might learn to fulfill these expectations. (This would be an example of intersubjectivity.)

However, a harsh response to a patient's emergency call is not the right approach either. Example 9.3 outlines how a therapist can be available while simultaneously setting limits and not encouraging evening or weekend comfort calls.

EXAMPLE 9.3

Assessment of a situation after an emergency call followed by a quick but empathic crisis intervention

Same scene: Sallie pages me Saturday night while I am at the movies after she missed her appointment the Wednesday prior because of reported illness.

THERAPIST: May I talk to Sallie Gane, please?

SALLIE: Well, remember. . . . [*See Example 9.2 for details of Sallie's fight with Gwen.*] What am I going to do?

THERAPIST: [*assessing whether the situation is an emergency*] How are you doing?

SALLIE: I just feel so upset. I didn't know what to do, so I called you.

THERAPIST: It sounds like it was a difficult situation.

SALLIE: Yes, I can't believe it. She never walked out on me before. What if our friendship is totally over and done with?

THERAPIST: Have you ever gotten into these types of fights with Gwen before?

SALLIE: Yeah, we do tend to disagree. But, this fight felt much more intense.

THERAPIST: I don't know a lot about your friendship with Gwen, but I can understand why the fight troubled you. We'll be able to discuss this situation with the attention it deserves at our next session. Could you write down everything that happened, so we can discuss it together on Wednesday?

SALLIE: Okay, but right now, I feel so overwhelmed.

THERAPIST: (*Continues calmly, but with firm tone.*) I think your first goal at this time is to take good care of yourself. At other times when you've been upset, what has been most soothing?

SALLIE: I don't know. Sometimes I feel a little better if I just veg out and watch a show. I guess sometimes I also write in my journal.

THERAPIST: These are good ideas.

SALLIE: Well, my weekend has gotten off to a fabulous start (*sarcastically*), but I should be okay. Can you give me any advice about Gwen?

THERAPIST: I don't think there is an easy answer, and I don't want to simplify a complex situation. Together on Wednesday, we'll try to make some sense of what happened (*with a tone of voice indicating that I am starting to end the conversation*).

SALLIE: Thank you for calling. I'm sorry I bothered you.

THERAPIST: It sounds like a distressing situation, but I look forward to talking to you more about it next week. If you'd like, you can also share with me what you write in your journal.

SALLIE: Okay.

THERAPIST: Take care. I'll see you on Wednesday.

SALLIE: Bye, I'll see you on Wednesday.

As a page from Sallie is an unusual occurrence, I assess whether her call is a true emergency at the beginning of our conversation. If I were the least bit unsure of the severity of Sallie's crisis, or if I didn't know Sallie well, I would screen for suicidality during this phone call, even if it felt overprotective. Since I know Sallie fairly well at this point in the treatment, I know that her risk of self-harm after a fight with a friend is very low. She has no history of self-mutilatory actions, suicidal gestures, or recent behavior consistent with a substance use disorder. Since Sallie is not in imminent danger, I limit our conversation to a brief empathic crisis intervention.

At the beginning of the phone call, I make a conscious effort to validate Sallie's feelings. Then, as it would be impossible to review the fight in adequate detail over the phone without supporting the Saturday night paging behavior and ruining my weekend movie night, I postpone a more detailed discussion until our upcoming session. The comment "We'll be able to discuss this situation with the attention it deserves at our next session" establishes the limits of the phone call while simultaneously acknowledging Sallie's concerns.

During our conversation, I avoid asking Sallie for any emotional associations to the upsetting episode. Instead, I help her identify readily available adaptive strategies that may enable her to feel a little better while enhancing her independence. I don't take on the role as the primary comforting person in her life, and I avoid any invitation to call me later if she continues to feel upset.

By returning Sallie's page, reminding her of our upcoming session, and then encouraging recall of other ways she can comfort herself, Sallie's isolation is diminished; a malignant regression is not encouraged; and my

private time is protected—all in a 5- to 10-minute phone call. In our subsequent session, I'll ask Sallie how she experienced our phone conversation. A discussion of her reaction will help increase my understanding of her predicament and will reinforce the therapeutic alliance.

A small percentage of patients try to contact me frequently between sessions. With a persistent, intransigent caller, I end each phone session as quickly as courtesy will allow and then discuss the calls in careful exploratory detail with the patient during the next scheduled session. If the nonemergency phone calls or pages continue, I might be at risk for unleashing my frustration on the patient after enduring numerous interruptions. Instead, I limit my availability for nonemergency phone calls using the empathic, firm, and effective approach illustrated in Example 9.4.

EXAMPLE 9.4

Setting limits empathically for outside phone contact between sessions

Sallie has contacted me several nights in a row to talk about her troubles with Gwen with frequent urgent pages to talk about her worries.

Twenty minutes into our first in-person session since the string of urgent calls:

SALLIE: And so, I just don't know what to do with Gwen!

THERAPIST: We need to continue trying to understand this friendship and what it means to you, but I think it's important to take a little time to talk about your calls to me this week.

SALLIE: Oh, you were really helpful. Thank you for being there for me. This has been such a tough week.

THERAPIST: I'm glad I was helpful, but ultimately, therapy works best if we also focus on techniques you can employ independently if you are feeling low between sessions. The best way to cope with an ongoing situation that is difficult to deal with—like Gwen—is to have a number of strategies in place, ready to use in case you are feeling low. Then, in our session, we will be able to give the topic the time it deserves.

Let's think together of other ways you've been able to soothe yourself when you've been upset in the past.

SALLIE: Well, I don't know. What do you mean?

THERAPIST: Before we started working together, what would you do to help yourself feel better when you felt upset?

SALLIE: I don't know . . . I might watch a show on my computer in bed.

THERAPIST: (*Nods.*) What else?

SALLIE: Well, sometimes I would call my mother. She tends to get impatient, but sometimes she listens when I'm upset, and then I feel better.

THERAPIST: What other activities help? Once, you mentioned that you liked to write in a journal?

SALLIE: Yeah, I know I told you about my journal, but honestly I haven't written anything for a long time. Do you think that might help?

THERAPIST: Journals may provide structure to help process a personal problem. High anxiety may benefit from 15 minutes of guided meditation or yoga available on many video-sharing channels and applications. I can provide specific recommendations if you would like. How do these suggestions feel to you?

SALLIE: I don't know. I guess I could do these things when I'm upset, but it really does help a lot to talk to you when I feel really overwhelmed.

THERAPIST: What is helpful about it?

SALLIE: Just touching base, I guess. Just hearing your voice helps.

THERAPIST: Can you tell me more?

SALLIE: I just have been feeling so alone and upset this week. I just feel a bit better after we talk. Otherwise, I feel totally alone.

THERAPIST: It does sound like it has been an especially painful week. My concern is that I am not always readily available to talk between sessions. Even when we are able to touch base, I'm not able to give your concern the attention it deserves until our scheduled session.

It seems useful for us to think about many options that might be helpful to you, rather than only relying on a call to me.

SALLIE: I don't know. . . .

THERAPIST: I have some ideas. Is there anyone at school you might feel comfortable reaching out to—a backup for when Gwen is not available?

SALLIE: Well, there is a girl Vanessa in my journalism class who has been friendly, but I feel shy about reaching out when I feel so revved up. I don't know her that well.

THERAPIST: I can understand that it isn't easy to reach out, especially when feeling so vulnerable. On the other hand, you wouldn't necessarily need to tell her that much—just ask her to study together so you don't feel so alone.

SALLIE: Maybe, but I don't know. I just like hearing your voice.

THERAPIST: Here's another option: if it is hearing my voice that is helpful, you could leave a message on my voicemail when you are feeling lonely, and we can discuss the message at our next meeting. What would that feel like to you?

SALLIE: Oh, I'd feel stupid doing that.

THERAPIST: How come?

SALLIE: Talking to a machine . . . I don't know. It might help, but it wouldn't make me feel that much better. I need to hear you talk back.

THERAPIST: Have you ever imagined what I might say at such a time? [*I'm trying to help Sallie conjure up an internal image of me for comfort between sessions so she won't need to call me after each difficult interaction with Gwen. This is an example of evocative memory.*]

SALLIE: No.

THERAPIST: What if you try it now?

SALLIE: Huh? How?

THERAPIST: Do you remember how you felt before you called me last night?

SALLIE: No, this feels stupid. I just need some extra support this week. Talking to you helps with that, not just talking to your machine.

THERAPIST: I understand that the phone calls are helpful, but I'm not always available. If you have a whole list of comforting strategies to choose from, you're less likely to become dependent on talking to me to feel better.

SALLIE: (*Nods.*) I understand, I think. But if it helps me the most to talk to you, what is so bad about continuing our talks?

THERAPIST: I'm glad our talks are helpful, but the helpfulness doesn't last. Also, there may be a significant wait from the moment you call me until I have a few open minutes to talk. If we can work together to help you find some coping strategies that you can access without me, you may be able to feel better more quickly. Over time, you will also feel more confident in your ability to take care of yourself.

SALLIE: That makes sense, but I have so much to tell you. I sometimes forget to tell you everything during this meeting, so I call you to fill you in.

THERAPIST: I am interested in being filled in, but therapy works best if we try to concentrate the work we do together during scheduled sessions. Since this is a crisis-filled week, would it be useful to meet an extra time?

SALLIE: Maybe . . .

THERAPIST: Can you say more?

SALLIE: I think it might help to talk more often. It feels like the one session a week is up before it has even started.

THERAPIST: How about we schedule an extra session this week?

SALLIE: I think it's a good idea. Let's do that.

THERAPIST: Let's also plan how you can help yourself feel better if you have another difficult evening this week between our meetings.

SALLIE: Yeah. What should I do?

THERAPIST: I would try some of the coping strategies we reviewed. You could write down your thoughts, phone your mother, watch a show, complete 15 minutes of guided meditation or yoga, or call my voicemail between the two sessions. Maybe if you feel up to it, you could reach out to Vanessa to see if she is free. If you are feeling that the situation is really an emergency and cannot wait, you can page me. If I don't answer right away and you feel you need to talk to someone immediately, it is important not to sit and wait, but to go straight to the nearest emergency room.

SALLIE: I don't get it. I wouldn't feel comfortable going to an emergency room. Why would I go there?

THERAPIST: Well, I view a page as an emergency communication. If for whatever reason you felt that you were in danger of hurting yourself in any way, that would be a reason to hightail it to the nearest ER. If you were in danger, I would want you to get immediate care in that instance and not just wait around for me to call you back. [*I reinforce the idea that my pager is for emergencies only.*]

SALLIE: Oh, I have never felt that bad. I don't think you have to worry about that.

THERAPIST: I'm glad. But it is good to review together how to use the beeper, so we both know how to approach an emergency.

SALLIE: Okay. I'm sorry if I paged you too much this week. If I need to talk to you, could I leave you a voicemail to ask you to call me back when you have a moment?

THERAPIST: Absolutely; a voicemail does make more sense if it isn't an emergency. We can touch base briefly between sessions, and then pick up the issue and talk in more detail when we meet in person. [*I continue to reinforce the idea that in-between session communications are quick and more superficial, and complicated topics are best saved for our in-person meetings.*]

SALLIE: Okay, I'm glad we will meet an extra time this week.

THERAPIST: I think it's useful that we talked about it. This new approach will actually serve you better than if we continued to talk frequently between sessions. The two meetings this week will provide some increased support. With fewer phone calls, you'll also learn how to help yourself feel better when I'm not readily available.

SALLIE: It feels a little scary, but it makes sense.

If I set limits before I've become frustrated with a patient's repeated calls, I'm much more empathic and able to follow the calm, firm approach outlined here. Shorter and more superficial phone discussions between

sessions are less enticing, and Sallie is more motivated to find outside supports to help manage her distress. By supporting Sallie's nonregressive coping mechanisms (methods of comforting herself that don't involve talking to me frequently on the phone), I play to her emotional strengths. When Sallie expresses her need to talk to me more often, the extra session is a viable alternative that works within the limits of my schedule and the frame of her treatment.

If Sallie continues to reach out for extra support during the week despite conversations such as the one modeled in Example 9.4, I may recommend ongoing twice-a-week psychotherapy or once-a-week individual psychotherapy combined with once-a-week group psychotherapy. I agree with the common therapist adage that twice-a-week psychotherapy is more than twice as therapeutically potent as once-a-week psychotherapy; sometimes increasing the intensity of treatment is the best intervention for the patient who remains unsettled with only once-a-week meetings.

As a trainee, one of my supervisors told me about a patient who would not respond to any clear restrictions, such as those outlined in Example 9.4. Despite frequent attempts at limit setting by all of his care providers, including his primary care doctor and various specialists, he paged them all frequently and at all hours whenever he became upset. To limit the patient's spiraling regression, his psychiatrist wrote a letter with the help and approval of the hospital's legal department. The letter was signed by all clinicians involved in the patient's care.

The letter outlined that the patient was not allowed to page any providers at any time if he wanted to continue to receive medical care at the hospital. Instead, frequent brief meetings with all of his clinicians were provided. All emergency care was referred to the hospital's emergency room. If the patient did page any of his clinicians, the practitioners were legally obligated to respond, but then, as documented in the letter, they could refer him to another facility for further treatment.

The psychiatrist on this multidisciplinary team presented the letter to his patient. He stated that the medical team was concerned about the patient's continued welfare and had outlined what care they could and couldn't provide, rather than just "refer" his care elsewhere, as had happened at numerous other hospitals. Since the therapist's resentment was held in check by the letter's protective limit setting, the document could be presented with consideration and concern, rather than with exasperation and desperation.

The psychiatrist was surprised by the patient's response. The patient viewed the letter as a caring gesture. It served as both a communication of treatment limits and a tangible memento of the hospital staff's interest in his condition. He carried it in his billfold for months. The serial pages ceased.

APPROPRIATE USE OF EMAIL WITHIN PSYCHOTHERAPY

While some psychotherapists avoid using email to communicate with patients, many others encourage email use for simple communications, such as setting up a phone time, straightforward simple questions, rescheduling appointments, and calling in medication refills. (See Chapter 1 for a more involved discussion on the use of encrypted or nonencrypted emails with patients.)

Overall, the addition of email to my practice brought a new level of efficiency to my work. With email, I am easily accessible without taking much time out of my private life. It is also useful to have a paper trail if my patient and I reschedule, avoiding any misunderstanding regarding a future meeting time and place. I encourage my patients to use email for simple straightforward questions Monday through Friday. I share that I don't regularly check or answer emails over the weekend, and my pager should be used to contact me in case of an emergency. If a patient emails me to ask for a phone check-in for a semi-urgent situation, and I don't respond quickly enough, it is appropriate to page me rather than wait for an email response. My pager is set up to be accessible 24/7 for true emergencies; my email is not.

Email also has the potential to become problematic if it is used to convey anything emotionally complex. Email can't be relied on to accurately convey subtleties of tone or affect. For instance, an email from Sallie, "I saw Charlie today at school and now I feel so upset," can be interpreted multiple ways. It is impossible to know if Sallie is despairing, enraged, or frustrated and annoyed. When I receive an email that tries to convey a complicated emotional experience, I avoid continuing the discussion by email. I don't reply with questions that facilitate the discussion ("Tell me more," "Can you tell me what exactly made you upset?"), as the answers are likely to be succinct and superficial, and I'm at risk for jumping to conclusions, rather than truly understanding Sallie's concerns. In addition, if I encourage a lengthier email discussion, I am now supporting the use of email as an extension of the psychotherapy hour—rather than trying to hold the treatment within the frame. When a patient's email outlines a complex emotional experience, I respond by scheduling a phone check-in that will enable me to assess the situation more thoroughly, and then to respond appropriately (as reviewed in other examples given in this chapter).

EXAMPLE 9.5

Redirecting the patient away from inappropriate use of email

SALLIE: [*via email*] Hi, Dr. Bender. Just wanted to let you know I saw Charlie today, and now I feel so upset.

THERAPIST: Not an easy situation. I look forward to talking to you about it at our next meeting. I want to hear all about it then. How does that sound to you?

SALLIE: I don't know. I'm having a really bad day.

THERAPIST: Then, I think we should touch base briefly today by phone. I'm free from 2 to 3 P.M. today. Can you email me your cell number again? I'll call you during that window. Does that work for you?

SALLIE: Yes, I'm free then. Thanks so much.

TEXTING WITH PATIENTS MAY HAVE UNFORESEEN NEGATIVE CONSEQUENCES

Some young adults, accustomed to texting with their peer group, may feel less comfortable expressing their emotions and concerns when meeting face-to-face because their peer group uses texting as a primary way to communicate. In recent years, mental health crisis lines have expanded to include texting, which allows increased access for populations in need during a crisis. (Texting 741741 provides free nationwide 24/7 mental health support, including suicide risk assessment.)

While I recognize that the 24/7 crisis text lines provide a critically needed service, I have chosen not to text with my patients, after careful consideration. Similar to emails, it is easy to misunderstand emotionally laden texts. Incoming texts may also be read by inquiring readers who happen to be leaning over your phone. In addition, to text in a HIPAA-compliant manner, one needs to use a secure approved platform (not the easily accessible texting application on a cell phone), and providers who text must also consider rules imposed by the Telephone Consumer Protection Act (TCPA). (See Chapter 1 for a more comprehensive discussion on the use of texting in psychotherapy.)

Some colleagues argue that so many young adults use texting as the main mode of communication with their friends, that we, as therapists, should allow them to contact us in the way that they feel most comfortable. As reviewed in detail in Chapter 1, I feel the risks of texting outweigh the benefits. In contrast to email, texting may involve a more rapid back-and-forth exchange, setting up an increased risk for the therapist or the patient to misread the emotional tone of the other, or to oversimplify a complex situation. If the patient requires a crisis evaluation between sessions, undistracted compassionate attention with a phone or video conversation allows careful attention to detail and decreases the chance for a misunderstanding.

COPING MECHANISMS FOR THE THERAPIST: HOW TO DEAL WITH FRUSTRATION

As patients tested my limits, I needed to find ways to release my frustration without affecting the treatment detrimentally. As a medical student,

I imagined that once I became a psychiatrist, I would always feel calm and contained when working with patients. In reality, even after years of experience, I sometimes feel irritated when faced with emotionally difficult clinical situations. The trick is figuring out how to release my frustration in an effective way that still spares my patient.

My first stop is often with supervisors and colleagues. Early on in my career, I paid for intermittent supervision. Now, even with over two decades of clinical experience, I am still a member of a peer supervision group and I don't hesitate to reach out to colleagues if I'm facing a particularly complex clinical situation. When grappling with complicated clinical scenarios, the mutual support makes all the difference.

I've also used directed fantasy to release frustration. This established technique, which Dr. Messner taught in his seminar for first-year trainees, works best if the fantasy is affect-laden, detailed, and intense. If I'm furious at a patient, an uncivilized fantasy may be an effective way to manage my feelings. In my head, I can express my frustration freely. When the distinction between fantasy and action is clearly delineated, there is no harm in releasing anger in any imaginary scenario. Such procedures are well documented in the cognitive-behavioral therapy literature.

Once I've expressed my anger in a forum apart from my patient, the treatment will be protected from my intense unprocessed irritation. By releasing pent-up patient-evoked hostility, I also will be protecting my family, friends, and associates from emotional spillovers of work-related emotions.

A therapy may benefit if the therapist is aware of an unsavory countertransference reaction toward a patient. If I'm aggravated by a patient, I'm probably not the first person to feel this way toward them, but I may be the first person able to talk to them about their actions in an empathic and curious manner. After privately pinpointing a patient's behaviors that are evoking my anger, either independently or with supervision as needed, I try to understand what benefit my patient might be deriving from these actions. Probably, they wouldn't be acting in this manner unless it satisfied some type of internal—perhaps unconscious—need. Sometimes, a patient's aggravating response may be providing emotional armor to protect themself from more painful feelings of sadness, fear, or loneliness. If my patient and I can explore this question thoughtfully, we may eventually learn the motivation fueling the behaviors. A deeper understanding may eventually lead to improved relationships at work and at home, with colleagues, family, and friends.

EMERGENCY PHONE CALLS

Fortunately, the true psychiatric emergency is a relatively rare event, but it does happen. In 2017, over 47,000 people died of suicide, the 10th leading

cause of death overall in the United States (National Institute of Mental Health, 2021), which was more than twice the number of homicides. A phone conversation with an actively suicidal patient is an anxiety-provoking experience for even the most experienced clinicians.

EXAMPLE 9.6

Emergency evaluation by phone

I receive a page from Sallie Gane on Saturday evening at 7:00. Sallie has not paged me previously.

THERAPIST: May I talk with Sallie Gane, please?

SALLIE: Dr. Bender, thanks for calling back. (*muffled, tearful voice*)

THERAPIST: You sound upset. Can you tell me what's happened?

SALLIE: I don't know. I can't really talk about it, but I just can't stand it anymore!

THERAPIST: What do you mean?

SALLIE: I'm not sure, but I thought I would call you before I did something stupid.

THERAPIST: I am glad you called me. What were you thinking of doing?

SALLIE: I don't know. I wish I could just go to sleep and escape.

THERAPIST: I'm concerned; you must be feeling pretty desperate. Have you made any plans to make this "escape"?

SALLIE: Well, I just went to the drugstore. . . .

THERAPIST: What did you get?

SALLIE: I bought a bunch of stuff. Umm . . . some pain relievers, some sleeping pills.

THERAPIST: Are you planning to take them?

SALLIE: Maybe. I haven't opened the bottles though. Everybody hates me—Charlie, Gwen. I thought getting away from it all would just make me feel better, but I thought I would call you first.

THERAPIST: I am really glad that you did. Let's think together what we can do now to help you.

SALLIE: I just feel so horrible!

THERAPIST: What would be helpful to you?

SALLIE: I'm not sure. . . .

THERAPIST: How safe do you feel tonight?

SALLIE: Ummm, what do you mean?

THERAPIST: Well, for starters, are you in a familiar place? Are you at home?

SALLIE: Yes, I'm in my room.

THERAPIST: Is anyone there with you?

SALLIE: No. I'm here alone.

THERAPIST: I wonder if you will be okay at your apartment alone overnight, or if it would be better for you to be seen in an emergency room tonight if you are at risk of hurting yourself.

SALLIE: I'm not sure.

THERAPIST: If you are not sure, then I think we should be extra careful and have you come to an emergency room to be evaluated.

SALLIE: Oh, I don't know if I want to go there. It's so cold out tonight!

THERAPIST: Here are our options. We can touch base later tonight and also by phone tomorrow, as well as at a special meeting in person on Monday, or it might make more sense to speak to someone tonight in an emergency room. I can call and let them know to expect you.

SALLIE: Then, someone I've never talked to before would want to know what's bothering me?

THERAPIST: Yes, but I can call ahead to let them know to expect you and to share a little background.

SALLIE: I think I'd rather just see you on Monday.

THERAPIST: Do you think you will make it through the night without hurting yourself?

SALLIE: Yes, I guess so. . . .

THERAPIST: "I guess so" doesn't feel safe enough for me. If you are unsure, I think you need to be seen tonight.

SALLIE: Well, I still feel depressed, but it does help to know that I have an appointment with you on Monday.

THERAPIST: Where are the pills?

SALLIE: On my desk.

THERAPIST: What about flushing them down the toilet?

SALLIE: Actually, in my town, where I grew up, there was a public health campaign to let people know they shouldn't get rid of unused medications this way.

THERAPIST: Thanks for educating me about this. Is there a better alternative?

SALLIE: I'm supposed to mix the pills with something gross like kitty litter or dirt, and put them in a sealable bag, before throwing them out in the trash.

THERAPIST: [*encouraged that Sallie is thinking of environmental protections during such a crisis*] This is useful information. Do you have what you need?

SALLIE: Actually, I do.

THERAPIST: You live in an apartment building—right?

SALLIE: Yes, why?

THERAPIST: Could you dispose of the bag in the community trash area so the pills leave your apartment?

SALLIE: You think that is necessary?

THERAPIST: I think it is a good idea to provide the most protection. I'm talking to you on your cell phone, right?

SALLIE: Yes . . .

THERAPIST: Why don't I stay on the phone while you do it right now?

SALLIE: Wow, you take this stuff so seriously!

THERAPIST: I really do.

SALLIE: Okay, I'll mix the pills with used coffee grounds; I remember that was another option.

THERAPIST: Okay, I'll hold on. Let me know your progress. (*I can hear Sallie walking down stairs, shutting doors.*)

SALLIE: Dr. Bender?

THERAPIST: I'm here. Did you throw out the pills in the community trash?

SALLIE: Yes.

THERAPIST: All of them?

SALLIE: Yes.

THERAPIST: How are you feeling now?

SALLIE: Better since you called.

THERAPIST: But still pretty awful?

SALLIE: Yes.

THERAPIST: One other thing: Would you tell me your address?

SALLIE: Why do you want to know?

THERAPIST: I don't have your record with me. I want to know where you are just in case I might need to send help at some point.

SALLIE: Oh, Dr. Bender, what do you mean? You wouldn't send the police over or something, would you?

THERAPIST: I feel good about our plan so far. But, I think it is important that I have your address available in case of an emergency.

SALLIE: Okay, I guess. I'm at 1111 Central Street in downtown Boston.

THERAPIST: Thanks so much. How are you feeling as we continue to talk?

SALLIE: Still pretty upset.

THERAPIST: How are the thoughts of hurting yourself right now?

SALLIE: Well, they still cross my mind.

THERAPIST: These type of thoughts are troubling; do you have any intention of acting on them?

SALLIE: No, I really don't think so.

THERAPIST: Would you like me to check in with you in a couple of hours?

SALLIE: No . . . I think I am going to watch a movie and then go to bed.

THERAPIST: Well, then let's plan on talking at 10 A.M. tomorrow. I want you to page me then and leave the best number to reach you. Does that time work for you?

SALLIE: Yes, I can do that. Thank you.

THERAPIST: What if the plan to hurt yourself returns before our scheduled phone call tomorrow or in the middle of the night?

SALLIE: I don't know . . . I'll call you?

THERAPIST: Yes, page me. If the thoughts start propelling you toward any self-destructive action, please also go straight to the nearest emergency room and ask them to page me when you arrive.

SALLIE: Okay, thanks.

THERAPIST: You are very welcome. I'm glad we have a time to talk tomorrow. How does 3 P.M. work for our extra meeting on Monday?

SALLIE: Let me check my book. . . . Yep, I can do that.

THERAPIST: Until our phone call tomorrow and Monday meeting, what will you do to comfort yourself?

SALLIE: Well tonight I am just going to watch a movie, but maybe later this weekend I might call this girl, Vanessa, who I met in my journalism class and ask her if she is free. I'd feel better if I had some company.

THERAPIST: What if Vanessa isn't available?

SALLIE: I guess I'll just go to the library then. There's a table where the economics students study together. Maybe I'll see someone I know from class there.

THERAPIST: I think that is a very good plan. Can you review your plans for tonight with me again?

SALLIE: I'm pretty tired now. I think I'll just go to bed soon. I feel better than when I called you.

THERAPIST: I'm glad. I look forward to talking to you tomorrow at 10 A.M. and seeing you on Monday at 3:00 P.M. [*establishing a future*]

SALLIE: Monday, at your office?

THERAPIST: Yes. I'll be waiting for you.

SALLIE: Thank you. I'll be there. [*confirming a future, an essential feature in estimating safety*]

A suicidal crisis is a psychiatric emergency that must be evaluated thoroughly and immediately. In Example 9.6, I assess Sallie's suicidal risk by reviewing her suicidal ideation, intent, plan, and actions. I devise my treatment strategy based on her current risk profile and her degree of cooperation.

Sallie has two current modifiable risk factors for suicide: depressed mood and limited social supports. Her excessive alcohol intake and laxative addiction during high school may be considered static risk factors for suicidality as they highlight a past history of impulsive self-destructive choices. Sallie's current mental state is particularly worrisome because she has suicidal ideation, a predefined plan, and has taken some steps to enact it. It is reassuring (and considered a protective factor in terms of her suicide risk assessment) that she called me before opening the pill bottles and taking the pills, showing some forethought, restraint, and a wish for help. During the phone evaluation, she is engageable, honest, and cooperative, so I feel comfortable postponing the face-to-face assessment until Monday.

In an emergency clinical situation, I don't limit my phone availability. Instead, I set up phone check-ins, as frequently as needed, to provide increased support and also to reassess Sallie's mental status regularly. I prefer scheduled frequent phone check-ins (or HIPAA-compliant video chats) as I can arrange the phone meeting at a time that works for me; this method often prevents repeated unexpected pages (or emergency phone calls if the clinician uses an answering service or cell phone rather than a pager for urgent clinical situations). Often, if a patient is in crisis but a phone check-in is planned, the patient will feel comforted by our scheduled phone call and be able to manage until then. I prefer being proactive, rather than reactive, during an emergency; this approach has served me well through the years and may have prevented some brewing crises.

If Sallie seems worse when we talk on Sunday morning, I may reconsider whether she needs to go to the emergency rom. If she does not need to go to the emergency room, but her psychological stability still seems precarious, I might schedule another phone check-in later in the day on Sunday. If Sallie is feeling fragile or is still contemplating self-destructive action, I may add a quick check-in Sunday night or Monday morning. While our planned phone check-in will provide some extra support, I also try to encourage emotional growth rather than regression by helping Sallie think of activities that would comfort her until we meet in person. I try to discern how much she is willing and able to accomplish for the sake of her own safety.

This type of intensive follow-up is not sustainable or appropriate in the long term, but in an emergency, it can be lifesaving. When a patient knows that I am engaged, concerned, and following up closely, the crisis becomes more manageable. Some suicidal attempts are impulsive actions that occur when an individual feels hopeless, misunderstood, and isolated. If I can provide some future hope, understanding, and connection, the crisis is easier for the patient to bear; then, in the office, we can take the necessary time to understand what occurred in more depth.

If I had any reason to believe Sallie was lying to me and had already taken the pills, or if Sallie had refused to go to the emergency room for further evaluation but had also been unable to convincingly contract for safety, I would be forced to call her local police department to escort her to the nearest emergency room against her will. With the possibility of overdose or other self-harm, I could also arrange to send an ambulance. It is my responsibility as a mental health clinician to protect Sallie if I believe her judgment is so affected that she cannot protect herself. The legalese is different depending on region, but in Massachusetts, I would request a Section 12(a), otherwise referred to as a "pink paper," for a patient to be transported to a hospital against their will for an evaluation of psychiatric risk. Section 12 interventions occur if a patient is actively suicidal, homicidal, or unable to care for themself (such as a patient with anorexia nervosa who denies suicidality but is medically unstable due to a dangerously low weight.) Sending Sallie to an emergency room against her will would probably cause at least a temporary rift in our therapeutic alliance, but that would be preferable to the dangers of postponing urgent treatment.

Some patients are at higher risk for self-harm than others. Men in the United States are at higher risk than women for completed suicides, although women may attempt suicide more frequently. Patients with a chronic medical illness; traumatic brain injury; a personal history of a suicide attempt; a history of impulsivity, violence, or arrests; a history of any diagnosed psychiatric illness, including substance use disorders, trauma, major depression, severe panic disorder, borderline personality disorder, or psychosis and a family history of suicide, are all at higher risk for completed suicide. Life stressors, including adolescence, conflicts within a romantic relationship, loss of employment with financial distress, divorce, bereavement, and advanced age (especially older men), are also associated with suicide attempts (Steele, Thrower, & Noroian, 2018). A review of a patient's risk factors helps guide my assessment, but ultimately my evaluation focuses on the details of my patient's clinical presentation.

Early in my psychiatric training, only 3 months after my internship, one of my former patients from the adult psychiatric inpatient unit overdosed and died 8 weeks after discharge. During her 12-week hospitalization, the patient had been treated with electroconvulsive therapy (ECT) for a malignant psychotic depression. At the time of discharge, she had been

hopeful and future-oriented, although still vulnerable due to the severity of her disease. She had close follow-up scheduled with her caring and competent outpatient provider. The attending psychiatrist on the inpatient unit and I tried to piece together what had happened. We were shocked and so sad. She was only 32.

Even though I wasn't this patient's primary psychiatrist, I still felt completely overwhelmed and guilt-ridden when I heard the news. During our first year of psychiatric training, Dr. Messner had mentioned that at least one member of my class might have a patient successfully commit suicide in the next 12 months. I had been sure that I would be spared, and I was wrong.

For months after this young woman's suicide, I obsessed about my suicidality assessments whenever a patient mentioned any thoughts of self-harm. During an evaluation, I would repeatedly ask a patient about their suicidal thoughts, intent, and plan. I began to worry that my evaluations were too lengthy or too anxiety-driven, and consulted with Dr. Messner. I remember exactly what he said, even though the conversation occurred so many years ago. "Take as much time as you need, Suzanne," he said. "Review your suicidality assessment as many times as you'd like in order to feel comfortable with your treatment decision." This is the wisdom I would like to impart to you. If you are unsure about a patient's risk of self-harm, keep talking to them in detail until you feel confident about their safety or the need for hospitalization. There is no need to rush these types of evaluations. Take your time to feel comfortable with your decision. The patient's survival may be at stake.

Over time (and after making many of the mistakes outlined in this chapter), I've learned how to provide intersession and emergency care effectively. Because I have followed the strategies I have provided in this chapter, my patients rarely page me, and the middle of the night page is an exceedingly rare event. This isn't because I have the most stable office practice in Boston; over time, I have learned how to help my patients maximize their coping skills and take advantage of our time together in the office. In a crisis, I rely on scheduled phone check-ins and/or extra meetings to respond to an emergency when it is simmering, rather than waiting for it to boil. All these strategies are designed to prevent self-injurious action; to limit regressive, intrusive, maladaptive dependency; to reinforce autonomy; and to cultivate collaboration.

CHAPTER 10

No-Shows, Late Arrivals, and Late Departures

Psychiatric emergency departments, many substance use counseling centers, and neighborhood mental health centers welcome patients on a walk-in basis. In contrast, psychotherapy of virtually all types is conducted by appointment only. A scheduled appointment ensures that the therapist will be available, and that the patient will meet with the same therapist each time.

Patients' late arrivals, delays in leaving at the end of the appointment, or absences without notice ("no-shows") may be frustrating for the clinician. If these occurrences are explored tactfully and empathically, they may ultimately prove to be treasure troves of meaningful communication.

A LATE ARRIVAL

As a trainee, I would anxiously await each session with my psychotherapy patients. About half an hour before a patient was scheduled to arrive, I would obsessively prepare the office for our upcoming meeting: moving the clock to an unobtrusive corner of the room, plumping pillows on the chair, checking tissue availability. . . . I was ready to start the session about 15 minutes ahead of schedule.

After such preparation, I was painfully aware if my patient wasn't absolutely punctual. I'd repeatedly check the waiting room a minute after they were due to arrive, and if I didn't see them, my imagination would start to wander. Maybe my patient had experienced an extraordinary metamorphosis since our last meeting. Perhaps they had dyed their hair blond

and grown 3 inches since our last visit. If an accelerated aging process had occurred over the last 7 days, they might be the middle-aged individual sitting in the corner reading a magazine.

These creative fantasies were a bit bizarre, but in retrospect, I understand how they were protective. My odd musings helped me to wait and to contain my anticipation. If my patient were present, even disguised in a new form, I would have something else to do rather than to mark time forlornly near the secretary, peering at the clinic's entrance.

HOW TO REACT TO THE LATE-ARRIVING PATIENT

I imagined that my supervisors could transform a patient's late arrival into a therapeutic breakthrough. After listening to the patient's complaints about traffic on the way to the office, they would pounce on the issue: "So, it's difficult to come on time? What do you feel this means about the treatment?" In my fantasy, the patient wouldn't respond defensively, but would engage instead in a barrage of psychologically meaningful associations. Together, the two of them would rapidly come to a new and deeper understanding of the patient's unconscious.

With experience and consultation, I've realized that my imagining is a bit fantastical, and my aspirations have become more humble and less dramatic. When I related my therapeutic expectations in response to a late arrival, my supervisors informed me that it is not useful to assign significant psychological meaning to a single event. Even when an unconscious drive is fueling the tardiness, direct confrontations often lead to defensiveness and withdrawal rather than to increased insight. I stopped hoping for the psychological epiphany and became more interested in how late arrivals might subtly affect the process of an ongoing treatment.

As a novice therapist, I was often overaccommodating when a patient was late. Although my intentions were good, extending the session to make up for the lost time had unforeseen clinical consequences.

EXAMPLE 10.1

The therapist is overaccommodating and extends the session to placate a late patient

SALLIE: (*rushing in 20 minutes late*) Dr. Bender, I got stuck in traffic. I couldn't call to tell you that I was going to be late because I didn't want to waste a moment. I'm so frustrated!

THERAPIST: I can understand that feeling. I'm glad to see you. Why don't we go in and get started?

(*We walk together to the office.*)

SALLIE: So, I have so much to tell you. I've told you about my friend Gwen, who had been my most supportive buddy after the breakup with Charlie? Well, lately she's changed, and I have no idea why. She rarely calls me anymore, and when we do talk, she seems sort of distant. (*Sallie continues to talk about her concerns until 5 minutes before the end of the session.*)

THERAPIST: It seems that your relationship with Gwen has become more complicated. I hope we can continue to discuss it next week.

SALLIE: Dr. Bender, I need to talk to you more today. This situation with Gwen is difficult, but something just happened at home that is really horrible, I wanted to bring it up earlier, but I was scared to because I hate even thinking about it. Honestly, my problems with Gwen are stupid in comparison. Please, could we talk a little longer? It wasn't my fault that the traffic was so bad.

THERAPIST: [*I'm curious and decide to extend the session.*] Okay, just this once. It's generally important to stick to our allotted appointment time, but we can take that up in a future visit. What is going on at home?

SALLIE: Well, I didn't really tell you much about this before, but my brother Tom is actually pretty sick. He has this problem with diarrhea.

It's sort of embarrassing to talk about, but sometimes it gets so bad, he has to go into the hospital. He has inflammatory bowel disease. Anyway, when I was in high school, he had his first attack and he was in the hospital for weeks. He had to go to the bathroom over 10 times a day, and it was bloody, too. My dad would sleep at home with me, and my mom slept at the hospital with Tom. I almost never saw her, but that was okay. I knew that Tom needed her more than I did.

What's strange is that sometimes he gets better, and then he's totally normal. For the last few years, he had been doing really well. But last night my parents called, and said that he had to go back to the hospital yesterday. It sounds like he's doing really bad again, and no one knows how long it will take for him to get better again. (*Sobs and reaches for tissues.*)

THERAPIST: Oh, I can understand why this unexpected news was very upsetting.

(*one minute to go before session is over*)

SALLIE: Right now, he is not allowed to eat, and he only gets food through an IV drip. My parents are both very upset, but my mom is a total mess. I asked her what I could do to help, and you know what she said? It's kinda strange.

THERAPIST: [*I can't resist.*] What did she say?

SALLIE: She said hearing about my courses, my economics courses, helps

her feel a little better. She said it distracts her from the hospital and all that stuff. When she thinks about my future in business, it really makes her happy.

So there was no way that I could tell her that I hate my classes right now. They are SO boring, but I tried to sound really interested, because I didn't want to burden her more. (*Blows her nose.*)

THERAPIST: What a tough position to be in. Can you tell me more?

SALLIE: She thinks I like business as much as she does. I like it, I guess, but I don't love it. I think she would be bummed if she knew my true feelings.

(*The session should end now.*)

THERAPIST: (*Nods, concerned look.*)

SALLIE: I just didn't want to talk to you about this before.

THERAPIST: [*I don't even begin to wrap up the session.*] What allowed you to bring it up with me today?

SALLIE: I don't know. Maybe the fact that he went back into the hospital, and I needed to talk to somebody about it. But, part of me sort of hopes that my worries might just go away if I don't talk about them.

THERAPIST: It took some courage to bring it up today. What does it feel like to talk about these worries with me?

SALLIE: Surprisingly okay. Maybe it took more energy to ignore them. I really appreciate you extending the hour for me, Dr. Bender. Gwen isn't there for me, but you certainly are!

[*The conversation continues for 15 minutes beyond the scheduled ending time. I miss my 10-minute break after Sallie's session and am late for my next patient.*]

Interestingly enough, patients who arrive late are often also the patients who are reluctant to leave. Sallie illustrates the "hand-on-the-doorknob" phenomenon, sharing the session's most emotionally intense information at the end of the hour. Sometimes patients employ this tactic—often unconsciously—when they don't feel comfortable talking about a topic in detail. In Sallie's case, she may also be unconsciously trying to push the time limits of the session by ending with powerful material.

As Sallie is not acutely suicidal, it is not in her best interest to bend the treatment frame excessively, as I do in Example 10.1. A significant extension of even just one session may have a number of future ramifications: Sallie might continue to request prolonged sessions, and her motivation for arriving on time might diminish. Even though she might appreciate the extra time and attention, it may also feel confusing if I vary a session's length depending on its content. A 60-minute session may be regarded as

an unexpected reward, while a shorter, 45-minute session could be viewed as a punishment.

If I prolong the session, it will be difficult to engage Sallie in an exploration of her end-of-the-hour actions. In contrast, if I end the session on time, Sallie will still be in touch with the feelings that fueled her request for an extended session. In a subsequent meeting, I can ask her how she experienced my limit setting and try to learn why it was difficult for her to talk about Tom's illness earlier in the meeting.

Example 10.2 illustrates how I could hold firm to a treatment's boundaries in an empathic but resolute manner.

EXAMPLE 10.2

The therapist does not extend a session to accommodate a patient who was late

Five Minutes Left to the Session

SALLIE: Dr. Bender, I need to talk to you more today. This situation with Gwen is difficult, but something just happened at home that is really horrible. . . . Please, could we extend the session a little today?

THERAPIST: I would like to hear what you want to tell me, but we will need to stop on time. I would like to know what is on your mind. Can you fill me in a little now and then we can definitely continue to talk about it next week?

SALLIE: Next week seems so far away. The problem is that my brother Tom is in the hospital again. I don't remember if I told you, but he has a chronic bowel disease. He's been fine for years, but now he is having a relapse.

THERAPIST: Oh, I can understand that can be very upsetting. What kind of chronic illness does he have?

SALLIE: It's called "inflammatory bowel disease." If he doesn't get better, he may need to have surgery. I just don't know what to do! (*Sniffles continue; reaches for a tissue and blows her nose.*)

THERAPIST: [*I refrain from asking exploratory questions such as "What allowed you to bring up these concerns today?"; "Can you tell me more about Tom's condition and what kind of surgery he might have?"; or "What does it feel like to talk about it with me?" and I start to sum up instead.*] I can see this has been very painful, and I hope we can talk about it in more detail next time. I know it may feel difficult to end our session once an issue like this comes up, but unfortunately, we need to stop soon. Would it be helpful to set up another meeting time later this week?

SALLIE: Oh, it just feels overwhelming. Dr. Bender, he is so sick. I need help dealing with this!

THERAPIST: (*gripping the chair and metaphorically gripping the frame*) I feel stuck because I really do want to hear more about this, but unfortunately, there isn't time to talk to you about it right now. Why don't we schedule an extra session to talk more about this later in the week, so we can give it the attention it deserves?

SALLIE: No. I don't have time. You can't talk now, even just 20 minutes more? (*A tear rolls down her cheek.*)

(*Sallie's session is over.*)

THERAPIST: I understand that it was difficult to bring up your brother's illness during our meeting, and the situation is, understandably, so upsetting to you. Unfortunately, this session is ending at a really inopportune time. Why don't you take a moment to collect yourself and to reconsider whether a second session this week might be useful; then, we could devote an entire meeting to this topic.

SALLIE: (*Nods, hiccups, doesn't move from her seat.*)

THERAPIST: (*Nods and waits patiently.*)

SALLIE: (*Grabs a handful of tissues and stands up.*) It is so hard to talk about this, so I don't think I want to think about it again this week. Let's just meet next week as usual.

THERAPIST: Okay. That would be fine. I look forward to seeing you then.

SALLIE: Okay. (*Leaves.*)

In Example 10.2, I follow each empathic comment with a remark about the end of the session, and Sallie leaves the meeting within a couple of minutes of the appropriate time. If she brings up emotionally intense material at the end of future sessions, we will try together to understand the meaning of this behavior.

EXAMPLE 10.3

A patient repeatedly brings up emotionally loaded topics at the end of the session

One week after Sallie tells me about her brother's illness for the first time; 5 minutes before Sallie's session is over:

SALLIE: Enough about Gwen. I guess I didn't talk very much about my brother Tom today, even though I planned to bring it up earlier this session. I need to tell you more about what is going on.

THERAPIST: (*Nods.*)

SALLIE: Dr. Bender, this week has really been the pits. I'm such a mess. Sometimes I'm frustrated with Gwen or upset about Charlie, but what really stresses me out is Tom's health. I'm so worried about him.

THERAPIST: What are you most worried about?

SALLIE: I just feel so bad for him, but I get overwhelmed even thinking about it. I don't know why I talked about Gwen today instead of Tom.

THERAPIST: Do you have any understanding why you talked about Gwen instead?

SALLIE: I don't know. Maybe it's easier to talk about Gwen and distract myself from what is really bothering me.

THERAPIST: That could be so. Not many people recognize such possibilities. [*I recognize and support Sallie's psychological mindedness.*]

SALLIE: I wish we could keep talking about it now.

THERAPIST: It is a difficult situation. I understand that Tom's health is such a sensitive topic, but by bringing it up at the end of the hour rather than earlier, we don't have the opportunity to talk about it with the attention it deserves. Our time today is drawing to a close, but I hope we can continue learning about this next time.

SALLIE: Okay. (*Gets up to leave.*)

When I hold to the parameters of the session, Sallie is able to acknowledge how difficult it is for her to talk about her brother's illness. In a future session, she also might share how she felt when I didn't extend the session in response to her request.

REPEATED LATE ARRIVALS

For some patients, arriving late to therapy, canceling at the last minute, or not showing up at all may become a recurrent problem. Because this behavior is a detriment to the therapy, it deserves some special attention.

Before I broach this topic with a patient, I try to distinguish whether the frequent late arrivals are due to obstructions or resistances to the therapy. Obstructions are factors out of a patient's control and often unpredictable (such as blizzards, lack of transportation, an unexpected poor Internet connection before a virtual session, or an illness in the patient or in the patient's family). Resistances to therapy refer to anything that interferes with the progress of therapy over which the patient has some influence (missing the bus, cancelling because of a minor ailment or an optional scheduling conflict). Some events are more difficult to label as obvious obstructions or resistances (such as an unanticipated change in

the patient's schedule that interferes with the therapy appointment), and I reserve judgment for these events until more information is available.

Whether or not the recurrent lateness is due to a resistance or to an obstruction, or a combination of the two, a discussion about lateness should be approached with empathy and curiosity. Timing is also important. As a beginning resident, I'd be so eager to broach the topic that I'd open a session by asking a patient about their tardiness. Not surprisingly, the discussion was rarely fruitful. It took me a while to learn that the best time to explore a late arrival or a missed session is not necessarily the first available second the patient is in the office. Instead, I've learned to wait for a cue, that is, some comment by the patient about time, appointments, wishing we had more time together, or people in their life who are late. Then I'll ask the question I've been harboring: "I've noticed that sometimes you have been coming to the therapy session about 15 minutes late. Any thoughts about what might make it hard to come on time for some sessions?"

At the beginning of Example 10.4, Sallie Gane refuses to admit that her recurrent late arrivals have any underlying meaning, but as our meeting continues, she is increasingly able to discuss the emotional significance of her actions.

EXAMPLE 10.4

Discussing repeated late attendance in a therapeutic manner

Sallie came to the session 20 minutes late today. She was also 10–15 minutes late for the three sessions before this one.

When the session has only 10 minutes remaining, she starts to talk faster.

SALLIE: You won't believe the latest incident with Gwen. Last night, she wanted to go to this foreign movie, and when I said I'd rather see the latest release for the school's Alfred Hitchcock revival, she hung up on me. This was one of the few times I even disagreed with her plans a little bit, and she responded by shutting me out! My night was ruined. I don't know what I did wrong, or what made her so mad. Maybe I am just a social failure.

THERAPIST: Gwen wasn't open to any discussion about the evening's activities?

SALLIE: That's right, but I should have just gone to the foreign flick. The last time Gwen and I got in a tiff like this, I didn't want to spend an afternoon shopping in the city with her, because I had a paper due. We didn't talk for a few weeks. It felt like forever. I can't afford to lose her now, because I need all the support I can get, especially with Tom being sick.

THERAPIST: It's difficult when a friendship that means so much is unable to sustain little disagreements.

SALLIE: It really is. Maybe I need some more friends so I don't have to depend on Gwen so much, but I have trouble making new friends. I get shy.

THERAPIST: It's important to talk about this, but we don't have the time today to talk about it in the detail it deserves. We only have a couple of minutes left.

SALLIE: Yeah, I wish I had more time.

THERAPIST: [*I grab the opportunity to talk about Sallie's recurrent lateness.*] Any idea of what might be making it hard to come on time? With a full session, we could give these topics more attention.

SALLIE: I don't know. . . . It's not easy to talk about this stuff every week, you know.

THERAPIST: (*Nods encouragingly.*)

SALLIE: Can I tell you just one more thing? It'll just take a minute. (*The session is over.*)

THERAPIST: We do need to stop, but I hope we can continue this discussion in the future. Perhaps the fact that it's not easy to talk about these painful topics has some influence on your lateness. It can be useful to try to understand it together, and maybe we can start to puzzle it out at our next meeting.

(*Sallie comes to the next session 15 minutes late.*)

SALLIE: Well, a lot has happened with Gwen since our last meeting.

THERAPIST: (*Nods encouragingly.*)

SALLIE: Well, like I expected, we didn't talk all week because I didn't go with her to that stupid movie. Then, she called yesterday and pretended nothing had ever happened. She invited me to a dorm barbeque, and we had a great time. I guess everything is normal between us again.

THERAPIST: How do you feel now that the relationship is back to baseline?

SALLIE: I'm so relieved. I don't know what I would do without Gwen. Other than you, she is my number one support in college. No offense, but talking to you once a week isn't enough. Gwen's an important part of my life here.

THERAPIST: No offense taken. I agree with you that it is really important for you to have close friends. How did you feel when Gwen pretended that your argument had never happened?

SALLIE: I felt so lucky. I would hate to talk to her about our disagreement.

THERAPIST: What would you hate about it?

SALLIE: I'd be scared that I might say something wrong, and she'd stop talking to me again. I can't afford to jeopardize my friendship with Gwen in any way.

THERAPIST: The friendship with Gwen is so important to you, but it also feels rather fragile?

SALLIE: You bet. I've seen her drop other friends in an instant. She collects friends, and then every so often she cleans house and discards the "uninteresting" ones. Sometimes she makes me feel like the best friend she has ever had, but she also has a definite mean streak.

The difference between us is that she can make a new friend in 5 minutes, but I'm more shy. I need her more than she needs me.

THERAPIST: It is a tough situation.

SALLIE: Yeah, I hate talking openly about feelings.

THERAPIST: We spoke a little last week about what might be making it difficult to come to sessions on time, and I'm wondering if it could be related to the fact that you hate talking openly about feelings. What do you think?

SALLIE: No, I don't think it relates at all. Do you?

THERAPIST: Maybe. I had some thoughts about it. Let me know how they sound to you. Maybe if you had some feelings that were hard to express directly to me, it might be more difficult to come on time.

SALLIE: What do you mean?

THERAPIST: Well, with Gwen, you have been concerned that more direct communication would lead to difficulties within the friendship. It makes sense that you might have mixed feelings within any relationship, and avoiding the issue is one way to cope with these feelings.

Coming late to therapy could be one way to protect yourself from talking about any mixed feelings you might have about our work. [*I feel proud to unveil my interpretation.*]

SALLIE: I don't have any mixed feelings about you.

THERAPIST: You don't? [*My interpretation didn't work? I had been perfecting it all week.*]

SALLIE: No, I don't. Dr. Bender, you are so important to me. I really treasure our sessions. I don't really understand what you are getting at.

THERAPIST: None of what I said fits with your experience? [*It's hard to give up my interpretation that I am so proud of. That said, my interpretation doesn't include enough input from Sallie, so it is premature and likely inaccurate. In addition, at this point in the treatment, Sallie may not be ready to talk so openly about our relationship.*]

SALLIE: No, it just makes me nervous, that's all. I don't think you are right. If I'm late, it is because of traffic, that's all.

[*Sallie is beginning to sound annoyed. I try to reinforce our therapeutic alliance.*]

THERAPIST: I'm glad you have corrected me so I can try to understand the situation better.

I've been asking about your lateness for the sake of the therapeutic process. When the session starts late, it reduces the time we have to work together.

SALLIE: I guess it does, but traffic is traffic, that's all.

THERAPIST: (*Nods, remains quiet to see what Sallie talks about next.*)

SALLIE: Well, it's hard to come here and talk about all this stuff, even though I generally feel better when I leave.

THERAPIST: Can you pinpoint what is hard about it?

SALLIE: Well, I sometimes get a little worried about what you think of me. I don't want you thinking that I am some kind of whiner who can't keep friends.

THERAPIST: Is that what you imagine that I think? (*curiously; nonconfrontational tone*)

SALLIE: I don't know. I just worry that one day you might get so sick of hearing what I have to say that you tell me to shut up. I talk about the same stuff every week, and even though I know that we are making progress, I figure you must feel sort of frustrated.

THERAPIST: Have I seemed frustrated to you?

SALLIE: No, you haven't at all, but maybe you are the type of person who is really patient for a long time but then erupts without warning.

THERAPIST: It is hard to trust that I won't become unpredictable and mean, sort of like Gwen?

SALLIE: I hadn't really thought about that, but I guess that is true.

THERAPIST: I can understand why this could hold you back. Can you tell me more?

SALLIE: What if I do say something offensive, and you are upset with me?

THERAPIST: Upset in what way?

SALLIE: Mad, angry, frustrated, bored . . . I don't know. I don't want to mess up this therapy. It's helping me.

THERAPIST: Actually, it is very useful to discuss this together in order to learn more about the feelings involved. Let's imagine for the sake of the therapy that I might feel some of the feelings you listed. What would that be like for you?

SALLIE: Oh, I'd be terrified.

THERAPIST: Can you tell me why?

SALLIE: Because the relationship would be over. . . .

THERAPIST: How so?

SALLIE: Well, you probably wouldn't want to work with me anymore.

THERAPIST: Why not?

SALLIE: Because you'd be pissed.

THERAPIST: I can see why this is so scary. There is a feeling that if any type of misunderstanding or disagreement occurs between us, the therapy would be over.

SALLIE: Yes. I would be very worried if I made you angry.

THERAPIST: What would you imagine would happen?

SALLIE: I don't know. I guess I'd feel really uncomfortable talking to you.

THERAPIST: Tell me if this sounds possible to you. You might expect that our relationship would be similar to your friendship with Gwen. It wouldn't be resilient, so it couldn't easily sustain a misunderstanding.

SALLIE: Yes, actually that does sound right.

THERAPIST: Do you think that being late might be protective in some way?

SALLIE: Well, I have less opportunity to be annoying if I'm not here the whole time. Even if you are a little annoyed at me for being late, I know I can be on really good behavior for 30 minutes.

THERAPIST: So, by being late, you are trying to protect our relationship?

SALLIE: I know it sounds stupid, but maybe I am.

THERAPIST: I don't think it sounds stupid at all. I think you have developed this approach in a hope it will be protective, after your experiences with people like Gwen. I am glad we can talk openly about it, and we might understand it even better over time.

Many patients, especially those new to psychotherapy, are similar to Sallie at the onset of Example 10.4. They may have trouble talking openly about their recurrent late arrivals, and the therapist must facilitate the discussion slowly and sensitively.

Midway into Example 10.4, I illustrate what can happen if the therapist creates a premature interpretation, without adequate patient input. I take control of the session's content with my carefully concocted analysis:"*Coming late to therapy could be one way to protect yourself from talking about any mixed feelings you might have about our work.*" Sallie balks and is unable to process my comment in any meaningful way. I realize that the interpretation was hasty and likely inaccurate when it doesn't facilitate a more open and honest discussion, and Sallie adamantly repeats that her recurrent late arrivals are meaningless.

The conversation does progress in the second half of the example as Sallie morphs into a patient with more psychological insight, and I evolve

into a therapist with more experience. I try to clarify Sallie's concerns ("It is hard to trust that I won't become unpredictable and mean, sort of like Gwen?") instead of presenting sweeping interpretations. I learn about Sallie's fear that she may not maintain appropriate behavior if she comes to her session on time, a very different explanation for her recurrent tardiness than the interpretation I had offered earlier.

Sallie's late arrivals may have many meanings. At this time, Sallie believes it is only an attempt to avoid confrontation, but it may also be her method of expressing hostility and resentment. Even if this conjecture is valid, Sallie appears far from ready to recognize her own animosity. It is not the right time to talk to her about this second possibility, so I think about it privately.

As Sallie's therapist, I also start to wonder why Sallie has trouble making new friends, and why she is so attached to Gwen even though Gwen treats her poorly. Early in treatment, I can only hypothesize some explanations. Maybe Sallie perceives Gwen as irreplaceable because Gwen is somehow symbolically tied to someone in Sallie's life who does have a unique and vital role, such as her mother, father, or brother. We'll learn more about this as the therapy continues.

A thoughtful exploration of recurrent late arrivals can be a therapeutic gold mine. Being late can have many different meanings. A 29-year-old graduate student who was regularly late to her psychotherapy appointments eventually shared stories of an adolescence filled with rigid study schedules created by her parents. For years, her time was controlled by others, and she hated this setup. Even as she found psychotherapy very helpful, she balked against the firm start time of the sessions and appreciated the opportunity to start the session 10 minutes late without personal repercussions. The 50 minutes was hers to use or not to use and I wouldn't scold, retreat, or judge if she wasn't on time. A 32-year-old salesman with attention-deficit disorder also regularly started his session 10–15 minutes late. Our discussions revealed that his frequent late arrivals reflected ongoing struggles with disorganization and time management, rather than any deeper psychological ambivalence about the treatment. Once we understood the reasons behind the recurrent late arrivals, he was able to implement some organizational strategies to help him arrive on time.

RECURRENT CANCELLATIONS OR NO-SHOWS

While late arrivals can be annoying, at least the patient shows up. As a trainee, I found cancellations or no-shows the most aggravating, mainly because I would bend over backward to try to accommodate my patient when rescheduling.

The typical scenario would unfold as follows. My patient would miss their scheduled appointment by cancelling or not showing up. Then, they'd call shortly afterward to apologize and to attempt to reschedule within the next few days. I'd feel concerned and, in order to meet as soon as possible, I would reschedule the patient in the evening or early in the morning. If I was lucky, the patient would show for this session, but sometimes the pattern would continue, and my resentment would escalate exponentially.

With experience, I've implemented a different strategy that is more protective of my time. While my adult psychiatry training recommended that I follow up with patients after the session no-show, I have become more flexible in my approach, since working in child psychiatry with teenagers and young adults. For intermittent no-shows, I start by calling my patient about 15 minutes into the scheduled session to see if they are on the way, or if we might salvage some of the unused time with a private conversation over phone or a HIPAA-approved video platform. Many patients who are interested in treatment are grateful to have the reminder call and the opportunity to reclaim the remaining session time. If the no-show is an expression of ambivalence about the treatment, then the patient may not pick up the phone when I call to check in.

If I do not reach the patient during their scheduled session, and they reach out afterward to reschedule, I use the moment as an opportunity to reassert the frame. Unless there is a compelling emergency, I set the next appointment at our regularly scheduled time during the following week.

The situation is trickier if the no-shows become a chronic problem.

EXAMPLE 10.5

Responding to a patient who recurrently misses her appointments

Sallie has just finished the consultation process, but then misses her first scheduled therapy session and does not call to cancel.

I call 15 minutes into her scheduled session with the following message, hoping to demonstrate interest:

"Hello, this is Suzanne Bender, calling for Sallie Gane. I'm calling during your scheduled psychotherapy meeting, and I'll be here in the office and with my video platform open until 1:50 P.M. I hope to see you soon; you can also call me back during this time with any questions. If we don't connect, please leave me a phone message or email if you are interested in rescheduling."

Sallie calls back 2 days later and leaves the following message:

"Oh, Dr. Bender, I got your message. I am very sorry I missed our appointment. I had a midterm at school the morning of our meeting, and I just completely forgot about our session. I still am very interested in therapy. Please call or email me so we can reschedule."

I contact Sallie to reschedule. If I have already reviewed my cancellation policy with Sallie during our consultation, I will charge Sallie for the missed session. If she is unaware of my cancellation policy, I will review it at this time: unless there are extenuating circumstances, such as illness or extreme weather, I will charge her for future appointments unless she calls to cancel at least 48 hours in advance.

While this exchange after a missed session may also occur via email, a phone call may be preferable, especially early in treatment. With a phone call, it is easier to communicate my complex message: While I am interested in seeing Sallie again if she would like to return to treatment, and I am not irritated at her that she missed the session, I also follow a professional protocol in these situations.

Sallie misses her next appointment without calling to cancel.

Two consecutive missed appointments are less likely to be due to chance alone. This time, I may not immediately reach out to check in, during or after the scheduled session. I may have a growing sense that the no-shows are not just due to a chaotic schedule but, instead, reflect an expression of ambivalence about the treatment.

For Sallie, the process of psychotherapy may feel comforting, revealing, and frightening at the same time. In response, she may feel simultaneously pulled toward and pushed away from treatment. If I call her back during or immediately after each missed session, she may react in an avoidant manner. If I wait before contacting her, she may feel less external pressure to continue therapy and may be able to experience both sides of her ambivalence. Then, if she decides to pursue treatment, it will be an independent decision, fueled by her desire for emotional relief.

After Sallie's second no-show, I'll wait a few days to a week before calling her.

If I'm unable to talk to her directly, my second phone message would let Sallie know that I would be happy to reschedule our meeting if she contacts me. If Sallie had missed multiple sessions in a row, I would add this addendum: "If I do not hear from you, I will assume you are not interested in meeting at this time, and I will close your file. If an emergency arises, please go to your nearest emergency room."

At the end of the month, I will send Sallie a bill, including a charge for any no-shows.

With two cancellations in a row, Sallie's ambivalence about psychotherapy is tilting toward aversion and avoidance. Unless the therapy can help her to talk openly about her recurrent no-shows, her resistance will continue unabated. If she contacts me in the future, I will make sure that we talk about the two no-shows shortly after she returns.

Sallie calls back a few weeks after her second missed appointment.

SALLIE: Dr. Bender, I am so sorry I missed a few appointments. My schedule is much lighter now, so I'd like to set up a time to meet. I have a lot to tell you.

THERAPIST: It's good to hear from you and I would be happy to meet. I also wanted to check whether you have had difficulty coming into the office because of financial constraints that you haven't mentioned.

SALLIE: No, my financial situation hasn't changed. I was just really busy for a while.

THERAPIST: I'm happy to reschedule, but unfortunately, the times I have available are relatively limited right now.

SALLIE: That's okay. My work schedule is much more flexible currently. Just name the time.

THERAPIST: How is this Thursday at 11:00? [*I choose a time to meet that is convenient for me. In case Sallie doesn't show up, I will go to an early lunch.*]

SALLIE: Great! Perfect! I'll see you then. Thank you so much.

THERAPIST: If for any reason, you find that you will be unable to make the appointment, please call to cancel, preferably 48 hours in advance.

(*Thursday arrives. Five minutes after 11:00, I check my voicemail. Sallie had left a message at 11:00 that she was unable to find a parking place and would be late for our appointment. At 20 minutes after the hour, Sallie rushes into the clinic, apologizing profusely.*)

SALLIE: Dr. Bender, it is so good to finally see you again. I am sorry I am late. I hope you got my message. I guess I'll have to talk fast. Recently, I have been really depressed.

THERAPIST: How would you describe the depressed feeling?

[*For the next 10 minutes, I focus on Sallie's main concern and assess whether her safety is at risk. When it is clear that her distress does not include a self-destructive component, I directly address her past avoidance of therapy, as I don't know when or if I will see her again after this meeting.*]

THERAPIST: With all this pain and turmoil, perhaps part of you didn't want to come to our sessions to talk about it, even though another part of you wanted some help and comfort.

SALLIE: I don't know. Well, I guess I have felt pulled both ways.

THERAPIST: That is how it is with a lot of people. If you decide you want to look into it more, we can keep meeting with the goal of helping alleviate some of this distress. Also, if you want to stop treatment now

because it doesn't feel like the right time to be in therapy, that is okay, too.

If Sallie continues to miss sessions after this discussion, she may be too ambivalent about therapy to continue at this time. Even if she repeatedly states that she is interested in treatment, she is "voting with her feet." I would follow up with a letter or an email (see Figure 10.1).

My letter purposely does not guarantee future treatment. If Sallie decides to stop treatment for the time being and then contacts me months later, ready to start, I will agree initially to meet for only one consultation visit. After the single-session consultation, Sallie and I can discuss her treatment options: continuing with me if I have the time available, placing her name on my waiting list for my next open time slot if the need is not urgent, or finding a new therapist who can meet her current clinical needs.

[Use the clinic's letterhead.]

Date

Ms. Sallie Gane
1111 Central Street
Boston, MA 02114

Dear Ms. Gane:

I am writing to you because I'm unclear about your decision regarding future treatment since we last met on MM/DD/YY.

I don't, of course, have any way of knowing what's going on with you currently, but I hope things are better.

If you want to be in touch with me about future psychotherapy, I would be happy to meet with you to discuss your treatment needs. I wish you well.

Sincerely,

Suzanne Bender, MD

voicemail#

email

FIGURE 10.1. Letter inviting the patient to resume contact.

CANCELLATION POLICIES

Cancellation policies vary widely among therapists. Some therapists consider a patient's session a rented hour and require that the patient pay for a cancelled meeting if the therapist is not able to find someone else to fill the time. Some therapists, with more chutzpah than I, even require the patient to pay for sessions when the therapist is on vacation! Neither of these policies has ever felt quite right to me.

In my private practice, I tell patients about my cancellation policy during the consultation or after the patient has missed their first session. I require 48 hours' notice for a cancelled session. I will charge for the missed hour if the cancellation occurs less than 48 hours before the session.

Of course, every rule has its exceptions. I don't charge for cancelled sessions until I've explained my policy to the patient. I also don't charge if the patient cannot come to their appointment due to extenuating circumstances such as extreme weather (although HIPAA-approved video platforms may allow psychotherapy sessions to occur during some major weather events, as long as there aren't power outages) or unexpected significant illness in the patient or a family member (in other words, an obstruction). A rare patient may take advantage of this flexibility and concoct incredible excuses for frequently missed sessions. In such a situation, I may start charging for all future missed sessions, after explaining to the patient that I am unwilling to save a session without payment. Thankfully, this situation is extremely unusual. Usually, the cancellation policy protects the therapy and it is rarely abused. Notably, once a patient realizes they may be financially responsible for a missed session, I've been amazed at how quickly attendance rates improve.

With patients who are using their insurance to pay for treatment, cancellation policies are not as straightforward. Insurance policies don't reimburse clinicians if a patient doesn't show up. For a private practice, it may be possible to negotiate a payment agreement with patients, so they will pay for abruptly cancelled sessions as long as this agreement complies with any restrictions outlined by the insurance carrier. With a clinic practice, it is still useful to discuss recurrent missed sessions within a treatment. I remind my patients that appointments cancelled without adequate notice cannot be made available to patients who might benefit from them. Sometimes people who are neglectful of their own well-being (and their own psychotherapy) may act more responsibly when they realize that their behavior might deprive or harm others.

If after lengthy discussions a clinic patient continues to abuse the privilege of a weekly reserved hour, I might taper access to my services. A patient might find it easier to attend psychotherapy more regularly with sessions on alternate weeks. If the no-shows continue unabated, I might talk to the patient about deferring further treatment until they can demonstrate that

they are able to protect the therapy time. In such a situation, I would also remind them of the availability of emergency services should the need arise.

THE THERAPIST IS LATE TO A SESSION

When the therapist is late to a session, a different set of dynamics come into play.

EXAMPLE 10.6

The therapist is late to the session

On the way to the clinic to see Sallie at 2:00 P.M., I realize that I left my wallet sitting on the table in the cafeteria. I rush back, retrieve the wallet, and then run to the clinic. I am 10 minutes late. It is the first time I have been late for a session since I have started working with Sallie.

THERAPIST: (*a bit breathless from running to the clinic*) Please come on in.

SALLIE: (*Looks quizzically at me.*) So, I have a lot to tell you about Gwen.

THERAPIST: Yes. I'm sorry to have kept you waiting.

SALLIE: Oh, I knew something unusual must have come up. It's okay. I'm not too picky about starting on time.

THERAPIST: I'm not usually late so it makes sense you might have some thoughts or feelings about it.

SALLIE: Nah, the stuff with Gwen is much more pressing.

THERAPIST: Are you able to stay an extra 10 minutes so we can make up the time?

SALLIE: Sure, that would be great. (*Proceeds to talk about Gwen.*)

(Ten minutes later)

SALLIE: Umm, I did have this weird thought that crossed my mind when you were late.

THERAPIST: I am glad you are bringing it up. What was it?

SALLIE: Well, I know this sounds paranoid, but I heard about a really bad car accident on the radio on the way here, and I was worried that maybe you were in it. Where were you anyway?

THERAPIST: You were worried that I was hurt?

SALLIE: Yeah, I felt a little scared.

THERAPIST: Can you tell me what you were scared of?

SALLIE: Umm, well, what if you were badly hurt? I don't want anything bad to happen to you. If you were late all the time, I wouldn't have

been so worried. But, you have never been late before so I got sort of freaked out.

THERAPIST: It may have felt frightening for me to be late when I'm usually on time.

SALLIE: I guess it was.

THERAPIST: For the sake of our work together, can you tell me more about what you imagined? What did you imagine had happened to me in the car accident?

SALLIE: I don't know. That feels like a weird question. I think I'm just wired this way. I usually get worried when people are late for a meeting. Gwen might be an exception, though. She's late all the time, and I don't ever worry about her. Maybe I don't care about her in the same way. (*Continues to talk about her feelings about people being late.*)

While some patients are unable to talk openly about a therapist's late arrival (Sallie at the beginning of Example 10.6), others will use the event to further the therapy (Sallie at the end of Example 10.6). Over time, it may become clear that Sallie has a barrage of feelings about my late arrival. While she may feel concerned and worried up front, other feelings, including insecurity about her importance to me, or anger or disappointment about the lost time, may surface in the future.

If I am late for a session, I will extend the meeting to make up for lost time. Some traditional therapists will end the session on time, believing it is better to maintain a strict treatment frame, and let the patient express how it feels to pay for a full hour but only receive a portion of it. I believe it is respectful and fair to extend the hour if I am the cause for the late start. If conflicting commitments make it impossible to prolong this particular session, I will talk to the patient about a future session extension to make up the lost time.

Now and then, I'll tell the patient some details about my tardiness. If I arrive at the office covered in grease after changing a flat tire, it would be absurd to ignore the obvious and pretend nothing unusual had happened. Early on, I was at risk for sharing too much information ("My tire was acting strange all week, and I should have taken the subway. It blew three blocks from the office"), but all the patient really needs to know is the bare details ("I had to change my tire on the way to the office").

Some patients may become overwhelmingly anxious if I'm late and imagine something terrible has happened in my life. In this type of situation, providing some information about my situation will alleviate the patient's anxiety and will facilitate a discussion of their emotional reaction.

It is especially meaningful if a therapist repeatedly breaks the frame with recurrent late arrivals. If such a sequence occurs, one's first reaction may be self-critical, but this response is actually the least helpful to the

therapy. To help the treatment progress, it is more useful to give oneself credit for noticing the pattern of behavior and then schedule a discussion with a trusted supervisor in order to understand what the actions might signify. Just as in the case of the patient, once the underlying dilemma fueling the repeated tardiness is verbalized and understood (in this case, in supervision), it should become easier to be on time and less necessary to act in response to the feelings.

No-shows, late arrivals, and late departures are all actions relevant to the therapy whether they are produced by the patient or by the therapist. By translating the meaning of relevant actions into words, the therapist and patient gain greater understanding of the process and of themselves.

CHAPTER 11

When the Therapist's Life Affects the Frame

Vacations, Pregnancies, and Illness

When the therapist is unavailable for any period of time, the therapy is affected. Treatment pauses due to vacations and maternity leaves may provide opportunities to learn about the patient's emotional experience of separation and reconnection. Clinical coverage must be available during treatment gaps. During treatment interruptions due to emergencies or illness, both the therapist's and patient's needs deserve thoughtful consideration. A professional will provide guidance on how to manage clinical and practice issues in the event of therapist incapacity or death.

In an ideal world, psychodynamic psychotherapy follows a predictable pattern, meeting regularly with the same person in the same place at the same time. The patient decides on the focus of the session; as the therapist, I follow their lead. For 50 minutes, my needs are secondary as I focus on understanding the person in my office.

Then, there's reality. Events in my life may change the therapeutic process by breaking the predictable session schedule. The intrusion can be as simple as a vacation or as complicated as a prolonged maternity or medical leave.

When my needs affect the treatment frame, my job as the therapist is threefold. First, if at all possible, I need to announce any upcoming change in the treatment schedule ahead of time, so my patient and I have time to process and plan. With the exception of unexpected emergencies, I will often have some warning before a significant change in my availability.

Second, once the news is out, I need to gently encourage my patient to share any feelings they may have about the change in the frame. My final challenge is to remain self-reflective during these discussions. For instance, if my patient is upset about a schedule change, I try to be curious and interested, not defensive. I pay attention to whether exciting or distressing events in my life are affecting my ability to attend to my patients' concerns, and I seek supervision if necessary.

VACATIONS

A therapist's vacation is the most common cause of a therapist-driven frame change. Dr. Messner and I drafted a chapter on this topic for the book's first edition; he impressed on me the importance of preparing patients for any anticipated treatment break, such as a vacation. As a trainee, I respected his perspective, but at first, I also felt his concern was an educational overreaction. It wasn't as if I were leaving forever. Other health care providers don't need to be so sensitive about an upcoming change in schedule. If my internist isn't available when I have a medical need, I see the physician covering the practice. If my tooth aches and my dentist is away, I am referred to a colleague.

As a novice, I didn't yet understand that the connection between a patient and a therapist is significantly more intimate than the bond between a patient and most other clinicians. Within a psychotherapy, any treatment break is potentially emotionally relevant.

For some patients, a short break from therapy is a neutral or even a welcome experience. While these individuals may have some curiosity about my vacation's destination, my announcement doesn't seem to carry any emotional valence. For others, my trip may occur during an especially vulnerable or fragile time. By leaving my patient alone while they are struggling, even temporarily, I may be reminding them of other times they felt abandoned during a time of need. Complicated feelings of jealousy or anger may also be added to the mix.

Navigating a discussion focused on the emotional ramifications of my upcoming vacation may be complicated for the patient and for the novice therapist. A patient may feel uncomfortable sharing that a treatment break might cause emotional distress. Patients who already struggle to tolerate undesirable feelings may be especially reluctant to talk openly about a negative reaction toward me. They may be concerned that they are overreacting, and then try to suppress expression of any complex feelings. In a parallel process, I also may not be eager to talk about the fact that my upcoming vacation is generating emotional distress for a patient. Somewhere deep down, I may have an intuitive sense of the patient's concerns, but excitement about my vacation, sprinkled with some guilt that I am leaving a patient in need, may color my ability to tune into their perspective.

EXAMPLE 11.1

Common errors that may occur when discussing an upcoming vacation with a patient

Four Weeks Prior to Vacation

I plan to announce my vacation at this meeting.

SALLIE: (*Comes into the office and bursts into tears.*) You'll never believe what happened!

[*I immediately forget to announce my vacation during this session, distracted by Sallie's current crisis.*]

Three Weeks Prior to Vacation

[*I plan to announce my upcoming vacation at the beginning of this session. Sallie is late and runs into the clinic breathless with only 20 minutes left to the session. I immediately forget to announce vacation during the shortened session.*]

Two Weeks Prior to Vacation

[*I am embarrassed to admit in supervision that I have still not announced my upcoming vacation to the patient. Before the next session with Sallie, I write a large* V *on a post-it and stick it on my coffee cup, hoping this will help me remember to announce my upcoming vacation during the session.*]

THERAPIST: [*I am eager to share the information immediately in case I am quickly distracted by Sallie's concerns.*] Sallie, before we start, I have some administrative information to share with you today.

SALLIE: Oh, what?

THERAPIST: Well, I'm going to be away from April 25th through May 1st. We have one more meeting next week before I am out of town. Right now, I'm not sure who will be covering my practice, but I will let you know next week.

SALLIE: Oh, going someplace fun?

THERAPIST: Yes, but tell me now about your week. I'm interested to hear.

SALLIE: Oh, it was nothing really. I don't know. Sometimes, I just get sick of talking about the same old stuff.

THERAPIST: Take your time. I'm interested to hear how you are doing.

SALLIE: Just the latest with Gwen. I feel a little stupid sometimes about complaining to you about her. I thought I wanted to talk about it when I came in, but maybe I don't really want to focus on it today.

THERAPIST: [*trying to facilitate a discussion about the vacation*] Maybe you have some feelings about my upcoming vacation?

SALLIE: No, that seems kind of weird. It's fine with me that you have a vacation.

One Week Prior to Vacation

Sallie is 15 minutes late.

SALLIE: Sorry I'm late.

THERAPIST: So, this is our last session before the treatment break next week. Do you think your lateness has anything to do with my vacation?

SALLIE: Huh?

THERAPIST: Well, I'm leaving you alone next week, and today you left me alone waiting for you.

SALLIE: Ummm, I just couldn't find a parking place as quickly as I usually do. (*Looks nervous and uncomfortable.*)

THERAPIST: Maybe you have a few feelings about my vacation that you haven't really recognized.

SALLIE: No, I don't. I think it is good that you are taking a break. I did just hear that Gwen might take a semester abroad next year. I am so jealous!

THERAPIST: She is not the only person going away. . . .

SALLIE: You know, I just don't get it. I don't want to be rude, but I'm not really focused on your vacation. It is just a week, and I'll be fine. You don't need to worry about it.

Example 11.1 is a compilation of common novice mistakes that may occur in the sessions before a therapist's vacation. First, I forget to announce the vacation several weeks ahead of time; by the time Sallie learns the news, my break is right around the corner. As a result, any discussion regarding the upcoming missed sessions is rushed and superficial. Ideally, I would announce a vacation a few weeks (minimum 3, 4 is even better) before my impending leave. With ample time, the discussion of the patient's reaction doesn't need to be forced and can evolve naturally.[1]

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[1]A colleague told me of an alternative method she uses to inform her patients of an upcoming vacation: she jots down basic information about her upcoming vacation on each patient's bill a month or two in advance. For my break with Sallie discussed in Example 11.1, I would add a statement at the bottom of the bill sent out on April 1st, noting that I planned to be away from 4/25 to 5/1, with vacation coverage details available on my voicemail and email during the break. While this notification method is especially useful for patients I don't see weekly, the written notation should not replace a thoughtful discussion with patients I see regularly.

In Example 11.1, when I finally remember to announce my vacation plans 2 weeks before the break, it is at the beginning of the session. I control the content of the opening minutes, rather than following Sallie's lead, affecting the dynamics of the rest of the meeting. Ideally, the opening of a session provides an opportunity for the patient to share what is on their mind. Often, patients have been thinking carefully about what to share with me; if I take control of the agenda during the first few minutes, it may be difficult for the patient to refocus on their concerns once our opening conversation is completed. In Example 11.1, my early announcement derails Sallie. She forgets what she wants to say and then disengages. If at all possible, it is better to announce an upcoming vacation during a natural break in the conversation about 20 minutes into a session.

Then again, sometimes I've found myself in situations where ideal timing isn't an option. For the divorced woman who just found out that her former husband is getting remarried, the architect who just got laid off, or the twentysomething college graduate who is concerned about their extremely critical boss, it is not helpful to interrupt an emotionally loaded conversation to announce my upcoming vacation. For folks in crisis, every minute of the session may be precious; there may not be a best time to announce my holiday plans.

When a patient is in crisis, I try to share my upcoming schedule change at a moment that is least likely to interrupt the flow of conversation. Sometimes, there isn't a spare moment until the session's end as the patient and I confirm our next meeting. While this compromise doesn't allow for time to discuss a patient's reaction to my news, it is more sensitive than interrupting a discussion of a pressing topic, or providing the vacation information right before the break. If the information is shared weeks in advance, we will have plenty of time to revisit the subject during future meetings.

Finally, at the end of Example 11.1, in an attempt to make up for lost time, and possibly to assuage my guilt for neglecting this topic, I push my agenda: my vacation must have emotional meaning for Sallie. Rather than wielding a psychological scalpel, I'm brandishing a chainsaw. The more I insist on the emotional importance of my upcoming vacation, the more Sallie denies the break has any meaning at all. If Sallie had any mixed feelings about my vacation, they are now deeply buried in response to my well-intentioned but pushy approach.

It's interesting to pay attention to the patient's choice of topic directly after a vacation announcement. For some patients, the schedule change doesn't feel emotionally relevant, and they have no problem continuing with their prior train of thought. Others may have a significant reaction to the fact I will be away, and they may feel comfortable talking to me about it directly. A third group may share their reaction via derivative: an indirect communication of a conflicted emotional reaction. They may displace their upset at me onto others whom they feel more comfortable criticizing. I tell

them I will be gone for a week, and their next association is to other people leaving, or the fact that other people aren't dependable in a crisis. Sallie does this in Example 11.1 when she associates to Gwen's upcoming semester abroad soon after the announcement of my vacation. In Example 11.2, a discussion of my vacation becomes a therapeutic opportunity.

EXAMPLE 11.2

The therapist talks openly with the patient about the upcoming vacation

Four Weeks before Break

Fifteen minutes into the session:

SALLIE: So, Gwen continues to make my life difficult.

THERAPIST: I definitely want to hear more and excuse me for interrupting, but before I forget, I did want to tell you about some upcoming scheduling changes.

SALLIE: What? (*Looks worried.*)

THERAPIST: Well, I'm going to be away from April 25th through May 1st. I will share with you more details about who will be covering for me when we get closer to the time. I wanted to let you know a few weeks ahead of time so it wouldn't be a surprise.

SALLIE: Oh, going someplace fun?

THERAPIST: Yes, but it will also be a break for our work together.

SALLIE: That's fine. You deserve a break.

THERAPIST: When is the last time you got a break or vacation?

SALLIE: I don't know. School vacations, I guess. I still am stewing about the latest saga with Gwen. Lately, she hasn't been there for me.

THERAPIST: I want to hear about it. What happened? [*Wondering privately if Sallie is concerned because I won't be available to her during my break, and if she is displacing the distress onto Gwen. Since my announcement was made weeks before the vacation, there is no need to push a more direct discussion today.*]

Three Weeks before Break

At least 10–15 minutes into the session at a natural pause in the conversation:

THERAPIST: I just wanted to remind you about the upcoming week when I will be away. I know now that Dr. Kadish will be covering my practice while I am gone. Her contact information will be on my voicemail and email.

SALLIE: Oh, okay. You know, there really isn't much more to say today.

THERAPIST: Take a minute. Tell me what comes to mind.

SALLIE: Well, I don't know. I have a test coming up next week. I feel worried that I won't do well on it. I just really feel stressed. I talked to Gwen about it, but it seems she doesn't really care. She just doesn't care about me the way I care about her. Sometimes, she doesn't seem to notice when I'm upset.

THERAPIST: It is hard to be attached to someone and to feel that she doesn't care about you in the same way. [*referring to Gwen but also realizing that Sallie may feel this about me as well*]

SALLIE: Yeah, that basically sums it up.

THERAPIST: While we are talking about people not noticing if you are upset, I also wondered if my vacation may have brought up any feelings for you. Our work is being interrupted while we are talking about some important topics. It would make sense that you might have some mixed feelings about it.

SALLIE: Huh?

THERAPIST: Well, you are struggling during a difficult time, and it isn't really the best time for me to be away.

SALLIE: Yeah, but you deserve a break. I can't really feel resentful of it.

THERAPIST: Why not?

SALLIE: What do you mean?

THERAPIST: Well, you are very gracious about my deserving a break, but it also makes sense to me that you might have mixed feelings, even resentment about the schedule change.

SALLIE: Yeah, but that feels so petty to me.

THERAPIST: It doesn't mean that there is anything wrong with you if you have mixed feelings about my leaving. Your feelings are valid. You just have them—you don't choose them.

SALLIE: It just feels rude to me to talk to you about it.

THERAPIST: It might be a hard feeling for you to tolerate, which is all the more reason that I would like to welcome it into the room. I am not offended if you have negative feelings about the fact I will be away.

SALLIE: Maybe it will feel a little weird to miss a week.

THERAPIST: Can you say more about what makes it feel weird? [*using Sallie's words*]

SALLIE: Well, I just depend on having this space to talk about the week and what has happened to me. I can't depend on anyone else to listen to me so closely. I don't listen to myself or pay much attention to my feelings when I'm not meeting with you.

THERAPIST: It makes sense to me that it might feel weird to miss some meetings. We have worked hard together to understand your reactions and feelings. When I'm away, you will have the opportunity to practice tuning into yourself without my help, but this situation isn't ideal because you didn't get to choose the timing of the break; I did. Right now, we are in the midst of some important work together.

SALLIE: I know I'll be okay, but it is better when we meet regularly.

THERAPIST: Would you like to meet with someone else while I am gone?

SALLIE: Nah. It's not that bad, but I will be happy to see you when you get back.

THERAPIST: I'll be happy to see you when I return, too. You are working hard in the therapy, and it makes sense to me that you feel an absence while I am gone. I'm very glad you were able to share your feelings with me directly. It takes some courage to be able to do that.

SALLIE: Yeah, I felt a little nervous. I didn't want to make you feel guilty about taking a break. I'm not used to telling anyone so directly that I will miss them.

THERAPIST: I don't feel guilty. I feel glad you could be honest with me. What do you usually do if someone is leaving, and it leaves a gap for you when the person is gone?

SALLIE: I just try to ignore the feeling; I don't want to be seen as a whiny needy person.

THERAPIST: If you express your feelings directly, does that make you a whiny or needy person?

SALLIE: Sort of . . .

THERAPIST: Actually, I feel very good that you felt comfortable speaking honestly with me. From my perspective, your feelings make sense to me, and they don't feel whiny or needy—just honest. I hope that over the next few weeks, as the break gets closer, we can check in again so you can update me on how you are feeling.

For patients who are attending therapy once a week or less, I try to slip a quick mention of the upcoming break into every session that follows my first announcement. Many people will forget that I am going away if I don't remind them; a fleeting reference is also an invitation for the patient to talk about their feelings regarding the leave. In contrast, if I ignore the upcoming change in frame, my patient will likely follow my lead.

In Example 11.2, Sallie is able to talk to me directly about her feelings. If she was unable to engage in an open discussion, such as the one modeled in 11.2, I wouldn't force the issue. Coercing a patient to discuss any issue is unlikely to be a fruitful venture.

As a beginning therapist, I felt guilty if a patient expressed distress that I was going away. As a clinician working to relieve emotional pain, I felt uncomfortable that my actions might contribute to my patient's suffering.

With experience, my perspective has shifted. When my break may reverberate with the patient's memories of friends or family taking leave during a time of need, an honest discussion may be a therapeutic goldmine. In the past, the patient may not have had the opportunity or wherewithal to talk openly with the person who left and became unavailable. In addition, the person taking leave may have been emotionally closed or physically inaccessible. It also isn't unusual for patients to repress painful feelings of abandonment to defend against emotional distress. Sometimes, in an attempt to assert control in a helpless situation, other symptoms (acting out, obsessive rituals, eating disorders, etc.) may emerge.

Now, within the psychotherapy, my short-term lack of availability can be processed and understood in a unique way. If Sallie expresses distress at my upcoming absence, I'm not defensive and I don't minimize her reaction. (Classic minimization: "I'll only be gone a week and then we'll meet again.") Instead, I take time to validate her experience.

Part of a successful therapy is my ability to take responsibility rather than to dodge or to deflect. I am modeling how a strong relationship can invite honesty and direct communication, while also weathering disappointment. Following my lead, Sallie can learn to accept and to tolerate the difficult emotions that emerge when an important person is unavailable.

Our honest conversations strengthen our working relationship. For some individuals, it is the first time they have experienced such open reflective communication. After navigating these discussions in psychotherapy, the patient can apply the new skills in complicated conversations with family or friends.

While I want to tune into my patient's emotional response to my vacation, I also remember that leaving on vacation is not a destructive act. In fact, to be in my top form while at work, it is critical that I care for myself and my family, and that effort includes vacations. I can hold both perspectives simultaneously: my vacation is important to me and to my work, and my leaving may also feel upsetting from my patient's viewpoint. Then, I do what I can, before I leave and after I return, to alleviate their distress.

VACATION COVERAGE

Before my vacation, I let my patients know the name of the person who will be covering my practice. While I am away, my voicemail and email outline how to contact this doctor if a clinical need arises. I don't check any emails or voicemails from patients while I am signed out. All pages are also forwarded.

I have a group of close colleagues whom I regularly ask for coverage, and I am happy to return the favor. Before I leave, I provide the covering doctor a list of any patients having a more difficult time and their current treatment plan. During my vacation, the psychiatrist covering me will answer phone calls, refill prescriptions, or coordinate an emergency room visit if safety is an acute issue.

For a patient in crisis, it is especially important to talk about my vacation ahead of time in case they may need some extra assistance while I am away. If necessary, a special session can be scheduled with the covering therapist during my absence. A patient who needs intensive follow-up during my break may be matched with a different clinician who has the open time available to meet as often as needed. If I have cell phone coverage during my vacation, I'll share my number with my colleague covering my practice. While I don't talk to patients during a break (because then it isn't really a break), I don't mind fielding a call from a coworker who is providing clinical coverage as an unpaid favor to me.

I have colleagues whom I respect greatly who have set up special phone sessions during their vacations for patients facing unusual circumstances, such as a significant surgery. While I'll never say "never," I don't anticipate scheduling any formalized patient contact during one of my breaks. It is quite possible that the patient might need more than I am able or willing to provide after the first communication, and then, from afar, I may not be able to find alternate coverage for them. Balancing the patient's needs with my potential resentment is a complicated maneuver that doesn't mesh with a restful holiday. Stepping outside of my vacation guidelines may have repercussions I don't anticipate.

That said, I did bend this rule a little bit after the Boston Marathon bombings of April 15, 2013. My patients didn't know that I was vacationing in another state; following the bombing, a few emailed me in a panic to make sure that I was not injured. In the aftermath of the attack, I was not heeding my normal vacation protocol and I was checking my emails. I responded to their messages to assure them that I was fine, and that I was glad to hear that they were safe as well. Then, I mentioned that I wouldn't be checking my email again until I returned but looked forward to seeing them in the office at our next scheduled session. My reply also included my coverage person's contact information. My limited response recognized the unique stressors implicit in a terrorist attack, while also allowing my vacation to continue. If one of my patients had emailed that they sustained significant physical or psychological trauma in the attack, I would have considered touching base during my break, but my vacations are generally just a week or two. Family and friends rally in an emergency, and in most situations, it makes the most sense to wait and to contact the patient upon my return.

PREGNANCY

Prepping for a vacation takes a few weeks. Prepping for a maternity leave is a more complicated venture but not an uncommon one; many female therapists face this challenge during their training. Parental leaves are also increasingly common. Whatever the circumstances, therapists can adapt information from this section to guide preparation for a prolonged break due to a baby's imminent arrival.

When the therapist is pregnant, the clinician's life constantly intrudes into the therapeutic space, both literally and figuratively. As the therapist moves through a number of physical and emotional changes during a pregnancy, the treatment also evolves over the 9 months.

First Trimester

During my first pregnancy, I was concerned how my patients and I would navigate this new significant frame change. At first, I viewed my time as a pregnant therapist as a clinical chapter to be endured; looking back, I recognize that my two pregnancies and maternity leaves also provided unique clinical opportunities.

With sufficient preparation, my practice weathered both events. My belly bump and the planning for my predicted but prolonged absence sparked enriching and challenging conversations in my office about transitions, loss, connections, and family. My unborn children acted as vessels for the projection of various wishes, fears, and resentments, providing fodder for emotional growth.

It was a new experience for my body to be the stimulus of such emotionally charged discussions. I used supervision and my own therapy for professional and personal support. I knew it would be a challenging and exciting time, but it was an unexpected bonus that my therapeutic skills advanced while I also prepared to meet the new addition to my family.

During my first pregnancy, I thought carefully about when to share the news with my patients. After consulting with a few close friends and colleagues, I chose to keep my pregnancy private during the first trimester. I was concerned that if I shared the information too early and the pregnancy didn't hold, I might have to "do and undo" my personal newsflash, that is, tell patients about the pregnancy and then provide an update about a miscarriage weeks later. As a significant percentage of first-trimester pregnancies end in miscarriage, it protects both the patient and the therapist to share the news around the 16th week when the odds are more in favor of a healthy gestation.

During my second pregnancy, I showed a little earlier, and I was worried that some of my patients would tell me that I was pregnant, rather than

the other way around. Thankfully, with a strategic investment in a few loose flowing shirts, it was fairly easy to keep my condition private until I was ready to break the news. As every pregnancy already includes many inherent unknowns, it felt important to have control over the dissemination of my personal information.

Throughout my pregnancies, I took special physical care of myself at work, even if that meant changing the frame slightly. During my first trimester, hard candies helped combat the nausea. If I needed a ginger chew during a session, I told my patients that the candy "helped settle my minor upset stomach." This partial explanation protected my privacy during the vulnerable first trimester while also recognizing that I had a physical condition that required attention during the session. Whenever possible, I moved my patients' hours so the bulk of my workday occurred after the morning sickness had passed. I told these patients that I needed to move a few sessions because of "unavoidable schedule changes." Small protective changes like these made a big difference in my physical comfort each day and resulted in better patient care.

It felt especially uncomfortable during my first pregnancy to pay special attention to my own needs, as so much of my training had been spent focusing on the worries of others. Now in retrospect, I recognize the clear parallels between being a good parent and being a good therapist. If a parent makes their own emotional and physical health a priority within the constraints of parenting and work, they have more energy and thoughtfulness when taking care of their children. Being a therapist is no different. By taking care of my own needs, I have more ability to tune into my patients.

Second Trimester

Eventually, the moment arrives that the therapist needs to tell her patients that she is pregnant, and explain what this means for the treatment. A few patients, especially parents who are attuned to subtle wardrobe changes, may not be surprised to hear the news. Others may be shocked and taken aback.

A maternity leave is more like a temporary termination than a vacation, because of its length, and the possible transfer of care to another provider while the therapist is unavailable. As in a termination, it is a good idea to share the news early on so there is lots of time to process the information. If the therapist is anxious about sharing the news, it may be easy to share too much too quickly, leaving little room for the patient's emotional response.

EXAMPLE 11.3

In her first announcement, the therapist shares too much information regarding her pregnancy and upcoming maternity leave

Start of the Session

SALLIE: Hi, Dr. Bender! How are you?

THERAPIST: I'm well, thank you. It's so nice to see you, Sallie, and I have important news to share with you today.

SALLIE: Oh, what?

THERAPIST: Well, I wanted to tell you that I am pregnant.

SALLIE: You are! Wow! How far along are you?

THERAPIST: I'm about 16 weeks.

SALLIE: You are going to have a baby—that's cool.

THERAPIST: Yes, it is cool. (*Smiles.*) I want to share my plans with you about the maternity leave. I will be taking off from April through June, so, unfortunately, I won't be around to meet with you during the last part of your spring semester. If you want to continue treatment during my time away, I have a therapist in mind for you. His name is Steve Lopez, and he is a very thoughtful clinician. I have known him for many years. I know you will be in good hands.

SALLIE: Okay. Well, congratulations, I guess. So, it was a weird week at school today; is it okay if I tell you about it?

THERAPIST: I definitely want to hear about your week. First, I just wanted to know if you have any questions or concerns about this new information and the fact I will be away this spring.

SALLIE: Umm, no. Not now anyway.

In Example 11.3, I share too much information too quickly to alleviate my own anxiety. While my approach is understandable, it overwhelms Sallie; there is too much to process. Thankfully, by making the announcement this early, around 16 weeks, there are still several weeks available to discuss Sallie's emotional reaction to my pregnancy in addition to the administrative details of my leave. That said, it would have been optimal to introduce the information slowly, midway through the session, rather than sharing all the information at the session's start.

EXAMPLE 11.4

The therapist shares the news of her pregnancy in a less hurried and anxious manner

Midway through the Session during a Pause

THERAPIST: I do have some information I wanted to share with you today.

SALLIE: Oh, what? (*nervously*)

THERAPIST: Well, I'm pregnant, a little over 3 months now, so I wanted to let you know.

SALLIE: Oh, that's great. Is it a boy or a girl?

THERAPIST: You know, I don't know yet.

SALLIE: Oh, is this your first baby?

THERAPIST: It is.

SALLIE: Oh, I'd want my first kid to be a girl. I think it is easier if the first child is a girl—it makes things calmer around the house.

THERAPIST: Well, in your family growing up, you were the oldest, so you speak from experience.

SALLIE: Yes, thank goodness I was the oldest. By the time Tom became ill, I was more independent. I didn't need my parents as much, which was good because they needed to be at the hospital with Tom fairly often.

Also, I helped Tom when he had to return to school after he had been out sick for many weeks. Big sisters are protective. It's hard for me to imagine how he would have managed without my support.

THERAPIST: From your personal experience, you felt the family worked well with the oldest child being a girl.

SALLIE: That's for sure. So, are you feeling sick?

THERAPIST: No, I'm feeling okay, thank you. Do you have any other questions for me?

SALLIE: Not really.

THERAPIST: Well, I want to hear all the questions you may have now, but we also have plenty of time to talk about it before I deliver. My maternity leave will be from April through June. I can tell you more about the maternity leave and coverage now—or we can talk about it more as the time approaches.

SALLIE: Oh, yeah, that's so far away. Let's talk about it later. I might not even be in therapy at that point.

THERAPIST: Okay. I'll bring it up again in a few weeks just to check in on how you are feeling about it.

SALLIE: Sounds good.

This conversation is fundamentally different from the one in Example 11.3. First, the session doesn't begin with my announcement; Sallie chooses the topic at the start of the meeting, and then, during a pause in the conversation, I share my pregnancy news. Sallie's questions that follow provide an opportunity for psychodynamic exploration, but our discussion proceeds at a leisurely pace. There is no urgency as we have plenty of time to discuss all of her reactions during the ensuing months.

The two most common patient questions when I was pregnant were "Is this your first child?" (if the patient hadn't experienced my first pregnancy with me) and "Are you having a boy or girl?" Personally, I didn't find it psychodynamically useful to withhold whether this was my first baby. My pregnancy becomes a part of the treatment for several months, whether I like it or not, and the burgeoning belly invites a few basic questions about my life. During my second pregnancy, I talked frankly about modeling my second leave and coverage after my first successful maternity leave. I did pay close attention to the patient's associations following our discussions to note if birth order was a topic with emotional valence.

For both pregnancies, I found it easiest to note that I wouldn't know the baby's gender until delivery. It was a simple way of inviting a patient's projections and fantasies about the topic, rather than limiting the potential discussion by sharing the information. If at some point, my patient wondered why I decided not to learn the baby's gender, I would ask what they might prefer if they were in my shoes. For more clearly intrusive questions ("Was this a planned pregnancy or a mistake?" "Was it easy to get pregnant or did I need fertility treatments?"), I explored the queries thoroughly but never answered them. (*"I don't share these details, but we can always learn from questions in therapy even if I don't answer them. Any ideas why these questions may have crossed your mind? We may discover something interesting if we are curious about this together."*)

In my experience, a fairly large subset of patients seemed to forget about my pregnancy entirely in the weeks following my announcement, even as my bodily changes became more and more apparent. Over time, I learned that this type of avoidance could have several meanings. There may be a wish that if the pregnancy is ignored, it doesn't exist. A patient may already feel annoyed that the baby is intruding on their time, so any discussion of the frame change may add insult to injury. Another individual may feel it is more civil and polite to ignore the pregnancy than to talk about it directly. I had to make sure that I facilitated a direct conversation, rather than also ignoring the embryo in the room.

As a vague but real intrusion into the therapeutic space, a pregnancy invites a whole host of patient reactions. Patients who already feel concerned about reaching for support may feel hesitant about leaning on me when my body is obviously changed by a new little being. Patients generally concerned about expressing hostile feelings may actively suppress any negative feelings toward me or my pregnancy. They may also worry that their less generous thoughts might have mysterious power that could damage my baby's development. These worries may be a psychodynamically meaningful echo of an early childhood experience. It is common that a child may have some magical thinking when a sibling is born. Young children may become worried that mean thoughts and envious feelings toward the baby might cause physical harm to the infant. If the therapist can help a

patient talk about the feelings they are trying to avoid with a nonjudgmental, understanding, and curious approach, these young patterns of thinking can be uncovered and understood. With the accompanying realization that negative emotions do not carry evil powers, new progress can be made.

Patients who have already struggled with issues of separation and abandonment may become increasingly distraught as the upcoming leave approaches. Patients sensitive to rejection may worry that the baby will be more interesting to me than they are. Individuals who view emotional connections as a finite product may expect that a new baby in my life will inevitably dilute our therapeutic relationship. Patients actively searching for a partner or hoping to get pregnant in the near future may feel envy, possibly combined with a substantial serving of guilt.

Young female patients, feeling lost and without purpose, might also identify with my life change, and consider whether a baby of their own might be a solution to ongoing emotional distress. These individuals might be at higher risk of an unplanned pregnancy in advance of my literal (maternity leave) and my figurative (to love and to attend to my baby) departure.

While patients may have mixed feelings about a pregnancy, some may avoid any direct talk about their emotional responses. Even patients struggling with the most serious psychiatric issues may be polite and superficial when asked to share any concerns about the treatment's frame change.

Just as with a vacation, some patients may share their reaction via derivative: an indirect communication of a conflicted emotional reaction. They may displace their upset at me onto others whom they feel more comfortable criticizing. For instance, Sallie may deny any feelings about my pregnancy, but then talk repeatedly about how Gwen is not available as a supportive friend. These comments might be a subconscious reflection of my future lack of availability during my upcoming maternity leave. Faced with this situation, I might wonder with Sallie if her disappointment with Gwen might also be unconsciously directed toward me, as my pregnancy will make me less available during a time of need.

It is in the best interest of the therapy to repeatedly encourage patients to explore all their feelings on the pregnancy and upcoming leave. Over many sessions, I provided lots of openings to facilitate a discussion. (*"As my pregnancy continues, it makes its presence known in the room. I don't know how that has been for you"* and/or *"I'm going to be on maternity leave in 2 months, and then we won't be meeting for 3 months. I wanted to check in with you about this. How does the change in treatment feel to you?"*)

EXAMPLE 11.5

The therapist encourages Sallie to express her feelings about the pregnancy

Twenty Minutes into the Session

THERAPIST: So, we haven't touched on this for a few weeks, but I wondered if you had any concerns or questions about my pregnancy or the upcoming leave.

SALLIE: I'm doing fine really. Are you doing okay?

THERAPIST: I am doing fine. Thank you for asking, but can you tell me any more about your concerns?

SALLIE: Mostly, I just wanted to make sure you are doing okay.

THERAPIST: I appreciate your concern, but could you say any more about what you have been worried about?

SALLIE: Well, I just think being a parent is such hard work. You never know what your child will need. It can be super-stressful. Probably being pregnant is stressful also.

THERAPIST: Can you say any more about this? When you mention that I might never know a child's needs, what specific needs are you thinking about?

SALLIE: Well, the child can get sick, for instance. Even during a pregnancy, I'm sure your doctors are checking to make sure everything is okay. I just want to make sure that you and the baby are healthy, that's all.

THERAPIST: The pregnancy is going fine, and I appreciate your concern, but I also think that we may have the opportunity to understand something more meaningful here as well. I'm thinking about your experience growing up with Tom. You have experience growing up with a child who wasn't healthy.

SALLIE: (*Tears up a bit.*) Well, Tom was so healthy when he was young. We never guessed that he would end up so sick. I'm sorry, I'm sure your baby won't have inflammatory bowel disease. I think it is fairly uncommon.

THERAPIST: You know, I'm so glad you can talk about this openly with me. I can imagine that it isn't easy. Do you worry that my baby might have the same disease Tom has struggled with?

SALLIE: (*Nods.*) I know it sounds silly, but it has crossed my mind a few times. Also, I don't want to worry you.

THERAPIST: You are concerned that it might worry me if we talk about the fact that some children can get sick?

SALLIE: Yeah, maybe.

THERAPIST: It might be difficult for you to share your worries if you are concerned I might catch them.

SALLIE: I am a little worried. It feels okay for me to talk about this with you?

THERAPIST: More than okay. I am so glad you have been able to bring up the topic. I think it is worth trying to learn more. I feel very comfortable talking about this openly.

SALLIE: Being pregnant must be so stressful. I told my mom you were pregnant, and she mentioned how tired she was while pregnant with Tom and with me. I don't want to make you more tired.

THERAPIST: You are being very thoughtful—but what would be tiring about talking to you? What about the possibility that it feels interesting and invigorating for me to talk to you?

SALLIE: Well, I never thought about it that way, but it just seems to me that you must be more tired as the baby grows. I don't know if I would be able to pay as close attention to work if I was pregnant.

THERAPIST: (*Nods encouragingly.*) During any of our meetings recently, have there been any moments when I seemed distracted to you?

SALLIE: No. You've felt pretty much the same. I just don't want to stress you out.

THERAPIST: It makes sense to me that you may be very tuned into the possibility of a parent feeling stressed out. You come by this feeling honestly.

SALLIE: Yeah. After Tom got sick, my mom was tired all the time. I felt bad for her. By the way, I meant to ask you; are you sure that you are coming back after your maternity leave?

THERAPIST: I have every plan to do so, but can you say more?

SALLIE: Well, I hope this isn't offensive, but maybe it will be just too much for you to work and to also take care of your family.

THERAPIST: I'm not offended, and I'm glad you feel comfortable bringing up your concerns directly. The intrusion of my pregnancy into the therapy naturally brings up these questions, and it is good for us to talk about them. It may be hard for you to imagine that I could have room in my life for both work and family.

SALLIE: Well, maybe.

THERAPIST: With your experience with Tom's illness, how did your parents balance working, taking care of Tom, and taking care of you?

SALLIE: Well, I think I told you. I was mostly self-sufficient by the time Tom got sick, so they didn't need to worry about me.

THERAPIST: I know you are very capable and you were able to manage independently, but that doesn't mean it was easy for you to be on your own.

SALLIE: I didn't really think about it. I just did what I had to do.

THERAPIST: I know. You were a good soldier. But now, with my pregnancy,

maybe it is bringing back some of these feelings from your adolescence—needing to become so self-sufficient before you are quite ready?

SALLIE: I just hope our relationship won't change too much.

THERAPIST: With your experience at home, it makes so much sense that you would feel concerned. With Tom's illness, your life fundamentally changed, and your ability to lean on your parents changed. You learned to rely on yourself a great deal, but it makes sense that it was also a difficult time.

It is natural and appropriate that you use the therapy for emotional support. It is my plan to be available to you after my maternity leave in the same way as I am now. I look forward to working and also being a mother. I don't see that one role requires me to give up the other.

That said, I hope we can keep talking about your worries openly. The treatment has been progressing, and it has been a support to you; it is relevant that I will be unavailable for a prolonged period. It makes sense that you would have feelings about this. I am so glad we could talk about this today, and I hope we can talk about it more in the upcoming weeks.

In Example 11.5, I encourage an exploration of Sallie's worries about my pregnancy, and a deepened understanding of her childhood starts to emerge. As Sallie anticipates that my attention may become more divided between home and work, she remembers how she felt during high school when her parents were less available because of Tom's illness. With my pregnancy stimulating the conversation, Sallie and I start to understand her high school experience in more depth.

In addition, during the consultation with Sallie at the beginning of her treatment, Sallie had reported that her mother experienced the "baby blues" after her birth. I don't know what Sallie understands about this period of time; it is possible that this description is code for a significant postpartum depression. Sallie may be worried about my risk for postpartum psychological issues, and how this might affect our relationship when I return to work. I keep this information filed and will try to learn more at an opportune time.

During the next several weeks, I continue to encourage Sallie to discuss her worries about our relationship without withdrawing my concern and attention. While it isn't easy work to facilitate these conversations, listening and validating a patient's emotional experience can be a powerful therapeutic intervention. These discussions may have special significance for Sallie if she has not talked openly with her parents about Tom's illness and its effect on her adolescence.

During our discussions, Sallie learns that her uncensored emotions are not overwhelming or difficult for me to manage. For some patients, as negative feelings are given airtime, symptoms that may have emerged during their repression (anxiety and panic, depression, obsessive rituals, eating disordered behavior, cutting, etc.) may improve.

When It Is Not in the Patient's Best Interest to Talk about the Pregnancy

For every rule, there is an exception, and there are some instances when a patient should not be actively encouraged to work through their emotional response with the pregnant therapist.

While I was pregnant with my first child, I spent some time working on a locked inpatient child psychiatric unit. At one point, I was assigned an out-of-control adolescent female patient, and she started making threats against my unborn child to the other teens on the unit. While it was unclear if there was any real intent behind the threats, it was clear that my current physical condition was too stimulating for this young woman. I did not want to assume that she had enough self-control to manage her feelings.

One of my colleagues encouraged me to view the patient's anger toward me as a therapeutic opportunity; I could help her to work through the rage transferred from her mother to me. I adamantly disagreed. This situation is fundamentally different from that of an individual in outpatient therapy with good boundaries and reality testing. I cannot treat any patient effectively if I am worried about the safety of my child and myself.

The teenager was reassigned to another psychiatrist. I gave her wide berth on the unit, making sure we were never alone in a room together. As Dr. Messner always said, "Fear is the first sign of impending violence." When I felt scared to be my patient's doctor, it was time to find her a new one.

Second and Third Trimesters: The Administrative Details

During my second trimester, my patients and I discussed the different options for clinical coverage during my absence. Some patients preferred to meet a new therapist weekly during my leave, while others just wanted a name available for unanticipated emergencies. I solidified my coverage plans far in advance in case of an unexpected pregnancy-fueled work limitation, such as mandated bed rest.

Several weeks before my departure date, I provided each patient with the contact information of their designated maternity leave therapist who would provide clinical care during my absence. For my MGH patients, the covering clinician's information was noted within the patient's medical

record, and outpatient clinic administrators were also given a master list. As part of the treatment transfer, I sent each covering clinician a short patient treatment summary (see Figure 11.1) via secure email, secure fax, or snail mail. My most vulnerable patients were given the opportunity to meet their "maternity leave therapist" while I was still available to discuss questions or concerns. For patients with long histories of self-destructive dangerous behavior, I set up phone times with the assigned covering clinician to discuss details of the history and the treatment plan during my absence. Everyone was "tucked in" in case I delivered earlier than expected. This matchmaking took weeks to organize, but it was time well spent. Upon returning, many of my patients had made therapeutic gains with their designated clinician.

For both of my maternity leaves, I decided to stop working about 2 weeks before my delivery date. During my last working month, I scheduled a final meeting with each patient. Toward the end of the pregnancy, the countdown toward our last session became part of the psychotherapy, helping us to process the upcoming break and to finalize coverage plans.

While some of my colleagues continued to see patients until delivery without a formal ending date, I don't think this approach is in the best interest of the patient. A scheduled good-bye provides clear boundaries that help the therapist and patient process the upcoming complicated separation. If the therapist continues to work until labor starts, there is no defined "last meeting" and it is easier not to discuss the emotional ramifications of the significant break. Rather than a thoughtful good-bye, the last communication from therapist to patient may be the clinic calling to cancel the remaining scheduled sessions.

Similar to my vacations, I decided to provide my home and cell numbers (without my patients' knowledge) to the colleagues covering me during my maternity leaves. It worked well for everyone. My colleagues had their questions answered; there was a smooth transition of care, and the coordinated treatment paved the way for my return.

Most of my patients resumed therapy with me after I returned to work. But for a few, those with whom my connection was tenuous, the break in treatment broke our bond. The result was some clinic attrition—a few patients lost with each leave.

Some patients requested to switch care permanently to their covering clinician. Before proceeding, I offered these patients a good-bye meeting, to see if an empathic lapse related to my leave was fueling the exit. (If the lapse could be repaired, the patient might change course and decide to continue with me after all. If so, I would be happy to reestablish our working relationship.) If the patient wasn't interested in a good-bye meeting, or continued to express a preference to transfer care, I wholeheartedly supported the handover. If my covering colleague was willing to continue with the patient, I facilitated the transfer with my best wishes.

Sallie Gane is a 21-year-old single female college student (pronouns: she/her/hers) whom I have been seeing weekly over the last several months for major depressive disorder, single episode, mild, triggered by a breakup with her boyfriend. No psychotropic medications have been necessary as Sallie's neurovegetative symptoms have improved with weekly psychotherapy—although these symptoms should be monitored intermittently. No current relevant medical issues, self-injurious behavior, or active suicidality. Meds: Oral contraceptive pill.

During high school, Sallie was psychiatrically hospitalized after laxative purging led to an emergency room evaluation. After the hospitalization, she completed several months of outpatient psychotherapy and found it helpful. While she has a history of eating disorder issues, high alcohol tolerance, and intermittent passive suicidal thoughts without intent or plan during high school, these behaviors have not continued during college. Our work together is her first return to psychotherapy since high school.

Currently, she drinks 1-2 alcoholic drinks per week and uses marijuana only occasionally, socially—no other drug use. Family history is notable for her younger brother's inflammatory bowel disease, which led to significant family stress during her high school years. Tom is 6 years younger, currently in high school, and having a relapse of symptoms.

Sallie's mother is a part-time real estate agent, and her father manages an electronics store. Sallie is Catholic, currently not practicing while at college. She has close relationships with extended family, although none are local: paternal grandmother is Filipina, married to her paternal grandfather who is White; they live in California. Mother's family is from Ireland, and they visit every summer.

Psychotherapy has focused on helping Sallie identify her thoughts and feelings on issues that concern her, with specific focus on future career aspirations, family, and friendships. Her mother, whom she is close to, strongly encourages Sallie to pursue a college major in economics, with hopes Sallie will pursue a future career in business, but privately, Sallie feels uncertain about an academic focus or career in this area. Although Sallie is unsure if she agrees with the career plan that her mother has proposed, she also wants to please her mother; so far, Sallie has not felt comfortable asserting a difference of opinion with her mother on this topic.

After the shock of the breakup lifted, the therapy has also focused regularly on Sallie's relationship with her best friend Gwen who is frequently available, but sometimes passive–aggressive and controlling. Sallie has invested a lot of time and effort into the friendship with Gwen. Any discussion that may explore Gwen's critical treatment of Sallie should also include a recognition that Sallie has considered Gwen to be an indispensable emotional support during college.

FIGURE 11.1. Maternity/paternity leave coverage information for Sallie Gane.

ADOPTION AND PARENTAL LEAVES

While a parental leave for the nonpregnant parent, or a parental leave after an adoption or a surrogate pregnancy, may lack the physical stimulus of the pregnant belly, the patient is likely to have many emotional reactions to news that the therapist's family is growing, and that the therapist will be unavailable during a prolonged leave. All maternity leave guidelines presented may be modified to fit the needs of each unique family.

While any leave longer than a few weeks requires comprehensive clinical planning as outlined previously, a shorter leave can follow the format of an extended vacation. For a 3-week leave, one clinician may be able to cover a colleague's entire practice.

For a brief (1- to 3-week) treatment interruption, the therapist may choose to present the break as either an extended vacation or a parental leave; each announcement has a unique emotional nuance. A 3-week break without further explanation may cause anxiety in some vulnerable patients if they assume that the extended leave is due to a medical mishap or family difficulty, while others may take the information in stride, with minimal questions. For an anxious patient concerned about a long break without any accompanying details, learning that the treatment disruption is due to a parental leave may feel comforting. That said, once patients know about an upcoming parental leave, they may experience the reactions that occur when a therapist is pregnant, albeit a muted version.

INJURY AND ILLNESS

Vacations and maternity leaves are joyful life events. While I need to be thoughtful of my patient's feelings about my impending absence, I am not in distress while I prepare for my time off. It is a more emotionally complicated scenario when the frame changes because of injury or illness in a family member or myself. In that case, I will be distracted by my own needs, but it remains important, although challenging, to tune into my patient's perspective. Trainees are not immune to personal or family injury or illness. When one is just starting out, it is especially difficult to think clearly and to find the right words under duress. This section was developed to provide professional and practical guidance to those facing these difficult situations.

If I am working with evidence of an obvious injury (such as a cast), I usually provide some elementary information ("I broke my wrist") and then wait to see if further questions emerge. If a train of detailed intrusive questions follow, I switch to a more exploratory approach in an attempt to understand the patient's underlying concerns.

More significant injuries requiring surgery require a bit more forethought, although preparing for a medical leave can follow the template outlined for a maternity leave. If at all possible, I provide the information about a medical leave ahead of time so there is time to process the information within the therapy.

Let's imagine I have a circumscribed diagnosis, such as a knee injury, that requires an easy-to-understand and uncomplicated intervention, such as orthopedic surgery. I may have already provided some minimal information about the orthopedic injury before I broach the subject of my upcoming surgery ("I'm wearing this knee brace for some increased support.").

If the treatment plan is straightforward, I may share a few details: *"I will be having knee surgery, and I can't drive for a few weeks afterward, so I won't be in the office. After my first recovery week, I may schedule some phone or video chat sessions. After the first part of my recovery is finished, I will be able to return to work in person, although I may have crutches or a brace."*

For a patient who has lived with ill family members (like Sallie Gane), it may be comforting to know a few sparse details. Without some facts, she may project her worst fears onto my medical leave. That said, it is clinically relevant if her questions evolve from understandable to intrusive ("What kind of surgery are you getting? At which hospital? Do you have family coming to help you?").

In such a situation, there is more therapeutic value and comfort in addressing the underlying anxiety, rather than just providing facts about my life that don't directly impact the psychotherapy. ("*That's an understandable question, and I can assure you I have a good treatment plan in place to take care of the injury. Rather than share medical details, I think we can learn the most if we explore the concerns brewing behind your questions.*")

Following the approach outlined for a maternity leave, I repeatedly encourage my patients to share any concerns about the upcoming change in frame, even if they seem unfazed by the news. Again, I keep an ear attuned to the possibility that they may displace their distress about the change in the treatment frame onto other individuals in their life who are leaving, unavailable, or ill. As with a maternity leave, if a patient is not stable as my surgery approaches, I will connect them with a clinician who has ample time to meet while I am unavailable.

Now let's imagine I have a more private physical ailment requiring surgery (such as a hysterectomy), and I don't want to share the basic details of my medical condition. In this circumstance, I may explore the patient's worries and fears about the break in treatment without sharing unwanted details of my life.

EXAMPLE 11.6

The therapist tells a patient about an upcoming medical leave while also protecting personal private information

Twenty Minutes into the Session

THERAPIST: Sallie, I did want to tell you today about a medical leave that I will be taking during the month of April. I won't be working during that time.

SALLIE: Are you okay? What's going on? (*worried voice*)

THERAPIST: I need to have some surgery, but my doctors tell me that I will be up and about, ready to work again in about 4 weeks.

SALLIE: What is going on? Is it okay to ask?

THERAPIST: I can understand why you might want to know, but I think it makes the most sense for your treatment to let you know that the surgery is straightforward, and I should be able to work without a problem after a short recovery.

SALLIE: You don't have cancer, do you? Will you need chemotherapy?

THERAPIST: Could you share with me your worries?

SALLIE: Well, I don't want to make you scared, but I hope you don't have cancer. Cancer is the scariest diagnosis to me. I just hope you are okay.

THERAPIST: Thankfully, I don't have a scary diagnosis. What I have is straightforward and will not require extended treatment. It is not very worrisome or life threatening.

SALLIE: How long will you be gone?

THERAPIST: I won't be available during the month of April. Would you like the name of a person you could see regularly during my absence? I will be providing you, and all my patients, with the contact information for a covering clinician in case of emergencies.

SALLIE: I don't think I want to talk with someone new while you are gone, but let me think about it some more. I might change my mind. April is just around the corner.

THERAPIST: You are right. This is fairly short notice. I am sorry that I was unable to provide more warning, but I hope that we can continue to talk about it over the next few weeks.

While a therapist remains calm while talking with patients, internally, they may be frightened about any sort of upcoming extensive medical treatment. It may be helpful to access increased professional or personal supports such as supervision or psychotherapy during this time.

AN ACUTE CHANGE OF PLANS

Sometimes life doesn't provide a warning. My child care provider has a family emergency and cancels at the last minute. Midway through my day, I contract an acute GI virus. The school calls, and my son has just spiked a fever. What is the best way to manage short notice cancellations with my patients?

Thankfully, in the age of cell phones and email (information I collect from patients during our first meeting), it is fairly easy to reach people. If I am unable to get hold of a patient by email, home phone, or cell phone, the office staff at the hospital will try to contact my patients, or will inform them of my unexpected cancellation when patients arrive at the clinic; in my solo office setup, one of my suitemates or I might leave a note explaining my absence taped to my office door. While it isn't ideal for any patient to learn about the cancelled session in this manner, sometimes ideal isn't an available option.

If the reason for my unexpected cancellation is logistically and emotionally straightforward, I usually provide a basic explanation for my acute lack of availability in my conversation or message: *"I'm sorry I need to cancel our session with such minimal notice but _____ [fill in the blank: e.g., I have a child care issue, I am headed out of town unexpectedly for a family obligation, one of my children is sick, I just contracted a bad virus, etc.]. I will contact you to reschedule as soon as I have a sense of my availability."* While classically trained psychodynamic therapists may prefer to cancel without any explanation, I feel comfortable sharing the basics if the basics are benign. For some patients who have experienced significant trauma, knowing a simple explanation for my unexpected absence assuages any worries and suppresses any disaster fantasies about my lack of availability. If I do share some basic information and it ends up feeling emotionally relevant to my patient, we can explore this in detail during a future meeting.

My approach changes if the cancellation event is emotionally charged for me (death of a very close family member, hospitalization of a child). Coping personally with this event will be difficult enough; it will protect both my patient and me if I am spared the stress of navigating the topic during future psychotherapy sessions. It is too precarious of a psychological tightrope: helping the patient to feel comfortable sharing their concerns if they are worried about me, welcoming the patients' associations to their past losses, while also managing my own increased vulnerability. For these reasons, I would not share details of a cancellation due to an emotionally loaded event and would instead be much more vague. My voicemail message will follow this approach: *"Due to an unanticipated schedule change [or family emergency], I am currently unavailable from _____/_____ until a date to be determined. Please contact Dr. Z for any clinical questions while I am unavailable."* I will set my email to automatically reply to any

message, and direct any clinical needs to my coverage. I will also sign my pager out to my emergency coverage.

I have two close colleagues/friends who have agreed to triage calls from my practice if I am unexpectedly unavailable due to an emergency. They would also continue to provide updates about my return, but only vague information ("unanticipated scheduling change," "family issue," or "family emergency") regarding the cause of my absence. If my leave needs to be extended and a patient is in need of more support, these colleagues are stable members of the Boston psychiatric community with many local connections; they will be able to find local providers to fill in during my absence.

Upon my return, it is likely that many patients will be curious about my absence. It is easy to feel tongue-tied after a stressful time or an unexpected absence, but it is fine to have a simple response when patients ask what happened: *"Thank you for asking. Yes, I needed to attend to an issue at home, but everything has been taken care of."* If patients push for details, I might say, *"It makes sense that it felt odd to have me disappear unexpectedly. Without sharing many details, I can reassure you that my family's needs have been taken care of, and now, in our meeting space, I am most interested in understanding how the unexpected break affected you."* If a patient pushes for details, I might also add that it is important to protect the privacy of my family members, just as I am committed to protecting the privacy of the patient's treatment.

Sometimes, patients request that I share specifics about my absence because they are wondering if I still have the ability to listen to their concerns despite the recent turbulence in my life. In response to these queries, I can focus on the theme within the session, but similar to the maternity leave example, I do not need to share the private details of my life to provide thoughtful psychodynamic therapy: *"I wonder if you want to know details because you are concerned whether I am okay. You might be wondering whether I have the capacity to manage my home situation while also listening carefully at work. While it was important for me to take off time because I wasn't in a position to pay good attention when my focus needed to be elsewhere, now I am happy to be back at work, and very eager to hear how you have been doing. That said, I would like to talk more about any uneasiness you might have as we restart our work together."*

IF THE THERAPIST REQUIRES ONGOING, EXTENSIVE MEDICAL TREATMENT

Integrating one's work and one's own medical care may become more complicated if a therapist is diagnosed with an illness that requires more extensive invasive treatment, such as a treatable form of cancer. In such a

scenario, the therapist often needs to prepare their practice for a surgery and recovery, followed by an extended period of chemotherapy or radiation that may change their appearance.

Conveying this news is difficult, especially as there often isn't much time between diagnosis and a planned surgery or treatment course. Even the most competent of therapists can feel tongue-tied when preparing to tell a patient about an upcoming personal medical leave. Over the years, I have worked with some colleagues facing this difficult situation; together, we developed a script (Figure 11.2) to guide this discussion.

With ongoing intensive medical treatment, it is a complicated dance to balance one's own medical and emotional needs with those of one's patients. For some clinicians, the diagnosis and course of treatment may be sufficiently overwhelming that the therapist may choose to take an extended medical leave. For others, work may feel like an emotional and financial anchor during a debilitating journey. Some patients may favor a transfer of care as it may feel overwhelming to worry about the therapist's illness; others may prefer to continue psychotherapy with the clinician they know.

Each life circumstance is unique; there is not a standard protocol for therapists who are facing extensive medical treatment. As the therapist weighs to work or not to work, each patient should be considered individually, with consideration for both the therapist's wishes and the patient's needs. The questions that need to be discussed are difficult to consider: What is in the best interest of each patient while I am undergoing taxing treatment? Even if I want to continue working, how do I balance my needs, to work and to feel structured and necessary during a time of great stress, with the needs of my patients? How do I factor in my need to make a living? How does it affect a patient if I am losing weight or losing my hair, but continue to schedule sessions week after week? How much do I need to tell them about my treatment? Who can help me recognize if the illness becomes so debilitating that it is not in my patient's best interest to continue therapy with me? This is a difficult situation to navigate on one's own. Frequent scheduled consultations with an objective trusted colleague or supervisor are highly recommended and allow a therapist to review work options as the medical situation evolves.

If a therapist does continue working through the illness, the patient may need to be informed a bit about the treatment. Just as the bulging belly of the pregnant therapist deserves explanation, obvious changes in the therapist's appearance due to medical interventions, such as the loss of hair and eyebrows as a result of chemotherapy, also deserve some attention and clarification. Simultaneously, the therapist needs to take the lead in encouraging patients to express complicated emotions about this change in frame due to the disease. If it is challenging to facilitate these conversations while

The announcement should be made approximately 15 minutes into the session. With a few modifications, this script could also be used to prepare for a therapist's family medical leave to care for an ill relative.

> "I need to share something important about my life today that will impact our work together. I was recently diagnosed with a medical condition that is going to require a fair amount of my time to treat. I am getting excellent care (and I have a good prognosis),* but I am still figuring out if and how much I will be able to work during my treatment. I have given this situation careful consideration, and I think, at least for a while, that my focus will need to be on my treatment. I won't be able to work for a while, and unfortunately, I don't know how long a period that will be just yet.
>
> "Right now, I am learning the details of my treatment, and I don't want to give you premature information regarding my availability that isn't accurate. I can tell you that I will need to stop working on _____ [provide date], and we will be able to meet for ___ [fill in number] more sessions."

At this point, it makes the most sense to pause before sharing more information and ask the patient to share their response. The therapist can validate the patient's experience that this news may feel very unsettling and unexpected.

> "During our remaining time together, I would like to make a plan with you to make sure your needs are met during my time away. I will provide you with the name of a coverage person during my absence.
>
> "I will be scheduling a date for us to check in by phone or email to provide an update on my availability once I have a greater sense of how to best balance my medical care and work schedule."

Again, now is a good time to pause and listen to the patient's response.

> "I know this information may be hard to digest. It is so unexpected, and I wish we had more time to process it together before I have to stop working. There is a lot that is uncertain, but the one plan we can make now is the plan for your treatment while I am not available. Sometimes, people prefer to switch their care to another clinician in this type of situation, and I fully support whatever treatment choice feels best to you. If that is your preference, I will help you transfer care to an excellent provider in the community. If you would prefer to stay in treatment with me, I promise to keep you posted on the details of my work plan as they emerge."

*The therapist can include this if they do, in fact, have a good prognosis. It is important to be honest, so if the prognosis is not positive, the therapist can focus on the fact that they are receiving excellent care.

FIGURE 11.2. Script for a therapist sharing news about an unexpected medical leave.

pregnant, it is even more arduous to encourage these discussions when the therapist is in medical distress.

In addition, when a therapist is undergoing extensive treatment, a subtle reversal of roles may occur. Patients may start to feel protective of the therapist—and try to shield their clinician from any additional stress. They may start editing the material they present during their session, avoiding more painful topics or negative transference emotions. They may privately wonder about transferring care, but dismiss the option to avoid hurting the therapist's feelings.

During any extended medical treatment, a clinician also needs to prepare in case the treatment is more difficult to manage than anticipated, and work needs to be put on hold. Even if a therapist plans to take minimal breaks during an extensive medical course of treatment, each patient should be assigned a backup coverage clinician to provide necessary care while the therapist is on leave, or if the therapist becomes acutely unavailable due to an unexpected medical complication. Guidance provided in this chapter on how to plan for a maternity leave may also be used to plan for a medical leave, expected or unexpected. By providing backup care during an unpredictable time, the patient always has treatment options and is never abandoned.

WHEN THE THERAPIST IS DYING

The situation is even more complicated if a therapist's diagnosis is more serious, with a less hopeful prognosis. Unfortunately, being a therapist does not protect one from the possibility of a tragic illness, although, understandably, no one likes to consider this future possibility. While the Americans with Disabilities Act (ADA) may cover the therapist's right to work, even while fighting a fatal illness, the ethical and moral obligations to one's patients should also be considered.

On a radio show years ago, I learned about a therapist who chose to terminate work with her patients after receiving a terrible diagnosis with a significant mortality rate. She then survived several years, despite medical prognostication, and restarted her practice with a new format. Recognizing that she couldn't take her ongoing survival for granted, she specialized in one- to two-session therapy consultations, and then matched patients with appropriate local providers. She took up new hobbies that were creatively and intellectually challenging. It was a thoughtful and clear-cut response to an ambiguous and trying situation.

It is also possible that the therapist may have trouble facing such a complex and difficult situation. Consider the case of Dr. Smith (a fictional story inspired by real-life experiences) and the clinical issues that may emerge.

A female child psychiatrist in her early 60s, Dr. Smith is diagnosed with aggressive metastatic breast cancer. According to her oncologists, there is no cure available, although palliative care may extend survival for 12 to 24 months. Her community of family, friends, and colleagues is devastated by the news. While it is clear from the get-go that her disease will be fatal, everyone hopes desperately for a miracle.

Dr. Smith is an established clinician, teacher, and mentor at a local academic hospital. Her colleagues at the outpatient clinic assume she will start terminating with her patients, or at least make adequate preparations for a future transfer of care.

In an attempt to stem the spread of the cancer, Dr. Smith first undergoes radical surgery. She organizes a comprehensive coverage plan for her patients during her medical leave and recovery. On return to work, she resumes therapy with her former patients, balancing the requirements of her own treatment (aggressive and experimental chemotherapy in the hospital's outpatient oncology treatment center) with her work as a clinician in an adjacent building.

She responds better than expected to the experimental treatment, and her cancer moves into remission in a few months. Her hair grows back, and she continues with her full practice.

At this time, as an outside observer and close colleague, I don't want to intrude on Dr. Smith's privacy with questions about her prognosis. My peers act in the same way. We don't want to cause her emotional distress. If she believes she can fight her fatal disease, then we want to support her quest. It is as if talking about the potential of her death might have some power to prevent a miracle cure. Even the acting director of the clinic doesn't feel comfortable asking Dr. Smith about her future plans for her patients. We assume, or perhaps just hope, that she is preparing her patients adequately for the inevitable.

Often, although not always, there is a small window of opportunity during palliative cancer treatment when the patient feels better as the cancer is temporarily held at bay. This is the ideal time to terminate one's practice, or to prepare the patients for a transfer of care. After an honest discussion, some patients may prefer to transfer care earlier, rather than later, if it is too emotionally painful to continue psychotherapy with a dying clinician.

Unfortunately, Dr. Smith avoids talking to her colleagues or patients about the possibility of a reoccurrence. During the time most suited for a termination, Dr. Smith is in full denial, continues her practice, and even starts treating a few new referrals. All her colleagues, including me, follow her lead and do not question her judgment.

Dr. Smith tells her patients that she is fighting breast cancer, but she has not shared her prognosis. Her patients all assume she has a treatable form of the disease. When Dr. Smith looks better during her brief remission,

her patients hope that their beloved doctor is cured; Dr. Smith doesn't challenge or correct their assumption.

Six months later, Dr. Smith learns from her oncologists that the cancer is back, with a vengeance, and the treatment options are now very limited. Dr. Smith is offered one last experimental therapy. It is an unusual protocol that requires her to have intravenous chemotherapy 24 hours a day. She continues to work and to see patients, now traveling the clinic's halls with her IV pole.

When Dr. Smith appears at the clinic ready to see patients, but requiring continuous IV therapy, many of her patients become understandably concerned, and ask her directly about her current diagnosis and prognosis. Unable to sort through her personal distress, and in an attempt to protect her patients one last time, Dr. Smith responds, "This is just like my prior chemotherapies; just another blip to get through." She does not share the information that her cancer is likely to be fatal, and in the near future.

(Psychotherapy is all about relationships and honest communication, so a patient's accurate insight should be affirmed, not denied. It is never therapeutic to deny the obvious. Furthermore, if a patient later discovers that their therapist has lied, the breach of trust may erode faith in the clinician and all aspects of the treatment.)

Dr. Smith continues to work for several weeks with her IV chemotherapy by her side. It is now common knowledge among her colleagues that she is dying. Again, we assume (probably because it is too painful to ask) that her patients are being prepared for a transfer of treatment, and that Dr. Smith plans to close her practice. None of us knows that her patients still do not understand the severity of her illness.

Weeks later, Dr. Smith continues to work, although her health is declining quickly. When Dr. Smith's oncologists start talking to her about hospice care, a distinguished leader in the Department of Psychiatry meets with Dr. Smith individually and insists that she transfer her patients to other providers. As they talk in more detail, the clinician realizes that Dr. Smith has become cognitively impaired. She has trouble recalling the names of most of her patients, and she admits that she now also has difficulty locating her car in the one-level parking garage she has used for several years.

Understandably depressed and overwhelmed, Dr. Smith abruptly departs on medical leave and enters hospice care. She tells the clinic director that she doesn't feel emotionally or physically capable of saying goodbye to any of her patients. The director of the clinic calls her patients to inform them that Dr. Smith is now on an extended medical leave, most likely without a date of return. The patients are stunned to hear this tragic news from a stranger on the phone; they had been under the impression that Dr. Smith's cancer was treatable.

Dr. Smith and I share one patient, a teenage girl called "Ali," whose father had abandoned her family without warning when she was in

elementary school. I provide the medications, and Dr. Smith is Ali's psychotherapist. When Dr. Smith enters hospice, I offer to become Ali's new psychotherapist.

Ali is distraught over the unexpected loss of Dr. Smith without the chance to say goodbye—a trauma not unlike the loss of her father when she was 8. I am upset by my prior passivity during this whole process and contact Dr. Smith at home. With my help, she is able to write Ali a goodbye note.

Ali cries when she receives the note. The written words from her beloved therapist are priceless; she decides to keep the paper in her backpack, so she can refer to it often. Ali responds to Dr. Smith with a beautiful note expressing her gratitude for their work together. Luckily, I am able to deliver it to Dr. Smith before she dies.

Dr. Smith dies 3 weeks after entering hospice. Patients are informed of this news by the covering clinicians they met just a few weeks ago.

While Dr. Smith had been so helpful to Ali in many ways, Ali is also traumatized by Dr. Smith's unexpected final exit. In the therapy with me, Ali worries that she had been a burden to Dr. Smith since she had talked freely about her own worries in therapy, not knowing that Dr. Smith was dying. She worries that her insensitivity to Dr. Smith's condition could have had some magical negative impact on the cancer's course. She wonders why Dr. Smith was unable to tell her the truth about her diagnosis and prognosis. She feels betrayed that Dr. Smith didn't prepare her in any way for the unexpected good-bye; then, in the next breath, she expresses tremendous guilt for feeling any negative feelings toward a dead woman who had been so helpful to her.

I have mixed feelings while I listen. I feel so sad about Dr. Smith's illness and death, but I also feel upset that Dr. Smith had maintained her practice to her patients' detriment. I am frustrated with myself for having a complicit role in the community's denial of her illness. Ultimately, I seek out supervision to process and learn from this experience. My take home: a therapist's death will always be a significant loss to patients, but like any other change in the frame, sensitivity to the patients' needs is therapeutic and protective.

In his wise and thought-provoking article "The Patient or the Analyst Dies," Dr. Stephen Firestein (2007) hypothesizes that almost every clinician, when faced with a fatal illness, is likely to respond "like all other people" (p. 30). Under duress, denial is likely to be the first and prevailing response, and it may be too difficult to consider the clinical needs of the patients first and foremost. Dr. Firestein imagines the internal dialogue that might occur in the minds of ill therapists: *"They are not yet seriously afflicted, so why stop? It feels better to be busy, so why stop? Interruption will be bad for the patient, so why stop? Besides, the analyst is offering*

a good demonstration of how to address serious adversity" (p. 30). Dr. Smith's bubble of denial may be typical, rather than unique.

It is so easy to shy away from thinking, talking, or writing about these topics. On the other hand, avoidance doesn't change reality. Dr. Paula Rauch, an associate professor at Harvard Medical School, created a child psychiatry service at MGH that helps seriously ill parents respond to their children's needs and plan for the future: Parenting at a Challenging Time (PACT). She notes: "Parents often exclude children believing they are protecting them. This is especially true for parents of anxious children and these are the children who most need to be included and not surprised or excluded from an evolving medical issue with the parent." She comforts: "Carrying an umbrella doesn't make it rain" (personal communication, January 2021). Being hopeful about one's prognosis shouldn't preempt planning for all future possibilities.

There are some similarities in considering how seriously ill therapists should respond to their patients' needs and plan for the future. Therapists can create a personalized "therapeutic umbrella" to protect patient care. Dr. Smith would have greatly benefited from an assigned colleague to help her think through the difficult questions as she continued to work with a known fatal illness. For instance, as one potential intervention, every patient of Dr. Smith's could have been assigned a backup clinician during Dr. Smith's treatment course. Each patient could have had at least one meeting with this backup therapist, so the new provider wasn't a stranger if they needed to take over without much notice. If Dr. Smith was willing, patients could have been informed a bit more about her prognosis, and then offered the choice to stay with Dr. Smith or transfer care. It may be unrealistic to expect the dying therapist to have a clear clinical perspective during such a trying time, but if the colleagues of the dying therapist can provide continued community support and guidance, fueled by honesty and concern, patient care will benefit.

THE PROFESSIONAL WILL

The professional will outlines a care plan for patients in case of a clinician's untimely death; it is another example of a "therapeutic umbrella" that responds to patients' needs and plans for the future. Clarity of thinking is much easier when life and death issues aren't front and center.

Oregon provides step-by-step guidelines to assist psychologists in the preparation of a professional will. As part of the document, the therapist names two close colleagues as professional executor (PE) and backup executor. These individuals develop the professional will with the therapist. In the event of the therapist's death, the PE is responsible for closing the practice by notifying the deceased therapist's current and past patients, triaging

clinical needs, and taking appropriate care of the clinical records. The will provides the information and passwords needed to locate and access records as well as change emails and voicemails. All financial records, appointment books, and related records are kept for the duration of the legal statute of limitations (Oregon Psychological Association Professional Affairs Committee, 2010).

Open discussion in the clinical community about the need for a professional will would have also protected both Dr. Smith and her patients. A PE could have met with Dr. Smith to help her design a professional will when she first became ill. The construct of the will would have provided another opportunity to discuss the treatment plan for her patients if she were unable to work at any point in her treatment. Discussing this issue directly instead of avoiding and denying the unfolding tragedy would have benefited the ill therapist, her patients, and the community.

While the professional will is a gift to our patients and our colleagues, the topic is rarely discussed. During my 6 years of postmedical school training in psychiatry, I never had any supervisor or teacher mention how a therapist should manage work responsibilities if they become ill; this chapter section is an attempt to fill this void.

Thankfully, most changes in the frame are not so tragic as a therapist's death, but any therapist-driven change in the treatment frame may cause some short-term upheaval in a therapy. As I've discussed, these moments may also provide an opportunity for deepened understanding and increased connection over time. I try to think carefully about how my life events may be impacting the treatment of my patients. I encourage my patients to share their reactions within the therapy. Just as we help our patients to be aware of their feelings and responses to our work, we continue to grow professionally and personally if we do the same.

CHAPTER 12

Confidentiality and Its Limits

Your patient must be able to rely on confidentiality to make the highly personal and often exquisitely sensitive disclosures that are essential in psychotherapy. However, your patient should know that if they are at clear risk of harming themself or others, your first obligation is to protect. Occasionally, you may need to break confidentiality to ensure safety.

PROTECTING PATIENT INFORMATION

As a therapist, I am the antithesis of a traditional storyteller. I am a story holder, privy to the details of my patients' lives, their most private attitudes, wishes, and disappointments. To protect my patients, I am bound to a code of silence (or "confidentiality," as it is called in professional circles); if I share information about a patient, it is only under specific and controlled conditions.

When I started training, it wasn't easy to adapt to the rules of my new profession. Emotionally laden information is inherently interesting, and part of me wanted to describe my patients' stories with my family and friends. During social gatherings, it was frustrating to refer to my work in vague technical terms as I listened to my nontherapist friends eagerly share the concrete details of their days.

In retrospect, I understand why it was so difficult to maintain confidentiality when I started this work. I craved emotional support after listening to my patients' suffering. I needed to debrief, but I wasn't sure whom I could tell.

I would have welcomed a "novice therapist information packet" that outlined the basics of confidentiality. Neophyte therapists need to know

how to process their experience while simultaneously protecting a patient's privacy.[1]

TELLING THE SUPERVISOR

As my professional contacts increased, it became much easier to maintain my patients' confidentiality during conversations with my friends and family. As a therapist, I can share patient care issues with colleagues if I protect the identity of the patient and restrict conversations to confidential settings; once I accessed these protected discussion spaces, the internal pull to talk to family and friends about work specifics diminished significantly.

As a trainee, I also reviewed the details of my patients' treatments with three or four instructors each week. My assigned supervisors, all experienced psychotherapists, provided crucial guidance and support for my work. As integral members of the treatment team during my training, they knew the identity of my patient and bore some clinical responsibility and authority for the therapy I provided. With their help, I was able to develop an effective treatment strategy for each patient. Disclosure to a supervisor is allowed by law in most jurisdictions, and these specialized practitioners are also ethically and legally bound to keep all clinical information confidential.

My supervisors became my trusted teachers and mentors. Our weekly meetings provided an approved professional structure in which I could talk openly about my concerns. With their help, I found it much easier to tolerate my patients' distress and to maintain clinical confidentiality.

As part of the informed consent requirement, patients who are under the care of a trainee need to be told that a supervisor is involved, from the diagnostic consultation to the therapy that might follow. Example 3.5 in Chapter 3 models a conversation between therapist and patient, illustrating how the trainee may explain the supervisor's supportive treatment role to a new patient.

Supervision remains valuable even after training is completed. I still seek clinical advice from colleagues intermittently, even though I've been out of training for a number of years. I attend a monthly peer supervision group and don't hesitate to seek consultation for a specific case if necessary. Ongoing attention to clinical work provides professional support and ensures a high quality of care. In contrast to the setup during training, peer supervisors or consultants do not have clinical authority or responsibility for any cases discussed.

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[1]Conversations with the Christine Griffin, JD, MGH Director and Privacy Officer in Health Information Management, were critically helpful in the development of this section.

During a consultation with a peer, I do not disclose my patient's identity. Unless there is a chance that the consultant will recognize the patient from the material presented, I do not need to obtain a patient's informed consent for the meeting.

TALKING TO A PATIENT'S OTHER CLINICIANS

There are some instances in which I share clinical information with my patients' other health care providers. Patients with eating disorders, for instance, benefit from a clinical team that includes a psychotherapist, an internist, and a nutritionist. As psychotherapy is an especially private venture, it's important that a patient provide permission for these discussions with a verbal or, best of all, a written release of information. During discussions with other care providers, I use discretion and reveal only what is necessary for optimal medical care. I don't share irrelevant clinical details that may be potentially embarrassing to the patient.

Patient Presentation for a Conference

During my residency, my colleagues and I were often asked to summarize a patient's treatment for a clinical conference. Starting out, I felt unsure how to prepare for the conference while simultaneously protecting the patient's privacy. To treat a patient with deference and respect, it makes the most sense for the patient to know if their clinical story is going to be presented at a formal conference. Here is one way an informed consent could be obtained.

EXAMPLE 12.1

The therapist requests permission to consult a group of clinicians at a case conference

THERAPIST: I've been offered an opportunity to consult a group of psychotherapists at a conference. With your permission, I'd like to ask for their advice about your treatment.

SALLIE: Tell them about me?

THERAPIST: Yes, but without revealing your identity. I wouldn't tell them your name or the names of any of the people you have mentioned. Also, I'd change a few facts that aren't essential to make it even less likely that you could be recognized.

SALLIE: I don't know. They might think my problems are stupid.

THERAPIST: Therapists donating their time to provide teaching are an empathic group trying to facilitate healing; they are not a judgmental crew. The people who will attend the conference will all be

professionals. They'll respect your courage as I have. They will view the problems you and I are discussing as just that: problems to be understood. They may have ideas for us that could be helpful.

SALLIE: I'm not sure.

THERAPIST: You can think about it, and let's keep discussing it. We don't have to decide for a couple of weeks.

SALLIE: Will you be mad at me if I don't agree to it?

THERAPIST: No, I wouldn't be a bit mad, and whether or not you agree to participate, we will continue working together. How does it feel to be asked about a conference presentation?

Once the situation is clearly explained, with procedural details provided on how one's identity will be protected, many patients feel grateful to have expert input on their clinical struggles. In both oral and written presentations, I would mask my patient's identity by referring to them and to important people in their life by a pseudonym or an initial. For example, Sallie might be referred to as "X," and Gwen might be referred to as "Y." Even without a name, it's possible that a clinician at the conference might identify the patient by the details in the handout. For that reason, I will disguise the information further by altering facts that are not essential and by generalizing where possible. (For instance, I would not refer to Sallie's college by name.) To avoid public dissemination of the handout's contents, paper handouts are preferable; then I can collect all copies at the end of conference. I might keep one copy of my written presentation for my records, but I'll shred the rest of the papers after the meeting.

Talking to Colleagues: Where and When

Sharing psychotherapy tips and discussing cases (without providing identifying details) with my colleagues continue to be a mainstay of my professional development. With experience, though, I've become more stringent about when and where these discussions take place.

As an eager beginner, I'd try to avoid talking about patients in any open place where others could easily overhear, but I would have to reprimand myself often. I'd be at lunch in an open public area with one of my fellow residents, and we would naturally fall into a discussion of our week's work. Occasionally, we'd catch ourselves spouting too much information midway through the conversation. Judging by my experience and observations of others, I can predict that many beginners will mention something about their patients in a public place early in training. Our hope is that by outlining the risks openly, the readers of this book will avoid these errors of confidentiality, both for the sake of their patients' privacy and their own medico-legal security.

I had been a psychiatric resident just a few weeks when a colleague of mine started talking about his new psychotherapy patient while we rode together on the subway. Even though he didn't mention the patient's name, he did share a number of identifying features of the patient as well as confidential information from the psychotherapy hour. I had an unusual visceral reaction, a mixture of interest and nausea.

Nowadays, I use this physical symptom as a personal cue. It signals that I (or the person I am talking with) need to be more vigilant about confidentiality. While my method of visceral introspection may seem unusual, this sort of self-knowledge (autognosis) can be highly useful in life in general and in psychotherapy in particular.

Subways aren't the only common area of risk. Clinic waiting areas or hallways where colleagues converge to wait for upcoming patients can be prime places to overhear information that should stay behind closed doors. Social gatherings, especially if a therapist's tongue is loosened with some alcohol, are also potential traps.

With experience, I've learned to avoid discussing case vignettes, even if I think I have sufficiently disguised a patient's identity, in heavily populated open spaces—or in closed public spaces like elevators. Although it's unlikely that anyone overhearing the conversation might know my patient, open discussions aren't respectful of patients in general and reflect poorly on our profession.

If I could "do over" the subway incident, I would have exited the conversation the minute it felt inappropriate. When the topic became unsuitable for public consumption, a simple "I don't think we should discuss this here. Let's talk about it later in a more private place" would have sufficed.

It is safest to relegate all discussions of patient information to private enclosed areas. A phone or secure video conversation that cannot be overheard is also acceptable. Ideally, any email coordinating care between clinicians should be secure. Some health centers provide encrypted email to allow clinicians to share information, but this extra layer of protection is not available in every organization. (For more information about email security and texting with patients, see Chapter 1.) As another layer of protection, it is best if emails between colleagues share clinical information without including many specific revealing details; if a more in-depth conversation is necessary, the clinicians can schedule a time to talk by phone.

THE INTERNET IS THE WORLD'S ELEVATOR

With the advent of the Internet and social media, new concerns have emerged regarding patient confidentiality. As Arash Mostaghimi and Bradley Crotty write in their thoughtful opinion piece in the *Annals of Internal Medicine*, "Social networks may be considered the new millennium's

elevator: a public forum where you have little to no control over who hears what you say, even if the material is not intended for the public" (Mostaghimi & Crotty, 2011).

I think the comparison of the elevator and the Internet is inspired. In both cases, it is easy to forget that other people may be listening in, or reading along. While I may not be as attentive as I should be to bystanders in an elevator or while posting online, these bystanders may be quite focused on me and my conversation.

The same autognostic response that helps me to avoid talking about work in public also needs to kick in when I am on a social media site. Patient care and work details should not be shared online. This may be a tricky transition for novice therapists as social media sites may be viewed as a useful place to vent frustration stirred up in the workplace.

As discussed in Chapter 7, the standard of conduct for the psychotherapist does not end at the conclusion of the workday. Even more than my friends in other fields, I have to pause before posting. In most circumstances, the best decision is to forgo a post that shares any work details. If I feel the need to talk about my workday, I'm better off picking up the phone or scheduling a face-to-face with a colleague for consultation. Setting up a phone time to talk may not provide the immediate feedback of an online post, but it prioritizes patient privacy. Professional societies also provide regularly updated guidelines as new digital communication options are created. (For more discussion on using social media as a therapist, see Chapter 7.)

Rules, rules, and more rules. I imagine at least some readers believe I am proposing an overprotective approach to treatment. It's true that these rules may be stricter than those of other health care providers, but our work is often more sensitive. In some ways, a therapist's attention to confidentiality is akin to that of a community religious leader. All confidential information must be carefully cherished and protected.

Because of the careful attention therapists pay to confidentiality, practicing psychotherapy 40–50 hours a week and not being able to talk openly about work can be a pretty lonely experience. For this reason, many clinicians mix teaching or writing with clinical practice. In public, one can talk freely about a class, paper, or book that is in progress in contrast to the more guarded approach appropriate for psychotherapeutic material.

WHAT SHOULD YOU WRITE IN YOUR NOTES?: THE OFFICIAL RECORD

The official psychiatric record of my patients includes a detailed write-up of the consultation as well as documentation of any follow-up visits. Ongoing treatment notes document therapy progress and are categorized by HIPAA

as a "psychotherapy office visits or progress notes." All of these notes are an official part of the medical record; at minimum, they include medically relevant diagnostic and treatment information and a safety assessment, reviewing risk to self or others, or major mental status changes. It is beyond the scope of this book to review the details of appropriate documentation; clinical, legal, and insurance documentation requirements change regularly and also vary by region. That said, one predominant reality applies to all psychotherapy progress notes; I cannot assume my notes will stay private and for my eyes only. They may be fairly accessible, either by the patient [as many electronic medical record (EMR) systems allow the patient full access to their notes, including their psychotherapy progress notes], by the patient's other clinicians (also via EMR), or by insurance companies. Courts may also subpoena psychotherapy documentation, so these notes should be written with the recognition that they may be shared with others at a later date.

Electronic Medical Records

Before the advent of EMRs, a psychotherapist rarely shared treatment notes with patients or a patient's medical team. Paper records were generally locked in a cabinet secured at the site of the psychotherapy practice; this practice is still common among many private practices.

As of April 2021, there is a federal mandate that most electronic medical notes, which include psychotherapy progress notes, may not be blocked and must be accessible to patients to review free of charge (OpenNotes, 2021). Clinicians may be allowed to block access to a medical record when it might cause harm to the patient or another person, but these exceptions are limited and rare, and should be used in close consultation with a clinic's attorney and the clinician's professional liability insurance company. Worth mentioning, the Open Note rule does not apply to psychotherapy notes (also known as *process notes*) that are the psychotherapist's personal notes regarding the content of a psychotherapy hour (and discussed in more detail in Chapter 6).

In addition, an EMR allows clinical providers within the same health care system to have an open discourse regarding patient care. Discussion with a mental health provider may require a specific additional release of information, but then, with a patient's permission, EMRs allow psychotherapists and other clinical care providers to communicate and collaborate quickly and easily.

EMRs support coordinated care, encourage direct communication, provide transparency, and build trust between patient and provider. That said, it may also be associated with less privacy protections from the patient's perspective. Within the EMR, the psychotherapy session may be included in a list of all recent clinical visits next to a dermatology appointment and scheduled flu shot.

In some EMR systems, any clinician treating a patient (not just the psychotherapist) may access the documented details of a patient's psychotherapy session with a few extra clicks on the computer mouse and a reentry of the EMR password. Sometimes, there is an extra layer of security protecting access to a patient's mental health treatment information. Of note, EMR systems may also include embedded surveillance tracking to ascertain whether the clinicians reading the psychotherapy notes need to know this confidential clinical information. Whatever the setup, the take-home message remains the same: if my psychotherapy progress notes are within an EMR system, my notes may be read by my patient, and potentially, numerous other providers within the patient's health care system as well. As I choose what details to document, I write my notes with thoughtfulness, empathy, and privacy in mind.

What I Don't Document in the Psychotherapy Progress Note

Even as the requirements for psychotherapy documentation expand, I remain cautious about sharing a session's content details in a note that will become embedded within a patient's medical record. For psychotherapy to work, my patient needs to feel secure that their private concerns remain private and just between the two of us.

To protect the patient's privacy, I only refer to a session's narrative details in oblique and vague terms within the EMR and do not document personal details of our discussion. Medically relevant information (e.g., bulimia) and safety assessments are exceptions, and require documentation of details, but other conversations about the patient's concerns deserve thoughtful privacy protections. While I might note that the patient and I are discussing marital issues, I never add details of my patient's extramarital affair. A notation of a divorce discussion does not include information about an increasingly fraught custody battle. I might note that the patient is struggling with insomnia or flashbacks after a "trauma," but I don't relate any details about a rape or an assault without the patient's permission. If a young woman is trying to figure out how to manage the inappropriate advances of her boss at work, I write "discussing work issues." Private concerns about sexual identity are documented as "discussions about development."

Certainly, whatever my personal take on a situation, my clinical note should always avoid any derogatory tone (e.g., "Patient X finally left her lying cheating husband") and should always be respectful and professional. ("Recent marital separation stressful" is a better choice.) While my work involves hearing stories imbued with strong emotions, those emotions should never be reflected within my documentation.

It is a great privilege to be entrusted with a patient's most private thoughts and feelings, and I try to be cognizant of this trust when I document my psychotherapy progress note for any patient. My patients need to

feel secure that their personal life struggles and private concerns will remain confidential and inaccessible, not part of an open medical record.

Documenting Substance Use

Within the confidential caring environment of a psychotherapy, I may learn details of ongoing substance use that the patient has not divulged to any other clinician on their medical team. Historically, the diagnosis and treatment of substance use disorders have had an extra level of privacy protection within the medical record, prioritizing privacy over coordination of care for these specific diagnoses. Federally funded alcohol and drug use disorder treatment programs require extra confidentiality protections beyond what HIPAA provides for other psychiatric treatment facilities. (This law is referred to as 42CFR.) Substance use clinic notes may be locked out of an EMR system, so medical providers may not even know a patient is seeking substance use treatment. In addition, in some health care systems, a unique additional release of information must be signed before sharing any information about substance use disorder treatment.

Other medical clinics or hospitals encourage a much more open discourse, and may recommend that the psychotherapist document any substance use within psychotherapy progress notes that may be reviewed by the patient's medical team on the EMR. This mandate may cover any or all use of cigarettes (including e-cigarettes), alcohol, marijuana, or other drugs. Substance use can cause or exacerbate medical issues. For example, weekend cocaine binges could have cardiac implications, and it is useful to know if the patient presenting for a chronic pain evaluation has a history of opioid abuse.

Suffice it to say, documentation of substance use requires an extra layer of thoughtfulness, taking into account the substance of concern, the frequency of use, the patient's concerns about confidentiality, whether the program is federally funded and requires a special set of privacy regulations, and the institutional stance on substance use documentation. During training and when starting work in a new clinical setting, it is useful to specifically ask about the institution's position on this issue.

The Insurance Company Wants Information about Your Patient

Sometimes insurance companies request a copy of my patient's outpatient medical record. With rare legal situations as exceptions, I cannot provide any medical information to another party without a release signed by my patient.

If a patient authorizes me to correspond with their insurance company, I provide the insurance with the basic information needed to support ongoing treatment while also protecting private sensitive details of the patient's story. Insurance companies aren't innocuous institutions interested solely

in a patient's welfare. It is even possible that they could misuse the information they obtain to deny present or future treatment benefits.

Whenever an insurance company asks for a summary of the ongoing treatment, I talk openly with my patient about the information to include in the report. Then, we complete the paperwork together during our session so the patient knows exactly what is shared and what is kept confidential. Some patients are less worried about confidentiality and more concerned that they obtain their full insurance benefits for mental health, no matter what needs to be revealed. Others are not willing to be so open and would rather end insurance coverage of sessions prematurely in order to protect their privacy. According to the HIPAA final omnibus rule that took effect in 2013, if a patient pays me out of pocket, I have an obligation not to share information about the services to the insurer. In this scenario, I would only interact with the insurance company if a patient specifically requests my assistance. For me, this situation has only occurred if a patient requires my help to obtain an insurance carrier's prior authorization for a particular and necessary psychiatric medication.

The take home: if an insurance company requests confidential information about a patient, the therapeutic alliance is protected if the patient is included in the process. As always, as a trainee, if I had any doubts, I would consult supervisors about their recommended strategies in such situations.

Psychotherapy "Process" Notes

For some psychotherapy patients, there may be a significant amount of confidential material that I don't want to forget, but that I do not want to include in a medical record accessible to my patient and other clinicians. Historically, detailed private notes on psychotherapy material have been called "process notes," but HIPAA has renamed them "psychotherapy notes," which is how I will refer to them moving forward. As also discussed in Chapter 6, I create a shadow "psychotherapy note" file for therapy patients; this file is for my eyes only in a protected area away from the official medical record. Psychotherapy notes include more detailed notes reviewing my patients' more personal concerns. These process notes may also include details of each psychotherapy meeting in an "I said, they said" format, along with nonverbal communications and any questions and concerns I might think of during and after a patient's session. I don't include the patient's name on these notes, although it is safe to include a coded designation on the papers, such as the patient's initials. (For more information on how to write process notes, see Chapter 6.)

The two-note standard described complies with HIPAA regulations, which have mandated a new national standard of psychotherapy documentation since 2003. These regulations legally differentiate between medical record psychotherapy progress notes (reviewed under "The Official Record" section above) and psychotherapy notes. HIPAA maintains that

psychotherapy notes are only for the therapist's own use and can be protected from others, including the patient, payer, other MDs, and so on.

While psychotherapy notes are intended only for my personal use, it is currently impossible to guarantee that no one else will ever read them. Psychotherapy notes are considered especially privileged, yet there is a chance, however unlikely, that any type of note could be subpoenaed by a court. (Currently, legal obligations differ depending on the jurisdiction.) Because the future is unpredictable, I write all notes with the knowledge that someone else may read them someday. I avoid writing anything in any record that could be misunderstood about my own countertransference reaction toward the patient (e.g., disparaging, angry, or sexual feelings toward a patient). These feelings deserve processing in supervision or in a clinician's own therapy, but it is inappropriate to include them in any type of clinical record, even a process note. In case my notes were ever subpoenaed, a countertransference feeling or fantasy could be easily misconstrued by those in the judicial system, and might even be used as incriminating evidence. In the courts, there is a danger that a documented thought might carry as much weight as a corresponding action.

Someone Wants Personal Information about Your Patient

In certain instances, I may be asked to divulge information about my patient to a stranger. Unless it is an emergency, as we will discuss later in this chapter, I am bound to protect my patient's confidentiality.

EXAMPLE 12.2

The therapist protects the patient's confidentiality in response to an unexpected phone call

The therapist's office phone rings:

GWEN: Hello, hello? Is this Dr. Bender?

THERAPIST: This is Dr. Bender. Who is this?

GWEN: Hi, my name is Gwen. I am a good friend of Sallie Gane's. I know you're her therapist. I wanted to call you, because I am really worried about Sallie. She's been acting strange lately, sort of distant or withdrawn. I don't know if something is very wrong. I figured you would want to know since you are her doctor.

THERAPIST: I cannot confirm whether Sallie Gane is my patient. [*I know Sallie is searching for other friends and is slowly withdrawing from Gwen.*]

GWEN: Oh, I know she sees you. I just wanted to check to see if she is okay. She has been acting so weird lately. I'm pretty worried about her, and I didn't know who else to call.

THERAPIST: If you want to provide information about someone, I am willing to listen, but I cannot disclose whether any person is actually my patient.

GWEN: Well, what if Sallie is suicidal or something? You would need to do something—right? I don't think she's in any immediate danger, but I don't want to make any mistakes. A cousin of mine had a friend who killed herself, and no one saw it coming. So, I wanted to do the right thing here.

THERAPIST: What I can tell you is that if any one of my patients were at risk for harming themself, I would be obligated by law to protect them and to let the appropriate people know about their condition.

GWEN: But, you can't tell me about Sallie specifically?

THERAPIST: I can only share my general policy regarding patient safety.

GWEN: Could you at least tell me if you think she's going to be okay? I may be overreacting, but she is acting differently toward me lately and it worries me.

THERAPIST: As you may know, a psychotherapist can only reveal information about someone with that person's consent. Would it be helpful to share what you could do if you are ever worried a friend might be at acute risk for self-harm?

GWEN: Yes, that would be great.

THERAPIST: Anyone can and should call 911 if they are concerned about a friend committing suicide or hurting someone else. 911 is not just for medical emergencies, but for mental health emergencies as well. You can also encourage a friend in crisis to go to the emergency room to be evaluated. The National Suicide Prevention Lifeline is available 24 hours a day, every day at 1-800-273-8255. A free crisis text line can be accessed 24/7 by texting a key term to 741741 from anywhere in the United States.

GWEN: Thanks—this is helpful, although I don't really think Sallie is at acute risk of hurting herself. She has been acting differently though. You can't tell me anything else?

THERAPIST: No. I am sorry if this is disappointing. I'm going to end this conversation now. Good-bye.

In Example 12.2, I protect Sallie's confidentiality while also treating Gwen with respect and empathy. Interestingly enough, as I have become more comfortable setting and holding boundaries within a treatment, it has become easier (and more effective) to link a polite attitude with firm limits. I can respond to Gwen's concerns by sharing public health information on how to respond to a mental health emergency without breaking Sallie's confidentiality.

I will inform Sallie of Gwen's call during her next psychotherapy session. Our therapeutic alliance might increase in strength when Sallie learns about my vigilance protecting her privacy. The situation is a little more complicated if the call is from a patient's concerned spouse, instead of a college friend. If my patient had not told their spouse about their therapy, the conversation would need to follow the outline of Example 12.2. If the marriage is unstable, I need to be cognizant that any spouse involvement might undermine the safety of the therapeutic space.

In a more stable situation, and if I am certain that the spouse is aware of the ongoing treatment, I could add that I will let my patient know about the call and concerns. In some cases, it might be comforting to both members of the couple to schedule a meeting with me to discuss my patient's diagnosis and treatment plan. If my patient feels that a couple's meeting is an intrusion into the individual work, a couple therapy referral would be another option. Suffice it to say, my priority is the patient's privacy first and foremost and any sharing of information may only occur with the patient's consent.

Even when I have a signed consent to talk to another individual about a patient, I make sure the person on the phone is the person I am authorized to talk to before sharing confidential information. For instance, if Sallie had agreed that I could talk with a school counselor, I could confirm the individual's identity by calling their business number directly before discussing any clinical issues.

Your Psychiatric Notes Are Subpoenaed

A subpoena is a document that requests the presence of a witness or of records before a court. While complete coverage of this topic is beyond the scope of this book, we have outlined a preliminary strategy that we follow if a subpoena requests a patient's psychiatric notes. If faced with this type of situation, we also recommend consulting a supervisor and/or an attorney to review the specifics of your clinical situation.

One example: I receive a subpoena requesting my patient's psychiatric record from the lawyer representing my patient's ex-husband. Currently, the couple is battling for custody of their only child. What should I do?

First, I'll call my clinic's or hospital's attorney. If the subpoena is *not* accompanied by the patient's authorization or a court order specifically agreeing to or ordering the release of the psychotherapy medical record, the hospital attorney and I should let the issuer of the subpoena know that I cannot comply because the patient's records are privileged under state law. I will not discuss any details of the treatment with the ex-husband's attorney.

At my patient's next session, I will inform them of the subpoena and my response to it. I will also call the company providing my professional liability insurance to inform them of the details of the situation.

If the subpoena includes the patient's authorization or a court order specifically requesting the privileged records, I am required to provide the court with a copy of the patient's official medical record. Again, I will also notify and discuss the situation with my clinic's attorney and my professional liability insurance company. In this particular situation, it is an advantage to have the two sets of patient notes: the official medical record and my own personal psychotherapy notes that don't include the patient's name. Personal notes are not part of a subpoenaed medical record, and I can provide the court with the patient's psychotherapy progress notes without sharing many private concerns discussed.

What if the subpoena specifically requests my personal psychotherapy notes or broadly requests any and all records related to the patient? If the attorney obtains a court order or the patient's authorization, I may be bound to release my private psychotherapy notes in addition to the medical record. Faced with this type of complication, I would also return to my supervisor and an attorney for more detailed guidance.

To avoid this type of situation, some therapists choose not to keep confidential psychotherapy notes for therapy cases that have a high likelihood of legal involvement. While this decision is certainly understandable, it's not a simple decision. The absence of notes may make it difficult—at least for some of us—to provide optimal treatment.

Sometimes, patients may wish to share their psychotherapy records with their attorney. They may hope the information in the notes will help them win their lawsuit, whether it be a custody battle or an insurance dispute. In fact, the release of these records is rarely helpful in a legal sense, and the decision may have many unforeseen negative emotional consequences. Once the psychotherapy file becomes part of the legal record, the opposing side has the opportunity to misuse, misunderstand, or manipulate the information. If I am subpoenaed to testify, I am required under oath to answer all questions accurately, even if that means divulging very private patient information. My role as an advocate could be very limited, and the process may damage future treatment if the therapeutic alliance is threatened. If a patient requests a psychological perspective as part of their legal argument, it is legally and therapeutically more secure to obtain an independent consultation with a clinician they will not see for ongoing treatment.

CONFIDENTIALITY MAY BE BROKEN WHEN THE PATIENT IS A DANGER TO THEMSELF OR TO OTHERS

There are a few situations in which it is in the best interest of the patient or the greater community for the therapist to disclose privileged information. In an emergency situation, such as when a patient is suicidal, homicidal, or

unable to care for themself, a clinician has the right—in fact, the duty—to obtain help. The process of obtaining a higher level of care, sometimes against the patient's will, involves divulging essential information about the patient's condition. The laws differ by state; in Massachusetts, a Section 12(a) is the name for the involuntary transportation order to a hospital for an urgent mental health evaluation to determine if the patient needs to be involuntarily committed (because of risk to self, others, or inability to care for self). In Massachusetts, a Section 12(a) can be ordered by a physician, nurse practitioner, qualified psychiatric nurse, qualified psychologist, licensed independent clinical social worker, or police officer.

It can be easy for a beginner to overreact and to bring in an emergency team prematurely when a patient expresses thoughts of suicide or homicide. I make this mistake in Example 12.3 when Candice Jones unexpectedly expresses suicidal and homicidal feelings during a session.

EXAMPLE 12.3

The patient recalls a history of physical abuse, expresses suicidal and homicidal feelings, and the therapist panics

CANDICE: I've never talked to you about this before, but I think I understand now why I am having so much trouble sleeping this month. It's the anniversary month.

THERAPIST: Anniversary of what?

CANDICE: Anniversary of the day I left home to escape my family and live with my aunt in Boston. I was just 16. It should be a happy occasion. I don't know why I always feel so upset around this time of year.

THERAPIST: This sounds like a very distressing memory. What were you escaping from when you went to live with your aunt?

CANDICE: I haven't told you the details about this, but my father used to hit me all the time growing up. I was his preferred target.

My family didn't tell anyone about it. We all kept the secret together. At a certain point, when I couldn't bear it any longer, I left. (*becoming increasingly agitated as she talks about this topic*)

THERAPIST: [*I am worried about Candice's ability to tolerate these feelings, so I check how Candice is experiencing the discussion.*] What does it feel like to talk about this?

CANDICE: It is infuriating! That man deserves to die for what he did to me and my family. When I think about it, I just want to kill my father for what he has done. Then, I might as well kill myself also. It would be easier than having to deal with these memories.

THERAPIST: I'm glad you could tell me about this incredibly traumatic time, and I want to learn more about it. I am worried to hear that these

memories are so unbearable that you feel like killing your father and yourself. [*I hear increased anxiety in my voice.*]

CANDICE: Well, that's the way it is. That son of a bitch should get what he deserves.

THERAPIST: I am sorry, but if you are at risk of hurting yourself or anyone else I must take you to the emergency room to be evaluated. (*I call hospital security to escort Candice to the emergency room.*)

When Candice becomes overwhelmed with affect, I panic and move into crisis mode before clarifying whether she actually has any true intent or plan to hurt her father or herself. While it is always better to be cautious, my reaction is based on fear rather than on a thorough assessment.

A deeper evaluation would have obtained additional information before leaning toward an emergency room consultation. Figure 12.1 outlines the

The therapist can ask, "Have you had a(n) _____?"

- Fleeting thought of death
- Passive wish for death
- Active wish for death
- Intent to pursue death
- Plan to pursue death
- Self-injurious behavior
- Actions to implement the plan for death

- Homicidal thoughts
- Violent or destructive thoughts
- Intent to harm others
- Plan to harm others
- Actions to implement harm to others

For each of these questions, the therapist can also ask whether the patient has had previous experience with these thoughts, feelings, and actions, and whether alcohol or other psychoactive drugs were involved. The patient should be asked about family history of suicidal attempts or completions. These factors may increase a patient's present and future risk.

Protective factors such as engagement in treatment, caring family, friends, a pet, or a meaningful job may also be noted.

Many institutions provide a template to guide the evaluation of risk in a suicidal or homicidal assessment.

FIGURE 12.1. Suicidal or homicidal assessment chart.

pertinent questions I need to answer in order to decide whether Candice needs an urgent extensive in-person evaluation of her suicidal and homicidal feelings in a contained safe space, such as a psychiatric emergency room. If Candice doesn't have a history of acting on her destructive feelings (a history of violence is a strong predictor of future violence) and can assert that she doesn't have a current intention or plan to hurt herself or others, it's likely that her threats are solely an expression of her distress. After a thorough evaluation, my note will document the details of my suicidal and homicidal assessment and will state the reasoning behind my treatment decision.

Example 12.4 illustrates a strategy I might employ if Candice is suicidal and/or homicidal with intent and a plan.

EXAMPLE 12.4

The therapist carefully assesses suicidality or homicidality in a high-risk patient

The scene opens with Candice becoming increasingly agitated as she talks about years of physical abuse by her father.

CANDICE: Dr. Bender, he deserves to be punished for his behavior. He was never legally charged for his crime. I still have chronic knee pain where he kicked me when I was 13. That son of a bitch should die. Someone needs to make him pay for his actions.

THERAPIST: I agree that your father's behavior was reprehensible, but I am also wondering if you have thought about being the one to exact revenge?

CANDICE: I have, in fact. Next week I'll return to Florida to see my mother, and I plan to stop by and see my father. It's time that he suffers the consequences of his actions.

THERAPIST: Make him pay in what kind of way?

CANDICE: Like I said, Dr. Bender, he deserves to die. I'm not worried about jail. Maybe after he's gone, I'll be ready to die, too. I haven't decided on the specifics yet.

THERAPIST: Let's think it through together. How would you make him pay?

CANDICE: I don't know. I'm not sure if I'll have the guts to go through with it, but it's definitely what he deserves. I'm not sure what will happen, but I can't promise. . . .

THERAPIST: Promise?

CANDICE: I don't know. I am just thinking about my options.

THERAPIST: Which options have you considered?

CANDICE: I'd rather not say. Let's just pretend I never brought this up.

THERAPIST: Therapy works best if you talk to me about this openly. You have survived significant trauma, and I think it is important to talk about how it is currently affecting you.

CANDICE: I'm not interested in discussing it anymore.

THERAPIST: Can you tell me why not?

CANDICE: I don't want you to talk me out of my plans. I know what I want to do.

THERAPIST: We need to talk about this here or, to protect you, we can walk down together to the emergency room downstairs and talk there.

CANDICE: Dr. Bender, I feel you are acting intrusive. This is my private decision, and I would rather not talk about this anymore.

THERAPIST: I understand that you would rather not talk about this anymore, but my first priority is your safety. This is an incredibly complicated situation, and I don't think we can work it out together if you are unwilling to talk with me. I'd like to bring in some other clinicians to get additional opinions on how to proceed. (*I reach for the phone and request security, using a code word to come to my office and to escort Candice to the emergency room.*)

If Candice were cooperative, I'd assess her homicidal impulses toward her father in detail. To protect Candice and her father, I need to know if she is truly planning to hurt her father in the near future by assessing her intent and plan and history of violent actions. When Candice becomes increasingly withdrawn and refuses to answer my questions, I am legally obligated to continue the evaluation until I can adequately assess both her safety and the risk to her father as a potential victim.

I don't need to tell Candice about my legal obligation to protect her father at this point. By managing her distress in a structured setting, I can protect both parties at once. Either Candice and I need to talk until we have formulated an effective and protective treatment plan, or I need to make sure she is evaluated immediately in an emergency facility.

During the emergency room visit, my colleagues and I can decide whether it is safe for Candice to go home or whether she requires hospitalization to protect herself and her father. If Candice has access to a firearm, it should be turned over to the authorities as part of the crisis intervention. Assuming that the intensive intervention would put an end to Candice's acute homicidality, inpatient care would protect her father while simultaneously preserving Candice's confidentiality. I would only contact Candice's father as a last resort, for example, if Candice eloped from treatment or if the homicidality did not decrease during her inpatient hospitalization. Any questions about my legal obligation to inform her father of Candice's threats would be run by my institution's legal department.

In Example 12.4, I call the hospital's emergency security number to ask for assistance in moving Candice from the clinic to the psychiatric emergency room. If the session was via telehealth or if Candice was in my private office and I was unable to convince her to obtain an emergency assessment, I would consider calling the police to my office or to Candice's home to escort her to the nearest emergency facility. If Candice flees from the office, I would ask the police to locate her and then take her to the nearest hospital for an evaluation.

If Candice's homicidality continued, I have the legal responsibility under laws that vary from state to state to protect a potential victim from an impending assault and to report information about a violent crime that might occur in the future. In Massachusetts, and many other states, clinicians also have a duty to report any potential or ongoing abuse or neglect that puts children, the elderly, or the disabled in harm's way. However, as a therapist, I do not have the responsibility to report details of a crime that has already occurred. In fact, this information is protected under the confidentiality agreement of the therapy.

Confidentiality is a complicated issue that pervades all aspects of psychotherapy. As a therapist, I have a fiduciary duty to safeguard a patient's privacy. In specific instances, I also have the conflictual duty to disclose information in order to protect the safety of the patient or other individuals. Each case is unique, and even with some experience with these issues, I have a low threshold to consult a supervisor or an attorney when new questions emerge.

PART III
CHEMISTRY

CHAPTER 13

Substance Use Disorders

Substance use needs to be thoughtfully assessed for any potential detrimental effect on a patient's emotional state, cognition, decisions, and relationships. Patients struggling with a substance use disorder benefit from adapted psychotherapeutic techniques.

Drugs associated with substance use disorders strongly stimulate the brain reward system, causing a quick pleasurable high that can be both physiologically and psychologically addicting. Individuals struggling with substance use disorders may carry a genetic biological risk; often the first use of a drug is so satisfying, the patient describes it as unforgettable. Add in a few additional risk factors such as ongoing emotional distress, impulsivity, or a substance-using peer group, and addiction may set in quickly.

Substance use disorders are regularly misunderstood and often stigmatized. Patients struggling with addiction may be mischaracterized as weak or incapable by those without addiction risk factors. No patient chooses to have a substance use disorder just as no patient chooses to have a mood disorder.

Once addiction takes hold, drug seeking may become the major focus of life, overriding personal relationships and occupational responsibilities. Self-deception, deception of others, and activities to protect drug access are both biological and psychological symptoms of the substance use disorder, just as anhedonia is a symptom of major depression.

In this second edition,[1] I have a greater recognition that the terminology I use to describe substance use diagnoses carries therapeutic importance.

[1]I am grateful for the wise input and guidance provided by Dr. Amy Yule during the update of this chapter.

Dr. John Kelly's comments on the need for an "addiction-ary" (Kelly, Saitz, & Wakeman, 2016) provide useful guidelines, promoting thoughtful language choices rather than terms with a punitive slant. Referring to patients as abusers, addicts, or those who have substance abuse issues embeds judgment in the treatment process. Instead, it is preferable to describe patients as having a substance use disorder, or as struggling with addiction; these alternatives are less derogatory and provide more empathy. As Dr. Kelly notes, we don't label patients with eating disorders as "food abusers," and it is long overdue that we take equal care describing individuals struggling with substance use disorders. As therapists, our words are the tools of our trade, and we must choose them carefully; a treatment approach that minimizes shame and promotes understanding has a greater chance of success.

Addiction treatment is a complex clinical subspecialty; this chapter introduces how to adapt psychotherapeutic techniques for the patient struggling with substance use issues.

UNIQUE ASPECTS OF PSYCHOTHERAPY FOR THE PATIENT WITH A SUBSTANCE USE DISORDER

When I started practicing psychotherapy, I had both the enthusiasm of a true believer and the naivete of a novice. I believed in the power of psychodynamic psychotherapy to alleviate distress, and I didn't see any reason to alter my approach for different clinical issues. The basic strategy seemed foolproof—every individual would experience sustained emotional growth if they had the opportunity to talk about the past and to connect its difficulties with the present.

While my model was well intentioned, it wasn't long before I realized that one treatment modality can't be applied effectively to every patient. For example, for patients struggling with active substance use, a more classic psychodynamic psychotherapy approach may be contraindicated. When a patient begins to talk about past or current emotional conflicts in therapy, their anxiety level is likely to increase before it subsides. For most patients, this increase in anxiety is relatively short-lived and tolerable. For patients with poorly honed coping mechanisms struggling with a substance use disorder, an immediate focus on emotionally stressful material may be destabilizing.

In response to the flood of feeling that accompanies an intense psychotherapy session, the patient struggling with addiction is apt to turn to alcohol or drugs to manage their distress. If the therapy continues to uncover conflicts without calming the patient's increasing dysphoria, the substance use with all of its related difficulties is likely to get worse instead of better. For treatment to be effective for this group of patients, the traditional psychodynamic insight-oriented approach needs to be modified.

The psychotherapy of a patient struggling with an addiction requires some special strategies. Early in treatment, a patient with a substance use disorder may deny that they have a problem. Often, the interpersonal and situational problems that beset the patient do not resolve until after the substance use issue is adequately addressed. Recognition and active discussion of the addictive pull of substances, consistent encouragement, and patience in responding to slips and lapses are necessary to help the patient recover.

To formulate the most effective treatment strategy for a new patient, I try to identify whether they have an active substance use disorder within the first few visits of the consultation. Doing this takes some clinical finesse, because active users struggling with addiction may deny or minimize substance use when asked about it directly.

To aid the discussion about substance use, I will introduce Anthony Lee, a 35-year-old business consultant who begins therapy because of increasing feelings of depression over the preceding several months. In Example 13.1, I fail to identify Anthony's substance use disorder during my initial assessment.

EXAMPLE 13.1

The therapist does not recognize that her new psychotherapy patient may have a substance use disorder

During the First Three Consultation Meetings

ANTHONY: I don't really understand why I feel so down, but one of my best friends encouraged me to at least try therapy, so here I am. I figured it couldn't hurt.

THERAPIST: I'm glad you took this first step to get some help; it sounds like you have really been suffering. Could you tell me, during this tough time, have you ever decided to drink or use any substances to change your mood or to distract from concerns that are bothering you?

ANTHONY: Nah. I don't think so. I just drink with my friends after work. It's part of the business culture. Nothing to really worry about.

THERAPIST: When you drink, how much do you drink?

ANTHONY: Nothing out of the ordinary, a few beers now and then. I'm just a social drinker.

THERAPIST: Okay.

To adequately assess a patient's substance use, a more in-depth discussion is necessary than the one modeled in Example 13.1. Example 13.2 illustrates a screening approach that is more likely to elicit whether a patient has concerning alcohol or substance use. As discussed in Chapter 5,

I have revised the addiction assessment questions in this new edition. The CAGE questionnaire, the recommended screening tool of choice in the first edition, has been critiqued for failing to pick up patients who lack insight into the negative impact of their alcohol or substance use. Now, following guidance from my colleagues who are specialists in addiction treatment, my go-to questions for assessing alcohol and drug use are derived from the more sensitive (in terms of being able to correctly identify those who have the disorder), reliable (as it provides consistent results), and brief Alcohol Use Disorders Identification Test-Concise (most often referred to as the AUDIT-C), combined with three questions from the National Institute on Drug Abuse (NIDA) Drug Screening Tool, Quick Screen. In Example 13.2, when I uncover Anthony's marijuana use, I take a deeper dive than modeled in Chapter 5 (identification of substance use during the consultation) and follow up with some questions inspired by the NIDA-Modified Alcohol, Smoking and Substance Involvement Screening Test, otherwise known as the NIDA *Modified ASSIST* or the *NM-ASSIST*. Questions in Example 13.2 derived from the AUDIT-C, NIDA Drug Screening Tool, and NM-ASSIST are highlighted in **bold**. (In addition, versions of these screening tools that you can reproduce to use with your patients are available as Therapist Tool 5.1 at the end of Chapter 5 and as Therapist Tool 13.1 at the end of this chapter.)

EXAMPLE 13.2

The therapist identifies her new psychotherapy patient as having a substance use disorder

During the First Three Consultation Meetings

THERAPIST: During this tough time, have you ever decided to drink or use any substances to change your mood or to distract from concerns that are bothering you?

ANTHONY: No. I just drink with my friends after work. It's part of the business culture. Nothing to really worry about.

THERAPIST: When you drink, what is your drink of choice?

ANTHONY: Oh, just beer mainly, especially the local brews made here in Boston. I don't know if I have a favorite.

THERAPIST: **How often do you drink?** [*AUDIT-C Question 1*]

ANTHONY: I drink a few times a week; everyone who works at my company does as well.

THERAPIST: About four times a week? [*aiming high as it is more likely Anthony will minimize his usage*]

ANTHONY: When I started this job, I was drinking almost every evening,

but over the last year, I've been trying to cut down. I'm only going out about three times a week now, but it would be stupid to cut down anymore. I'd miss too many networking opportunities. [*3 points for AUDIT-C Question 1*]

THERAPIST: Important deals after hours?

ANTHONY: I definitely think pub time is also important work and social time.

THERAPIST: **When you go out on a typical night, how much do you drink?** [*AUDIT-C Question 2*]

ANTHONY: I don't know. Probably around four or five. Usually five—but, I space them out over many hours during dinner and hanging out. I know how to do it. My coworkers are drinking about the same amount; the amount I drink isn't atypical for my crowd. [*2 points for AUDIT-C Question 2*]

THERAPIST: **Do you ever have six or more drinks at a time?** [*AUDIT-C Question 3*]

ANTHONY: I don't know. Now and then, I guess

THERAPIST: **About how often**? [*AUDIT-C Question 3*] Once a week? A few times a week?

ANTHONY: Probably on Sunday, especially if I'm watching sports. I might drink a six-pack—but again it is over several hours. I don't chug beers like a college student. [*3 points for AUDIT-C Question 3 for a total of 8*] It's all normal stuff.

THERAPIST: I appreciate you taking the time to answer thoughtfully. Alcohol, tobacco, and drugs can affect health and mood and interfere with other medications, so it is an important part of your medical history. **Do you ever smoke cigarettes or use any tobacco products? Any electronic cigarettes?** [*NIDA Drug Screening Tool: Quick Screen question*]

ANTHONY: No—never been into that.

THERAPIST: **Have you ever used prescription drugs for nonmedical reasons?** [*NIDA Drug Screening Tool: Quick Screen question*]

ANTHONY: In college, I used my friend's Adderall once to help me study for a final, but that was only once. I felt nauseous and revved up on it—it was awful. I don't plan on doing that again.

THERAPIST: Thanks for reviewing this information with me. Next, I have a fairly long list of drugs that I want to review with you. Please bear with me as I go through the list with you. All of these drugs can affect mood, so it is useful information to review. **Have you ever used marijuana?**

ANTHONY: Sure, I like to smoke weed. I started in college, and I don't think it has caused any harm. It relaxes me. I often smoke on weekends, but I'm not a stoner.

THERAPIST: **How much do you smoke on weekends?**

ANTHONY: Maybe two joints a day; it's nothing to worry about.

THERAPIST: **Have you ever used cocaine, heroin, or any type of opioid?**

ANTHONY: Nope. I stay away from the hard stuff.

THERAPIST: **Anything known as an "upper" such as methamphetamine or speed, or a "downer" otherwise known as a sedative or sleeping pill?**

ANTHONY: No.

THERAPIST: **Any psychedelics, which are also known as hallucinogens, like LSD or magic mushrooms or synthetic drugs such as Ecstasy, Molly, or MDMA?**

ANTHONY: Doc, I don't want you to get the wrong idea. Like I said, I've always been really careful about the hard stuff. Never tried any of it and never will.

THERAPIST: Thank you for clarifying. I know it's a long list to review. **Regarding your weed use, do you look forward to smoking on the weekends?** [*mirroring Anthony's word choice, question inspired by NIDA Modified ASSIST*]

ANTHONY: Well, sort of. My job is pretty stressful. Weed helps me relax.

THERAPIST: **From your perspective, has smoking weed caused any problems for you?** [*question inspired by NIDA Modified ASSIST*]

ANTHONY: I don't think so. I don't think it gets in my way.

THERAPIST: **Has any friend or relative ever been concerned about your smoking or drinking?** [*question inspired by NIDA Modified ASSIST*]

ANTHONY: Well, my parents have questioned me about my drinking, but they are so conservative, I don't think they count. They don't know about the weed use, and if they did, I bet they would worry about that also. To be honest, I don't take their concerns that seriously. My friends have never said anything.

THERAPIST: What have your parents said about your drinking?

ANTHONY: They just worry about my health. They always say I drink too much during family dinners, but that is because they hardly drink at all.

THERAPIST: You mentioned earlier that you are trying to drink less. **Have you ever tried to cut down on your weed use?** [*question inspired by NIDA Modified ASSIST*]

ANTHONY: I mean I used to smoke daily for a bit, toward the end of college,

and I know that wasn't good, but now I'm mainly using on weekends—unless there is a special occasion. Not a big deal, I promise.

While Anthony seems to be direct and honest about his alcohol and marijuana use, it is also no secret that I'm assessing his substance use, and his comments reflect that he may be concerned how I interpret his reported use. While listening to his responses, I remember that it isn't unusual for patients to minimize their use as a way to protect the status quo, and to avoid shame and potential judgment. So, I keep in mind, as Anthony reports his use, that in fact, he may be drinking more than the reported five beers, three times during the week with a six-pack on some Sundays, and his marijuana use may not be confined to the weekend, and might at times leak into his work week.

Substance use disorders are unique in that patients may not always recognize how their use is detrimentally affecting their lives. While substance use disorders detrimentally affect mood, anxiety, and relationships, a patient may feel temporarily less anxious and relieved of psychological distress while intoxicated. Motivation may be low to change behavior that seems to be helpful in the short term. In contrast, patients with high anxiety or depression know that their symptoms are causing emotional distress; they are motivated to understand the underpinnings to their pain and to make changes.

Using the interpretation guidelines for the AUDIT-C, I determine that Anthony scores an 8. Men with more than 4 points, and women with more than 3 points, are flagged for a potential alcohol use disorder, so Anthony's alcohol use deserves more attention and concern within his treatment.

I try to clarify the extent of Anthony's marijuana smoking by using questions inspired by the NM-ASSIST (Therapist Tool 13.1). The NM-ASSIST focuses on identifying the drugs used; the amount of use; and also the social, health, legal, financial, and emotional consequences of substance use. While my interview doesn't collect enough information to officially score the NM-ASSIST, my questions do identify Anthony's marijuana use as another potential health issue that deserves more evaluation and follow-up within his treatment.

Once I've identified that a patient may have a substance use disorder, I start to strategize. For Anthony, I'll start by focusing on the alcohol use since he admits to drinking all week long and has recently tried to cut down on his alcohol intake. (The strategies illustrated in upcoming Examples 13.4 and 13.5 may also be used to discuss Anthony's marijuana use at a later date.) I will choose my words carefully when I talk to Anthony about his alcohol intake; I recognize that my questioning may lead Anthony to become defensive and withdraw. The topic is sensitive, but it deserves attention, as Anthony's psychological and physical health may be detrimentally affected by his frequent and clinically significant alcohol use.

Learning how to effectively talk to a patient about concerning substance use is not intuitive, and it takes specialized training and practice. It is easy to fall into a more authoritative approach, as illustrated in Example 13.3, which is unlikely to be clinically beneficial to the patient.

EXAMPLE 13.3

The therapist confronts her patient about his substance use in an authoritative and ultimately nontherapeutic manner, and then colludes with the patient to ignore the mounting evidence that the patient may have a substance use disorder

Following Up on the Conversation in Example 13.2

THERAPIST: As I think about your answers to my questions about alcohol, I wonder whether you are drinking excessively, and whether this should be our first focus in your treatment.

ANTHONY: Oh, I don't think my drinking is a problem. I don't drink any more than any of my friends. I don't drink every night. I told you I have already cut down my pub runs compared to last year. My work reviews have been excellent. Not what you would see with an alcoholic, I would think.

THERAPIST: Have you ever gotten into any trouble with your drinking?

ANTHONY: No, not at all. I don't want to offend you, but you may be overreacting because your circle of colleagues has fun in a different way than mine. I don't see shrinks being the drinking type. My work is different. I don't think you need to worry. My drinking is not a big deal.

THERAPIST: Why doesn't it feel like a big deal to you?

ANTHONY: Well (*sounding irritated*), because it's not. I don't see how you came to this conclusion in the first place. I'm not at all worried about my drinking.

THERAPIST: (*becoming somewhat authoritative and a little defensive*) Well, I *am* worried about your alcohol use. The questions I asked you were created to screen individuals for alcoholism. The data have shown that if a man scores higher than a 4 on certain questions, then further evaluation and counseling are indicated. You scored an 8!

Now, we can ignore this information, or we can use it to benefit our work together. I'm concerned that if we ignore it, any work that we do would be unlikely to make you feel better. Alcohol is a depressant, and if we don't address your drinking head-on, your suffering is likely to continue, or even get worse.

ANTHONY: (*Responds with an offensive approach.*) Look, I appreciate your

concern, but I came to see you because of the difficulties I have had concentrating at work and this depressed feeling I sometimes get. If anything, alcohol makes me feel better, not worse. I didn't come to you to talk about my social life with my work buddies. My time hanging out with these guys is one of the few parts of my life that is fun, and it isn't causing any problems. In fact, I've made some of my best deals at the pub. If anything, drinking while networking makes me more successful.

THERAPIST: [*I feel intimidated and unsure. I don't want to make Anthony more upset than he already is.*] Okay, maybe I'm wrong. Can you tell me about how you view your difficulties?

ANTHONY: Well, it's like this. . . .

Anthony becomes more defensive and oppositional when I confront him about his alcohol use in a commanding manner. My personal take, "*I am worried about your alcohol use,*" doesn't facilitate a discussion of any ambivalence he may be privately harboring about his drinking. Instead, the discussion is set up with a more parental flavor: I am worried and I am going to tell him what to do. This approach doesn't trigger Anthony to self-reflect on the potential downsides of his alcohol use or motivate Anthony to drink less. In fact, the opposite occurs. As I express increased concern about his alcohol use, he sits squarely on the other end of the seesaw and is increasingly protective of his pub time with his work buddies. (*"Alcohol makes me feel better, not worse."*) In an attempt to avoid further conflict and to salvage the therapeutic alliance, I concede and switch topics. The discussion stalls.

Example 13.4 illustrates a more effective way to talk openly but sensitively to a patient about a substance use issue. Since the publication of the first edition, I have become more conversant in a therapeutic approach known as *motivational interviewing* (MI), which is often employed by clinicians treating patients with substance use disorders (Miller & Rollnick, 2013). MI attempts to strategically move an ambivalent patient toward positive change. By definition, patients struggling with addiction and in treatment are ambivalent: they would like to stop using, but they are also attached to their drug use for any number of reasons. MI avoids an arm wrestle approach to push behavioral change; instead, specific strategies are employed to empower the patient considering heathier choices. This chapter only introduces the MI approach; see the Additional Readings and Resources for more resources on MI methodology.

In Example 13.4, I utilize some MI techniques, identified in **bold**, to guide my discussion with Anthony. The MI comments in Example 13.4 and 13.5A are also consolidated in Figure 13.1 on pp. 290–291 for easy review.

EXAMPLE 13.4

The therapist sensitively confronts a patient who may have a substance use disorder

Following Up on the Discussion in Example 13.2

THERAPIST: **I was wondering if you could share with me what you know about alcohol use in general and how you view your use?**

ANTHONY: Oh, well, I'm no expert on alcohol use, but I don't think my drinking is a problem. I don't drink any more than any of my colleagues. I don't drink every night, and I don't drink alone. It's more of a social thing.

THERAPIST: I appreciate you talking to me about your alcohol use. **Would it be okay for me to tell you a bit more about how alcohol and mood interact?**

ANTHONY: Sure, you can tell me, but I'm not seeing you to discuss my social drinking. I'm seeing you because I feel depressed most of the time nowadays. If anything, drinking makes me feel better.

THERAPIST: I agree that it is very important to understand why you have been feeling so depressed lately. Many people don't realize that drinking may exacerbate a low mood. Although alcohol can make a person feel better briefly, over time it can act as a chemical depressant, lowering mood significantly.

ANTHONY: I think alcohol has been one of the few joys left in my life, to be honest. I never considered that it might be an issue.

THERAPIST: **You had previously considered alcohol as only a positive aspect of your life, so it may feel unexpected to consider the potential negative effects of alcohol on your mood. What are your thoughts upon hearing this information?**

ANTHONY: I have never thought about alcohol as a problem in any way.

THERAPIST: **Alcohol has never caused you any problems.**

ANTHONY: Well, I did decide to drink less this year to try to be healthier.

THERAPIST: **You had a sense that excess alcohol use could have health consequences.**

ANTHONY: Yeah, but I did decrease my use. I don't drink every day anymore. Now, I think I'm fine.

THERAPIST: **The amount you are drinking now feels fine to you, and it is clear to you that alcohol's depressive qualities are not exacerbating the low mood that brought you into treatment.**

ANTHONY: No, I don't know. I'm not sure.

THERAPIST: **What would you want to do, moving forward?**

ANTHONY: Well, what are you asking me to do? What would you want me to do differently?

THERAPIST: Well, for starters, would you be willing to have some blood tests? They could give us some indication of whether alcohol has detrimentally affected your body.

ANTHONY: Sure, but you'll see. I'm sure the tests will be normal. I'm very healthy.

THERAPIST: I hope that's true. I appreciate your willingness to get the blood tests.

ANTHONY: Yeah, but you see I came in for help with my depression. That's my biggest concern at this point.

THERAPIST: **It's a very good point. We won't lose sight of the fact you are struggling with depression, and we should make sure that this concern gets the time and attention it deserves.** [*I make a point to use Anthony's terms to describe his melancholy mood.*]

I'm starting with the focus on alcohol because of alcohol's depressant qualities, bringing the mood down and potentially weakening any antidepressant medication effects. Decreasing intake could make a significant difference.

ANTHONY: I don't really understand. A beer after a long day of work just helps me relax. What could be wrong with that?

THERAPIST: As the blood level builds up, alcohol can feel relaxing, but over time, even days later, its chemistry fosters depression. Many people don't realize this—but even a day or two after drinking, a low mood may be a reaction to the recent alcohol use.

ANTHONY: Alcohol is the great escape from all my day-to-day pressures. I don't think it's an issue.

THERAPIST: **I appreciate your honesty. If I understand correctly, as your alcohol use helps you manage day to day, it doesn't feel worthwhile to consider whether it might also be fueling the depression, rather than just alleviating stress.**

ANTHONY: I never even had a second thought about my drinking. I definitely never thought it was a problem in any way. I'm not an alcoholic; I'm a businessman who drinks. Most of us do.

THERAPIST: What does the term *alcoholic* mean to you?

ANTHONY: You know the image. The homeless guy asking for a dollar with a bottle inside a brown paper bag. You have to agree. That's not me at all.

THERAPIST: That's certainly not you, but only 3% of alcoholics are on "Skid Row," and the other 97% have other kinds of problems. I'm glad you have been doing so well at work, but your mood drop and increased alcohol use do closely correlate in time.

ANTHONY: I hear your concerns, but I also think you may be chasing an issue that really doesn't exist.

THERAPIST: **You are willing to talk about this topic but unsure if it even applies to you. How willing are you, on a scale from 0 to 10, to consider changing how much you drink on a weekly basis? Zero is not at all willing, and 10 is very willing.**

ANTHONY: I really hadn't thought about it as an issue before today. Maybe a 5. I think I should probably consider your concerns, even if I don't know if I agree with them. I do hate feeling so low even if it isn't all the time. (*Looks a bit upset.*)

THERAPIST: **The low feeling was bad enough that you decided to seek help for it. If I'm understanding correctly, you are willing to consider this new perspective on alcohol, even though it is extremely unexpected.** [*affirming Anthony's motivation to feel better, and his openness to our discussion, validating a strength in self-care, without pushing any specific action*]

ANTHONY: Yeah, I guess I'm willing to have the conversation. Well, if you really think it's that important, I guess I can get the blood tests, and it shouldn't be so hard to avoid drinking for 1 week, and then we can see if it actually makes any difference.

THERAPIST: **You have an open mind because you are invested in feeling better. I appreciate that you are willing to consider a decrease in alcohol use and to continue the discussion while we learn more about your physical and mental health.** [*recognizing the patient's flexibility, affirming patient's talk that supports healthy change, confirming that discussions will not only center on alcohol but also on the patient's general physical and mental health*]

ANTHONY: Yeah, I can give it a try.

Example 13.4 illustrates a number of therapeutic techniques a clinician can employ when talking to a patient about a potential substance use problem. In a nutshell, MI asserts that patients generally have some ambivalence about substance use, but may feel overwhelmed and unsure how to change. This treatment approach is especially useful with patients struggling with an active addiction as deeper psychodynamic exploration may be contraindicated.

MI attests that patients are more likely to change when they talk more about change and less about the status quo. When one choice is healthy and in the patient's best interest, and the other (alcohol addiction) is not, expressing both sides of the issue is not helpful in promoting active change. This approach is in clear contrast to a more classic psychodynamic therapy that would encourage a patient to express and to understand both sides of a

complex topic. For instance, Sallie is struggling to decide on a career focus and how her choices may affect her relationship with her mother. Detailed discussions on this subject uncover and clarify the internal conflicts embedded within the emotionally loaded topic

In contrast, in MI, it is clear what behavior needs boosting, and the therapist's strategy is to help the patient actively voice the reasons for internal change ("change talk"), while avoiding reinforcement of talk that supports sustaining the current situation ("sustain talk") (Miller & Rollnick, 2013). If the patient can't imagine changing the status quo, the therapist can acknowledge this fact, joining in the sustain talk and reflecting the patient's current perspective. Sometimes, when the therapist amplifies the patient's resistance to change, the patient will respond by voicing the other side of their ambivalence, and by reconsidering healthier options. For instance, in Example 13.4, when I reflect Anthony's sustain talk, with *"The amount you are drinking now feels fine to you, and it is clear to you that alcohol's depressive qualities are not exacerbating the low mood that brought you into treatment,"* Anthony backpedals ("*No, I don't know, I'm not sure*") and reconsiders whether substance use may be more of an issue than he had previously considered.

A therapist using an MI approach is respectful of the patient's autonomy. The overarching goal is to help the patient harness their internal motivation for change. An authoritative directive approach is unlikely to help an ambivalent patient give up a behavior.

Example 13.4 illustrates many MI techniques. First, before providing information to Anthony about the interaction of alcohol and mood, I ask Anthony to share with me what he already knows. This is respectful of his autonomy and avoids a lecturing tone. After asking permission, I share information outlining the connection between alcohol use and depression, while avoiding phrases or statements such as "I'm very concerned about . . ." or "I'm convinced you have a problem. . . ." I also don't use authoritative phrases such as "You should" or "You need to." Such opinionated imposing language creates a power differential between clinician and patient and doesn't facilitate the active collaboration that is necessary to facilitate change. By excluding directive comments, I am more likely to solidify the therapeutic alliance, which increases the likelihood of a useful intervention.

When I start to share information, my statements review the facts while excluding my opinion within the sentence structure: *"Although alcohol can make a person feel better briefly, over time it can act as a chemical depressant, lowering mood significantly."* I normalize his lack of knowledge on this topic: *"Many people don't realize that drinking may exacerbate a low mood."*

I externalize the substance use issue so Anthony and I can critically examine it together. Alcohol is discussed as a problem, separate from the

person who is drinking it. I use this strategy in Example 13.4 when I comment, *"As the blood level builds up, alcohol can feel relaxing, but over time, even days later, its chemistry fosters depression."* This statement carries a different emotional valence from "When *you* drink, *your* alcohol level builds up, and that causes *your* depression to get worse."

When Anthony responds to information about alcohol with a comment that protects the status quo, *"I have never thought about alcohol as a problem in any way,"* I respond to the "sustain talk" by joining him and reflecting his perspective. *"Alcohol has never caused you any problems."* He responds by pivoting to "change talk," noting that he has recently tried to drink less to be healthier; I reinforce his statement by affirming his concern for his health: *"You had a sense that excess alcohol use could have health consequences."*

Throughout the discussion, I chose my words carefully, always wanting to bolster the collaborative tone in the discussion. I reflect Anthony's perspective, sometimes using his own words. I aim to impart the same message of empathy and concern for a patient struggling with a substance use disorder that I might for any other patient. Shame doesn't promote emotional change. The moment the patient feels I am judging them unfavorably, their defensiveness will increase, and my therapeutic effectiveness will diminish. Throughout the discussion, I respect Anthony's autonomy; I ask how he sees the way forward, rather than pushing my agenda. He responds by involving me in his next treatment steps. I assess his motivation for change on a scale of 1–10 to make sure I'm not pursuing a topic in which he has no investment.

I also don't push Anthony to embrace a diagnosis or label. While the term *alcoholic* can be helpful for individuals embracing the treatment program in Alcoholics Anonymous (AA), a patient can also recover from an alcohol use disorder without ever accepting this label. For some, an insistence on a specific diagnostic term with pejorative connotations may delay insight into the addictive behavior. If I pushed this agenda, Anthony might be much more likely to drop out of treatment after just a few meetings, which would be the worst of clinical outcomes.

When Anthony offers a trial week without alcohol intake, he is modeling the substance use treatment strategy of *sobriety sampling*. A time-limited abstinence trial will provide useful information in understanding the role of alcohol in Anthony's life, no matter what the outcome. If he is able to stay sober, we can discuss how that experience felt to him; if he is unable to keep to his self-designated limit, we can learn more about his internal tug toward alcohol use despite his goal to avoid intake. As Anthony is a fairly heavy drinker, it is possible he may feel shaky and anxious when he doesn't maintain his current alcohol intake, which would highlight the physical aspect of his addiction. Severe symptoms (sweating, high heart rate, insomnia, nausea, or vomiting) are consistent with an

alcohol withdrawal syndrome. (If these occur, it is useful to include a psychiatrist or internist in the substance use treatment plan moving forward.)

Of note, while sobriety sampling is also useful for cannabis users, the regular cannabis user needs more than a week off of marijuana to truly experience what it feels like to be sober. The syndrome of cannabis withdrawal should be included in any discussion of sobriety sampling and treatment planning with a patient struggling with cannabis use disorder. [For more information about this syndrome, see pages 517 and 518 in DSM-5 (American Psychiatric Association, 2013a).]

The MI techniques employed in my discussion with Anthony protect the therapeutic alliance, respect his autonomy, and amplify any "change talk" he provides; by the end of the meeting, Anthony agrees to a basic lab screening with liver function tests to assess whether he has any liver damage associated with his increased alcohol consumption. Nonprescribing clinicians could refer patients like Anthony to their primary care physician to obtain this medical screening.

Once Anthony agrees to discuss his substance use openly within the treatment, the therapy continues to employ MI techniques and proceeds with a different slant from that of a traditional insight-oriented psychotherapy. In Example 13.5A, I continue to highlight in **bold** the comments that utilize MI techniques.

EXAMPLE 13.5A

Patient with a substance use disorder in the early stages of recovery, Part I

ANTHONY: Doc, it feels like a month since our meeting last week. Damn, it was a difficult week at work!

THERAPIST: (*concerned look*) What happened?

ANTHONY: Well, my boss (remember the one I told you about who drinks every night? His name is Bruce, by the way) had some sort of vendetta against me this week. I'm not the only one who has noticed it. While he used to go out of his way to help me out, over the last 7 days, he has become obsessed with critiquing my work. I think the highlight of his day is pointing out what's wrong with me. It's all I can do to stay calm in the office.

THERAPIST: I can understand that this would be very upsetting. Has he ever done this before?

ANTHONY: Never. In general, I get along with him better than most of my colleagues. I worked so hard to create a place for myself at this firm; this is *not* what I need right now. I hear his ex-wife is in town this week, and maybe that's why he is being such a pisser. Whatever the reason for his attitude, it's making my life impossible.

THERAPIST: **It's been a very difficult week.**

ANTHONY: Agreed.

THERAPIST: How are you coping with the stress?

ANTHONY: Ummm, well, I went drinking last night with some friends from work and that helped. A little escape can do wonders, you know.

THERAPIST: How much did you drink?

ANTHONY: Not much, just a few beers.

THERAPIST: It wasn't easy to take a week off from drinking when faced with these unexpected stressors. [*I remember that Anthony is likely to minimize his alcohol intake. Also, of note: during the last session he had agreed to abstain from alcohol for a week to see if it might help him to feel better overall. It is notable that Anthony wasn't able to avoid drinking since our last session a week ago.*]

ANTHONY: Oh, yeah, I didn't forget our discussion that alcohol could be making my depression worse. I didn't touch the stuff until yesterday. At that point, I needed any pick-me-up I could find and I won't lie; it did help. It was a hellish day. Bruce was impossible.

THERAPIST: **Drinking helped distract you after Bruce was so unreasonable.**

ANTHONY: Yes, and it made me feel better, but so what? A lot of people have a drink or two after a hard day at work.

THERAPIST: **Could you share with me how alcohol helps you to feel better?**

ANTHONY: Well, I was so angry, and the beers helped me to mellow out back to normal. It was such a relief to take a break from the pressure and have some fun.

THERAPIST: I appreciate you being honest with me and sharing the details of the rough week. How many drinks did you have?

ANTHONY: Well, they were having a cider tasting, so I probably had my usual five because I wanted to taste the product from each brewery. It was a promotion, and we were all drinking together. It was a fun time and I needed the break, to be perfectly honest. Bruce was unbearable.

THERAPIST: I understand that the conflict with Bruce is very tough.

ANTHONY: Yeah, it is.

THERAPIST: **It is very important to have a way to relieve your stress after dealing with Bruce.**

ANTHONY: The ciders came through for me.

THERAPIST: **Alcohol provided what you needed to manage the week with Bruce.**

ANTHONY: Well, yes, it did. It isn't easy to access other stress relievers after a long day.

THERAPIST: **What other stress relievers work for you?**

ANTHONY: Well, I feel better after I work out.

THERAPIST: **Working out is a great way to feel better, and it improves physical and emotional health.** How often do you exercise?

ANTHONY: I try to go to the gym a couple of times a week, but work has been too busy lately, so I haven't been able to go for a while.

THERAPIST: Your work schedule does sound very taxing. If you aren't able to make it to the gym, what other ways can you decrease your stress?

ANTHONY: Other than drinking?

THERAPIST: Yes.

ANTHONY: Umm, well, I do like to watch sports, especially basketball.

THERAPIST: A tricky one because I remember you also like to drink while you watch sports. . . .

ANTHONY: But, that would be easy to give up. The sport itself is like a drug for me. I love it so much.

THERAPIST: Why basketball specifically?

ANTHONY: I played in high school and intramurals in college. I've got a good outside shot—which is important because I'm not that tall.

THERAPIST: It was your chosen sport growing up and then as a young adult?

ANTHONY: Yeah. Definitely.

THERAPIST: Can you tell me more about your basketball experiences?

ANTHONY: Well. I'm too small to be really good, but I love the game. Plus, when I was playing often, I was in good shape and hung around with some great guys. They are still some of my best friends.

THERAPIST: **Basketball provided a community and a way to get into good physical shape. It's quite special when an activity provides so many good things at the same time.**

ANTHONY: Yeah, it feels good to be really fit, and I miss playing the game.

THERAPIST: **Would you be interested in thinking about how to incorporate fitness and basketball back into your life?**

ANTHONY: I've been trying to, but my work schedule is too demanding. Also, I don't have a team to play with anymore.

THERAPIST: **It could be a real challenge to find a new team at this stage in your life, but you also remember how good it felt to play the sport you love on a regular basis. Are there any first steps to explore how to incorporate basketball or fitness back into your life? As a side benefit, exercise is also a healthy stress reliever.**

ANTHONY: There is a basketball court at my gym. If I hang out and work on my shot, I may meet some people who are interested in playing a pick-up game.

But honestly, I don't want to give up drinking. I don't understand why it has to be all or nothing.

THERAPIST: [*pivoting to a harm reduction strategy*] **I appreciate you letting me know what does and doesn't make sense to you as we learn more about your drinking.** Maybe it makes more sense to work on harm reduction—decreasing your alcohol use so it is less likely to affect your mood—and then reevaluate.

ANTHONY: Yeah, that makes more sense to me.

THERAPIST: Well, there are some governmental standards from the National Institutes of Health [NIH] that define low-risk drinking. **Would you be interested in hearing their guidelines?**

ANTHONY: Sure, that would be helpful actually.

THERAPIST: The NIH defines low-risk drinking for men as no more than 4 drinks on a single day and no more than 14 drinks per week. According to their research from the National Institute on Alcohol Abuse and Alcoholism (NIAAA), the likelihood that the person who drinks within these limits has an alcohol use disorder is only 2 out of 100.

ANTHONY: Okay, that seems more reasonable than not drinking at all. I'm going to note these guidelines in my phone, and I don't think they will be that difficult to follow.

THERAPIST: I'm glad that you find the information useful. We will be tracking your mood together; we can see if it improves with less alcohol intake, as alcohol is a depressant, and more exercise, as exercise is a natural antidepressant.

The discussion in Example 13.5A is much more structured than some of the other therapeutic interchanges modeled in this book. First, when Anthony starts talking of his current difficulties with Bruce, I don't delve deeply into his feelings about this relationship. I purposely avoid questions that might evoke an intense reaction, such as "Can you tell me more details of what you feel when Bruce criticizes you?" or "Does he remind you of anyone else in your life from the past?"

These explorations can come later, after Anthony has some healthy coping mechanisms in place. To address Anthony's concerning substance use, we spend our time recognizing the events that trigger alcohol use, amplifying any talk about alternative coping strategies such as playing basketball, and pivoting toward a harm reduction strategy to decrease alcohol use when Anthony clearly states that he doesn't want to give up drinking. The meeting aims to create a supportive environment that allows for an honest collaborative discussion about substance use.

Work buddies spending time together at a bar may add social pressures that may oppose sobriety or even low-risk drinking. Often, people

drink when they feel lonely or misunderstood, and a social structure of other heavy drinkers supports the habit. Becoming sober may also be more difficult if Anthony feels his special connection to his boss is linked to his alcohol intake. In the future, Anthony and I may discuss strategies that simultaneously protect networking opportunities and his health—one option might be substituting some nonalcoholic beverages at the after-work get-togethers.

As Example 13.5A unfolds, I shift from discussing sobriety sampling to a strategy of harm reduction. If Anthony is no longer invested in a trial of alcohol abstinence, it is better to discuss low-risk drinking as an alternative and then reevaluate based on the results of this approach. The NIAAA (within the NIH) is a useful resource. (Of note: the NIAAA title—the National Institute on Alcohol Abuse and Alcoholism—does reflect the older addiction terminology as it references *alcohol abuse* vs. an *alcohol use disorder*.)

Currently, the NIAAA defines low-risk drinking differently for men than for women.

Low-risk drinking for women is defined as no more than 3 drinks on a single day and no more than 7 drinks a week. Low-risk drinking for men consists of no more than 4 drinks on a single day and no more than 14 drinks per week. Binge drinking is defined as drinking that brings the blood alcohol concentration (BAC) to 0.08 g/dl, which is generally 4 drinks for women and 5 drinks for men if ingested in 2 hours or less. These guidelines are likely to evolve over time, so it is useful to check intermittently to see if these recommendations have changed.

In general, Anthony reports that he spreads his drinking over several hours, although binge drinking cannot be definitively ruled out. He is drinking more than the recommended amount per sitting (at 5 drinks a night) and definitely more than 14 per week (his consumption may be as high as 21 drinks per week if he has a six-pack on a Sunday). If he can moderate his drinking, his mood, energy, and overall health will likely improve. If he cannot manage these guidelines, I will consider how to intensify the treatment approach.

EXAMPLE 13.5B

Patient with a substance use disorder in the early stages of recovery, Part II

During the next 2 months, Anthony and I discuss many different adaptive mechanisms to help him deal with stress. During each discussion, he seems interested in trying new alternative coping mechanisms, such as imagery, physical activity, music, or social activities that don't involve alcohol. While he has every intention of following the NIAAA guidelines for low-risk drinking, he admits that he continues to drink heavily and frequently, up to 5 drinks at a time, and up to 21 drinks a week. It is time

to talk about additional clinical supports to augment his current treatment plan.

Midway into the Next Session

THERAPIST: You have tried many different healthy ways to manage stress, but drinking always returns as an option, especially if your buddies are going out to drink.

ANTHONY: Yeah, it is hard to avoid alcohol when I go out with my work buddies.

THERAPIST: You are not alone in facing this challenge. It is not unusual for a person to have difficulty giving up drinking when it is such an integrated part of one's social and work life. I wondered if I could share with you some additional clinical approaches that have helped other patients in a similar situation.

ANTHONY: Sure—what do you have in mind?

THERAPIST: Often, it can be helpful to talk to others who have coped with similar difficulties; they can share strategies on how to manage this issue.

ANTHONY: Where would I do that?

THERAPIST: Well, there are a number of options. Self-Management and Recovery Training [SMART] is a program that sponsors face-to-face meetings and online daily meetings for those struggling with substance use; there is lots of information on the Web if you are interested. I also have a list of AA meetings, some virtual and others that meet in the financial district and attract people in professions that are fast-paced like yours. What would you think about attending a meeting sponsored by either of these organizations?

ANTHONY: WHOA! This is too much! I know I haven't been able to keep to the drinking limits, but I am not an alcoholic, and NO WAY am I going to an AA meeting or to any other program. Look, I know this is on the top of your agenda, but frankly, I think your focus on my alcohol use is more annoying than therapeutic.

THERAPIST: Can you tell me more about what has felt annoying?

ANTHONY: Well, I realize you have my best interests at heart, I do, but I've been trying to decrease my alcohol intake, so what's the problem?

THERAPIST: It has been difficult for you to moderate your drinking these past months even though you have had every intention of doing so. What do you make of that?

ANTHONY: Look, if that's what you are worried about, then I'll just stop drinking, cold turkey. I'd rather stop drinking altogether than to have

to keep returning to alcohol as a central topic. Actually, no drinking might be easier than trying to stick to the NIAAA guidelines because once I'm drinking, I'm not thinking about these rather random limits, you know?

THERAPIST: Okay, let's see if you are able to stop cold turkey one more time. But if you are unable to stop drinking altogether, what will that mean to you?

ANTHONY: Okay, if I don't stop, we can discuss these other programs again. . . . But when I stop, you'll see that you have worried unnecessarily. Don't get me wrong. I appreciate your concern. I just think it is misplaced. And, I don't want to see any meetings like AA in my future . . . ever.

THERAPIST: Of course, I can't make you go to a meeting, but I had hoped that this recommendation wouldn't be seen as a punishment, but rather as the next indicated step in treatment. We can also discuss other additional supports that have been helpful to others in a similar situation. But, for now, let's go with your personal challenge approach, avoiding all alcohol.

ANTHONY: Yeah, I'm always up for a challenge. No more alcohol use for me, period. I don't think it will be that difficult.

THERAPIST: I would have no trouble being proven wrong, but you need to let me know if you do drink again.

ANTHONY: Sure, I think that is fair.

THERAPIST: Let's take it step-by-step together and see what happens. Meanwhile, we will continue to work on other stress relievers that will help you to feel better and to improve your low mood.

In Example 13.5B, we see that Anthony's drinking continues unabated despite our ongoing discussions about limiting his use. In response, I introduce the idea of mutual help organizations (SMART Recovery or AA) as potential adjunctive treatments. Both of these programs support sobriety by providing ongoing contact with sober people in recovery.

AA includes a spiritual perspective as the members are urged to seek the help of a power greater than themselves in their fight against addiction. If this approach doesn't appeal to a patient, SMART Recovery is a mutual help alternative that doesn't highlight this perspective. Both organizations provide an easily accessible support system of individuals who are not using alcohol or drugs. It adds what a patient with an alcohol or substance use disorder may be unconsciously seeking: the soothing effect of social peer support and community combined with techniques to fight addiction.

If Anthony had agreed to try a mutual help meeting, we could search online together to find a group composed of successful adults in their 30s.

Therapist Questions	Motivational Interviewing Techniques
Example 13.4	
"I was wondering if you could share with me what you know about alcohol use in general and how you view your use?"	Asking the patient what they know, respecting their autonomy, deferring to the patient as an expert on themself.
"Would it be okay for me to tell you a bit more about how alcohol and mood interact?"	Asking permission before sharing information.
"You had previously considered alcohol as only a positive aspect of your life, so it may feel unexpected to consider the potential negative effects of alcohol on your mood. What are your thoughts upon hearing this information?"	Start with reflective listening on sustaining the status quo followed by reflection on possible change, while emphasizing autonomy.
"Alcohol has never caused you any problems. The amount you are drinking now feels fine to you, and it is clear to you that alcohol's depressive qualities are not exacerbating the low mood that brought you into treatment."	Reflection of patient's current understanding and emotional experience.
"You had a sense that excess alcohol use could have health consequences."	Accentuating patient's perspective that supports positive behavioral change.
"What would you want to do, moving forward?"	Emphasizing and respecting the patient's autonomy.
"It's a very good point. We won't lose sight of the fact you are struggling with depression, and we should make sure that this concern gets the time and attention it deserves [*using Anthony's terms to describe his melancholy mood*]."	Reflective listening using the patient's own words.
"I appreciate your honesty. If I understand correctly as your alcohol use helps you manage day to day, it doesn't feel worthwhile to consider whether it might also be fueling the depression rather than just alleviating stress."	Supporting the honest and open exploration that reinforces the partnership approach. Also, affirming the status quo, noting its potential difficulties rather than pushing for change when the patient has some ambivalence about the topic at hand.
"You are willing to talk about this topic but unsure if it even applies to you. How willing are you, on a scale of 0 to 10, to consider changing how much you drink on a weekly basis? Zero is not at all willing, and 10 is very willing."	Opening with a reflection, then assessing readiness to consider change.

(continued)

FIGURE 13.1. Reviewing motivational interviewing techniques used in Examples 13.4 and 13.5A.

Therapist Questions	**Motivational Interviewing Techniques**
"The low feeling was bad enough that you decided to seek help for it. If I'm understanding correctly, you are willing to consider this new perspective on alcohol, even though it is extremely unexpected."	Affirming motivation to feel better and openness to our discussion about change, without pushing any specific action.
"You have an open mind because you are invested in feeling better. I appreciate that you are willing to consider a decrease in alcohol use and to continue the discussion while we learn more about your physical and mental health."	Recognizing the patient's flexible thinking and affirming patient's talk that supports healthy change.
EXAMPLE 13.5A	
"It's been a very difficult week. Drinking helped distract you after Bruce was so unreasonable. Could you share with me how alcohol helps you to feel better? It is very important to have a way to relieve your stress after dealing with Bruce. Alcohol provided what you needed to manage the week with Bruce."	Reflecting patient's experience and asking for clarification without any push for change.
"What other stress relievers work for you?"	Asking for elaboration when patient mentions healthier coping skills.
"Working out is a great way to feel better, and it improves physical and emotional health."	Affirming interest in healthier coping strategies without pushing my treatment agenda.
"Basketball provided a community and a way to get into good physical shape. It's quite special when an activity provides so many good things at the same time."	Reinforcing talk about a healthy coping skill.
"Would you be interested in thinking about how to incorporate fitness and basketball back into your life?"	Asking questions that support autonomy.
"It could be a real challenge to find a new team at this stage in your life, but you also remember how good it felt to play the sport you love on a regular basis."	Start with validation of ambivalence to change, but then follow up by amplifying previously expressed comments that noted healthier approaches to managing stress.
"Are there any first steps to explore how to incorporate basketball or fitness back into your life?"	Supporting collaboration and recognizing the patient as the expert on themself.
"I appreciate you letting me know what does and doesn't make sense to you as we learn more about your drinking."	Recognizing patient autonomy, welcoming patient input.
"Would you be interested in hearing their guidelines?"	Asking permission.

FIGURE 13.1. *(continued)*

In a group with respected peers, it is more likely that Anthony would find input useful and accessible. Virtual meetings have also increased accessibility and have allowed patients to attend mutual help meetings anywhere in the country.

When Anthony balks at my recommendation, I agree to his challenge to pursue abstinence one more time. It is a no-lose proposition: Either Anthony's drinking subsides, or he will have new insight into the severity of his substance use disorder when he is unable to abstain. The treatment alliance is reinforced when I respect and support his reasonable alternative approach.

Psychotherapy with patients struggling with addiction is slow work. In the 21st century, we are fortunate to have an expanding arsenal of medications to help these patients decrease use or abstain if they are struggling with an addiction to tobacco, alcohol, or opioids. Over time, additional medications will become available to help those with an addiction to marijuana, amphetamines, and cocaine, among other drugs. In addition, if a patient is struggling with comorbid mood instability or anxiety, the addition of nonaddicting psychotropic medication should be considered while the patient works in psychotherapy on the substance use issues. If the therapist is unable to prescribe these medications, it is appropriate to connect the patient with a physician who can. Medications should not be used as a last resort, but discussed early in the treatment process; pharmacology support can make all the difference for a patient having trouble accessing sobriety. If all of these outpatient interventions fail to help Anthony and/or if his suffering begins to endanger himself or others, I may consider a referral to a more intensive intervention, such as day treatment or an inpatient stay, as the next therapeutic step.

DISRUPTIVE BEHAVIOR IN PATIENTS WITH A SUBSTANCE USE DISORDER

Patients with a substance use disorder require a special therapeutic touch because they may exhibit comorbid antisocial behaviors. Such behaviors might not remit until the patients have been abstinent for a prolonged period of time. It makes some psychological sense: If a person is ashamed of their substance use but is also psychologically and/or physically addicted to a drug, deceptive behavior patterns are likely to follow. It's not unusual for active users to lie, to minimize their drug use, and to pursue illegal behaviors (stealing) to obtain more of the drug. In fact, whenever I have any suspicion that addiction may be an issue, I make a point of asking the patient if they have had any troubles with the law.

When the illness is severe, the patient may have a difficult time being honest, which then affects the active user's relationships with family and

friends and eventually their therapist. When a patient relapses multiple times, they are unlikely to confess to each incident and may lie or minimize their substance use. As the therapist, I'm most effective in this situation if I maintain a sensitive but clear therapeutic stance. Early in treatment, I may rely on the patient's report to track substance use. Following the guidance of my colleagues who are experts in addiction medicine, I praise the effort in curtailing substance use, while also recognizing that relapses are to be expected; if my focus is only on results (vs. process), the patient may be more apt to hide information about their recovery if it isn't positive. If it becomes clear that a patient is having a difficult time telling the truth about ongoing use, I'll either ask for corroborated information from a significant person in the patient's life or introduce other methods, such as urine screens, to monitor drug intake objectively.

As a naive beginner, I had a humbling experience treating a patient with an active substance use disorder who did not feel comfortable sharing the trials of his recovery with me. I saw the patient, whom I'll call Roy, for 6 months in weekly therapy and psychopharmacology sessions that included discussions about his concerning substance use. He was a 25-year-old aspiring artist who was also working as a waiter at a local restaurant. He had been smoking marijuana daily for a few years when he sought treatment at the clinic for mood and anxiety issues. He denied any addictive behaviors during his adolescence. He did admit that his focus and motivation had decreased over the last year or two, symptoms associated with chronic marijuana use. He was surprised to learn that frequent marijuana use could also exacerbate mood and anxiety issues; he was willing to discuss his drug use with me, as long as we also focused on his other concerns.

At first, the treatment seemed like a success in the making, and I was pleased with Roy's progress. We started some medications for his depression with the caveat that their efficacy may be impaired as long as his substance use continued. Within the first few months of treatment, he moved to a new apartment with friends who didn't use marijuana. He agreed to attend two mutual help meetings a week. I didn't ask for written proof of attendance, since he related the details of each meeting during our sessions.

Addiction experts talk about *recovery capital*: "The resources (social, physical, human and cultural) which are necessary to begin and maintain recovery from a substance use disorder" (see *www.recoveryanswers.org*, the website of the Recovery Research Institute). At the beginning of treatment, Roy increased his recovery capital by moving to a new apartment with roommates who didn't use marijuana, while attending meetings with a mutual help organization and continuing treatment with me. With three sources of increased support, each day without use was a deposit to shore up a healthy future. Sobriety isn't easy and support is critical. (I recommend the website above as an excellent resource for patients and clinicians wanting to learn more about substance use treatment.)

Then, after approximately 30 days of sobriety, Roy relapsed. I do not have extensive training in addiction treatment, so I recommended that he obtain a consult from a substance use disorder specialist to supplement and to provide guidance for our weekly meetings. He was reluctant to pursue this, but after 2 more weeks of active using, I insisted on the consult as part of his treatment. I also asked that he allow open communication among his various clinicians in order to facilitate comprehensive care. He agreed, although without a lot of enthusiasm. He reported the next week that he was completing an extended consultation with a clinician named Randy Freeman, at the MGH's addiction specialty clinic.

According to Roy, he was sober at this point, but over the next several weeks, he continued to share a litany of new difficulties in his relationships with his family and friends. He complained that no one understood him, and everyone was too judgmental. He didn't feel motivated to create any art. He missed some work shifts at the restaurant and was threatened with termination. I wondered whether he was hiding details of a recent relapse. I obtained a release from Roy and called the addiction specialty clinic to follow up on the results of his recent consultation.

I quickly discovered that Roy had been extremely late for the first visit of the consultation and then didn't show for the scheduled follow-up. The clinic reached out to Roy to reschedule, but he never returned their calls. When I mentioned this to Roy, he also confessed that he had only attended two mutual help meetings during our work together, many less than the previously reported rate of twice a week. He was embarrassed at being exposed, but blamed his lack of follow-up on disinterest: "None of these ideas seemed very helpful, anyway." Despite Roy's report that he hadn't used marijuana for over a month, a toxicology screen was positive.

I was naive to trust that Roy would only be honest with me about his substance use. Still, I felt foolish and furious when I learned the extent of Roy's factitious reports. As mentioned before, difficulty telling the truth is a symptom of an active substance use disorder, which is challenging for the patient's family, friends, and clinician.

As Roy's clinician, I needed to understand my first reaction, but then to respond in a way that was therapeutic, rather than impulsive or angry. The goal of the conversation outlined below is to set up a treatment protocol that acknowledges Roy's vulnerability while protecting the therapy from a similar deception in the future. It's a fine line we walk as therapists: trying to understand without condoning self-destructive behavior.

EXAMPLE 13.6

Confronting a patient with a substance use disorder who has been misleading his therapist

Moments after I tell Roy that I discovered he never completed the consultation with the addiction expert:

THERAPIST: Can you tell me more about what happened?

ROY: Look, Dr. Bender, I am really sorry, but it didn't seem like they knew what they were doing at that clinic. Plus, I like you as my therapist. I didn't want to see anyone else.

THERAPIST: I know it can be hard to work with a new clinician, but patients with a cannabis use disorder with difficulty maintaining sobriety can truly benefit from a specialized consultation with an expert. We have discussed that it will be hard for us to make progress in treating your mood disorder if your cannabis use disorder is not treated as well.

ROY: I'm sorry I lied to you. I'll try to tell you the truth from now on.

THERAPIST: I appreciate that. I also know it can be very difficult to be honest about substance use since the pull of cannabis is so powerful, especially in the first weeks of sobriety. As we discussed before, the first weeks off cannabis can be difficult for many people because of the psychiatric and medical symptoms that emerge as your body reequilibrates off the drug.

I know you want to tell the truth, but you have also expressed guilt and shame about relapsing, so it may be difficult for you to report your use accurately in the future.

I hope you realize that your continued use is a sign that you need some more support, just like your low mood and symptoms of depression were signs that we needed to focus on more aggressive treatment for your mood disorder. As we face this together, we would both benefit from input from an expert in addiction, particularly someone who can discuss any new medication options that might be available for the treatment of cannabis use disorders.

ROY: Well, I'm not really using that much that often anymore. The last time was about a week ago. I think I can taper off. I've got the message now, and I promise that I'll tell the truth to you from now on.

THERAPIST: I hope that is the case, but again, cannabis's pull is very strong. If an emotionally difficult situation presents itself, the tug toward marijuana will be intense and you may use to feel better temporarily. For some people, it then feels difficult to talk openly about the use if it happens, even though we both know that no one ever plans a relapse.

ROY: Well, maybe.

THERAPIST: Again, we need to have a different treatment plan since what we have been doing so far has not been effective in stabilizing your mood or cannabis use disorder. For us to continue to work together, I would like you to complete an expert consultation with a trusted colleague of mine, Dr. Rathbun. We will both benefit from her input as we learn how to approach the hold that marijuana has on you. I would like to speak with Dr. Rathbun to provide background on what we have been working on, and to coordinate your consultation with her.

Roy: I don't have time to meet with another clinician. I am not going to do this.

Therapist: That is your choice. Again, though, marijuana use may cause issues with motivation, focus, and mood, and it isn't easy to stop; an expert consultation will be very helpful in guiding us in your treatment. If you refuse to meet Dr. Rathbun, we can monitor your progress over the next month with weekly toxicology screens. If you continue to use marijuana over the next month, I will then need you to meet in consultation with Dr. Rathbun or another substance use disorder expert in order for us to continue to work together. I hope you will also reconsider attending some mutual help meetings such as Marijuana Anonymous or SMART Recovery as a peer support resource. We can look together to find what meetings might work for you.

Roy: Why are you doing this to me?

Therapist: As we have worked together, your cannabis use has continued and your art, your job, and your relationships have suffered. Addiction requires treatment, just like depression and anxiety, or heart disease or cancer. This is not something that is going to go away on its own. Of course, it is ultimately your choice what you would like to do, but I have to feel comfortable that your treatment plan is addressing your safety and functioning.

Roy: But, you are my doctor. You can't fire me.

Therapist: Roy, I am reviewing all of this with you in detail because I would prefer to continue working with you. If you continue to struggle with cannabis use despite your best efforts, but then agree to a consultation with Dr. Rathbun, we will continue to meet. Let's try to take this one step at a time. Cannabis addiction is complicated to treat; you deserve and need to have the best team available to help you recover. [*I externalize "the problem" as outside of Roy, which makes it more tolerable and less shaming.*]

With 20/20 hindsight, I realize I should have insisted that Roy sign a release of information right after I referred him to the addiction specialty clinic; with the release, I could call to confirm that his consultation occurred as scheduled. The collaboration of care could have started right away. Another important addition to the treatment could be patient-authorized contact between the clinician and someone in the patient's life—a spouse, partner, relative, or friend—to monitor clinical progress. For patients struggling with significant substance use, a family approach may be useful; a second therapist may be assigned to the patient's close family member, and the two clinicians can work strategically to amplify change motivation for the patient with the substance use disorder.

When a patient is struggling with a severe addiction, a structured approach with contingency management (rewards for adaptive behavior;

i.e., a clean drug test and consequences, such as more intensive treatment, for increasing substance use) may be necessary from the start. Meanwhile, it is helpful if the therapist has a team of clinical peers to consult for supervision and support. Patients with substance use disorders are bound to relapse repeatedly, and for the clinician, worrying alone is the worst. Clinical support keeps the therapist resilient and in the best frame of mind to be helpful to the patient.

Roy and I continued to work together for 2 months after the confrontation illustrated in Example 13.6. He continued to deny the severity of his cannabis use disorder despite repeated toxicology screens that showed ongoing use. He continued to insist that each relapse was just temporary. He lost his job. He didn't create any art. His new sober friends started to avoid him, and he drifted back to spending time with his friends who used cannabis daily.

After 2 months with signs of continued use, I told Roy that I could not continue to work with him without an evaluation by Dr. Rathbun or one of her colleagues with addiction expertise. He refused. If I were an addiction specialist, I may have felt comfortable continuing with Roy without consultation assistance; since I do not have expert training in addiction, it felt critical to have a specialist weigh in as his treatment reached an impasse.

After the therapy ended, I reached out to Roy to express concern and invite him back to treatment under the prior outlined conditions. Dr. Messner always recommended using a certified letter with a return receipt in these circumstances. (Nowadays, a secure email, ideally with a confirmed receipt, might be another option.) Roy didn't respond.

The clinical recovery of a patient with a substance use disorder takes much patience and determination on the part of the therapist as well as powerful motivation on the part of the patient. As this treatment is specialized, we recommend that your supervisor for these patients be highly experienced in using motivational interviewing and contingency management techniques to treat addiction. Consultations with a physician experienced in addiction medicine may be helpful as medications might treat comorbid psychiatric conditions or help a patient manage cravings or withdrawal symptoms. If outpatient visits aren't adequate to address the escalating debilitation caused by the substance use, experts can also provide guidance on how to access more intensive treatment options, such as detoxification centers, inpatient hospitalizations, partial day programs, and sober living and recovery homes. After an extended period of continuous sobriety, a patient will have developed more healthy coping mechanisms and the therapist can cautiously try a more open-ended psychotherapeutic approach. With sober supports in place, the patient may be able to tolerate a more insight-oriented treatment and the increased affect that may emerge in its wake.

THERAPIST TOOL 13.1

Questions 1–8 Derived from the NIDA-Modified ASSIST V2.0

These questions can be used to clarify substance use if the patient has a positive answer to the NIDA Drug Screening Tool (in Therapist Tool 5.1). For significant substance use, please consult an addiction specialist to guide your treatment approach.

Instructions: Patients may fill in the following form themselves, or screening personnel should offer to read the questions aloud in a private setting and complete the form for the patient. To preserve confidentiality, a protective sheet should be placed on top of the questionnaire, so it will not be seen by other patients after it is completed but before it is filed in the medical record.

Question 1 of 8, NIDA-Modified ASSIST	**Yes**	**No**
1. In your *LIFETIME*, which of the following substances have you ever used?		
***Note for Physicians: For prescription medications, please report nonmedical use only.**		
a. Cannabis (marijuana, pot, grass, hash, etc.)	___	___
b. Cocaine (coke, crack, etc.)	___	___
c. Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	___	___
d. Methamphetamine (speed, crystal meth, ice, etc.)	___	___
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	___	___
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Xanax, Librium, Rohypnol, GHB, etc.)	___	___
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	___	___
h. Street opioids (heroin, opium, etc.)	___	___
i. Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	___	___
j. Other—specify: _____	___	___

- Given the patient's response to the Quick Screen, the patient *should not indicate* **"No"** for all drugs in Question 1. If they do, remind them that their answers to the Quick Screen indicated they used an illegal or prescription drug for nonmedical reasons within the past year and then **repeat Question 1.** If the patient indicates that the drug used is not listed, please mark **"Yes"** next to "Other" and continue to **Question 2** of the NIDA-Modified ASSIST.
- If the patient says **"Yes"** to any of the drugs, proceed to **Question 2** of the NIDA-Modified ASSIST.

(continued)

Source: National Institute on Drug Abuse; National Institutes of Health; U.S. Department of Health and Human Services.

Question 2 of 8, NIDA-Modified ASSIST

2. In the past 3 months, how often have you used the substances you mentioned (first drug, second drug, etc.)?	**Never**	**Once or twice**	**Monthly**	**Weekly**	**Daily or Almost Daily**
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	2	3	4	6
b. Cocaine (coke, crack, etc.)	0	2	3	4	6
c. Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	2	3	4	6
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	2	3	4	6
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	2	3	4	6
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)	0	2	3	4	6
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	2	3	4	6
h. Street opioids (heroin, opium, etc.)	0	2	3	4	6
i. Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	2	3	4	6
j. Other—Specify: _____	0	2	3	4	6

- For patients who report **"Never"** having used any drug in the past 3 months**, go to Questions 6–8.**
- For any recent **illicit or nonmedical prescription drug use, go to Question 3.**

3. In the past 3 months, how often have you had a strong desire or urge to use (first drug, second drug, etc.)?	**Never**	**Once or twice**	**Monthly**	**Weekly**	**Daily or Almost Daily**
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	4	5	6
b. Cocaine (coke, crack, etc.)	0	3	4	5	6
c. Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	3	4	5	6
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	3	4	5	6
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	3	4	5	6
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)	0	3	4	5	6
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	3	4	5	6
h. Street opioids (heroin, opium, etc.)	0	3	4	5	6
i. Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	3	4	5	6
j. Other—Specify: _____	0	3	4	5	6

(continued)

4. During the past 3 months, how often has your use of (first drug, second drug, etc.) led to health, social, legal, or financial problems?	**Never**	**Once or twice**	**Monthly**	**Weekly**	**Daily or Almost Daily**
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	4	5	6	7
b. Cocaine (coke, crack, etc.)	0	4	5	6	7
c. Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	4	5	6	7
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	4	5	6	7
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	4	5	6	7
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)	0	4	5	6	7
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	4	5	6	7
h. Street opioids (heroin, opium, etc.)	0	4	5	6	7
i. Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	4	5	6	7
j. Other—Specify: _____	0	4	5	6	7

5. During the past 3 months, how often have you failed to do what was normally expected of you because of your use of (first drug, second drug, etc.)?	**Never**	**Once or twice**	**Monthly**	**Weekly**	**Daily or Almost Daily**
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	5	6	7	8
b. Cocaine (coke, crack, etc.)	0	5	6	7	8
c. Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	5	6	7	8
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	5	6	7	8
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	5	6	7	8
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)	0	5	6	7	8
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	5	6	7	8
h. Street opioids (heroin, opium, etc.)	0	5	6	7	8
i. Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	5	6	7	8
j. Other—Specify: _____	0	5	6	7	8

(continued)

6. Has a friend or relative or anyone else ever expressed concern about your use of (first drug, second drug, etc.)?	**No, never**	**Yes, but not in the past 3 months**	**Yes, in the past 3 months**
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	6
b. Cocaine (coke, crack, etc.)	0	3	6
c. Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	3	6
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	3	6
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	3	6
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)	0	3	6
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	3	6
h. Street opioids (heroin, opium, etc.)	0	3	6
i. Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	3	6
j. Other—Specify: _____	0	3	6

7. Have you ever tried and failed to control, cut down, or stop using (first drug, second drug, etc.)?	**No, never**	**Yes, but not in the past 3 months**	**Yes, in the past 3 months**
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	6
b. Cocaine (coke, crack, etc.)	0	3	6
c. Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	3	6
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	3	6
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	3	6
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)	0	3	6
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	3	6
h. Street opioids (heroin, opium, etc.)	0	3	6
i. Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	3	6
j. Other—Specify: _____	0	3	6

(continued)

Instructions: Ask Question 8 if the patient endorses any drug that might be injected, including those that might be listed in the other category (e.g., steroids). Circle appropriate response.

- Recommend to patients reporting any prior or current intravenous drug use that they get tested for HIV and Hepatitis B and C.

Note: Recommend to patients reporting any current use of alcohol or illicit drugs that they get tested for HIV and other sexually transmitted diseases.

8. Have you ever used any drug by injection (NONMEDICAL USE ONLY)?	**No, never**	**Yes, but not in the past 3 months**	**Yes, in the past 3 months**

(continued)

TALLY SHEET FOR SCORING THE FULL NIDA-MODIFIED ASSIST

Instructions: For each substance (labeled a–j), add up the scores received for Questions 2–7 above. This is the Substance Involvement (SI) Score. Do not include the results from either the Q1 or Q8 (above) in your SI Scores.

Substance Involvement Score	**Total (SI Score)**
a. Cannabis (marijuana, pot, grass, hash, etc.)	_____
b. Cocaine (coke, crack, etc.)	_____
c. Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	_____
d. Methamphetamine (speed, crystal meth, ice, etc.)	_____
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	_____
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)	_____
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	_____
h. Street opioids (heroin, opium, etc.)	_____
i. Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	_____
j. Other—Specify: _____	_____

Use the resultant SI Score to identify patient's risk level.

To determine patient's risk level based on their SI Score, see the table below:

Level of risk associated with different SI Score ranges for illicit or nonmedical prescription drug use:	
0–3	Lower risk
4–26	Moderate risk
27+	High risk

CHAPTER 14

Integrating Psychopharmacology with Psychotherapy

Either an overeager drive in favor of medications or a bias against their use may interfere with optimal psychiatric treatment. If psychotropic medications are indicated, the clinician needs to talk with their patient about the risks and benefits of the treatment and to respond to any concerns the patient may have. Appropriately prescribed medication may enable the depressed, panicky, manic, or psychotic patient to engage more meaningfully in the work of psychotherapy. Depending on the specifics of the clinical situation, it may be preferable to have separate treaters provide the medication and the psychotherapy.

As an undergraduate majoring in psychology, I debated the impact of nature versus nurture on human behavior. As a psychiatrist, I view the two as inextricably intertwined. Experiences affect biology, and biological changes may affect experiences. For example, the complex alterations in brain chemistry seen in clinical depression can affect a person's ability to relate to others. The converse is also true. Emotional events from birth onward have an impact on brain development. It makes sense that comprehensive psychiatric treatment may include both biological [medication and also transcranial magnetic stimulation (TMS), electroconvulsive therapy (ECT), or other treatments] and psychological (the psychotherapies) interventions.

Psychotherapeutic and pharmacological treatments ought to enrich one another. Psychotherapy provides a detailed understanding of the patient, which can then inform the choice of medication. Meanwhile, when psychiatric symptoms cause significant suffering, the appropriate medications can accelerate recovery and enhance the psychotherapeutic process.

Some psychodynamic therapists worry that the introduction of medications will alter the transference in a countertherapeutic manner. Patients might leave psychotherapy prematurely once they feel some symptomatic relief. Traditionalists believe the patient may have more difficulty transferring their feelings from other important relationships onto the therapist when the clinician assumes a directive, rather than neutral, stance around psychopharmacological issues.

As a graduate psychoanalyst and a prescriber of medicine for more than 30 years, Dr. Messner found (as I have now, writing this new edition with over 20 years of experience under my belt) that if medication is indicated, an effective and empathic psychopharmacological intervention will nearly always help a therapy to evolve. As the patient feels understood and experiences some relief through the medications, the therapeutic alliance will be enhanced. With increased emotional stability, the patient may be less distracted by their symptoms and more able to talk meaningfully about all issues. The transference will become more accessible to the therapy rather than less. (For more about transference, see Chapter 17.)

Table 14.1 lists a range of psychiatric symptoms that are associated with some common psychiatric disorders. If a patient's ability to function is substantially and repeatedly impaired by even a few of the symptoms listed, I recommend a psychopharmacological evaluation to assess whether medications may be indicated in conjunction with psychotherapy.

When I am prescribing medications for a patient who sees another clinician for psychotherapy, I'll ask both the patient and the referring therapist to detail the troublesome symptoms that prompted the psychopharmacology referral. The specifics of the patients' experience will help me choose the appropriate psychotropic medication.

HOW PSYCHOTHERAPY MAY BE AFFECTED BY THE INTRODUCTION OF MEDICATIONS

A new patient, "Elaine Guzman," will illustrate some of the clinical dilemmas that may emerge when a psychotherapy patient is started on medications. Elaine is a 32-year-old single high school English teacher. When we first start working together, she suffers from a few mild symptoms of depression. We begin insight-oriented psychodynamic psychotherapy once a week. As treatment progresses over a few months, Elaine experiences a progressive decline in functioning with an increase in dysphoric symptoms. As her psychotherapy continues, it becomes necessary to reassess whether she may need psychotropic medications.

Example 14.1 exaggerates a mistake I made again and again before I became comfortable acting as therapist and psychopharmacologist simultaneously. Early on, I'd worry that my therapy patient would feel annoyed if I

TABLE 14.1. Target Symptoms That May Be Improved with Psychopharmacological Treatment

Mood disorders
Symptoms of major depression Disturbances of sleep, interest, energy, appetite, concentration, with concurrent depressed mood and/or irritability, hopelessness, anhedonia, and possibly suicidality
Symptoms of a variant of bipolar disorder Distractibility, impulsivity, grandiosity, flight of ideas, increased activity, decreased sleep, and pressured speech
Thought disorders
Delusions, hallucinations, disorganized speech, disorganized behavior, or severe withdrawal
Anxiety disorders
Panic attacks with or without agoraphobia, persistent inhibiting fear in social situations, generalized significant anxiety affecting quality of life
Obsessive–compulsive and related disorders
Recurrent distressing obsessions or compulsions that affect the patient's ability to function
Trauma- and stressor-related disorders
Flashbacks, nightmares, avoidance of stimuli associated with the trauma, general numbing of affect, hypervigilance, or irritability
Feeding and eating disorders
Binge eating followed by purging (self-induced vomiting or abuse of laxatives, diuretics, or enemas)
Severe food restriction associated with a concerning low body weight
Inability to consume enough calories due to difficulties eating, fear of eating, or fear of swallowing
Substance use disorders
Craving for or excessive consumption of alcohol or drugs
Attention-deficit disorders
Frequent careless mistakes affecting school or work performance; difficulty sustaining attention and inability to manage or finish tasks that require sustained mental effort, affecting school or work performance; difficulty organizing; and forgetfulness

spent precious minutes running through psychopharmacological questions, even if it were clear that they would benefit from a psychotropic medication. To return to a discussion of psychosocial issues, I'd rush through my inquiry as quickly as possible.

EXAMPLE 14.1

The therapist does not complete a thorough psychopharmacological evaluation for a psychotherapy patient

ELAINE: Dr. Bender, while I've enjoyed talking to you, I must admit that I don't think the therapy is helping me. I've been seeing you once a week for a few months now, and over the last 3 weeks or so, I've started to feel worse instead of better. I am only sleeping a few hours a night now, and I am exhausted at work. I'm barely functioning during the day.

THERAPIST: You have really been suffering. Is your appetite also affected?

ELAINE: Not really. Well maybe, I just don't feel hungry.

THERAPIST: I think we should discuss starting some medication that could help you with these symptoms. It sounds like your symptoms have progressed over the last few months so they are now consistent with a diagnosis of major depression. Here is a prescription for fluoxetine. Start taking one pill a day, and you will begin to feel better in a month or so. Now, let's think together if there are any new stressors that could also be making things more difficult.

ELAINE: Well, in general, I feel lonely all the time. But wait, I'm not sure I want to take a pill.

THERAPIST: Okay. You don't need to start the medicine right away. We can wait and see if you feel better as we learn more about the loneliness. Can you tell me more?

In Example 14.1, I rush through the psychopharmacology evaluation in order to talk to Elaine about her loneliness in more detail. The review of psychiatric symptoms isn't complete, and the risk of suicide is overlooked. I also don't inform Elaine of any of the risks, specific benefits, and possible side effects that may occur with fluoxetine treatment. In fact, this evaluation borders on medical negligence.

Of note: the mention of fluoxetine in Example 14.1 does not represent a general clinical recommendation. Fluoxetine is a member of an effective antidepressant class called "selective serotonin reuptake inhibitors" (SSRIs); prescribing clinicians are fortunate to have an arsenal of antidepressant choices for patients in need, including many types of SSRIs as well as other antidepressants with different neurotransmitter targets, such as bupropion, venlafaxine, and mirtazapine, to name a few. To make the best choice of an antidepressant for a patient, the psychopharmacologist carefully assesses

the patient's unique depression symptom profile to choose the antidepressant best suited to address the patient's debilitating symptoms.

Example 14.2 illustrates a more complete approach that balances a psychopharmacological and a psychotherapeutic perspective.

EXAMPLE 14.2

How to talk to a psychotherapy patient about starting medications

Elaine begins as in Example 14.1:

ELAINE: Dr. Bender . . . I'm barely functioning during the day.

THERAPIST: It sounds like things have gotten more difficult instead of easier. When did you notice the change?

ELAINE: Well, everything seems to have become just unbearable over the last few weeks. I'm not sleeping at all anymore. I've never felt this horrible before.

THERAPIST: Clearly, we need to pay special attention to these problems right away. Any idea of what might be making things worse?

ELAINE: No, it is a mystery to me. I feel sad most of the time, and I don't even have a good idea why.

THERAPIST: I can imagine that would be very upsetting. Let's take a little time and see if we can try to understand this together.

Because you have been feeling so low, it is possible you may have a major depression. May I ask you a few questions to get more information about your current symptoms?

ELAINE: That would be fine.

THERAPIST: You mentioned that your sleep has been troublesome. In general, how many hours do you sleep at night?

ELAINE: Oh, I don't know, not enough. Maybe 2 or 3 hours on average.

THERAPIST: It would be very difficult to function on such little sleep. Have you missed any days of work?

ELAINE: Last week, I stayed home on Wednesday because I just couldn't manage to haul myself out of bed. That's unusual, though. In general, I've been going to work, but I'm so tired all the time.

THERAPIST: [*briefly screening for history of mania or hypomania in case I hadn't done so during the consultation*] Have you ever experienced any time in your life where you didn't need much sleep for more than one night, but you didn't feel tired in the way one might expect?

If you had an episode like this, it is often accompanied by a feeling of distractibility, and your thoughts may seem to move faster than

usual. Sometimes, the episode is also accompanied by either increased productivity or increased agitation.

ELAINE: No, I've never had anything like that. I've always been very sensitive to sleep deprivation. That's why I am so exhausted these days.

THERAPIST: During the last few weeks, has your appetite been affected, either increased or decreased?

ELAINE: I hadn't really noticed this, but now that you mention it, I haven't been very hungry lately. Food just doesn't look appetizing.

THERAPIST: Have you lost any weight?

ELAINE: I'm not sure, but my clothes do feel a little more loose. I didn't notice until you asked.

THERAPIST: Have you been able to concentrate at work even though you have been feeling so badly?

ELAINE: Of course not! (*with an irritable tone*) It's impossible to function adequately on so little food and little sleep. I don't know if my students have noticed that I am acting strangely, but I'm sure they will soon. I used to feel energized when I left work, and now I'm exhausted before lunch time. I can't cope with this much longer! I don't know what is happening to me.

THERAPIST: The symptoms you are suffering from are classic indicators of an illness called "major depression." Major depression is very serious because its symptoms are so debilitating. Sometimes, when someone is having such a tough time, thoughts of suicide come up as well. Has this happened to you?

ELAINE: Sure, sometimes I think about it, but I don't think I would act on it. Not at this point anyway.

THERAPIST: What do you think about?

ELAINE: When I am feeling very low, I imagine jumping in front of a car or out of a window—something like that. But it's just a passing thought. I don't think I would ever act on it, at least not yet. I still have hope that I'll feel better someday.

THERAPIST: I think there are a number of treatment options that may help you, but first let's talk a bit more about your safety. If you ever have a change of heart and want to hurt yourself, would you call me right away or find your way to the nearest emergency room if you weren't able to connect with me immediately?

ELAINE: I think so.

THERAPIST: Could you commit to making your mental health a priority in case of a crisis?

ELAINE: Yes, yes, I don't want to die. But, I don't want to feel like this anymore either. Is there anything you can do to help me?

THERAPIST: Yes, medications can make a great deal of difference when someone is suffering with depressive symptoms. Major depression can be viewed as a chemical imbalance in the central nervous system. Medications can return the imbalance back to normal; with the right medication at the right dose, a number of distressing symptoms may lift within about 2 to 6 weeks.

ELAINE: Even two more weeks of feeling like this is a long time.

THERAPIST: It is a long time, especially since you have been feeling poorly for a number of weeks already. Some of the symptoms, such as your difficulty sleeping, might improve even sooner.

ELAINE: I heard, though, that some of these antidepressants either act like a happy pill and change your personality, or work the other way and make you suicidal. I don't want a pill that affects how my mind works.

THERAPIST: Can you tell me more about your concerns?

ELAINE: Well, is it true? I don't want to turn into a Pollyanna and feel happy about things that are upsetting, and I don't want to become more suicidal than I already am. I'm not comfortable with the idea that a drug might change the way I see the world.

THERAPIST: I am glad you bring up these questions. I also don't support the idea of you taking any medication that would change your personality or make you feel worse. We will be in close touch as you start this medication, and if there is a side effect that is intolerable, we will stop this particular medication and change course. Sometimes, it takes a few trials of different medications to find the best one. I will never expect you to continue with a medication that you don't feel comfortable taking.

It is a common worry that an antidepressant will change a person's personality or make them a "Pollyanna." Luckily, this isn't the case. The medications help diminish the symptoms I reviewed with you: trouble sleeping, eating, concentrating, and feeling motivated. These are known as neurovegetative symptoms, and they are specifically targeted by the antidepressants.

It is extremely unusual for an adult with your psychiatric history to have an increase in suicidal thoughts after taking an antidepressant medication. That said, we will start the medication at a low dose and increase it slowly, so if there are any unforeseen side effects, we can intervene quickly. You have my contact information to leave me a message or page me in an emergency if there are any unexpected negative side effects from the medications.

It is actually much more likely that the low feeling and intermittent suicidal thoughts that you have now will improve with the medication. That said, no medication will shield you from the ups and downs of everyday life.

ELAINE: I did hear about this news story that sometimes antidepressants might make people suicidal. That sounds scary.

THERAPIST: There had been some concern that antidepressants could be associated with an increased suicide rate, but this question has now been studied extensively. Overall, for the grand majority of depressed people, antidepressant treatment reduces the risk of suicide. There is a small percentage of people, probably around 1% of the population, who may feel agitated with an increase in depressive thoughts after the start of an antidepressant. These individuals have a different type of mood disorder that responds better to some other medications.

ELAINE: Oh, geez. What if I am in this group? That sounds scary.

THERAPIST: I will start the medication at a very low dose and then increase it slowly, and we will be in close contact during your first weeks on the medication and after any medication increase. Your family and personal history put you in a low-risk group, but we will still monitor you very closely after starting the medication to make sure it isn't causing any unexpected side effects. As I mentioned, if you are concerned about any side effects that occur between our sessions, you should contact me to let me know and page me if the situation is urgent.

ELAINE: I feel so low, I think I am ready to try anything. You really think it is a good idea?

THERAPIST: I do. You are suffering from symptoms that can be treated effectively and safely. But, now, before I know which medicine to recommend, I need to ask you a few more questions about your medical history.

ELAINE: Fine, but this whole process still makes me nervous.

THERAPIST: What makes you nervous about it?

ELAINE: I'm concerned what this might mean about my brain. Am I so weak that I can't tolerate the basic stressors of life?

THERAPIST: I think the best way to think about major depression is to compare it to other diseases that sometimes require medication to improve. If you had diabetes, high blood pressure, or asthma, you probably would not consider your illness a sign of weakness. The type of depression you have is also an illness. It's different from the blue mood people get after a bad day. In a way, you already know this because you can feel that this state is so different from anything else you've ever experienced.

ELAINE: I still feel very odd about taking a medicine that will change the way my mind functions.

THERAPIST: Research shows that when a person is depressed, the chemical balance in their brain is abnormally altered. The medications actually return these chemical changes and your brain function to their normal predepression state.

ELAINE: It's possible I have a weak character. Otherwise, I would be able to make myself feel better.

THERAPIST: It is the depression itself that makes a person feel weak. The illness isn't a reflection on your character.

ELAINE: It's true that I haven't been feeling myself lately.

THERAPIST: It's clear that you have been suffering quite a bit.

ELAINE: (*Nods tearfully.*)

THERAPIST: Well, I think it is crucial that we continue to talk about this openly and approach the problem as a team.

ELAINE: Okay.

My interview in Example 14.2 balances psychopharmacological and psychotherapeutic approaches. Before I recommend a medication trial, I complete a structured interview to clarify Elaine's diagnosis and to evaluate her safety. While my approach is more focused and cognitive than during a typical therapy hour, I make sure to leave ample time to discuss Elaine's misgivings about psychotropic medications.

As Elaine lists a number of neurovegetative symptoms that are impairing her ability to function on a daily basis (such as decreases in sleep, energy, concentration, appetite, and ability to experience pleasure, accompanied by an intensification of depressed mood, hopelessness, and suicidality), it becomes clear that she is suffering from major depression. I confirm once again that she does not have any history of mania. (Antidepressants given to patients with bipolar disease might instigate a manic reaction, increase agitation, or trigger suicidality; this patient group is best treated with mood stabilizers.) Antidepressants should provide Elaine with substantial relief.

One might argue, "Maybe Elaine hasn't had enough time to benefit from therapy. If you just gave her more time to talk about the problems in her life, her condition might improve without medications." While Elaine's symptoms may also improve with long-term therapy, it is in the best interest of her treatment to pivot to a more aggressive approach as her functioning declines and her risk of suicide increases. A medication trial is clinically indicated.

Before writing out a prescription, I would review the benefits and potential adverse side effects of the recommended medication with Elaine. I would also review my contact information for nonurgent or urgent medication concerns.

INFLUENCES OF PSYCHOTROPIC MEDICATION ON THE THERAPEUTIC RELATIONSHIP

While psychopharmacological treatment will not hinder the psychotherapeutic process, therapy does change with the introduction of a prescription. If I am acting as both therapist and psychopharmacologist, I need to balance the open forum of psychotherapy with the more structured medical evaluation. Once the patient starts taking the medication, I need to inquire about efficacy and side effects on a regular basis. Some clinicians formalize this arrangement as part of the treatment and set aside some time each month or at each prescription refill to follow up on psychopharmacological issues.

With experience, it has become second nature to balance the two clinical roles. As a novice therapist, though, I found it difficult to juggle the two approaches. Once I had prescribed medication for a patient, I was at risk of attributing any future symptoms to dosages or side effects. Example 14.3 illustrates how it's possible for the psychopharmacological "hat" to get stuck on the prescribing therapist's head.

EXAMPLE 14.3

The therapist becomes too medically oriented within the psychotherapy after the patient starts taking a medication

Elaine has been taking fluoxetine for the treatment of major depression for approximately a month.

ELAINE: I've been feeling better since taking the fluoxetine—until yesterday, that is.

THERAPIST: (*concerned look*) What happened?

ELAINE: Well, I was just thinking a couple of days ago how I've been feeling so much better the last few weeks. But, then yesterday, I was unable to function again. I'm concerned that maybe the medication isn't working after all.

THERAPIST: This sounds upsetting. Can you tell me more about what felt so bad?

ELAINE: Last night, I tossed and turned for hours. I think I only slept 3 hours last night.

THERAPIST: How is your appetite?

ELAINE: Well, it was a little better, but then last night I felt so nauseated that I skipped dinner completely.

THERAPIST: Let me ask you a few more questions. We may need to increase the medicine.

ELAINE: Oh, I was wondering about that also.

It is notable that Elaine had been feeling much better until the night before our appointment. Usually, antidepressants don't change efficacy from day to day. In this example, I don't ask many detailed questions about Elaine's change in mood, but prematurely jump to a review of her current neurovegetative symptoms. This is an oversight. Maybe something upsetting occurred yesterday that can explain Elaine's renewed difficulties.

It isn't unusual for a patient who has just started on medication to attribute any new emotional distress to "the depression," ignoring any psychosocial issues that may be involved. It's easy to collude with this approach, as I did in Example 14.3. Manipulation of medication doses may be simpler for both parties than the empathic detective work necessary to understand a psychological reaction.

Example 14.4 illustrates how Elaine's concerns could be addressed with a combined biological and psychological perspective.

EXAMPLE 14.4

When the psychotherapist incorporates both biological and psychological perspectives

Elaine has been taking fluoxetine for treatment of major depression for about a month.

ELAINE: Well, I was feeling better for a time, but now I feel worse again. The medication is no longer working.

THERAPIST: It's always difficult when things take a turn for the worse. Can you tell me what happened?

ELAINE: Well, yesterday, the day seemed to be progressing fine, but then all of sudden, I just felt like crying.

THERAPIST: Hmm, any understanding of what could have made you feel so sad?

ELAINE: No . . . not really. I must need a higher dose of medication.

THERAPIST: I think it will be important to review your progress on the fluoxetine, but let's try to understand when the terrible feeling started.

ELAINE: I think I was fine until lunch, and then all my energy seeped out of me, and I left work early to go to bed. I felt exhausted. And then, last night, even though I was extremely tired, I still couldn't go to sleep. Dr. Bender (*voice becomes more panicked*), I cannot return to the way I was feeling before. Can you just increase the medication?

THERAPIST: We can consider that option together, but first can you tell me what went on at lunch yesterday? Did anything upsetting happen?

ELAINE: Well, I did have an upsetting talk with Anjali at lunch. I don't know if I've told you about Anjali before. She is the student teacher in my

classroom this year; it is her internship placement before she receives her teaching degree. She has been just wonderful to work with.

She had heard some gossip from some of the other teachers that she shared with me yesterday. We have a new principal this year, Irene Jones. She has been friendly, but we all worry that she might want to shake things up, and change the organization of our departments without getting to know us first.

According to Anjali, Irene may want to restructure the entire English department. She feels the students need to have an understanding of all the classic texts, and wants to emphasize this in a revamped curriculum. I don't like this idea, especially because I love to teach Modern American Literature.

Then, Anjali told me that Irene doesn't see the purpose of creative writing in high school and may want to cancel one of my very favorite classes that I have taught for over 5 years. The kids love it. I love it. I don't know why she would do that, but it would be a great loss for me. At this point, this information is just gossip, so I don't feel comfortable asking Irene if these changes are actually going to take place.

THERAPIST: This is tough news to digest. How are you managing?

ELAINE: I feel terrible. Up until now, I have felt so free and supported at my school. If this news is true, my role in the English department will change in a fundamental way. It's heartbreaking, to be honest.

The writing class was my creation, and it is very popular among the students. The class is my favorite hour of the day. The students and I become very close during the year together. Teaching wouldn't be as fulfilling if I'm not allowed to offer this elective. If Anjali is right, this is very depressing news.

THERAPIST: (*Nods, with encouraging eye contact with Elaine.*)

ELAINE: And this time of the year is especially heinous for me.

THERAPIST: How so?

ELAINE: Well, it's November 2nd today. In just a few weeks, it will be Thanksgiving, and then Christmas is right around the corner.

THERAPIST: What feelings come up when you start to think about Thanksgiving and Christmas?

ELAINE: Well, Thanksgiving is okay, but Christmas has not been a happy time for me recently.

THERAPIST: Can you say more?

ELAINE: Last year, I drove to Washington, D.C., to spend some time with my father. It didn't go very well. Since my mother died a couple of years ago, he's been a mess. He drank too much the entire visit. Oh, I don't want to go into the details right now, but it was a disaster.

THERAPIST: A disaster?

ELAINE: Yes, but being alone is worse, and it's too expensive for me to fly across country to see my sister in Seattle.

THERAPIST: And now the unexpected news that you might lose a class you love to teach must certainly add to this distress.

ELAINE: Yes. You can see why I am feeling so depressed.

THERAPIST: Yes, I hope we can talk more about both topics, but it's beginning to make sense to me why yesterday was such a difficult day for you. You were facing two very upsetting situations, just when you were beginning to feel a tiny bit better.

ELAINE: But maybe it is a medication issue.

THERAPIST: Well, let's take a little time to review the symptoms that the fluoxetine should improve. Before yesterday, how were you sleeping and eating?

ELAINE: Fine, both had improved. But, like I said, the last 24 hours have been unbearable.

THERAPIST: Have your energy and concentration improved at all since being on the fluoxetine the last few weeks?

ELAINE: Before yesterday, I was doing much better overall.

THERAPIST: Before we started the medication, you would think about dying or hurting yourself but didn't have any intention to act on it. How is that now?

ELAINE: It had improved until yesterday. Now, I am thinking about jumping out of the window again, but again, it's just a thought. I don't plan on acting on it.

But, it bothers me that it even crosses my mind. I hadn't thought about it for a couple of weeks.

THERAPIST: How do you understand the fact that you were feeling so much better before yesterday?

ELAINE: I don't know. Maybe the medicine just stopped working. I also know the lunch discussion upset me a lot.

THERAPIST: I think you are right that yesterday was very difficult. The news about the potential changes in the English department is very upsetting. It also doesn't help that the holidays are just around the corner. I wonder if the combination threw you off balance.

Overall, I think the medication is starting to help alleviate your neurovegetative symptoms of depression. But the medicine doesn't prevent a person from feeling sorrow or pain about troubling experiences, and yesterday was a tough day, without a doubt.

ELAINE: You think the medicine is working, but yesterday was so bad because of the news from Anjali?

THERAPIST: It's certainly a possibility. Yesterday was a very upsetting day. The disheartening news caused some increase in your symptoms. To me, this doesn't mean that you necessarily need more medication, but that we need to talk more about your concerns regarding job stress and the holidays, and how best to deal with them.

ELAINE: You can't just give me a pill to feel better?

THERAPIST: That's a natural wish, but the fluoxetine won't protect you from feeling upset about your class or about Christmas. It makes sense that you have strong feelings about both of these issues.

Increasing the medicine might prove necessary in the future, especially if you continue to feel this low over the next week, but right now, I think we need to concentrate on this news that is causing you quite a lot of pain. (*Pauses.*)

ELAINE: (*Sniffles.*) Yes, maybe it will be helpful to talk more about this. Usually, I try to ignore how I feel, because it is so uncomfortable to talk about this stuff.

THERAPIST: So the feelings are very painful and you have been alone with them as well.

ELAINE: Yes.

Elaine's concern is a common point of confusion for patients who have just started taking medication. While a medication increase is indicated if neurovegetative symptoms are unrelenting over a series of days, an increase in symptoms for a day or two in response to a life stressor is usually temporary. Psychotherapy is the indicated treatment for these intermittent emotional crises.

It is worth reconsidering whether Elaine might benefit from a higher dose of the medication if her impaired sleep, appetite, lower mood, or suicidal ideation worsen in the ensuing days or weeks.

DIVIDING THE CARE

In some instances, it may be clinically necessary or beneficial to split a patient's psychotherapy and psychopharmacological care between two providers. The most common treatment split occurs when a patient starts psychotherapy with a nonmedical therapist and medication becomes necessary. It is almost always best for the patient to continue psychotherapy with their therapist and to obtain medication from a psychopharmacologist.

If the option is available, psychotherapy patients with complex mood disorders who require frequent medication changes may prefer the one-stop shopping of a prescribing psychotherapist. That said, if the frequent focus on medication issues starts to distract from the psychotherapy, dividing care may be the best solution to allow both treatments the attention they deserve. Each clinical situation is unique; the goal is to create a treatment plan that is in the best interest of the patient.

THE PATIENT WHO REJECTS MEDICATIONS AS A TREATMENT OPTION

Sometimes, even when a patient is not taking any psychotropics, the issue of medications plays an important and recurring role within a psychotherapy. I have encountered this situation when a patient repeatedly refuses to start or to complete a medication trial even though they are clearly suffering from symptoms that medications could alleviate. Often, such patients believe that taking medications is a sign of character weakness or that medications are chemical toxins that will cause multiple unbearable side effects. In either case, a psychotropic medication trial may be doomed from the get-go.

If the therapist becomes too invested in a patient's decision to take medication, both individuals can become frustrated. I've found it is most therapeutic to view the patient's refusal of medications as another psychodynamic topic that deserves revisiting every once in a while. With this tack, the patient doesn't feel pressured, and often, over time (although it may be months or even years), the patient may reconsider medications as an option if their symptoms do not improve with psychotherapy alone. Example 14.5 illustrates how I might discuss this issue with Elaine if she completely refuses a medication trial despite her barrage of severe depressive symptoms.

EXAMPLE 14.5

Discussing medication as an option for a patient who refuses psychopharmacological treatment, although she may benefit from it

ELAINE: Dr. Bender, my condition hasn't improved over the last 6 months, even though we have been meeting twice a week. It's become unbearable. What do we do now?

THERAPIST: I think it is time to talk again about a trial of an antidepressant to help you with these symptoms. The symptoms you are describing to me are consistent with an illness called major depression that can be extremely debilitating—as you can see. With medication developed

specifically to treat depression, over 2–4 weeks, there can be some improvement in sleep, appetite, interest, and even hopelessness and suicidality.

ELAINE: Oh, you know that I am not interested in medications. I've seen friends go crazy on psychiatric drugs. It's not a viable option for me.

THERAPIST: What did you experience with your friends?

ELAINE: Well, one of them was recently diagnosed with manic-depressive illness, but they didn't know this when they gave her medication for depression. After taking the pill for a week, she was unable to sleep. Over the next few days, she started hearing voices. She had to be hospitalized. I'm not interested in going through that.

THERAPIST: It's natural that your friend's experience has concerned you. I don't want you to experience that type of reaction either. It is true that a person with manic-depressive illness can have this reversible but very scary reaction to an antidepressant, but we have no evidence that you have this illness. For the vast majority of people, antidepressants are well tolerated and extremely helpful. If you decide to try a medication, we will start at a low dose and slowly increase it based on your response. I will be available to discuss any concerning side effects so we could intervene quickly if you had a worrisome issue at any time. If you ever wanted to discontinue the medication after starting it, for any reason, that is always an option.

ELAINE: I don't care. I don't want to put any new mind-altering medication in my body.

THERAPIST: Of course, that is your decision, but I hope we can continue to discuss this over time.

ELAINE: You can discuss whatever you want, but my mind is made up.

THERAPIST: (*Nods)* [*waiting to hear Elaine's next association*]

ELAINE: I just hate feeling so alone every night.

THERAPIST: I can understand how it might feel particularly painful to feel alone while you are already feeling so vulnerable. What is a typical evening like for you?

ELAINE: Well . . .

One Month Later

ELAINE: Dr. Bender, I'm still feeling like I can barely make it to work every day.

THERAPIST: Let's review some of the symptoms you were struggling with previously. How well are you sleeping and eating? How is your energy?

ELAINE: My appetite is a tad better, but I still have trouble sleeping every night, and my energy has been gone for months.

THERAPIST: How about the hopelessness and suicidality? Have those feelings increased, decreased, or stayed the same?

ELAINE: Well, I'm not thinking about suicide as much, but I am still pretty hopeless.

THERAPIST: You really are suffering. I feel stuck in a certain way, because I believe a trial of an antidepressant could be so helpful for you, but you have not even wanted to discuss it. Could we revisit the issue?

ELAINE: No! It's not an option for me.

THERAPIST: The depression is taking a toll on your body over time with just the decreased sleep. Would you be willing to discuss the option of a sleeping medication at least to help you through these difficult nights?

ELAINE: I'll have to think about that, but right now I am not interested in taking anything.

THERAPIST: You have very strong feelings about this issue.

ELAINE: Yes, I do.

THERAPIST: Can you tell me more why medications don't seem like a viable option to you?

ELAINE: If I improve, I want it to be because I helped myself, not because I popped a pill.

THERAPIST: Taking a pill makes you feel like the improvement isn't truly earned, that it isn't really yours?

ELAINE: I guess that's true. That is how I feel.

THERAPIST: There appears to be a conflict. You want to feel better, but you reject some help that I'm offering. This method has left you isolated, lonely, and with an unrelenting depression. Perhaps we can try to understand together why some kinds of help are acceptable and other are not.

In Example 14.5, I illustrate some strategies that may be helpful for a patient who refuses to consider medication. First, I try to remain open and interested in Elaine's opinion and not to become too invested in the idea that she needs to start medications immediately. Therapy alone can be a great support to a patient. Increased resolution of one's underlying conflicts can sometimes diminish neurovegetative symptoms.

The next time Elaine openly complains about her distressing symptoms, I reopen the issue of medication. My understanding of Elaine's concerns is deepened as we continue to discuss the topic. Repeating this

pattern, a review of the medication issue and a clarification of her concerns, might help Elaine reevaluate her stance over time. This scenario also illustrates how resistance to medication can reveal a profound psychodynamic conflict with the patient only feeling comfortable accepting certain types of help despite profound suffering.

If a patient refuses to take medication and continues to suffer from symptoms that could be easily targeted by psychotropics, our clinical power and ability to intervene effectively are limited. As psychotherapists, whether or not we prescribe, our job is to help patients to understand their condition and to provide an environment in which recovery and psychological growth can take place. Whether the patient takes advantage of this opportunity is ultimately up to them. Meanwhile, our task is to understand the process and to help our patients as much as they will permit.

PART IV
THERAPEUTIC DILEMMAS

CHAPTER 15

Managing Impasses

An impasse is a pause in the progress of a psychotherapy. The therapist may gain an understanding of the dynamics of the impasse through careful listening, gentle inquiry, and empathic responsiveness. A resolution may be reached by using a nondirective exploratory approach, or by offering clarifications and interpretations.

When I started training, I found the process of psychotherapy both fascinating and anxiety-provoking. When faced with a therapeutic dilemma I hadn't encountered before, I coped with my nervousness by adopting a "fix it" attitude. I dispensed lots of advice and direct guidance. "Coulds" and "shoulds" would start to dominate my sentences. As Sallie's therapist, I might advise her to confront her mother directly about her career concerns. She should find a new friend to replace Gwen. She could join the school paper. And on and on.

Although my intentions were good, my instructive approach definitely impeded my patients' therapeutic progress. It was rare that a patient would follow my advice (if it were that easy, why would they be seeing me in the first place?), and sometimes the therapeutic alliance seemed to suffer after one of my overzealous interventions. As I started to observe my behavior more closely, I tried to understand which situations triggered my directive stance.

With some supervisory guidance, I learned that I became more preachy whenever I felt the therapy was at a standstill. My anxiety grew as I listened to a patient share a few of their concerns repeatedly without increased understanding or emotional relief. As a beginner, I didn't know that most therapies pass through some slow-moving stages. Instead, I attributed the lack of progress to my inexperience, and I reacted by dispensing more and more advice.

Over time, I've learned a number of alternative techniques that help a therapist and patient weather a therapeutic impasse. In this chapter, we'll illustrate several ways to respond to a slow-down in Sallie's treatment, modeling effective and ineffective techniques.

THE POWER OF A NONDIRECTIVE EXPLORATORY APPROACH

First, let's review how Sallie's therapy has progressed so far. Sallie came to therapy seeking help after her breakup with her boyfriend, Charlie. However, with time, as revealed in the last few chapters, her story has become more complex.

After several sessions, I have an increased understanding of Sallie's family dynamics. Sallie's mother and father have a stable loving marriage, but, according to Sallie, her father often bends to her mother's will. Sallie's younger brother, Tom, has suffered from a chronic disease for years, and Sallie has alluded (in Example 10.1) to Tom's medical needs monopolizing their mother's attention.

Once Sallie recovered from the acute stress of her breakup with Charlie, most of the therapy has focused on her relationship with her bossy friend, Gwen. It's psychologically interesting that Sallie has invested so much time and energy into this nonsupportive friendship. Simultaneously, Sallie continues her studies in economics, the major her mother chose for her, even though Sallie's heart isn't invested in the subject.

Sallie spends multiple sessions discussing these issues repetitively. Gwen is often mean, and Sallie is intensely sensitive to every rebuff. When Tom is ill, Sallie's mother is less available emotionally. Even though Sallie doesn't enjoy studying economics, she revels in her mother's attention when they discuss her professional future.

In Examples 15.1 and 15.2, Sallie talks about these topics once again. Although beginning therapists may rely on responses like those modeled in Example 15.1, such tactics are unlikely to advance a treatment and may even undermine the therapeutic alliance.

EXAMPLE 15.1

The therapist employs directive tactics to respond to an impasse in the treatment

Sallie is talking about her studies in economics as well as the continuing difficulties in her friendship with Gwen.

SALLIE: Well, I don't have anything that new to say today, Dr. Bender. I hate Economics 203. Hate it, hate it, hate it! And I thought it couldn't get

worse after the intro courses. Well, I was wrong. Another great semester to look forward to, I guess. (*sarcastically*) Lucky me.

THERAPIST: What is it that you hate about Economics 203? [*I choose the direction of the session right away, instead of helping Sallie to associate freely for the first 10–15 minutes of our meeting.*]

SALLIE: It's just so boring. I know if I study the information, I'll do fine, but I just don't like it.

THERAPIST: [*I feel frustrated because Sallie has been unhappy with her studies for months now, but never seems to do anything about it.*] Well, you could change majors. Maybe that would help. [*I give advice in hope of promoting psychological change.*]

SALLIE: Oh, that's not an option at all. I need to be an economics major. It's a done deal.

THERAPIST: What if you make a list of all the aspects of economics that you like and dislike and we could review it together? [*I assign a cognitive task.*]

SALLIE: Okay, I guess I could do that.

THERAPIST: So, what about your other classes? How are they? [*I feel unsure how to help Sallie resolve these issues she talks about every week, so I redirect the conversation in an attempt to talk about a new topic.*]

SALLIE: Well, I love my journalism class. I love writing the assignment articles.

THERAPIST: Maybe you should join the school paper. [*I recommend action, moving away from affect. I'm relying heavily on "should" and "could," a sign that I am feeling increasingly unsure how to help Sallie.*]

SALLIE: Oh, I'm not that serious about it. It's a class for fun. Journalists don't make much money. It's not a viable future option for me. But, I would like to tell you more about my latest tiff with Gwen.

Next Session

THERAPIST: So, did you make out your sheet listing the pros and cons of studying economics?

SALLIE: Oh, sorry; I totally forgot to do it. My mom was excited to hear about my latest assignments in Economics 203, so I spent a lot of time talking to her this week. She was really supportive, especially after Gwen was such a turd.

THERAPIST: [*I minimize Sallie's distress out of my own frustration.*] Your friendship with Gwen hits some trouble spots now and then, but you seem to take it in stride.

SALLIE: Well, maybe I look okay, but I feel like crap. I know I should be looking for new friends, and I've tried to spend less time with Gwen. It's hard, though. When she's nice to me, I don't want to spend time with anyone else.

I don't get it. Sometimes she's amazing and tells me that I am the best friend she has ever had, and other times, she's just mean. I don't know how she'll act from one minute to the next.

THERAPIST: It must be a great stress to be with a friend who makes you feel like crap. Why don't you find some new friends who treat you well? [*While using Sallie's words to reflect her internal state is helpful and I stop minimizing, I quickly revert to a fix it approach and recommend action.*]

SALLIE: How can you say that? Even though the friendship is sort of up and down, I still think of Gwen as my best friend. She's all I have, except for you, and I pay you to listen to me. [*The moment I start criticizing Gwen directly, Sallie starts defending her.*]

THERAPIST: You have been struggling with this for a while now. Do you ever imagine your relationship with Gwen improving?

SALLIE: (*Tears arise.*) I don't know. I'm just scared to do anything.

THERAPIST: I understand that you are scared, but you'll keep suffering unless you change something about this situation! Do you have any idea why you stick with her?

SALLIE: Because she is special to me. That's all I know.

THERAPIST: Can you say anything else about it? Think hard. [*I push for cognitive understanding on an emotional topic. This tactic doesn't promote Sallie's understanding of her actions.*]

SALLIE: No. I don't want to talk about this anymore. Can we talk about something else?

THERAPIST: [*I confront the resistance head-on.*] If you never talk about this, how can the situation ever improve?

SALLIE: Just forget it. I know it doesn't make sense, but Gwen is special to me, even though the friendship is so complicated. I wish you could understand that. Maybe this therapy just isn't working.

THERAPIST: I understand more than you think. For some reason, you stick with Gwen despite the fact that she treats you so poorly. She holds a lot of power over you, just like your mother does. [*My therapeutic hypothesis: Gwen doesn't feel replaceable because she is an emotional stand-in for someone unique in Sallie's life—probably her mother who has been less available to Sallie because of her brother's illness. While Gwen is often mean to Sallie, she is usually available.*]

SALLIE: (*more tears*) I don't understand what you are getting at. Gwen isn't

anything like my mother. But, she is my best friend. Even if she doesn't treat me well lately, I can't just give up on a friendship that I have had for years.

Sallie misses the next session and doesn't call or cancel.

My anxiety and sense of helplessness fuel my ineffective directive approach illustrated in Example 15.1. If anything, Sallie becomes more protective of her emotional status quo as I push for her to change.

At the beginning of the example, I direct the content of the session prematurely rather than encouraging Sallie to associate more freely. Next, I try to instigate change by suggesting how to "fix" Sallie's situation ("Well, you could change majors") and organizing her thinking by assigning cognitive homework (listing the pros and cons of an economics major). While a cognitive approach can be extremely useful to calm and to redirect a patient who is drowning in affect, it is not the best strategy for Sallie, who needs more help getting in touch with her emotions.

Next, I redirect the topic of conversation rather than following Sallie's lead ("What about your other classes?") and minimize Sallie's ongoing concerns about Gwen ("Your friendship with Gwen hits some trouble spots now and then, but you seem to take it in stride") Finally, as my frustration mounts, I aggressively confront Sallie's resistance and interpret her behavior in an un-empathic manner. ("Gwen holds a lot of power over you, just like your mother does.")

These expressions of my internal frustration are examples of countertransference enactments. (Expressions of feelings or attitudes of the therapist in response to the patient, which are partly or wholly outside of consciousness.) These particular enactments involve complementary identification: Sallie's behavior evokes a domineering attitude in me that is similar to the mindset of Gwen and possibly of Sallie's mother as well. (For more about countertransference, see Chapter 17.)

Sallie reacts as many patients might. Her views of Gwen become more entrenched rather than more flexible. From her perspective, this makes emotional sense. If it has always been difficult for Sallie to examine her relationship with Gwen, a bulldozing confrontation will only increase her resistance. Sallie manifests her intensified resistance by avoiding the next session.

It would have been more effective if I had helped Sallie discover her inner barriers to change instead of providing instruction. As Sallie's self-awareness slowly increases, she might find it easier to expand the limited range of life choices she currently allows herself.

Example 15.2 replays the previous example and employs a number of tactics that may be more conducive to progress when therapy reaches an impasse.

EXAMPLE 15.2

The therapist employs a nondirective approach to the therapeutic impasse

SALLIE: Well, I don't have anything that new to say today, Dr. Bender. I hate Economics 203. Lucky me.

THERAPIST: (*Nods with an interested look.*) [*I am trying not to intervene too early in the session, so I can hear how Sallie's concerns develop.*] Can you say more?

SALLIE: I guess I should be more interested in the class and not complain. I've heard that companies really like to hire students who have studied economics in college. My choice of major is an important investment in my financial future. I have to keep reminding myself of this when I start to feel upset about my classes.

THERAPIST: (*Nods again.*) [*While I am purposely saying little to allow Sallie to talk freely and to reveal new material, I am staying emotionally involved in the conversation nonverbally through body language and frequent eye contact.*]

SALLIE: [*Continues to associate freely.*] Sometimes I wonder what it will be like to be in the business world after graduation. I guess it will be fine.

THERAPIST: What do you imagine it will be like?

SALLIE: I don't know. Maybe a little bit boring. I'm sure I'll grow to love it, though.

THERAPIST: [*I try to learn more details that are affect-laden. Why does Sallie choose to study a subject that she doesn't really like? Emotional forces that she is unaware of must be preventing her from changing majors.*] What do you imagine it will be like after graduation?

SALLIE: I'm sure it will be fine. It has to be.

THERAPIST: It has to be? What do you mean? [*I repeat a sentence that doesn't make logical sense but seems to have a lot of emotion beneath it.*]

SALLIE: I need to get some work experience after I graduate and then go on to get my MBA. It's basically already decided.

THERAPIST: How was it decided?

SALLIE: It's just the way it is.

THERAPIST: It doesn't feel like a subject that you want to explore more deeply?

SALLIE: Right. There is no use. Why talk about something that has already been decided?

THERAPIST: Can you explain to me how it was decided? [*I try one more time to help Sallie investigate her decision in more depth.*]

SALLIE: Well, I've told you how my mother has had a lot of influence on my career decisions. She wants to make sure I don't make the same mistakes she did.

THERAPIST: What were those?

SALLIE: I don't know. She always talks about her wish to open her own business someday, but in the next sentence, she'll say how glad she is to have a flexible job so she can take care of her children. Tom's illness underscored this point. (*Looks away.*)

Mom was an amazing student in college. But then she got married and had us in her early 20s; when we were little, she was at home full-time. In fact, she only started working in real estate a few years ago, and she has had to limit her work hours to be available for Tom in case he is sick. She has never been able to fully invest in a career.

I think she might be sad that she didn't get a chance to see what was possible workwise before having children. She'd never say that, but it's easy to guess by the way she talks. Sometimes, I wonder whether she'd make different choices if she could do it over.

THERAPIST: If she could do it over, what choice do you think she'd make this time?

SALLIE: I think she'd really go for it when she was younger. She would figure out a way to resolve the work/children issue, and I think she would have been a great corporate executive. I can imagine her as the head of a start-up company. She's a very smart woman.

Maybe it helps her to cheer me on instead. She always says that it's really important that I choose a profession that will empower me and will support my financial independence. Business school seemed the best way to go about it. We decided that together.

THERAPIST: How did you and your mother come to this decision? [*I follow the emerging theme to gain a deeper understanding of the issue. I also think silently about the fact that Sallie's directive approach toward Charlie echoed her mother's approach with her.*]

SALLIE: Well, even before I started college, my mother started talking to me about how to plan a profitable career. I don't need to be rich, but I want to be able to support myself easily and to pursue leadership roles. My mother says these are the two key factors that are important for a successful career.

How many daughters have mothers who take the time to discuss this stuff with them? I'm lucky, I think. She takes a special interest in my future.

She thinks business, law, or medical school are the three best choices. Law and medicine aren't options for me. I've never been interested in law at all, and I'm so squeamish that I had trouble with

dissections in high school biology. I couldn't handle medical school. Business school leaves me a lot of choices. So, we decided together that this is what I should do.

So, being upset about my classes is a waste of time. I don't know why I even bother complaining about it in here.

THERAPIST: How is it a waste of time?

SALLIE: Well, if it's a done deal, why am I struggling against it?

THERAPIST: Part of our work together involves recognizing your feelings, and sometimes feelings and thoughts are in conflict. What would it feel like to consider a different major and a future career in something other than business? [*a strategic question that asks Sallie about her feelings, but doesn't suggest that she act any differently*]

SALLIE: I don't know. I just don't.

THERAPIST: (*Nods empathically.*)

SALLIE: I don't know. I guess I'd feel overwhelmed if I started thinking about changing the plan.

THERAPIST: What would feel overwhelming about it?

SALLIE: Umm, it just feels wrong. I don't really want to talk about it.

THERAPIST: It gives me a sense of how wrong it must feel if even thinking about other options feels overwhelming. But, thinking isn't the same as acting. Is it okay for me to ask one more question on this topic?

SALLIE: Maybe. What do you want to ask?

THERAPIST: How do you imagine your mother would feel if she thought you had any misgivings about your major?

SALLIE: I think she'd be mad. College is a privilege, not a right. That's what she says to me all the time, and I appreciate my parents' financial and emotional support. I don't want to squander my studies on a major that doesn't have any potential.

THERAPIST: Which majors don't have potential? [*asking a follow-up question but being ready to pivot to another subject if Sallie notes that she doesn't want to discuss this topic any further*]

SALLIE: I don't know. I guess journalism is the one I am thinking about specifically. If I knew I would be successful at it, I might major in journalism. (*Looks uncomfortable.*)

THERAPIST: What does it feel like to talk about this?

SALLIE: I feel nervous. Uneasy.

THERAPIST: Where do you feel it in your body? [*I move the topic away from college majors and instead help Sallie expand on her feelings by describing her emotions in terms of other senses.*]

SALLIE: My stomach, I guess.

THERAPIST: How would you describe it?

SALLIE: I feel nauseous. Queasy.

THERAPIST: It's clearly a tender topic, and it takes some courage to delve into it.

SALLIE: Yeah, it does feel a little scary to talk about.

THERAPIST: Sometimes, it can be easier to learn more about a troubling subject by using imagery. When you talk about this, does any particular image come to mind?

SALLIE: I feel like a little mole, and I want to burrow back into my hole.

THERAPIST: It's an interesting image. Can you tell me any more about the mole?

SALLIE: I don't know. I just feel confused, and it's easier to hide out in a little cave.

THERAPIST: Are you alone down there?

SALLIE: Oh yes, definitely. There's not enough room down here for anyone else.

THERAPIST: What does it feel like to be alone?

SALLIE: Okay, actually. It's safer than having to worry about any other moles. (*Grins as she becomes involved in the imagery and metaphor.*)

THERAPIST: (*Smiles back.*) Hmmm, what would be your worry if there were any other moles?

SALLIE: I'm not sure, but I like having my own space. I don't have to worry about anyone else, and I feel safe. I don't feel squished, and I don't have to worry that the other mole would try to take over. It's all mine.

THERAPIST: Sharing is dangerous because the person might not just share but also take over?

SALLIE: Yeah, now that you mention it, I do feel like that.

THERAPIST: The images are very powerful. Do they feel familiar to you?

SALLIE: Sort of . . .

THERAPIST: (*Raises eyebrows.*) [*Nonverbal message:"Please go on."*]

SALLIE: Ummm, when I really think about it, I feel this way fairly often.

THERAPIST: Can you tell me more?

SALLIE: Well, first at school, I feel this way with Gwen. She takes over when she bosses me around. I know it sounds stupid, but I worry she will also take away my other friends. Does that sound stupid?

THERAPIST: It sounds like a concern that has bothered you; it doesn't sound stupid. Have you felt this way in any other places?

SALLIE: I sometimes feel this on trips home. Maybe sometimes with my brother.

THERAPIST: (*Nods.*)

SALLIE: Don't get me wrong. Tom's a great person. When he's healthy, he's unstoppable. He's popular, handsome, and smart. I'm just not as interesting or talented as he is. When he's in a room, people are drawn to him. That doesn't happen to me. And when he's sick, people are drawn to him because he's ill, and he needs special care.

I understand that. I'm lucky to be healthy. I'm not jealous of that type of attention.

I don't know. I like the idea of having a safe place to hide out that I wouldn't need to share with anyone. (*Smiles.*)

THERAPIST: Climbing down into your hole to stay safe and protect your space?

SALLIE: Yes. Sometimes, I even resent the fact that Tom's illness intrudes into my therapy hour. Isn't that horrible! I just like having you all to myself. I want to talk about me, not him.

Anyway, when Tom is well, he's better at most things than I am. I'm good at sports; he's great. I'm okay at math; it's his favorite subject.

THERAPIST: Talking about him feels like you have to share me with him?

SALLIE: In a certain way, it really does.

THERAPIST: Let's look at the associations here. Maybe you have an idea how to put them together. At first you talked about your mother and her concern about your choice of study. Your next association and image involved the mole, and then Tom, and not wanting to share anything or anyone with him. Do the topics seem related to you in any way? [*I have an idea how they might be related, but it is much more effective and informative if Sallie is able to tie the two together.*]

SALLIE: Well, maybe a little bit. Tom has never had to work for my mom's attention. Even before he was sick, he was the more charismatic kid. Tom and my mom always seemed to have a special bond. I wasn't really jealous. Well, maybe just a little bit.

But then, when he got sick, all bets were off. He needed mom more, and she was always there for him. I shouldn't be jealous of that. He was suffering. I'm glad she paid so much attention to him.

But, I've got one thing on Tom. I'm the only daughter, and mom enjoys being my mentor. She's always taken a special interest in my studies. It's the only area where I have Tom licked. I hope you can understand why I wouldn't want to change my major. Mom and I bond over these discussions and that bond deserves protection.

THERAPIST: That makes a lot of sense. I understand why you would want to protect this special bond with your mom.

SALLIE: I know, but for some reason, I still don't feel good about economics.

THERAPIST: That is the dilemma. Your choice of classes continues to bother you for reasons we don't fully understand at this point, but even discussing it feels acutely uncomfortable. It took some courage to delve into the topic more deeply today. [*I outline Sallie's dilemma while also positively reinforcing her willingness to open up a bit more on this complex subject.*]

SALLIE: Thanks—it is hard for me to talk about this. So, what do I do?

THERAPIST: I think we need to search for greater understanding of the dilemma at a pace that feels tolerable to you.

SALLIE: Maybe so, but right now, I'd rather move on and tell you about Gwen.

THERAPIST: Sure. Perhaps we can talk more about your classes and career goals another time. [*While I follow Sallie's lead in changing the subject, I make a comment about the unfinished business.*]

Example 15.2 illustrates a number of effective procedures that may help a treatment evolve beyond the therapeutic impasse. All the tactics attempt to look at the same emotional material through a different lens in order to understand old concerns in a new way.

At the beginning of the session, I remain relatively quiet to facilitate Sallie's associations, rather than to direct them prematurely. This approach can be helpful to many patients who use the first 10–15 minutes of a session to "warm up" toward a troubling topic. Even though I don't talk much, my silence is an amiable one. While I avoid any comments that might interfere with the gradual emergence of new material, I use nonverbal cues to convey my interest.

If Sallie seemed uncomfortable with this approach, I might ask her to describe how she experiences the silence. ("As we sit here together, I am wondering what this silence is like for you? Some people appreciate the space, while others feel it is a little too quiet. What is it like for you?") Learning how Sallie interprets my less active approach may reveal some useful information. If it is difficult for her to tolerate an approach with less questions, I can also respond by saying more, but will preferentially choose more open-ended questions to avoid narrowing any topic prematurely.

As the session evolves, I ask Sallie a number of detailed questions about her school concerns, rather than assuming we have exhausted this recurring topic. Her replies slowly reveal how her study of economics is tied to an understandable desire for her mother's attention and approval. Before Sallie will be ready to make any significant changes in her career path, we need to appreciate her conflicting wishes and fears in more detail.

As illustrated in Example 15.1, direct confrontation in this situation may increase her resistance. In fact, if I insisted that Sallie choose an

alternative career path, I would be acting like her mother by directing Sallie's life according to my priorities.

Instead, I acknowledge and respect Sallie's resistance by gently asking what it would feel like if she didn't experience these internal limitations. The question is worded carefully. I don't recommend that Sallie change her perspective or act any differently. ("What would it feel like to consider a different major and a future career in something other than business?")

When Sallie starts saying she would rather not speak further about the topic, I ask permission before posing a follow-up question. If she had expressed distress about any further questioning on this subject, I would ask her what she would like to talk about instead and then follow her lead. It is very useful that Sallie feels comfortable telling me when she can't tolerate any further conversation on a loaded topic. By expressing her concerns directly, she and I can titrate the discussion to a pace that feels empathic rather than pushy.

After Sallie expresses that she doesn't want to talk much further about this topic, I change my approach and start to discuss Sallie's concerns in displacement, first focusing on where she feels her distress in her body and then helping her develop an image of herself as a shy mole. Sallie mentions that her space will not feel protected if it is shared. In response to open-ended questions, she is able to relate her metaphor of the mole to her feelings about Gwen, her brother Tom, and her mother.

Although Sallie is able to talk about her fantasy in detail, these strategies may be useful even if her image had been less well defined. If Sallie's image were murkier ("I just see a grey fog"), I might ask more questions to develop the image ("Does this remind you of anything in particular?" or "What might be hidden in the fog?"). If I am open to this creative venture, she is likely to follow. For a more aurally inclined patient, I might ask, "Does this make you think of any type of music or sound?" With an action-oriented patient, I may ask about impulses: "When you talk about this, do you feel an impulse to do something?" Many an emotion that cannot be tapped verbally can be explored through directed imagery, a creative displacement, or an affective equivalent.

As the discussion about Tom and Sallie's mother evolves, Sallie starts to clarify her emotional dilemma: in order to stay close to her mother, she doesn't want to assert an independent career choice. I empathize with her concerns (*"That makes a lot of sense. I understand why you would want to protect this special bond with your mom"*) and acknowledge the emotional complexity of the issue (*"Your choice of classes continues to bother you for reasons we don't fully understand at this point, but even discussing it feels acutely uncomfortable"*). I take a moment to recognize Sallie's courage as she delves into a topic she had previously avoided; it is supportive to acknowledge the emotionally taxing work.

Soon after, Sallie changes the topic back to Gwen. It isn't unusual for a patient to have a limited tolerance for an emotionally intense subject. In response, I note that it would be useful for us to continue our discussion about her classes and career goals in the future, and then follow her lead on to the next topic.

CLARIFICATIONS AND INTERPRETATIONS

In addition to careful listening, gentle open-ended exploratory questions, and nonverbal and verbal encouragements, clarifications and interpretations can advance a psychotherapy. Clarifications are explanatory interventions that do not necessarily include a historical or developmental perspective. (In Example 15.2, my question "*Sharing is dangerous because the person might not just share but also take over?*" is a clarification.) Interpretations are comments that link the patient's past experiences with their present, for example, "Your boss's self-centered approach is so difficult for you to tolerate because he reminds you of your father." Both of these interventions help the patient to think, to feel, and ultimately to talk about and to understand sensitive subjects. They may be met by some resistance, the psychological defenses a person uses to protect themself from emotional distress.

When I started psychiatric training after a year of internal medicine replete with clear, objectively based diagnoses and algorithmic treatment plans, I imagined clarifications and interpretations as verbal procedures that could dissect emotional pain and immediately relieve distress. If I could manage to "explain" the patient's inner motivations, a sustained cure would follow. I felt confident that a healing interpretation existed for each patient. I just had no idea what it was or where to find it.

During my first few years as a psychotherapist, I tried to make this fantasy come true multiple times. Many hours were spent offering various epiphanies to my few psychotherapy patients, hoping beyond hope that I had hit the therapeutic jackpot. Needless to say, it never worked. Even if the patients were polite and acknowledged my attempt to "solve" their problems, their conditions never seemed to improve after my psychological sermons.

I reevaluated my method after one patient disappeared for 3 months following one of my "enlightening" comments. In my haste to interpret their distress, they may have felt misunderstood and emotionally exposed. Finally, I realized that a psychotherapeutic cure cannot be distilled into one or two chin-stroking observations.

Although the wish for curative interpretation is certainly understandable, psychotherapy is a lengthy process without any easy answers. In fact, the therapist who can endure a problem's ambiguity and avoid pigeonholing

the patient's experience does their patient a much greater service than the therapist who is overeager to reach a simplifying explanation.

In addition, there is therapeutic power in the therapist and patient working together in a search for understanding. Unlike the emergency doctor's intervention starting antibiotics or chest compressions in a cardiac crisis, the pace of psychotherapeutic change is slow and the process is collaborative. Ideally, as patients understand how therapy works and learn more about themselves, they will slowly become empowered to make their own clarifications and interpretations, exponentially increasing the emotional power of the insight.

The following examples will illustrate how overclarification or overinterpretation can flummox a treatment, while their careful use at the right time can promote understanding.

CLARIFICATIONS: MISUSE AND USE

Example 15.3 illustrates how a well-meaning beginner may misuse the art of clarification after hearing a patient's dream.

EXAMPLE 15.3

Premature and inaccurate clarifications

SALLIE: Dr. Bender, I had the weirdest dream last night. Can I tell you about it? I felt sort of shook up when I woke up this morning.

THERAPIST: Please, I'd like to hear about it. [*I'm excited and nervous to hear about the dream but feel some immediate pressure and responsibility to understand and to explain its underlying meaning during this session.*]

SALLIE: Well, okay. I remember swimming in a deep, dark river. It was warm and very comfortable, and I felt like a fish, which is funny because I'm not a very good swimmer. Instead of hands, I think I had some fins that glowed in the dark. It was so calm and peaceful; the river slowly crept along and I swam with the current. Then, I saw a cave. I crept inside of it, and it was really dark, but I could make out this ledge on the side of the cave that had enough room for me to lie down. All of a sudden, I got really tired and didn't feel strong enough to keep going, so I went to sleep on the ledge. And that's when I woke up, feeling upset. . . .

THERAPIST: [*I am excited that I have thought of a clarification, and I interrupt, happy that I have thought of something smart to say.*] Somehow you needed to escape the river; it wasn't safe to continue swimming by yourself.

SALLIE: Huh?

THERAPIST: I am just struck by the fact that the cave served as an escape so you would no longer have to move forward alone in the river. As you are in school and growing in independence, it's scary. Sometimes, you may want to find a cave that is safe to hide in.

SALLIE: Oh, is that what it meant?

THERAPIST: That is how I understand it, anyhow. [*I feel a bit proud and smug.*]

SALLIE: That's interesting. Umm, I wanted to make sure that I tell you what happened in school yesterday. Also, Gwen has been up to her usual tricks.

THERAPIST: [*I nod but miss the fact that Sallie has chosen to change topics rather abruptly.*]

SALLIE: You know, I think Gwen might hate me! (*Starts to cry, which is unexpected by both of us.*)

THERAPIST: What happened?

SALLIE: I don't know. (*Chokes through sobs.*) She's ignored all of my calls this week. I don't know what I did wrong. I must have done something to cause this. I feel so guilty.

THERAPIST: [*I feel an urgent need to relieve Sallie's distress and jump to explain Sallie's behavior with another attempted clarification.*] You feel guilty so easily. As you gain independence, Gwen is shutting you out, and guilt is a much easier emotion than anger.

SALLIE: Oh, I don't feel angry at Gwen. She's my closest friend. (*Becomes silent for a few moments.*) I don't like to criticize her. Also, my professor clarified what will be on the economics midterm next week. It's on a ridiculous amount of material. I have no idea how I am going to prepare.

THERAPIST: Why the change in subject all of a sudden? Did I say something to upset you?

SALLIE: I don't know. I am just sick of talking about this stuff all the time. The situation with Gwen is really hard.

In Example 15.3, I try to make sense of the dream after hearing Sallie briefly outline its contents one time. In my fantasy as a novice psychotherapist, this is Sallie's cue to say something like: "Eureka! I finally understand that I try to avoid making independent decisions because of a complicated dynamic with my parents that I can just now understand. Thank you so much. I know my life will be different now." What happens in Example 15.3 is more reality-based. Sallie's passive agreement is a common response to an overzealous therapeutic approach.

When Sallie changes the subject to discuss her ongoing difficulties with Gwen, I repeat my previous error and present another clarification of Sallie's behavior ("*Guilt is a much easier emotion than anger*"). Two premature clarifications in a row reflect more on my internal state than the patient's. In this situation, it is a signal that I am probably feeling anxious, insecure about my psychotherapeutic skills, and frustrated about the patient's slow progress.

Even though I have good intentions when I try to resolve Sallie's difficulties, Sallie begins to cry after my comments. From her perspective, my intervention may have felt more like an emotional assault. Yet, when I ask her directly how she experienced our discussion, Sallie doesn't tell me how uncomfortable my comments made her feel. She blames her emotional distress on the situation with Gwen.

The more therapeutic approach is less flashy and humbler. Nowadays, if I think I understand something very quickly, I suspect that I probably don't understand it thoroughly, because most significant issues are multidetermined. When a patient first reports a dream or a difficult situation, I'll ask more questions and withhold my opinion. I'll also try to elicit associations to some of the more salient elements of the story. Basic queries such as "Let's try to understand this together. Can you tell me more? How did you feel at each segment of the dream (or difficult situation)? How does it feel to tell me about it?" provide openings for deeper exploration, and help the patient disclose details that they hadn't been aware of before.

When a patient shares a complex narrative (such as a story or a dream), I may have a hypothesis regarding its meaning, but only further and deeper discussion with the patient will show whether I'm even in the right ballpark. In fact, I've found that it is rare any dream or personal dilemma is fully understood during the session in which it is reported.

Example 15.4 illustrates how a therapist can use a dream as nourishing fodder for discussion without jumping to clarify its meaning.

EXAMPLE 15.4

Using a dream to clarify the goals of therapy

SALLIE: Dr. Bender, I had the weirdest dream last night. Can I tell you about it?

THERAPIST: Sure. (*Waits patiently.*)

SALLIE: (*Presents the same dream as in Example 15.3.*)

THERAPIST: It's an interesting dream. Thank you for sharing it with me. Let's go through it another time a bit more slowly. Can you tell me the beginning again?

SALLIE: Okay. First, I just remember swimming in this slow relaxing river. I was all alone, but I didn't feel lonely. I felt very adventurous instead of

feeling scared. That is one of the weird parts because, like I said, I'm usually not that comfortable in the water.

THERAPIST: What else did you feel during the dream?

SALLIE: Well, in the beginning, I mainly felt free and not tied down at all. Before I climbed on the ledge, I felt that I could float or swim in the river forever. Something bad seemed to be missing.

THERAPIST: Something bad?

SALLIE: It seemed like I didn't feel bad about myself at all. Maybe that part of me that is always so self-critical was missing. I'm not sure.

THERAPIST: (*Nods.*)

SALLIE: Now as I listen to myself, I feel annoyed. My dream was all about being free and feeling good about myself, but even as I talk about it, I hear this aggravating voice in my head making critical comments.

THERAPIST: What does the voice in your head say?

SALLIE: You know, it sounds like Gwen. I don't know. She'd think of some way to make me feel stupid about the dream. She's expert at that.

THERAPIST: Gwen can be very critical at times. . . .

SALLIE: Yes, but right now I'm talking about the voice in my head—and at least in the dream while I was swimming, my criticism of me didn't exist, and that felt really great.

THERAPIST: I can understand that it would feel great to be free of self-criticism. What do you make of the river?

SALLIE: What do you mean?

THERAPIST: Well, did it remind you of any particular river or any particular place?

SALLIE: Umm, I don't know if the river in the dream was a river I have actually visited. The feeling of being free is a little bit familiar, though. I used to feel this way during our family's summer trips to national parks. I don't think I've told you about this. We went to a different one almost every year. I always looked forward to it.

My mother always made a ceremony of taking off her watch as we drove through the park gates. She was more relaxed during these weeks than any other time of the year. We even went the summers that Tom wasn't feeling well. The trip might be a little shorter, but we always went.

As a kid, I loved those vacations. We all got along well, and it felt so relaxed and free. All the everyday stress was gone. It's hard to explain how special they were.

Every year, I make a donation to the national parks. I feel attached to them.

THERAPIST: National parks are beautiful—and it does sound like the parks have been a place of great freedom for you.

SALLIE: Yes, they were, but it doesn't make a lot of sense that my dream focused on swimming. I don't like to swim very much. I do like to hike, and we would do that together as a family, but I never manage to make time for it these days. There's actually a hiking club at school, but I haven't joined.

THERAPIST: Can you tell me what holds you back?

SALLIE: I don't know.

THERAPIST: [*As I continue to review the dream in my mind, I remember that Sallie also had a cave in her "mole" image from Example 15.2. I continue to be silent to see if Sallie starts talking again spontaneously. When she doesn't, I decide to ask a question.*] The cave, can you tell me how you felt in the cave?

SALLIE: I felt my old self creeping back while I was in the cave. I wasn't fearful during the first part of the dream, but in the second part it became very dark, and I started to get scared. I feel sort of stupid admitting it, but I actually get scared of the dark fairly often—when I'm awake, I mean.

THERAPIST: Can you tell me more about this fear of the dark?

SALLIE: Well, it generally happens when I'm home alone, but I've also noticed that it definitely gets worse when I'm upset, like after a fight with Gwen.

THERAPIST: It isn't unusual that a fear increases when a person is upset. Your observations are useful. They will help us understand the fear better. How do you act differently when you feel this fear?

SALLIE: I just get nervous, and I'll check to see if the front door is locked. Sometimes, if I am really wigged out for some reason, I sleep with a light on. I just don't feel comfortable all by myself. I know it must sound stupid.

THERAPIST: It doesn't sound stupid at all. I appreciate you sharing this with me, and it will help lead us to a deeper understanding of what is bothering you.

So, during the last part of the dream, you felt differently?

SALLIE: Yes, for a short while, I felt okay being by myself doing what I like to do, even if I wasn't the best at it. By the end of the dream, that feeling was gone.

THERAPIST: (*Nods empathically.*)

SALLIE: It's not like that in real life.

THERAPIST: The dream gave you a taste of what would it be like not to feel so afraid or self-critical while you are awake.

SALLIE: Yes, do you ever think I could feel less afraid?

THERAPIST: I think we are working on that together, even by talking about the dream. Over time, we may learn more about the dream and what it tells us about fear and freedom. With increased understanding, you might begin to feel more like you did as you swam down the river.

When Sallie slowly reports her dream the second time, I pay special attention to her emotional experience during each section. The type of exploration illustrated in Example 15.4 can also be used to facilitate any discussion, whether about a dream or about a difficult situation that the patient is struggling with during waking hours.

If I had more time to discuss the dream with Sallie, I would also ask her about the events of her day prior to the dream to see if that helps us understand more of the dream's meaning. Daytime experiences that find their way into a dream are known as the *day residue*. Other questions such as "Does any particular part of the dream stand out to you? Are the feelings in the dream familiar to you? Where have you felt them before?" could further facilitate the discussion.

Once the discussion of the dream is finished, I'll take special notice of Sallie's next associations. In contrast to Example 15.3, I don't hazard a sound-bite clarification that would prematurely connect all the pieces of the dream with the content of recent sessions. I could ask Sallie to say more about how fear and freedom impact her daily life at college; this approach prevents me from overreaching; any connections or clarifications created by Sallie will empower her understanding without being intrusive.

Now and then my patient and I will discuss a dream in detail, and it still won't make any cohesive sense. While I often feel a pull to explain and to tie up the loose ends, the dream remains available for future exploration if I refuse to simplify it with a quick and dirty explanation.

Sigmund Freud would sometimes spend weeks reviewing a dream with a patient. Because he was practicing psychoanalysis, he had the time to delve deeply into a dream to understand its underlying conflicts and its origins. Once-a-week psychotherapy doesn't offer this luxury, but dream material and the subsequent associations can be valuable as inroads to new understanding.

The discussion in Example 15.4 does highlight some patterns in Sallie's thinking that I will note privately, even if I don't share them with her at this time. It is noteworthy that Sallie is often fearful and is aware that this sensitivity makes life unnecessarily difficult. Meanwhile, as I've commented before, Sallie is rarely openly angry in her dealings in life in general and with Gwen in particular. It's possible that the two are related.

Maybe Sallie's fearfulness has an unconscious purpose. A useful procedure in psychodynamic thinking is to look for the feeling *opposite* to the patient's conscious emotional experience. Perhaps Sallie's ubiquitous

fear keeps her aggression in check. It is unclear why aggressive and angry impulses are unacceptable to Sallie, but the recognition of this conflict may form the seed of future insight. For now, I will keep this hypothesis to myself, but I make a mental note to ask Sallie more questions about her experience of anger at a future opportune time.

INTERPRETATIONS

Interpretations differ from clarifications in that they tie together a patient's difficulties in the past and present in a meaningful way. To illustrate: let's say I start to work in therapy with a 30-year-old woman we'll call Martha, who wants to discuss her ongoing difficulties with her critical and reproachful father. She is an only child of a single parent who never remarried; her mother died when she was a toddler. As a child, she was intimidated by her father's inflexible attitude. Her father would scold or punish Martha if she didn't follow his instructions to the letter. In response, Martha learned to assert her independence covertly by withholding or delaying: classic passive–aggressive behaviors. While living at home and attending school, Martha wouldn't start her homework that was due Monday morning until late Sunday evening. Her father would be aggravated by these delaying tactics, but Martha would always manage to complete most of the work on time. Although she might "forget" to relay an important message to her father for a number of days, she would eventually share the information. Her father responded with an even more rigid attitude. By the time I met the patient, this cycle had been in place for years. (Of note, reading this narrative over now as a child psychiatrist, I would also wonder if Martha might have undiagnosed attentional or learning issues. For the sake of simplicity, I will clarify that her actions are purely psychodynamically motivated.)

Martha might use similar withholding and delaying techniques in her current life or with me within the therapy. She may finish work projects at the last minute, irritating her coworkers, or repeatedly pay her therapy bill a few weeks late.

As the therapy progressed, I would try to help Martha connect her current actions in her adult life with her old ways of coping as a child. For this interpretation to be effective, we would discuss details of her experiences growing up, and learn how this ineffective coping mechanism evolved. Eventually, we would talk at length about Martha's understandable frustration and annoyance with her father. Over time, we would also learn how Martha has processed the loss of her mother at such a young age.

Martha must feel that I understand the motivations for her past behavior before we can fully examine her present difficulties in relationships. As we maintain a nonjudgmental but curious approach, we may recognize together how Martha is using obsolete (and replaceable) coping

mechanisms, possibly without conscious knowledge, in her current responsibilities and relationships.

Example 15.5 illustrates an interpretation to deepen Sallie's understanding of her ongoing difficulties with her friend Gwen.

EXAMPLE 15.5

The therapist interprets a patient's recurring difficulty with her friend

SALLIE: Ugh. Sometimes I hate Gwen, Dr. Bender, even though she is my best friend. Yesterday, we had another fight. It ruins my whole evening when we battle.

THERAPIST: It is upsetting that these fights keep recurring with a friend who is so important to you. What happened?

SALLIE: Well, you know I generally let Gwen choose how we are going to spend our time together. After our last session, I figured it was time for a change, and last night I asked her to come with me to a campus event. A senior friend of mine, Melanie, spent her junior year spring semester abroad in South Africa, and she organized a slide show to share her experiences. I love travel and I wanted to support Melanie, so I really wanted to go. Oh—and also Melanie is a journalism major! That's the major I may have considered if my mother approved of it. I was really interested to hear about her experiences.

I was a little nervous asking Gwen to go with me, but I thought she might be interested. Well, anyway, she had already planned to go to a party in a nearby dorm, because a guy she likes was going to be there. I asked if we could go to the party after the talk, but she wouldn't compromise. It wouldn't have been a big deal if we could have just gone our separate ways for the evening. I suggested that idea, and she went completely ballistic.

THERAPIST: What did she say?

SALLIE: She said I was a mediocre friend who couldn't be counted on, and joining her at the party after the talk just wouldn't cut it. If I really wanted to prove myself as a good dependable friend, I needed to come with her and help her meet up with this guy and skip the talk. Otherwise, her opinion of me had seriously declined, and I wasn't a true friend after all.

THERAPIST: How did it feel to you when she said this?

SALLIE: I felt horrible, but I skipped the talk and went to the party with her, and it was awful. It was so bizarre. Once she got her way, she was so grateful to have company. She said all these nice things to me.

This time it didn't make me feel any better. I kept reviewing the fight in my head last night, so I hardly slept at all.

Plus, remember I told you that sometimes I have trouble falling asleep in the dark? Well, last night I kept the lights on all night. I still feel upset. (*Tears well up, and she reaches for a tissue.*)

THERAPIST: It sounds like a very upsetting evening. You have tried so hard to be a good friend to Gwen, but it is difficult when she doesn't allow you any leeway.

SALLIE: Yes! She really gets to me. But, it was okay to have a separate idea and want to go to the talk, wasn't it?

THERAPIST: Of course, it was, but the fact that you ask the question shows me that you aren't quite sure that it's okay for you to express a preference and still be a good friend.

SALLIE: Yeah. I do feel so unsure of myself with Gwen. Like I have to do things her way in order to make sure she still likes me.

THERAPIST: It adds a great deal of pressure because it doesn't allow you to express any wishes you have that are different from Gwen's. How do you understand finding yourself in such a situation?

SALLIE: What do you mean?

THERAPIST: Well, have you ever experienced this type of relationship pressure with anyone else?

SALLIE: I don't know, maybe. I think I told you about my friends Kim and Dawn. They were my best friends growing up. They were never as mean as Gwen, but sometimes they would be kinda bossy in the same way. But it's my fault, too. I just don't feel comfortable standing up for myself.

THERAPIST: Have you ever felt this way with anyone in your family?

SALLIE: Not that I can think of. Oh, I don't know.

THERAPIST: Well, I have an idea, but I don't know if it will feel right to you. Tell me what you feel about this.

SALLIE: Okay. What?

THERAPIST: Do you think the way you describe Gwen, Kim, and Dawn sounds a little bit like the way you describe your mother?

SALLIE: What do you mean?

THERAPIST: Well, we've talked about your mother's influence on your career choice. On the one hand, it is a special bond that you two share, but it has felt complicated to tell her when your interests may differ.

SALLIE: Yeah, if my Mom got mad at me, I'd feel terrible.

THERAPIST: Can you say more? What would make her mad?

SALLIE: I think she would be very upset if I changed the plan for my future after we developed it together so carefully. I really don't want to get in

a fight with her. It's not worth it. I'm sure she knows what's best for me anyway. Economics isn't too bad.

THERAPIST: It is a difficult situation. Ideally, you would want to be able to talk to your mother more openly and share your ideas, but you don't want to risk her getting mad at you like Gwen does when your opinions are different.

SALLIE: Right.

THERAPIST: The difficulty arises when you feel that you must ignore your own ideas and wishes to maintain an important relationship.

SALLIE: I know. I'm used to it, though. My mom and I get along well when I do things her way.

THERAPIST: That may account for how the behavior evolved. When you were a child, it was easiest just to submerge your feelings and follow your mother's advice, but now that you are older, it is increasingly difficult because you have your own independent ideas.

In Example 15.5, I hazard an interpretation, tying Sallie's ongoing difficulties with Gwen with her own fears of asserting herself with her mother. In fact, because Sallie has repeatedly chosen bossy friends who tell her what to do, she may be experiencing a *repetition compulsion*. This term was coined by Freud and refers to situations in which a person tries to rework an old conflict through current relationships. It makes sense that Gwen may be an emotional stand-in for Sallie's mother. Gwen feels irreplaceable, like a mother, which is probably a reason why Sallie continues in the nonsupportive friendship.

I use several techniques to try to make the interpretation palatable to Sallie. Prior to the interpretation, I reinforce our therapeutic alliance by supporting Sallie's tentative move toward independence with Gwen. Then, before sharing my ideas, I first ask Sallie if she sees any similarities between her friendship with Gwen and any other important past relationships. After hearing Sallie's input, I strategically hedge the interpretation as a question ("Do you think the way you describe Gwen, Kim, and Dawn sounds a little bit like the way you describe your mother?"). With this approach, the discussion will evolve around Sallie's agreement or disagreement with my ideas. Either way, our understanding of the topic deepens. Finally, as the conversation progresses, I explain my view of Sallie's behavior gently and with empathy for how it evolved over time.

Example 15.5 avoids a number of common pitfalls. The interpretation is not humiliating or condescending. It does not attempt to be a therapeutic epiphany. In fact, its power lies in the fact that it isn't a great surprise to Sallie. It reformulates information that Sallie has shared with me over time. It is only a slight stretch for Sallie to acquire the new perspective.

As Sallie's mother becomes the focus, Sallie might discover that she has, without conscious awareness, resented the control exerted by her mother's giving and withholding of attention. It's possible that much of that resentment has been turned against herself in the forms of self-reproach, devaluing views of herself, impaired confidence, and unearned feelings of guilt. As she allows herself to express her hostile feelings in the safe arena of the therapy sessions rather than turning her anger inward, her self-assurance may increase.

Over time, she may also gain the courage to imagine talking to her mother, as one adult to another, about a career focus other than business. She may begin to conceive of the possibility of maintaining her mother's attention and care while pursuing her own interests and developing her own talents. If Sallie is game, mental imagery or rehearsals during the therapy sessions could help her prepare for a talk with her mother.

As these therapeutic developments emerge coincident with Sallie's improved ability to communicate, her relationship with her mother may improve. Even if they continue to disagree about Sallie's career opportunities, they may still feel closer if they are able to talk more openly and honestly. As Sallie's confidence increases and she realizes that ignoring her own feelings doesn't guarantee a fulfilling friendship, she might become more open with Gwen. If Gwen cannot tolerate mutuality, Sallie might start to search out new relationships.

While progress with such profound consequences may be triggered or catalyzed by well-timed interpretations, a large part of these changes may be mediated through the relationship between the patient and the therapist. This is the focus of the next two chapters.

CHAPTER 16

Empathic Lapses

An empathic lapse occurs when the therapist misunderstands the patient. If the lapse is not acknowledged by the therapist, the treatment may suffer. If the incident is recognized and discussed, the relationship and the treatment may be revitalized and even fortified.

As a novice psychiatrist during the first months of my training, I'd fantasize about my future as the most empathic therapist of all time: a therapeutic super-hero. Eventually, I would learn how to create psychological change in a single bound. I would cure long-standing emotional pain that had been resistant to all previous treatment. I would understand everything.

After I gained some clinical experience, my perspective on empathy underwent a fundamental change. Even if it were possible to do so, I'm no longer interested in becoming the most empathic therapist on record.

Misunderstandings, as unpleasant as they can be, offer unique therapeutic opportunities. Some patients avoid close relationships because of the "baggage" that accompanies them: a fear of being misunderstood and a fear of rejection. If I can model how to work through conflicts in a constructive manner while maintaining an emotional connection, my patient's trust in me and in their own capacity to bear intimacy will ultimately increase. Rather than aim for perfection, I now work toward relationship resiliency.

WHAT IS AN EMPATHIC LAPSE?

Empathic failure is the term used in the psychotherapeutic literature to describe an interaction in which the therapist misunderstands the patient. From my perspective, it's a harsh and inaccurate term. I've employed the

term *empathic lapse* as a replacement, promoting the view that these are not failures but valuable opportunities for discussion and learning.

Patients may respond to an empathic lapse in any number of ways. They might laugh and pretend it didn't happen; talk about their upset in displacement, by focusing on an individual in their life who feels easier to criticize directly; withdraw and cancel the next session; or cry openly and express how hurt they feel. As a beginner, I found the angry patient to be the most challenging. It's comparatively easy to listen to a patient's rage regarding family or friends, but it feels entirely different to have a patient's fury directed at me.

REACTING TO AN EMPATHIC LAPSE

The unprepared therapist may feel at a loss when faced with an angry patient after an empathic lapse. Example 16.1 illustrates how an inexperienced therapist might respond to this predicament.

EXAMPLE 16.1

An empathic lapse occurs between the patient and her therapist; the therapist responds by becoming defensive, focusing on the patient's past, and then trying to repair the misunderstanding too quickly

Midway into a Session with Sallie

SALLIE: I don't know, Dr. Bender. Sometimes I feel so independent, and other times I just want to curl up into a little ball and cry.

THERAPIST: So, sometimes you feel like an adult and other times you feel like a little girl?

SALLIE: (*Looks down at the floor and twists a tissue in her hands.*) I guess so.

Next Session

SALLIE: I don't have anything to say today.

THERAPIST: (*Nods.*) [*I do not say anything, hoping Sallie's associations will emerge naturally.*]

SALLIE: I am not a little girl! (*Blurts angrily.*)

THERAPIST: (*taken by surprise*) Huh?

SALLIE: Last session, you said this thing that just wasn't true. Remember when you said that I sometimes act like a little girl?

I don't know. Is that how you see me? I don't even know what to say to you anymore if that's the case.

I can't believe that I have been confiding in you for months, and you don't understand me at all.

THERAPIST: I said what?

SALLIE: Last session, I told you this very personal thing, and you called me a little girl.

You don't even remember? Whatever. Just forget it.

Therapist: I think this is important to talk about. As I remember it, I did not say you were a little girl. I said that sometimes you feel like a little girl.

SALLIE: It only feels worse to hear you say it again! You know, I had no idea you were this judgmental.

THERAPIST: I was not judgmental. I don't think I said that you were a little girl. I think you are remembering the interaction incorrectly.

SALLIE: Whatever . . . if you say so. . . . (*Breaks eye contact and looks at the floor.*)

THERAPIST: It seems this really upset you.

SALLIE: Well, sort of. You usually understand what I say. I don't even know what to do now. I feel shot down.

THERAPIST: I must have reminded you of your mother. You have told me how alone you feel when your mother misunderstands something important about you and doesn't listen to your point of view.

SALLIE: Huh? (*Starts to cry.*) I don't want to talk about my mom. I wasn't even thinking about that.

THERAPIST: Can you tell me why you are crying?

SALLIE: Because you just don't get it.

THERAPIST: Am I reminding you of your mom right now?

SALLIE: No, you are not. I don't think you are like my mom at all. Just forget it.

THERAPIST: [*I don't know what to do, but I figure that validating Sallie's emotions can't hurt. I decide to change tactics.*] I can understand how hard it could feel to begin to trust me and then to feel "shot down."

SALLIE: I just don't understand what you meant if it wasn't a put-down.

THERAPIST: I definitely didn't mean to put you down. I apologize. Let me think for a minute what I was trying to say.

I think I meant to say that you may have a part of you that sometimes feels like a little girl, while other parts of you are functioning like an independent adult. I am really sorry if my comment hurt you.

SALLIE: Well, I don't like to think about it in those terms. It seems derogatory to me.

THERAPIST: I didn't mean it in a derogatory way at all, but I can understand how painful it might be if that is how it sounded. Again, I'm so sorry.

SALLIE: (*Looks uncomfortable.*) Yeah, yeah. Let's talk about something else.

Example 16.1 illustrates a number of common, understandable, but not very therapeutic tactics that a novice therapist might employ when faced with an unexpectedly angry patient after an empathic lapse. I start by defending my comment ("As I remember it, I did not say you were a little girl. I said that sometimes you feel like a little girl") and Sallie reacts with exasperation followed by withdrawal.

During my second defensive maneuver, I refer to Sallie's family dynamics to escape a direct discussion of my actions. ("I must have reminded you of your mother.") My psychodynamic sidestep is a reaction to my internal discomfort, and it isn't a therapeutically useful response.

By the end of the example, I become a bit more compassionate. I stop trying to argue Sallie out of her feelings, and I'm open to the idea that I could have hurt her unintentionally. Then I try to repair the misunderstanding in record time to alleviate the unease that has penetrated the office environment. In certain subtle respects, this approach is also an easy way out.

While some of my comments start with the phrase "I can understand . . ." in an attempt to show empathy for Sallie's current state, my choice of words doesn't address that we reached this impasse because of my prior inability to understand Sallie's perspective. The use of mollifying words forces a semblance of empathy. They don't demonstrate a true grasp and acceptance of Sallie's angry and hurt feelings and of her current need to express them.

In addition, my profuse apologies are so repetitive that they seem automatic. I am too eager to regain Sallie's good graces. By not encouraging Sallie to express a range of emotions in response to the incident, I might give the impression that I can't tolerate and survive her anger.

Apologizing for hurting the patient may be important, but first it's crucial to learn more about the misunderstanding. Example 16.2 illustrates how a more experienced therapist might respond to the empathic lapse.

EXAMPLE 16.2

The more experienced therapist talks with a patient in detail about a recent empathic lapse

SALLIE: Sometimes I feel so independent, and other times I just want to curl up into a little ball and cry.

THERAPIST: So, sometimes you feel like an adult, and other times you feel like a little girl.

SALLIE: (*Looks down at the floor and twists a tissue in her hands.*) I guess so.

THERAPIST: What are you feeling? (*with a gentle look*)

SALLIE: Nothing. I'm just thinking of the work I need to do tonight.

Next Session

SALLIE: I don't have anything to say today.

THERAPIST: (*Nods.*) [*I do not say anything. I want to allow Sallie's associations to emerge.*]

SALLIE: I am not a little girl! (*Blurts angrily.*)

THERAPIST: Hmm? (*quizzical and concerned look*)

SALLIE: Last session, you said this thing that just wasn't true. Remember when you said that I sometimes act like a little girl?

I don't know. Is that how you see me? I don't even know what to say to you anymore if that's the case.

I can't believe that I have been confiding in you for months, and you don't understand me at all.

THERAPIST: Feeling so misunderstood is understandably upsetting. Can you tell me more? What do you remember of what we both said?

SALLIE: Well, I've just started to feel totally comfortable talking to you. I mean, before last week, I thought I could tell you anything, and then *boom*!

THERAPIST: *Boom*?

SALLIE: Boom, you label me as a little girl! I am coming to therapy to help me grow up and deal with these types of problems. Maybe sometimes I need a little extra help, but I'm not a kid.

THERAPIST: I agree that needing a little extra help doesn't mean that you are a kid. I also appreciate that you are sharing your concerns from our last meeting. Do you remember any more about the interaction?

SALLIE: Well, all week after your comment, I wondered if I should stop therapy. I'd thought you were on my side, and then all of a sudden you were so judgmental.

THERAPIST: My comment about feeling like a little girl felt like a judgment?

SALLIE: Of course, it did. I am trying so hard to act grown-up and mature in my life. Then you label me as a "little girl." It shows me how little you understand me.

THERAPIST: I am glad you can tell me this so directly. It sounds like I really did miss the boat, as my mention of "little girl feelings" felt insulting. Even though I did not mean it in an insulting way, my choice of words didn't reflect your efforts to master the problems we have been discussing.

I think it's important to add that I don't see you as a little girl at all. I see how hard you are working to find your path as an adult, and my comment didn't support that growth.

SALLIE: That's true. It really hurt.

THERAPIST: The hurt has a special sting if you had felt comfortable confiding in me before I made this comment. How are you feeling as we revisit the moment from last week?

SALLIE: I was unsure if I should bring this up with you, so I feel good that I did.

THERAPIST: It takes some courage to bring up a disconnection. I'm really glad that you did. I hope I won't make such mistakes again, but if I do, I hope you'll tell me right away. I am always open to hearing your perspective if you feel misunderstood.

SALLIE: Thanks, that means a lot. It is hard to share, but I will try.

THERAPIST: I think you also mentioned wanting to curl into a ball and cry during part of our discussion last week. I wish I had asked you to describe that experience in more detail instead. Perhaps some time you can tell me more about it.

Example 16.2 illustrates procedures that a therapist can employ when reviewing an empathic lapse with a patient. When Sallie starts to relate her disappointment, I don't immediately validate her feelings or move on to another topic as quickly as possible. Instead, I ask her to recall the upsetting events in detail, with the questions: "Can you tell me more? What do you remember of what we both said?"

As I learn about the prior misunderstanding in more detail, I do not share the details of my personal perspective of the preceding event. I focus primarily on Sallie's emotional position to understand why the interaction was so painful for her.

Meanwhile, I try to stay calm and nonjudgmental throughout the experience. After I "get it," I can provide, during the replay, the empathy that was missing the first time around.

AN EMPATHIC LAPSE AS A RESULT OF A THERAPIST'S COUNTERTRANSFERENCE REACTION

Sometimes an empathic lapse occurs when my countertransference—my subjective reaction to the patient—interferes with my ability to respond therapeutically. I find these empathic lapses especially challenging as I need to respond to the patient's needs while simultaneously analyzing my own inner experience.

We've set up an example of a countertransference reaction leading to an empathic lapse in Examples 16.3 and 16.4. When Sallie starts to make some new friends other than Gwen, I'm surprised to find that I am not as pleased as I might have expected. Maybe I feel unconsciously possessive of Sallie after working with her intensively for many months, and I am reluctant to share my special niche as her confidant.

Occasionally, I have felt pangs of jealousy when a young adult patient has found a special mentor in their life and has talked repeatedly about how this person is so helpful, unusual, creative, and so forth. Although my patient's comments are evidence of emotional growth, I might feel a bit competitive with the idealized figure.

I'm sharing this story to encourage you not to disregard these feelings, unappealing as they may be. Recognizing and processing my internal emotional responses advance my professional growth while protecting the therapy. In contrast, ignored feelings may inadvertently and negatively infect the treatment.

When I don't admit my competitive feelings to myself in Example 16.3, I unconsciously act on them by criticizing Sallie's new friend.

EXAMPLE 16.3

The therapist's countertransference reaction results in an empathic lapse, and the therapist cannot immediately untangle her own issues from those of the patient

SALLIE: I am so excited! I went to a campus forum sponsored by the local newspaper, and I met some really neat girls. They live together in an all-girls co-op on campus, and they invited me to dinner. I had an amazing time.

There was one girl, Uzma, who stood out. She was so nice to me. She's also kinda interested in journalism, but she's actually done something about it. She writes for the campus paper, and, if I get up the guts, I may start working there a little, too.

She seems so generous. I needed to get some stuff off campus, and she let me borrow her car. Wow! It's hard to believe she might become a new friend. I was so happy all week after meeting her. She's everything I could wish for in a friend. She's incredible!

THERAPIST: But you really don't know her very well yet. . . . [*I feel a little annoyed at Sallie's news, but I'm not able to recognize my competitive feelings. I formulate this question in response to my unprocessed internal state. If I had been able to recognize my state of mind, I would have chosen a different question that was more protective of Sallie's emotional growth.*]

SALLIE: What do you mean? Uzma already seems so different than Gwen. I don't understand. I thought you wanted me to make new friends.

THERAPIST: It just seems it is easy for you to idealize Uzma when you hardly know her. [*I am still unaware of any countertransference feelings that are fueling this line of questioning.*]

SALLIE: Dr. Bender, that seems like a weird thing for you to say.

THERAPIST: What sounds weird to you?

SALLIE: Well, I don't know. . . . I was so excited about this news. I thought you would be also. Do you think Uzma sounds problematic?

THERAPIST: Well, let's look at this together. What if I did have a problem with Uzma, and what if I didn't? [*still unaware of how my commentary is affecting Sallie emotionally*]

SALLIE: I don't know. . . . I don't know. . . . I just don't know what to say now.

I thought you would be happy for me. Maybe you're right. I don't really know Uzma very well yet, even though we've talked every night on the phone this week.

THERAPIST: It's hard for you to hear me state an opinion.

SALLIE: I don't know. I was feeling so happy about this. Now I just feel upset. (*Wipes her eyes.*) Usually, you are happy for me when I am happy. I don't think you have ever acted critical like this before. I don't get it. Did I do something wrong?

THERAPIST: No. It's fine that you have a new friend.

Sallie accurately picks up on my countertransference and is gutsy enough to share her thoughts with me directly. While patients are rarely able to share their thoughts so candidly early in a psychotherapy, we imbued Sallie with this attribute to illustrate this challenging clinical situation.

Unfortunately, while Sallie has the ability to confront me, I'm not up to the challenge. My unconscious worry that Sallie's new friends might replace me fuels my slightly snide, insensitive, and countertherapeutic reactions. The therapy would have been better off if I could have recognized my true feelings about Sallie's news, and then processed them independently of Sallie, either alone or in supervision. A therapist's own therapy is also a haven for understanding countertransference enactments.

Example 16.4 illustrates how a therapist can process a countertransference reaction while simultaneously protecting the patient.

EXAMPLE 16.4

The therapist realizes her countertransference reaction resulted in some unempathic responses and accepts responsibility for her behavior

SALLIE: I am so excited! . . . [*See Example 16.3 for the full text.*] . . . It's hard to believe she might become a new friend. I was so happy all week after meeting her. She's everything I could wish for in a friend. She's incredible!

THERAPIST: But, you really don't know her very well yet. . . . [*I feel annoyed and then notice that I feel a little jealous of Sallie's new friends, especially Uzma.*]

SALLIE: What do you mean? Uzma already seems so different than Gwen. I don't understand. I thought you wanted me to make new friends.

THERAPIST: Let me think for a minute. My words may have been too hasty. Can you tell me more? [*I notice after the words pop out of my mouth that my first comment responded more to my own internal state than to Sallie's comments. By asking for Sallie to tell me more, I allow myself extra time to process my feelings during our session, rather than just react. I make a mental note to think about this more as I write up my process notes at the end of the session.*]

SALLIE: Well, I am so happy about this new group of friends, and Uzma seems especially nice. So far, I don't feel stupid when I'm with Uzma, and that happens with Gwen all the time.

Haven't we been working on this idea that I could have better friends for a long time? I don't understand why you are criticizing Uzma who has only been nice to me.

THERAPIST: [*I hear Sallie's point, and I don't want to dismiss her anger.*] It was a bad choice of words actually, and my comment wasn't supportive. I'm sorry I spoke so impulsively. I agree that we have been working on the idea that you could find more caring friends.

SALLIE: (*Looks upset and at a loss for words.*)

THERAPIST: [*I wait for a moment for Sallie to gather her thoughts.*]

SALLIE: I don't get it. It's not like you to say something sort of mean. Did I do something wrong? Are you mad at me?

THERAPIST: I'm not mad at you, and you certainly didn't do anything wrong. I think my first take on the news was off base. I did not give you enough credit for your good judgment. It sounds like the friendship with Uzma has a lot of potential.

SALLIE: It is okay for me to talk about my new friends with you, isn't it?

THERAPIST: Absolutely. I'm very interested in hearing about Uzma and any other new friend you want to tell me about.

It makes sense, though, that you might feel distrustful after I make a hasty comment that isn't thoughtful. If I make another such mistake, I hope you'll let me know about it.

SALLIE: I just don't feel like talking about this anymore today.

THERAPIST: Would you feel comfortable sharing what's going through your mind?

SALLIE: I don't really know. I feel sort of blank.

THERAPIST: Did I hurt your feelings?

SALLIE: No, it just was a surprise—that's all. I don't expect that type of comment from you.

THERAPIST: I wonder if this has undermined your trust in me. [*sensitively forthright*]

SALLIE: I don't know. Maybe a little. It's just unexpected because we've been talking for weeks about my need for more supportive friends. I thought you would be excited for me.

I don't know. I feel weird talking to you about this.

THERAPIST: What's weird about it for you?

SALLIE: I don't want to make you feel bad, but I also didn't like what you said.

THERAPIST: I'm glad you let me know your concerns. I appreciate your honesty, and I always want to hear from you if I say something that feels problematic. I think we can both learn a lot if we work this out together.

SALLIE: I don't know. I can't think of anything to say. I'm sorry Dr. Bender, but I don't want to say something wrong, or have you say something wrong again.

THERAPIST: You didn't say anything wrong. I did. My comment was hurtful. I agree with you; we have been talking about how nice it would be to find some friends other than Gwen. I didn't acknowledge how exciting it feels to be getting to know Uzma.

I chose my words too hastily, but I hope we can work it out. One of the most important lessons in life is to learn how to resolve problems when one person hurts another.

SALLIE: That sounds good, in theory. . . .

THERAPIST: Can you tell me what crossed your mind?

SALLIE: Well, I don't think it is that easy to repair a relationship after a fight. That has been my experience anyway.

THERAPIST: What has been your experience?

SALLIE: Well, when my mom and I fight, for instance . . .

THERAPIST: (*Nods encouragingly.*)

SALLIE: There always seems to be a major rift between us after all of our fights. Even the stupid ones.

THERAPIST: Can you give me an example?

SALLIE: Well, a couple of weeks ago, I wanted to talk to her about my new friends, and she said she was too busy. I got really angry and hung up. I know I overreacted, but I was really upset at the time.

Anyway, she hasn't called me since. And I don't want to call her, after she dissed me.

THERAPIST: It struck a very sensitive nerve when she couldn't provide what you needed?

SALLIE: Well, yeah. She never seems too busy to do things for my brother, but if I have a simple request, she has better things to do. Now that we are in a fight, we may not talk to each other for a few weeks. See what I mean? Fights hurt relationships. They don't help them grow.

THERAPIST: Well, I agree with you that the relationship may have trouble growing when the fight stays unresolved. If you would like, maybe we could talk more about your fights with your mother and how they evolve.

SALLIE: I don't know. How can I be sure you won't insult me again?

THERAPIST: You can't right now, but in my experience, a relationship grows in trust if a misunderstanding is processed and resolved.

SALLIE: You think so? I've haven't really experienced that in my relationships.

THERAPIST: I've seen it happen, and I hope we can accomplish this together, starting with our discussion of my insensitive comment.

SALLIE: How do we start?

THERAPIST: Well, how are you feeling right now?

SALLIE: Kind of overwhelmed. I wish the session were over already.

THERAPIST: The first few times it can feel overwhelming to try to work through a major misunderstanding. Can you tell me more about how you are feeling?

SALLIE: Well, what happens now? I don't really feel like talking about my mother and our stupid fights. I'd rather tell you about this article I agreed to help Uzma with. It's for the school paper, but you probably aren't interested.

THERAPIST: Actually, I am very interested.

SALLIE: You are? It's not a big problem. It's more of a success. Is that okay to talk about, too?

THERAPIST: Absolutely. I want to hear about anything that you would like to share with me, your successes in addition to your struggles. My first reaction during this session may have made it seem that I wasn't interested in your achievement—finding Uzma as a new friend. I'm sorry for that, but I am interested in hearing more about Uzma and also this new article.

SALLIE: (*excitedly*) Okay. Well, after Uzma and I finish this article, I may try to write one on my own. [*eagerly sharing more information about her plans*]

THERAPIST: (*Nods and smiles.*)

In Example 16.4, I am able to identify my unhelpful countertransference reaction within the session. I can try to understand the details of my

reaction after our meeting is over. Meanwhile, I am able to repair my lapse in understanding with Sallie soon after it occurs. While this is the ideal, often a therapy doesn't evolve so smoothly.

Example 16.5 illustrates how I might repair an empathic lapse 1 week after it occurred and effectively respond to Sallie's insistent curiosity about the incident.

EXAMPLE 16.5

After responding unempathically to the patient in a previous session (Example 16.3), the therapist works through her own countertransference reaction and, in the next session, talks with the patient about the interaction

One Week after the Session in Example 16.3

Sallie is talking about her courses for the first 15 minutes of the session. She seems to be avoiding any mention of her new friends.

THERAPIST: I would like to hear more about your new courses, but I wanted to make sure we had a chance to get back to our discussion last week about your new friends.

SALLIE: Oh, it's okay. I have enough other things to talk about. It felt uncomfortable talking about them last week anyway. Let's just forget it.

THERAPIST: Actually, I think it is important to discuss. I can appreciate that it was uncomfortable for you last week. As I thought about it later, I realized that I may have missed the boat.

SALLIE: Huh? What do you mean?

THERAPIST: I think you may have felt uncomfortable talking about your friends last week because my reaction wasn't very understanding. If you agree, I'd like to try to talk about it again.

SALLIE: Oh, geez, do we have to?

THERAPIST: What would it be like to reopen the topic?

SALLIE: I don't know. I just felt like you weren't supportive of my new friends last week, and that was so weird. I thought that was a mutual goal: helping me to find new friends. When I finally make some progress, you didn't trust my choices.

THERAPIST: You were reaching out to new people, and I criticized your growth and courage with a new group of friends. I was wrong to do that.

SALLIE: It means a lot to hear you say that.

THERAPIST: What does it feel like?

SALLIE: Well, you made me so mad last week. I almost skipped this week's session.

I knew you didn't understand, and then I wondered if you disapproved of me. You just couldn't see my point of view. Like I said, I almost cancelled our meeting today. I didn't really want to come back.

THERAPIST: It took self-discipline and courage for you to come to your session today. It was understandably hard to return after I disappointed you.

I'm glad you made it. By coming, we have the chance to work this out together.

SALLIE: Usually, you let me talk about what is important to me, but you were so different last week. I don't know what to talk about now.

THERAPIST: You are right. My intention is to talk with you about whatever feels important to you, and last week I didn't do that. When you brought up Uzma for the first time, my response wasn't very sensitive or useful.

SALLIE: Yeah, you made things worse instead of better. That's never happened before. Did I do something wrong? Why did you do that?

THERAPIST: [*Being fully open wouldn't respond to Sallie's needs.*] You did nothing wrong at all. My comments were off base, and they did make things worse instead of better. That is why I wanted to make sure we talked about it today.

SALLIE: Yeah, you don't usually make comments like that. It would just help me to know why it happened.

THERAPIST: How would it help you?

SALLIE: I don't know. I feel a little worried.

THERAPIST: Worried about what?

SALLIE: Well, are you okay? Did my problems upset you?

THERAPIST: Did I seem upset last week?

SALLIE: I don't know. Maybe a little bit.

THERAPIST: Perhaps I may have seemed upset to you last week, because my comments weren't supportive. But, it's important for you to know that my comment reflected a temporary lack of focus and an insensitive choice of words. I still agree that it is important for you to find new good friends. [*Sharing the details of my reaction wouldn't be therapeutic. It had more to do with me than with Sallie.*]

Now I'm encouraged that you were able to tell me your feelings so directly. You're right. I wasn't being very helpful last week.

SALLIE: Well, I don't want our relationship to change because I've told you that you did something wrong.

THERAPIST: The misunderstanding makes our relationship feel more tenuous?

SALLIE: Yeah, sort of.

THERAPIST: I think we'll learn more over time about this concern, but I view our relationship as stronger for weathering a troubling interaction. If I ever misunderstand anything in the future, I hope you will tell me as you did this time.

SALLIE: (*beaming*) Sure, you know it seems pretty brave to me that you brought last week's spat back up. I'm glad we talked about it.

THERAPIST: And you were brave, too.

SALLIE: Yeah, I guess so. Maybe you are right.

Many individuals seek therapy because they have experienced a lack of empathy from important figures in their life. One of the healing aspects of psychotherapy is the experience of feeling safe, affirmed, and understood. This experience is fortified when a misunderstanding is worked through, rather than denied or deflected. Once Sallie has experienced working through a misunderstanding with me, she might feel more capable of talking openly and honestly after a disagreement with other significant people in her life.

UNCOVERING A POTENTIAL EMPATHIC LAPSE

While Example 16.5 illustrates a potentially stressful situation, it is easy in a few respects: it is clear that my comment is hurtful from the get-go, and Sallie doesn't deny that my reaction upset her. Rather than being shy or indirect, she tells me exactly which of my statements bothered her and why. Many patients aren't this direct.

Sometimes, I wonder whether I committed an empathic lapse during a session and missed the patient's cues that my comments were hurtful. In my early days in psychiatry, I worried about this possibility often as I reviewed conversations from prior sessions. I fretted until I reached supervision to confess my most recent "mistakes." Words that had felt direct and sincere at the time seemed judgmental and harsh when I reviewed my notes. Questions that had appeared crucially insightful sounded like unnecessary, insensitive interruptions.

Lucky for me, most of my supervisors were extremely supportive when I started sharing my concerns. Here are some of their tips: First, if a therapist makes a less than ideal comment during a session and the patient *doesn't* react, it is impossible to assess how the patient experienced the moment. (This is a situation different from Example 16.3, in which I misunderstand

Sallie during the session, and she immediately expresses disappointment.) Second, if the patient didn't seem taken aback by my comment when I made it, it is not therapeutic for me to confess to a possible empathic lapse at our next meeting. Since I don't possess psychic powers, I have no idea how last week's statement was interpreted by the patient. My patient may not even remember the comment I wish I had never uttered.

If I'm really concerned, I might ask a patient at a natural pause in the session how they experienced a certain part of last week's meeting. If they brush it off, I follow suit. In my experience, the statements that I wish I had never uttered are rarely the ones that my patients tag as empathic lapses.

Another tactic is to listen carefully during the next session to see if Sallie alludes to a potential empathic lapse from the previous meeting. Then, I can ask for further clarification. If Sallie shares her reaction directly, I can respond, using the advice outlined in the previous examples.

Let's pretend Sallie had not expressed her frustration when I wasn't very supportive about her new friendship with Uzma. As I review my notes in supervision, I start to wonder whether my comments could have been upsetting to her. Example 16.6 illustrates how to handle the situation in the following session if Sallie drops some subtle hints about a prior empathic lapse.

EXAMPLE 16.6

The patient alludes to an empathic lapse in the previous session, and the therapist helps her talk about it directly

SALLIE: So, I had a horrible week.

THERAPIST: Oh (*concerned look*), what happened?

SALLIE: I don't know really. I just felt lonely all week. I didn't see any of those new friends I told you about. Maybe I avoided them a little bit.

THERAPIST: How did you avoid them?

SALLIE: Well, I didn't hang out where I thought I might see them. I just felt so exhausted. You know, normal college burnout.

THERAPIST: Do you have an understanding of what might be burning you out?

SALLIE: Not really. I just feel very out of it this week. It started after our last session.

THERAPIST: Did anything happen in our last session that made your week more difficult?

SALLIE: Not really . . . I don't know.

THERAPIST: (*quiet, encouraging look*)

SALLIE: Well, I did wonder about one comment that you made.

THERAPIST: Could you tell me about it?

SALLIE: Well, remember I told you that I had met this really nice girl, Uzma, and I was really excited to have a new friend?

THERAPIST: (*Nods.*)

SALLIE: Well, you said a weird thing.

THERAPIST: What was the weird thing?

SALLIE: Well, you said something that questioned my judgment about Uzma. I don't really remember the words.

THERAPIST: Do you remember any more about my comment specifically?

SALLIE: Yes, it was something about not knowing her very well. I got this feeling that you didn't want me to be friends with her.

THERAPIST: As I think back on it now, I can see how my comment might have felt upsetting. How did it affect you?

SALLIE: Well, I respect your opinion. You're probably right that Uzma isn't that great. I was just really excited after I met her.

THERAPIST: While I appreciate that you respect my opinion, I think my comment was misguided. If you were really excited after meeting Uzma, she is someone worth getting to know better.

SALLIE: You really think so?

THERAPIST: I do, and I'm sorry that I wasn't able to express this message first and foremost.

SALLIE: I am, too, but I feel better that we talked about it today.

During the first part of the session in Example 16.6, Sallie alludes to her disappointment in vague, derivative terms. My open-ended question acknowledges that the therapy could have contributed to her distress, and Sallie slowly starts to talk about her discontent.

What should I do if Sallie does not attribute any of her current distress to the previous therapy session? I could repeat a couple of comments such as, "I wonder if anything in the therapy could have contributed to your stressful week?" But if Sallie doesn't respond, I would not pursue the topic. Forcing an issue is not therapeutic. First, I can't be certain that Sallie's distress is a result of an interaction that occurred in the therapy. While the therapy hour is a significant part of a patient's life, it is only 1 hour in a busy week. I need to avoid overemphasizing its importance. Second, Sallie may not be ready to talk about the misunderstanding so directly. If this is the case, it is enough that I express my interest in talking about our interaction. I can hope that sometime in the future she may be ready to express her feelings more openly. In the meantime, we can focus on the issues that Sallie feels comfortable talking about in more detail.

Empathic lapses are challenging, especially for the beginning therapist. As we have indicated, an honest approach of reviewing the incident, responding to the replay empathically, and taking responsibility as indicated may ultimately result in a therapeutic experience for the patient. Again, the goal is not to pretend to be the perfect and invariably sensitive therapist. The best therapists try to help the patient work through misunderstandings as part of the emotional growth process.

Therapists may also evolve and mature from these experiences. We may acquire the ability to keep cool in the face of hostility, instead of acting in an offensive or defensive manner. We can learn to accept that empathic lapses occur and that they needn't be the end of a psychotherapy. Finally, situations in which we are insufficiently empathic can serve as indicators, pointing us toward facets of our own inner life that need attention.

Through our own efforts at introspection or with the help of colleagues, supervisors, or our own therapists, we can develop strength where there had been vulnerability. Over time, the recognition of our areas of limitation can help us develop greater maturity, serenity, and skill.

CHAPTER 17

Transference and Countertransference

As human beings, we learn from our experiences with others. We transfer expectations based on important relationships to new individuals we meet. This phenomenon is known as *transference*. Sometimes, unconscious transference can impair psychological functioning. When transference enters the psychotherapeutic relationship and is discussed openly by therapist and patient, profound learning and maturation may result.

Therapists can also transfer their own expectations to their patients and react to their patients emotionally; this is known as *countertransference*. Courageous recognition of those feelings combined with constructive examination can diminish obstacles to the patient's therapeutic progress.

Transference is a form of social memory. Experiences with primary people from our childhood, usually our parents, teach us what to expect from relationships outside the immediate family. Either consciously or unconsciously, we transfer expectations that we carry from our most important past interactions onto new relationships. This effect may be subtle or dramatic. For example, a patient with a supportive family may expect authority figures to be helpful and comforting. A patient who has experienced neglect and abuse on the home front may assume that this experience will continue in other venues, personal and professional. One feature of emotional health is the capacity to revise expectations appropriately as we expand our experiences with people over time.

Unconscious transference may fuel relationship difficulties and psychological distress. As a therapist divulges little personal information and

doesn't make any personal demands, the transference from patient to therapist is more easily observed than with many other relationships. With an empathic approach, the therapist can facilitate an open discussion of the patient's treatment transference, enhancing the patient's understanding of themself.

Naturally, therapists also respond emotionally to their patients. This phenomenon is called "countertransference." Countertransference reactions can be intense and may feel distracting to a novice therapist who is trying to pay attention to a patient's concerns. If understood rather than avoided, these reactions may inform the treatment rather than pollute it, providing emotional data that would be otherwise unobtainable. Such introspection may reinvigorate the psychological treatment.

TRANSFERENCE IN THE FIRST MEETING

While a patient's transference toward their therapist tends to deepen as the therapy progresses, it may begin with the first consultation meeting. For instance, during a first session, a patient may have a strong emotional reaction—favorable or unfavorable—to a personal feature of the therapist, such as the therapist's gender or age.

If the reaction is favorable and fueled by transference—for example, the patient wanted to see a young female therapist and the therapist is young, female, and reminds the patient of their comforting sister—it is unlikely that the issue will ever need to be discussed. On the other hand, if the patient has a strong aversive first impression of the therapist, the treatment will benefit if this issue is addressed as soon as it becomes evident.

Example 17.1 illustrates how a therapist can attempt to forge a therapeutic alliance with a new patient who has an aversive transference reaction during the first session.

EXAMPLE 17.1

The therapist responds appropriately to a patient with a strongly aversive first impression

First Meeting

THERAPIST: Hello, I am Dr. Bender.

SALLIE: My goodness, you are so young!

THERAPIST: What?

SALLIE: I expected someone older. You don't look older than 25. I'm sorry. I was just hoping for someone with some more experience.

THERAPIST: More experience?

SALLIE: Well, you sounded older over the phone. I just wanted to see a therapist with more life experience than I have. You know, with wisdom—no offense, I hope.

THERAPIST: No offense taken. I can imagine it is quite a disappointment meeting me if you were hoping for someone older. [*Although I want to tell Sallie I am older than I look, I resist the urge.*]

SALLIE: Yes, it is. Could I switch to someone else in the clinic?

THERAPIST: It might be possible to arrange that. If I know a bit more about what you are looking for and what brought you to therapy in the first place, I can make a more informed referral.

How would you feel about meeting with me for a session or two to talk about these issues? Then, I can use this information to find you a clinician you may feel more comfortable with.

SALLIE: Okay, but I'm pretty sure I'll want to switch after the first few meetings.

THERAPIST: I can understand your concern. It is important to try to find a therapist you feel comfortable with, so they can be helpful to you.

In Example 17.1, I don't take Sallie's comments personally. Her preference for older clinicians predates her meeting with me and may be in response to previous interactions with younger and older helping figures in her life. The offer of the extended consultation followed by a referral to an older clinician is empathic and clinically strategic. The plan validates Sallie's wish for an older provider, while the future meetings give us the opportunity to work together briefly. Although some unfavorable initial transference reactions are formidable, a large percentage dissipate once the patient feels validated, respected, and understood. It is possible that once we get started, our therapeutic alliance will evolve and the referral to another clinician will be unnecessary.

Of note: it is a different situation if a patient's strong negative first impression of a therapist includes biased or discriminatory behaviors against aspects of the therapist's identity, such as the therapist's race, ethnicity, or gender. If a patient rejects treatment because of prejudice, such as racism, homophobia, misogyny, or anti-immigrant sentiment, I recommend the therapist reach out to a supervisor with whom they feel comfortable. Every therapist deserves to feel supported in their work, and this situation deserves thoughtful time and attention. Discussions should include the institutional stance when a patient requests a treatment transfer motivated by bigotry, how the institution ensures the well-being of its clinicians, and offering flexibility to a clinician who may or may not feel comfortable continuing with a patient who has openly expressed prejudice. A deep dive into this important topic is beyond the scope of this book, but it is discussed

at length in Chandrashekar and Jain's (2020) thoughtful article "Addressing Patient Bias and Discrimination against Clinicians of Diverse Backgrounds."

TRANSFERENCE IN AN ONGOING TREATMENT

Usually, transferential issues, when the patient expects the therapist will act like a previously encountered important person in their life, emerge slowly as the treatment evolves. Great therapeutic gains can be made if these matters can be discussed openly and sensitively. The therapist can also use their own feelings toward the patient, the countertransference, to inform this discussion further.

The interaction requires some clinical finesse. First-timers may be subject to some of the common difficulties outlined in Example 17.2.

EXAMPLE 17.2

The therapist experiences a transference reaction as a personal attack and responds countertherapeutically

SALLIE: I've been thinking about the possibility of changing majors, but like I've said before, I'm too scared to disappoint my mother. I don't know what to do.

THERAPIST: Can you say more about what you are scared of?

SALLIE: Well, I want my mother to be proud of me. That isn't abnormal, right? I'm her daughter who might get rich after graduation. I'm her future CEO. You should see her beam when she talks about this.

I don't want to mess with it. It means so much to me that she cares.

THERAPIST: (*Nods.*)

SALLIE: I don't want to talk to her about the fact that I might be sort of interested in becoming a journalist.

THERAPIST: Hmm-mm. (*Nods in understanding.*)

SALLIE: Dr. Bender, I just don't feel comfortable talking to her about this, no matter what you say.

THERAPIST: [*I hadn't felt a need to force Sallie to confront her mother, and I feel miffed that she would assume I would be so directive.*] I don't care what you do. It's your life. I don't feel the need to direct your life.

SALLIE: I thought caring was part of this. (*Tears up.*) Never mind.

THERAPIST: No—what I meant was I don't have an investment in whatever you choose to do. I am more interested in helping you find the

direction that feels best to you. [*doesn't address Sallie's clear increased distress as a response to my statement*]

Next Session

SALLIE: I felt really terrible this week. I didn't sleep well at all last night. I kept the lights on at night. I think I told you that I do this sometimes when I'm feeling stressed.

Don't ask me why I'm feeling down. I have no idea, and I know that is your next question.

THERAPIST: This one is hard to figure out?

SALLIE: Yeah. I don't get it. Don't get mad at me, though. That would make it feel worse.

THERAPIST: Do you feel that I'm mad at you?

SALLIE: Well, you don't seem mad now, but I thought you might have been a little aggravated at me last week.

THERAPIST: Aggravated? Why would I be aggravated? [*I did feel a little aggravated last week, but I have no idea how to address this with Sallie.*]

SALLIE: Well, you said that you didn't care if I talked with my mother about my career worries, but I know that it would be in my best interest to talk to her. I feel sort of stupid that I just complain to you about my problems with her, but never talk to her directly.

THERAPIST: Can you say more?

SALLIE: Well, I kind of worry that I might be disappointing you because I'm too scared to talk to her. Meanwhile, you must be bored of hearing me come in here and obsess about the fact that I don't like my major.

THERAPIST: [*I remember now that I was annoyed last week when Sallie made a similar statement. I still don't understand why she thinks I would be as directive as her mother when I have tried so hard to help her find her own way. I start to worry about my ability as a therapist.*] Yes, I know you feel that, but I don't understand why. I am more interested in helping you find your own direction, not choosing it for you. (*frustrated tone*)

SALLIE: I'm sorry. I know you said that last week also. I just still feel a little worried about it.

THERAPIST: [*I suddenly understand Sallie's reaction in terms of transference. To assuage my increasing feeling of insecurity about my therapeutic prowess, I present my next comment with great authority.*] Why, of course! You feel I have expectations of you just like your mother does!

SALLIE: What do you mean?

THERAPIST: Well, you feel that your mother wouldn't care for you unless you follow her agenda. Now you feel that about me, too! It all makes perfect sense. [*I feel less helpless after I've made my interpretation. I don't have an understanding of my own countertransference, and how it is fueling my current insensitive approach.*]

SALLIE: Umm, well, I don't know.

THERAPIST: I think we have figured this out. So, can you tell me what it would be like to talk to your mother about changing your major?

SALLIE: I just don't want to. I hope that's okay. (*timidly*) I don't really get what you are saying anyway. I know you aren't my mother.

THERAPIST: Yes, of course, but since you've experienced your mother as making demands on you, you've started to feel that way with me as well. [*I feel proud of my theory and don't notice Sallie's increasing discomfort.*]

SALLIE: No, not really. (*Averts her eyes.*)

THERAPIST: Well, just think about how much sense it makes. It's very hard for you to assert yourself with confident women, but that's okay. We'll work on that.

SALLIE: (*Embarrassed.*) Umm, whatever you say. I guess you know best. You are the doctor.

THERAPIST: This sounds familiar to me. With women in authority positions, you always assume they know best rather than listening to yourself. It is your way of trying to maintain a connection, but it means you always have to be in the subservient role. [*I still don't notice Sallie's increasing withdrawal.*]

SALLIE: (*Looks like she is about to cry and doesn't respond.*)

Sallie's expectations that I will act in a directive manner like her mother may be an example of transference, but my approach in Example 17.2 lacks the sensitivity required for the discussion to be fruitful. At the start of the example, my understanding of Sallie's insecurities is limited: "*I hadn't felt a need to force Sallie to confront her mother, and I feel miffed that she would assume I would be so directive.*" As the discussion continues, I identify Sallie's expectation (or transference) that she needs to follow the guidance of a trusted woman with authority to maintain the relationship's emotional connection. My confrontational manner is an attempt to assuage personal concerns about my lack of expertise. Even if my interpretation may be factually correct, my method of presentation combined with bad timing is more of an emotional assault. Sallie doesn't gain emotional understanding from the interaction. Instead, she withdraws during my subsequent line of questioning.

My comments in Example 17.2 also illustrate two important psychological phenomena: countertransference enactment and complementary identification. Sallie becomes a target of a countertransference enactment when my unresolved insecurities (my countertransference toward Sallie during this session) are expressed outwardly in a way that affects her. The complementary identification occurs when I inadvertently mimic Sallie's mother's authoritative female role after all.

Example 17.3 illustrates a more therapeutic intervention in response to Sallie's concerns.

EXAMPLE 17.3

The patient's transference reaction is used to inform and to advance the therapy

SALLIE: I've been thinking about the possibility of changing majors, but like I've said before, I'm too scared to disappoint my mother. It's such a difficult situation.

THERAPIST: Can you say more about what you are scared of?

SALLIE: Well, I want my mother to be proud of me. That isn't abnormal, right? I don't want to mess anything up. It means so much to me that she cares.

THERAPIST: (*Nods.*)

SALLIE: I don't want to talk to her about the fact that I might be more interested in journalism.

THERAPIST: This is a complicated topic. What else comes to mind?

SALLIE: I just don't think you understand that talking to her is too risky.

THERAPIST: Do you feel that I want you to talk with her?

SALLIE: Maybe. You've pointed out that I've never talked to her about my worries, and I figured you wouldn't have said that unless you thought it was a good idea. I know you want what's best for me, but I'm just not up to it.

THERAPIST: [*I feel annoyed that Sallie would think I would act in such a directive way, but then decide to understand my response as an informative piece of countertransference. It is interesting that Sallie would assume I would be directive, as her mother is. Her assumptions are incorrect because I hadn't been thinking Sallie should confront her mother. Could Sallie be misunderstanding her mother as well? Food for thought.*] How long have you felt I wanted you to talk with your mother?

SALLIE: I don't know. Maybe the last couple of weeks or so, since I've been telling you more about my mom. I just assumed you would want me to

confront her if it bothered me so much. It must be annoying to hear me complain without actively trying to change the situation. I've just been a little worried about it.

THERAPIST: [*With supervision, I had felt comfortable continuing to explore Sallie's concerns rather than pushing her to act. Sallie's assumptions about my reactions continue to be inaccurate. I suppress a desire to correct her impression that I have a covert agenda. There is more information to be gained if I continue to learn more about Sallie's perspective.*] I'm so glad you had the courage to speak with me directly about this. Can you tell me more about your worries?

SALLIE: Well, I'm worried about what you'll think if I don't do what you want, even if it is the best thing for me. I respect you so much, and I don't want to disappoint you.

Last week you mentioned that I should explore the direction that feels best to me. I don't know. It made me feel weird. But, I don't want you to feel bad about it. I know you just want the best for me. I just felt sort of pushed after you said that. That's my fault, though. I'm the spineless jellyfish here.

THERAPIST: You are letting me off the hook here. It might feel easier to blame yourself rather than to stick with your gut reaction: Did my comments last week feel directive and not helpful? [*I'm trying to respond in a way that validates Sallie's experience without overtly expressing an opinion about my wishes for her future.*]

SALLIE: Yes. I guess I'm worried you might get upset if I don't follow your advice and do things your way.

THERAPIST: If we had different approaches to an issue, that might feel worrisome to you?

SALLIE: Well, sure. I like you and I want you to like me.

THERAPIST: Do you feel that I might not like you if our opinions differed?

SALLIE: Umm, well maybe. You might get mad at me if I didn't follow your advice.

THERAPIST: Mad at you?

SALLIE: Maybe. Well, I don't know. I feel a little worried that you might be upset at me if I don't meet your expectations.

THERAPIST: Worry that I would be upset at you if you follow your own beliefs?

SALLIE: Yeah, if my beliefs and your expectations are different—that feels tricky to me. But, that's not a new feeling for me. It's also my life with Gwen. I usually always do what she wants me to do. Otherwise, she's not as interested in spending time with me.

THERAPIST: I could imagine that feels very tricky—if you always have to do what the other person wants you to do to maintain the relationship. Do you experience this feeling with anyone else?

SALLIE: No. Not really with anyone that I can think of.

THERAPIST: Do you ever feel this way with anyone in your immediate family?

SALLIE: Umm, well maybe with my mother.

THERAPIST: How so?

SALLIE: Well, you know that I worry about disagreeing with my mother on my future career because I don't want her to be disappointed in me.

THERAPIST: To maintain the closeness, you don't disagree with her when you discuss your future career.

SALLIE: Yes, but that's just the way it is. I need to learn to deal with it.

THERAPIST: I understand that it is quite a dilemma. Tell me if I am understanding this correctly. You try to ignore your own wishes with your mother because the relationship feels less secure when there is a disagreement. Does that fit to you?

SALLIE: Yes, but it's not that simple.

THERAPIST: Tell me more. What part doesn't feel right to you?

SALLIE: Well, I do worry that my mom might get angry if I disagree with her. But, that's not the whole story. I also love the attention I get from her when we do agree about important things. I'm not just avoiding something that feels scary. I also don't want to mess with something that feels so right.

THERAPIST: That makes a lot of sense. Thank you for clarifying this for me. Your mother's attention is understandably so valuable to you.

SALLIE: (*Nods.*)

THERAPIST: Perhaps mine is too.

SALLIE: You mean that your attention is valuable to me?

THERAPIST: (*Nods.*)

SALLIE: Umm, I guess so; otherwise, I wouldn't be so worried about us having different opinions.

THERAPIST: I think it's important that you know I'm not upset at you in any way. I think it's fine that you've chosen not to talk to your mother about your interest in journalism. If you ever change your mind, I am supportive of any new approach as well. I don't have an agenda except to help you figure out what feels right for you.

SALLIE: It helps to hear that.

THERAPIST: I'm glad, but even if it helps to hear that, your fears of disagreeing with me may not disappear right away. I hope we can keep

discussing any worries you might have. We'll see what we can learn together by talking about it openly.

Example 17.3 illustrates how an explanation of transference can flow naturally from a discussion of the patient's concerns. First, Sallie and I talk extensively about her fear that I am disappointed in her. Gradually, we understand how her worries about my reaction are derived from her prior experiences with her mother. After some exploration of the topic, I do let Sallie know that I am not upset with her and I don't have a hidden agenda. I am transparent about my feelings and approach, which then highlights Sallie's assumptions about me as an interesting psychological phenomenon to be discussed and understood. It is possible that after openly working through her concerns about me with me, Sallie may become emboldened to talk more directly and openly with her mother, testing her assumptions about their relationship.

Ultimately, the empathic conversation focused on our relationship combined with the resolution of our personal conflict may have a highly therapeutic impact. Sallie gains both an increased understanding of her internal experience and real-life practice discussing a loaded topic in a thoughtful manner.

A single conversation won't put Sallie's worries to rest. To work through this issue, we will need to talk about it repeatedly in slightly varied contexts from different emotional angles. It will take time before there is any substantial emotional change.

WHEN TALK OF TRANSFERENCE IS DESTABILIZING

In general, a psychotherapy evolves as the therapist and patient focus together on the patient's transference reaction. With some patients, though, namely those with impaired reality testing, talking openly about the transference may precipitate a decrease in functioning rather than an increase in insight. As illustrated in Example 17.4 with Candice Jones, I change therapeutic tactics if a patient's reality testing becomes impaired during a transference discussion.

EXAMPLE 17.4

The therapist moves the focus away from the transference when the patient becomes paranoid

In previous sessions, Candice described her father as manipulative and devaluing.

I have taken down a framed poster in the office after it cracked, without providing any replacement art.

CANDICE: Oh, you decided to remove the picture of the water lilies by the doorway. . . .

THERAPIST: Yes.

CANDICE: The walls seem so naked to me now. I do understand the purpose of the change, though. It's not lost on me.

THERAPIST: What?

CANDICE: Well, I know we don't have an egalitarian relationship. You are the one with the power, because I am coming to you for help. Without the art, it is even more obvious that I am the patient. It's a rather antiseptic move, Dr. Bender. Even if you are trying to be more professional, it felt much safer when you actually decorated your office.

THERAPIST: [*Candice's comments are increasingly disorganized and paranoid, but I think it can't hurt to validate her experience.*] So, it feels less safe and less equal without the poster?

CANDICE: Oh, it's not that big a deal. I know this is part of your work in order to help focus all the attention on me and all my failings. I can handle it. But, you should know this for your other patients. They may not be able to tell you their feelings so openly. But, I know this is all part of your treatment plan.

THERAPIST: My treatment plan?

CANDICE: Well, empty walls may cause some patients to have trauma flashbacks. The new decor will help you get material.

THERAPIST: [*Candice is clearly decompensating as she transfers expectations from some other relationship onto my change in office decoration. Her associations are less reality-based and more paranoid with each open-ended question. I move to a more reality-based and cognitive approach.*] Actually, I don't have those intentions. The poster's frame cracked, and I am trying either to replace it or to find another poster to take its place.

CANDICE: You don't have an ulterior motive with your new sparse decorating scheme?

THERAPIST: No. No ulterior motive at all. But, your point is well taken that the office looks a little bare without the poster to brighten it up. [*I support the part of Candice's opinion that is more reality-based.*]

CANDICE: Yes, I really did like that picture. [*The paranoid associations cease.*]

Transference explorations are relatively unstructured and can be emotionally evocative. For patients with a poor grasp on reality, this approach can be disinhibiting and destabilizing. For patients like Candice Jones, a more cognitive approach is appropriate to maintain the therapeutic connection and to maximize emotional functioning.

COUNTERTRANSFERENCE AND AUTOGNOSIS

Countertransference reactions range as widely as their transference counterparts. Some of them are challenging. Feeling angry, saddened, or helpless in response to a patient's dilemma may be difficult to tolerate and to process. A novice clinician may be inclined to suppress the reaction. While this is an understandable emotional response, the unanalyzed feelings may subtly alter or inhibit the therapist's ability to tune into the patient's concerns. In turn, the therapy may be affected detrimentally. On the other hand, if the countertransference feelings are understood, the therapy may benefit. As mentioned earlier, *autognosis* refers to this kind of self-knowledge.

The therapist's favorable transference to the patient may also affect the treatment. For example, I might look forward to working with one patient in particular because she reminds me of my best friend from elementary school. This response of mine might lead me to underestimate the patient's vulnerabilities and difficulties.

A clinician's reactions toward patients may also include implicit bias against certain patient groups, which can be identified using the Implicit Association Test (Project Implicit, 2011). Once one's unconscious biases are recognized, a therapist can learn to disregard first impulses that may detrimentally affect patient care. For a more comprehensive discussion on this topic, refer to Chapter 5 and sources listed in the References and Additional Readings and Resources.

Often, countertransference reactions are subtle. Sometimes, within a session, I become aware of an unexpected feeling that comes on quickly and powerfully. The patient may be unconsciously manipulating the situation to induce me to share their emotional experience, an occurrence known as *concurrent identification*. If I can recognize this, I can use this information to shape my intervention.

EXAMPLE 17.5

The therapist notes her own increasing feeling of helplessness in the session and uses the experience to shape her next intervention

SALLIE: Dr. Bender, I really don't think this therapy is helping at all. I understand my dilemma now. Like you said, it feels overwhelming to assert myself with my mother when I am afraid of losing her approval. But so what? I don't feel any better. I'm no expert, of course, but I don't see where this therapy is going.

THERAPIST: [*All of a sudden, I feel at a loss for words.*] Umm, well, how long have you been feeling this?

SALLIE: Oh, I feel it every now and then. Sometimes I feel like I am getting better, and then other times I just don't see the point. I come here every

week and talk about my problems. Whoop-de-do. I can talk about my problems forever. That doesn't mean my problems are going to change.

THERAPIST: [*I feel helpless as Sallie talks about her experience. I wonder if we may be experiencing the same emotional state. I use this information to guide my next line of questioning.*] With all the work you have been doing, do you feel rather helpless with the slow improvement?

SALLIE: Yes, I guess I do.

THERAPIST: Do you have any understanding of why the helplessness is so prevalent right now?

SALLIE: Well, it's nearing the end of the school year, and next year I'll be a senior. I guess the issue we are talking about is really coming to a head. After I graduate, I plan to go to business school, and the whole idea makes me feel nauseous.

THERAPIST: It's so difficult to feel stuck between your mother's wants and your own.

SALLIE: It is. I don't know what to do about it. I know I need to make a change in order to feel better, but I haven't figured out what that will be yet.

THERAPIST: The conflict has been with you for a long time, so it's not surprising that it takes some time to find a resolution. [*offering reasonable hope*]

A concurrent identification occurs in Example 17.5 when my feelings of helplessness mirror Sallie's emotional state. I use my experience to guide my approach with Sallie. After validating her feelings, the content of the session deepens. As it turns out, Sallie's true concerns center on her dilemma involving her mother more than the efficacy of the treatment.

For a therapist, it's not always as clear-cut to recognize, and easy to tolerate, one's internal emotional state as it appears in Example 17.5. For example, irritation may not evaporate after a private acknowledgment that it exists.

In such a circumstance, I try to express my emotions internally so as to avoid hurting the patient. Directed fantasy is one way to dispel difficult emotions during or after a difficult interaction with a patient. For instance, if I feel exasperated with a devaluing and narcissistic patient, I might imagine yelling or fighting with the patient to express my frustration. By expressing my feelings in fantasy, it may be easier to act professionally and appropriately during trying clinical moments.

It takes knowledge and experience to process one's emotions while simultaneously attending to the patient. I may postpone the fantasy for a private moment to make sure none of the content from my internal imagery trickles inadvertently into the treatment. The use of fantasies is strategic;

using my imagination makes it less likely that I will act out my suppressed aggravation.

Now and then, a therapist's internal reactions to a patient are too intense to be contained simply with a directed fantasy. In these situations, therapists can access supervision and/or their own therapy if personal reactions toward a patient are infecting a treatment rather than informing it. Attending to these complicated clinical situations increases a therapist's emotional resilience and advances professional growth. Supervision is nearly always provided by training programs and some supervisors may offer continued mentorship and guidance after graduation. If one moves to another city after training has been completed, colleagues, professional organizations, or local training institutions can recommend competent local supervisors or therapists.

While the work of a therapist is meaningful, purposeful, and interesting, it also has the potential to be emotionally strenuous and draining. Self-care protects against clinical burnout and should be a priority for every therapist. By focusing on my own mental health, I can sustain my ability to focus on others. Protecting meaningful time in mutual relationships with friends, partners, or relatives, and spending time in activities that bring satisfaction and joy, are necessary to maintain psychological well-being. Knowing one's self well and maintaining one's inner health must be given high priority in order to preserve one's ability to listen to others carefully, empathically, and effectively.

CHAPTER 18

Termination

Termination is the ending phase of therapy. A mature termination is one in which the goals of therapy have been attained. Premature terminations occur when therapy must end for other reasons. Like other separations in life, the ending of therapy may evoke strong feelings, both in the patient and in the clinician. Skillful conduct of this part of therapy creates an emotionally meaningful experience for the patient as well as for the therapist.

It wasn't easy saying good-bye to all of my patients during the last several weeks of my training in adult psychiatry. Even though the therapeutic relationships were professional, the connections were real and the separations evoked myriad feelings.

Two parallel processes emerged. I would talk at length with my patients about their experience of the treatment's ending and then rush off to supervision to express how I was coping with it. The extra emotional support was necessary. Without independently processing my own perspective, I couldn't fully concentrate on my patient's concerns. Similarly, in this chapter, I pay equal attention to both the patient's and the therapist's needs as I review the process of termination.

WHEN DOES TERMINATION OCCUR?

When a therapy has had time to mature, its ending, known as a "termination," is an important chapter within the treatment. Patients who drop out of therapy without warning are quitting treatment, not terminating care. (For an approach to a patient who leaves treatment abruptly, see Chapter

10.) While some patients may make quick progress within a psychotherapy, for many, fundamental emotional change takes a long time. Trust is not a given, and it can take several months before some patients feel comfortable speaking honestly about private concerns. Although each person's rate of progress in therapy is unique, it takes time—often years—to accomplish the clinical gains necessary for a mature termination. In the best circumstances, a mature termination begins when a patient and I realize they have resolved the main difficulties that brought them to therapy. The parting doesn't feel forced, because the patient is ready to independently apply the emotional knowledge and competence they have acquired.

At MGH as a psychiatry resident, I first worked in the adult psychotherapy clinic for 3 years, and then transferred to the child clinic for an additional 2 years of training. At the end of each training interval, the vast majority of my patients weren't ready to terminate treatment and were transferred to a new trainee taking my place. Even though the patient was not concluding care with the clinic, it was still important that we processed the end of our work together and said good-bye.

My experience isn't unusual. Since training blocks for psychotherapists usually run for 2 or 3 years, many clinicians won't complete a long-term psychodynamic psychotherapy as a trainee. Geographical moves or graduations (by the trainee or by the patient) actually make premature terminations the norm early in one's career. Patients deserve to hear this information. I recommend that trainees inform their patients when they will be leaving the clinic at a treatment's onset, as illustrated in Example 3.5.

The first examples in this chapter consider how to discuss a premature treatment termination with the patient if it is initiated by the clinician's circumstances. The subsequent examples illustrate how the treatment might end if a geographical move by the patient necessitates an early ending to the therapy. Much of the information presented can be applied to mature terminations as well.

THE THERAPIST'S LEAVING LEADS TO A PREMATURE TERMINATION

While I was tempted to keep "forgetting" to tell my patients that I would be leaving the clinic in a few months at the end of my residency, the delay would have been a therapeutic error. Processing the end of treatment is an important aspect of a psychotherapy. Many patients also appreciate the time to prepare for a good-bye. Facing the unexpected separation with no time to process the event is the least therapeutic approach.

If the therapy must end prematurely because I need to leave the patient, I ideally share the news approximately 6 months ahead of time. If I'm not able to provide 6 months of lead time before a termination, the approach

outlined below is still applicable, implemented at a faster clip. Knowing the exit date is important as it allows the patient to identify and to solidify gains made in the therapy. The therapist will also pay particular attention to the patient's emerging feelings as the ending approaches.

It's easy to feel guilty about leaving a patient. Example 18.1 illustrates the subtle and not-so-subtle ways in which the ambivalent therapist may overcompensate during the remaining treatment time.

EXAMPLE 18.1

The therapist is unable to maintain a focus on the patient and steps out of her professional role after announcing that she will be moving out of state in 6 months

15 Minutes into the Session

THERAPIST: I have some news I need to tell you today.

SALLIE: Oh, what?

THERAPIST: Well, in July I will be leaving Boston.

SALLIE: Oh, okay. (*nonchalant*) So, when is your last week here exactly?

THERAPIST: I will be leaving the last week in June.

SALLIE: Where are you going?

THERAPIST: I will be moving to Florida. I know it's unexpected news. I hope you can feel free to share any reactions you may have in the upcoming months.

SALLIE: Oh, I don't need months to tell you how I feel. I don't care that much. People move on; I understand that. I can see someone else at the clinic, can't I?

THERAPIST: Yes, I can set you up with a referral to continue therapy after I leave. But, what about us?

SALLIE: What do you mean?

THERAPIST: Well, we've worked together for almost 2 years now. What will it be like to stop?

SALLIE: I already told you. I wish you well, but I won't crumble or anything without you.

Something interesting did happen at school today though. . . . (*Voice trails off.*)

THERAPIST: Moving away from the fact we will be stopping?

SALLIE: What?

THERAPIST: I just think it might be easier to talk about school than the fact that our relationship will be ending.

SALLIE: No. Six months is far, far away. I probably will be ready to stop then anyway.

THERAPIST: Is it so easy for you to give up on our relationship?

SALLIE: Whatever . . .

THERAPIST: [*I feel guilty about leaving Sallie and then uncomfortable with Sallie's indifference. I decide to share my own personal feelings about the termination as it might help Sallie open up.*] I do feel very bad about leaving the area, as we can't continue to work together. I know it is disruptive for me to leave you just as you are making progress with the issues that have been concerning you. I will really miss working with you.

SALLIE: Oh, you don't need to say that. You are paid to work with me. I knew that you would leave sooner or later anyway. You told me that you were in training during one of our first meetings.

In Example 18.1, Sallie reacts to our unexpected upcoming termination date with a veil of denial and indifference. Her response may be both emotionally protective and retaliatory.

I don't recognize that her reaction may be a defense against possibly intolerable feelings of abandonment and loss. Instead, I repeatedly move the topic back to my upcoming exit. I try to induce Sallie to express a set of emotions that is more in tune with my own feelings. The fortitude of Sallie's defenses, basically the "I don't care" stance, is strengthened.

Then, because Sallie's indifference is so unexpected, and because I feel guilty for ending the therapy prematurely, I interject my own personal emotions about the upcoming termination. My comments may make it even more difficult for Sallie to explore any mixed feelings she might have about my news. Her responses become even more distant.

It is rare for a patient to be able to process their feelings about a termination upon first hearing the news. This is one of the reasons I recommend announcing the termination date far ahead of time. After a while, Sallie may be able to express fear, anger, or sadness about the upcoming parting. My job is to tolerate whatever emotions she is experiencing at the moment and, over time, to help her understand her feelings—and the defenses against them.

EXAMPLE 18.2A THE INDIFFERENT PATIENT

The therapist announces that she will be moving out of state in 6 months and listens carefully to her patient's reactions

15 Minutes into the Session

THERAPIST: I have some news I need to tell you today.

SALLIE: Oh, what?

THERAPIST: Well, in July, I will be moving away from Boston.

SALLIE: So, I won't be able to see you anymore?

THERAPIST: That's true. Our work together will need to end before I leave.

SALLIE: Oh, okay. (*nonchalant*) So, when is your last week here exactly?

THERAPIST: I will be leaving the last week in June.

SALLIE: Where are you going?

THERAPIST: I will be moving to Florida. But, I know this unexpected news affects our work together. What is it like to hear the news?

SALLIE: Oh, I don't care that much. People move on. I can see someone else at the clinic, can't I?

THERAPIST: Yes, if you wish. I can set you up with a referral to continue therapy after I leave. (*Nods encouragingly.*)

SALLIE: Okay, that's fine. One therapist is as good as another, I guess.

THERAPIST: [*I wait quietly, but I don't nod in agreement to Sallie's last comment. I remember that my supervisors predicted that some patients would respond to my announcement with indifference, and I try not to take Sallie's remarks personally. While I feel hurt that Sallie, a patient I have enjoyed working with, is acting this way, I make an effort not to react. Instead, I mentally bookmark her response to process in my next supervision. I listen carefully to Sallie's next association.*]

SALLIE: I'm not a big fan of endings, so I just ignore them.

THERAPIST: How do you ignore them? (*This is an interesting lead.*)

SALLIE: I just don't think about them at all. It makes it easier than getting all choked up.

THERAPIST: Getting choked up isn't easy.

SALLIE: No, of course, it sucks. I don't want to think about it. I'd rather tell you about the latest stuff at school.

THERAPIST: Okay. We can leave this for now. Maybe we can talk about it more another time.

EXAMPLE 18.2B THE UPSET PATIENT

The therapist announces she will be moving out of state in 6 months and listens carefully to her patient's reactions

15 Minutes into the Session

THERAPIST: I have some news I need to tell you today.

SALLIE: Oh, what?

THERAPIST: Well, in July, I will be leaving Boston.

SALLIE: You will—*what*?!

THERAPIST: (*sensitive look*) I will be working in the clinic until June 30th.

SALLIE: That is horrible news! I can't believe it—and I was just beginning to feel comfortable working with you. Where are you going?

THERAPIST: I will be moving to Florida.

SALLIE: Well, that is fine and nice for you, I guess. I'm glad one of us will be happy, while I continue to struggle along here in "balmy" Boston.

THERAPIST: (*I notice but don't react outwardly to the sarcasm in the previous comment.*) It's difficult news to digest.

SALLIE: It's horrible. You know, I was just starting to think that maybe you cared about our work together. I guess I was wrong about that one.

THERAPIST: Does it feel like I don't care about you because I'm leaving you at a sensitive time?

SALLIE: That's right. (*Starts to cry.*) I don't know what to do now.

THERAPIST: (*I sit quietly with Sallie crying for a few moments.*) I understand it is a difficult situation to be working so hard in therapy and then to hear that I'm leaving. During our time together, we have worked closely on many important issues, but my upcoming move doesn't attend to your needs. The timing of my move isn't optimal for your treatment.

SALLIE: So, now what?

THERAPIST: Could you share with me the words behind the tears?

SALLIE: I don't know. Nothing and everything, I guess.

THERAPIST: It makes sense that the news I'll be leaving brings up a whole host of feelings. I do want to hear about them.

SALLIE: Whatever. I just feel in shock right now.

THERAPIST: Can you tell me more? People mean different things when they mention being "in shock."

SALLIE: I don't want to think about it anymore. I think I'll go to the gym and work out.

THERAPIST: Separations, especially when they are a surprise, can feel shocking. We will have many meetings to talk about this; it isn't unusual to have numerous feelings in response to unexpected news.

Examples 18.2A and 18.2B illustrate two common reactions in response to an unexpected termination date: an emotional withdrawal or an intense expression of feeling. In the withdrawal example (18.2A), I tolerate my own distress at Sallie's indifference. Eventually, I learn that Sallie's attitude is her *modus operandi* when faced with a sad good-bye. In Example 18.2B, I avoid diminishing Sallie's intense reaction to my news and try to affirm it instead. Since some patients react self-injuriously to an impending loss of a therapist, I gently asked Sallie what it means for her to "feel in shock." Her response is reassuringly healthy and adaptive.

In both cases, I do not push Sallie to delve deeply into her feelings right after my announcement. Since I made the announcement months ahead of time, there will be plenty of time to discuss her reaction in more detail during future sessions.

SOME POSSIBLE PATIENT RESPONSES TO A TERMINATION

Once I set the date of the last session with a patient, I can anticipate a variety of responses during the process of saying good-bye. Some patients may start flooding each remaining session with a barrage of new material, pushing themselves to discuss previously avoided problems in view of the new time limitation. Others may have more trouble with the impending separation. Patients who were always on time may start coming late to sessions or missing them altogether. Others may become more openly hostile as the date of the last session approaches. For them, it might be easier to leave in an angry state, rather than to work through the sadness of our good-bye.

Patients with a fragile adaptive capacity and a limited support system outside of therapy may be at increased risk for regressed behavior or even a decompensation. A previously stable patient may stop taking their medications and become morose, depressed, and even suicidal. If the termination has been announced months in advance, there may be ample time to work through the crises before our final meeting.

Whatever the instigating stressor, preserving the patient's safety is always the first priority at any stage of treatment. As the termination date approaches, I may refer patients who need increased emotional support to self-help or therapeutic groups, or adjust medications as needed. Appropriate religious or social organizations may also offer community support during a difficult time. If the patient's safety is at risk, a day program or an emergency hospitalization during the termination period may become necessary. (For more details on how to help a suicidal patient, see Chapter 9.)

I may also handpick the new therapist who will take my place for patients who need to continue treatment without a break. Overlapping my last sessions with the first few consultation sessions with the new therapist may be immensely comforting to a patient who relies on therapy to support everyday functioning.

In Example 18.3, Candice Jones has trouble coping with our upcoming termination.

EXAMPLE 18.3

The patient decompensates after the therapist announces the date that treatment will end

CANDICE: Dr. Bender, since you told me that you were going to leave, I have been feeling very odd. I haven't slept well at all the past couple of weeks. (*Starts to cry.*) Now and then, I feel as bad as I did when we first met!

THERAPIST: Anticipating our good-bye has been really tough.

CANDICE: Sometimes, I don't even know if it is worth continuing the struggle. I know I will feel so lost without our sessions. I don't know what will happen to me. (*Grabs for many tissues.*)

THERAPIST: Have you been thinking of giving up or hurting yourself in any way?

CANDICE: Now and then. Yes, to tell you the truth, I have. I feel so lost. I'm not sure where to turn.

I complete a thorough evaluation of suicidal risk as outlined in Chapter 9. Candice's actual risk of hurting herself is low.

THERAPIST: Feeling lost after you had been feeling better is very distressing. Let's create a plan together to help you weather this difficult time safely. [*I take a supportive, problem-solving, cognitive stance because Candice is already overwhelmed by her feelings.*]

CANDICE: I need *you,* Dr. Bender, not a babysitting plan. Therapy helps me manage.

THERAPIST: It is not easy to lose a therapist. I know it doesn't take the pain away, but I do want you to know that I have a great deal of trust in Dr. Williams. I feel confident that she will be able to help you during this transition time. [*Dr. Williams is the new therapist I have found for Candice.*]

CANDICE: That helps a little bit, but you know that it is incredibly stressful to start working with someone new. (*Sniffs.*)

THERAPIST: It is stressful. I think that is absolutely true. You didn't ask for this situation, and it affects you deeply.

CANDICE: Yes, and I still feel overwhelmed.

THERAPIST: It is hard to digest that I will be leaving and that you will have to start anew.

Right now, it may be difficult to recognize the progress you have made since we started working together. Over the months to come, you and I will develop a plan to provide you with extra support during this tough transition.

In Example 18.3, Candice has trouble coping with her conflicting feelings of dismay, yearning, and anger about our parting. She regresses, losing

the ability to calm herself and falls back on old faulty coping mechanisms. To shore up Candice's more mature adaptations, I employ a cognitive approach. She will also do better during this stressful time with additional therapeutic supports that attempt to minimize regression and to maximize adaptive psychological functioning.

THE PATIENT SETS THE TERMINATION DATE

When I was a trainee, I imagined a successful psychotherapy as a clearly defined process. Patients would start, continue with me as long as necessary, and then finally terminate, never needing to return. Historically, terminations were viewed as permanent endings. Once patients had finished psychoanalysis, for instance, it was not considered therapeutic, by some analysts, for them to return to treatment even if they ran into future emotional difficulties. With experience, I have found this construct rigid and unrealistic. The mature termination of a completed psychotherapy, which includes a protected period to process and review the psychotherapeutic process, may, in fact, be the outlier. A successful psychotherapy may evolve in a number of different ways.

There is a subset of patients who prefer to invest in ongoing psychotherapy in a sustained way because it provides emotional support that isn't available elsewhere. A treatment may continue for several years, even decades, for a number of reasons. For some patients who are isolated, who lack a supportive infrastructure in their life, who are battling chronic psychiatric conditions (such as severe anxiety, mood, trauma, substance abuse, or psychotic disorders) or chronic debilitating medical conditions, psychotherapy may provide a long-term emotional buttress. For these patients, graduating from treatment is not the goal. Just as a patient with chronic orthopedic injuries may have a long-term relationship with a physical therapist, a patient with chronic emotional struggles may greatly benefit from the ongoing presence of a thoughtful psychotherapist.

There is a larger group of people who never truly terminate because they prefer to drop in for intermittent therapy sessions ("tune-ups," as some have called them) depending on their need. When these folks start to feel better, they often taper their session frequency (for instance, from once a week to once a month or less). Sometimes, patients will plan a longer break away from treatment without scheduling a future session, and my door remains open if or when they want to return. If a patient reappears and wants to resume our work at a weekly frequency, I can't guarantee that a weekly spot will be immediately available, but I will do the best I can to accommodate their clinical needs. With some notice, I can usually fit intermittent as-needed sessions into my schedule. Patients interested in decreasing the frequency of therapy or breaking from therapy

for a number of months still benefit from a review of the treatment that has just concluded.

In other instances, the patient leaves the psychotherapy before it has reached its natural conclusion. As already discussed, in a clinic setting with a trainee, some patients exit therapy prematurely in order to end treatment at the time of their therapist's graduation, rather than having to start from scratch with a new clinician. A patient may also stop therapy prematurely because of a geographical move, scheduling difficulties, or a lack of motivation to continue after a crisis has been averted. Even if the patient is the instigator of the premature termination, a thoughtful review of the therapy in the time remaining is very useful, following the approach outlined in this chapter. Interestingly, similar psychodynamic issues emerge whether the therapist or the patient initiates the termination.

Ideally, the patient will leave treatment with the construct that psychotherapy is a useful meaningful venture, allowing for the possibility of future treatment if the need arises. Treatment can be completed in chapters with new clinicians in different regions, spurred on by a developmental challenge—such as a career move, raising children, children leaving home, or an illness or death in the family.

SALLIE GANE'S TERMINATION

In order to discuss termination issues in Sallie Gane's therapy, I fast-forward her treatment past our transference discussions that began in Chapter 17. To resolve her emotional conflicts about her career and family, many more sessions would need to follow, focusing on Sallie's difficulties with her female peers and with her mother. During this process, I could continue to use information gleaned from the transference to increase our understanding of these issues.

This process would be slow. Psychodynamic psychotherapy is not a microwavable process; it percolates along more like a crockpot. In order for Sallie to sustain long-term psychological change, her core emotional issues would need to be examined jointly multiple times from many different perspectives. (In the psychodynamic literature, this process is known as *working through*.)

Both the experience of feeling validated and the increased understanding of her conflicts and motivations will be therapeutic for Sallie. As the therapy evolves, Sallie and I may wonder whether her controlling behavior toward Charlie was an identification with her mother. We may discuss how Sallie views some relationships through a lens of control, assuming that one person within the duo has much more power than the other. In the relationship with Gwen, Sallie ceded control to Gwen and then felt uncomfortable asserting herself. As her awareness progresses, Sallie may make a conscious

choice to behave differently in future relationships. Slowly, she may foster friendships with people like Uzma, who, unlike Gwen, treats Sallie as an equal while appreciating Sallie's strengths and individuality.

Eventually, Sallie might gather the courage to plot her own career course and to discuss this plan with her mother. Let's say she decides to pursue journalism as a profession after all and finds the courage to apply to graduate school in her chosen field. As noted, the psychological change wouldn't happen quickly. The move to follow her own academic dreams would evolve from many hours of therapy, using many of the techniques outlined in the previous chapters.

Eventually, the time to say good-bye would approach. Our termination would become another therapeutic opportunity. As Sallie and I review our work together, we'll discuss aspects of the therapy that have been helpful as well as those that have been disappointing. Again, even in its ending, therapy can model a relationship that is resilient enough to weather constructive criticisms as well as compliments.

In Example 18.4, Sallie announces her upcoming move to New York to pursue graduate school in her chosen profession. This vignette also illustrates another typical termination pattern—when a patient copes with an upcoming termination by ignoring it. Even though it may feel easier to collude with this process, it is my responsibility to intermittently refocus the treatment on our impending separation.

EXAMPLE 18.4

The patient announces her forthcoming move and then tries to ignore the upcoming ending of treatment

SALLIE: [*in April*] Dr. Bender, I have amazing news!

THERAPIST: Let's hear it!

SALLIE: Well, you know how we have talked *ad nauseum* about the fact I am more interested in journalism than business? And, you know how we talked about how my mother was surprised to learn this but was not anywhere near as upset as I had imagined?

THERAPIST: Yes. (*Nods encouragingly.*)

SALLIE: Well, I didn't tell you this because it felt sort of scary, but after one of our sessions, I filled out an application to a New York City graduate school program in journalism. The only people who knew about it were the teachers I needed to ask for letters of recommendation. It felt like it was such a gamble. I didn't want to let people know because I didn't think my chances of getting in were very good. I hope you aren't upset that I didn't tell you before now.

Umm, well, guess what? I'm in! I can't believe it. I just received my acceptance letter this morning. After I graduate this spring, I'll need to

move to New York City to get settled. That is, if I am brave enough to go through with this. I can't believe it.

THERAPIST: (*supportive tone and smiling*) I am not upset that you didn't tell me. I can understand why you wanted to pursue this process privately during the application process, but I am so glad to hear the update now. This is very exciting news. Congratulations!

SALLIE: It just sounds so amazing. But, I keep pinching myself. I can't believe this is happening to me!

As the weeks progress, Sallie relates her plans to move to New York but does not mention anything about our impending termination. She almost acts as if I will be moving away with her.

SALLIE: So, I am leaving Boston July 15th to find an apartment in New York, and I'm starting at my new school on the first of September. I have so much to do. I need to find housing. I need to find roommates. (*Eyes widen.*) It still doesn't feel real.

THERAPIST: There is a lot to do to get ready for the move, including a review of our work together and saying good-bye.

SALLIE: Well, if my New York lease doesn't start until September, I'll probably be in Boston for most of the summer. We will actually have a few more months to meet.

THERAPIST: After you do settle in New York, what do you imagine it will feel like without our meetings?

SALLIE: Oh, I am just trying to ignore it.

THERAPIST: I imagine you have an exciting adventure waiting for you, so it may be easier to ignore any endings that occur here in Boston, but is there a way that I can help you to notice it?

SALLIE: What do you mean?

THERAPIST: Well, it is an important part of the psychotherapy process to take the time to say good-bye while reviewing the work we have done together.

SALLIE: Why?

THERAPIST: Reviewing the treatment underscores all the gains you have made. Also, learning how to say good-bye in a meaningful way is a skill in itself.

SALLIE: Well, if I don't say good-bye, it doesn't feel as complete or as sad. It's more like a "see-you-later."

THERAPIST: "See-you-laters" are easier than complete good-byes?

SALLIE: Yes, I'll really miss you, and I just don't want to think about it.

THERAPIST: Can you tell me what is hard about thinking about it?

SALLIE: I feel so excited to be doing something just for me. This is what we have talked about for months. You know, following my dream, not my mother's. But, it is also scary to be ending therapy. You've been a really important person in my life. I don't like to think about giving you up. It makes me nervous.

THERAPIST: It is very normal to have lots of feelings during a big transition, from excitement to fear to nervousness. It makes sense that you have feelings about ending therapy because we have worked so closely together on such important issues. It has been a privilege for me to be your therapist during your college years.

Over these next weeks, we can take time to understand all the feelings that emerge around this transition, including any and all feelings about ending the treatment with me. Maybe if we talk about it together, you may feel a little less nervous.

SALLIE: I doubt it. I'd rather just ignore it for now. It feels weird to say goodbye to you forever. What if I get to New York and freak out? I just get scared thinking about it.

THERAPIST: What do you imagine happening?

SALLIE: I don't know. I'm just used to having you around, and it will be weird not to have our weekly session to depend on.

THERAPIST: I'm so glad that therapy has been a dependable support to you; it makes sense that it may feel weird without our weekly meetings (mirroring Sallie's word choice). If you are visiting Boston and would like to drop in for a session, we can definitely set up a time, but that isn't the same as meeting regularly. I'm glad we will have these next weeks to process this transition.

SALLIE: Thanks; while it is good to know that I can always visit, it will feel strange not to have you live in the same city as me.

THERAPIST: Would it help support the move to find you a New York psychotherapist now, so you have someone available as you get settled? How would that feel to you?

SALLIE: I don't know. Even though I'm nervous, I'm not sure that I want to continue therapy after my move. I know I just said I will miss meeting weekly, but I think I want to try life in New York on my own without a therapist. I'm not sure I'm ready to start over with someone new.

THERAPIST: There's a lot to think about and to process. I'm glad we have time to talk it through before you leave.

If Sallie tries to ignore our impending separation, it is my responsibility to remind her gently, fairly often, of how many sessions we have left. If

the ending of therapy is dealt with in an honest, direct, and genuine manner, Sallie might be able to use this experience to strengthen her ability to cope with other separations throughout her life. Complicated grief reactions may be partially due to unresolved partings, so an increased ability to process good-byes may even prevent future psychological distress.

Of note: it can feel tempting to offer transitional telehealth sessions with a patient who is about to move out of state. I don't offer this option to Sallie because I don't have a license to practice psychotherapy in New York. That said, if Sallie calls me from New York in crisis, I would accept her call rather than just provide a referral list of local treatment options. If she requires an urgent telehealth crisis intervention, my focus would be acute stabilization while finding her a local therapist as quickly as possible. To facilitate the transfer, I will ask colleagues or local professional networks for referrals to reputable clinicians or clinics in Sallie's area; a warm handoff offers additional emotional support during the transition to a new provider.

WHAT ABOUT TELEPSYCHOTHERAPY?[1]

What if Sallie requests to continue long-term treatment with me via video sessions after she moves to New York? In the years since Dr. Messner and I wrote the first edition, telehealth has become an increasingly accepted alternative to in-person care. Before the 2020 COVID pandemic, many clinics and hospitals were already starting to set up their own HIPAA-compliant system for telehealth, and many private clinicians had incorporated video sessions into their practice. This process was accelerated during the stay-at-home order of the COVID-19 outbreak as psychotherapy practices throughout the United States shifted to 100% video or phone sessions.

An MGH pilot study performed before the COVID-10 pandemic (Donelan et al., 2019) assessed the efficacy of Virtual Video Visits (VVV) in different departments (including psychiatry); it found that 32.5% of patients and 45.9% of clinicians reported that the "office visit is better" (in reference to all types of clinic visits, not just telepsychotherapy). While more than half the patients (59.1%) and clinicians (50.8%) said there was no difference, 40.9% of patients and 49.2% of clinicians experienced a difference between in-person and virtual visits. The data reflect the complexity of the issue.

Over the years, many patients have requested to continue weekly long-term psychotherapy with me via telephone or a HIPAA-approved secure video after moving out of town, rather than terminate or transfer care to

[1]This section benefits from the wisdom and input of Drs. Deborah Kadish and Janet Wozniak.

another clinician. One's first reaction may be to ask, "Why not?" Free secure telehealth services are available, and for a monthly fee, a provider can purchase access to a secure platform with 24/7 administrative and technical support. Psychotherapy via video is increasingly covered by insurance and considered a viable treatment option. During the COVID-19 outbreak (see the sidebar for more details on video therapy during the pandemic), some telehealth regulations and restrictions were relaxed to support easy access to care, even across state lines.

Prior to the COVID pandemic, administrative hurdles for interstate treatment were formidable. (Postpandemic regulations for interstate virtual treatment can be expected to evolve and change over time.) Historically, treatment across state lines (e.g., if I continue as Sallie's therapist when she moves from Massachusetts to New York) has been legally complicated. Virtual visits need to meet HIPAA requirements and be in compliance with Massachusetts and New York state telehealth regulations as well as relevant state laws pertaining to out-of-state treatment. To be Sallie's clinician of record, I must be licensed by the State of New York if Sallie is living in New York. If Sallie's journalism program includes some travel, I should be licensed in every state in which she schedules a virtual visit. During any video session, I should also know Sallie's immediate address/location; this could be important for any unexpected crisis (such as acute suicidality) that may require local emergency assistance.

Until telehealth requirements and regulations across all state lines become more streamlined, the nuances of nationwide remote virtual care are myriad and deserve careful review, and are beyond the scope of this book. I also recognize that our understanding of the strengths and limits of telepsychotherapy is evolving. If a clinician decides to provide long-term interstate remote therapy, I recommend consulting one's malpractice insurance with an attorney well versed in the latest telehealth regulations. Local clinical societies can also provide up-to-date guidance regarding the standards and rules for one's specific specialty.

My caution about long-term long-distance virtual care (in nonpandemic conditions) evolved from personal experience. Fifteen-year-old Abigail was referred to me for psychotherapy when her mother's cancer diagnosis caused significant emotional distress and high anxiety. She found weekly psychotherapy throughout the rest of her high school years to be helpful. As she left for college in western Massachusetts, about 2 hours away by car, she asked to transfer our work to weekly telepsychotherapy sessions as she didn't want to start treatment with someone new. She had been stable for several years and was remaining in state. I agreed.

The transition to college seemed to be going well until Abigail unexpectedly refused to get out of bed during finals because of overwhelming panic. She had significant difficulty explaining her abrupt clinical descent via video session from bed. I didn't feel I could accurately assess the crisis

remotely, but she was unable and unwilling to make the 2-hour journey back to Boston to see me in my office. As she became more frightened and extremely anxious, her thinking grew more disorganized; she felt unable to find a spot on her college campus where she could talk to me freely, without interruption, and feel secure in the privacy of the interaction. My efficacy as Abigail's therapist was significantly diluted when she was unable to see me in person during the crisis.

Thankfully, this story has a happy ending. I reached out to my community contacts and matched Abigail with an outstanding local clinician, Dr. Chen, whose office was within walking distance of Abigail's college. (Another option would have been to send Abigail to her college's student health services.) Abigail provided permission for me to contact her family and her dorm resident advisor during this crisis. (In an urgent clinical situation, I have the legal right to reach out to Abigail's emergency contacts without her consent if I am concerned about her safety. That said, it is always preferable, if at all possible, to obtain a patient's permission to talk to others and to work together to develop a treatment plan.) Abigail's resident advisor helped her to set up a first appointment with Dr. Chen and, when asked, walked with her to the first intake meeting.

Meeting a new therapist while in the midst of a crisis isn't ideal, but thankfully, Abigail and Dr. Chen clicked and they set up a weekly meeting time. Weekly scheduled in-person meetings provided the confidential space Abigail needed to discuss her concerns; this was the treatment structure she needed to start her recovery. As a long-term resident of Abigail's college community, Dr. Chen also knew of numerous university resources that could provide Abigail with extra emotional and academic support. With intensive local treatment, the crisis was assessed and addressed, and Dr. Chen became Abigail's local point person for all future psychotherapeutic needs during the school year.

Some therapists might argue that Abigail's difficulty with long-distance telehealth should not be viewed as typical. From their perspective, long-term long-distance virtual care (when a pandemic is not limiting in-person care) may be a safe option if reserved for the appropriate patients. They might say that Abigail, as a freshman in college managing a developmental milestone, was not an ideal candidate for long-term long-distance video therapy. Yet, it isn't unusual for any telepsychotherapy patient to be weathering a geographic move, or a change in job or responsibility; this may be the specific reason the patient requests the transition to 100% telehealth in the first place.

Some therapists only offer long-distance virtual care to their most stable patients, but I view a patient's clinical state as fluid, not static. Case in point here: when Abigail left for college, she had been emotionally stable for a prolonged period of time. I cannot foresee how patients will feel in the future or what unexpected difficulties they may face. Life is unpredictable.

Even if a patient is not facing a major obstacle at the start of a video treatment, a new job, relationship, or medical difficulty may be right around the corner.

After my experience with Abigail, consultation with peers, and careful consideration of this topic (and with the assumption that in-person care options are not limited), I have decided that I don't feel comfortable providing long-term video therapy if a patient moves far away and they are unable or unwilling to follow-up with me in person, as frequently as needed, in the event of a crisis. Patients who are not improving still deserve the treatment gold standard, that is, an in-person assessment. An in-person visit guarantees confidentiality and allows for a full mental status exam, with the therapist able to observe all nonverbal input (not just from the neck up). In addition, for a small group of patients, specifically those with psychotic or delusional disorders and a tenuous grasp on reality, remote treatment may be contraindicated.

It is fair to wonder whether Abigail's crisis might have been averted if I had transferred her treatment to a local clinician at the beginning of her freshman year. Using long-distance video therapy until an emergency occurs contains its own set of risks. Abigail's story has a happy ending, but it contains a number of lucky breaks. What if it had taken some time to find a local capable clinician who was also available? Finding a new therapist for a patient while they are stable is much easier than finding a new therapist when they are in crisis.

Now, let's get back to Sallie's potential request to continue therapy with me after her move to New York. Let's imagine, for the purposes of discussion, that licensing is not an issue. There are some specific risks for Sallie with long-term long-distance video therapy. As Sallie adapts to her new life in New York City, what if she starts to misuse laxatives as she did during high school, but she doesn't share this information with me during our weekly telepsychotherapy sessions? In person, I have a greater chance of picking up subtle nonverbal cues that she is not doing well; in person, any weight loss is much easier to detect. If I am only able to see her head during our video session, it would be easy to miss this important information and to provide suboptimal treatment. In addition, Sallie is not a good candidate for ongoing remote treatment because she cannot see me in person, as often as needed, in the event of a crisis that doesn't resolve with teletherapy, The long drive between New York City and Boston makes this next to impossible.

New York City is an area with a vibrant psychotherapy community; if Sallie would like to continue psychotherapy after her move to New York, I believe it is in her long-term best interest to transfer her treatment to a new local clinician. Ideally, Sallie and I would work to find her a New York–based provider before her move. If she is not interested in pursuing

further treatment at this point, I will recommend, during our last sessions in Boston, that she locate an urgent care site near her new home in case of any health-related emergencies.

In contrast, there are certain specific instances where local telehealth might be a preferable treatment option for patients in need. For patients who are medically ill and physically restricted, have significant difficulty making it to the office on a regular basis because of inflexible work hours or limited transportation or child care, or for in-state patients who live in remote areas far away from any in-person clinic options, video psychotherapy may provide otherwise inaccessible care. Intermittent remote virtual visits are also useful for all patients facing extenuating circumstances, such as family illness, inclement weather, or child care issues. As noted previously, I ask patients who prefer virtual care to agree to in-person consultations if they aren't doing well clinically and telehealth interventions have been insufficient.

It seems likely that the future of psychotherapy will be a hybrid toggling between in-person and remote meetings. I recognize that my understanding of the safety and effectiveness of telehealth will continue to evolve. For now, I see that the power of seeing a patient in person is unparalleled, but the accessibility of virtual therapy is a positive game changer. As a provider, I continue to weigh the pros and cons of all therapeutic options, with an aim to balance treatment accessibility with a high standard of care.

Additional Thoughts about Telepsychotherapy during a Pandemic

Before the global COVID-19 pandemic, I was a hesitant adopter of video psychotherapy. I supported the option of videoconference, Internet, or telephone therapy as a viable treatment option for patients with limited mobility or in remote areas that lacked adequate treatment options, but my personal experience with the new platform was limited. Then the world turned upside down in early 2020 with global stay-at-home orders to stem the spread of COVID-19 infection. On March 12, 2020, I saw patients in my office in person. On March 13, 2020, I moved my entire MGH and private practice to a secure telehealth platform.

With social distancing in place to curb the spread of the virus, I felt unbelievably grateful that telepsychotherapy enabled me to treat my patients, and to provide consultations to new patients without endangering their health or my own. Over the first 6 weeks of the Massachusetts social distancing/stay-at-home advisory, telehealth licensing restrictions across state lines were lifted throughout New England, and I logged over 100 hours of video visits. Catapulted from a novice perspective to that of an experienced user, my

view on telehealth has broadened and deepened. In a pinch, it is a godsend and more than adequate, but I still believe the in-person visit provides some unique features that the virtual visit cannot replicate.

Moving completely virtual was a jarring experience. My first week was spent learning how to navigate the platform, while also teaching every patient how to contact me via this new medium. Most of my patients, even those who are struggling financially, were able to download my secure telehealth connection for a HIPAA-approved video visit on their computer or phone. For those patients with technological limitations, inadequate Wi-Fi, or lack of privacy in areas with adequate Wi-Fi, treatment proceeded with phone sessions.

There were many positives to teletherapy. Whether by phone or video, continuing treatment without pause felt critically important in a time when so many normal life activities were curtailed. While I started the quarantine indifferent to whether the patient chose video or phone for the session, I began to prefer video visits (if this option was available), as I increased my familiarity with the modality. The welcoming hello smile between my patient and myself used to take place in my waiting room; now it occurred as our video feeds connected. In a time defined by social distancing, talking to someone face-to-face was a better approximation of an inperson visit than a phone call. While it is easy to inadvertently interrupt a patient during a phone call, with a video call I can see when the patient has finished talking before adding my input. While my ability to read nonverbal signals via video screen was not optimal, I could still watch the patient's face closely for small changes in expression. With experience, I improved at reading nonverbal communications on my screen. With the right lighting and the patient close enough to the camera, I could see the minute facial changes that herald a wave of emotion or preceded tears.

My no-show rate was next to zero. Late arrivals due to bad traffic disappeared. Even while balancing the difficulties of working at home, most patients were able to make time for treatment. Single parents who might struggle to come into the office for in-person sessions as they balanced financial responsibilities and child care benefited from the increased flexibility of virtual sessions. Treatment became more accessible rather than less; patients might have our session in the car, or in the bedroom while their child watched TV in the living room. The setup wasn't ideal, of course, but for families with less financial resources or minimal flexibility, mental health treatment was within reach and more available than ever before. After months of telehealth experience, it was clear to me that virtual visits expand treatment access, both in normal times and during a pandemic.

I learned some new information about my patients during our remote sessions. I met many pets. Teens and young adults took me on tours of their rooms. Over time, I gained a sense of how tightly the family was packed into the home and whether high density was an additional stress during the stay-at-home order. When I asked medication questions, patients could retrieve

the bottles and confirm exactly what they were taking. One patient recently out of the hospital after a suicide attempt, decided, on a whim, to show me a stash of pills she had hidden in her room as an "exit strategy" in case she decided to impulsively overdose in the future. I'm not sure I would have learned this information if we had been meeting in my office. Following a lengthy discussion of the feelings behind her life-threatening secret pill supply, a crisis intervention was created to increase her future safety and to decrease her immediate access to such a tempting danger.

Telehealth also provided its own unique frustrations. With phone or video psychotherapy, it may be difficult for the patient to find a truly secure space with minimal distractions where they may speak comfortably on any topic without being bothered or overheard. I started each session asking if the patient was in a private space and able to talk freely. I worried about the increasing prevalence of domestic violence during the pandemic, and if my patients would be able to tell me if they were unsafe at home. They did share that some complex emotionally loaded topics were off limits for a virtual visit. One patient noted that she would like to speak to me about some sexual concerns, but she would wait until we could meet again in person. Another noted that he could not share the details of his partner's increasing alcohol use over video while working at home; he felt concerned his partner might quietly listen in without his knowledge. While the videoconference HIPAA-approved chat function enables confidential written messages back and forth, it works best for short bursts of communication; it doesn't lend itself to a more complex open discussion.

While I disabled any incoming message alerts on my screen, I regularly noticed my patients being sidetracked by incoming emails or texts on the device they used for the session. Dropped connections, freeze frames, and time delays also affected the flow and content of a psychotherapy video session. Technological glitches are not only frustrating at baseline; they may be therapeutically detrimental if they occur while a patient is grappling with a sensitive issue that is difficult to discuss.

The nonverbal communications during a video session are diluted when compared to an in-person visit. On video, I can't clearly lean forward to express increased interest. If I make any sounds that reflect I am listening, it will cut into the video feed of the talking patient. Instead, I nod more often and use hand signals to express support—gesturing with a thumbs-up or a fist raised in the air as a celebratory motion.

Sometimes, a poor video transmission affects my ability to connect with the patient. If the patient's video picture is grainy or the lighting isn't optimal, I might ask them to move to another area of the room so I can see their face more clearly, but I also do not want to waste valuable psychotherapy minutes on the video setup. Ideally, I prefer a focus on the patient's face; the alternative, a view from the chest up (similar to a museum bust), may leave me too far away to see small but inordinately valuable emotional communications. With more distance, I may miss the quick side-eye expressing a lack

of comfort or the tiny facial changes that occur when a patient is fighting back tears.

I realize that only seeing the upper half of a patient's body deprives me of some important information. With the camera focused on the patient's face and shoulders, I miss a fair amount of nonverbal communications: the jiggling leg, the tapping hand, and the hand gestures to make one's point. Finally, for some of my new evaluations (patients I have only met via virtual visits), I feel uncertain if I would recognize these individuals if we walked past each other on the street. After meeting a patient from just the neck up, I often don't have a good sense of my new patient's height, weight, or how they walk or hold their body. In talking to close colleagues adapting to the same virtual world, I found they shared this new disconcerting unease.

After months working exclusively as a telehealth provider, I now feel comfortable using the medium, and my perspective on video visits is more nuanced. For some patients, remote psychotherapy is a game changer in a fully positive sense; telehealth allows patients with complex scheduling limitations to access therapy more fully, or for the first time. For others, remote therapy still has therapeutic power, but the platform may be experienced as a loss, similar to remote education and remote FaceTime with family. In all cases, virtual visits allowed the continuation of treatment during a time of great anxiety, stress, and uncertainty, without jeopardizing the patients' or providers' health and safety.

While face-to-face conversations in a quiet private undistracted space remain the gold standard, telehealth therapy is here to stay. Hybrid therapy, mixing in-person and virtual visits, supports continuity of care despite scheduling or transportation difficulties. For a specific subset of patients facing significant obstacles to treatment access, virtual treatment may become the preferred treatment modality. Over time, with more experience, our understanding of the pros and cons, safety, and efficacy of telehealth will continue to evolve.

THE PATIENT WHO DISAPPEARS AS TERMINATION APPROACHES

Now and then, patients might feel so threatened by the upcoming loss of treatment that they may stop attending sessions weeks before the termination date. Because it can be so easy to under- or overreact when a patient disappears, it is useful to have a protocol in place for this type of situation. (See Chapter 10 for more details.)

If Sallie unexpectedly no-showed for a session as her termination date approached, I would either call her during the missed session time or at a later time when I expected her to be at home. If I am unable to talk to her directly, I might leave the following message, worded carefully to preserve confidentiality: "Hello, this is Suzanne Bender calling for Sallie Gane. I was

concerned when I did not see you at your scheduled appointment today. Please call me to confirm our appointment for next week at our regular time." I might also send a similar message by email.

This message encourages Sallie to stay in touch with me regardless of whether she plans to return for her next appointment. Sometimes after one missed session, a patient will return to their regularly scheduled session without difficulty. We'll then have ample time to discuss the upcoming termination. Other times, the first missed session might be a harbinger of repeated absences with numerous excuses, a reaction to our future separation.

In response to Sallie's hypothetical disappearance, I would follow my billing protocol for last-minute cancellations or missed sessions. (See Chapters 8 and 10 for more details.) If she doesn't respond to my messages and disappears from treatment for a number of weeks, I might also consider writing a letter (or email) inviting her back to officially conclude treatment before her move (see Figure 18.1).

If Sallie returns to treatment after she receives my note, I will address any prior repeated absences midway through our reunion meeting. As Sallie's disappearance obviously endangers the possibility of a thoughtful termination, it deserves immediate attention.

[Professional letterhead]

Date

Sallie Gane's address

Dear Ms. Sallie Gane:

I am sorry that I have not received a response from you since our last phone call on July 8th. Since I have not heard from you, I do not know how you are doing, but I hope you are doing well.

I am still available to meet with you to conclude our work together before you leave. I hope that we shall have this opportunity. If I do not see you before you leave, I want you to know that I wish you the best. If you desire to schedule a meeting any time in the future, please feel free to call me.

Sincerely,

Suzanne Bender MD

My office phone numbers

FIGURE 18.1. Letter inviting the patient to return to treatment.

It's possible that Sallie may deny that her repeated missed sessions have any emotional meaning. If so, there isn't much I can do but follow her lead. Termination is like every other part of therapy. The treatment proceeds at the patient's pace. Topics can be introduced, but forcing the discussion will rarely produce any useful results.

THE PATIENT EXPRESSES APPRECIATION DURING THE TERMINATION

Interestingly enough, sometimes a patient may be better at expressing their gratitude at the end of treatment than a therapist might be at accepting it. I was caught off guard the first time a patient sincerely expressed how much I had helped them and how much they would miss me. I had to learn how to acknowledge a patient's compliments just as I had to learn how to listen to complaints.

While it isn't useful for me to lead with my own feelings about a termination, I have an opportunity to share my own feelings when Sallie expresses her appreciation.

EXAMPLE 18.5

The patient expresses her gratitude toward her therapist, and the therapist responds

SALLIE: So, today is our last session.

THERAPIST: Yes.

SALLIE: I'll really miss you.

THERAPIST: I will miss you, too.

SALLIE: (*Smiles.*) That is so nice to hear. I know you aren't supposed to feel connected to your patients or anything. Rules of the trade, I guess.

THERAPIST: The rules of therapy don't allow me to feel connected to you?

SALLIE: Sort of. You have so many patients. I can't imagine that I mean something special.

THERAPIST: Why not?

SALLIE: I don't know. I don't want to set myself up for disappointment. Anyway, I have learned so much in here. It has been a good experience.

THERAPIST: I have learned as well. I have admired your hard work regarding your relationship with your mother and how you have built a new support system at school. It has felt meaningful to me to be a part of this process. While therapy does lay out some unique rules to protect the power of the treatment, the connection between the therapist and patient is definitely real.

SALLIE: Really?

THERAPIST: Really.

SALLIE: That is so nice. The therapy has really helped me. There were times I was sure my life would never improve, but in fact, it so much different now, and so much better.

THERAPIST: You have worked very hard. It has been gratifying for me to be a part of this process.

SALLIE: Wow. It really means so much to hear you say that.

THERAPIST: It comes as a surprise?

SALLIE: I just never imagined that I was affecting you as well.

THERAPIST: Any idea why not?

SALLIE: I never felt that important.

THERAPIST: How do you feel to hear that you are?

SALLIE: Scared, but really happy also.

THERAPIST: Scared?

SALLIE: I don't want to do anything wrong to disappoint you. I'm not perfect, you know.

THERAPIST: Do you feel that I'll be disappointed if you are not perfect?

SALLIE: A little bit. I don't want to mess it up. I don't know. I still feel this way sometimes with friends, too. You know, same old thing.

THERAPIST: You have an increased awareness and understanding about it, but it still might feel like a lot of pressure for you to endure.

SALLIE: Yeah, I guess that's true.

THERAPIST: (*Nods.*)

SALLIE: I'm sorry that I can't just savor our last meeting, and we have to talk about this uncomfortable stuff.

THERAPIST: I don't think there is any need for an apology. Does it feel to you that you've used up your time to talk about uncomfortable stuff? (*empathic look*)

SALLIE: Maybe. (*Smiles.*)

THERAPIST: It can be difficult to say good-bye when there are issues that remain that you would have liked to work on. [*I had mentioned in previous meetings that Sallie could always seek further therapy in New York if she thinks it might be useful. During our last session, I keep the focus on Sallie and me rather than punting the issue to a future therapist.*]

SALLIE: Right. I also wish we had talked more about how to find better friends in the future. I don't want to make the same mistakes in New

York; the last thing I need is to become close friends with the New York equivalent of Gwen.

THERAPIST: It makes sense that there is some unfinished business, and it is normal that this is frustrating. While you have learned so much about why you chose Gwen in the first place and what helped you seek out Uzma more recently, I agree that there is more to learn. It is not easy to end a conversation when it doesn't feel completed.

SALLIE: Yeah, I'll really miss how you make things feel okay instead of overwhelming.

THERAPIST: We have done good work together, and it makes sense that it feels hard to stop.

SALLIE: If I ever move back or visit Boston, can I give you a call or set up a special session?

THERAPIST: Of course. I would be glad to know how you are doing.

SALLIE: Okay. That makes me feel better. I guess it is time to stop now.

THERAPIST: It is.

SALLIE: (*Stands up.*) Thanks for everything.

THERAPIST: You are very welcome. I wish you all the best.

In Example 18.5, Sallie and I express our mutual appreciation for one another. The parting is bittersweet, as many are. While Sallie recognizes how much she has grown during the therapy, she can also identify some remaining issues that might require future attention. She may also be bringing up these difficulties in the final session as a way of reconnecting with me before she leaves. With this possibility in mind and because Sallie has been clear that she does not want to transfer care to a new provider, I do not jump to refer Sallie to a therapist in New York City for work on these remaining issues. Instead, I keep the focus on our separation.

While it is important to view a therapy's termination as a completion of a piece of work, I don't close the door on future contact. While therapists who are ending practice, moving, or finishing training are notable exceptions, many clinicians explicitly invite their patients to contact them in the future if they are in town and would like to set up a follow-up meeting. It might be helpful to meet again if setbacks occur or to report progress or further success.

Sallie may leave for New York to attend journalism school but then return to Boston the following summer and request a few sessions. I welcome intermittent meetings with patients after more frequent treatment is concluded. It might be fruitful for Sallie to meet for a short time over the summer, if only to review her experience during the academic year. Because I know Sallie so well, the therapy can carry on rather nicely once she has

filled me in on the recent details. It is also possible that Sallie may move back to Boston when her education is completed. She may wish to restart therapy with me during a subsequent phase of her development. Again, leaving the door open for future work can be highly beneficial.

What if Sallie is seeing a new therapist in New York but spends the summer in Boston and calls to see me for a few sessions? Should I see Sallie even if she is in formal treatment with someone else in New York? This dilemma should be approached gingerly, trying to keep Sallie's best interests in mind. Option 1: Sallie could set up a few transitional phone or video sessions with her New York therapist over the summer if her therapist has a Massachusetts license. Option 2: If this isn't possible (e.g., if the New York therapist is not licensed in Massachusetts, is on vacation, can't provide therapy sessions during the summer, or Sallie prefers to see me during her stint in Boston), I could serve as the interim therapist working in consultation with Sallie's New York clinician. It wouldn't be right to leave Sallie without any treatment, especially if her problem is urgent.

With some planning and open communication, it is possible to share patients across state lines, especially for young adults who may split their time between college and their hometown. As I see many college students in Boston, I often coordinate care with therapists from the patient's home state if the patient is in need of ongoing year-round treatment. I see the patient while they are in school for most of the year, and then I transfer care back to the original therapist during long vacations. If the patient finds it confusing to have two therapists, I avoid this collaborative care model, but many appreciate the coordinated approach and benefit of two different perspectives.

THERAPY: A LONG-TERM INVESTMENT WITH A POSITIVE PAYOFF

In a world that moves at an increasingly fast pace with instant communication and global access at the touch of a button, psychodynamic psychotherapy is moving against the grain, promoting a gradual process that promotes long-standing emotional growth. If a trainee asks me how long a therapy will take to work, my answer is honest, although it may be frustrating to hear: it depends. It depends on the patient's motivation and how often they attend therapy. (Twice a week is more than twice as potent as once-a-week treatment, but is not always possible due to time restrictions, less interest in intensive treatment, or insurance or self-pay limitations.) It depends on the problem at hand. Generally, the problems we face in the office are long-term and complex; finding traction that promotes sustained change takes significant time and effort.

Early on, it may feel like a leap of faith to believe in such an extensive drawn-out process. From the perspective of a novice, it can be difficult to trust in the power of a treatment that takes so long to complete. While patients often start to experience some emotional relief at the start of a psychotherapy, sustained alleviation of psychic pain and understanding of complex motivations take a significant amount time. With increased clinical experience and possibly one's own successful psychotherapy, the slow trajectory of psychodynamic treatment doesn't feel as strange.

During residency, I repeatedly heard the adage that it takes about 10 years to feel truly competent as a psychotherapist, the amount of time it takes to experience several successful completed treatments. Only after observing multiple successful treatments did I truly feel comfortable with the slow pace of the psychotherapy process.

THE EFFECT OF TERMINATION ON THE THERAPIST

Therapy is an exceptional experience in many ways. While the therapist and patient work together closely, the ultimate goal is for the patient to complete the work and to end the relationship. A therapist must play successive roles: being available to the patient during therapy and being ready and willing to support the patient's leaving when the treatment is over.

Inner strength and equanimity combined with an emotionally fulfilling life can help a therapist weather the partings with patients. Knowing oneself and connecting with family and friends reduce the likelihood of the therapist clinging to patients emotionally.

Meanwhile, with each ending of therapy, I learn something new about myself. Partings with people we care about are experiences we work on throughout our lives and not always with as much forethought and autognosis as we bring to the therapeutic encounter. The more we can be in touch with the feelings that emerge in separations, the more we will mature as people and as therapists.

PART V
BEING A THERAPIST

CHAPTER 19

Professional Development

A therapist's professional development continues after training concludes. As a career evolves, expertise expands and new challenges emerge while some concerns first faced during training continue to be relevant. To obtain and maintain clinical excellence, the therapist must maintain curiosity combined with an ability to self-reflect and critique one's work.

When I started writing the first edition of *Becoming a Therapist* with Dr. Messner, I was midway through my psychiatry residency training at MGH. My life was a series of firsts: my first long-term psychotherapy patient, my first twice-a-week treatment, my first outpatient who needed hospitalization for serious psychiatric illness. While it wasn't unusual to feel overwhelmed, I also never felt bored. Nothing was routine: there was too much to learn.

Fast-forward over 20 years, and now my perspective is one of a seasoned clinician. My title is Assistant Professor in Psychiatry, Part-Time, at Harvard Medical School. I split my time between a faculty position within the MGH Child Psychiatry department and a suburban private practice focused on psychopharmacology and long-term psychotherapy with children and adults. I continue to be interested in the process of learning psychotherapy, and I teach a weekly year-long introductory psychotherapy course for the MGH Child Psychiatry fellows.

Nowadays, my reflections are more about "being a therapist" rather than becoming one. As my perspective has evolved over many years, I've developed some clinical tenets that guide my work. Paying it forward, I list them here as they would have been very helpful to me when I was starting out.

FOR TREATMENT TO WORK, THE PATIENT NEEDS TO COMMIT TO THE TREATMENT PROCESS

When I started training, I hoped to fundamentally improve the life of every patient who walked into my office. While I understood therapy as a collaboration between patient and therapist, I also believed I could successfully treat any individual if I just tried hard enough and obtained the right supervision. It was an energetic but naive mandate.

I didn't understand that for any adult psychodynamic treatment to work, two basic conditions must be met: the patient needs to come regularly, and they need to talk about what is on their mind. The individual seeking treatment needs to commit to the process.

If these two prerequisites are met, every psychotherapy has a fighting chance. While resistances and psychological roadblocks are bound to emerge, the therapist and patient will have the time and attention to untangle and to understand the patient's concerns and the complex interactions that occur during the therapeutic process.

Meeting these basic requirements for a successful psychotherapy may be more complicated than anticipated. Regular attendance may require a fundamental change in a patient's schedule. Even virtual meetings, which are fairly easy to schedule, require the patient to reserve time and a quiet and confidential space in order to delve into psychological concerns without distraction. Ideally, to spark and to cultivate internal change, the patient will attend psychotherapy at least once a week. While meeting less than every week may provide emotional support, maintain the status quo, and promote slow psychological growth, meeting every week (or more often) provides the therapeutic traction that best promotes understanding and healing.

Once the session starts, the patient is encouraged to share their concerns at a pace that feels tolerable. Talking about sensitive topics with a stranger requires courage and a leap of faith, but it is a critical first step in a successful treatment.

The therapist faces an especially complicated clinical quandary if a patient is unable or unwilling to invest in weekly treatment during a psychological crisis. Imagine "Kelly," a 35-year old woman with severe depression in remission. (As noted in the Preface, the clinical narratives based on actual patients have been altered with descriptions and identifying features revised. As a result, the patient's privacy is wholly protected, but the critical teaching points are preserved.) Kelly and I worked together during a depressive episode in her late 20s; her successful treatment ultimately consisted of both weekly psychotherapy and antidepressant medication. Now, settled in a town about 30 minutes' driving distance from my office, Kelly is married with two children under 4 years of age, and she works part-time within the family plumbing business. Her husband's mother is ailing and

living with the family. Kelly reaches out to me after feeling increasingly upset over several weeks. We set up an appointment for the following Monday. She doesn't show and doesn't cancel. I call to check in, and she says the appointment slipped her mind. As an aside, she shares it often takes an hour to reach my office if there is traffic.

She wants to reschedule, and we meet the following week. We discuss some recent difficulties with her husband and mother-in-law, and hypothesize that these conflicts may be one reason for her growing dysphoria. I recommend a series of weekly meetings to untangle the issues; we need to understand how much of her dysphoria is due to the situation with her family, while also considering whether her increasing distress might be partially fueled by an impending relapse of major depression. It is a complicated emotional dissection: irritability as a symptom of depression could be fueling some of the marital issues, or the marital issues could be the main engine for the irritability. Kelly agrees that meeting weekly is a good idea and then is a no-show at our next scheduled session. I offer a mix of virtual and in-person sessions as an option, but Kelly says she would prefer to meet in person. At home, she is often juggling child care, her mother-in-law's needs, and work; she doesn't feel confident that she could locate a confidential space where she could talk freely.

I call to follow up, and she again remarks on transportation issues that make it difficult to come to my office. I ask her if she would like to transfer care to a provider closer to home. After working in the area for so long, I am familiar with many excellent clinicians and could find Kelly a well-regarded therapist in her local community. Kelly says she'd prefer to continue with me because I have known her for so many years. We reschedule, again.

A day before her next session, Kelly urgently pages me in tears after an especially upsetting verbal tussle with her husband. We talk briefly, with the plan to continue the conversation at tomorrow's scheduled meeting. I also set a limit. Especially as Kelly has struggled with severe depression in the past, her current symptoms deserve and require frequent follow-up. In addition, at this point in a crisis, in-person sessions (vs. the option of virtual sessions) are the standard of care (if not in the middle of a pandemic). If Kelly wants to continue to work with me, her attendance at our scheduled sessions must improve. If Kelly is unable to follow up with me in person on a regular basis, then it makes the most sense to transfer her care to a clinician closer to her home. Kelly is upset by this idea and agrees to make an extra effort to come to our appointments. The next day, she is 30 minutes late for her 50-minute session.

Through word of mouth, I find the name of a respected therapist, Dr. Tran, who works in Kelly's town and has some open available hours. I call Dr. Tran directly to discuss my potential referral (without providing identifying patient information), and I am impressed by his thoughtfulness.

During Kelly's next session with me, I share my concerns that the long commute to my office is jeopardizing her mental health treatment. I give her the referral information for Dr. Tran and agree to provide care until she has her first appointment with him, within the next 4 weeks. Kelly is upset with me and afraid of meeting a new person. After talking to Dr. Tran directly, I am confident that Kelly will be in good hands, and I try to assuage her fears.

After meeting Dr. Tran, Kelly settles into the new treatment after a few meetings. We meet for one last session to say goodbye, and then she transfers her care with my best wishes. While I would have liked to continue as Kelly's therapist, I wasn't in a position to provide the help she needed if she couldn't see me regularly. Transferring care, even if it was originally against Kelly's wishes, provided better care than continuing a treatment without any traction.

I wouldn't have been so rigid with my recommendation of weekly psychotherapy, if Kelly didn't have a history of depression and the issues with her family had been less disabling. Hopscotching from meeting to meeting every few weeks depending on Kelly's availability, I could have provided some emotional support, with the recognition that increased insight and understanding of complex issues would require more frequent appointments. Without a crisis around the corner, I feel more comfortable with this approach. Sometimes, patients edge toward the more effective weekly psychotherapy after first testing the waters with a less frequent clinical commitment.

TO BE EFFECTIVE, I NEED TO BE WELL VERSED IN THE TREATMENT MODALITY THAT THE PATIENT NEEDS

Psychodynamic psychotherapy is not the most appropriate treatment option for every psychological difficulty; a patient's presenting problem needs to be matched with the appropriate type of therapy. Then, if I am going to be the therapist of record, I need to be competent in this preferred modality.

My fictional patients "Maurice" and "Adriana" illustrate how patients with somewhat similar presenting symptoms may benefit from different types of psychotherapy. Maurice, an electrician, suffers with recurrent episodes of palpitations, sweating, trembling, and nausea. His attacks are triggered by driving across a bridge. At first, Maurice was understandably concerned that his symptoms were consistent with a cardiac event. After a comprehensive negative medical workup, he is sent to my office for an evaluation.

By the time of our consultation, Maurice's recurrent panic attacks have become so debilitating that his business is suffering. If a new client is only accessible across a bridge, Maurice rejects the work request. As Maurice

and I talk more about his concerns, it becomes clear that his symptoms meet the criteria for panic disorder with some increasing avoidance; he is highly motivated to obtain relief as his symptoms are both incapacitating and distressing. At this time, he is not interested in talking about his relationships with his wife and children or any stressors at work; he specifically wants to focus on the panic attacks and how to best get rid of them. I refer Maurice to classic cognitive-behavioral therapy (CBT) for his panic disorder. If he is interested, we may also discuss psychopharmacologic treatments available for symptom relief.

In contrast, Adriana, a pediatric nurse, focuses on free-floating anxiety and weekend panic symptoms during her therapy consultation. Adriana's panic attack symptoms, sweating and feeling concerned she is going crazy, only occur on Friday and Saturday nights if she doesn't have time to clean her apartment until it is spotless. Unlike Maurice who is hampered by his avoidance of bridges to prevent a potential panic attack, Adriana does not feel conflicted about continuing the behaviors (intensive weekend cleaning) that keep her panic symptoms at bay. She lacks a community of friends at work, she doesn't have any current hobbies, she is not close with her family, and she doesn't feel comfortable with Internet dating. She is distressed about the isolation in her life and wishes to build a social community, although she isn't sure how to address these concerns. It is possible, although this is only a hypothesis so early in treatment, that Adriana manages her weekend loneliness by focusing on an activity she can control and then enjoying her immaculate home.

Adriana is ambivalent about investing in a CBT exposure program focused on alleviating her weekend panic symptoms, as her cleaning is egosyntonic, that is, she likes a pristine home. Her cleaning may protect her from unrecognized painful thoughts and feelings. She does not have symptoms consistent with obsessive–compulsive disorder (OCD) with excessive cleaning during the week; her cleaning urges only occur during weekend evenings, a time when many people schedule fun social activities. After learning more about her presenting symptoms, I feel comfortable treating Adriana with a mix of psychodynamic and cognitive-behavioral approaches rather than referring her to CBT.

Adriana is more open to discussing her ongoing free-floating anxious discomfort in a less structured treatment, similar to the therapy approach provided to Sallie Gane. Over time, the therapy may focus on Adriana's anxieties about relationships. As her understanding evolves, her compulsion to clean may diminish.

In reality, the Maurices and Adrianas of the world aren't so cleanly delineated, and many patients benefit from an eclectic mix of psychotherapeutic approaches. That said, most patients end up preferring and responding better to either a more structured CBT approach or a more open psychodynamic methodology. During a psychotherapy consultation, the patient

and I discuss the different treatment modalities available to address their particular concerns. Based on my experience, I recommend the treatment plan that I think will be most effective. If the patient prefers to try a different therapeutic approach than my recommendation, we review the pros and cons of their chosen treatment modality, whether I feel comfortable providing the requested treatment, or if the next best intervention would be a referral to another provider.

I think it is important to be transparent during this discussion. By this point, I have a sense of my strengths and weaknesses as a clinician; I know the therapies in which I am proficient. My rule of thumb is that if I don't use a treatment modality often, and the patient is best served by this approach, I refer the patient to a trusted colleague. I have extensive experience providing individual psychodynamic psychotherapy, with CBT problem-solving strategies embedded throughout the treatment. If a new patient requests a CBT therapist, I refer further treatment to a clinician who specializes in this approach. I follow a similar procedure for referrals to group psychotherapy as well as family or couples therapy.

I also recognize the ages and diagnoses I am comfortable treating. While I have extensive expertise treating children, teenagers, and adults, I do not have much experience with geriatric patients. With several years of practice under my belt, I feel competent treating many different types of anxiety, mood, eating, personality, and attention-deficit disorders. I have been helpful to patients who are intermittent bingers of food, alcohol, or drugs.

Over the years, I have struggled to treat patients battling debilitating chronic substance use disorders. Once, after only one diagnostic consultation meeting, I transferred the psychiatric care of a young adult to the MGH outpatient center for addiction treatment. I felt badly that I couldn't provide more for the young woman in distress, but I knew she would receive more skilled care from an expert in substance use disorders. A few months later, I received a thank-you voicemail from her mother. The consultation with the specialty unit was incredibly helpful. The patient was referred to an established residential program for comprehensive treatment; with the extra help, she was doing better than ever before. It turns out that the referral to substance use disorder specialists was exactly what she needed.

CLINICAL RESULTS DIFFER, DEPENDING ON SEVERAL FACTORS

Is it possible to predict how well a patient will do, if all the stars are aligned: if the patient attends therapy regularly and talks openly, if the therapeutic alliance is solid, and if the diagnosis and treatment approach are appropriate? While the chance of a successful therapy increases substantially with

all these factors in place, clinical results still vary. Personally, I have experienced three categories of patient outcomes.

There are some patients who tell me that I have saved their lives or fundamentally changed their lives for the better. It is gratifying to hear that our work has had such a positive impact. These individuals and families invested significant time and energy into their treatment, and their style and mine were a good fit.

Then, there are my patients who have improved significantly in treatment, although not to the extent of the first group. It's difficult to know what differentiates the patient who has a fundamental life change with therapy from the one who improves, albeit more modestly. Sometimes, life events complicate treatment. It may not be possible to invest in the ideal frequency or length of therapy; fundamental change possible with more intensive work may be an elusive goal. On the other hand, it might be that I am not the ideal match for this patient. I am doing the best I can; they are doing the best they can; but for whatever reason, the improvement is not as extensive as either of us would have hoped.

And, then there is the smallest group, about 5–10% of my practice. This group keeps me humble. With these patients, I have given my best effort, but, under my care, they have not significantly improved. At the end of the day, I am unable to provide what these particular patients need.

From my perspective, it is important to reserve time to review and to understand failed treatments. As a beginner, I rarely heard a seasoned clinician share the details of a case that didn't work out well—which is all the more reason for me to share the clinical vignette below.

A patient of mine called "Marlo" eventually changed therapists when his treatment with me hit an impasse that we were unable to navigate. Marlo, a married business man in his early 40s with three children, started therapy with me to discuss issues at his job and at home. When we started our work, we were in the same developmental stage in our lives—married, with young children, and settled into our careers. He had been in psychotherapy before, but always with male therapists. He was willing to try working with me when I was recommended by a trusted friend.

For several months, the treatment seemed to be going well. Then, unexpectedly Marlo found himself facing new crises at home and at work. I expected the therapy would be helpful during the tough time, but instead, something in our relationship shifted. After Marlo's wife started to talk to him about a potential separation and the stress at work escalated, Marlo reported feeling disengaged and misunderstood during our meetings. While he recognized that I was trying to be helpful, my input no longer felt useful or supportive to him.

At first, I viewed our difficulties as a series of classic empathic lapses; I expected we could work through them, ultimately deepening the treatment. I was pleased he felt comfortable enough to share his concerns about

our working relationship; I recognized that there was transference in play that was important to understand. Just as Marlo felt unsupported by his wife and boss, he felt unsupported by me as well—even as I tried to be thoughtful and empathic. I hoped by discussing the misunderstandings in our relationship, some light would be shed on his difficulties with family and coworkers. When this approach didn't gain traction, I changed tactics and tried to provide more emotional support instead of focusing on the transference issues. It didn't matter. Marlo continued to feel that I was increasingly aloof and uncaring in the office. No matter how I responded, he felt empty and isolated in my presence.

Eventually, we did learn that I reminded him of his successful older sister, with whom he felt competitive. As he felt less competent at home and at work, he felt increasingly uncomfortable sharing his worries and concerns with me. He felt insecure in his job, and he could see my practice was thriving. He was getting divorced, and he saw my wedding ring. Talking with me wasn't consoling; it felt embarrassing and shaming. It didn't help, I think, that we were approximately the same age.

Unfortunately, recognizing the specifics driving the disconnection did not make it go away. I supported Marlo's decision to transfer care to an older thoughtful male colleague. We said good-bye with my best wishes. I still wish I could have been more helpful. I had permission to talk to his new therapist, and I explained how our work together had evolved; I hoped that the new therapy could be informed by Marlo's experience with me.

It is humbling to review these cases either on my own or in peer supervision. I have always believed that focusing on my less successful patient experiences is critical for my professional growth. By reflecting on all patients, especially those who have been more complicated and difficult to treat, I learn and improve.

BEWARE OF FORMULATIONS LEANING TOO FAR INTO INDUCTION OR DEDUCTION

As outlined in Chapter 6, the best formulations and treatments deftly combine induction and deduction. With deduction, I guide the interview and ask targeted questions about specific symptoms; I am assessing if my patient's clinical presentation meets criteria for a particular disorder. I am using deductive reasoning when evaluating a patient for a DSM or medical diagnosis. In contrast, when switching to an inductive process, I spend time collecting information without a predefined agenda. Instead, I work to develop a narrative that will explain a patient's unique struggles. The psychodynamic process, with the therapist and patient generating a narrative of a patient's concerns, employs more inductive reasoning. Now, with years of experience under my belt, I have some personal vignettes that

demonstrate how a treatment may suffer if a therapist's approach unconsciously favors one approach over the other.

Several years ago, I worked with a 26-year-old patient, "May," who was struggling with a 6-month increase in overexercising. She was a conscientious and intelligent graduate student, but she was also in significant emotional distress. Every day, she completed an extensive video workout to the point of utter exhaustion. She didn't feel comfortable completing only a portion of the video as that "would be cheating" and she wanted to "do it right." She was careful about her nutrition, and her weight was normal, but the exercise commitment dominated her life. She also was scrupulous about personal hygiene and wouldn't leave her apartment unless every hair was in place. Between graduate school classes, homework, workouts, and hours spent on makeup application, she had little spare time to spend with her family and friends, although she was able to meet all the academic expectations of her graduate program, despite her increasing distress. In the office, she was soft-spoken. She paused frequently to question her choice of words as she related her story.

She had already seen a psychopharmacologist, who had recommended medications for OCD. She was ambivalent about using medications and invested instead in a 6-month stint of intensive CBT. Although she was motivated to feel better, her symptoms continued unabated despite her commitment to the CBT approach. She made an appointment with me for a second opinion.

During my first meeting with May, I wondered if her prior clinicians had relied too heavily on deduction when diagnosing the cause of her distress. Focusing on the presenting obsessive symptoms with a focused CBT treatment had not provided any relief. Using a more inductive approach, I wondered if her symptoms might also be acting as defense mechanisms against internal emotional conflict and distress. If I was right, an intensive psychotherapy focused on learning the specifics of her story might provide us the best chance of understanding and then alleviating her symptoms. As she was motivated and eager to jump in, she agreed to twice-a-week treatment, which allows for increased introspection at a more rapid rate. We agreed that if she did not notice any improvement after a 6-month psychotherapy trial, it would be clear that we needed to reconsider medication or another treatment approach.

During the first several weeks of psychotherapy, I learned much more about May's relationships. She was a generous person, but sometimes at unreasonable cost to herself. Family and friends knew that if you asked May for help (a car ride, a listening ear, a home-cooked meal), she would make time for you. Prior to graduate school, she always had enough time in her life to care for others while also carving out time for herself. Now, as a graduate student, she had limited free time. She deprived herself of any relaxation and only slept about 5 hours a night in order to both finish her

work and to be wholly available to her family and friends. The physical and emotional exhaustion that followed was unbearable, but she didn't want to let anyone down, ever.

After a few months of this grueling schedule, the exercise and makeup rituals started to emerge. While the rituals were upsetting and time-consuming, they also allowed May to say "no" to the next stream of requests. She didn't have time because she had to exercise or "get ready." The neurotic symptoms were distressing but also protective. The obsessive symptomatology also acted as a type of personal punishment for fulfilling her own needs.

After 6 months of therapy, May and I were beginning to understand the psychological underpinnings of her symptoms. We continued to monitor her progress without medications. Little by little, she felt increasingly comfortable asserting herself, first within the therapy and then in her life outside of therapy. Slowly but surely, her obsessive exercising and extreme focus on personal hygiene subsided.

I felt proud of our successful work, and this set the stage for my next professional blunder. Fast-forward 2 years, and I am referred a 20-year-old college student, "Frank." Frank was a perfectionist, like May, but over the 2 years prior to our meeting, his ability to function at school had decreased significantly. He had great trouble handing in any schoolwork because he would write and rewrite drafts of papers, continuing revision even after the submission due date. Unlike May, his presenting symptom affected his academic progress in college because the need "to be perfect" was paralyzing. Attention-deficit disorder and learning issues had been carefully ruled out with a comprehensive neuropsychological evaluation. When I met him, he, like May, had been diagnosed with OCD and had just completed a year of intensive CBT combined with high-dose antidepressants with no relief.

With hubris, I started working with Frank, sure that the prior successful treatment with May could guide Frank's recovery as well. I noticed how the two patients were similar. They both had obsessive symptoms. May also hadn't improved with CBT treatment for her OCD-like symptoms. After May graduated from treatment, I scheduled Frank during May's old session times; the two cases felt very connected to me from the start—and as I eventually learned, this construct was problematic.

My work with Frank did not unfold as planned. I used too much deduction as I planned my therapeutic approach—forcing the pieces of Frank's story into a predefined treatment plan constructed after my successful work with May. By leaning too heavily on one cognitive process, I ignored the many ways that the two patients were fundamentally different.

Frank started the therapy focusing, not on his own worries, but on the many ways that his teachers, former counselors, and parents had let him down. He was adept at identifying inadequacies in others and discussing

them at length. According to Frank, he couldn't function because the significant people in his life weren't calm enough, sensitive enough, or flexible enough. He felt judged by others who weren't understanding of his current crisis.

Unfortunately, I remained in my deductive fog and I continued to paste my formulation of May onto Frank's treatment. Using the approach that had worked so well with May, I encouraged Frank to assert himself within the therapy and I validated his experience. I believed he would improve, as May did, as he tuned into his own needs more carefully.

For too long, I didn't pay close enough attention to the many ways the two patients differed. For Frank, his locus of control existed outside of himself. He believed his psychiatric symptoms would cease if everyone else would just treat him with more respect, sensitivity, or flexibility. He was waiting for the world to change. May had been willing and eager to reflect on her internal experience. She had worked to change internally to live more fully within the world.

When I finally started asking Frank to reflect inward, he criticized my wording and my timing. Shouldn't I know how to ask about his feelings in a different manner—with phrasing that would make it easier for him to respond? He spent the majority of each session critiquing my technique. "You need to talk to me differently," he noted. When I asked him for more details, and what kind of approach he might prefer, he answered, "How should I know? You are the doctor." I wasn't just walking on eggshells; I was tiptoeing.

Frank had a talent for criticizing people in their areas of vulnerability, and now he'd found mine. When I was found lacking, my response was to try harder, rather than reflect on the bigger picture. After telling me I wasn't helpful, I went into empathic overdrive. I twisted and turned, trying again and again to access more sensitive wording. Maybe everyone else in the world couldn't understand his difficulties—but this was my specialty—I should be able to help him feel understood.

I needed to take a step back. What did it mean about Frank and the treatment that he spent the majority of our time critiquing my every move? Autognosis, an increased understanding of my feelings and my role in the treatment, was necessary to clarify my formulation.

As the therapy became stuck and I felt more and more helpless, I presented the case to trusted colleagues for supervision. I talked about my countertransference and my commitment to understanding this young adult who felt so alone and misunderstood. Slowly, and with help, I gained some perspective that helped me approach the case in a fundamentally different, and ultimately more effective, way.

I started to understand that while May and Frank both shared presenting complaints of debilitating obsessive symptoms, the underlying source of their distress was very different. I reviewed Frank's symptoms carefully.

Using deduction, induction, and autognosis, I created a new formulation to explain his difficulties. I moved my focus from Frank's obsessive symptoms and externalization to his significant mood instability and school difficulties. I added a mood stabilizer and it was helpful, but ultimately, Frank didn't improve until he transferred to another school that embedded intensive academic and therapeutic assistance within the curriculum. Only then, within a program organized to provide concentrated support, was he able to complete his degree.

I learned a great deal from my experience with May and Frank. Now, I try to be aware how clinical assumptions can quietly embed themselves in a treatment plan, unnoticed but with tremendous power to divert a therapy off course. A few years ago, I was asked to consult on a female 16-year-old patient, "Luna," who blamed her mother for all her troubles and avoided all responsibility by playing video games several hours a day. Luna spent hours in therapy discussing the foibles of others, while avoiding self-reflection. I had to be careful not to jump to conclusions, as my first reaction was to wonder if her struggle was similar to Frank's. But now, rather than presuming that two patients were comparable, I collected much more information from Luna, her family, and my referring colleague to test my hypothesis. This time around, I examined my assumptions thoroughly, rather than accepting them without reflection.

I CAN TREAT COMPLICATED PATIENTS WHO USED TO FRIGHTEN ME

Slowly but surely, clinical expertise increases with experience. During my residency, I was in awe of my peers who treated patients with frightening self-destructive tendencies, or debilitating mood disorders. During training, I didn't trust my capacity to treat the more complex individual, and I quietly dodged the referrals of the most ill outpatients.

My perspective started to shift when I was hired onto the MGH faculty after I finished my training. One of my first assigned patients was a 30-year-old female scientist, "Whitney." She was referred to me for an urgent evaluation after she screamed at her internist for several minutes during an annual visit. She agreed to see me because she did have some insight that her moods were increasingly erratic.

At our first meeting, Whitney shared that she had previously been diagnosed with bipolar II disorder, and it became clear that her current presentation was consistent with a depressive episode with mixed features. She was talking fast, not sleeping, impulsive, agitated, and upset. She also alluded to a trauma history and confessed that she would manage unbearable flashbacks by cutting her wrists, sometimes repeatedly, although never deep enough to cause significant blood loss. Her repeated impulsive

self-destructive behavior had landed her in locked psychiatric units or specialized residential therapeutic settings for the majority of her adolescence. During her intake evaluation with me, she didn't meet a hospital level of care, but she urgently needed a therapeutic team: a weekly therapist and a psychopharmacologist to restart medications she had stopped taking months ago.

As she related her story, I felt my familiar internal struggle emerge. She needed care, but did I have the skills to provide it? I liked her right away. She was honest, direct, and thoughtful. While I managed to maintain a professional attitude while we talked, internally, I felt increasingly anxious. What if I wasn't "good enough" for this complicated patient? What if she hurt herself on my watch? Would she be better served with someone better equipped and more experienced? My usual tactics—duck, dodge, and refer to someone else—weren't easily available now that I was a staff psychiatrist. Whitney needed immediate treatment, and I was her designated doctor.

I agreed to provide her medications and to meet with her regularly until her mood stabilized. She asked if I would be her therapist as well; I'm embarrassed to report that I responded with my well-honed juke maneuver. I told her that I didn't currently have time to provide that aspect of her care, and I referred her to a local clinic for psychotherapy.

While we waited for her to find a therapist, we met every other week. Her mood became more stable with the appropriate medications. Meanwhile, she unambivalently invested in our work together. She came on time to our biweekly meetings and asked me repeatedly to reconsider whether I could be her therapist as well as her psychopharmacologist. I was impressed by her commitment to treatment and felt complimented that she felt so connected to me.

Even though I was still nervous to become the sole provider for a patient with bipolar II disorder, PTSD, and ongoing self-destructive behavior, it became clear that the requested "local therapist" was never going to materialize. At this point, I was also invested in Whitney's care, and I signed on as both her therapist and psychopharmacologist. We started meeting weekly for medication management and psychodynamic psychotherapy.

Over the next several years, Whitney rarely missed one of our weekly sessions. Over time, she started to share details of the traumas she had endured. I did my best to understand her experience. We learned together when it was useful to talk about an experience in more detail, and when to back off if the topic became unbearable.

The treatment was definitely challenging. Whitney could be abrupt and easily angered if I said something that offended her. She still struggled with intermittent severe self-destructive impulses and behaviors that made me very nervous, and logistically, we were unable to meet more than once a week.

Our strong alliance helped us devise an effective therapeutic approach to keep her safe during tough times. While I learn something about life or the therapeutic process from every patient, Whitney was my primary instructor (more than any book, article, or supervisor) on how to help a patient who is actively self-destructive. I was honest with her and shared that her self-injurious tendencies made me nervous; I had a low threshold for discussing and seriously considering hospitalization if I felt we couldn't keep her safe as an outpatient.

After enduring several hospitalizations as a teenager, Whitney was motivated to avoid any future inpatient stays. It also helped that our therapeutic alliance was strong, and she was invested in our outpatient work. Together, we designed an outpatient care plan for whenever her mood became unstable and the suicidality increased. During these episodes, we scheduled a 5- to 10-minute daily phone check-in. Since the phone calls were frequent, I scheduled them for a time that didn't disrupt my family's schedule.

These phone calls weren't long conversations, but they were critical ones. We reviewed coping strategies that had been helpful during prior crises. We thought about which friends or family might be available for comfort during an isolating episode. I learned that her love for Boston sports teams was a vital distraction when her mood disorder or PTSD symptoms became overwhelming. The Patriots, Celtics, Bruins, and Red Sox provided solace and company during some very tough times; I developed a whole new appreciation for the importance of sports as a diversion during illness.

She knew I would be checking in on her and that I cared. When her self-destructive impulses were strong, I was adamant that I would contact her family members to ensure she was safe if she was a no-show during one of our designated check-in times. Until the suicidality lifted, we hopscotched from phone call to phone call. If she continued to be in crisis, a follow-up phone call was scheduled for the following day. If she was feeling a bit better, we might wait to talk for 2 or 3 days. Meanwhile, I made medication changes during these times, aggressively treating any biological component fueling the fire. We continued the quick check-ins until she stabilized (usually in about a week)—either because the medication change kicked in or the urgent issue resolved.

While my pager is available for urgent issues I don't anticipate, I prefer being proactive if I sense that an emergency is brewing. I still regularly use this phone check-in technique if I sense an impending crisis for a vulnerable patient. I don't encourage phone calls between sessions that increase a patient's dependency (see Chapter 9), but the calculation changes if the patient is unstable and at risk of self-harm. A quick phone call at a mutually agreeable time is an effective intervention; I would rather attend to an impending clinical crisis promptly and briefly rather than chancing

escalation. With my proactive approach, I am able to choose the time to talk that doesn't interfere with my family's schedule and my pager rarely goes off.

Fast-forward several years, and Whitney is one of my patients who is in a fundamentally better place because of our work together. I don't see her very often anymore, although we continue to stay in touch. She has three thriving young children. Her self-destructive behaviors are long gone.

Without a doubt, I know I am a better clinician because of our work together. After working with Whitney, I retired my "dodge the complicated referral" side-step. She taught me that I can handle a frightening psychiatric crisis. I am no longer scared of treating patients with complex psychiatric illnesses (bipolar disorder, severe depression, self-destructive behaviors, severe trauma, or psychiatric illness interfacing with complex medical illness). It may seem obvious to state, but clinical skill level during training does not predict the clinical acumen developed over the course of a career.

At a recent gathering of my colleagues, a fellow psychiatrist from a neighboring community came up to me and said, "I've heard of you. You are known for not being scared of the tough cases." Rewind several years: I would have never believed that this would be my future local reputation. With the help of Whitney, followed by a number of other patients who have taught me through the years, here I am.

THE PROCESS OF SELF-EVALUATION NEVER ENDS

When a treatment is working, it has traction. The discussions in the office increase in depth. Slowly but significantly, distress decreases. Joy increases.

Frequently though, the process of change occurs in fits and starts, with times in between when the therapy doesn't seem to be progressing. The patient may be cooperative and attend regularly, but the therapeutic process may feel stagnant. Maybe I feel a little bored. The patient may talk freely, but without any emotion attached to their story. We may spend months talking in detail about a particular issue, but without any increasing understanding of the conflict.

The trick in this type of situation is to avoid rationalizing "okay" treatment. It is in the best interest of all involved if I recognize when a treatment is stuck. I don't feel ashamed if I notice a treatment's lack of progress. From my perspective, critiquing my clinical ability does not mean that I am a subpar therapist. In fact, the opposite is true; by having the fortitude to scrutinize my efforts, my therapeutic skills continue to evolve. In this way, I see myself as a work in progress, always becoming the best therapist I can be.

I mentally review my caseload on a regular basis in order to pinpoint which treatments may need a tune-up. My goal is to differentiate the therapies with slow but notable improvement from those that are jammed into

an immovable psychological corner, even with regular attendance and treatment investment.

Once I identify a treatment that could benefit from more scrutiny, I reevaluate my formulation of the case and consider different clinical approaches that may be more fruitful. If I don't understand why a patient isn't getting better, I use my resources to gather alternate perspectives.

Mentorship and collegial input are available in many different formats. Conferences review cutting-edge approaches for a variety of topics. The writings of present-day master clinicians and great psychotherapists who are no longer with us provide useful wisdom and guidance. My patients and I benefit from the clinical acumen provided by leaders in the field.

To maintain my work at the highest possible level, I also meet with many different colleagues on a regular basis for peer supervision. My monthly peer supervision group has been meeting for over 20 years now. We take turns presenting complicated clinical scenarios (with identifying information removed) to obtain a fresh perspective from trusted colleagues. I am blessed that my father is also a psychiatrist/psychoanalyst, and he remains one of my touchstones—providing insight and wisdom from decades of experience. At MGH, I am lucky to have many expert colleagues, and we all "curbside" each other on a regular basis for help with difficult cases. Finally, over the last several years, I've added a weekly walk with a close friend who happens to also be a child and adult psychiatrist. While our hour together isn't defined as supervision, we use it for that purpose if we need to.

All these colleagues share some special qualities. They are calm, thoughtful, and experienced clinicians. They are not easily rattled. They don't jump to conclusions before hearing the entirety of any story. I trust their judgment. While they all support my work, they don't just "yes" me when I ask for guidance. They are not indiscriminate cheerleaders chosen because they will tell me that I am doing everything right. We thoughtfully critique each other's work to help create the clinical approach that is in the best interest of the patient.

My patients benefit greatly from the wisdom of my colleagues. Case in point: a number of years ago, I was working with a 32-year-old man, "Victor," who was suffering from a debilitating depression. He took a medical leave from work as an accountant and agreed to start antidepressants and meet with me weekly for psychotherapy. I asked about substance use to evaluate whether it might be contributing to his present difficulties. It was not: his alcohol use was not concerning, and he did not use any recreational drugs.

During his evaluation, I learned that Victor's father had been verbally abusive throughout his childhood, and his mother had been complicit—watching and not intervening as Victor was the repeated target of his father's wrath for as long as he could remember. After providing an outline

of a childhood full of fear, Victor told me directly that he didn't want to talk about this topic anymore—especially as he was already feeling overwhelmed with the severe depression. Instead, once the psychotherapy started, he preferred to come in each week and focus on the details of the medication trials for the depression, especially as he wasn't responsive to the first antidepressant I prescribed. He then preferred to spend the rest of our allotted time talking about his favorite TV shows or movies.

Now and then, he told me a bit about some important friendships he had maintained since high school, but generally he avoided deeper talk about any relationships. He attended therapy regularly, but even as he started to feel better and returned to work, he preferred to focus his session on psychopharmacology questions and the latest entertainment he was watching. I did not want to push Victor to talk about more emotionally loaded topics before he was ready, but after a few months of talking about action dramas and his love for reality TV that highlights social drama, I wondered if my approach was colluding with Victor's avoidance strategy.

I presented Victor's story in peer supervision. While he was always on time for our meetings and had expressed an interest in psychotherapy, should I move him to 25-minute psychopharmacology follow-ups because he wasn't using the therapy to talk about emotionally loaded issues? Or, did I need a new perspective on my patient's struggle?

My colleagues wondered if Victor might need a much longer time to feel safe within the psychotherapy as his primary experience growing up was being attacked and not protected. Starting therapy in the first place was an act of great courage and hope, as he believed there might be trustworthy and helpful people in the world who could provide a safe harbor to discuss sensitive topics. That said, once in psychotherapy, it might feel frightening to share personal vulnerabilities if one is primed for attack or retaliation. Talking in displacement, about dating on reality TV shows that track relationships' ups and downs, may be a way to suss me out and see if I understand his perspective while also protecting himself emotionally. My colleagues' recommendation: unless Victor requested a move to shorter psychopharmacology visits, I should not present a shorter meeting as a treatment option. Pivoting to quick check-in meetings would prevent the evolution of the psychotherapy; the move might also insinuate that I didn't think the content of Victor's session was valuable. My current job as his therapist was to be patient, to follow his lead, and to validate his choices, rather than redirect and push.

The advice was golden. I relaxed. Growing up, Victor had not experienced patience. He didn't need an impatient therapist as well.

I doubled down and asked more questions about the shows he enjoyed. Over several months, he expanded his topics to include his relationships at work. Only after a year, did he start to tell me about his former romantic relationships in more detail. As he felt better, he shared some of his dating

escapades. It took a long time, but eventually, Victor trusted me enough to fill me in on the relationships in his world and reflect on the impact of his parents' abuse. My colleagues' guidance was on target.

There is another reason ongoing professional supervision should be part of every therapist's work schedule. Over the years, I have watched a few accomplished therapists lose their licenses after behaving inappropriately with patients. While I don't know the inside details of each situation, I have wondered about one thread of similarity; it wasn't clear to me that these powerful well-regarded clinicians had ongoing peer supervision to reflect upon their work. With a trusted group of colleagues, small problematic boundary crossings may be identified quickly and then addressed, decreasing the likelihood of escalating inappropriate behaviors.

My perspective is always to seek consultation if I feel any concern about boundaries within a treatment. In fact, I might argue that a treatment protected from a peer critique is actually a treatment that deserves some consultation. I don't see supervision as an optional part of my profession; it is a mandatory unofficial part of my continuing medical education.

I contrast my perspective to a comment I remember from a training conference during my residency. A locally well-known therapist remarked, "I have treated so many patients now, I know how the therapy will evolve after the first session with a new person. I know what I am going to say. I know the issues that will emerge and the interpretations that will be necessary. I know what is going to happen before it happens." As a novice, I figured this experienced clinician was so talented that she was able to connect with her patients in a way that I couldn't imagine. They were intimidating words to hear from a beginner's perspective—probably why I remember them years later.

Now, with the benefit of experience, I have a different take. The statement was grandiose, and it reflected complacency from a therapist who had stopped paying close attention to her patients. The omnipotent perspective had allowed her to tune out. If she thought she knew it all, she didn't have to listen all that carefully.

I believe the learning process had become stagnant for this experienced therapist—and she didn't even realize it. It is a simpler process to listen with one ear and fill in the gaps without paying close attention. It is much more complex work to actively engage in the process with every new person, carefully noticing what makes their story unique.

TO HELP OTHERS, I MUST KNOW MYSELF

Dr. Messner and I met weekly for 6 years during the writing of *Becoming a Therapist*. After the first edition was published in 2003, Dr. Messner and I occasionally met for lunch, but we both pursued other interests. I had two

little ones at home so it was difficult to find any time to write, but I slowly increased my teaching responsibilities at MGH. Dr. Messner continued his clinical work, teaching, and other creative projects.

In 2006, Dr. Messner passed away. His death was a great loss: to his family, to MGH, to the Boston community, and to me personally. With the help of the MGH Psychiatry administration, I organized a memorial service at MGH Psychiatry Grand Rounds in honor of our beloved teacher. Dr. Messner had taught three generations of psychiatrists; during the service, his former students filled the auditorium and told stories of his teaching, mentorship, and wisdom. I was honored to be one of the speakers.

As my children grew older and I had a bit more free time, I thought about pursuing new writing projects, but I was easily distracted. After my clinical responsibilities were attended to, email, laundry, dinner, and bills always seemed to take priority over any new creative venture. Eventually, I admitted to myself that the transition from writing with a beloved mentor to writing alone felt complicated. While I no longer needed someone to help me with a writing project, the prospect of writing solo felt sad, an immediate reminder of Dr. Messner's absence.

I tried to push my distress aside. I worked on some small unassuming pieces, but they moved at an exceedingly slow pace. It was difficult to focus on writing when my feelings kept intruding on the process.

I didn't expect that some of my unresolved grief might bleed into my work with my patients. With hope that I would adapt to authoring without a mentor, I reserved weekly writing time and simultaneously started to feel increasingly frustrated with my psychotherapy patients. At this point, I didn't realize it, but my complicated feelings about writing had affected my patient work, fueling my diminished patience.

Case in point: a new patient, "Kyra," a young elementary schoolteacher shared her worries that she couldn't trust her teaching ideas. She lacked confidence but not ability and would stay up late at night second-guessing her lesson plans.

My job should have been to try to understand Kyra's insecurities and their source while also encouraging her own creative process. Over time, we might learn more why she didn't trust her innate abilities. Instead, during our session, I took a more active stance that wasn't therapeutic; I dismissed one of her ideas and instead offered up my own third-grade science lesson plan as an alternative.

My approach was not tuned into Kyra's needs. Everyone else in her world had already provided plenty of advice. My job was to help her find her own way and build confidence in her own voice—not to hijack her creative process and lead her down a specific direction of my choosing.

Kyra's difficulty creating a lesson plan that was hers and hers alone resonated too closely with my own current mixed feelings about writing solo, so I had trouble tolerating her distress. As I labored to complete

writing projects independently, I became more directive of patients also trying out new skill sets.

Also, as I gave more advice, I felt somewhat bored with my work, an unusual experience for me. Providing advice is less intellectually stimulating than trying to understand a patient in depth. Until I fully acknowledged my lingering grief, my subtle disengagement would continue.

I did not immediately connect my complicated feelings about writing without Dr. Messner to my work with patients. I did know something was bothering me. As I've mentioned before, I don't hesitate to seek consultation if I feel there is a need. I started confiding in a close group of colleagues to figure out what was going on. It became clear how deeply conflicted I felt about writing without Dr. Messner—I had some left-over grieving to do. Once I gave my feelings the attention they required, I slowly adapted to writing by myself. That said, if I hadn't figured out my work and writing concerns with my support system, I would have called my former therapist to set up an appointment.

As I understood my own struggle, my clinical skill set returned and I felt reenergized at work. Over time, I have become more comfortable completing writing projects by myself, including this second edition, with Dr. Messner in my mind and in my heart, just not by my side. The take home: understanding myself deserves thoughtful emotional attention—for my sake and for my patients.

TO TAKE ADEQUATE CARE OF OTHERS, I MUST TAKE CARE OF MYSELF

As a final sign-off, I want to underscore the importance of self-care for every therapist. Being a therapist is consistently meaningful and interesting, but it also may be draining. While I am not a classic first responder such as an ambulance driver or fireman, my day is spent listening to raw versions of life's most difficult moments. I hear about the most significant losses that may occur: illness, traumas, violence, divorce, neglect, and deaths. Patients express anxiety, fear, profound sadness, loss, rage, and grief. While my inner emotional strength has developed over the years, it is not infinite; refueling is a critical part of staying present and doing my best work.

When I work with exhausted parents of young children, I often refer to the classic safety discussion shared at the beginning of an airline flight as it also outlines the importance of parental self-care: "Parents, in the event of an emergency, put on your oxygen mask first before assisting your child." A parent may become disabled in an emergency if they prioritize placing the oxygen mask on a child. Similarly, if a parent only recognizes a child's needs, the parent's mental and physical health may suffer. The same tenet holds true for the therapist–patient relationship.

Self-care can come in many forms. I have prioritized two approaches: investing in professional pursuits that support the creation and sharing of new ideas, and ongoing attention to important relationships and joyful activities that support resiliency.

As a therapist, I spend a significant portion of each day listening closely to my patients and trying to deepen our understanding of their concerns. The work is incredibly meaningful and interesting, but it is not always in my patients' best interest for me to assert myself freely.

Teaching, writing, research, and administration all welcome a more directive forward approach—a great contrast to the therapist's role of following the patient's lead. Patient care is supported if I develop my own voice as I help my patients find theirs. Writing and teaching allows me to express my thoughts more freely in the outside world, which also preserves my ability to listen carefully while in the office.

I also protect my ability to tune into my patients by making sure to recognize and care for my own needs on a regular basis. Vacations are the most obvious part of this process, but I also prioritize regular rejuvenation that isn't elaborate or expensive. Most of the time, it's pretty simple. I protect time with family and close friends, exercise several times a week, watch my favorite shows, and reserve some time to read and write.

One summer, the suffering index of my patient population was unusually high. I sat in my chair and listened as one grieving mother shared the unexpected death of her preschool child. Another family was tortured by their teenager's severe debilitating psychiatric illness. I worked intensively with a college student who had survived a violent traumatic episode a few months prior. And then, a young lawyer whom I had treated for anxiety when he was as a teenager walked into my office frankly manic, with a flight of ideas, lack of sleep, pressured speech, and the beginnings of psychotic thinking.

It was too much bad and scary news in a short amount of time. The emotional weight from the office followed me home. All of my patients needed tender loving care. I did, too.

What helped? To handle the extra stress, I didn't find new activities; I just reserved more time for my old favorites. I read some wonderful fiction—not about psychiatry. I discovered some new shows to watch that provided another welcome distraction. I took some long walks and sought out green space, which bolsters mood and provides stress relief. With the help of a phone app, I engaged in 15 minutes of restorative yoga most days of the week. I made sure to protect the time reserved for my creative ventures. I closed my practice to new referrals until the patients in crisis started to improve. I reserved extra time to talk to colleagues, accessing the professional support I needed.

Protected time connecting with close family and friends provided an emotional buttress and shored up my sagging shoulders. With my support

system, I was able to manage the heavy weight from work. The take home: taking good care of myself allows me to take good care of others.

By recognizing the strain of my work and responding to my own needs, my resiliency increased. Again and again in this profession, I have learned that being aware of one's own response is not a hazard, but a gift. My hope is that my honesty about my professional development, both as a beginner and now as a seasoned teacher with decades of experience, will encourage my readers to self-reflect as well. Self-awareness and compassionate critique provide the fertilizer needed for continued growth and proficiency. Being a therapist is a wonderful career—one that is impossible to perfect, because when could anyone ever truly understand the mysteries of the human condition? The discoveries continue as long as one is willing to work for them.

Glossary

Dr. Messner and I started this glossary together to highlight terms I struggled to understand as a novice therapist. The second edition glossary has been expanded to include more information on substance use disorder treatment, electronic medical records, and multicultural therapy. The glossary is intended to act as a resource for readers confused about any term referenced in the text.

Abstinence. Avoidance of a particular substance or activity, usually in reference to alcohol, substances, or sexual activity. When referring to the recovery from a substance use disorder, abstinence is considered a complete cessation of alcohol or drug use.

Acculturative stress. Psychological stress associated with adapting to the majority culture as an immigrant or as a member of a marginalized group. Stress may increase with discrimination and/or stressors associated with immigration. The negative psychological impact may be mitigated by family, cultural and community supports.

ADD. Attention-deficit disorder: the term used before 1987 to refer to attention-deficit/hyperactivity disorder (ADHD).

ADHD. Attention-deficit/hyperactivity disorder: a persistent condition that begins prior to age 7 and that causes impairment in functioning at home and at school or at work through patterns of inattention and/or hyperactivity and/or impulsivity.

Addictionary. Addiction terminology compiled by the Recovery Research Institute (*www.recoveryanswers.org/addiction-ary*), with a focus on changing language to decrease the stigma of substance use disorders.

Adjustment disorder. A condition that involves impairment of social, occupational, or academic functioning with symptoms that arise within 3 months of one or more recognizable psychosocial stressors.

Affect. The outward expression of emotion through vocalization, facial expression, or other nonverbal behavior.

Affective equivalent. A symptom that substitutes for an emotional expression, for example, a pain in the neck (or elsewhere).

Agoraphobia. An irrational dread of open spaces or public places.

Alcoholics Anonymous (AA). Founded in 1935, AA is the largest mutual help organization in the world, using a 12-step program to help its members address problematic alcohol use.

Ambivalence. An internal conflict when an individual holds contradictory feelings about something or someone. Sallie Gane feels ambivalent about her friendship with Gwen because Gwen is often dismissive and controlling, but she is also Sallie's closest college friend who provides her with many social opportunities.

Anhedonia. Inability to feel pleasure with activities or experiences that are usually pleasurable. The anhedonic patient may say, "Nothing feels fun." Often a symptom of major depressive disorder.

Anorexia nervosa. An eating disorder defined by a voluntary reduction of food intake resulting in a significantly decreased body weight and associated with an intense fear of gaining weight and disturbance of body image.

Anxiety disorder. Psychiatric disorders defined by disabling persistent anxiety, fear, and/or worry. Specific examples include phobias, panic disorder, and generalized anxiety disorder.

Association. A word, thought, image, feeling, or other experience that arises spontaneously in response to an internal or external stimulus.

AUDIT-C. The acronym for the Alcohol Use Disorders Identification Test-Concise, which screens for problematic alcohol use with a three-question survey.

Autognosis. Knowledge, with understanding, of one's self.

BIPOC. Acronym that refers to Black, Indigenous, and People of Color.

Bipolar disorder. Historically referred to as "manic depression," but now referred to within DSM-5 as "bipolar and related disorders": a set of disorders that are defined by mood swings from depression to hypomania or mania; cause changes in sleep, energy, thinking, and behavior; and are associated with significant work and/or social impairment and psychological distress.

Blank slate. A metaphor often used to describe therapists who disclose little about themselves in order to encourage fantasies and transference from their patients.

Boundaries. The limit to personal or social contact between clinician and patient.

Bulimia nervosa. An eating disorder that features a recurrent pattern of binge eating followed by efforts such as self-induced vomiting, misuse of medications such as diuretics or laxatives, or overexercising in an attempt to avoid weight gain.

Cardiac dysrhythmia. Irregular heartbeat.

Change talk. A term used in motivational interviewing to describe language and expression that supports change.

Chief complaint. The main symptom or problem that a patient reports to a clinician.

Clarification. An explanation by the therapist intended to enlarge the patient's understanding of current subject matter. It does not necessarily include a historical or developmental perspective.

Cognitive-behavioral therapy (CBT). Developed by Aaron Beck in the 1960s, CBT is a form of psychotherapy that helps patients relearn beliefs, concepts, and attitudes to help change their actions. Within a cognitive-behavioral treatment, the patient learns to identify harmful thoughts and to assess whether they are accurate. CBT also focuses on replacing unhelpful coping strategies with healthier options.

Comorbid. The relationship between two or more disorders that afflict a person at the same time.

Complementary identification. The therapist experiences emotions or attitudes similar to those experienced by significant people in the patient's personal life.

Concurrent identification. The experience by the therapist of emotions or attitudes similar to those experienced by the patient.

Confidentiality. Privacy protection of information revealed to a mental health clinician as mandated by ethical principles and law.

Conflict. Mutual opposition, usually referring to wishes, goals, or purposes.

Confrontation. The process in which a clinician calls the patient's attention to ideas or other information.

Consultation. The first few meetings with a patient during which the therapist will obtain a history, make a diagnosis, and recommend a treatment plan. As defined in this book, a consultation does not guarantee that the therapist will become the patient's individual psychotherapist. Until the consultation is complete, the therapist cannot assume that individual psychotherapy is even the treatment of choice.

Contingency management. An approach often used in addiction treatment that provides prompt rewards in response to positive patient treatment behavior such as a negative toxicology screen or treatment compliance, and provides undesirable consequences in response to a positive toxicology screen or treatment noncompliance.

Contract. An agreement, usually spoken although sometimes written, between a patient and a clinician, about specific behaviors related to treatment. For example, a patient may promise to call the clinician or to go to the nearest emergency room if or when suicidal intentions increase, as a contract for safety.

Contraindication. A factor or circumstance that makes a particular treatment or procedure undesirable or fraught with unnecessary danger.

Countertransference. Subjective responses of a clinician toward a patient.

Countertransference enactment. Expression of feelings or attitudes of the therapist in response to the patient, which are partly or wholly outside of consciousness.

Cultural competence. The ability to interact with others of a different culture with an understanding, appreciation, and respect for cultural differences. The concept of cultural humility was developed in response to the construct of cultural competence because the latter implies a discrete endpoint that may encourage overgeneralizing about individuals with a particular cultural background.

Cultural humility. A commitment to engaging in ongoing active self-evaluation and critique in recognizing one's own biases, and acknowledging one's knowledge gaps regarding another's culture. Cultural humility includes being open to input and new ideas, with respect toward to each individual's expression of their own culture. Cultural humility may be practiced on the individual level, such as within the therapist–patient relationship; within an organization (in its mission statement, the demographic composition of its staff, etc.); and within systems (as reflected in policies, programs, services, etc.). The concept of cultural humility was developed in response to the concern that the construct of cultural competence was fixed and less responsive to input.

Cultural identity. The feeling of belonging to any group. The definition of a cultural identity is inclusive and is determined by the individual. A person's cultural identity may be multidetermined. Some factors that may contribute to an individual's cultural identity: ethnicity, race, religion, nationality (or nationality of parents or grandparents), social class, generation, sexual or gender identity, languages spoken, or locality. (See Figure 5.1 for more examples.)

Day residue. Portions of recent experiences that appear in a dream.

Deduction. A process that collects data to confirm or disprove a previously created hypothesis or conclusion; when a clinician asks a list of questions about neurovegetative symptoms to see if the patient meets criteria for a major depressive disorder, they are using a deductive process.

Denial. An immature psychological defense mechanism created in early childhood that refuses to acknowledge the reality of a present problem as a way to cope with it. For example, when accused of sneaking a cookie from the cookie jar, a small child may attest, "I did not eat any of the cookies" while their face is smeared with cookie crumbs. Denial may lessen as a person more becomes psychologically functional; however, varying degrees of denial may continue to exist.

Derivative. An indirect communication of a conflicted emotional reaction, an unconscious communication.

Developmental crisis (also known as a *normative crisis*). A time associated with a substantial role change (such as puberty, marriage, parenthood, or retirement) that requires significant psychological growth and behavioral adjustment.

Diagnostic and Statistical Manual of Mental Disorders. A detailed and descriptive catalogue of mental disorders, currently in its fifth edition (DSM-5), and generally accepted as authoritative in the United States, Canada, and other countries.

Directed fantasy. Something that is imagined intentionally, with a purpose or design.

Directed imagery. A mental likeness of a person, place, situation, or story, actual or fanciful, created with a conscious purpose.

Displacement. A psychological defense mechanism in which feelings that are difficult to tolerate are transferred from the original source to a safer person, object, or event. A classic example: a boss yells at a parent; the upset parent yells at their children; and the upset children yell at the dog.

Duty to report. A legal requirement, which overrides confidentiality, that a clinician inform governmental authorities when they learn of such matters as current or intended abuse of children, the disabled, or the elderly. Duties vary among jurisdictions.

Dysphoria. An unpleasant emotional state of unease and restlessness often associated with depression or anxiety.

Eating disorder. A condition in which extreme eating behaviors endanger health and interfere with personal or occupational functioning.

Ego-syntonic. Thoughts, feelings, or actions that do not cause emotional distress and are aligned with one's self-concept or worldview.

Electroconvulsive therapy (ECT). The use of a weak electric current applied to one (unilateral) or both (bilateral) sides of a patient's head. This treatment is offered to patients suffering from disorders such as severe depression or mania, usually after multiple trials of medication have not provided relief. The treatment is conducted with brief general anesthesia aided by muscle relaxants under the care of a trained anesthesiologist with full resuscitation equipment.

Empathic failure. A term used in the psychotherapeutic literature to describe an interaction in which the therapist misunderstands the patient. With the perspective that this is a harsh and inaccurate term, *empathic lapse* is used as a replacement within this text, promoting the view that these are not failures but valuable opportunities for discussion and learning.

Empathic lapse. A therapist's misunderstanding of their patient.

Empathy. The attempt to recognize another person's subjective state cognitively and emotionally.

Enactment. The interpersonal expression, through speech, movement, or activity, of ideas, emotions, attitudes, or other internal (intrapsychic) experiences.

Encryption. When information is encoded so it remains secure, confidential, and will not be understood if it is intercepted. Emailing with patients using encryption protects the security of the conversation.

Ethics. Considerations of what is good or bad, right or wrong, acceptable or unacceptable in human behavior. Social meetings (such as a coffee date) are considered unethical within the framework of the therapist–patient relationship.

Evocative memory. The ability to call up or to bring to consciousness an event, image, or experience as desired. Also known as *explicit memory* or *conscious memory*.

Explicit memory. *See* Evocative memory.

Fiduciary. Someone who is entrusted with power for the benefit of someone else.

Fixed mindset. A concept developed and popularized by psychologist Carol Dweck that views traits such as personality, intelligence, and abilities as fixed, leading to a perspective that performance cannot be improved or developed.

Formulation. A systematic appraisal of an individual's biopsychosocial makeup that reflects on the development of a patient's struggles and strengths, considers different diagnoses, and includes recommendations for the most appropriate treatment approach.

Frame. The limits or boundaries of the relationship in which psychotherapy is conducted.

Free association. An association that arises without either internal or external prompting.

Generalized anxiety disorder. Worry and anxiety that are difficult to control, for a majority of days over a period of 6 months or more, and cause significant distress and impairment of functioning in social, occupational, or other important areas.

Group psychotherapy. Any form of psychosocial treatment in which a therapist or leader works with more than one patient.

Growth mindset. A concept developed and popularized by psychologist Carol Dweck that views difficulties or failures as challenges and opportunities for growth and not as a reflection of innate abilities. Often contrasted with a fixed mindset, in a growth mindset, hard work and resilience are prioritized values and mistakes are viewed as an opportunity to learn and grow. From an educational perspective, a growth mindset best supports a therapist's ongoing pursuit of excellence.

Harm reduction. Any approach that prevents or reduces the harm associated with substance use.

Here and now. The current relationship of the therapist and the patient.

HIPAA. The acronym for the Health Insurance Portability and Accountability Act that was passed by Congress in 1996. HIPAA covers many areas but specifically mandates standards for protecting and handling confidential health information.

Hostility. An attitude of antagonism or animosity. Its emotional quality tends to last longer than anger.

Hypomania. An abnormal state of mind that lasts at least 4 days and manifests with elevated mood or significant irritability that affect thoughts, mood, and behavior. Hypomania may include pressured speech, decreased focus, decreased ability to sleep, impulsivity, and agitation. It often is associated with a bipolar or related disorder. Unlike mania, hypomania by definition is never associated with psychosis. It is not debilitating enough to require hospitalization.

Idealization. A defensive process in which someone or something is thought of as perfect or as having extremely favorable qualities.

Ideas of reference. A belief that one is the object of special attention, messages, or meaning. For example, someone named Tom might see a sign with the letter *T* advertising the Boston public transportation system and believe it is a message meant for him individually.

Identification. A psychological process by which a person adopts characteristics of another individual and is changed by this process. The person may be aware to some extent of this process.

Imagery. A mental likeness of a person, place, situation, or story, actual or fanciful.

Impasse. A pause in the progress of a psychotherapy. A therapist may gain an understanding of the dynamics of the pause through careful listening, gentle inquiry, and empathic responsiveness.

Implicit Association Test (IAT). A free measure available online developed to identify areas of implicit bias by measuring an individual's association of good/bad or stereotypes to specific groups of people, with a focus on groups that have been more affected by prejudice or stereotypes such as BIPOC communities, women, or the LGTBQIA+ community (Project Implicit, 2011).

Implicit bias. Unconscious bias toward a group of people that has the potential to drive discriminatory actions. All individuals are affected by implicit bias but may not be aware how their implicit bias is affecting them. By choosing to learn about their unconscious biases, therapists can learn to override first impulses that may be harmful.

Induction. A process that relies on observations and notation of patterns to create a tentative hypothesis; when a clinician creates a psychodynamic formulation based on a patient's unique story, they are using an inductive process.

Informed consent. Permission given by a patient, without coercion, regarding an offered procedure and based on adequate knowledge of benefits, risks, costs, duration, and other factors.

Insight. Understanding one's emotional processes and experiences with a combination of feelings and intellect.

Institutional racism. *See* Structural racism.

Interpersonal racism. Conscious or unconscious discriminatory actions when interacting with those of a different racial background.

Interpretation. An explanation offered by a therapist to help the patient understand their inner experience in a way that includes their feelings as well as thoughts, and that links their experiences in the past with those in the present.

Intersubjectivity. The effects that the emotional experience and attitudes of the patient have on the emotional experience and attitudes of the therapist and vice versa.

Latency. The period of a child's life from about the age of 5 or 6 until the onset of puberty.

Learning disorder. The term used in DSM-5 to signify a learning issue, which was previously referred to as a learning disability. A condition in which an individual experiences ongoing specific difficulty in learning, such as a difficulty with reading, spelling, written expression, mastering calculations, or using academic skills, that cannot be explained by other conditions—for instance, an intellectual disability, psychosocial difficulties, uncorrected visual or auditory issues, a neurological disorder, or lack of proficiency in the tested language.

LGTBQIA+. An acronym referring to Lesbian, Gay, Transgender, Bisexual, Queer, Intersex, and Asexual individuals, as well as those not explicitly mentioned.

Limit setting. When the therapist's behavior or explanation reinforces the boundaries of the therapeutic relationship.

Major depressive disorder (MDD). Also referred to as "clinical depression," MDD is a mental health condition defined by a low mood and disinterest in daily activities, impeding an individual's ability to fully participate in their own life for at least 2 weeks; other symptoms of MDD might include fatigue, an inability to concentrate, suicidal ideation, insomnia or hypersomnia, feelings of worthlessness, and significant weight gain or loss.

Managed care. A type of health insurance that manages and may restrict, a patient's health care options, including any mental health coverage, in an attempt to bring down costs. Managed care organizations often only pay for care within a predetermined network of providers.

Mania. A condition characterized by elevated or irritable mood, persisting for at least 1 week, accompanied by at least three of the following symptoms (four if the mood is irritable rather than elevated): grandiosity, decreased need for sleep, flight of ideas, tangential or pressured speech, distractibility, increased goal-directed activity or psychomotor agitation, or impulsivity. The condition is sometimes accompanied by psychosis. It must interfere with social or occupational functioning.

Manipulation. The process of influencing someone, often without that person's awareness of what, how, or why it is being done.

Mentor. A trusted advisor and educator.

Microaggressions. Casual comments or interactions toward a member of a marginalized community that might seem like a compliment or a joke but reflect the bias of the instigator, who may not recognize the harm caused. The interactions leave the member of the marginalized group uncomfortable and insulted. These interactions take a psychological toll, may increase anger and dysphoria, and may cause the work or school environment to feel hostile or not welcoming.

Mood. One's internal current emotional state.

Mood disorder. Psychiatric disorders that affect mood in a sustained substantial disabling manner. Mood disorders affect feelings, thoughts, and behavior. The two more well-known mood disorders are major depressive disorder and bipolar disorder.

Motivational interviewing (MI). A collaborative, compassionate, goal-oriented counseling approach focused on strengthening an individual's motivation for positive change, often used in substance use disorder treatment.

Multicultural counseling and therapy (MCT). A counseling approach that welcomes a patient's cultural experience into the treatment and treatment planning. In addition, MCT specifically promotes cultural humility and requires therapists to learn about their own internal biases and prejudices, and how they might affect therapeutic interactions. There are many defined multicultural counseling competencies that are beyond the scope of this book but can be found in the writings of D. W. Sue, listed in the References and Additional Readings and Resources.

Mutual help. Help found through self-help or peer support groups. Mutual help organizations include all the of Anonymous groups (such as Alcoholics Anonymous, Gamblers Anonymous, or Overeaters Anonymous), Smart Recovery, and Al-Anon.

National Institute on Alcohol Abuse and Alcoholism (NIAAA). Established in 1970, NIAAA is one of the 27 institutes within the U.S. National Institutes of Health (NIH). Its name, citing the stigmatizing term of alcohol abuse rather than alcohol use disorder, is outdated (*see* Addictionary). The institute supports worldwide research on the effects of alcohol use; go to *www.niaaa.nih.gov*

National Institute on Drug Abuse (NIDA). Established in 1974, NIDA is one of the 27 institutes within the U.S. National Institutes of Health (NIH). Its name, citing the stigmatizing term of drug abuse rather than substance use disorder, is outdated (*see* Addictionary). Its mission is to "advance science on the causes and consequences of drug use and addiction and to apply that knowledge to improve individual and public health" (*www.nih.gov/about-nih/what-we-do/nih-almanac/national-institute-drug-abuse-nida*).

Neurochemistry. The science that deals with the properties and interactions of substances important to the nervous system.

Neurotic symptoms. Symptoms that are generally associated with high levels of anxiety due to a distressing but unconscious conflict. The neurotic symptom often acts as a solution.

Neurotransmitters. Chemical substances that mediate communication between nerve cells.

Neurovegetative symptoms. Basic life functions controlled by the nervous system such as appetite, sleep, energy, and motion. Neurovegetative symptoms are often affected when a patient is struggling with a mood disorder.

Normative crisis. *See* Developmental crisis.

Objectivity. A condition of being unbiased and not affected by one's personal feelings, attitudes, or goals.

Obsessive–compulsive disorder (OCD). A psychiatric disorder that is often chronic in which the patient has disturbing recurrent persistent thoughts (known as *obsessions*) and/or recurrent disabling behaviors the patient feels mandated to complete (known as *compulsions*) with both the obsessions and compulsions feeling out of the patient's control. These symptoms cause emotional distress and/or affect the individual's functioning in relationships, work, or school.

Obstructions. Factors affecting a patient's ability to attend therapy that are out of their control and often unpredictable (such as blizzards, power outage before a remote therapy session, lack of transportation, or an illness in the patient or in their family).

OpenNotes. As of April 2021, there has been a federal mandate that most electronic medical notes, which include psychotherapy progress notes, may not be blocked and must be accessible to patients to review free of charge (OpenNotes, 2021). Clinicians may be allowed to block access to a medical record when it might cause harm to the patient or another person, but these exceptions are limited and rare, and should be used in close consultation with a clinic's attorney and the clinician's professional liability insurance company. The Open Note rule does not apply to psychotherapy notes (also known as *process notes*) that are the psychotherapist's personal notes regarding the content of a psychotherapy hour.

Osteoporosis. A condition in which the density of bones, and therefore their strength, are reduced and the possibility of fractures is increased. Patients suffering from anorexia nervosa complicated by amenorrhea are at risk for this condition.

Paranoia. Feelings of ongoing persecution leading to an irrational mistrust of others, and the feeling of being victimized in absence of a threat. Paranoia may be caused by medical conditions such as dementia, or psychiatric disorders such as schizophrenia or substance use disorders.

Peer supervision. Mutual teaching and learning between colleagues.

Personal therapy. Psychotherapy undergone by a trainee or graduate clinician.

Personality disorder. A condition consisting of a lasting set of inner experiences and outward behaviors that impair social, occupational, or

academic function and/or that produce intense subjective distress. It begins in early adulthood.

Posttraumatic stress disorder (PTSD). A condition persisting for more than 1 month with symptoms such as recurrently distressing recollections, hypervigilance, avoidance, exaggerated startle responses, nightmares, or emotional dulling, following an event or events in which the patient experienced horror and helplessness when exposed to a threat of death to self or others, abuse or dire injury to self or others, or the death or mutilation of others.

Premature interpretations. Therapist interpretations offered that the patient is not psychologically ready to incorporate. There is a risk that the interpretation, which prematurely ties together a patient's past experiences with their present, may be experienced as intrusive, inaccurate, or unempathic to the patient.

Privileged communication. Information provided by a patient to a clinician that must be kept secret, in accordance with laws and ethical principles, unless the patient authorizes disclosure.

Process notes. A therapist's detailed private notes on psychotherapy material that can include descriptions of interactions and nonverbal communications as well as the clinician's reactions and perceptions. These notes are for the therapist's use only and are not part of the official medical record or accessible by the federal Open Note mandate that was issued in April 2021. HIPAA refers to process notes as "psychotherapy notes."

Professional executor (PE). An individual who develops a professional will with the therapist. In the event of the therapist's death, the PE is responsible for closing the practice by notifying the deceased therapist's current and past patients, triaging clinical needs, and taking appropriate care of the clinical records.

Professional will. A document outlining a care plan for patients and directions on how to close a clinician's practice in case of their untimely death. The professional will designates a professional executor (PE) who is responsible for closing the practice by notifying the deceased therapist's current and past patients, triaging clinical needs, and taking appropriate care of the clinical records. The will provides the information and passwords needed to locate and access records as well as change emails and voicemails. Legal directives will guide how long financial records, appointment books, and related records are kept (Oregon Psychological Association Professional Affairs Committee, 2010).

Protected health information (PHI). As defined by HIPAA, PHI is identifying patient information attached to a patient's medical and mental health history that is used by a health care provider, health plan, or health care institution. PHI can be sent through electronic media (such as secure

email), maintained on computer servers (such as with electronic medical records), or may be secured in other forms (such as paper records in locked cabinets). Some examples of PHI include a patient's name, address, phone number, Social Security number, or medical record number.

Psychodynamic psychotherapy. Psychosocial treatment that focuses on self-reflection, free association (rather than a predefined treatment plan), and an examination of the transference to more deeply understand the psychological roots of a patient's emotional distress. Psychodynamic psychotherapy examines the multiple intrapsychic forces that oppose more adaptive behaviors and have repeatedly interfered with the patient's ability to act in a way that would promote their own happiness and productivity. In psychodynamic psychotherapy, the psychotherapeutic relationship itself is involved in the healing process. The relationship can provide a model for mature and empathic interactions. Examination of the patient's transference toward the therapist allows a deeper grasp of the patient's unique experience and struggles while also increasing the patient's understanding of maladaptive communication strategies.

Psychoeducation. Teaching about psychological, emotional, or interpersonal conditions or disorders.

Psychological review of systems. A series of questions posed by a clinician to a patient about the possible presence of symptoms related to the main categories of mental disorders, such as anxiety disorders, mood disorders, substance-related disorders, psychotic disorders, and others.

Psychomotor agitation. Excessive motion that is unproductive, tends to be repetitive, and is accompanied by inner feelings of tension.

Psychomotor retardation. A general slowing of motion and speech often accompanied by apathy or unhappy mood.

Psychopathology. Referring to either the study of mental disorders based on scientific research or the psychological impairments associated with a mental disorder.

Psychopharmacology. A subspecialty of medicine that deals with medications for mental health disorders.

Psychosis. A condition that exists when an individual sees, hears, or believes things that aren't real. Psychosis may be caused by medical conditions or multiple psychiatric diagnoses, including bipolar mania, schizophrenia, trauma, severe major depressive disorder, or substance use or withdrawal.

Psychotherapy. Any treatment of a mental or emotional disorder that relies on communication between patient(s) and clinician(s) without the use of medicine.

Psychotherapy notes. The official HIPAA term that refers to process notes.

Psychotherapy office notes. Also known as *psychotherapy progress notes,* ongoing treatment notes that follow documentation guidelines and record therapy progress. These notes are an official part of the medical record and may be reviewed by the patient; at minimum, they include medically relevant diagnostic and treatment information and a safety assessment, reviewing risk to self, others, or major changes in mental status.

Psychotherapy progress notes. *See* Psychotherapy office notes.

Psychotropic. Mind-affecting. Commonly refers to drugs, both legal and illegal.

Rapport. A harmonious, positive, respectful relationship between two people. For a patient to feel safe and comfortable addressing complex sensitive issues within a psychotherapy, the therapist and patient must have a good rapport.

Rational Recovery. A copyrighted, somewhat controversial approach to addiction recovery that outlines an independent approach to permanent abstinence with a focus on urge coping, using a cognitive orientation that is different than the spiritual approach of AA. The program does not include any mutual help groups or rehabilitation centers. The addiction program Smart Recovery, which does include mutual help groups, evolved out of Rational Recovery.

Recovery capital. The resources required to begin and to continue recovery from a substance use disorder; these resources may be emotional, physical, financial, social, or cultural, and so forth.

Reliability. The consistency with which a test or other measuring method will show closely similar results when employed repeatedly under similar conditions.

Repetition compulsion. The impulse to reenact previous developmental experiences with people in one's current life.

Resistance. Any behavior over which the patient has some influence that interferes with the progress of treatment.

Reversal of roles. A situation in which a person, who is under the care of another, is induced to provide care to the original caretaker.

Review of systems. A series of questions posed by a clinician to a patient about the possible presence of symptoms related to the major physiological systems, such as the cardiovascular, respiratory, gastrointestinal, neurological, and other systems. A psychological review of systems screens for various categories of psychiatric disorders, such as anxiety disorders, depressive disorders, bipolar disorders, and so forth.

Risk assessment. Evaluation of a patient's risk of hurting themself or others by identifying suicidal thoughts, self-harm thoughts, homicidal thoughts, violent or destructive thoughts, static risk factors, modifiable risk factors, and protective factors. The clinician will create an appropriate treatment plan based on the results of a risk assessment.

Secure network. Any electronic network (that may be employed by a home, business, school, or other entity) that includes safeguards and security to protect from unwanted breaches.

Self-injurious behavior (SIB). Deliberate self-harm as a reaction to emotional distress. Self-harm is usually not a suicidal attempt, but it is associated with a higher risk of future suicidal behavior. SIB examples include head hitting, head banging, cutting, or burning.

Selective serotonin reuptake inhibitors (SSRIs). A generally well-tolerated class of antidepressants that work by increasing the levels of serotonin in the brain. They are used to treat many psychiatric conditions, including anxiety disorders and major depressive disorder. Any medication dose requires approximately 4–8 weeks to achieve its full therapeutic effect. SSRIs may destabilize mood in patients with bipolar and related disorders.

Situational crisis. A sudden unexpected event associated with significant psychological distress such as a natural disaster, a crime, or the COVID-19 pandemic.

SMART Recovery. Self-Management and Recovery Training is a nationwide free nonprofit addiction program that utilizes cognitive therapy principles combined with online mutual help support groups. This treatment approach evolved out of Rational Recovery but ended its affiliation with the latter in 1994.

Sobriety. Definitions vary. Some define sobriety as a lack of impairment when using substances or the state of not being intoxicated. From the perspective of some addiction treatments, sobriety refers to an individual's decision to abstain from all mind-altering substances.

Structural racism. Historical, social, cultural stereotypes and norms, as well as public policies and institutions, that advantage Whites and disadvantage People of Color. An example for some is the U.S. criminal justice system, which may provide a harsher sentence to a person of color, as compared to a White defendant accused of the same crime. Structural racism also leads to unequal distribution of necessary resources, such as loans, housing, opportunity access, income, and jobs. Also known as *systemic racism* or *institutional racism*.

Subpoena. A document that summons witnesses, documents, or other evidence before a court or other official body.

Substance use disorder (SUD). A disorder defined by ongoing substance use (such as alcohol or drug use) despite the physical harm associated with its use and the significant difficulties the use causes in an individual's work, school, or social relationships. Also referred to as a "drug addiction." An SUD is additionally defined by the individual's craving for the substance, increased tolerance of the substance over time, and repeated relapses.

Suicide. The act of intentionally taking one's own life.

Supervision. A therapist's presentation of the details of a patient's ongoing treatment to an established colleague or teacher for evaluation, feedback, and guidance. When in training, supervision is offered to the novice therapist at regular predefined intervals (often weekly) to provide required oversight and treatment guidance. With supervision during training, the supervisor may be aware of the identity of the patient as the teacher also holds some clinical responsibility for patients in a trainee's care. For supervision after training, the therapist presenting the case will withhold identifying information to preserve the patient's confidentiality, and the supervisor providing feedback does not hold any clinical responsibility for the case discussed.

Supportive intervention. A procedure in psychotherapy in which the clinician reinforces the patient's most adaptive coping mechanisms or introduces more effective ones.

Sustain talk. A term used in motivational interviewing to describe language that favors the present circumstances rather than change.

Systemic racism. *See* Structural racism.

Telehealth. Remote clinical services provided using telecommunication technologies.

Telephone Consumer Protection Act (TCPA). Laws and regulations pertaining to phone calls and texting established by the Federal Communications Commission (FCC) to protect privacy and reduce unwanted telecommunications. It mandates a Do Not Call registry and text messaging (SMS) restrictions, including a stipulation that individuals consent before receiving texts, that texts must not contain confidential information, and that consumers may opt out of texting at any time.

Telepsychotherapy. Using a secure video connection or a phone to provide psychotherapy.

Termination. The ending phase of treatment.

Therapeutic alliance. The collaboration between a patient and a clinician intended to accomplish the goal(s) of treatment.

Therapeutic relationship. The relationship between the therapist and the patient that follows practice guidelines (collectively known as the frame) to create a safe environment that supports rapport building, while also maintaining the therapist's relative objectivity.

Thought broadcasting. A belief or subjective experience that one's thoughts are converted into sound and can be heard by others.

Thought insertion. A belief or subjective experience that others can put thoughts into one's mind. The "inserted" thoughts are not experienced as one's own.

Transfer of care. When the comprehensive care and responsibility for a patient are moved from one clinician to another.

Transference. Preconceived attitudes or expectations toward a person based on one's experience in prior relationships. For instance, a patient with a critical parent may expect the therapist to be critical as well.

Validity. The degree to which a test or other measuring method truly measures what it is claimed to measure. For example, an intelligence test printed in Japanese administered to subjects who can read only English would have extremely low validity because correct answers would occur only by chance (random guessing).

Working through. A process that leads to insight, based on a person's examination of their problems multiple times and from various points of view.

Additional Readings and Resources

These additional readings and resources provide increased depth on introduced topics.

American Psychiatric Association. (2013). Cultural formulation. In *Diagnostic and statistical manual of mental disorders* (5th ed., pp. 749–759). Arlington, VA: Author.

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Cardemil, E. V., & Battle, C. L. (2003–2006). Guess who's coming to therapy? Getting comfortable with conversations about race and ethnicity in psychotherapy. *Professional Psychology: Research and Practice, 34*(3), 278–286.

Dimeff, L., Rizvi, S., & Koerner, K. (2020). *Dialectical behavior therapy in clinical practice* (2nd ed.). New York: Guilford Press.

Dweck, C. S. (2008). *Mindset: The new psychology of success*. New York: Ballantine Books.

Eberhardt, J. L. (2019). *Biased: Uncovering the hidden prejudice that shapes what we see, think and do*. New York: Viking. Excellent book for therapists working to recognize their own biases.

Faber, A., & Mazlish, E. (1980). *How to talk so kids will listen and listen so kids will talk*. New York: Avon Books. A great book for beginning therapists as it clearly teaches how to listen empathically.

Firestein, S. K. (2007). The patient or the analyst dies: Ethical considerations. *The American Psychoanalyst, 41*(3), 30–31.

Gabbard, G. (2016). *Boundaries and boundary violations in psychoanalysis* (2nd ed.). Arlington, VA: American Psychiatric Association.

Gerner, C., & Neff, K. (2019). *Teaching the mindful self-compassion program: A guide for professionals*. New York: Guilford Press.

Grisel, J. (2019). *Never enough: The neuroscience and experience of addiction*. New York: Doubleday. Excellent book on addiction from the perspective of a behavioral neuroscientist who has recovered from a substance use disorder.

Harris, R. (2019). *ACT made simple: An easy-to-read primer on acceptance and commitment therapy* (2nd ed.). Oakland, CA: New Harbinger. ACT outlines many supportive interventions to help patients access adaptive coping skills and increase psychological flexibility during difficult times.

Hays, P. (2007). *Addressing cultural complexities in practice: Assessment, diagnosis, and therapy* (2nd ed.). Washington, DC: American Psychological Association.

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