

# Becoming a Therapist

*What Do I Say, and Why?*

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## About the Authors

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After his military service, Dr. Messner's psychiatric training consisted of 2 years of adult residency at the Boston Veterans Administration Hospital, 1 year of child fellowship at the Thom Clinic in Boston, and then 2 years as a clinical and research fellow at MGH. At the same time, he received training at the Boston Psychoanalytic Institute and was graduated as a certified psychoanalyst. During Dr. Messner's career in the MGH Psychiatry Department, which has been rated number one in the United States for 7 consecutive years, he has earned the Teacher of the Year award six times.

# Prologue

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 first 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, 1994 became my year to sweat as I intently listened 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 firmly confront,

and words that would comfort. Many of my supervisors gently teased me when I wrote down their advice verbatim for reference pre-session. 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 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. A mental review of psychotherapists in film wasn’t helpful. 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 are hard to come by on the big screen. At best, therapists are featured as comic relief, quirky, and somewhat odd. At worst, they’re sleeping with their patients or their patients’ family members. In general, Hollywood provides a clear outline of what *not* to do.

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 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. He has won numerous Teacher of the Year awards, most recently in 1999. 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—now. 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 am still in touch with all the gnawing questions that bother a beginner, and Dr. Messner can explain what to do clearly and concisely, based on more than 40 years of clinical experience.

Although our 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 psychotherapy. People are curious about what goes on during talking treatment, including how therapists think or feel, and what they say—and why. As we revised our text, we have kept our nontherapist readers in mind. We have included a glossary to define the technical terms that we could not reasonably avoid. The book still “talks” directly to the beginning clinician, but the information should be accessible to nontherapists as well.

The text before you represents our combined judgment. Common predicaments faced by the beginning psychotherapist will be presented in my voice while explanations and guidance will be presented in the plural, as our collaborative effort. Innumerable hours of supervision, with colleagues and mentors, also helped me to formulate my questions and to find my own answers. We gratefully recognize these clinicians in the acknowledgments.

We 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, we 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. Our greatest hope is that this book will provide for you what I was looking for just a few years ago.

# List of Dialogues

## I. The Consultation

### Chapter 1. First Contact

- 1.1. The therapist's vague phone message in response to the patient's first call
- 1.2. The therapist's clear phone message in response to the patient's first call
- 1.3. The first phone conversation: In her excitement, the therapist agrees to meet at an inopportune time
- 1.4. The first phone conversation: The therapist sets up a viable appointment time

### Chapter 2. The First Moments

- 2.1. A method of introduction that preserves the patient's confidentiality
- 2.2. Starting the session with a statement that may set the stage for a paternalistic relationship rather than a collaboration
- 2.3. Starting the session with a statement that may make the patient defensive
- 2.4. Starting the session with a statement that may facilitate discussion
- 2.5. Starting the session with a statement that should avoid defensiveness

### Chapter 3. Initiating an Alliance and Assessing Safety

- 3.1. Framing the first three visits
- 3.2. The therapist takes an overly passive stance during the first interview
- 3.3. An overstructured approach for the first interview

- 3.4. Balancing the need for information and the need to create a therapeutic alliance during the first consultation session
- 3.5. Collecting some basic information at the end of the first session

#### **Chapter 4. Enhancing the Therapeutic Alliance and Eliciting History**

- 4.1. Opening the second session
- 4.2. Clarifying the patient's current psychiatric symptoms—a more directive approach in the second consultation session
- 4.3. The therapist assumes incorrect information about the patient
- 4.4. Collecting a personal and family psychiatric history
- 4.5. Collecting a personal and family medical history
- 4.6. Closing the second session

#### **Chapter 5. Collecting a Psychosocial History and Screening for Common Psychological Disorders**

- 5.1. Obtaining a developmental history by following the patient's lead
- 5.2. Three strategies to assess substance abuse during the consultation
- 5.3. Assessing substance abuse using the CAGE questionnaire
- 5.4. Screening for anxiety disorders during the consultation
- 5.5. Screening for psychosis and mania during the consultation interview

#### **Chapter 6. Formulating a Treatment Plan**

- 6.1. Explaining the process of psychotherapy to a new patient
- 6.2. The therapist sensitively refers the new patient to another clinician early in the consultation
- 6.3. An excerpt from a session followed by a typical process note that abbreviates the action and formulates the therapist's questions

## **II. Frame and Variations**

#### **Chapter 7. The Frame**

#### **Chapter 8. Setting the Fee and Billing**

- 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
- 8.2. The therapist discusses her fee and insurance issues during the first phone call
- 8.3. Discussing managed care as payment for psychotherapy and how to set a reduced fee
- 8.4. The therapist confronts a private practice patient receiving a reduced fee who has monetary resources that were kept secret
- 8.5. Discussing payment with the patient who hasn't paid



- 8.6. How to react when a patient's relative refuses to subsidize the therapy as previously promised

### **Chapter 9. Telephone Calls: From Dependencies to Emergencies**

- 9.1. The therapist sets herself up for abuse of her pager and of her emergency services
- 9.2. The therapist allows and then encourages extended phone calls outside the session
- 9.3. Assessment of a situation after a page followed by a quick but empathic crisis intervention
- 9.4. Setting limits empathically for outside phone contact between sessions
- 9.5. Emergency evaluation by phone

### **Chapter 10. No-Shows, Late Arrivals, and Late Departures**

- 10.1. The therapist is overaccommodating and extends the session to placate a late patient
- 10.2. The therapist does not extend a session to accommodate a patient who was late
- 10.3. When a patient repeatedly brings up emotionally loaded topics at the end of the session
- 10.4. Discussing repeated late attendance in a therapeutic manner
- 10.5. Responding to a patient who recurrently misses her appointments
- 10.6. The therapist is late to the session

### **Chapter 11. Confidentiality and Its Limits**

- 11.1. The therapist-in-training informs the patient that a supervisor will advise and guide the therapist
- 11.2. The therapist requests permission to consult a group of clinicians at a case conference
- 11.3. The therapist tries to learn the meaning behind the patient's request to see her own psychotherapy records
- 11.4. The therapist protects the patient's confidentiality in response to an unexpected phone call
- 11.5. The patient recalls a history of physical abuse, expresses suicidal and homicidal feelings, and the therapist panics
- 11.6. The therapist carefully assesses suicidality or homicidality in a high-risk patient

## **III. Chemistry**

### **Chapter 12. Substance Abuse**

- 12.1. The therapist does not recognize that her new psychotherapy patient is also an active substance abuser

- 12.2. The therapist identifies her new psychotherapy patient as an active substance abuser
- 12.3. The therapist confronts her patient about his substance abuse in an authoritative and ultimately nontherapeutic manner and then colludes with the patient to ignore the mounting evidence that the patient has a substance abuse problem
- 12.4. The therapist sensitively confronts a patient with an active substance abuse problem who is in denial
- 12.5. Typical therapy session with a substance abuser in the very early stages of recovery
- 12.6. Confronting an active substance abuser who has been lying about his treatment compliance

### **Chapter 13. Integrating Psychopharmacology with Psychotherapy**

- 13.1. The therapist does not complete a thorough psychopharmacological evaluation for a psychotherapy patient
- 13.2. How to talk to a psychotherapy patient about starting medications
- 13.3. The therapist becomes too medically oriented after the patient starts taking a medication
- 13.4. When the psychotherapist incorporates both biological and psychological perspectives
- 13.5. Discussing medication as an option for a patient who refuses psychopharmacological treatment although she would clearly benefit from it

## **IV. Therapeutic Dilemmas**

### **Chapter 14. Management of Impasses**

- 14.1. The therapist employs ineffective tactics to respond to an impasse in the treatment
- 14.2. The therapist employs effective responses to the therapeutic impasse
- 14.3. Premature and inaccurate clarifications
- 14.4. Using a dream to clarify the goals of therapy
- 14.5. The therapist interprets a patient's recurring difficulty with her friend

### **Chapter 15. Empathic Lapses**

- 15.1. 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

- 15.2. The more experienced therapist talks with a patient in detail about a recent empathic lapse
- 15.3. The therapist's countertransference reaction results in an empathic lapse, and the therapist cannot immediately untangle her own issues from those of the patient
- 15.4. The therapist realizes that her countertransference reaction resulted in some unempathic responses and accepts responsibility for her behavior
- 15.5. After responding unempathically to the patient in a previous session (Example 15.3), the therapist works through her own countertransference reaction and, in the next session, talks with the patient about the interaction
- 15.6. The patient alludes to an empathic lapse in the previous session, and the therapist helps her talk about it directly

### **Chapter 16. Transference and Countertransference**

- 16.1. The therapist responds appropriately to a patient with a strongly aversive first impression
- 16.2. The therapist experiences a transference reaction as a personal attack and responds countertherapeutically
- 16.3. The patient's transference reaction is used to inform and to advance the therapy
- 16.4. The therapist moves the focus away from the transference when the patient becomes paranoid
- 16.5. The therapist notes her own increasing feeling of helplessness in the session and uses the experience to shape her next intervention

### **Chapter 17. Termination**

- 17.1. The therapist is unable to maintain a focus on the patient and steps out of her professional role after announcing that she will be leaving the city in 6 months
- 17.2A and 17.2B. The therapist announces that she will be leaving the city in 6 months and listens carefully to her patient's reactions (2A, the indifferent patient; 2B, the upset patient)
- 17.3. The patient decompensates after the therapist announces the date that treatment will end
- 17.4. The patient announces her forthcoming move and then tries to ignore the upcoming separation from the therapist
- 17.5. The patient expresses her gratitude toward her therapist, and the therapist responds

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