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.

[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,

[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.