Social Work Talk April 1, 2006

Looking Backward: 30 years of Experiences I Wish I'd Had When I First Became a Therapist.

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INDRODUCTION

Good morning. I am delighted and honored to be here. It is a special privilege to be speaking at the school where I began my career 34 years ago.

I'm looking out at the audience: So many people, so many familiar faces who've come out early on a Saturday morning. It's amazing!

I've got this thought I've never had before – and probably will never have again: (PAUSE)

Thank goodness they made continuing education compulsory!

(PAUSE)

In my checkered past, I've formally studied English Literature, Social Work, Psychology, and Psychoanalysis. I graduated from the UNC School of Social Work in 1974. After a brief stint in public welfare, I worked at a Family Service Agency for six years. In 1981 I entered full-time private practice which I've continued ever since.

Naturally *anyone* who's worked at *anything* for over 30 years has to have learned a great deal. So in that respect, my experience is no different from anyone else's.

The most distinctive aspect of my talk might be the form I've chosen to relate my perspective and point of view. Instead of presenting a typical paper in the usual linear format with a beginning, middle, and conclusion, I am doing something different. My narrative takes the form of a series of brief, distinct episodes: "sound bites," if you will.

We have all listened to lots of presentations and papers over the years. I don't know about you, but me, I have come to the conclusion that if I had some truly important issue on my mind, something that required my intense, undivided concentration, I'd go to hear an analyst present a paper.

It's that experience I want to spare you.

There is nothing new under the sun. I don't claim much originality. Some of the people who taught me what I know are, in no particular order, John Howie, Don Rosenblitt, John Fowler, I H Paul, Roy Schaefer, Charlie Keith, Hilda Lipman, Ruth Falk, Paul Lerner, Dave Freeman, Pauline Kael, and Sigmund Freud. I especially want to thank my friend Bill Meyer for doing so much for clinical social work and for making this presentation possible.

Finally to avoid the awkwardness of using two genders all the time, I've opted to refer to the patient as <u>she</u> or <u>her</u> and to the therapist as <u>he</u> or <u>him</u>. I intend no disrespect or hierarchical judgment with this convention.

(1) So many therapists: so little skill

Given the choice, most people would prefer to be in therapy with someone who can't help them. This explains why so many lousy therapists are so successful. Never underestimate the power of resistance.

(2) No good deed goes unpunished

When you are too nice to a patient, it puts a burden of guilt on them. And that will backfire. We social workers are most susceptible to this problem. We entered the field because we want to help people, which is fine except when our own need to be benevolent conflicts with the patient's need to struggle toward improvement.

(3) You can't always get what you want

If you want to make it in private practice, don't be a fussy therapist. People don't want to refer to a prima donna. Remember: The referring therapist is basically helping you out. It's obnoxious and a turn-off to act like you are doing *them* a favor by (QUOTE) "accepting the referral."

I once tried to refer a child patient to a colleague. He grilled me about the case. Then the coup de grace: "Send me the raw data from your testing and I'll let you know." Enough said.

(4) Lessons from Dirty Harry

A Clint Eastwood character was known for the line, “A man’s got to be aware of his limitations.” We psychotherapists have expertise in only one thing: The conduct of psychotherapy. None of us received a Ph.D. or MSW in raising children, choosing or letting go of a mate, maintaining a good marriage, having a satisfying sex life, or any of the other trying and confusing situations life hands us. To look in the Yellow Pages though a lot of therapists think they are experts about everything. This reminds me of what my friend Mike, who’s a trial lawyer, said: “An expert is someone who declares himself to have expertise in something.”

(5) What’s trendy this year?

Mental illnesses come and go in and out of fashion.

Whenever a whole lot of therapists report seeing a huge number of people with a particular diagnosis, something is wrong.

Without a show of hands, who here has seen a multiple personality disordered patient recently? The MPDs and their “alters” have receded into the woodwork, thank goodness. In my six years of clinic experience and 25 years of full-time private practice, I have never seen a case of repressed memory. *My* patients are trying to *forget* about bad stuff, not remember more of it.

I evaluate a lot of children and have diagnosed only one or two case of Asperger's Syndrome though dozens are referred to me with that label.

My current favorite saying is: "If the only tool you have is a hammer, then everything looks like a nail."

(6) Do you ever wish you were smarter?

When I was younger I used to think I was pretty smart, but I wasn't satisfied. My first analysis taught me that I wasn't really all that smart, but I was plenty smart enough.

The practical application of that insight is this: If I can't understand an article or a book about therapy, there is a problem with the book – not with me. There's a clear and intelligible way to explain any concept or idea. Read anything by Roy Schaefer – in fact, read *everything* by Roy Schaefer – and you'll see what I mean.

(7) Winnicott was right

No one knows a child better than the mother.

The technical corollary to this rule is: It's always helpful to tell the mother that you believe this.

(8) The sounds of silence

Don't say anything that doesn't improve on silence. And don't be afraid of silence. I have noticed that most of the time when the therapist breaks the silence by asking a question he is trying to manage his *own* anxiety, not the patient's. Besides, the therapist's questions don't usually help us understand the patient better anyway. After all, they're our questions. They reflect what's going on in our mind, not the patient's.

(9) Doctor, I'll do whatever it takes.

When I hear someone say "I'll do whatever it takes" I want to run the other way.

Only a fool would say "I'll do whatever it takes" before he knows anything about what it's going to take. These people shoot from the hip. They don't ask questions or think things through. I'll say, "I'm sorry, but your insurance does not cover psychological testing." "Oh – I'll do whatever it takes" they say. Time and again I never hear from them after I tell them the cost. I guess that spending money on their child wasn't one of the things they thought it would take to get help.

(10) Too much of a good thing

Don't be too (QUOTE) "analytic." Remember that neutrality does not equal distance, frigidity or inaction.

Early in my career a patient said to me, "Have a nice vacation." Silently I shot back a withering stare. (Pause) I was proud. Embarrassed, she slunk away. I have often thought to myself, "I can't believe she ever came back."

(11) First impressions

"Anybody with any brains knows that his first impressions are worth, next to nothing." Harry Stack Sullivan said that. I agree.

There have been so many times my first impressions have been wrong about patients. Most often I'll think the patient is more insightful, more introspective, less defensive, that is, a "better patient" than turns out to be the case. It's fine to be optimistic but the important thing here is to admit to yourself when you've made a mistake and refashion your expectations. Don't let your narcissism get the better of you.

(12) More pain, less gain

I'm not a member of the "No pain, no gain" school of therapy. I tell patients this. People new to therapy have some wrong-headed ideas about how it works – particularly how *our* type of therapy works. One common misconception is that it is really going to hurt – it *has to* or it won't help. Many therapists also buy into this myth.

That has not been my experience; either as a therapist or a patient. We should model ourselves after dentists: When their patient screams in pain they don't think "Great! We're really getting somewhere." Our job is to make therapy as free from anxiety possible. And I will tell the patient that. Some people really need that reassurance.

(13) Don't be confused by the facts

It is not a good idea to learn from other people what is going on in your patient's life.

As a therapist your main task is to understand how your patient experiences and construes the world. Extra-therapeutic information can diminish your capacity to see things from the patient's own personal, idiosyncratic point of view.

When I begin with a new patient who has seen another therapist before, I'll tell the patient, "I'll get in touch with your former therapist later. I like to make up my own mind about people." They always appreciate that I want to get to know them personally. And I do.

(14) Investment advice

The best financial investment I ever made was good supervision. It doesn't matter how many referrals you can get if your patients don't want to stay with you. Good supervision is the best way – probably the *only* way – to learn how to develop a therapeutic *process*. I won't say that everything I know I learned in supervision, but most of it is.

(15) Medication versus therapy: Beware of side effects

Medication can be really good at relieving symptoms. And that's important because symptoms really can mess up your life. Psychotherapy on the other hand can help resolve the issues and conflicts that create the symptoms and keep them alive.

Unlike therapy, medication works fast. That's another real advantage. But here's the worst side effect medication can have in my experience: Medicine often makes patients feel just good enough to not want to continue their therapy. Sometimes you can head off this problem by talking to your patient about it in advance.

(16) You are the expert

I've done quite a bit of "real" psychoanalysis – 4 to 5 sessions a week on the couch. But the thing is that few of those cases were referred specifically for analysis by other analysts. Most of them were the worst cases! Totally unsuitable for analysis.

Don't think that someone else knows more than you about how you should do your work. This goes for other "helpful" advice offered by psychiatrists medicating your patients, marriage counselors seeing a couple, or therapists of your patients' husbands or wives. Trust your own heart and your impressions and convictions

(17) Out of sight, out of mind

The law of lunches dictates that you will receive referrals from therapists you have had lunch with in the last two weeks.

This is a fact: When people don't see you, they don't remember you. Stay in circulation.

(18) Who are the best therapists?

Real psychoanalysts – the ones who've graduated from an institute – are *not* necessarily better clinicians, though I used to think so.

One of my favorite quotes from Freud is "Never underestimate people's craving for authority"; that is, our own regressive craving to have an authority over us. Hero worship is a universal character flaw.

(19) Sometimes less really is more

We psychoanalytic therapists sometimes think that more sessions or more frequent sessions is all that it takes to achieve results from a refractory patient. That hasn't been my experience. I've found that the single most important quality in a good patient is a degree of "psychological mindedness;" an interest and pleasure in understanding what make one's self and other people tick.

When a patient just doesn't have that quality, more frequent sessions might fill up your schedule but it is not going to turn a supportive therapy case into a good analytic one. That's like when a foreigner doesn't understand what you are saying so you just talk louder.

(20) Less is more - Part II.

Beware of too many people in one family being in therapy at one time.

You've got your patient. Then the husband gets into treatment. The kids go to see someone. This is expensive. And it's time consuming. The parents are running around like crazy to different therapists. The cure becomes worse than the disease. Therapy is supposed to make people feel *less* anxious and *less* pressured, not more. It is better to take things one at a time. Otherwise, the whole enterprise can blow up in your face.

(21) Rule #1

Never get angry with a patient no matter how provocative the patient gets. There will be times when you find yourself rationalizing how it will actually help the patient for you to express your own feelings. This kind of fatuous thinking usually falls under the category of "Reasons why it will be good for this patient to experience me as a real person." Believe me – our patients' lives are full of so called "real people" who our patients will not allow to be helpful. If the psychotherapy relationship is to be constructive, it must be altogether unique; which means entirely neutral.

(22) Who's in charge here?

Don't be afraid to take charge and command the patient sometimes: "You have to go to the hospital" or "I want you to come back in tomorrow at 5 o'clock", for instance.

We social workers are not accustomed to doing this the way physicians are. They've been giving people orders since they were 5. But sometimes it really is what's needed. They want this from you. You can always back up if you have to.

(23) Therapy can't make people happy

You hear patients tell you, "All I want is to be happy." That's all they want. That's a little like saying "All I want is a billion dollars" – only less realistic. Happiness, when it comes, visits us in brief spurts and flashes. The wish to be always happy – which is really what they mean when they say this – is a regressive desire for an infantile experience or longed-for feeling state. The promise that therapy will make a patient happy is a promise you can't keep.

(24) <u>Managing managed care</u>

There are plenty of good reasons not to deal with managed care. Being married to an orthodontist or a radiologist – or being a female psychiatrist – helps you avoid it. But if you <u>choose</u> not to be a managed care "provider" – what a stupid term: "provider" – don't kid yourself that you are helping out the patient – I mean, "consumer." How does it help a patient to charge her a $100 when there is another therapist out there who is just as competent as you – and there are several – who will do it for $10?

(25) <u>What is your patient's favorite wine? "You never say anything!"</u>

Sometimes it is true. When I was younger, I acted more "analytic." That means I had more of the *trappings* of a psychoanalyst than I do now – now that I actually <u>am</u> a psychoanalyst. I never did purchase a Harris Tweed sport coat though.

These days unless I'm doing analysis, I'll usually be the one to start the session with "What's been on your mind?" It is a neutral question and it directs the patient inward – versus "How are things going?"

If a patient struggles with what to talk about and asks me what we should discuss I might suggest something that came up in the last session or maybe "How was your weekend?" The worst answer to the question "What should I talk about?" is "What do <u>you</u> want to talk about?" It sounds gamey and manipulative.

(26) If you want to understand your child patient, then sit down and shut up

Children hate to be questioned. They don't know what's bothering them and if they did they wouldn't tell you anyway. The more clever ones will figure out what it is you want to hear and then give that to you. The other ones will just clam up. Either way, they won't want to come back. I tell children "I want to try to help you with your worries, but I won't be asking you a lot of questions. You can tell me whatever you want to; I'm not a Guidance Counselor or an Assistant Principal." This really helps.

(27) What goes around comes around.

When I don't have time to see a referral I'll usually spend time with the person on the phone trying to find someone else. Sometimes I'll fax back my recommendations from a managed care list. These people are desperate. They have nowhere else to turn. In Hebrew a charitable act like this is called a *Mitzvah* ; a good deed.. As my friend Mike says, "You can't go wrong by doing right" – and he is a lawyer.

(28) I don't mind lowering my fee, (though my wife is not so enthusiastic about it.)

Lowering the fee does not mess up the treatment - not even an analysis. I did an interesting study on this subject for my graduation paper at the institute. Therapists and analysts who persist in believing that lowering the fee causes insurmountable problems

are rationalizing their own greed. There's nothing wrong with *not* lowering fees. Just don't pretend it's for the *patient's* good, not yours.

If you do reduce the fee, keep in mind that, like everything else you do, it does send messages to the patient. She might think that you love her more than your other patients for instance. But like other neurotic beliefs, such ideas can usually successfully be handled interpretively..

(29) To explain or not to explain

I routinely explain to patients some things about how therapy works. It's naive to think that the average patient will intuitively catch on all by herself. Not every patient is a clinical social worker.

For example, when a patient is bewildered by what to talk about, I'll explain: "Don't worry about that. Therapy is like writing a novel. A writer doesn't write the whole novel in her head, and then type it all out. She starts with a theme or a character sketch, then starts to write. It's in the writing that the novel is created. It's in the writing that the novel is created That's how therapy works."

You want to be careful however not to explain therapy so much that you explain it away.

Here is the last one: I hope you don't think I've been too brief. As the philosopher Pascal wrote: "Please excuse the length of this letter; I lack the time to make it short"

(30) Pandora's Box

In the myth of Pandora, the innocent but curious girl couldn't resist opening the forbidden box. Out flew pain, pestilence, and all of the other deadly things of the world. And that's how evil and unhappiness came to be. Most people forget or don't know the end of that story. At the bottom of the box one thing remained: Hope.

Hope – what Emily Dickinson called "The thing with feathers" – might be the most valuable thing psychotherapy can give a patient. I try to remind myself: If I can do that I have done my job well.

Thank you.