Q&A WITH DR. BETSY GLASER, Ph.D.©

For an Audio Recording of this Interview
Please visit www.TerryWise.com/Resources

INTRODUCTION:

When *Waking Up* was first published, I created aliases for each of the characters. It was not because their identities were a secret. Rather, it was because I was the one who chose to write the book and make this story public, and while each of them gave me their blessing and full support, I still felt that it was appropriate to provide each of them with a layer of privacy. However, much time has since passed and Dr. Glaser's identity has become more public. *Waking Up* is now required reading at numerous universities and clinical training programs nationwide. I became a public speaker and I have delivered hundreds of keynote speeches and full-day continuing education seminars. At various times, Dr. Glaser and I have co-presented workshops together, offering audiences the rarely-heard dual perspectives of a patient and former therapist. Dr. Glaser graciously agreed to be interviewed for this new edition of *Waking Up* to provide readers with the answers to some of the most Frequently Asked Questions each of us receives about her insights and reactions from the therapist's side of the couch. To avoid confusion, the following interview, as well as this edition of *Waking Up*, now contain her real name: Dr. Betsy Glaser, Ph.D.

****

What kind of therapy do you practice? How would you classify your technique?

I am asked this question a fair amount and I always have the same answer. My technique is anything that will work! I will use different strategies that I feel are beneficial to the patient at any particular moment. I adapt my technique to patients rather than having patients adapt to me. Therapists who are stuck...uhm, I mean therapists who practice only one type of treatment technique regardless of the presenting issue, may not always be using the treatment modality that is in their patients' best interests. My job is to help the person sitting in front of me and it seems best that I have a repertoire of techniques at my disposal.

****

How did you re-establish trust with Terry following her suicide attempt?

Waking Up covers the process of re-establishing trust quite well. Trust is a mutual experience in the treatment room and we worked hard to arrive at a place where we both felt comfortable enough to continue working together. This required entering into several new agreements. I want to underscore the use of the word "agreements." Agreements are collaborative and require mutual commitment. They are different from the more commonly referred to model of a "contract" where the patient is told what the therapist requires from them and he or she agrees to

the terms or not. Terry agreed to commit to treatment, seek a consultation for antidepressant medication, and to no longer drink or take drugs. I, on the other hand, agreed to be as available as possible, and that if the need ever arose, not to involuntarily hospitalize her unless we first had the chance to talk about it.

What if Terry had not agreed?

I would have worked incredibly hard to figure out a way that, together, we could create a plan that would help her. However, I would not have been able to continue working with Terry if she refused to come to some agreement about how we could keep her safe. Fortunately, that was not a situation I had to face.

****

Can you comment on professional boundaries in the therapeutic relationship?

Terry and I co-presented to clinical psychology graduate students at a well-known university. They were an extraordinarily intelligent group of trainees. *Waking Up* had been required reading and their professor had asked them to critique the treatment techniques I had used in the book. Many of the students suggested that I "ignored protocol," had "loose boundaries," and was "overly involved." I found this to be ironic given that during Terry's treatment, I was much more cognizant of therapeutic boundaries than I had been with any of my other patients. What followed our presentation was a really interesting dialogue about ethics and boundaries and where caring about a patient falls on the spectrum of appropriate and inappropriate behavior.

How many times have we seen therapists depicted on TV or in the movies where a patient is talking about something important and the therapist says, "Time is up"? Rather than adopt a preset notion about therapeutic boundaries, such as you must end your session at exactly 50 minutes, I would hope that I am able to appropriately adjust to each and every patient. Each of my therapeutic relationships depends upon what is needed, what works, and what is beneficial to the person seeking help.

A well regarded professional in an audience Terry and I spoke to once commented, "It is not professional or ethical to be so caring in a clinician-client relationship." Can I be so bold as to say, "Hogwash"? Certainly there are ethical parameters that are critically important to maintain. However, I do not understand why our profession is so busy focusing on practicing "defensive psychology" rather than promoting the idea that compassion is often a necessary component of the therapeutic relationship.

****

****

There is a chapter in *Waking Up* called "White Rage." Can you explain a little more about how you felt when you found out that Terry had made a suicide attempt?

When Terry told me that she had tried to kill herself, the world went white.

At the moment of impact, I was overwhelmed and bombarded by emotion. All of my feelings were intensified—rage, inadequacy, sadness, concern—and they continued to buzz in my ears long after Terry had left my office. Patients often believe that therapists cannot honestly care about them because they get paid. It is as if billing by the hour negates genuine concern. While it is true that the therapeutic relationship is unique, it does not preclude a therapist from having genuine human feelings. All of those feelings gave me a great deal to think about, to work out, to process, and ultimately to try to use, in the most therapeutically appropriate way, to help Terry recover. At the same time, I knew that we had to focus on the work of understanding the attempt and preventing another one. After all, it was Terry's treatment not mine.

What was my white rage? I often think about what caused the world to change so immediately and so thoroughly for me. Perhaps I responded the way I did because I had been so invested in the treatment, and had given so much to Terry and worked so hard. I had to "absorb" the fact that it had not been enough to prevent her attempt. I think my white rage was a human response to an incredible event.

The weight of responsibility became extraordinary. I had to balance *that* responsibility with all of the responsibilities of my life, including other patients and my *own* personal life apart from work. The nature of treating suicidal patients means managing their needs, and these needs usually do not fit into a 50-minute hour, once a week. One of the important repercussions was the struggle to help myself feel comfortable enough to continue being Terry's therapist. This led to some critically necessary agreements between us. In addition, I sought a consultation from another professional in order to ascertain whether or not there was any part of the treatment I was missing. This was particularly helpful because I was able to better understand the challenges of working with a chronically suicidal patient.

And perhaps most importantly, we had to figure out a way to re-establish trust so we could continue to work together.

I often think about how my life would have changed had I lost this patient. Would I have stopped practicing psychology? Would I have left the field because I had lost faith in myself and my abilities? I really cannot answer because, in the end, I simply don't know.

People of faith believe that there is a reason for Terry's survival. People more scientifically inclined believe that we don't have enough sophistication to determine how she survived such a massive overdose.

What I do know is that I got a second chance to help her fight her demons and to discover reasons to stay alive.

****

****

Did your relationship with Terry impact your treatment of other patients? Did your unwavering support of her become exhausting?

In many, many ways, it helped me with my ability to treat other patients. I learned so much from Terry's treatment. It energized me, made me re-connect with the work, renewed my passion, raised incredible questions, and pushed me hard. All of the time? Of course not. Sometimes it drained me, but I was careful not to fill my practice with "10 Terrys" so I could remain available to all of my patients.

Yes. It is a simple fact. Treating chronically depressed and suicidal patients is, at times, exhausting. I needed to take care of myself when it became overwhelming in order to prevent professional burnout. I needed to be vigilant about my own self-care. The other side, though, is that it was also one of the most invigorating, challenging, incredible experiences of my life.

****

When you were treating Terry, what was the impact on your personal life?

I had a full practice, three children, and a husband who worked and deserved attention. I had a pager that went off way too often and interrupted many soccer games. It was difficult to balance caring for patients, family, and myself. There were definitely times when I didn't do a good job of it. I suspect that if you ask my children, they will remember a time when their mom was not as available as they would have wished. However, if you ask me now, over a decade later, if I would have done the same thing in terms of my availability to patients…I would say absolutely, without a doubt I would have done the same thing.

****

What do you think was the most important or effective therapeutic technique you utilized during this treatment?

I questioned Terry relentlessly. When she doubted she had answers, I encouraged her to guess. I refused to accept her frequent, "I don't know" in response to my inquiries. However, I would have to say that the most effective therapeutic technique was to never assume I knew what she meant when she spoke. For example, Terry often asked me what seemed to be a simple question, "Where are you going on vacation?" or "How many children do you have?" If I wasn't committed to the notion that everything Terry said had layers of complexity and significance, I would have missed a tremendous number of opportunities. Because of this "dictum" and not making any assumptions, we were able to learn so much more about what we would have otherwise missed.

****

****

Do you think that you made any mistakes while you were treating Terry? Is there anything you wish you had done differently?

I continue to make mistakes in every session. These are inevitable and I am aware of my own idiosyncrasies as a therapist. I interrupt with a question when I should be silent, I reassure when I should listen, I relate another story when the patient doesn't see the relevancy. These are common everyday mistakes and they happen. I made many of these common mistakes during the course of Terry's treatment.

From the moment Terry told me about her suicide attempt on Christmas Day, I have wondered what more I could have done to help her. It would be so much easier if I could just blame her. Don't be fooled. Many therapists blame their patients for not getting better—patients are "resistant" in treatment, they fail to grasp insightful therapeutic interpretations, and they cling to their misguided cognitions.

I worked incredibly hard treating Terry. I had mountains of emails and telephone bills, memories of missed soccer games and late dinners with my family. I sacrificed a lot of personal time. I used years of experience treating her. Perhaps most importantly, I was relentlessly determined to help her because I really cared about her. In retrospect, Terry's disconnect and alienation from all her friends and family were key elements leading to that fateful day. Interfering with that disconnect is something more I could have—and should have—done. There are other things I realize, too. Further exploration of critical relationships in her life might have gained us some more time. And with time, I might have had more success procuring her agreement to a trial of medication and understanding the ramifications of her death on others.

Certainly, a major mistake was not understanding why Terry refused to even consider medication. Despite my best efforts, she stubbornly refused to discuss it and I never fully understood why. I continued to bring up the possibility of a psychiatric consult and she continued to refuse to consider it. In retrospect, I wish I had better explored the impact of her history on the medication issue.

Monday night quarterbacking is useful if we learn from it.

****

Do you think there was anything of importance that was left out of the book?

In order to capture the essence of treatment, Terry had to consolidate many of our sessions into single chapters. It may appear as if we were able to accomplish a lot of work in a very short time period. However, there was a lot more effort, missteps, and time spent sorting through the many issues that arose during treatment. For example, in the chapter called “The Swirl” when we dissected Terry’s despair and anxiety, this process actually took longer than it may appear. I hope that readers understand that therapy is a process and that “Ah Hah!” moments are the product of a lot of time and work together.

****

****

How did your relationship with Terry evolve after treatment ended?

After treatment terminated, Terry began to write her book, *Waking Up*, which detailed the work we did in therapy. As her writing evolved, she began to consult me on some of the points she needed to clarify. She hadn't recorded our sessions or taken notes during her treatment and she wanted to double-check some of the dates and the timeline of events. She was committed to the book's accuracy and had to make sure that when she quoted me, it was something I had said.

After *Waking Up* was published, we were invited to speak at Columbia University's Graduate Program in Clinical Psychology, where the book was required reading. As a result of the positive feedback we received about that presentation, the opportunities for us to speak together continued to grow. Our format provided audiences with a unique opportunity to ask questions to both a patient and her former therapist. It is remarkable to me how hungry people are for this dual perspective. So many of life's issues are in the book—loss, grief, caregiving, abuse, anxiety—and the remarkable thing Terry was able to capture was the ability to find hope again.

We are often asked by audience members if it is awkward or uncomfortable for either one of us. We are able to answer, without hesitation, that it is not. Our therapeutic work ended years ago. A new chapter in Terry's life has begun and we both feel committed to sharing all the lessons both of us have learned.

****

For an Audio Recording of this Interview
Please visit www.TerryWise.com/Resources