

**Matchmaker, Matchmaker, Make Me a Therapist Match**

by Rebecca Sachs, PhD



I often get asked by family and friends "do you know someone?" Their hope is that I will have a colleague who will be a good fit to work with them in therapy. Over the years, I believe I have gotten better in making these "Matches." Partly this is a result of my "Yenta-Superpower-Skills"; as my professional network has expanded I know many more great therapists. But another critical part of my learning curve has come from personal experience. Several years ago, when I hit "re-set" on my life, I sought out therapy. From my own experience in seeking out a therapist, I gained a better understanding of the critical questions to ask and the information to seek when selecting a therapist.

Initially, I now realize how the initial step of **deciding** to do therapy is critical to finding the right therapist. Since this first step is so important to making the right match, when I now make a referral I try to understand why a person is seeking therapy and what has led up to that point. If the answer isn't obvious, I encourage my friends, family or clients to ask themselves and answer these important questions:

- What's going on in your life/your family member's or your child's life that you want to change? For how long has that been going on?
- Do you/your family member/your child have a diagnosis or label? Do you agree with that diagnosis/label?
- How have the difficulties been impacting your life/your family member's or your child's life?
- Who would be involved in therapy?

Once people can articulate, in their own way, these therapy goals and what they're hoping to gain, there are some boring but essential questions to ask about logistics. Moreover, individuals should have a good understanding of their mental health/behavioral health insurance benefits (including out-of-network benefits and limitations), their budget, their availability, and how far they are willing to travel. Important questions to ask the professionals are:

- What are your fees? Do you have a sliding scale option?
- Do you accept insurance?
- Where is your office located?
- How flexible is your availability?
- Are you available for case management, such as speaking to or going to a school for IEP meetings,

- working with service coordinators, and completing important paperwork?
- What is your communication policy and the best way to be in touch with you?
- How quickly do you return calls? And are you available for emergency?

While these details may seem unimportant, they can play a significant role in the delivery of your care. As a therapist, I put a lot of time into how I want to answer these questions. For instance, as I realized that my typical fees may be out of reach for some people and thus have therapy be less accessible, I worked hard to institute a fair and transparent sliding scale policy, as well as a commitment and plan to train and supervise other professionals in my area of expertise who would charge less. Also, as I transitioned from single woman to single Mommy, I recognized that my ability to return calls and communicate by email would be impacted. As a result, I put a lot of thought into a realistic communication policy and tried my hardest to educate current and potential patients of my new policies and limitations.

Equally important is understanding a professional's training, expertise, and general approach to being a therapist. In asking this question, I think it's key to focus on what a person actually does, not just their training. Important questions to ask:

- What are your privacy and confidentiality policies, and what are the limits? *This is especially important for work with teens and young adults.*
- How do you involve parents in your work? *Believe it or not: this is important for families with children of all ages.*
- What conditions do you treat and how many years have you been working with these patients? What percentage of your practice consists of work with people with these conditions? Additionally, which conditions do you NOT treat?
- After about a month, are you willing to articulate a diagnosis, treatment plan, and what our therapy goals are? *Hint- if a therapist cannot do this, I encourage you to look for another therapist.*
- How do you typically collaborate with other professionals, such as psychiatrists and speech therapists? Is this something standard you do or something you wait for the patient to request? Will you make referrals to other professionals if applicable?

- How will I know I am/my child/my family member getting better? How do you measure progress? *While there are no guarantees in therapy, and while the answer may change as your therapist learns more about you, if a therapist has a difficult time answering these questions, I encourage you to look for another therapist.*
- What are your views on medications? *For certain conditions, medicine can play an important role. The key is to look for a therapist who is open-minded, collaborative, and questioning in this area.*
- What are the techniques/specific skills for (fill-in-the-blank-for-specific-condition)? Can you provide an example of that? Is that a first-line treatment for this condition? *Some therapists will say they "treat" a condition, but when pressed, it is difficult for them to articulate the important components of its treatment, know what is the first recommended treatment for that disorder and what research and evidence say about treatments for a condition. Just as you would want antibiotics for strep throat (a first line treatment with good scientific evidence to support that it works) and a doctor who knows the proper dosage and days to prescribe for the antibiotic to be most effective, you would want a therapist to be able to similarly do this for a mental health condition.*
- How often is assigned HW planned? *My recommenda-*

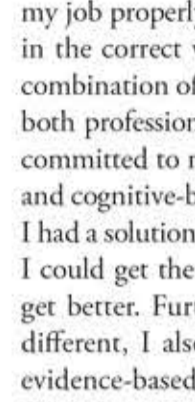
*tion is that out of session work is given almost every week and central to therapy. It is unrealistic to expect much change to happen from just 45 minutes a week. As I tell my patients, "I'm good, but I'm not that good."*

Last but not least, just like in a marriage, there are important intangibles in therapy. In fact, previous research indicates that the therapeutic alliance is one of the main factors in determining successful outcomes of psychotherapy. There should be a certain "chemistry" (or in therapist-speak, "rapport and alliance") between therapist and patient. Experience does not always increase the odds of success in therapy. When talking to a therapist, ask as many questions as you want. Pay attention to how much time they give you, their style in answering these questions and their patience with you. And just like in marriage, it is totally appropriate to divorce a therapist; in fact terminating at any point is a patient's right. If you are working with a therapist and you don't feel like they are the right fit, it is appropriate to seek out someone else. Life is hard enough. Therapy is the one place where the therapy may be challenging, but you want understanding, empathy, expertise, a clear plan, and a good match.

Rebecca Sachs, PhD, is a New York City based psychologist specializing in treatment of autism, OCD, and anxiety.

**The Parent Club**

by Rebecca Sachs, PhD



All my years working as a psychologist with both children and their parents, I had grown to dread one comment: "You don't have kids. You wouldn't understand." I knew the parents were speaking honestly and meant no ill will when delivering that comment. In fact, I learned to interpret the comment in a compassionate way. These parents were likely frustrated with me – feeling misunderstood or judged. Rather than get angry at me, it was kinder for them to assume that I just couldn't understand since I wasn't a parent.

This comment was a red flag, indicating that I wasn't doing my job properly. I wasn't listening enough, explaining things in the correct way, supporting the parents sufficiently or a combination of all three. However, the comment still cut me both professionally and personally. As a psychologist deeply committed to my work and to the principles of behaviorism and cognitive-behavioral therapy (CBT) I often thought that I had a solution to their challenges at my fingertips and if only I could get the parents to access that solution things would get better. Furthermore, while each situation is somewhat different, I also believe that tried-and-true principles and evidence-based strategies are immutable. On the personal front, for most of my professional career I desperately wanted to be a mother; the details of my life hadn't aligned properly just yet. A comment like that was a painful reminder that as fabulous and fulfilling my career was, it was "falling short" in another part of my life. I understood that typical parenting was tough, and even though when a child was struggling with the challenges of anxiety, autism and OCD, but I still wanted to slog through these tough moments with my own child.

Last year, even when the details of my life hadn't aligned in the way I single imagined, I decided to make them align and pursue my motherhood. And come this past December I joined the parenting club. And while I don't ever have to face that exact dreadful comment again, I do understand that my parenting experience will still be very different from other parents' experiences. Every child is different, and it would be impossible to generalize my personal experiences to that of another parent. Yet, the laws and principles of behaviorism still hold, and the strategies of CBT still apply. In a short 10 weeks I have personally experienced many of the lessons I teach in my parenting sessions:

- **Parenting can feel unpredictable and is ever changing:** Just when I think I know how often and how much my child will eat, she goes through a growth spurt or starts to eat a little less. Poop and spit up?

Somehow it seems like those things almost always happen the exact moment I'm mid-diaper-change (or just freshly changed) or the burp cloth is across the room. I share with my parents: *While we do know the core symptoms of anxiety and OCD and the primary challenges of Autism, they show up in different ways and surprise us at different life stages and in unexpected settings.*

- **Structure helps:** Newborn advice is to feed on demand and shush-swaddle-rock at every immediate cry. But when you're sleep deprived and the baby is still fussy, you come to realize that a little structure helps. While in hindsight this all seems obvious, until my baby-nurse came at 6-weeks, a bedtime ritual and any structure were absent from our lives. However, once the baby-nurse came, nightly bath was instituted at the same time each night, and mini-massage-diaper-change-feeding-swaddle routine was instituted. Baby Girl started going down in her bassinet far less fussy and sleeping for longer stretches like, well ... a baby. After this nighttime routine was established, a flexible daytime routine including a balance of play, sleep, tummy-time, a long walk outside, more sleep, independent time in swing, cuddles and feeds fell into place. Not only did I feel a bit more at ease, Baby Girl also responded positively to the structure. I share with my parents: *While it can be a challenge to move out of survival mode in which you are attending to each new or challenging occurrence in the moment, the creation of a behavior plan that has consistent structure and expected behaviors for both parent and child can be transformative for many of my patients.*
- **You can have an ideal vision of your child, but that likely isn't your child.** Accept and appreciate the child you do have. While pregnant I had many wonderful visions of birth and nursing (amongst many other things!). Well, into my last trimester my baby flipped into a breach position and no matter what I tried she stayed put. Also, whenever I would try to nurse, she would push me away screaming. So the magical birth I envisioned turned into a C-section and the sugar-plum-fairy visions of nursing turned into bottle feeds. And while the illusions were smashed, the reality was that if I didn't embrace my real child and her actual needs versus the ones I imagined, she wouldn't have safely entered the world and wouldn't now be thriving in her own way. Interesting, all on her own at week eight, baby girl decided to nurse and now happily

*The Parent Club, cont'd on page 6*

*The Parent Club, cont'd from page 5*

takes both bottle and nursing alike. Speaking to other mommies returning to work and having their babies fuss over the bottle, I appreciate how easy it is for Baby Girl to switch between the two despite the challenging two month start. I share with my patients: *It is understandable to want certain things for your child, but we need to be attuned to our child's real needs and challenges and support those needs even if they clash with what we always envisioned. Equally important is to recognize the unique strengths of our child and appreciate their differences.*

- **What's the function of a behavior and the role of reinforcement.** At first I would jump to my baby's every cry. Soon this plan of action became exhausting and unsustainable. I learned, instead, to be aware of my child's cries and then take a deep breath and wait a few moments before picking her up. Often in these moments of waiting she would look happily at something, be soothed by her pacifier, and then go back to sleep with calm washing over her. I realized that if every cry was reinforced with me picking her up I'd have a baby always crying and some very tired arms. What I really wanted, on the other hand, was to reinforce real distressed crying by picking her up. In those times when she continued to cry, I began to be able to distinguish what she was crying for, or the function of each cry. An "I'm hungry" cry sounded different than an "I need my diaper changed" cry and different from an "I want attention" cry. By figuring out the function of her cries, not only was I able to meet her needs better, I also was able to reduce her frequency, intensity and duration of crying. I share with my patients: *Behaviors don't appear in a vacuum. Instead, they happen to serve a purpose or function and, if reinforced, these behaviors linger and are maintained. The behaviors that parents come to me about often serve one or more of the following functions: escaping a demanding or uncomfortable situation, getting attention, meeting a sensory need, and getting something tangible. I encourage parents to notice what the function of the behavior is, intentionally choose whether or not to reinforce it, and try to encourage or reinforce a more appropriate behavior that can still serve the same function.*
- **My kid needs me, but sometimes less than I think.** I never thought that I would be so content sitting on my couch in my sweatpants, snuggling with my little one. I could do it all day. But if I did, nothing else would get done, including the important things that were needed for my Baby Girl. At first it felt odd to put her down in the swing; but I quickly saw she loved

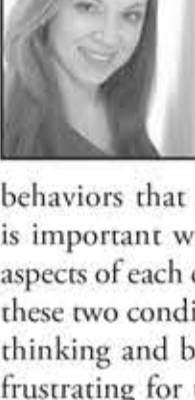
hanging out in it, cooing at the mobile above, and drifting off to sleep with a smile on her face. She also loves hanging out on her changing table looking at all the things around and kicking at her towel after bath. And while it makes me feel good to see that I can bring a smile to my daughter's face, it also makes me feel wonderful to see my Baby Girl independently making herself laugh. One important thing to note – she did not like the first THREE swings I had. It was important that I continued to experiment until I found the right swing to support her being happy on her own. I share with my parents: *It's a careful balance of doing things and allowing our kids to do things independently, even if it means they must "fail" and be miserable at the first three (or more) attempts. We discuss that experimenting and collecting some data is always helpful in trying to strike this balance.*

- **When your kid is upset, you're upset.** I discuss all the time with the parents the importance of being "non-reactive" in the face of a meltdown, extreme anxiety or the "demands" of OCD, as well as how difficult this can be. The moment this truth hit home was one night during a diaper change. In general, Baby Girl's response during diaper change can range from extreme glee to piercing screams. When it's piercing screams and kicking legs I can get upset and I find that I'm far slower during these diaper changes. One night though, bungling through a screaming diaper change I felt particularly pressured and raised my voice, "Baby Girl," I shouted, "stop crying." Hearing my voice raised, my daughter looked at me with a frightened face. Immediately I felt bad, realizing that being reactive was not only NOT effective, but also had the potential to make a situation worse and more confusing. I share with my parents: *Do effective self-talk, defuse unhelpful thoughts, breathe through and be mindful of physical sensations in tough moments, remember their values and goals as a parent, and congratulate themselves for using these techniques to remain nonreactive.*
- **You do a lot of laundry.** Finally, having a daughter showed me how much laundry you actually do as a parent! I share with my parents: *While anxiety, OCD, and autism can make daily living skills challenging they're equally important to learn as academic, social and emotional skills. Because trust me, no one wants to be doing their kid's laundry for 30 years!*

Rebecca Sachs, PhD, is a New York City-based psychologist specializing in treatment of autism, OCD, and anxiety.

**Autism & OCD: What to Do When Feeling Stuck, Stuck, Stuck**

by Rebecca Sachs, PhD ABPP



While the symptoms of autism spectrum disorder (ASD) and obsessive compulsive disorder (OCD) can overlap, there are some core differences between the obsessions and compulsions that accompany OCD, and the restrictive and repetitive thinking and behaviors that are associated with autism. Therefore, it is important when receiving treatment that the distinct aspects of each condition are addressed. Yet, the overlap of these two conditions can often appear as a pattern of rigid thinking and behaving. This rigidity can be particularly frustrating for the individual with autism and OCD, as well as the people in their lives. Despite putting forth best efforts, in and out of therapy, there can be the sense or feeling of being "stuck, stuck, stuck" because of this overwhelming rigidity. Fortunately, we now have research and clinical experience to support meaningful change.

The hallmark of this change is to provide more flexibility – flexibility in both thinking and acting in all areas of life, and most specifically flexibility in a willingness to tolerate discomfort. This may sound counter-intuitive. However, when you have the mindset that all things that are new, challenging and uncomfortable cannot be tolerated and, therefore, you must avoid them, all you are left with is feeling, "stuck, stuck, stuck." This does not mean you should dive into all things uncomfortable right away. There is wisdom in:

- Taking a break from situations with overwhelming sensory information (too loud, too bright, too crowded, etc.)
- Following challenging activities with preferred ones and rewards
- Pacing treatment and change appropriately
- Cultivating a sense of choice and autonomy when approaching difficult things.

The types of cognitive behavior therapy that incorporate this flexible mindset include Exposure and Response Prevention (EX/RP) and Acceptance and Commitment Therapy (ACT). When doing EX/RS, Exposure means confronting distressful thoughts, sensations, objects and situations, while Response Prevention means choosing not to do a behavior after encountering things that make the individual distressed. Exposures can be in person or imagined, and can involve sensory sensitivities, obsessional thinking linked to rituals, or social avoidance. The goal of EX/RS is to teach you that you can experience relief without doing

the compulsive behaving, and that while uncomfortable you can withstand and conquer distress and still be able to engage in a meaningful life (distress tolerance).

Part of shifting this mindset from being "stuck, stuck, stuck" to one of flexibility is moving from accommodation to acceptance. It is important to accept that discomfort exists, that uncomfortable feelings and thoughts naturally happen and ought not to be controlled or avoided, and that perfection or absolute safety are not worthy goals because they are impossible to achieve. It is this willingness to be uncomfortable, to sit with scary thoughts and negative feelings, to be imperfect and enter situations in which positive outcomes are not guaranteed, that ironically lead to a more comfortable, meaningful and successful life and get us out of the pattern of being "stuck, stuck, stuck." Support and understanding from family and other important people in your life is critical, because they may often be unwittingly providing reassurance and accommodation to your avoidance of being uncomfortable.

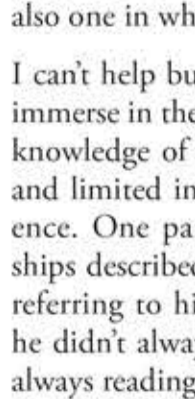
Another way to shift from feeling "stuck, stuck, stuck" is to purposely connect with and engage in whatever is happening in this moment. We can easily get caught up in our thoughts and lose touch with the people and experiences around us. To shift from being on automatic pilot we can bring our awareness to the physical world. An additional way to make a shift toward flexibility is to take a step back from our thoughts, images, and sensory overload. Rather than get caught up in our thoughts or having them dictate how we act, we can let these uncomfortable moments ebb and flow like waves at the shore. By stepping back and observing our thinking and feeling we can avoid getting caught up or "stuck, stuck, stuck" in it.

Of course this is all easier said than done and there are legitimate barriers to shifting this mindset such as: low motivation, difficulty understanding the rationale for treatment, social skills deficits, and sensory and emotional dysregulation. All these factors should be addressed in therapy in conjunction with attempting a more flexible mindset. But ultimately the aim is to create a rich and meaningful life while accepting the discomfort that unavoidably goes with it.

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**Impaired Theory of Mind**

by Rebecca Sachs, PhD



I stand at only 5 feet. I don't typically recognize this fact in my daily life minus the occasional blocked view at the movie theater. But, then there are these striking moments when my short stature becomes far more obvious and I get to see the world as most others do. I find that I am suddenly eye-to-eye with the friend I'm hugging goodbye or even get to look down at a person in conversation when standing on the stairs two steps above. It's disorienting at first to experience the higher-than-usual vantage point. And there also comes the realization that this is how others must typically experience me – looking down – versus the way I see them – looking up.

However, this is not a story about short therapists, but rather about the experience of being a psychologist to individuals on the autism spectrum, and of many of my patients who experience obsessive-compulsive disorder (OCD) as well. To be a psychologist with a "neurotypical" brain spending numerous hours in conversation with my patients is a fascinating professional space to inhabit, but also one in which I can sometimes feel like an imposter.

I can't help but doubt myself since I am unable to fully immerse in their experience. I am limited – limited in my knowledge of autism and OCD, limited as a therapist, and limited in my understanding of the human experience. One patient who often struggled with relationships described to me that he would relate to others by referring to his favorite books and movies, but wished he didn't always have to. In his words, "I feel like I am always reading a script." As a therapist without autism or OCD, I too can feel like I am reading a script, lacking the genuine understanding of my patients' points of view. Some therapists I know who work in the "OCD world" came to the profession based on their own experiences of coping with obsessions and resisting compulsions. There are many times when I sit in my office with a particularly difficult case that I envy the "advantages" of my colleagues' personal perspectives.

Many of the individuals who temporarily occupy my therapy space arrive with questions. Some are adults who have heard a piece on public radio, read a recent book on autism, have an loved one who has suggested the possibility of being autistic, or had another professional finally put a label to decades of experience. Others are children and teens who have embraced the label of "autistic" since receiving early intervention services, but now come to me

confused by their OCD and bombarded with questions: Am I dirty? Will something bad happen to me? Did I do something wrong? Is my teacher mad at me? Will I have enough time? Why don't I feel just right?

No matter why they come to me with questions, I try to provide answers. In the moment, I avoid questioning myself. Instead, I use metaphors and stories and rely on my expertise to try and convey in real terms what "compulsions," "reassurance and accommodation," "social-communication deficits," "rigid thinking and behaving," "sensory sensitivities," and "executive dysfunction" mean.

I compare their autism and OCD to my "shortness." "You have a tricky brain." I say. "Just like I have a tricky body." My tricky body is also great sometimes, like on airplanes or other tight spaces, I explain, just like the huge advantages their distinctive way of processing and expressing information can be in certain situations.

I talk that I arrange ways to live the life they want. I let them know that I new ways to pots and pans on the low shelf because of my "tricky body." If my environment can't be changed to accommodate my shortness, I use resources like a step stool or ladder. When accommodations and resources have failed me and I simply cannot reach the light bulb on a high ceiling, I use the ultimate strategy and ask for help.

These stories seem to help, but there is still a gulf in our relationship. The largest distance between them and me is the often-looming self-concept that many share: they hate that they are different and at times difficult. When they express that they "need" accommodations, resources, or help, their frustration can be palpable. Or, worse yet, the despair they describe of being rejected and denied help over the years can hang thick, like stale air in my office. As one patient described, "I could never really ask for help because it was usually denied. After a while I just stopped."

I struggle in these moments with how to respond. Intellectually, I know my patients are often more rejected and bullied than others in this world. I also know that they can have an altered perspective of social interactions, perhaps skewing them to see situations more negatively than in actuality or in more absolutist terms than reflecting the nuances of life. I observe their language – "always," "never," "everyone," and "no one" – and the sense of impossibility that results. I wish I could step inside their minds at that moment. Instead, I have to accept the limits of my own

moment. Instead, I have to accept the limits of my own impaired perspective-taking and am left to wonder – "is this a matter of not seeing the stairs, or that the staircase truly does not exist for them in that situation?" These are the times I come to my patients with questions so I may provide them with answers.

So, I breathe in their frustration and despair. I try to listen with compassion and understand their reality and how their perception can still feel so real to them. I feel at odds because no matter how much I question, listen and reflect, there is something in my patients' stories that makes me feel like I'm looking down from atop the staircase and never fully sharing their perspective of looking up.

be how my patients with autism feel – constrained simply because a societal norm is at odds with the way their unique brain works. So, I pay attention to the deep frustration of a confounding week in which I can't perform at is matched with "falling back" or "bringing forward" at my best with my circadian rhythm.

And while I love to travel, I don't like the pressure of needing my passport. In weeks leading up to a trip, I'm plagued with intrusive worries: "Where is my passport?" and "When does it expire?" even though I very much know the answers to these questions. On the trip itself, I get urges to constantly check my pocket, check my bag, or check the safe in my hotel – all futile attempts to quash the uncomfortable feelings I get whenever I think about my passport. The funny thing is that I have never lost my passport or know anyone who has. I now realize these irrational, unwanted thoughts and feelings are similar to what my patients with OCD can experience almost daily, and that my attempts to feel better by looking for my passport could be considered a compulsive behavior. So, instead of checking for my passport on a trip, I have learned to try to be an active observer of my experience. I notice my urges and thoughts. I sit with the accompanying flutter of my heart, pit in my belly, tension in my jaw, and the swirling thoughts in my head and just try to be a witness to them. I take in these moments and desperately try to hold onto my discomfort. To help bridge the gap between my patients and me.

It is in experiences like these, something that can't be learned at any conference, journal article, or academic work that I begin to feel like I am standing eye to eye, or I to I, with my patients. I will likely always feel like a therapist with some type of impaired theory of mind, but perhaps by continuing to ask questions, my patients will provide me with the answers.

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