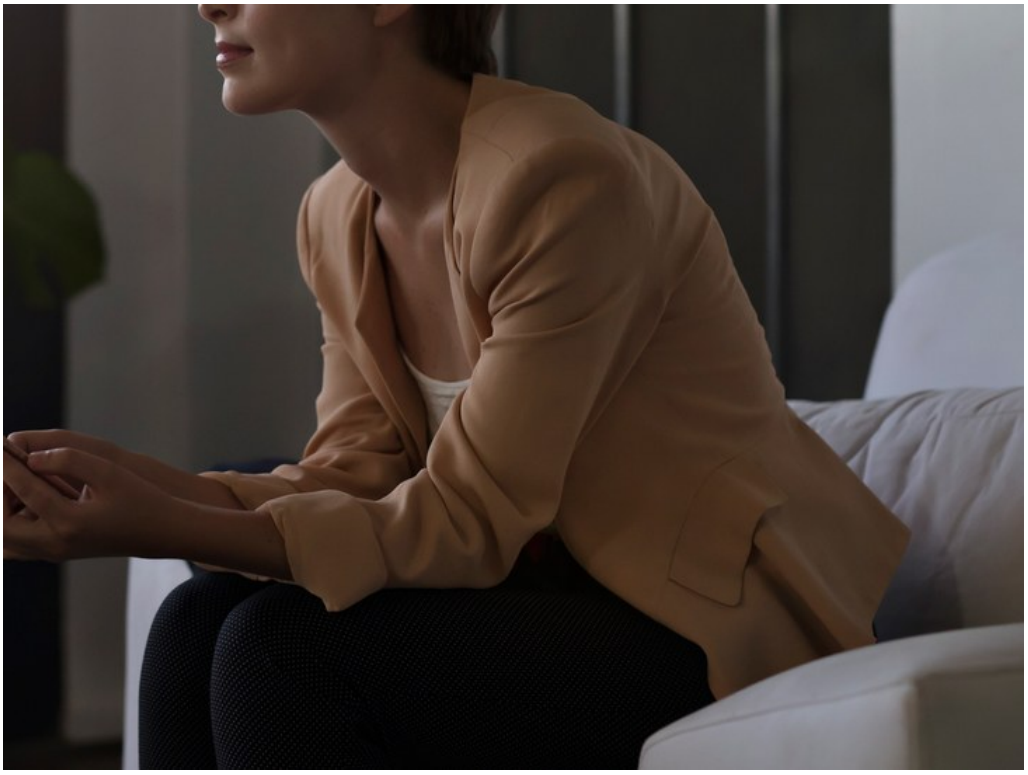
9 Awkward Questions You Probably Want to Ask Your New Therapist

We welcome these questions, promise.



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Going to a new mental health provider can feel a lot like going on an uncomfortable first date (minus the romantic stuff, obviously). Before you meet in person, you likely have very little information about them. Maybe you saw their face online and thought, *they seem nice*. And you probably did a quick online search to find out a few details like where they went to school and what they're focused on, which is also probably what encouraged you to set up a meeting in the first place.

When it's time to meet in person, you're likely feeling nervous and skeptical that this complete stranger could actually improve your life and have your best interests in mind at all times. But you're also hopeful that something good might just come out of this and it won't be a total flop. Maybe you keep your guard up and put out feelers throughout the first visit (or two, or seven) to see if you can actually vibe with this person. You know you should ask questions—and you have so many questions!—but you're a little wary of coming on too strong and accidentally saying something inappropriate.

The thing is, when it comes to finding a therapist—just like with dating—you deserve to know what you're getting yourself into. As a psychiatrist, I often do get questions that you might think are inappropriate to pose to your new therapist. But I can assure you we welcome these curiosities, especially if they help *you* feel more comfortable and open to continuing therapy—or even going in the first place. It's completely normal to feel distrusting of the process in the beginning. And it is more than OK to ask questions about the person's professional background, your treatment, and any and all fears you have about the mental health services you're getting.

Here are some of the most common, seemingly awkward questions I receive, and exactly how I handle them. Hopefully by answering these questions, I can help you feel at least a little bit less jittery about your first appointment with a new provider.

1. Is there a reason you're a psychiatrist/psychologist/social worker/family therapist/etc. rather than some other title?

There are a lot of different types of providers in the mental health space, and this can make things pretty confusing when you are looking for someone to see. To start, the term "therapist" is ambiguous and could refer to any person who is able to provide therapy (or what some people colloquially call "talk therapy"). This list includes social workers (LCSW), nurse practitioners (NP), physician assistants (PA), mental health counselors (MHC or LPC), marriage and family therapists (MFT), psychologists (Psy.D. and Ph.D.), and psychiatrists (M.D.). (You can find a pretty comprehensive list here.) While all of these listed degree holders can be great options to see for one-on-one counseling or therapy, it really comes down to what your needs are and what specializations you're looking for in a provider.

So the answer to this question will completely depend on the expert you're asking and their personal reasons for going into a particular field. Someone who chose to, say, pursue clinical social work helps people cope with mental health problems and diagnoses and treats mental and behavioral issues, in many of the same ways that I do as a psychiatrist. But their career can also reach many other facets that I wouldn't necessarily cover, such as helping a family in need find housing, helping parents navigate the process of adopting a child, and many other situations. Different degrees mean different job purviews and training focus, and one is not necessarily better than another. They are just different and allow the expert to cover and provide service in niche situations.

To speak to my degree specifically, psychiatrists and psychologists require the most years of training. They might also, subsequently, charge more, which may be a barrier for some people and a reason they don't want to see a psychiatrist/psychologist. Psychiatrists, like me, are also the only group that goes to medical school, and as a result, are able to prescribe psychiatric medication. We have the same training as all other doctors prior to specialization, so we also understand psychological manifestations of physical illnesses (like experiencing depression as a result of a cancer diagnosis or cancer treatment) and what else to be looking and testing for (we often order lab tests).

Due to our ability to prescribe and our medical background, psychiatrists often see people with more severe mental illness (typically therapy alone is a first step for many illnesses and medication is considered as a next step if needed). However, the reverse is not true, meaning if you feel you want to see a psychiatrist, that does not necessarily mean you have a serious mental illness. We still see patients for psychotherapy alone.

So don't be afraid to ask your provider why they chose their specialty and what makes them uniquely suited (or not) to care for you as a patient. You can even ask them this upfront, before your first visit, to make sure you are going to the right person. In my case, I chose to become a psychiatrist as I always wanted to have medical training, but I didn't know what type of doctor I wanted to be when I went to medical school. I loved the ability to have time with my patients and get to hear their stories, while also still being a physician, ultimately leading me to psychiatry.

2. Can I actually trust that everything I say to you stays between you and me?

The short answer to this question is mostly yes. Everything you tell me (and other mental health professionals) in session is confidential, *except* in instances where you are an imminent danger to yourself, a danger to someone else, or are expressly unable to care for yourself anymore due to your psychiatric illness. In those circumstances, we are legally obligated to breach confidentiality to protect you or the person you want to harm.

The word imminent, however, is key. For example, a patient can have suicidal thoughts, which in theory implies they pose a danger to themself, without having a plan or intent. This is an incredibly important distinction. This means that just telling me you think about dying will not result in me breaking confidentiality. However, telling me that you thought about killing yourself today and bought something to help you to go through with it would lead me to break confidentiality. The difference is ever so slight, but very important.

Psychiatrists are also mandated reporters for things like child abuse and elder abuse and would have to disclose those things if they came up in conversation. Domestic violence reporting is more complicated and state-dependent, and often isn't mandated.

We also do document each visit like other providers do with medical records, mostly for insurance purposes. These notes, again, are confidential. In most institutions, psychiatry notes are protected and require an additional level of clearance to even be seen by other providers. Psychiatrists often will put minimal details in the notes, particularly in regards to psychotherapy, to further protect the sanctity of the patient-provider relationship. For example, we might write in a note that a patient is "learning to cope with his abuse history." Even though we talked in detail about that specific abuse being referenced, those details may be left out of the chart. We will always have to include a diagnosis, and this often will be seen on the chart by other providers.

3. If you have so many patients, how do I know you'll be focused on and care about me individually?

I can only speak for myself on this one, but the training we undergo in this field teaches us to multitask, and to multitask well. It also teaches us to look at each individual person and their experience, and to not only associate them with a particular diagnosis or disease (e.g. you are not a schizophrenic, but a person who happens to have schizophrenia). I give each patient the same attention, empathy, brain space, and thought, and I place equivalent value on each and every interaction. But the only way you would know that, I think, would be to actually trust me, which is easier said than done when you just meet someone. But I tell my patients who exhibit this skepticism: Trust that I am doing the best I can to care for you as an individual and not another number.

If, however, you ever feel like your provider isn't listening to you or doesn't remember you or your presentation, it's really important that you bring it up with them. You can say, "I'm feeling like you don't remember my story or details about me when I come to our sessions," or, "I feel like I've repeated a few things in our conversations together, and I hope that my story is not getting lost on you or confused with others." It gives them a chance to know how you are feeling and what you are noticing in session. It also gives your provider a chance to do better as we are all human, after all. After that, if you still are unsatisfied, it is more than OK to try to find another provider who you connect with better or who seems to listen to you more.

4. Are you going to push medication on me?

This is by far the most common question I get as a psychiatrist, and also the most common stereotype of my field. Again, I can only speak for myself here, but if you are referred to me for a medication evaluation, the key word to me in this context is "evaluation." This means that I will ask you a lot of questions about your symptoms, other possible connected symptoms, your psychiatric history (including medications, diagnoses, and hospitalizations), your family history, your social history (substances, support system, your education, your background), and your medical history. I then will try to use all of that information to decide if I think what is going on with you would be managed well by medication.

If I think that medication could benefit you, I will present my case to you for why I think medication would help, what medication in particular I think makes sense, the risks of that medication, the benefits of that medication, and the alternatives to that medication. Then, it is really up to you whether you actually want to take the medication.

You could go home and read about it some more, you could (and should) ask any questions you might have, and you could ask to start at a lower dose if you feel you are sensitive to medication and side effects. I typically lay out a good amount of options for my patients as I don't want the relationship to feel paternalistic. I want them to feel like we are making an educated decision together, because we are. By doing so, I feel like patients will feel more motivated to take medication daily and will have more belief in their efficacy.

It is ultimately your choice, and I am just here to present the facts and what I think will be best for you and help you the most. There are very few instances where medication can be "forced" on any person, and they are all, by definition, emergencies.

5. Am I going to need medication forever?

This is another medication-related question I get frequently, and the answer entirely depends on what your diagnosis is, how long you have had it, and how many "episodes" you have had. Medication for bipolar and schizophrenia, for example, generally will require a person to stay on their medication plan long term or perhaps permanently. For people with these disorders, it is always my goal to help them land on a medication or combination of medications that they tolerate and truly feel like the benefits outweigh the risks.

But for some conditions, the length of time a person stays on medication may vary greatly depending on the individual. A good example of this is someone with depression: If you have never had depression before and this is your first episode that has required medication, I may tell you that you can try coming off of the medication (with my guidance, not on your own) after you are stable in your mental health for about six months.

If, however, you have had an episode before and this is a recurrence of depression, chances are you will need to stay on that medication. In this case, I will encourage you to think of daily medication as a prevention method—taking medication is *not* a sign that you or your health has failed in any way. Think of cholesterol medication—a person may need to take this so that they can prevent a heart attack or stroke. Taking a medication to prevent an episode of depression is just as important to your overall well-being as using one to manage your cholesterol.

6. How do I know your advice is good enough for me to take it?

I hear you. It's incredibly hard to have blind faith in a person telling you what you should be doing to "get better." The cool thing is therapists aren't actually in the business of advice-giving. Think of therapy more as a safe space to work through things you are struggling with. I might help give you tools (or help fortify or identify existing strengths within you), but you actually do all the work. You might practice some things in this safe space we create together, within our therapeutic relationship, but then you alone go out into the world and hopefully use what you learned to strengthen your connections and relationships outside of therapy. In other words, I'm never giving you some exact blueprint for how to solve an issue. I'm helping you examine yourself and your life and relationships, I'm a sounding board, and I'm a place of trust and security.

I also want my patients to know that you're allowed to gut-check your experience with a new provider to help build that trust and sense of security. You are obviously welcome to read about the recommendations and/or medications your provider is suggesting before making your decision to follow their guidance or continue working together. But, I would caution you from blindly searching about psychiatric medication and methods on the internet, as there are far too many pages with misinformation out there. You want to make sure you are reading the evidence and studies that decision-making in psychiatry has been based on. You can always ask your provider where you can go to learn more or better understand where a medical recommendation or therapy method derives from. They may be able to provide you with specific studies or further academic reading. Or, the websites for the National Alliance on Mental Illness (NAMI) and the American Psychiatric Association (APA) are excellent, credible places to start.

7. If you're already prescribing me medication, do I really need to see you for therapy too?

I wish we had some miracle medication that worked not just on its own for every mental health condition, but also quickly and flawlessly. But at the present time we don't, and a lot of our medications take a good deal of time to work, and they don't necessarily work by themselves without guidance and support and other forms of treatment to supplement them.

For instance, antidepressants can take six to eight weeks to start working, and many people notice side effects long before they notice benefits. Because of this, and also because studies suggest that medication alone is inferior to medication plus therapy, I recommend therapy to pretty much everyone.

I am also of the opinion that the majority of people, even those who don't think they have a mental health-related reason to work with a therapist, can benefit from having an outlet outside of their friends and family to just talk openly and confidentially. Therapy can be useful for prevention and self-care. The type of therapy that you choose to do might be based on what your current diagnosis is and the evidence-based intervention for that disorder (exposure response prevention for OCD or dialectical behavioral therapy for borderline personality disorder, to name just a few examples) or based on what you prefer and/or how you like to structure your thinking (perhaps more open-ended methods, like psychodynamic psychotherapy or cognitive behavioral therapy fit your needs).

8. If I spot you in line at the grocery store, what should I do?

Run. KIDDING! This happens to me a lot, given that I work on a college campus. If I see someone in public, I typically don't acknowledge them until they acknowledge me. This can sometimes make a person feel like I ignored them if we did not previously discuss the possibility of this scenario happening, which is why I try to talk about it first with my patients and let them know I will not wave and call out their name in public and will take cues from them on how to interact.

I err on the side of caution when interacting with patients outside of our sessions in part due to the stigma (that needs to disappear) associated with psychiatry and mental health issues. If, for instance, someone else on campus knows that I am a psychiatrist and sees that we know each other, I would never want this interaction to make you nervous that an outsider now assumes that you see a therapist or that you have mental health issues. It sort of "outs" you accidentally, something I *never* want to do to someone.

Believe me, I wish this wasn't a thing and that I was viewed the same way as your primary care provider, but I get it, we are not there yet in our society. I also know the things you discuss with a mental health provider you may not discuss with anyone, so seeing your therapist in public can just make you feel weird or vulnerable, so I don't try to emphasize that by making you acknowledge me in a different setting.

So, speak to your mental health provider about what they tend to do in a scenario where you spot each other outside of your one-on-one time, and tell them how you prefer they handle it.

9. No offense, but what if I just don't like you as a provider—should I stick it out?

If you can afford it and there are other options in your community (mental health resources can be dreadful in many places and for many socioeconomic groups, I get it), you should absolutely leave a provider with whom you're just not connecting.

Studies suggest that "fit" and the therapist-provider relationship are actually some of the strongest indicators of success in treatment. Because of this, I will often tell patients that we are using the first few sessions to get to know each other and that it is OK to not like me. The way I see it is, we don't have some machine that can do therapy perfectly for every single person, so if you don't like the "tool" (meaning the therapist), you should try another one to see if it works better. I would much rather someone leave me and find someone else and still get treatment than be scared out of mental health treatment completely.

That being said, keep in mind that the first few visits (especially the very first one) are pretty data collection-heavy, and you should try to give it more than one visit if you can stomach it.

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