## Chapter 1

# *INTAKE AND INTERVIEWING*

A good clinician is like a detective trying to solve a mystery (D. L. Segal, June, & Marty, 2010). Clues must be gathered, facts ascertained, leads followed up, and a time line of events created. These are pieces of a puzzle that will form the big picture and, one hopes, answer some important questions: "*What* is this person's diagnosis?" "*When* did these problems begin?" "*Why* is this person seeking help now?" and "*How* can I best help?"

Like a detective, the clinician needs a specific set of skills and tools to find the answers. This chapter reviews the most fundamental skill, the ability to conduct a comprehensive intake interview (Hook, Hodges, Segal, & Coolidge, 2010; Jones, 2010). The primary goals of the intake interview are to develop rapport and a therapeutic alliance with the client and to gather relevant data about the nature and context of the client's problems (J. Sommers-Flanagan & Sommers-Flanagan, 2014). This allows for an accurate diagnosis and informs therapeutic decisions (D. L. Segal et al., 2010).



## PREPARING FOR THE FIRST INTERVIEW

A good intake interview provides clients with an opportunity to tell their own stories and express the meaning of their symptoms and experiences (S. B. Miller, 1987). This information creates a road map that ultimately guides the clinician and client toward an appropriate diagnosis and treatment plan. When an interview is poorly conducted, treatment decisions are based on incomplete or inaccurate information and a client's well-being is directly threatened (S. M. Turner, Hersen, & Heiser, 2003).

### Determine What You Know and Don't Know About Your Client

Depending on the setting in which you work, you may have very little or quite a bit of information about a new client prior to the first meeting. Clients seen at outpatient clinics have often been screened by a staff person, so information on the presenting problem, past treatment, current medication, and more may be available. If the client previously received services, there may be old records that can provide invaluable information.

In contrast, a private practice clinician may opt to do a relatively brief screening over the telephone and will have only the most basic idea of the client's presenting complaint prior to the first meeting. In both cases, it is helpful to begin building a profile of what is known about your client and what you need to find out before the first meeting (Lukas, 2012). For example, if phone intake notes indicate that the client has recently been hospitalized, during the intake interview you will want to find out

- the reason(s) for the hospitalization (including any thoughts and behavior indicating an intent to harm oneself or others),

- the length of stay and if the hospitalization was voluntary,
- diagnoses and medications administered to the client,
- if this was the client's first inpatient stay, and
- if the client followed up with the discharge recommendations.

It is crucial from the beginning to listen for information on the client's strengths, adaptive coping, resources, and support systems. Although the client's diagnosis and full range of presenting problems may not be known before the first meeting, you will likely have some general idea of the problems or symptoms the client is experiencing. It is useful to refamiliarize yourself with diagnostic criteria and diagnostic features for the relevant and comorbid disorders in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*DSM-5*) that are likely to be considered (American Psychiatric Association, 2013).

Reviewing past treatment records (obtained with the client's permission) is a good way to do this advance preparatory work. Remember, the value of this information depends on the competence and insight of the initial interviewer. Some clients may be reluctant to release records to a clinician they have not met in person and are not certain they will continue seeing. That said, it is important to be flexible and remain open to attending to and following up on information that may contradict preconceived ideas about the client's problems or diagnosis. Do not rush to premature closure of the interview because of your discomfort with uncertainty (Cozolino, 2004). Effective interviewers take care to avoid the *confirmatory bias effect*, or asking only questions that will confirm diagnostic preconceptions, as well as the *halo effect*, in which an initial impression of the client guides subsequent questioning and diagnostic decision making.

## Gather Relevant Paperwork

Basic paperwork should be collected prior to the initial interview, including

- the consent to treatment form,
- Health Insurance Portability and Accountability Act (HIPAA) forms, and
- release of information forms.

Clients should also be given:

- the clinician's business card,
- information on how to contact the clinician in an emergency, and
- information regarding clinic/office policies and procedures.

Because a great deal of information is gathered in the first session, it is useful to have an interview form on which notes can be written and organized. While it is helpful to jot down key phrases or descriptions that the client uses or any instances of unusual language use (see the section on the mental status examination [MSE], later in this chapter), avoid trying to write down verbatim everything that the client says. This makes it difficult for you to listen to the individual, observe his or her behavior, make appropriate eye contact, and maintain rapport. Clients usually will not mind if notes are taken during the interview; however, do

obtain their consent before writing. In fact, some clients may resent the clinician who writes nothing during the interview and may assume that the clinician does not take their comments seriously (H. I. Kaplan & Saddock, 2010). It is also helpful to keep an up-to-date referral notebook that contains contact information for adjunctive services (e.g., psychiatrists for medication evaluations) the client may be referred to.

## Consider How the Setting Will Guide the Interview

The type, structure, and style of the interview, and the key areas emphasized, may vary depending on your work setting. D. L. Segal et al.'s (2010) work on diagnostic interviewing has been adapted in Table 1.1 to provide interview formats for three different common clinical settings.

## Preparing the Setting

Ideally, the therapy room should be a comfortable refuge that helps put the client at ease and encourages open dialogue. An uncomfortable or inappropriately furnished room reflects poorly on one's professionalism. It may distract the client, discourage disclosure, and decrease the likelihood that the client will return for treatment. Consider whether any furnishings would be likely to upset clients. A cherished photograph of family members in clear view of a client may invite unwanted personal questions about your family life or result in the client's reluctance to divulge troubling feelings about parenting issues for fear of the therapist's disapproval or disappointment.

When interacting with clients, be professionally dressed. The therapy room is not the place to make a fashion statement, and care must be taken to consider how a variety of clients might interpret your dress. For example, novice therapists who look very young and are planning to work with older adult clients may wish to avoid dressing in clothes or wearing hairstyles that accentuate their youth. Research shows that the majority of clients prefer and are more likely to follow the advice of a clinician who is professionally dressed (Morrison, 2014c).

Furniture in the therapy office should be arranged in such a way that the client and clinician do not have to sit too close together (e.g., feet almost touching) or too far apart. By sitting at a 90- to 120-degree angle, they ensure that the client or therapist can look away without discomfort (J. Sommers-Flanagan & Sommers-Flanagan, 2014). Ivey, Ivey, and Zalaquette (2010) note that seating arrangements may need to be modified based on the client's cultural comfort with direct eye contact. Allowing clients a personal space of about 3 feet around their bodies should be sufficient (Twemlow, 2001). Tissues should be available in the event a client cries during the session. Keep paperwork and client files so that they cannot be seen when the client enters the office or is seated. If child clients are seen, age-appropriate toys, books, and furniture (e.g., low table and small chairs) should be available. Lighting should be moderate; strong overhead fluorescent lights that can impart an institutional feeling should be avoided. Conversely, a darkened therapy room with minimal light or use of lit candles can evoke an inappropriately intimate atmosphere. The therapy office should afford privacy and protection from interruptions. Take care to ensure that there is adequate soundproofing, all phones and other electronic devices are silenced, and other people are instructed not to enter the office.

**Table 1.1 A comparison of three interview settings**

| Emergency Diagnostic Centers/Crisis Settings | Outpatient (Clinics/Private Practice) | Medical Centers (VA, University, or Rehabilitation) |
|---|---|---|
| **Goals:** | **Goals:** | **Goals:** |
| ❖ Address crisis issues (e.g., suicidality, abuse). | ❖ Learn as much as possible about client's emotional functioning. | ❖ Evaluate the role of general medical conditions. |
| ❖ Gain enough information for diagnosis, and determine immediate disposition. | ❖ Determine reasons for seeking consultation. | ❖ Gain enough information for diagnosis and immediate disposition. |
| **Additional considerations:** | **Additional considerations:** | **Additional considerations:** |
| ❖ Clients may be frightened by their symptoms, agitated, and intimidated by the setting. | ❖ Client problems may be less acute/severe and more varied than in crisis settings. | ❖ Clients are often referred by treating physician and not self-referred. |
| ❖ Adopt a calm, structured, understanding, reassuring manner to put the client at ease. Consider a crisis intervention approach. | ❖ Devote ample time to the establishment of rapport and a strong therapeutic relationship. Fully explore client's personal history. | ❖ Clients may have doubts about their need for psychological treatment and may be reluctant to be interviewed. |
| ❖ Client's ability to clearly provide history may be diminished. Decrease emphasis on obtaining a detailed psychosocial history. | ❖ More time is available for detailed questioning. Client may be more inquisitive and more likely to ask about clinician's diagnostic impressions, treatment recommendations, and prognosis. | ❖ Client's pain, fatigue, and physical discomfort may impact format and length of questioning. Interview may be protracted and involve adjunctive medical procedures and laboratory tests. |
| ❖ Focus on mental status examination; assessment of abuse, and risk for self-harm and harm to others is crucial. | ❖ In-depth assessment of strengths and challenges. Important not to slip into a therapy mode. | ❖ May need to slowly approach idea of psychological (versus solely medical) factors contributing to client functioning. |
| **Challenges:** | **Challenges:** | **Challenges:** |
| ❖ Clinician will likely need to supplement information from client with other sources (e.g., family, police). | ❖ Clinician may need to educate client about therapeutic process to decrease dropping out or premature termination. | ❖ Client may try to get clinician to ally with him or her against the treating physician. Critical to adopt a professional stance. |

## Attending to Safety Issues

When conducting the initial interview, clinicians frequently omit or fail to ask about suicidal and violent or homicidal ideation and behavior, and physical, sexual, or emotional abuse or neglect. Consequently, the seriousness of potential risk and safety issues may be underestimated, and treatment decisions may be made based on incomplete information

(S. C. Shea, 2011). Because crisis-related information can present itself unexpectedly, always be attuned to information that warrants a direct response and be prepared to respond quickly (see Chapter 3, "Fundamentals of Treatment").

All clinicians, regardless of the setting in which they work, should take steps to keep themselves safe from potentially aggressive or violent clients (Morrison, 2014c; Reid, 2008). If the client is impulsive or agitated, it is crucial before meeting to review available records for prior indicators of impulsivity and aggression (see Table 1.2).

Unfortunately, assaults (verbal and physical) by clients are not rare and are probably underreported. A survey of psychiatry residents across the United States found that 86% had been threatened, 71% had been physically intimidated, 58% had received unwanted advances, and 25% had been physically assaulted (Dvir, Moniwa, Crisp-Han, Levy, & Coverdale, 2012). Despite these sobering statistics, many mental health professionals receive no or inadequate training on dealing with verbally or physically aggressive clients (Coverdale, Gale, Weeks, & Turbott, 2001). Flannery, Staffieri, Hildum, and Walker (2011), using data from the Assaulted Staff Action Program (ASAP), identified the following *violence triad* that can be used to identify clients who pose the greatest risk for assaulting clinicians and staff: individuals with a history of violence, personal victimization, or a substance use disorder. This research group also found that older males with a history of violence toward others, a diagnosis of Schizophrenia and a Substance Use Disorder, as well as younger male or female patients with personality disorders and the violence triad were the most frequent assailants (Flannery, Farley, Tierney, & Walker, 2011). Several basic safety guidelines are summarized in Table 1.3.

Morrison (2014c) recommends at the beginning of every session that clinicians instinctively check for their own safety and the safety of others. If you suspect that a client may pose a danger, intake or waiting room staff should be questioned prior to the interview about behavioral manifestations of client agitation (e.g., pacing, verbally threatening

**Table 1.2 What to look for in a review of client records**

| Historical/Behavioral Data | Potential Associated Diagnoses |
|---|---|
| ❖ Juvenile history of aggression, violence, and behavioral control problems<br>❖ History of violent behavior, homicidal ideation or plans, restraining orders<br>❖ Work problems, suspensions and terminations, entitlement<br>❖ Driving under the influence (DUI), gambling, or bankruptcies<br>❖ History of impulsivity, anger problems, self-destructive or injurious behaviors<br>❖ Delusional, bizarre behavior, involuntary holds, violence associated with psychosis, altercations<br>❖ Suicidal ideation or attempts<br>❖ Impulsivity, recklessness<br>❖ Poor or impaired judgment, confusion, agitation, and disorientation | ❖ Disruptive, impulse, and conduct disorders<br>❖ Antisocial Personality Disorder<br>❖ Narcissistic Personality Disorder<br>❖ Substance-related and addictive disorders<br>❖ Borderline Personality Disorder<br>❖ Schizophrenia spectrum and other psychotic disorders<br>❖ Mood disorders (e.g., Major Depressive Disorder)<br>❖ Bipolar and related disorders<br>❖ Neurocognitive disorders, dementia, central nervous system (CNS) damage, head injury |

**Table 1.3 Basic safety strategies**

- ❖ Know the agency's emergency and security procedures prior to intake.
- ❖ **Do not see a new client when you are alone in the office.**
- ❖ Be sensitive to scheduling and the availability of others.
- ❖ Review the client records and intake information for indicators of violence.
- ❖ Conduct the interview in a safe environment being mindful of physical surroundings, door access, and furnishings.
- ❖ Observe a safe distance when approaching a client, and attend to verbal and nonverbal cues.
- ❖ Do not make abrupt moves, and approach in a calm, nonthreatening manner.
- ❖ Use appropriate interviewing techniques; do not make provocative or threatening comments.
- ❖ Calm and reassure the client; assist the client's reality testing and self-control.
- ❖ Be alert for escalating emotions; address threats directly; explore veiled or indirect threats.
- ❖ Leave physical restraint to those trained in these procedures.

behavior, intimidating posture) and whether the client appears intoxicated, psychotic, cognitively impaired, or in possession of a weapon or other potentially dangerous object (Flannery, 2007). The clinician and intake staff should also stay alert for changes in the client's demeanor and for signs of escalation and increased agitation.

When working with impulsive clients, be aware of your physical surroundings, including knowledge of emergency alert procedures, panic buttons, distress codes, and access to the door. Do not place yourself in a physically vulnerable position (Reid, 2008). If you have concerns about the client's level of agitation, make arrangements for the interview to be conducted in the vicinity of other staff members. It may be appropriate to use a quiet corner of the waiting room, where the client's confidentiality may be maintained and visibility with other staff members ensured. New clients should always be scheduled at times when other staff is present and support is available.

In the therapy room, the clinician should avoid sitting so that access to the door is blocked. Any items that could be used to inflict injury (e.g., letter openers, paperweights, vases) should be removed. The clinician's hands should be visible, and he or she should make no abrupt gestures. A physically safe distance from the client is often considered two quick steps from the client, since this allows one to easily avoid or intervene should the client's behavior escalate. A sideways stance also avoids the potential for a direct body assault or injury. Finally, rather than sitting directly opposite the client, which may be perceived as confrontational, the clinician may favor sitting at a lesser angle, suggesting a supportive role and also making it easier for the client to disengage from eye contact (Cozolino, 2004).

When interacting with an agitated client, avoid the tendency to match the client's level of heightened emotionality and to rush through the interview. Instead, display a relaxed, natural, empathic, nondefensive manner that imparts a sense that the clinician is knowledgeable and in control. The client should be firmly told that violence is not acceptable (Twemlow, 2001).

When dealing with stressful clients, Cozolino (2004, p. 42) recommends "don't panic"; stay centered, provide structure and hope, and discuss the client's strengths and resources. Maintaining a verbal and emotional tone that is below the client's in intensity also serves to model appropriate affect, and most clients who are feeling out of control will find a clinician who is calm and in control reassuring (J. L. Hipple & Hipple, 1983).

Genuine interest and concern in the client's story can further help reassure the client that the interview is a safe environment and can discourage the use of inappropriate ways of communicating distress. Twemlow (2001, p. 517) suggests that "rational maneuvering" or pointing out the consequences of a client's violent actions in a nonthreatening manner can also help with de-escalation, as can encouraging the client to verbalize rather than act on impulses. In order to minimize the likelihood of escalation, emotionally charged material should be approached cautiously and only after rapport has been established and the client has calmed down.

One guideline for working with agitated clients is that the therapist be active for 10 seconds of every minute (Eichleman, 1996). Agitated clients with cognitive limitations may require frequent restating, paraphrasing, and reaffirming of what has been said. If the client appears psychotic, the interviewer can provide reassurance about the purpose of the interview in a straightforward manner, thus assisting the client's reality testing.

The clinician should assess the client's ability to respond to verbal limitations and interventions (e.g., is the client calmed or further agitated when the clinician attempts to change topics or asks the client to breathe deeply and collect his or her thoughts?). If escalation occurs, the clinician may change topics or choose to end the interview altogether. The interview may also be stopped if the client is intoxicated, extremely psychotic, highly disorganized, or paranoid.

In summary, clinicians should trust their instincts regarding danger. If you are at all concerned, have another person present or move the interview to a more secure setting. Basic self-defense training is a good idea for clinicians, particularly those who work in settings where agitated or potentially violent clients are frequently seen. The assessment of danger to self and others and appropriate interventions are discussed further in detail in Chapter 3, "Fundamentals of Treatment."

## LEGAL AND ETHICAL ISSUES

### Informed Consent

Just as the decision to enter psychotherapy is not made lightly by most individuals, clinicians too must take seriously their obligation to provide prospective clients with information that will allow them to make an informed decision about pursuing treatment. Disclosure and voluntary consent are two key aspects of informed consent. Clients should be provided with full information about issues that could affect their decision to engage in treatment, and their decision to enter treatment should not be the result of coercion or undue pressure.

Major mental health professional organizations (American Association of Marriage and Family Therapists [AAMFT], 2012; American Counseling Association [ACA], 2005; American Psychiatric Association [APA], 2010; National Association of Social Workers [NASW], 2008) contain within their ethics codes guidelines regarding informed consent. The language used in these codes varies somewhat, but important principles emphasized in them include

- obtaining informed consent prior to treatment,
- providing adequate information to the client in developmentally and culturally appropriate language,

- ensuring that the client has the capacity to consent,
- avoiding coercion of the client,
- communicating the right of the client to refuse or withdraw from services, and
- documenting the client's consent.

What constitutes adequate information in the context of informed consent? Clients should be informed of your credentials and training; information relating to the process of treatment (e.g., goals, therapy techniques); confidentiality; and practical issues such as fees, cancellation policy (e.g., how far in advance appointments must be canceled to avoid being charged), and how to contact you in an emergency or after hours (see Table 1.4).

Informed consent is not solely addressed at the start of treatment or by the signing of an informed consent form, but is a process and is part of the ongoing dialogue as issues, goals, risks, and benefits of treatment change over time (Handelsman, 2001). However, informed consent should be addressed at the outset of treatment so that the client is made aware of information that could affect his or her willingness to pursue treatment. Although state laws vary regarding the requirement to document informed consent in writing, it is good practice to provide clients with a written informed consent form that they sign and receive a copy of, rather than relying solely on an oral consent procedure. Oral consent alone is problematic, as most clients will have difficulty remembering everything covered in an informed consent procedure, and a client who chooses to sue a clinician may deny having given oral consent (Sales, Miller, & Hall, 2005).

In addition to documenting informed consent through the use of a signed form, any discussions that pertain to issues of informed consent that occur throughout treatment should be clearly documented in the client's case notes. It is important to ensure that an individual has the capacity to consent. If an individual is deemed unable to provide consent meaningfully because of psychiatric, developmental, or cognitive limitations, consent must be obtained from a legally authorized individual.

Children are not recognized as being legally capable of providing informed consent, because of limitations in their judgment and experience. Consent must be provided by the child's legal parent or guardian (Schetky, 2007). If parents share custody of a child, obtaining the consent of both parents is advisable (Welfel, 2012). Sales et al. (2005) note the

**Table 1.4 Elements to include in an informed consent**

| |
|---|
| ❖ Clinician's education and training (including licensure, status as a trainee) |
| ❖ Confidentiality and its limits (e.g., mandated reporting) and access to treatment records |
| ❖ Purposes, goals, procedures, and techniques of therapy |
| ❖ Risks and benefits of treatment and treatment alternatives |
| ❖ Treatment length (e.g., length of sessions, estimated length of overall treatment) |
| ❖ Right to ask questions and receive answers regarding treatment |
| ❖ Involvement of third parties (e.g., insurance claims, coordination among treatment providers, supervision, consultation) |
| ❖ Fees and billing arrangements (including actions in the event of nonpayment) |
| ❖ Cancellation policies and how disputes and complaints will be handled |
| ❖ Emergency and after-hours contact procedures and information |
| ❖ What happens in the event the clinician becomes disabled or dies |

importance of determining the custodial status of any parent seeking to place a child in treatment, as some states will allow only a parent with legal custody to consent to treatment and/or will allow a noncustodial parent to consent to treatment only in certain emergency situations. Under certain circumstances, a child (i.e., person under the age of 18) may be able to consent to mental health services. Certain states recognize the rights of emancipated minors to consent to mental health treatment services. Some states also allow unemancipated minors to consent to certain forms of treatment such as contraceptive services, testing and treatment for HIV and other sexually transmitted diseases, pregnancy, prenatal care and delivery services, and treatment for alcohol and drug abuse. Clinicians who treat minors should become familiar with their state laws in this area.

Even when an individual cannot legally provide informed consent, it is advisable to obtain his or her *assent* to treatment. This means that the client agrees to services even though the agreement is not legally recognized. The information imparted to an individual in such a situation must obviously be tailored to his or her psychological capacities. For example, although very young children may not be able to meaningfully understand what agreeing to treatment means, Morrison and Anders (2001) suggest that beginning around age 7 children are able to reasonably participate in discussions of issues such as confidentiality. As Welfel (2012) notes, in the case of older adolescents the information imparted in an assent procedure will increasingly approximate what is included in a typical informed consent process with an adult client.

In addition to obtaining consent for treatment, you also need to review with the client the Health Insurance Portability and Accountability Act (HIPAA) forms. HIPAA's Privacy Rule outlines who can and cannot receive an individual's protected health information; requires that reasonable administrative, technical, and physical safeguards be put in place to protect the privacy of such information; and mandates that clients be notified of their health care provider's privacy policies. This means you need to make a good-faith effort to obtain the clients' written acknowledgment of receipt of such notice. The notice of privacy policies informs clients of how their personally identifiable health information may be used and disclosed, and specifies those situations in which written authorization from the client is required for disclosure and when disclosures of information can be made without the client's authorization (Sales et al., 2005). The U.S. Department of Health and Human Services' website has detailed information on HIPAA. One's professional organization can also be contacted for HIPAA-relevant information. All reports should be marked "Confidential" and include a confidentiality statement (J. Sommers-Flanagan & Sommers-Flanagan, 2014).

## Confidentiality

A hallmark of the therapeutic relationship is confidentiality, and most clients enter psychotherapy with an expectation that what they disclose and discuss will be kept strictly confidential (D. L. Segal et al., 2010). Although this expectation is reasonable, clinicians have legal and ethical responsibilities both to maintain confidentiality and also to breach it under certain circumstances. All 50 states require mental health professionals to report cases of suspected child abuse or neglect. Most states have similar mandated reporting laws for cases of suspected elder or dependent adult abuse and intimate partner violence.

Similarly, when a client discloses a threat to harm a specific individual, laws specify the steps clinicians must take to protect these potential victims from dangerous clients, which may include breaching confidentiality (D. L. Segal et al., 2010). Confidentiality may also be breached if an individual is at risk of self-harm (e.g., a clinician can discuss the client's case with other treatment professionals in arranging for an involuntary hospitalization).

If a client initiates legal action against a therapist, client confidentiality is waived to allow the clinician to defend him/herself by discussing details of the treatment in court. Also, if a client is involved in litigation in which he or she is claiming psychological harm (and citing treatment with you in building his or her case), confidentiality is not protected (Welfel, 2012).

Clinicians can also be compelled by a court order to produce treatment records or give testimony about a client. In certain states, if a client is being investigated by law enforcement officials and discloses the intent to commit a crime in the future, the clinician may be compelled to report this to the officials (Glosoff, Herlihy, & Spence, 2000). Some states require new HIV-positive test results (including the names of affected individuals) to be reported to governmental agencies, and some states require disclosure of HIV-positive status to an individual's sexual partner (Sales et al., 2005).

This not an exhaustive list of conditions in which confidentiality may be breached; see Sales et al. (2005) or Welfel (2012) for more detailed reviews. Most clients will not be aware of the many circumstances in which confidentiality cannot be assured. These exceptions should be discussed with the client and clearly documented in an informed consent to treatment form that the client reads and signs at the start of treatment. It is important to take responsibility and become familiar with the laws governing confidentiality in the state where you practice and to keep abreast of changes in relevant statutes and case law. This can be achieved through participation in continuing education workshops and through updates provided by one's professional organization. Clinicians should also be familiar with their professional organization's ethics code related to issues of confidentiality (AAMFT, 2012; ACA, 2005; APA, 2010; NASW, 2008).

Since a child is rarely able to consent to treatment (Schetky, 2007), this raises interesting questions about the confidentiality of the child's disclosures in treatment. From a legal perspective, if a parent consents on behalf of the child, the parent will have the right to access the child's treatment records. However, parents and guardians consenting to a child's treatment may also have an expectation that you will discuss with them everything the child says in sessions with you. Parents and guardians need to understand that the development of a trusting relationship between the therapist and the child is a crucial part of treatment and that if an agreement to disclose to parents/guardians everything a child says in session is made, it is very likely the child will not be forthcoming and the course of treatment could be adversely affected. Of course, parents and guardians have a right to know if a child discloses anything in a session that indicates the child's health or well-being is in jeopardy (e.g., if the child expresses suicidal ideation or reports abuse). This should be explained to the child's parents or guardians, along with the fact that certain disclosures required by law (e.g., child abuse) necessitate that third parties (e.g., department of children's services, local law enforcement agencies) be informed.

In cases where confidentiality must be breached, it is important to fully document in the client's case notes the rationale and the steps taken in reaching this decision. Such documentation can show that a clinician thoughtfully considered issues pertaining to the client's

confidentiality and can be valuable should questions later arise as to the appropriateness of a clinician's actions (Reamer, 2005).

### Release of Information

It is not uncommon during the course of an intake interview to determine that it is useful or necessary to gather additional information about the client from a knowledgeable third party. This might be a prior therapist, a past or current general physician, or a family member or significant other. In some cases, the purpose is to obtain additional information that will aid in diagnosis and/or treatment planning; in other cases, contact with collateral sources is needed to coordinate treatment. In all cases, it is necessary to obtain the client's (or parent's or guardian's) signed consent to contact these individuals. A release of information form accomplishes this purpose. Even when a client has provided verbal permission to contact a third party, this should be documented on a signed release form.

The HIPAA regulations outline the elements that should be included in a valid written authorization to release information, including the name of the client, the name and address of the facility or person from whom information will be obtained and to whom information will be released, the purpose of the disclosure, limitations of the disclosure (e.g., regarding the type of information to be released), a statement that the client can revoke the authorization, and the length of time for which the authorization will be valid (e.g., 1 year). We recommend including these in any written release of information form. The release form should be signed and dated by the client or his or her legal guardian (e.g., in the case of a child client or a client under conservatorship). When requesting information from a third party, always send a copy of the release request to the individual or agency. Keep the original form in the client's file.

Sometimes clients are hesitant to have others contacted as part of the intake process. They may be reluctant to reveal being in treatment to others, or, if there were conflicts with previous treatment providers, they may be concerned about how these individuals will portray the client. Such concerns should not be summarily dismissed by insisting that additional information is necessary. Address the client's concerns first.

## INTERVIEWING THE CLIENT

### Issues That Impact Interview Effectiveness

The clinician's past experiences (e.g., events, relationships), current needs, motivations, physical state, cultural assumptions, biases, and blind spots can all affect the quality of the relationship that is established with the client, which in turn can affect the quality of information obtained in the initial interview (J. Sommers-Flanagan & Sommers-Flanagan, 2014). These problems may come to the clinician's awareness during or after the initial interview. However, it is possible to anticipate some issues ahead of time. If you make a concerted effort to remain aware of them during the interview, you can reduce the likelihood they will adversely impact your working relationship with the client.

For example, suppose a 28-year-old male clinician is scheduled to meet a 56-year-old male client for an intake interview. Prior to the session the therapist reflects on how he typically interacts with older male clients or older men in general. He recognizes that he often

feels insecure, is overly deferential, and can be hyperattuned to any verbal or nonverbal signs that the older man is disappointed or irritated with him.

Being aware, the clinician can then take steps to address these issues. He may practice role-playing before the interview and make a list of specific questions he thinks he might (un)consciously be reluctant to ask. He can exert special effort to catch himself and question his motives when he decides not to ask a particular question or make a certain statement. He may practice cognitive reframing of possible client reactions ("If the client frowns during the interview, that doesn't necessarily mean I've asked the wrong question; he may just be remembering something upsetting").

The astute clinician is mindful throughout treatment of the ways personal reactions to clients can affect clinical impressions, diagnostic decisions, and treatment interventions. *Countertransference* is a psychoanalytic concept that refers to the development of feelings in a therapist about a client that are similar to those the therapist has had toward someone from his or her past. One does not have to be working from a psychodynamic framework to experience such feelings, and countertransference will be experienced with all clients to some degree (I. Weiner & Bornstein, 2009). Countertransference reactions can clue the clinician in to understanding the client's impact on others, which can be particularly helpful in assessing problematic aspects of the client's personality and interpersonal relationships. It can also help clinicians identify areas in their professional and personal development that need to be addressed and monitored to improve their ability to provide optimal care. When left unchecked, countertransference reactions can obscure clinical judgment and lead to inappropriate diagnosis and/or treatment (Wiger & Huntly, 2002). When strong reactions are aroused in us by a client, consultation with a colleague, supervisor, or personal therapist may provide insight into why these feelings are being aroused and how they might be affecting the treatment process (Cozolino, 2004). The impact of countertransference on treatment is discussed further in Chapter 3, "Fundamentals of Treatment."

Interviewer variables such as gender, ethnicity, age, and other demographics can influence the behavior, comfort level, and openness of clients. Findings from the literature are mixed. On one hand, there is evidence of reduced dropout rates and improved outcomes in empirically based treatments when the client and therapist are ethnically similar (Erdur, Rude, & Baron, 2003; Flicker, Turner, Brody, & Hops, 2008; Halliday-Boykins, Schoenwald, & Letourneau, 2005). In contrast, Cabral and Smith's (2011) meta-analysis of mental health treatment outcomes found almost no benefit from racial/ethnic matching of client and therapist, and the authors noted that "clients and therapists from the same race may be very dissimilar" (p. 538). Perhaps more important than an ethnic match between client and therapist is a willingness on the part of the therapist to understand how the client's ethnic/cultural background and worldview impact how mental health issues are viewed and typically handled. This is addressed next.

## Cultural Competence

Ethnic minorities currently comprise 25% of the U.S. population. By 2050 more than 50% of all U.S. residents will be members of groups that are currently considered minority groups, so there is a high probability that as a clinician you will treat a diverse group of clients during your career (La Roche, 2005). The impact of culture is consistently present in the therapeutic relationship and is a complex, dynamic factor that needs to be acknowledged

and incorporated for effective treatment (La Roche, 2005). From the outset, it is necessary to be sensitive and attuned to clients' cultural or ethnic identity and their comfort level with you as a clinical provider.

According to Sue and Sue (2012), *cultural competence* involves three components: (1) a self-awareness of your assumptions, biases, and values; (2) understanding an individual client's worldview; and (3) knowledge of culturally appropriate and specific intervention techniques and strategies. J. Sommers-Flanagan and Sommers-Flanagan (2014) recommend the importance of both *multicultural sensitivity* and *multicultural humility*, and Lo and Fung (2003) encourage the clinician to develop generic and specific cultural competency skills that can be applied throughout the therapeutic relationship. These skills include cultural sensitivity, curiosity, perceptiveness, respect, an understanding of different cultural explanatory models, and an awareness of the importance of cultural identity and connection to the community at large. Hays (2007) describes the importance of respect as a central value in many cultures. She recommends avoiding psychological jargon, being aware of the different meanings of nonverbal communication, and looking at the client as an individual, not a cultural stereotype (see Table 1.5).

Incorporation of culturally based knowledge should not be indiscriminately applied, and multicultural competence involves "having the knowledge, awareness and skills to know when and how culture can be best used" (W. M. Liu & Clay, 2002, p. 178). Thus, when working with any client it is important to appreciate his or her individuality, personal

**Table 1.5 Steps to include diversity in the clinical intake and treatment**

- ❖ Determine which diversity factors are relevant and salient for the client.
- ❖ Determine the need for a possible referral or consultation.
- ❖ Evaluate the impact of diversity on the establishment and maintenance of rapport.
- ❖ Consider the role of diversity factors on information gathering.
- ❖ Determine when and how to incorporate diversity issues into intake and treatment.
- ❖ Assess the level of skill and information necessary for competent treatment.
- ❖ Examine the potential treatments and the cultural assumptions for each diversity factor.
- ❖ Consider the cultural role of supports and the client's willingness to include supports.
- ❖ Implement treatment using the individual's cultural strengths.

**ADDRESSING (acronym for within-group) Diversity Factors***

- ❖ **A**ge and generational influences, **D**evelopmental and acquired, **D**isabilities, **R**eligious and spiritual orientation, **E**thnic and racial identity, **S**ocioeconomic status, **S**exual orientation, **I**ndigenous heritage, **N**ational origin, **G**ender

**Cultural Questions to Consider****

- ❖ Do the individual's beliefs and values reflect his or her culture?
- ❖ Do these beliefs and values influence his or her openness to treatment?
- ❖ Does the individual see culture as important?
- ❖ Are the individual's beliefs and behaviors influenced by culture?
- ❖ Do cultural issues impact on treatment acceptability and treatment goals?

*From *Addressing Cultural Complexities in Practice: Assessment, Diagnosis, & Therapy*, by P. A. Hays, 2007, Washington, DC: American Psychological Association. Adapted with permission.

**From "Multicultural Counseling Competencies: Guidelines in Working With Children and Adolescents," by W. M. Liu and D. L. Clay, 2002, *Journal of Mental Health Counseling, 24*(2), pp. 177–187. Adapted with permission.

perspective and understanding of their presenting issues, and the unique context in which these problems emerged (Hays, 2007; W. M. Liu & Clay, 2002).

On intake and prior to starting therapy, educate yourself on different cultural norms and expectations, and conduct a self-audit of your own biases and worldviews. This may appear to be a daunting task, but a very practical starting point is to use U.S. Census data to identify the populations you will be treating and to educate yourself about these cultures (W. M. Liu & Clay, 2002). Strive to develop an understanding of how different groups are likely to view and cope with mental health issues. For example, among Asian communities, seeking mental health treatment is frequently associated with stigma and shame, and Asian individuals often enter treatment with more severe symptoms because they delay getting help (Okazaki, 2000; Tung, 2011). Similarly, delays getting treatment, poor treatment outcomes, and decreased satisfaction with treatment have been noted in Latino communities.

Although, as previously noted, an ethnic match between therapist and client may not be a necessary factor for treatment success, cultural congruence between the therapist and client has been identified as crucial to improving mental health services in ethnically diverse communities (Pope-Davis, Coleman, Liu, & Toporek, 2003; Smith, 2009). When clients experience incongruities between typical treatment approaches and their own cultural values (e.g., individualistic versus collectivistic orientation, self-reliance), the likelihood of dissatisfaction with treatment and poorer treatment outcomes increases (Alegria et al., 2002; Antshel, 2002; M. Paris, Añez, Begregal, Andrés-Hyman, & Davidson, 2005).

Thus, approach all clients with an attitude of kindness, concern, and genuine interest. This is crucial to helping the individual feel at ease. Remember that the client is the expert on his or her culture, and asking about his or her values and beliefs may facilitate rapport, foster the development of a culturally congruent treatment approach, and encourage the client's involvement in the therapeutic process. This is particularly crucial when the individual is likely to have experienced discrimination, labeling, stigmatization, and other negative interactions. These experiences may significantly impact your ability to establish and maintain rapport and will be a major factor in your choice of therapeutic interventions and in the client's participation. Remember, too, that the client may have gender, age, or religious beliefs that need to be inquired about, and the client's language of choice may be different from your own (Hays, 2007). With regard to the last of these, even when a clinician is able to communicate with a client in his or her preferred language, it is important to remember that basic linguistic competence does not impart familiarity with the subtle nuances that often characterize emotionally laden speech.

## Establishing Rapport

The new client, however motivated for treatment, faces a daunting task in the first session: He or she must be prepared to reveal highly personal thoughts, feelings, and experiences, many of which may be distressing or embarrassing. Clients must feel sufficiently safe with a clinician to lower their defenses and provide meaningful information to assist in diagnosis and treatment (Wiehe, 1996). According to Goldfried and Davila (2005), the establishment of rapport and a good working relationship with the client is a necessary component of this process. J. Sommers-Flanagan and Sommers-Flanagan (2014) suggest focusing on what the client is communicating by quieting oneself, being fully present, and not being distracted by one's own worries.

Rapport can be defined as the feeling of harmony and confidence that exists between client and clinician (Morrison, 2014c) or the open, safe, and trusting relationship that is established with the client (D. L. Segal et al., 2010). Being sensitive to diverse cultural communication practices, including the role of less formal interactional styles (e.g., the role of small talk or *charlar* for Latino clients), can place clients at ease and contribute to their feeling understood (Gallardo, 2013; Hays, 2013). Rapport can instill hope that the clinician has the insight and expertise to help (Othmer & Othmer, 2002a). As Phares (1992, p. 166) aptly notes, "Rapport . . . is not a state wherein the clinician is always liked or always regarded as a great person. It is, rather, a relationship founded upon respect, mutual confidence, trust, and a certain degree of permissiveness. It is neither a prize bestowed by an awed client nor a popularity contest to be won by the clinician." Rapport and a strong therapeutic alliance are critical not only for eliciting information during the initial interview, but also for the implementation of effective intervention, and consistently predict more positive overall outcomes in psychotherapy (M. J. Constantino, Castonguay, & Schut, 2002; Norcross & Lambert, 2011). Thus, the establishment and maintenance of rapport are not just goals to be sought during the initial interview, but are also ongoing processes that operate throughout treatment.

Dealing with defensive, resistant, or unwilling clients poses challenges to the establishment of rapport and the development of a therapeutic alliance. In these cases it is important to understand the nature of the client's defensiveness. Gold and Castillo (2010) suggest finding out if the client's defensiveness serves a self-protective function. Does it relate to the stigma associated with seeking mental health services? Does it reflect the threat of change, concerns of betrayal, difficulty relinquishing a solution, or acknowledgment of personal responsibility for a problem? In situations like these, remember Cozolino's (2004, p. 42) earlier advice "don't panic," and recognize that sometimes adopting a wait and see approach is what is needed (S. N. Gold & Castillo, 2010).

W. R. Miller and Rollnick (2012) describe a very practical approach to dealing with client resistance called *motivational interviewing*. The focus of this approach involves the therapist helping the client identify and resolve ambivalence by voicing the reasons for and against change (J. Sommers-Flanagan & Sommers-Flanagan, 2014). Motivational interviewing also assumes that resistance does not necessarily reflect a problematic client behavior that must change, but rather that the therapist may need to reconsider how he or she is approaching the client (e.g., *rolling with resistance* rather than adopting a confrontational approach; W. R. Miller & Rollnick, 2012).

Acknowledge that the interview and questions often make individuals feel uncomfortable. Empathize with the client's concerns in a respectful and caring manner, provide emotional validation, reframe, and use concession and genuine feedback. These techniques can contribute to the client feeling less threatened and defensive (S. N. Gold & Castillo, 2010; J. Sommers-Flanagan & Sommers-Flanagan, 2014). Novice clinicians often feel pressured to gather as much information as possible during the intake interview and initial treatment sessions, and may consequently err in paying insufficient attention to establishing rapport, placing the client at ease, and improving the quality of the relationship. Skills such as the ability to be centered, stay focused, listen, reflect and summarize, ask pertinent and correctly timed questions, and display appropriate nonverbal behaviors contribute to the process of establishing and maintaining rapport and are at the heart of clinical work (Cozolino, 2004).

Priebe and colleagues (2011) have identified five guiding principles that can be used to enhance clinician communication with clients:

1. Focus on the client's concerns.
2. Show positive regard and personal respect.
3. Ensure appropriate involvement of the client in decision making.
4. Display genuineness with a personal touch.
5. Use a psychological treatment model.

Before addressing specific content areas that should be covered in the initial interview, it is helpful to review the fundamental skills of good interviewing.

## Setting the Tone

The verbal style adopted in the interview does much to facilitate or hamper the establishment of rapport. An overly casual style ("Hi, Mary" versus "Hello, Mrs. Chang") may be viewed as nonprofessional by some clients. When in doubt about how to address a client, the least offensive alternative should be adopted, which usually means using the most formal option (J. Sommers-Flanagan & Sommers-Flanagan, 2014). However, some clients (e.g., adolescents) may feel the clinician is out of touch with their experiences if more casual terminology or vernacular with which a client is comfortable is not used.

The wording you use throughout the interview (in asking questions, making comments, and providing information) should be appropriate to the client's cognitive, linguistic and developmental level. Take care to avoid jargon or the use of technical words that the client may misunderstand or not know (Morrison, 2014c; D. L. Segal et al., 2010). Balance active listening with questioning and commenting (Littauer, Sexton, & Wynn, 2005).

## Introducing the Interview

The purpose and format of the interview should be presented before asking why a client seeks treatment or inquiring about his or her background (Morrison, 2014c). The client should be told how long the interview will last, what you hope to accomplish, and how you will go about trying to achieve these goals (e.g., taking notes, utilizing a fairly structured interview style). Because so much is covered in the initial interview, it is helpful for clients to know that you may occasionally interrupt them to ask about something else. Explain that this ensures you have a thorough understanding of their situation and the events preceding it.

If you work in a clinic setting, where the clinician conducting the intake interview may not be the person who treats the client, you should indicate this at the start of the interview. Although some clients may be anxious to begin telling you why they are there, most will appreciate waiting to hear you discuss how the session will be structured. Clients value therapists being prepared, organized, and behaving in a calm and confidence-inspiring manner.

We favor establishing a collaborative tone with the client. Ask the client what he or she hopes to get out of the interview. This simple question can reveal the client's expectations, concerns, and misperceptions of the interview process. If the client expresses goals that are clearly not possible to achieve (e.g., "I want you to tell me whether I should leave my

wife"), the clinician can correct such expectations up front and avoid a situation where the client feels frustrated or duped. By finding out what the client expects and desires to occur, the clinician can structure the time so that both parties' goals can be met to the fullest degree possible.

## Listening and Attending

Listening and attending are the most important skills the clinician brings to the interview situation (Ivey et al., 2010). Attentive listening demonstrating interest, concern, warmth, respect, and compassion in the context of a positive interpersonal relationship is a central clinical skill that facilitates the establishment of an effective alliance (Cozolino, 2004). Although effective and accurate listening may appear to be a relatively easy and somewhat passive activity, in reality it is an active process that challenges clinicians to attend to multiple tasks simultaneously. While noting the content and emotional tone of a client's responses, the clinician must formulate questions, integrate new information, and identify inconsistencies or issues needing clarification. As McWilliams (2004, p. 133) notes, "Listening in a professional capacity is a disciplined, meditative, and emotionally receptive activity in which the therapist's needs for self-expression and self-acknowledgment are subordinated to the psychological needs of the client."

A good way to begin an interview is to allow some unstructured, uninterrupted time that allows clients to tell their story. This simultaneously facilitates the development of rapport and allows the clinician an opportunity to observe the client's manner of relating, mood, organization of thought processes, and other important behaviors that are key elements of the mental status exam (discussed later in this chapter). Effective interviewers adapt questions based on the story they hear from the client. To be a receptive listener, the clinician should not be distracted by extraneous thoughts or physical discomfort such as extreme fatigue or hunger (J. Sommers-Flanagan & Sommers-Flanagan, 2014). Allow sufficient time before client sessions to collect your thoughts. Scheduling sessions too closely together or after rushing from another appointment can hurt your ability to focus on your client and to listen accurately.

Effective listening skills include becoming comfortable with periods of silence. Silence allows clients space to consider their thoughts and feelings, to reflect on something they or the clinician has just stated, to free-associate, or to recover from difficult material that has been discussed (J. Sommers-Flanagan & Sommers-Flanagan, 2014). Although silences are important, overuse in the very early phases of treatment can be counterproductive because the client may experience considerable anxiety in response to them (McWilliams, 2004). Research indicates that therapist-initiated but client-terminated silences are more likely to contribute to rapport than silences initiated and terminated by the therapist (C. F. Sharpley, Munro, & Elly, 2005). In the intake interview it is crucial to focus on the task of gathering information and to not be tempted to engage in psychotherapy prematurely.

Clinicians convey that they are attending and listening through verbal and nonverbal channels, including eye contact, body language, verbal tracking, and vocal qualities (Ivey et al., 2010). Beginning therapists may be particularly attuned to what they are saying to a client; however, more than 60% of communication is estimated to be nonverbal (Burgoon et al., 1993), so one should not underestimate the power that nonverbal communication plays in establishing rapport (Dowell & Berman, 2013). Leaning toward a

client, maintaining a relaxed and attentive posture, minimizing extraneous movements, using smooth and unobtrusive hand gestures, and maintaining facial expressions congruent with feelings expressed by oneself or the client will convey that the therapist is attuned to the client (C. F. Sharpley, Jeffrey, & McMahan, 2006; J. Sommers-Flanagan & Sommers-Flanagan, 2014). Other nonverbal behaviors that have been empirically demonstrated to aid the therapeutic process include a warm, relaxed vocal tone, facial expressions of interest, and forward leaning; a moderate degree of head nodding and smiling; and frequent (but brief) eye contact (Darrow & Johnson, 2009; Dowell & Berman, 2013; C. F. Sharpley, Jeffrey, & McMahan, 2006). With regard to the last of these, eye gaze is central to establishment of attachment, and eye contact is a powerful means of communication (Cozolino, 2004). A clinician who is listening but fails to indicate this through his or her nonverbal behavior (i.e., fails to make appropriate eye content, does not nod) can mistakenly convey inattention to the client. Because we are often unaware of our nonverbal actions, we recommend videotaping at least one interview (with the client's permission) and reviewing this important aspect of interpersonal behavior.

Listening is also conveyed through reflections, interpretations, and facilitative comments including "Mm-hmm" or "Tell me more." In fact, experienced clinicians tend to use such minimal verbal encouragers more frequently and are rated more highly in terms of client-perceived rapport than their less experienced counterparts. This suggests that the use of minor verbalizations by a skilled interviewer can effectively maximize rapport (C. P. Sharpley, Fairne, Tabay-Collins, Bates, & Lee, 2000). Listening can also be conveyed to the client verbally through appropriately timed questions that incorporate information already given and seek to clarify ("Do you mean . . . ?"), or invite additional information ("Tell me more about that"). It is crucial to focus on what clients are talking about, verbally track, and selectively attend and respond to what they are sharing with you (Ivey et al., 2010).

## Reflections and Interpretations

When clinicians use a reflection, they are restating or rephrasing something the client has expressed. There are different levels of reflective responses: verbatim repetition or paraphrasing something the client has said, restatement of an emotion the client has expressed or that he or she is experiencing in the moment, clarifying meaning implied by the client's statements, and summarizing major themes or information the client has disclosed (J. Sommers-Flanagan & Sommers-Flanagan, 2014). Some examples are:

> ***Client:*** I don't know if I should change jobs. I like the financial security, but I'm constantly behind on deadlines, and everything I do just keeps piling up. I used to think what I did was interesting but not anymore.
>
> ***Verbatim reflection:*** You're not certain if this job is for you. There are some things, like the money, that are good, and other things, like the deadlines you have to meet and what you do at work, that you don't like.
>
> ***Reflection of feeling:*** It sounds like you feel quite ambivalent about your job and often overwhelmed.
>
> ***Reflection of meaning:*** It sounds like you no longer find your work meaningful and that you're not sure that financial security is enough reason to stay at something you don't really like.

These kinds of statements let clients know that you have been listening to what they said, convey a sense of empathy, enhance rapport, encourage discussion of an issue, allow you to check that the client has been correctly heard, and mirror for clients what they are feeling and saying (D. L. Segal et al., 2010).

Interpretations go beyond a simple restatement of what the client has expressed and attempt to uncover underlying, deeper meaning and/or feelings. J. Sommers-Flanagan and Sommers-Flanagan (2014) classify interpretations as directive listening responses (i.e., those designed to direct a client toward certain material). Interpretations attempt to provide explanations of behavior that a client may not have considered, and involve renaming the client's thoughts and feelings from the viewpoint of the clinician (Compas & Gotlib, 2001). You should exercise caution when using interpretations during the initial interview, because they can adversely affect rapport if the client is not ready to hear them (Morrison, 2014c). Remember that the process of extracting key underlying themes or issues from the interview requires not only skill, but also a certain degree of knowledge about the client that may only come with time.

## Questioning

Effective questioning enables the clinician to collect specific information, control the quantity or quality of information, reveal the client's feelings and motives, and encourage the client to disclose general information. Questions allow the clinician to develop a structure or agenda for the interview, redirect the interview, and obtain a deeper understanding of information revealed by the client. However, if a clinician asks too many questions, the client may feel offended, bombarded, or confused (Ivey et al., 2010).

Successful questioning relies on good listening skills. During the interview, client responses that suggest the need for follow-up questioning are those that (a) are vague ("I was *sort of* anxious"); (b) use extreme terminology ("That relationship was the *worst*"; "I can *never* concentrate"); (c) seem overly minimizing ("My depression *wasn't that bad*"); (d) contain psychological or diagnostic jargon or terminology ("I had a *nervous breakdown*"; "When the *panic attacks* happened . . . "); or (e) use words (e.g., *hopeless*) or are accompanied by affect (e.g., crying) indicating strong emotional content.

It is important for clinicians to understand the difference between open-ended and closed-ended questions (Morrison, 2014c). Closed-ended questions can be answered using only one or two words (e.g., "When did you meet your partner?"), whereas open-ended questions require longer responses (e.g., "Please describe your relationship with your partner"). Open-ended questions can broaden the scope of information, convey interest in hearing the client's story, allow more opportunities to observe the client's behavior, encourage the free expression of feelings, and be better received by clients who have complex or ambivalent feelings about a topic (Morrison, 2014c).

An effective interviewer utilizes both open- and closed-ended questions to match the verbal skills, emotional state, attentional ability, and cognitive capacity of the client (Lukas, 2012). Structured, closed-ended questions may be needed for guarded or reticent clients, persons of limited cognitive capacity, or individuals who are extremely tangential or disorganized and who cannot be easily redirected to answer the original question. J. Sommers-Flanagan and Sommers-Flanagan (2014) describe a third kind of question (swing questions), which can be answered using yes or no but encourage the client to

elaborate on feelings, thoughts, or issues. These questions typically begin with the words *could*, *would*, *can*, or *will*. Swing questions should be used only when rapport has been established and should generally be avoided with children and adolescents (Ivey et al., 2010). Pederson and Ivey (1993) note that a really good question will not have a simple answer but will encourage a great deal of constructive exploration.

There are certain types of questions that should be used judiciously. Some believe that "why" questions should be avoided during the initial interview because answering these (a) requires a level of insight that the client may not yet possess, (b) may lead the client to feel inadequate if he or she does not know the answer, and (c) may result in the client feeling prematurely intruded upon to share highly personal feelings (Lukas, 2012).

On the other hand, appropriately timed "why" questions may help to uncover a client's motives (Pederson & Ivey, 1993). Saying, "How do you account for that?" "Help me understand," or "Tell me more about that" may yield more information than asking "Why?" Questions of a confrontational nature should generally be avoided during the first interview or should be restricted to one or two key issues about which there are contradictions. In broaching such questions, avoid an adversarial tone. Instead, ask such questions in a way that expresses genuine puzzlement and a desire to understand exactly what the client meant. This may avoid putting the client on the defensive and breaching rapport (Morrison, 2014c). With agitated clients, confrontation must be used very cautiously, as this may result in an escalation of aggression. While confrontation can be used to provide clarity to the client, it is best used in the context of a solid therapeutic alliance, such as later in therapy (J. Sommers-Flanagan & Sommers-Flanagan, 2014).

Clinicians should avoid leading questions and should instead strive to pose questions in a neutral manner so a preferred or desirable answer is not suggested. This is particularly important when interviewing children. Failure to do so may result in answers that reflect what the client thinks the clinician wishes to hear, rather than the reality of the situation. There are times when it may be appropriate to suggest possible responses to a client who is having a difficult time answering ("Did your sister's disapproval about your engagement anger or sadden you, or cause some other feeling?"). This could occur when interviewing clients with impoverished thinking (e.g., an individual with Schizophrenia who has prominent negative symptoms) or limited cognitive abilities, those who experience difficulty describing emotional states (a condition known as alexythymia), and clients who are difficult to engage.

In an attempt to gather more information in an initial interview, novice clinicians often err by asking multiple questions at once ("Can you tell me about the problems you have been having at work? Are these something new, or have you had them before? And what has your boss said to you?"). This can be difficult for clients who are nervous or who have attention or concentration difficulties. Be mindful of this tendency, and rehearse questions mentally or practice them before the interview to reduce the temptation to ask compound questions.

## Answering Client Questions

During the initial interview, one should expect to be asked some questions by the client. Some schools of therapy discourage answering clients' questions to avoid fostering

dependence and circumventing self-examination and self-inquiry (Pederson & Ivey, 1993). However, you are ethically bound to respond to certain questions such as your training and experience, the type of therapy you practice, and how you propose to treat the client (i.e., treatment plan). Information about fees, cancellation policy, and emergency contact procedures should be discussed and included in the consent to treatment form. Answering questions regarding diagnostic impressions and treatment recommendations is important because they help the client develop a realistic perspective on his or her treatment (what can and cannot be done) and prognosis (D. L. Segal et al., 2010).

Some client questions may involve requests for the clinician to self-disclose personal information (e.g., details of one's life, one's feelings about a particular issue). Inquiries about a clinician's personal life usually reflect a broader underlying concern or issue; for example, questions about marital status or children may indicate concern about the clinician's ability to understand, empathize, or help with family-related concerns. Redirecting clients toward discussing these underlying issues is generally more helpful than answering their initial question. In some cases, therapists may choose to disclose their own feelings or personal information as a means of strengthening the working relationship with a client. For example, the disclosure of a therapist's feelings in the present moment can be a powerful intervention that can enhance rapport and can model how to talk about one's emotions (Compas & Gotlib, 2001).

However, the disclosure of personal feelings or information should be done with a clear therapeutic purpose in mind and not to fulfill the needs of the therapist. Self-disclosure can result in numerous problems, such as

- creating a need for clients to take care of the therapist's feelings and censor what is mentioned in treatment,
- making clients feel as if a boundary has been violated,
- overtaking or infringing on a client's story,
- making it difficult to determine whose agenda is being addressed because the client's and therapist's stories have become too intertwined, and
- making a client believe the therapist is redirecting interest away from the client and toward the therapist (J. Roberts, 2005).

While C. E. Hill (2009) suggests that therapist self-disclosure can facilitate a client's insight, D. L. Segal et al. (2010) recommend keeping self-disclosures to a minimum and disclosing only details that you "would not mind seeing in a local newspaper" or could justify if questioned by your supervisor (D. L. Segal et al., 2010, p. 12).

Clients frequently come to the first session in distress and want answers that will help alleviate their suffering quickly. As a result, you may be asked for direct advice on how to handle a particular problem. Directive guidance and active intervention are appropriate in some circumstances, such as dealing with clients in crisis (see Chapter 3, "Fundamentals of Treatment"). However, many schools of therapy caution against offering direct advice or rushing to reassure, and instead prefer for solutions to emanate from clients themselves (J. Sommers-Flanagan & Sommers-Flanagan, 2014). In most cases the first session should be devoted to information gathering.

## WHAT TO ASK

The goals of a standard outpatient intake interview include identifying, evaluating, and exploring the client's primary complaint and treatment goals; getting a sense of the client's interpersonal skills and style; obtaining information about the client's personal history; and evaluating the client's current life situation (J. Sommers-Flanagan & Sommers-Flanagan, 2014). Another goal of the intake is to determine whether you (or someone in your agency) have the appropriate knowledge and skills to treat the client and if your agency has the resources to provide treatment. The more information you can obtain, the more accurate the decisions regarding diagnosis and treatment disposition will be. See Table 1.6 for the main content areas that you will typically want to cover in an intake interview.

The intake interview should be fairly structured and will contain many questions for the client. While nondirective and directive interviews may produce similar numbers of reported problems, directive interviews tend to elicit more extensive, detailed, and better quality information about reported problems. It is important to maximize the information

**Table 1.6 Areas to cover in the initial interview**

- **Identifying information:** Demographics; ethnic, racial, cultural, and spiritual identity; relationship status; level of education; occupation; date of intake; referral source (e.g., clinician's name and title).
- **Chief complaint and presenting problem(s):** Client's own words; consider why treatment is being sought now.
- **History of the presenting problem(s):** Recent significant life events and stressors (positive and negative); coping attempts (adaptive and maladaptive); resiliency.
- **Psychiatric and psychological history:** Individual and family history of psychiatric symptoms/disorders; specific details of current and past treatment, response to treatment, alcohol and substance history and current use, traumatic events, and prior coping strategies.
- **Medical history:** Individual and family history (including potential genetic predispositions/vulnerability to certain illnesses/conditions). Past treatment, hospitalization, surgeries, current or chronic medical conditions. Recent physical exam results and physician contact information; medication, including current, past use, and adherence. Head trauma, loss of consciousness, accidents, injuries, or physical limitations and challenges.
- **Cultural formulation and sense of identity:** Cultural, racial, ethnic, and spiritual identity; impact on help seeking, view of problems, and degree of support.
- **Family, developmental, and social history:** Family of origin, family relationships, friendships, developmental milestones (especially important for child clients), dating and marital history, sexual functioning. Hobbies, interests, strengths, available resources and support systems.
- **Educational and occupational history:** Attendance, academic, behavioral, and social functioning at school and college; relationships with teachers/mentors. Military service; work history, including specific jobs, duration of employment, promotions, unemployment, accomplishments, competencies, and strengths. Financial history.
- **Legal history:** Past or current/ongoing litigation, incarcerations, crimes, involvement with civil or criminal legal system.
- **Resilience, strengths, competence, and challenges:** Resources, accomplishments, and coping. Environmental stressors such as poverty or discrimination; *DSM-5*'s "Other Conditions That May Be a Focus of Clinical Attention."*

*These are discussed further in Chapter 2, "Essentials of Diagnosis."

gathered during the first interview, as clients are often most receptive to discussing their presenting problems and history because of the distress they feel. Between the first and second sessions some clients may develop resistance and reluctance toward the therapeutic process, may be less forthcoming, and may even drop out or no show (Corning & Malofeeva, 2004).

The initial interview generally takes 50 to 90 minutes. In some training programs or clinics, you may have the luxury of conducting an intake over several sessions, but this is the exception rather than the rule. You should aim to gather as much information as possible, but more than one meeting may be required depending on the complexity of the client's history, presenting problems, cognitive and verbal abilities, level of insight, and comfort level with you, and whether the client is in a crisis state. The information collected during the clinical interview provides the framework for future treatment, and initiating treatment based on inadequate information not only is ill-advised and unprofessional but may also be dangerous (J. Sommers-Flanagan & Sommers-Flanagan, 2014).

Be flexible, and recognize that it may not be possible or necessary to gather all the information listed in Table 1.6. It is natural to focus on getting the facts, but failure to attend to feelings in the pursuit of information can lead clients to feel misunderstood, reduce the likelihood of disclosure of important information, and result in missed opportunities for understanding the emotional experiences connected with certain topics (J. Sommers-Flanagan & Sommers-Flanagan, 2014). Asking questions about feelings often yields specific information about events, but asking about events will not always lead to the disclosure of feelings. Morrison (2014c) recommends dividing the intake time into the following amounts: 15% for chief complaint; 30% for diagnostic information and issues of impulse control; 15% for medical history, review of symptoms, and family history; 25% for personal and social history; 10% for the mental status exam; and 5% discuss diagnosis, treatment, and follow-up.

## How Theoretical Orientation Affects Interview Content

The interview framework outlined here is not intended to reflect a particular school of therapy. The clinician's theoretical orientation will influence which interview areas receive the greatest emphasis, as well as the specific type and amount of information gathered. Thus, in listening to clients' descriptions of their problems, a behaviorally oriented clinician will direct questions toward obtaining descriptions of current, observable problematic behaviors and information on the antecedent conditions that facilitate these behaviors. The clinician would also seek to understand sources of positive or negative reinforcement that help maintain the behaviors—a process collectively known as a functional analysis (Beavers, Iwata, & Lerman, 2013). The behavioral therapist may also use role-plays to assess specific skills and imaginal exposure techniques to evaluate beliefs and emotional reactions to specific stimuli. The cognitive therapist will try to determine the thoughts and/or images that accompany a client's negative emotional states (e.g., all-or-nothing thinking as related to depression). Through Socratic questioning, this clinician will attempt to get the client to recognize the long-standing dysfunctional beliefs and schemas that underlie these thoughts and images (J. S. Beck, 2011).

Psychodynamically oriented and person-centered therapists may utilize less directive questioning and give the client greater latitude in taking the initiative and determining the content of the session (J. Sommers-Flanagan & Sommers-Flanagan, 2014).

A psychodynamic clinician may also have more questions aimed at understanding the nature and quality of relationships with early caregivers (Freud, 1955; Messer & Wolitzky, 2007). In contrast, a person-centered therapist may focus on providing unconditional positive regard and exploring factors that may contribute to the individual's personal growth (C. Rogers, 1951, 1992).

*Identifying Information*

Demographic information should include age, gender, marital or partner status, number and ages of any children, occupation, religious affiliation, and self-identified ethnic/cultural group. It is important not to make assumptions about a client's ethnic or cultural background based on appearance or name. A biracial/bicultural individual may have a bicultural self-identity or may identify more strongly with one culture or neither (C. I. Hall & Turner, 2001). A more detailed discussion of factors that contribute to the client's uniqueness and sense of identity will be presented later. During intake, concentrate on identifying crucial demographic descriptors. This may also include the reason for referral, which guides the interview, and gathering basic information about the referring professional who will receive the report.

*Chief Complaint and Presenting Problem(s)*

One of the first questions to ask is why your client is seeking treatment. The answer to a question such as "What brings you here today?" or "How can I help you today" can reveal vital information, including the client's conflicts or stressors, level of insight or denial, and aspects of mental status such as mood, behavior, and thought processes (D. L. Segal et al., 2010). Experienced interviewers often allow clients as much as 10 minutes of uninterrupted free speech to answer an initial question and will make note of the client's exact words in describing the reason for seeking treatment (Maxmen, Ward, & Kligus, 2009; Morrison, 2014c). Jumping in too quickly when clients are describing why they sought treatment can result in a loss of valuable information and redirect the clients away from problems they view as most pressing. Typically, you are gathering information about what precipitated the current visit. If the client describes a chronic problem, it is helpful to ask "Why now?" or what factors contributed to the client's seeking help at the present time (Maxmen et al., 2009; J. Sommers-Flanagan & Sommers-Flanagan, 2014). Details about the presenting problem are gathered in the context of the client's history.

*History of Presenting Problem(s)*

Ask questions about the client's beliefs about the source or cause(s) of difficulties, if the problem has a name, the symptoms associated with the problem, and what kind of treatment the client thinks the problem requires. The answers can reveal culture-specific interpretations of the symptoms and experiences. Never assume your definition of the problem is the same as the client's definition. Always ask for clarification, even for such common diagnostic labels as depression and anxiety, especially when the client is different from you (Cozolino, 2004). Failure to consider the client's conceptualization of his or her problems may result in nonadherence to recommended treatments and/or premature termination from therapy. The mnemonic CLIENTS can be used to ask about different aspects of the client's presenting problem(s) (see Table 1.7).

**Table 1.7 CLIENTS: Assessment of presenting problems**

| |
|---|
| **C**ause: What does the client think has caused the problem? |
| **L**ength: How long has this been a problem (chronic versus recent onset)? |
| **I**mpairment: What areas of the client's life have been negatively affected by the problem (e.g., work or school, relationships, finances)? |
| **E**motional impact: In what ways has the client's problem impacted him or her emotionally? |
| **N**oticed: Have other people noticed changes in the client's mood or behavior? |
| **T**ried: Has the client tried anything to alleviate the problem? How successful have these attempts been? |
| **S**topped: In what ways would the client's life be different if his or her problem stopped or was no longer present? |

The client's perception of the **C**ause of a problem can reveal the level of insight and knowledge about the difficulties. For example, a client who is convinced that he will contract HIV from touching a doorknob in a public building unless he washes his hands for 10 minutes afterward demonstrates less insight into his Obsessive-Compulsive Disorder symptoms than the client who recognizes that this belief is unfounded yet feels compelled to engage in repeated hand washing. It is important to determine if the current problem is similar to or different from previous problems (D. L. Segal et al., 2010).

Questions regarding the duration or **L**ength of time a problem has been present provide information on chronicity, which may, in turn, give an indication of how lengthy treatment is likely to be. Generally, the longer the client has experienced the problems, the more difficult they will be to change. Many *DSM-5* disorders have specific diagnostic criteria related to their duration, onset, and frequency and the course of the clinical symptoms, so you will need this information in order to assign a diagnosis (American Psychiatric Association, 2013).

The scope of **I**mpairment is a crucial dimension to inquire about. Ask about impairment in all domains, including school or work, family and romantic relationships, friendships, household maintenance, personal health and hygiene, use of community resources, and finances. Are the clinical symptoms causing distress to the client? Are they disturbing to significant others? Ask about the client's strengths and ability to complete age-appropriate daily activities (J. Sommers-Flanagan & Sommers-Flanagan, 2014).

Questions about the **E**motional impact or the distress that a client's problems have caused can provide clues to possible diagnoses (e.g., anxiety, depression). Almost all the disorder criteria in the *DSM-5* require evidence of distress and/or significant impairment in functioning (e.g., social, occupational) before a diagnosis can be made (American Psychiatric Association, 2013).

Inquiries about changes others have **N**oticed in the client not only provide convergent evidence supporting the client's observations of his or her own functioning, but may also reveal client denial or lack of insight. How disturbing the symptoms are to others may also identify underlying cultural considerations.

Knowing how the client has **T**ried to alleviate or fix the problem will tell you about his or her coping strategies and resourcefulness and can steer you away from interventions that may have limited effectiveness. Be sure to inquire about formal attempts (e.g., previous

psychotherapy, talking to a family physician, taking medication) as well as informal attempts (e.g., talking to family or friends, reading self-help books, searching for information on the Internet, praying, journaling), and culturally specific attempts (e.g., use of culturally based healers or medicinal practices) to deal with the problem.

If the client is taking psychotropic medications, write this information down. Document the length of time the medication has been taken, side effects experienced, and to what extent the client has adhered to the prescribed medication regimen. In these cases, the clinician should plan to coordinate treatment with the prescribing physician and obtain the necessary release of information forms from the client.

Ask clients to imagine what life would be like if the presenting problems **S**topped and were no longer present. Although clients may primarily mention positive changes, it is helpful to ask about new difficulties or challenges that might be created (e.g., having to return to work or socialize more with others). Answers to such questions can uncover possible reinforcers for the problem and may help expose any function the problem might be serving in the client's life. For all presenting problems, comorbid conditions, and associated features, ask for specific details about the **F**requency, **I**ntensity, **D**uration, and **O**nset (FIDO) of clinical symptoms, as this information is essential to understanding the nature of the clinical presentation.

Research has demonstrated that for a variety of psychiatric conditions—including mood, anxiety, substance use, and eating disorders—the occurrence of significant life events can place an individual at risk for symptom exacerbations (Hammen, 2006; Maxmen et al., 2009). Even strongly biologically linked disorders, such as Schizophrenia, are adversely affected by significant life stressors (Docherty, St-Hilaire, Aakre, & Seghers, 2009). In addition, enduring stressful life events is associated with increased risk of physical illness as well as early death (S. Cohen, 2002). This research underlines the importance of understanding what recent stressful life events your client has experienced and how they may relate to his or her presenting problems.

Although your client may cite a specific recent stressor as a reason for coming into treatment, do not assume that this is the only stressful life event the client has experienced within the past 6 to 12 months. Be sure to ask clients about *any* significant events or changes that have happened over the past year. Events that we normally think of as positive (e.g., marriage, birth of a child, going to college, getting a new job or promotion) can be as stressful as events we typically think of as negative. Also consider chronic stressors your client may be facing, such as poverty, economic hardship, poor physical health, or discrimination (including microaggressions—subtle discriminatory insults). It is crucial to determine if the stressors are temporally related to the problem's onset or if they are caused by the problem (Hutchings & Virden, 2010).

Since it can be difficult for clients to remember all significant events that have occurred over a year, it can be helpful to present a list of possible events and have them indicate which ones they experienced. Measures such as the Social Readjustment Rating Scale (T. H. Holmes & Rahe, 1967) and the Family Inventory of Life Events (FILE; McCubbin, Patterson, & Wilson, 1983) are useful for this purpose.

Finally, recognize that the stressor that may have precipitated the client's problems may not be a recent acute event or a chronic stressor, but something more subtle, such as the anniversary of a significant event (e.g., death of a loved one). Such anniversary reactions

may occur out of the client's conscious awareness and may not be mentioned in the initial interview.

When asking about stressors, listen for adaptive skills, coping strategies, the presence of support, and evidence of resiliency (Luthar & Prince, 2007). In particular, listen for factors that contribute to resiliency, including the presence of both familial and nonfamilial caring, and of supportive relationships; the capacity to make realistic plans; the ability to accept that change is a part of life; flexibility; being able to take decisive action, maintain a hopeful outlook, and seek help (American Psychological Association, 2014).

*Psychiatric and Psychological History*

While the problems and symptoms a client initially presents may directly relate to his or her ultimate diagnosis, this is not always true. Novice interviewers are at risk of relying excessively or exclusively on information presented early in the interview to form diagnostic opinions (*primacy effect*). They may ask questions geared only toward confirming this impression, while neglecting to ask questions that may disconfirm it (*confirmatory bias*; Groth-Marnat, 2009). A study examining the concordance between information provided by clients in the first 5 minutes of a psychiatric interview and their final clinical diagnoses found correspondence in only 58% of cases (Herrán et al., 2001).

This is why it is important to devote sufficient time and questions to understanding the range of psychiatric symptoms the client has experienced in the past and the present. We recommend asking a screening question about each of the following major domains of psychiatric symptomatology:

- *mood symptoms* (including depression and mania);
- *anxiety symptoms* (including excessive worrying, phobias and fears, obsessive thoughts and compulsive behaviors, panic attacks);
- *symptoms and dissociative experiences related to Posttraumatic Stress Disorder (PTSD) and related conditions*;
- *psychotic experiences* (e.g., hallucinations, delusions);
- *substance use*;
- *eating problems*;
- *impulse control problems* (including suicidal or other self-injurious behavior, anger control problems or aggressive acting-out, and other impulsive behaviors such as excessive gambling or spending);
- *cognitive problems* (e.g., memory problems, learning difficulties);
- *sexual difficulties or conflicts*; and
- *sleep disturbances*.

Follow-up questions regarding specific disorders can be asked if the client endorses any symptoms in response to the screening questions. Specifically, ask if any symptoms endorsed are currently a problem, how these symptoms have interfered with functioning (in the past or currently), and what treatment (if any) has been sought to alleviate the symptoms (including medication). Any history of psychiatric hospitalization should be

noted, including the approximate dates and lengths of stay, the circumstances leading to the hospitalization, treatments received in the hospital, and whether the hospitalization was voluntary (Lukas, 2012). Also ask about prior therapy experiences, particularly what was or was not effective.

Many psychiatric disorders have a strong heritable component, and a notable family history of a particular type of disorder can be important when making diagnostic decisions (Bostic & King, 2007; Hutchings & Virden, 2010). A familial history of psychopathology can be revealed by a general question, such as "Did anyone in your family ever have emotional problems or problems with alcohol or substances that they sought treatment for or that you or someone else thought they should have sought treatment for?" Gather information on specific diagnoses and/or symptoms, any treatments received, and the level of the family member's impairment (e.g., recurrently hospitalized, unable to work, impaired relationships).

***Substance Use History*** The assessment of current and past problematic alcohol and substance use involves collecting specific details related to the onset, type of use, quantity, and setting or conditions of use (Hodgens, Diskin, & Stea, 2010; Magidson, Bornovalova, & Daughters, 2010). Clients with substance use problems often present with a lack insight and denial, which may result in a minimization of problems and a lack of awareness of the level of the client's impairment. Hutchings and Virden (2010) recommend asking directly, "How much alcohol do you drink?" rather than "Do you drink?" Such phrasing may help clients feel that it is acceptable to discuss their alcohol use.

The CAGE questions (Ewing & Rouse, 1970) are a reliable and valid screening tool for problematic alcohol use (O'Brien, 2008). The client is asked:

- Have you ever felt you should **C**ut down on your drinking?
- Have people **A**nnoyed you by criticizing your drinking?
- Have you ever felt bad or **G**uilty about your drinking?
- Have you ever had a drink first thing in the morning (**E**ye-opener) to steady your nerves or get rid of a hangover?

"Yes" answers are assigned a value of 1. The higher the score on the CAGE, the greater the probability the individual may have alcohol problems (Dhalla & Kopec, 2007), although more detailed questioning would be required to confirm as Substance Use Disorder diagnosis. An assessment of substance use should also include prescription and over-the-counter medication, tobacco, and caffeine. Determine if the client has used or uses multiple substances and if there is a preferred substance, and the impact that use has had on educational, occupational, and interpersonal functioning. This will help clarify potential substance-related diagnoses and the nature of interventions that may be helpful to the client. Many individuals with severe mental illnesses and a history of trauma have comorbid alcohol and substance disorders (Leeies, Pagura, Sareen, & Bolton, 2010). Chronic alcohol and substance use is also often associated with homelessness, interpersonal violence, incarcerations, and involuntary holds, so these factors should also be explored on intake. The assessment of alcohol and substance use is discussed further in Chapter 11, "Substance-Related Disorders."

***Traumatic Experiences*** Although exposure to multiple traumatic events is common, beginning clinicians often forget to investigate a client's history of traumatic experiences (E. Smith & Rauch, 2010). Many people experience physical, emotional, or sexual abuse in childhood, adolescence, or adulthood or have survived life-threatening events (e.g., earthquake, car accident, mugging). Remember that an individual does not have to be the direct victim of a threatening experience in order to be traumatized by it. The woman who saw her younger brother beaten on a regular basis by her father and the store clerk who witnessed a customer getting shot during a store robbery may be highly traumatized by these events.

Also, do not rely on the term *trauma* as it is defined under the diagnostic criteria for PTSD in the *DSM-5* (American Psychiatric Association, 2013). This technical definition of trauma is an event involving actual or threatened death or serious injury or sexual violence, which the individual directly experiences, witnesses in person, learns of, or experiences repeated exposure to. Experiences outside of the boundaries of this definition may also be perceived as highly traumatic or life altering to a client. Some research indicates that stressful life events (e.g., divorce, unemployment) can be associated with at least as many—in some cases more—posttraumatic symptoms than traumas that have been defined in the *DSM* system (Mol et al., 2005).

Given that it has been estimated that 70% of adults have experienced at least one traumatic event and 20% of these people developed symptoms of PTSD, it is crucial to assess for these experiences on intake (Hutchings & Virden, 2010). Never assume that clients will spontaneously divulge this information, and take extra care when asking questions about these sensitive topics (E. Smith and Rauch, 2010). Unless an individual specifically presents with complaints stemming from a trauma, questions about traumatic events should be saved until sufficient rapport has been established. These questions may need to wait until later treatment sessions. Further information on assessing trauma is presented in Chapter 9, "Anxiety, Obsessive-Compulsive, and Trauma Disorders," which focuses on the assessment of individuals presenting with trauma-related clinical symptoms, and Chapter 3, "Fundamentals of Treatment," which discusses interviewing individuals in crisis.

### *Medical History*

Gathering information about the client's current health status (including approximate date and results of the last physical exam, chronic conditions, and current medical treatments, including medications); past significant illnesses, accidents, injuries, and hospitalizations; and family medical history is important for several reasons. Knowledge of a client's current health status provides information on potential stressors he or she is facing. In addition, some medical conditions can cause symptoms that mimic psychiatric conditions (e.g., hypothyroidism can mimic symptoms of depression, including anhedonia, forgetfulness, diminished concentration, low energy, and sleep disturbance). If a client presents with emotional or behavioral symptoms that may be associated with a medical condition, the clinician should refer the client for a medical evaluation.

Certain psychological syndromes (e.g., *DSM-5* Somatic Symptom Disorder) are associated with physical symptoms (American Psychiatric Association, 2013). Psychological symptoms can also develop secondarily to a medical condition, as in the case of a client who develops depression following a diagnosis of Type II diabetes and becomes unmotivated to monitor his or her daily blood sugar and make dietary changes. If the client reports

health problems, remember to ask about interventions, treatment, or involvement with other health care professionals (Hutchings & Virden, 2010).

Information about past health concerns can lead to questions about the client's emotional, physical, and social development (Morrison, 2014c). A question such as "How was your physical health growing up?" or "Did you have any health problems as an infant, child, or teenager?" will usually suffice to gather this information. When asking these questions, it is appropriate to also inquire about the client's birth history. Many adult clients will not have detailed information on their own developmental history but will generally be able to report whether their mother had any significant problems during the pregnancy, if there were complications with the labor and/or delivery, and if there were any notable problems during the neonatal period. Similarly, clients may not be able to recall the precise ages at which various developmental milestones were reached, and this degree of detail for an adult client is typically not needed. Adult clients are more likely to recall parental comments such as "She walked early" or "He talked late," or general comments about temperament and personality, and this degree of detail is usually sufficient to get a general sense of the client's developmental history. The importance of a thorough developmental history when treating children and adolescents is discussed later in this chapter under "Interviewing Children and Their Families."

Family medical history can reveal stressors (either past or current) that may have affected the client's development or current functioning. For example, did the client grow up with a chronically ill mother? Is the client the primary caretaker for his father with Alzheimer's disease? In addition, family medical history may reveal conditions the client is at risk for (e.g., a 50-year-old woman whose mother, sister, and grandmother all developed breast cancer in middle age). Questions about medical conditions and treatment may reveal general attitudes about medical providers and treatment adherence. Understanding a client's experiences, thoughts, and feelings about his or her health care can help a clinician understand if the client has positive or negative feelings about previous treatment-related relationships.

If your client is currently taking medications for a medical condition, note the medication name, amount, length of time taken, and any side effects that have been experienced. Consult with a text such as J. D. Preston, O'Neal, and Talaga's (2013) *Handbook of Clinical Psychopharmacology for Therapists* or the *Physicians' Desk Reference* (2011) so you can learn more about the purposes, possible side effects (including psychological symptoms), and potential complications (e.g., overdose potential) of your client's medications. Clients can also present to therapy as noncompliant with medication, or in need of a medication evaluation, all of which require a referral to a physician (J. D. Preston et al., 2013).

Older adults may be on a regimen of medications to treat physical ailments, and the side effects of these agents can mirror or contribute to psychiatric conditions (C. Gould, Edelstein, & Ciliberti, 2010). It is important to determine whether involvement of a medical professional is necessary in the client's assessment or ongoing treatment. The possibility that a general medical condition (GMC) may be the cause of or an exacerbating factor contributing to a client's psychological symptoms must always be considered in the diagnostic process (Morrison, 2014a). A crucial intake decision is whether the client needs a medical evaluation or a medication consultation. If the client needs a referral to a physician, the clinician should be certain to obtain the client's consent and authorization to release information to the physician.

*Cultural Formulation and Sense of Identity*

Despite the importance of understanding how racial, ethnic, and cultural background influences self-identity and worldview, many therapists neglect to ask about these aspects of a client's background. Clinicians may be uncomfortable asking clients these questions because they lack of training in this area, have mistaken assumptions that such questions are racist (i.e., that the therapist should somehow be color-blind), or have conflicts regarding their own ethnic identity. If a client senses discomfort or unwillingness to openly address issues of race, ethnicity, and culture, the therapeutic alliance may be undermined. To find out more about a client's identity, ask the client questions such as "How would you describe yourself?," "What has this meant for to you to be . . . ?," "What do you value about being . . . ?," "What has been difficult about being . . . ?," and "Have you experienced, comfort, support, or discrimination because of who you are?"

A client should always be asked about his or her feelings about working with a therapist who is of a different cultural/ethnic background and which language the client prefers. The clinician should not shy away from asking directly about acceptable beliefs, behavior, and values among the client's ethnic or cultural group and the extent to which the client accepts these or identifies with his or her cultural/ethnic group (Sue & Sue, 2012).

Consult with clinicians who are of the same cultural/ethnic background as your client, and read relevant clinical literature to learn about the beliefs, value systems, and traditions of particular groups (Gallardo, 2013; Ponterotto, Casas, Suzuki, & Alexander, 2010). Do not neglect the sociopolitical environment in which your client was raised, and do consider how world events may have shaped the client's belief systems and identity (Hays, 2007). The *DSM-5* contains a cultural interview and a guide to a cultural formulation (American Psychiatric Association, 2013), which may be helpful in exploring issues of cultural identity. These are discussed further in Chapter 2, "Essentials of Diagnosis."

Religion is an important part of the lives of many individuals and can be a major factor that shapes values, behavior, coping strategies, and thinking patterns. Religious belief can profoundly influence how psychological difficulties are viewed and handled. There are more than 2,000 identifiable religious groups in the United States, and between 80% and 90% of Americans identify themselves as associated with a religion (Kosmin, Mayer, & Keysar, 2001; Roof, 2001). An even higher percentage of individuals (94%) report a belief in God (Roof, 2001). Despite the important role that religion and spirituality play in the lives of many clients, questions about these areas are often neglected during intake. Many mental health professionals feel inadequately prepared to discuss issues related to spiritual or religious development (Sperry & Shafrankse, 2005).

Examples of appropriate questions in the initial interview (Hedayat-Diba, 2000; Shafrankse, 2000) include

- past and present religious experience and affiliation,
- the evolution of one's religious practice,
- religious training or upbringing and how religion influences identity and day-to-day life,
- familial attitudes toward religion,
- use of religious resources during challenging and crisis periods,
- perceived relationship to God or deities,

- participation in a faith community,
- observance of religious rituals and holidays,
- relationship with spiritual advisors and teachers,
- conflict versus congruence between values prescribed by religion and how one's life is lived, and
- how religion may affect the client's conceptualization of his or her difficulties and their solution.

Also remember that clients may identify themselves as spiritually oriented but not ascribe to any organized religion. In such cases, use a careful and sensitive approach to evaluate the meaning and beliefs of the individual's private spirituality.

It is useful to discover whether clients' religious beliefs have helped them confront or evade issues with which they are grappling, enhanced interpersonal intimacy, fostered social isolation, increased self-care, or contributed to self-neglect (Finn & Rubin, 2000). Psychopathology must be viewed through the lens of culture and within the context of religious belief. The clinician should strive to determine if experiences that might otherwise be labeled as psychopathology are acceptable and normative within the client's religious community. An example is the phenomenon of speaking in tongues, or *glossolalia*, that is practiced by some Pentecostals. Glossolalia involves the utterance of ecstatic speech that is unintelligible to others—behavior that could be mistaken for symptoms of thought disorder (Hempel, Meloy, Stern, Ozone, & Gray, 2002). For Pentecostal believers it is a way to pray, and by committing to God's care those overwhelming concerns that may be difficult to articulate, it provides relief in times of extreme tension and anxiety (Dobbins, 2000).

Separating out psychopathology from religious experience can be challenging, as some individuals vulnerable to certain psychiatric symptoms (e.g., psychosis, schizotypal symptoms) may gravitate toward religion to provide meaning for unusual experiences and thoughts (Farias, Claridge, & Lalljee, 2005; Maltby & Day, 2002).

*Family, Developmental, and Social History*

The amount and quality of information acquired regarding a client's social history may vary depending on the theoretical orientation of the clinician. Regardless of theoretical framework, however, it is helpful to gather some basic information on the client's important social relationships and experiences, including basic facts about the composition of the family of origin (e.g., family size, marital status of parents, whether significant family members are deceased) and where the client was born and raised. Gathering a family history should also include questions about siblings, birth order, and the nature of the individual's relationship with parents, siblings, and other significant family members (Lukas, 2012). Questions can include extended family members if they were present in a significant way (e.g., supportive or nonsupportive role) during the individual's development. Information on child-rearing practices, patterns of communication, conflict resolution, and family traditions in both the nuclear and the extended family can also clarify the nature of family functioning and relationships (Hutchings & Virden, 2010).

The educational levels and occupations of parents and siblings can identify family values and expectations. The number of family moves, the reasons for these moves, the types of neighborhoods the individual lived in, and the presence of poverty can elucidate potential

psychosocial stressors. The individual's and family's connection to a cultural group and level of assimilation may highlight the availability of support and a sense of cultural identity. Additionally, the attitude of family members to treatment and their level of involvement in the individual's life may guide later interventions (e.g., family therapy).

It is helpful to initially adopt a nondirective stance when gathering information about the client's personal history (Morrison, 2014c). This allows one to learn which relationships and experiences the client sees as most salient and significant (J. Sommers-Flanagan & Sommers-Flanagan, 2014). Eventually, more directive questions can be asked to address information not mentioned by the client. By asking a range of questions, you can gather *objective* information about significant individuals in the client's life, as well as the client's *subjective* impression of them. A simple question such as "Tell me three adjectives that would best describe your mother" can be used to quickly gather preliminary information on a client's view of important figures in his or her life. Ask about the quality of the client's relationships with parents and caregivers, siblings, and anyone else who played a significant role; also inquire how these relationships have changed over time. If time permits, ask a few questions concerning the values emphasized in the family, how family members spent time together, important family traditions, similarities and differences among family members, and what each person's role in the family was perceived to be. Answers to these questions can be exceedingly helpful in painting a fuller picture of the environment in which the client grew up. Construction of a genogram (i.e., a graphic representation of family relationships that resembles a family tree) can aid in keeping track of complex family relationships. This may also uncover repetitive patterns, events, and themes in family relationships (see McGoldrick, Gerson, & Petry, 2008 for a more detailed description of family genograms). During the discussion of family relationships, listen for the identification of supportive family members and strong familial ties, as this information may facilitate later therapeutic interventions.

Maxmen et al. (2009) suggest asking clients to name the three to four most crucial turning points in their lives and to describe the most significant or memorable event during each major developmental period (e.g., childhood, adolescence, early adulthood, middle adulthood) as a time-efficient way to gather relevant information about a client's social history. When interviewing a child, a more detailed developmental history is needed (Lukas, 2012), and this will be reviewed later in this chapter.

Questions about the client's friendships, both past and current, are very useful. Because clients may be reluctant or embarrassed to admit to having few or no friends, a face-saving way to elicit such information is to neutrally structure questions so that either end of the relationship spectrum appears acceptable (e.g., "Some people like having a lot of friends and being around others, and other people may have fewer friends or do things more on their own. How was it for you growing up?"). Follow up on responses indicating that a client had few or no friends with a question as to whether this was the client's preference or if he or she wished things had been different; this distinction can have important diagnostic implications (e.g., suggesting schizoid versus avoidant characteristics). Listen for the nature of the interpersonal interactions, the client's interpersonal style, problem solving, and maladaptive inflexible response patterns.

When inquiring about dating and relationships, ask about the length and level of satisfaction of any current romantic relationship, as well as the history of significant past relationships, in a culturally sensitive manner (Hutchings & Virden, 2010). Remember,

some clients experiencing relationship distress may focus primarily on negative aspects of their current relationship and omit reporting any positives that exist. It may be necessary to probe for this information. Conversely, individuals whose primary complaint does not involve relationship issues may underreport problems in this area to appear more socially desirable or to save face.

Victims of partner violence may not spontaneously mention maltreatment for a number of reasons, including fear of the consequences of disclosing abuse and decreased awareness that such behavior is problematic. Asking about strengths of the relationship as well as areas in need of improvement can help to provide a balanced view. General screening questions about how conflicts are resolved and whether either member of the couple has been verbally or physically aggressive with the other may help uncover any abusive behavior that should be followed up. The assessment of abuse and partner violence is discussed further in Chapter 3, "Fundamentals of Treatment."

When assessing the nature of the client's interpersonal relationships, do not neglect questions about sexual functioning, such as the frequency of sexual activity, level of satisfaction with sexual activity, whether client and partner agree on the frequency and nature of their sexual contact, changes in sexual behavior, and history of any sexual symptoms (e.g., premature ejaculation, lack of sexual desire). Because of social and cultural taboos, some clients may be reluctant to discuss such information with a stranger (Fontes, 2008). It is important to become comfortable asking clients about their sex lives without appearing embarrassed or judgmental. Recognize that because of the sensitivity of this topic, questions about sex are best saved until later in the interview, when you have better knowledge of the client and the client has a degree of comfort with you (Morrison, 2014c). An exception to this general rule is if a client's presenting problem concerns sexual issues.

Finally, be sure not to assume what a client's sexual orientation is. For example, even a seemingly straightforward question about what type of birth control a sexually active female client uses upon closer analysis reveals a presumption that the client is having sex with a male partner (H. I. Kaplan & Saddock, 2010). When assumptions about heterosexuality are made, homosexual, bisexual, or transgender clients may feel that the clinician is uncomfortable with other orientations and may avoid discussion of this important aspect of their lives. If a client is homosexual, bisexual, or transgender, it is helpful to understand the degree to which the client feels comfortable with his or her sexual orientation, whether the client has come out to others, and (if so) the degree of acceptance and support the client has received. This may lead into a discussion of how cultural and societal attitudes toward homosexuality or sexuality may have affected the client while growing up or currently. Always ask about experiences of bullying during childhood and past discrimination.

### *Educational and Occupational History*

Questions about a client's educational history should include age at starting school, highest educational level completed, particular strengths or difficulties, and general performance (e.g., history of grade retention or grade skipping) in school (Hutchings & Virden, 2010). In cases where cognitive functioning is of concern, or when a client is a child or adolescent, more detailed information on academic history should be obtained. This could include favorite/best and least liked/most challenging subjects, performance on standardized tests, and special educational services received. When asking a client about educational history, include questions pertaining to relationships with teachers and peers, as well as any history of behavioral difficulties (e.g., detention, suspensions, truancy). Accomplishments and

academic and educational strengths may suggest coping resources and assets that can be used in treatment planning.

Spend some time in the initial interview inquiring about the client's current and past employment. For any significant jobs, the clinician should obtain brief descriptions of work responsibilities and schedules, length of employment, promotions, any work-related difficulties (e.g., being fired, coworker conflicts), level of job satisfaction and stress, and reasons for leaving. The clinician can also evaluate such factors as whether the client seems under- or overqualified for his or her current position, which may provide interesting areas for exploration in future sessions (e.g., is the client's history of employment in jobs below his or her level of training and education related to low self-esteem or fears of failure?). Questions about employment can also yield fruitful information about ability to handle responsibility, interpersonal skills, stress tolerance, persistence, and motivation.

Inquiries should also be made regarding any military service, including the branch of the military served in, length and location(s) of service, highest rank attained, job responsibilities, disciplinary actions, commendations received, combat experience, injuries sustained, and discharge status (e.g., honorable). Combat experiences should prompt later follow-up questions regarding PTSD symptomatology since rates of this disorder are elevated among combat veterans and associated with particularly high rates of disability (Prigerson, Maciejewski, & Rosenheck, 2001).

*Legal History*

Some clients will have past or current legal troubles such as excessive traffic tickets, arrests, incarcerations, and/or litigation (either initiated by the client or against the client). Inquiries in this area can lead to diagnostic possibilities that should be explored. For example, an individual who has been charged with driving under the influence should be thoroughly assessed for past and current alcohol and substance use problems. Reports of illegal activity or repeated physical altercations should prompt exploration of diagnostic possibilities such as Conduct Disorder or Antisocial Personality Disorder. Ask about current or ongoing litigation, since a client may have some expectation that records from treatment either will or will not be used in the legal proceedings.

Although many clients in crisis are motivated to be open and honest to obtain help, this is not always the case. Court-mandated clients, paranoid individuals, those with poor insight, persons experiencing intense feelings of hopelessness and futility, and those fearing involvement of the legal system may not readily disclose information regarding harm to self or others (R. G. Meyer & Weaver, 2007; R. I. Simon & Gutheil, 2002). In these cases, you should openly acknowledge the difficulties the client may have in disclosing information, but also explain that openness and honesty will assist you in effectively helping the client. In spite of such encouragement, some clients will continue to be evasive about risk issues. Concerns about the veracity of a client's report should be carefully and fully documented. The assessment of danger to self and others is discussed further in Chapter 3, "Fundamentals of Treatment."

*Resilience, Strengths, Competence, and Challenges*

As mental health professionals, we are trained to focus on problems so that we can understand their scope, possible causes, and consequences in order to resolve them. However, this focus can blind us from seeking information on client strengths. In fact, therapists may subtly encourage clients to primarily discuss negative behaviors by providing greater verbal

attention to negative self-statements than to positive self-statements. By focusing on past as well as current functioning, a more accurate assessment of the individual's stress tolerance and coping may be obtained. Take note of positive behaviors and attributes that are revealed during the course of the interview (J. Sommers-Flanagan & Sommers-Flanagan, 2014). Specifically ask questions to elicit these details if the client does not spontaneously provide them. This information serves two purposes. First, it informs the clinician about client strengths that can be marshaled in treatment. The client who displays a good sense of humor during the interview may be able to use that humor to cognitively reframe difficult situations in a manner that makes them easier to handle. Second, gathering information on strengths and competencies reminds clients that they are not defined solely by their problems, and may encourage a more balanced view of the self. Table 1.8 presents examples of positive qualities to look for in the initial interview.

The American Psychological Association (2014) provides a guide, *The Road to Resilience*, which offers invaluable tips on assessing and building resilience. It includes questions assessing personal strengths, such as "Have I been able to overcome obstacles, and if so how?" and "What has helped make me feel more hopeful about the future?" These can be modified so clients can reveal underlying adaptive coping resources. It is exceedingly useful to find out how a client copes with stress. Information about coping strategies may be obtained at various points throughout the interview.

It is also helpful to determine if the coping strategies that have contributed to the individual's resilience were evident in childhood or have developed more recently (Luthar & Prince, 2007). As reviewed earlier, clients should be asked how they have coped with the chief complaint or presenting problem. Similar questions should be asked about any stressful or problematic experience that a client mentions during the interview (e.g., job loss, divorce). Also find out how a client deals with lower-level, everyday stresses (e.g., "What do you do to relax or unwind at the end of a busy day?").

There are many ways to conceptualize coping. For example, in problem-focused coping, an individual tries to solve the problem perceived to be at the source of the stress, whereas in emotion-focused coping, the individual tries to deal with the negative emotional consequences that a stressor produces (Folkman, 1984). An individual may try to cognitively reframe difficult situations so that they are less stressful or may turn to social supports (e.g., family, friends, community supports) or spirituality or religion (e.g., prayer). One can also deal with stress through potentially harmful means such as rumination, distraction, or engaging in maladaptive behaviors including substance or alcohol use.

**Table 1.8 Positive qualities and strengths to look for in the initial interview**

| | | |
|---|---|---|
| Intelligence | Optimism | Insight |
| Sense of humor | Candor | Spontaneity |
| Empathy | Kindness | Thoughtfulness |
| Persistence | Responsibility | Resourcefulness |
| Confidence | Assertiveness | Self-control |
| Courteousness | Cooperativeness | Flexibility |
| Creativity | Close relationships | Caring |

If a client relies primarily on maladaptive ways of dealing with stress, this can be targeted in treatment. The section "Other Conditions That May Be a Focus of Clinical Attention" in the *DSM-5* identifies nine major areas of stressors and challenges that should be assessed (American Psychiatric Association, 2013). These conditions include a range of problems such as upbringing away from parents, problems related to military deployment status, homelessness, extreme poverty, and being the victim of terrorism (see Chapter 3, "Fundamentals of Treatment").

J. Sommer-Flanagan and Sommers-Flanagan (2014) recommend about halfway through the interview mentioning to the client the remaining time and soliciting feedback on the interview process. This provides the client with a time marker and allows you to obtain client input and reflect on the information still to be gathered (Lambert & Shimokawa, 2011).

## The Mental Status Exam

Up to this point, we have primarily focused on collecting information from clients about various aspects of their current and past functioning. Such information constitutes what might be termed the *subjective* portion of the interview, because we must rely on clients' accounts of their experiences without directly observing the events and situations described.

A comprehensive initial interview also contains an *objective* portion, or the *mental status examination* (MSE) composed of the clinician's observations of the client's behavior, appearance, and manner of relating during the interview (Daniel & Gurczynski, 2010). The MSE is rooted in psychiatry, and is an essential part of the psychiatrist's clinical evaluation. Nowadays, MSEs are routinely conducted by other mental health professionals and at various points during treatment, not just at the initial interview.

Mental status exams provide snapshots of the client's presentation at a particular point in time. When serial MSEs are available, they can help the clinician see how a client's behavior has changed over time (Morrison, 2014c). MSE information can be particularly helpful in determining the validity of the information reported by the client. For example, if a client is noted on an MSE as having disorganized thought processes, being extremely guarded, or exhibiting extreme emotional lability, additional information from collateral sources should be gathered because the quality of historical information provided by the client may be compromised. In cases where a client is confused or extremely uncooperative, the MSE may constitute the total initial evaluation.

Areas covered in an MSE can be roughly divided into noncognitive and cognitive. Table 1.9 summarizes noncognitive areas typically covered in an MSE and provides information on specific elements to assess.

Note that the MSE includes statements about various aspects of the client's physical presentation, such as general descriptions of health status (e.g., robust, gaunt, sallow-complexioned), age (including whether the client looks much younger or older than his or her stated age), approximate height and weight, grooming (e.g., appropriateness and cleanliness of clothing, body odor), and unusual or notable physical characteristics (e.g., tattoos, body piercings).

A statement is usually included in the MSE that addresses aspects of the client's psychomotor behavior (Daniel & Gurczynski, 2010). For example, was the client agitated (e.g., pacing, fidgeting) or moving and talking very slowly (i.e., psychomotor retardation)? Were

**Table 1.9 Areas typically covered in a mental status examination**

| Area | What to Evaluate |
|---|---|
| Physical appearance | ☐ Ethnicity ☐ Height and weight ☐ Age ☐ Sex<br>☐ Notable physical characteristics ☐ Clothing ☐ Grooming<br>☐ Health status |
| Psychomotor behavior | ☐ Agitation ☐ Retardation ☐ Gait ☐ Posture<br>☐ Unusual movements or mannerisms<br>☐ Stereotyped or repetitive movements |
| Manner of relating to clinician | ☐ Eye contact ☐ Openness ☐ Cooperation<br>☐ Evasive ☐ Anger or hostility ☐ Boredom ☐ Passivity<br>☐ Boundary issues ☐ Ability to express warmth<br>☐ Response to empathy |
| Speech | ☐ Rate ☐ Volume ☐ Prosody ☐ Fluency ☐ Latency<br>☐ Articulation ☐ Speech impediments or paraphasias ☐ Regional or cultural factors ☐ Neologisms or bizarre language use ☐ Mutism |
| Emotional state | ☐ Mood (client's report): Normal (euthymic), sad (dysphoric), happy (euphoric), angry, bored<br>☐ Affect (observed): Range, lability, intensity, appropriateness |
| Thoughts | ☐ Process: Logic, coherence, associations, goal directedness, special features (e.g., clanging, perseverations)<br>☐ Content: Nature of themes and intensity, delusions, ideas of reference |
| Sensory disturbances | ☐ Hallucinations ☐ Illusions ☐ Derealization/depersonalization |
| Impulse control | ☐ Danger to self/others ☐ Impulsivity |

there any abnormalities in the client's gait, posture, or mannerisms? A description of the client's emotional presentation is always included in an MSE and identifies the client's mood (i.e., self-reported emotional state) as well as affect (i.e., the emotional tone observed by the interviewer and manifest in behaviors such as facial expression, voice tone, gestures, and posture). Affect is assessed for appropriateness to content, range and duration, lability or intensity, and volatility. The descriptors euphoric, depressed, labile, inappropriate, angry, flat, blunted, or shallow are often used to describe affect (Lukas, 2012).

The MSE will document the client's manner of relating to the examiner, which can include level of cooperation, openness in answering questions, respect for boundaries, ability to respond to empathy, and ability to convey warmth (Wiger, 2011). As J. Sommers-Flanagan and Sommers-Flanagan (2014) note, you should not make an assumption that the client's behaviors toward the clinician reflect general patterns of responding to others unless there is sufficient evidence from the history to do so. How a clinician perceives a client is also influenced by the clinician's own personality, background, motivations, and issues. Thus, a soft-spoken, low-key clinician may be more put off by a loquacious, highly gregarious client than a clinician with a similar personality and interpersonal style.

Aspects of speech that are typically evaluated in an MSE include the rate and speed, clarity (e.g., are there speech impediments?), volume (overly soft or loud), fluency (amount of

speech and ease of production), and prosody. Prosody refers to the rise and fall or musicality that is inherent in normal speech. Individuals who speak in a monotone or robotic voice or who evidence other peculiarities in the lilt of their speech (that are not due to cultural factors such as a foreign-language accent) may be broadly described as *dysprosodic*.

Descriptions of a client's speech may also include regional or cultural factors such as accented speech and use of slang or colloquialisms. In evaluating a client's speech, clinicians should also note abnormal use of any words (paraphasias, such as substituting a word that is semantically related to the intended word or that sounds like the target word). Clients may present with limited or impoverished speech, neologisms (made-up words), or difficulty finding words, *clang associations* (combining unrelated words because of similar sounds or rhyming), or *mutism* (complete verbal nonexpression; J. Sommers-Flanagan & Sommers-Flanagan, 2014). Language impairments such as nonfluent aphasia (slow, halting, labored speech) and fluent aphasia (e.g., word salad) may suggest the need for an evaluation of cognitive functioning or the presence of a psychotic disorder. Table 1.10 reviews areas of cognitive functioning that may be evaluated as part of an MSE if a client is suspected of cognitive impairment (e.g., appears confused or disoriented or displays impaired memory).

The clinician will describe a client's thinking by noting two aspects: process and content (Daniel & Gurczynski, 2010). Comments about *thought process* address the client's ability to answer questions and relate information in a relatively straightforward and organized manner (sometimes referred to as "linear and goal-directed"), as opposed to thought processes marked by frequent digressions that either eventually return to the original point (i.e., circumstantiality) or do not (tangentiality). Additional descriptions of client thought processes include *flight of ideas* (continuous, overproductive speech that reflects fragmented ideas), and *loose associations* (a lack of logical relationship between thoughts).

Statements about *thought content* concern identifiable themes that may occur in the course of the interview. Usually this includes notation of any psychotic thought processes (e.g., delusions), expressions of fears or phobias, depressive thoughts, obsessions, and suicidal or homicidal desires. It is imperative to *always* inquire about suicidal and homicidal thoughts in an intake interview and to carefully document the client's responses in the case notes and intake report (Morrison, 2014c). If the client indicates that suicidal or homicidal thoughts are present, the clinician must immediately shift gears and determine whether the client is in immediate danger of harming self or others (see Chapter 3, "Fundamentals of Treatment").

Morrison (2014c, p. 138) describes a delusion as "a fixed, false belief" that cannot be accounted for by the individual's culture and education. Delusions may appear reality-based ("The IRS is watching me") or bizarre ("I am from another galaxy"), disorganized or systematized and highly complex, stable or changing (Daniel & Gurczynski, 2010). The theme(s) of a delusion can be paranoid, grandiose, or somatic, or include the belief that objects, people, or occurrences in the environment have special meaning or significance to the client (ideas of reference). Further information on delusions can be found in Chapter 6, "Schizophrenia and Other Psychotic Disorders."

The MSE may also include a statement regarding whether the client exhibited any evidence of perceptual disturbances such as hallucinations (i.e., perceptual experiences occurring in the absence of sensory stimulation, such as hearing or seeing things that are not really there) or illusions (i.e., misperceptions of actual sensory stimuli, such as mistaking a cane for a snake). Asking about these experiences can be challenging for new therapists.

**Table 1.10 Cognitive areas typically covered in a mental status examination**

| Cognitive Function<br>Definition | Examples/How to Evaluate |
|---|---|
| **Consciousness**<br>Assessed on continuum from alert to comatose | ❖ ***Fully alert:*** Able to respond quickly to environment; aware of surroundings.<br>❖ ***Drowsy:*** Awake, but less than fully alert.<br>❖ ***Stuporous:*** Partially aroused; may need vigorous physical stimulation to respond.<br>❖ ***Coma:*** Unable to be aroused by any stimuli (pain, odor). |
| **Orientation**<br>Awareness of oneself in relation to person, time, and place ("oriented × 3") | ❖ ***Person:*** Does client know his or her name?<br>❖ ***Time:*** Does client know date (month, day, year, day of week, approximate time of day)?<br>❖ ***Place:*** Does client know the location of interview?<br>❖ ***Situation/Context:*** Does client know the purpose of interview? |
| **Attention and concentration**<br>Ability to focus on topic at hand and sustain focus over time | ❖ ***Serial 7s:*** Ask client to count aloud backward by 7s beginning at 100.<br>❖ ***Digit repetition:*** Ask client to repeat aloud strings of digits of increasing length (5 to 8, 3 to 9 to 12, etc.).<br>❖ ***Registration:*** Ask client to repeat a list of three common objects. |
| **Language**<br>The ability to use and understand spoken and written language | ❖ ***Comprehension*** **(receptive language):** Does the client understand questions and simple commands?<br>❖ ***Expression:*** Does client's speech flow easily without evidence of unusual word usage, long pauses or response latencies, poverty of content, etc.? Ask client to name various everyday objects.<br>❖ ***Repetition:*** Can client repeat single words, simple phrases, and complex sentences stated by examiner? |
| **Memory**<br>Ability to remember information presented during exam, in recent past, or long ago | ❖ ***Immediate memory:*** Ability to remember things presented within the past few seconds. Assess digit repetition or ability to recall a series of three common objects.<br>❖ ***Recent memory:*** Ability to recall information presented after minutes, hours, or days. Ask client to recall a series of three common objects after a few minutes. Ask questions about recent meals or activities (must be able to verify responses).<br>❖ ***Remote memory:*** Ability to recall information or events that occurred in previous years. Ask questions about important personal facts (date of marriage, high school graduation) or historical events (names of past presidents). |
| **Visual motor skills**<br>The ability to draw or construct 2-D or 3-D shapes or figures | ❖ Ability to copy simple shapes such as vertical diamond (◊), 2-D cross (†), or 3-D cube (⧈), clock face, or intersecting pentagons. |
| **Intelligence**<br>Gross estimate of client's overall intellectual abilities (e.g., above average, average, below average) | ❖ ***May be inferred from:*** Complexity and range of client's vocabulary, or from educational and occupational achievement.<br>❖ ***Abstract reasoning:*** Ask client to interpret common proverbs; identify common concept linking objects (e.g., "How are a car and an airplane alike?"). |

**Table 1.10 (Continued)**

| Cognitive Function<br>Definition | Examples/How to Evaluate |
|---|---|
| | ❖ ***General fund of knowledge:*** For example, "Name four presidents since 1940"; "What is the capital of Spain?"; "Who wrote *Macbeth*?" (However, recognize ability to respond is highly dependent on cultural and educational experiences.) |
| **Judgment**<br>Ability to make sound, reasonable decisions that are adaptive | ❖ ***Infer from client history:*** Is there evidence of repeated poor judgment (e.g., drinking and driving, staying in problematic relationships, getting fired for poor work performance, repeated offending)?<br>❖ ***Pose hypothetical questions:*** "What would you do if you saw smoke and fire in a theater?" |
| **Insight**<br>Client's awareness and understanding of his or her problems | ❖ ***Ask questions:*** Does the client have a reasonable understanding of cause(s) of his or her problems? Does he or she feel in need of treatment? Does he or she have realistic expectations regarding treatment? |

We recommend normalizing the experiences by saying, "Sometimes when people are under a lot of stress they see or hear things that others do not. Has this ever happened to you?"

The level of detail included in an MSE will vary depending on the setting in which a clinician works and the type(s) of clients typically seen. A formal MSE includes information about the client's attention and concentration; memory (immediate, recent, remote); and estimated intelligence, insight, and judgment (Daniel & Gurczynski, 2010; Morrison, 2014c). These mental functions will usually be evaluated by a series of brief tasks, such as those outlined in Table 1.10.

Several structured MSEs have been created to assess cognitive function. The Folstein Mini-Mental Status Exam (M. F. Folstein, Folstein, & McHugh, 1975) is a good example. Structured cognitive MSEs typically utilize cut scores to detect individuals who might have an organic brain disorder (e.g., dementia) so that the clinician can refer them for an in-depth evaluation. Studies on the psychometric properties of structured cognitive MSEs have found that they are generally reliable (i.e., they produce consistent results across repeated testing [test-retest reliability] and across different raters [interrater reliability]) and useful for documenting cognitive changes in moderately to severely demented individuals. However, cut scores do not always detect dementia, and some instruments have produced high percentages of false-negative cases (i.e., individuals identified as nonimpaired who have true cognitive impairment; R. Rogers, 2001). A negative finding on a cognitive MSE does not necessarily rule out the need for further evaluation, particularly if there are other indicators of cognitive impairment in the interview or history. Remember that even when formal tasks are used to assess client functioning, the results are only gross estimates of ability in the areas tested.

Furthermore, some tasks used to evaluate cognitive functioning on MSEs can be strongly influenced by educational and cultural factors. For example, if one chooses to estimate general intelligence by asking the client a series of general knowledge questions

(e.g., "Name four individuals who have been president of the United States since 1940"), it is important to ensure that the client had an opportunity to learn this information (i.e., intelligence should be assessed relative to an individual's premorbid life experiences; E. Schwartz, 1989).

Many clinicians will not use a full, formal MSE to evaluate a client's cognitive functioning. In general outpatient settings, clinicians are less likely to evaluate aspects of the client's cognitive functioning through the administration of formal tasks. Written statements about the client's attention, verbal ability, and suspected level of intellectual functioning are likely to be based on the client's responses in the interview. For example, did the client need to have questions repeated or evidence difficulties in understanding them? Were his or her responses clear and well organized?

Morrison (2014c) identifies several situations in which all portions of a formal mental status exam should be administered: (a) when used as part of a forensic or other legal exam (e.g., competency evaluations, commitment proceedings), (b) when a baseline level of client functioning is needed to evaluate treatment effects, (c) when a client is suicidal or has threatened violence, (d) for evaluations of inpatients, (e) when major psychiatric diagnoses must be investigated, and (f) when brain injury is suspected.

Although information gathered from the MSE can assist in making a diagnosis, it should never be the only information used for this purpose. For example, brightly colored clothes or exaggerated or dramatic makeup could suggest mania, and inappropriate clothing could reflect psychosis (Morrison, 2014c), but these are by no means pathognomonic signs. As Lukas (2012) notes, a client who comes to a summer appointment dressed in a heavy winter coat may not be exhibiting bizarre behavior reflecting psychosis, but instead could be poor and own only one coat or may be a victim of abuse attempting to cover bruises.

It is particularly important to consider cultural and ethnic variations in interpersonal behavior. A clinician might interpret infrequent eye contact as a sign of shyness, poor social skills, or evidence of psychopathology, but some cultures consider this behavior to be respectful and perfectly appropriate. Results of the MSE are usually summarized in a paragraph format in an intake report (Lukas, 2012) under a separate heading that may be identified as "MSE" or "Behavioral Observations."

### Immediate Concerns

During the course of an initial interview, clinicians may learn of life-threatening crises faced by clients, including disclosures of suicidal or homicidal ideation and reports of abuse or neglect. Such issues require an immediate response that is thoughtful, thorough, and designed to maximize client safety (see Chapter 3, "Fundamentals of Treatment"). We recommend that throughout the interview you stay alert for and ask about issues that warrant immediate attention (see Table 1.11). These issues necessitate gathering additional information, and may involve using a crisis intervention approach.

## ENDING THE INTERVIEW

Intake interviews should never be ended abruptly. It can be upsetting for clients who have spent close to an hour talking about their lives and troubles to be unexpectedly told that their

**Table 1.11 Intake immediate concerns checklist**

Always be alert for the presence of and assess for the following:

- ❖ Danger to self and others (e.g., suicide, dangerousness, abuse)
- ❖ The need for a medical or medication evaluation
- ❖ Impulse control issues, substance relapse, nonadherence to treatment
- ❖ Diversity concerns and their impact on rapport and information gathering
- ❖ Factors that impact the establishment and maintenance of rapport
- ❖ Legal/ethical issues such as informed consent, confidentiality, releases of information, HIPAA, and clinician competence
- ❖ Additional considerations such associated features and comorbid conditions

time is up. Ten minutes prior to the end of the session, the client should be informed that your time together will soon be ending. This creates an opportunity for you to summarize what has been discussed in the interview and for the client to ask questions. A useful strategy is to say, "I would like to take a couple of moments to review my notes to make sure I have everything. Can you take this time to think about what we have talked about and see if there is anything we may have omitted or overlooked that you think is important for me to know?" It is crucial to offer reassurance and support at this stage, recognize how difficult it may have been to answer your questions, acknowledge the amount of information that has been provided, and thank the client for having the courage to take this first step in getting help.

It is reasonable for a client to expect that you will now provide information on the next steps in the treatment process (e.g., further interview, proceeding to therapy sessions, referral to another clinician or for adjunctive services). A client may also have questions about how the treatment might proceed, what the clinician thinks about the client's problems, how long the treatment might last, what the prognosis might be, and possible diagnoses.

You may not be able to provide firm answers for all these questions, but you should be prepared to give clients some answers and to tell them when you might be able to address their other inquiries. In some cases, a client may ask you questions that you cannot possibly answer and you should tell the client so. For example:

> ***Client:*** Am I going to get worse?
>
> ***Clinician:*** I understand how upsetting this is, and often when individuals are in the midst of a crisis it feels like things are not going to get better. However, coming to talk to someone is the first step. You have given me a lot of very helpful information and I am committed to working with you [this will vary if you may not see the person in therapy] to find ways that you can cope and not feel so upset or overwhelmed.

Always thank the client for participating in the interview and being willing to disclose information to you. Even when a client has been challenging to interview (e.g., reticent, argumentative), it is usually possible to come up with an appreciative comment to make (e.g., "I know that answering all of these questions was not easy, and I appreciate your willingness to discuss some of the things I asked about; I also appreciate your honesty in letting me know that you're not yet comfortable talking about certain issues, like your relationship with your husband"). This is also the time to review important themes discussed, offer a

sense of hope, guide and empower the client, describe how psychotherapy or treatment may be helpful in addressing their presenting problems, and tie up loose ends in relation to the next steps (D. L. Segal et al., 2010; J. Sommers-Flanagan & Sommers-Flanagan, 2014).

## LIFESPAN CONSIDERATIONS

The information discussed thus far has been geared toward interviewing young to middle-aged adults. Interviewing individuals at either end of the age spectrum requires sensitivity and an appreciation for how developmental changes and aging can affect a client's reactions to and understanding of the intake interview. You will need different specific skills to build rapport and establish trust with your youngest and oldest clients.

### Interviewing Children and Their Families

*How Child Referrals Differ From Adult Referrals*

Children rarely refer themselves for treatment. So the child client may have little understanding of why he or she is seeing you and may actively disagree that he or she needs to see you at all (M. A. Phillips & Gross, 2010). The reasons children are referred for treatment are quite varied. In some cases, as when evaluating very young children (e.g., toddlers), the purpose may not be to assess psychopathology in the child, but to identify parental problems, to develop an early intervention plan for the child, or to assess risk in siblings or other children in the home (Morrison & Anders, 2001). If a child disagrees with the idea that he or she is experiencing some sort of difficulty or has been told by parents that the visit is to set him or her straight, it will be more difficult to establish rapport and obtain information.

*Children's and Adolescents' Understanding of Treatment and the Initial Interview*

Most adults have some idea of how psychotherapy works (even if it is as basic as conceptualizing therapy as a place where you talk to someone about things that bother you), but most children have no idea what psychotherapy is. If you are a doctoral-level practitioner, a child client may think that going to see "the doctor" means having to get a shot (Phillips & Gross, 2010). Based on negative portrayals in popular culture, older children and adolescents may associate seeing a mental health professional or "shrink" with being crazy or insane.

This underscores the importance of giving the child's or adolescent's parents and caregivers adequate instructions on how to prepare their child or adolescent in advance and suggestions about what to say. For example, parents can tell him or her that the visit to the clinician is to meet someone who will talk with the child about his or her feelings and how things have been going at school and at home (distinguish the visit from a routine doctor's appointment; for example, the child will not be asked to get undressed, will not get a shot, etc.).

The child client should be told the appointment is not a form of punishment, and that part of the time the clinician will be talking with the parents and child together and then with the child alone. The child should be reassured he or she will return home after the appointment (unless an evaluation is being done for residential or inpatient placement; Morrison & Anders, 2001).

*Interviewing Parents*

New child clients should usually be seen with their parents, and a brief interview should be conducted with the parents alone. Some clinicians opt to have a parent meeting prior to seeing the child to assess the appropriateness of the referral. A separate interview with the child alone can follow. Interviewing parents first allows them to feel that their views, observations, concerns, and opinions are valued and will be taken seriously. This provides an opportunity for the clinician to establish rapport with the parents, and to observe how the parents interact with each other as well as the degree of agreement between parents on beliefs about and approaches to managing challenging child behaviors. This strategy also gives the child time to become acclimated to the office surroundings. Even though the parents will be interviewed first, the clinician should explain to the child why he or she is being seen and what the session will involve (e.g., talking together with Mom and Dad a bit first, and then talking with the child alone). Although you may have provided information and coaching to the parents on how to explain the visit to the child, you cannot assume that all parents will follow through on this information and prepare the child for the interview. Highly sensitive topics or those that are inappropriate to discuss in front of the child (e.g., the quality of the parents' relationship) should not be addressed when the child is present, but can be discussed later with the parents alone.

One exception to the rule of interviewing parents first is when the client is an adolescent (Bostic & King, 2007). Adolescents face the developmental challenges of identity formation and the dependence/independence conflict (McConaughy, 2013). Adolescents desire recognition of their own unique identity, views, and interests, and they may actively reject the conceptualizations that parents or other adults have of them (R. A. King, 2007; Naar-King & Suarez, 2011). Thus, interviewing adolescent clients before interviewing their parents sends a message that the adolescent's thoughts and feelings are valued.

When interviewing the parents in the child's presence, observations should be made of how they interact with the child (such observations can also begin when the child and parents are initially greeted in the waiting room). If children are old enough (e.g., 7 years or older), they can be asked questions that focus on the family in general, rather than just those pertaining to the child's identified problems. Discussions of this kind can help reveal systemic issues and the family's power structure, alliances, coalitions, and cultural mores, as well as bring to light specific conflicts that may exist between family members (Lukas, 2012).

Important information about parent–child interactions can be acquired by observing the parents and child engaged in an activity, such as a simple game, playing with toys, or planning a meal. Examples of qualities to note in parent–child interactions are summarized in Table 1.12.

Most of the general content areas in an initial interview should be covered in the parent interview (Bostic & King, 2007). In addition, obtain detailed information about school history. This includes the age at which the child began school, academic performance (strengths and weaknesses, grades, standardized test scores if applicable), history of grade retention or grade skipping, history of learning problems, and any evaluations or interventions (Lukas, 2012). Ask if the child has a history of behavioral difficulties in school or with peer and/or teacher relationships. Note if the child had truancies, excessive absences due to illnesses, school transfers, or disruptions in schooling.

**Table 1.12 Observations to make during parent–child interactions**

- ❖ How easily does the child separate from parents?
- ❖ Are the child's attempts to gain attention or solicit help noticed? How are they responded to?
- ❖ What is the general emotional tone of the parents' behavior toward the child (e.g., happy, interested, anxious, distracted, irritated) and vice versa?
- ❖ What are the parents' reactions to the child's positive emotional expressions (e.g., interest, excitement, happiness)?
- ❖ What are the parents' reactions to the child's negative emotional expressions (e.g., sadness, anger, irritation, fear)?
- ❖ How do the parents set limits or discipline the child? Is this done in a consistent manner?
- ❖ What are the child's reactions to praise, limit setting and discipline, frustration, and novelty?
- ❖ Are there recurring themes or topics in the child's interactions or play?

The earlier described mnemonic CLIENTS can be adapted when asking parents why they are seeking treatment for their child. Ask about significant changes and life events (either positive or negative) that may have coincided with the onset or worsening of the child's symptoms. When inquiring about the child's medical history, take time to create a thorough developmental history. This information is best gathered when parents are interviewed alone. It can be helpful to have the parents prior to the interview complete a developmental history questionnaire or form.

A developmental history consists of data about the child's earliest environment and includes information pertaining to all major periods of the child's development, including the circumstances of conception and details about the gestational period, infancy, toddlerhood, early childhood, and adolescence (Bostic & King, 2007). The history also includes parents' recollection of their child's behavior, temperament, attachment to caregivers, achievement of developmental milestones, and reactions to significant personal and family events (e.g., birth of a sibling) and potentially traumatic experiences (e.g., medical problems, accidents and injuries, losses).

A summary of the expected ages for developmental milestones is presented in Table 1.13. This guide is useful for the parent interview and when directly observing the child. Note that the ages listed in this table represent times when a milestone is *typically* achieved. Many milestones have a wide range of ages in which it is normal for the behavior to appear. For older children and adolescents, learn the developmental tasks faced during these periods so that you know if the child's behaviors are normal (Bostic & King, 2007). For example, a child displaying severe separation anxiety in middle school is a red flag requiring further investigation since this is unusual in early adolescence (P. Barker, 1990).

The developmental history represents an opportunity for the clinician to learn about the parents' expectations for their child and any delays in meeting developmental milestones. Be specific when asking about developmental milestones. Ask parents to recall specific ages rather than using general terms like "late" or "early," as parents may not know what constitutes delayed or accelerated development. Recommend that parents bring in a baby book in which various milestones and other observations were recorded to help them recall important dates. For children suspected of having an autistic spectrum disorder, early family videos can demonstrate early difficulties with eye contact and play (see Chapter 4, "Neurodevelopmental Disorders I: Autism Spectrum Disorder").

**Table 1.13 Developmental milestones**

| Milestone | Age (months) |
|---|---|
| Social smiling, reaches for dangling objects | 3 |
| Sits with support, holds a rattle | 4 |
| Babbles, pays attention to small objects | 5 |
| Makes 2-syllable sounds, responds to name, rolls over and back | 6 |
| Plays peek-a-boo, can self-feed some foods, begins to show stranger anxiety | 7 |
| Sits unsupported, begins to show separation anxiety | 8 |
| Picks up tiny objects, goes from stomach to sitting by self, crawls on hands and knees | 9 |
| Points, pulls self to standing, waves bye-bye | 10 |
| Cruises (i.e., walks while holding onto furniture, etc.) | 11 |
| Says "Mama" and "Dada," takes first steps alone, is fearful of strangers | 12 |
| Can say several simple words | 15 |
| Can say 10 to 50 words, can point to own body parts, scribbles well | 18 |
| Runs, can throw a ball overhand, can kick a ball | 19–20 |
| Can follow a 2-step request, can draw a straight line | 22 |
| Can make short sentences (e.g., 2 words), walks downstairs | 23–24 |
| Speaks clearly most of the time, builds a tower of 5 or 6 blocks, can name several body parts | 25–26 |
| Uses 4 or 5 words in a sentence | 30 |
| Separates fairly easily from parents | 35–36 |
| Begins toilet training | 24–36 |
| Has working vocabulary of 1,000+ words, can feed self without spilling, can imitate vertical and horizontal lines, able to use objects to represent people in play | 36 |

Ask the child's parents to describe a typical day in their child's life. This will yield a wealth of useful information. For very young children (e.g., toddlers), ask about activities such as eating and sleeping schedules and play activities the child enjoys. For older children, gather information about school and recreational or extracurricular activities and friends. Descriptions of a typical day will offer insight into the organization of the household and patterns of family interaction, which establish the context for understanding a child's difficulties. Be certain to also inquire about a child's strengths, talents, accomplishments, and other positive attributes and characteristics.

*Interviewing the Child*

P. Barker (1990) suggests conceptualizing the child interview as having three stages: (1) introduction, (2) information gathering and giving, and (3) termination. During the introductory stage, the clinician should tell the child what will occur during the session. Even if an explanation was offered during the initial family meeting, it is good to reiterate this information when you meet alone with the child. Before offering this information to children, ask them why they think they are meeting you. This allows you to correct any misconceptions they may have.

Older children and adolescents can be asked if there is anything they hope to achieve. If the interview is conducted in a playroom (as with a younger child), the clinician can review any rules, such as children are allowed to play with anything, but cannot break things or hurt themselves or you (Greenspan & Greenspan, 2003).

During the introductory phase, gather basic information about the child. Ask questions about the school the child attends, extracurricular activities, pets, hobbies, interests, and friends. If you plan to treat children on a regular basis, you should become familiar with games, television shows, music, and celebrities popular with the age groups you treat. It is easier to establish rapport if you understand your child client's world. Remember to not just focus on difficulties or problems child clients may be having, but to inquire about things they like about themselves, what they do well, and (for older children) their accomplishments.

Use age-appropriate games and toys to help ease younger children into the interview process. Such play also provides the clinician an opportunity to observe gross and fine motor development, ability to play by rules, cooperativeness, and frustration tolerance. If a child enjoys drawing, the clinician can employ projective drawing techniques (e.g., kinetic family drawing, house-tree-person). Analysis of a drawing, as well as responses the child may give to questions about it, can yield information about the child's preoccupations, drives, and mood state. Hammer (1980) and J. L. Cummings (2003) provide more detailed information on the use of children's and adolescents' drawings.

With children, Greenspan and Greenspan (2003) caution against conducting a highly structured interview, as this may prevent opportunities to examine how children organize themselves in an ambiguous situation. The structure of the child interview will also depend on the emotional and cognitive level of the child (Bostic & King, 2007; W. S. Gilliam & Mayes, 2007). Younger child clients will need a more inferential and nondirective interview and primarily closed-ended questions (Morrison & Anders, 2001). When interviewing children, be careful to avoid asking multiple questions at once, leading questions, and multiple-choice questions (unless the interviewer can be fairly certain that all possible relevant responses are included). Make sure the child is able to easily understand your questions. The clinician should understand the quality and complexity of responses that can be expected from children of different ages (McConaughy, 2013).

When interviewing a toddler or preschool-age child, one should use short, simple questions and expect that responses will be brief and concrete (W. S. Gilliam & Mayes, 2007). Toddlers require more verbal probes than older children, and it may be difficult to obtain reliable information from them. Furthermore, toddlers will not be able to deal with abstractions, and examination of play content is more likely to yield information than interview questions are (P. Barker, 1990).

The play interview is an ideal format for interviewing young children because children's familiarity with play can help allay their anxiety and ease transition into the interview setting. Also, by expressing things indirectly through the play materials (e.g., dolls, puppets), the child is able to maintain a safe distance from troubling emotions and concerns. Morrison and Anders (2001) and O'Conner and Braverman (2009) describe how to conduct a play interview with a young child.

For a client who is in middle childhood (i.e., the period between kindergarten and puberty), it may be possible to conduct the interview entirely through talking (or through a combination of play and talking). The child will likely be able to provide clinically rich responses to projective-like questions, such as "If you had three wishes, what would they

be?" or "If you were shipwrecked on a desert island and could have any three people in the world with you, who would you pick?" (P. Barker, 1990). Children at this age are able to report facts fairly accurately, especially if asked open-ended questions, but may still have difficulty accurately making judgments of events or situations (e.g., whether something happened often or infrequently; Morrison & Anders, 2001). Table 1.14 summarizes what developmental variations clinicians can expect from children's interview responses.

As children enter into adolescence, their ability to report on events becomes increasingly similar to that of adults, which allows the clinician to gather more history directly (Bostic & King, 2007). Adolescents develop an ability to think abstractly, which widens the scope of questions a clinician can ask. Morrison and Anders (2001) suggest addressing several content areas with adolescents, including (a) identity formation; (b) self-esteem; (c) independence/dependence issues; (d) friendships and activities with peers (especially important given the influence friends exert during this time period); (e) use of drugs, alcohol, and tobacco; (f) sexual knowledge and experiences; (g) empathy and conscience; (h) delinquent behavior; and (i) family life.

If the clinician knows that particular subjects are likely to be very sensitive for the child, it is better to save them for later in the interview, after sufficient rapport has been established. An exception to this would be when it is clear that the child is anxious to discuss a problematic issue (e.g., an adolescent child who strongly desired referral for treatment of a specific concern; P. Barker, 1990). To make an adequate assessment of child problems,

**Table 1.14 Developmental variations in relevant cognitive processes**

**Preschool**

- Descriptions of people are undifferentiated, concrete (e.g., focused on physical characteristics, behavior), and limited in number.
- Perceptions of people exist on global dimensions (i.e., good-bad; strong-weak).
- Impressions are strongly biased by observable, immediate events.
- Child may not be able to express feelings with words.

**Kindergarten**

- Believe feelings are provoked by events rather than through internal states (e.g., thoughts, memories).
- Feelings provoked by a current event override competing feelings from the past.
- Inability to integrate contradictory feelings leads to all-or-nothing expressions of feelings that are temporary (e.g., "I hate Mommy").

**Middle Childhood**

- Understands that two contradictory feelings can exist about the same object or person at the same time and that contradictory feelings modulate each other.
- Is able to provide longer descriptions of others, acquire more complete conceptions of social roles, make more inferences about others, and use more constructs.
- Is able to report facts fairly accurately, but may still have difficulty accurately making judgments of events or situations (e.g., judging *often* versus *infrequently*).

**Adolescence**

- Can inductively reason about people (e.g., determine someone is shy after multiple observations).
- Is increasingly able to think abstractly.
- May still not be fully capable of reflecting on experiences and articulating feelings.

clinicians must be able to tolerate some discomfort and allow the client's psychopathology to be expressed (Greenspan & Greenspan, 2003). While it is important to recognize when intervention is needed to calm or comfort a child, it is critical to avoid prematurely trying to avert a child's distress because of one's own countertransference reactions.

As with adults, it is important to avoid ending an interview with a child abruptly. Express appreciation for the child's willingness to participate in the interview, and allow time for the child to ask questions or add any information that he or she wants the clinician to know. As with adults, reassuring the child, summarizing, clarifying, and providing information about the next step in the treatment process are critical (J. Sommers-Flanagan & Sommers-Flanagan, 2014).

## Interviewing Older Adults

The Administration on Aging (U.S. Department of Health and Human Services, 2012) has reported that in 2011 there were 41.4 million individuals older than 65, and 1 in every 8 Americans is an older adult. In this demographic, 21% are members of ethnic or racial minority groups. Although interviews with older clients may appear similar to those conducted with younger or middle-aged adults, there are important differences: Older adults may come to therapy knowing less about what to expect and experiencing a greater sense of stigma or embarrassment than younger adults. These attitudes may be amplified for older minority clients (N. G. Choi & Gonzalez, 2005; Morano & DeForge, 2004).

Connor and colleagues (2010) found that for African American elders, the stigma associated with a mental illness such as depression negatively influences their attitudes and intentions toward seeking treatment. Many older adults view seeking help as a sign of weakness, and access to services is particularly challenging for older adults of color (Sorkin, Pham, & Ngo-Metzger, 2009). In isolated communities or rural areas, ageism and inequities in services have created additional barriers to treatment (Lawrence & McCulloch, 2001).

Older adults may minimize or deny symptoms and seek help from primary care physicians who may not assess for mental health problems (Blazer, 2009; Scogin & Shah, 2006). Thus, clinicians may need to spend more time explaining the therapy process and addressing client concerns. A client may doubt a significantly younger clinician's ability to understand or help because of the generational gap. In such situations, it is best to nondefensively acknowledge that you lack the same life experiences as your client, but note that you are trained to provide information about skills and experiences that can be helpful (e.g., specialized training or education, work with similar clients). Interestingly, older adults who enter therapy may be less prone to dropping out and more compliant with treatment than younger individuals (G. J. Kennedy, 2000).

Older adults may appreciate being approached using a more formal means of address (e.g., "Mr. Jones" rather than "Frank"). You may want to allow greater time to gather information, conduct the interview at a slower pace, begin with less sensitive questions, and have shorter sessions because of client fatigue. Clinicians may also want to repeat information frequently, use a slightly louder speaking voice if there is suspicion or knowledge of a hearing impairment, sit closer so the client can see lip movements, and allow time for clients to reminisce while recounting their history (C. Gould et al., 2010).

Use of a cognitive MSE may be necessary when interviewing older adults, because they often have more memory problems or confusion than younger adults. Several structured MSEs are available that can be used as screening tools for cognitive functioning, including the Mini Mental State Examination (M. F. Folstein et al., 1975) and the Montreal Cognitive Assessment (Nasreddine, Phillips, Bedirian, Charbonneau, Whitehead, Colin, . . . & Chertkow, 2005). Cognitive disorders common among older adults are reviewed in Chapter 12, "Neurocognitive Disorders," including dementia and delirium, and specific intake strategies to employ in suspected cases are described.

You many need to determine the client's capacity to provide consent to treatment. Evaluating capacity to consent can be complex, and it is important to identify the characteristics of decisionally capable individuals. They must have the ability to

- understand that a choice is being made,
- express a decision consistently,
- comprehend the nature of their condition (e.g., diagnosis, prognosis, potential treatments),
- possess the capability to weigh risks and benefits of different choices,
- apply a reasonably stable set of values in making decisions, and
- communicate the rationale behind choices made (Kennedy, 2000).

A formal assessment instrument such as the MacArthur Competency Assessment Tool for Treatment (Grisso & Appelbaum, 1998), a 20-minute semistructured interview that quantitatively evaluates capacity to consent to treatment, can help evaluate decisional capacities in older adults.

With a client of any age, recognize the unique physical and social challenges that each life cycle stage brings, and understand presenting problems within this biopsychosocial matrix. Erikson's (1993) stages of psychosocial development identify the challenge of integrity versus despair and isolation as the major task to be resolved for persons over 65. At this stage in life, people become aware of their own mortality and will begin to review their lives. A healthy resolution of this stage occurs when a person is able to reflect on his or her life with a sense of contentment and meaning. The individual is able to take responsibility for his or her life and accept the inevitability of death. When this ego integrity is achieved, wisdom results. In contrast, a failure to resolve this stage of development results in feelings of despair and a fear of death. Hopelessness, depression, bitterness, and anxiety may occur if an individual feels life has been meaningless or full of regret, failures, and unfulfilled aspirations (H. I. Kaplan & Saddock, 2010).

Building on Erikson's (1950) work, Peck (1968) identified three additional developmental tasks facing older adults:

1. *Ego differentiation versus work role preoccupation* concerns whether one is able to develop new interests and aspects of one's identity when work roles end (as a result of retirement, grown children leaving the home, etc.), or whether self-esteem and identity are too strongly tied to these old roles and one is unable to fill the void left by their loss.

2. *Body transcendence versus body preoccupation* has to do with the ability to overcome preoccupation with the physical ailments and deterioration of the body that naturally accompany aging and accept and make use of those capabilities that remain in order to enjoy life.
3. *Ego transcendence versus ego preoccupation* refers to whether the older adult is able to look past the inevitability of death and appreciate the contributions and legacy of his or her life to the world.

These theoretical models help us to understand the meaning and challenges posed by the many changes that aging brings. These changes include role changes (e.g., worker to retiree, parent to grandparent, spouse to caregiver); financial changes (e.g., reduced income, greater medical expenses); decline of physical health (e.g., onset of age-related illnesses, worsening of preexisting conditions); and loss and isolation (e.g., deaths of spouse, siblings, or friends; children moving away).

In addition, issues arising in these areas can create a ripple effect that causes change in other areas. An older adult who is slowly losing his or her hearing may experience greater isolation when around others because of an inability to hear conversations. Changes in cognitive functioning, memory abilities, sensory processes, and even circadian rhythms create additional challenges for the aging individual (C. Gould et al., 2010). An excellent detailed description of adult aging is provided in Whitbourne and Whitbourne's (2010) *Adult Development and Aging* text.

Health problems, a common concern among the elderly, may be at the root of why the client is seeking treatment (e.g., depression resulting from chronic pain). The consequences of health problems may also be of concern (e.g., a retiree struggling to find meaning in life after leaving a job and who cannot pursue certain new activities due to rheumatoid arthritis). Because health issues can greatly impact an older adult's life, you should devote sufficient time during the initial interview to explore the client's physical health and the impact on his or her physical and emotional functioning.

Obtain a list of current medications, as many older adults are on multiple medications, and polypharmacy in the elderly is associated with negative health outcomes and is a risk factor for morbidity (C. Gould et al., 2010; Hajjar, Cafiero, & Hanlon, 2007). Qato and colleagues (2008) in conducting a nationally representative community survey found that 81% of individuals aged 57 to 85 years used at least one prescription medication, with 29% using five or more prescription medications concurrently.

Physiological changes associated with aging can affect the absorption, distribution, and metabolism of medications and make it more likely that older adults will experience side effects, drug toxicity, and unexpected reactions (Saxon, Etten, & Perkins, 2009). It is critically important to collaborate with the client's primary physician and obtain appropriate release forms to allow open communication between care providers. Older adults typically expect the therapist to communicate with their primary care provider (G. J. Kennedy, 2000). Do not assume that a client's primary care physician is addressing the client's emotional problems (C. Gould et al., 2010).

Finally, when interviewing older adults, the clinician should be attentive to any information (e.g., client appearance or disclosures, aspects of the history) suggesting elder abuse. Such abuse may include physical or emotional abuse or neglect or financial abuse (e.g., withholding funds that should be rightfully accessed by the elder). Be aware that older

adults have an increased risk for suicide and may lose the ability to care for themselves. Older adults should be questioned about their living conditions, ability to provide for their basic needs, and the presence of an active involved support system. Many older adults live alone with limited contact with family members. These issues should be fully explored in a sensitive manner during intake.

## STRUCTURED INTERVIEWS

Beginning in the 1960s, researchers began to recognize that information obtained from unstructured interviews often resulted in poor diagnostic reliability and validity (C. H. Ward, Beck, Mendelson, Mock, & Erbaugh, 1962). Researchers in the 1970s and 1980s sought to develop structured psychiatric interviews that would ensure consistency in procedures used to evaluate clinical symptoms and specific areas covered.

R. Rogers (2001) defines a structured interview as a method of systematic evaluation that standardizes the language used to question clients, the sequence in which questions are presented, and the quantification of the client's responses. Some structured interviews (e.g., Structured Clinical Interview for *DSM* Disorders [SCID]) utilize a branching format in which the interviewer is led to certain questions based on the client's responses to previous questions. This allows interviewers to skip a particular diagnostic section if the essential criteria for a disorder are not met (D. L. Segal, Mueller, & Coolidge, 2012).

Dozens of structured clinical interviews are now available to evaluate psychiatric symptoms in adults and children (e.g., SCID and Kiddie Schedule for Affective Disorders and Schizophrenia [K-SADS]). Some are broad-based and evaluate a range of different disorders, whereas others (e.g., Anxiety Disorders Interview Schedule [ADIS]) focus on specific disorder categories or diagnoses. A sample of these broad-based interviews is presented in Table 1.15. Symptom- or diagnosis-specific rating scales will be reviewed later in the specific disorder chapters. Several of these measures are currently being updated to reflect *DSM-5* changes.

Among the advantages of structured clinical interviews over their unstructured counterparts are (a) comprehensive coverage of disorders; (b) reduced likelihood of clinician bias or lack of knowledge influencing results; (c) consistency in interview content and diagnostic decision making across interviewers, resulting in greater reliability; (d) improved ability to assess change across settings and time; (e) ease of administration, so lay interviewers may be used with less expense; (f) excellent training tools; and (g) more accurate diagnoses than unstructured interviews with ethnic minority clients (C. Miller, 2010; D. L. Segal et al., 2012; Whaley & Geller, 2007).

However, there are some disadvantages in using structured interviews. Many require significant training to ensure accurate administration. It can be difficult to establish rapport using a highly structured interview that requires the clinician to read questions verbatim and follow a strict sequence of questioning (C. Miller, 2010; D. L. Segal et al., 2012). A clinician who uses only a structured interview may miss opportunities to learn about unique experiences or beliefs of a client. Clients can often report clinically significant and idiosyncratic information, when they are given an opportunity to speak freely. This information may be lost when relying on a structured interview.

**Table 1.15 A sample of structured clinical interviews**

| Interview *Authors (date)* | Population, Completion Time | Areas Covered, Additional Notes |
|---|---|---|
| **Structured Clinical Interview for the *DSM-5* (SCID-5)**<br>*First, Spitzer, Gibbon, and Williams (2016)* | ❖ Adults<br>❖ 60–180 minutes | ❖ *DSM-5* Disorders commonly encountered in clinical practice (e.g., anxiety disorders, psychotic disorders, depressive and bipolar disorders, PTSD, OCD and related disorders, ADHD, etc.)<br>❖ Does not cover certain classes of disorders such as personality disorders, autism spectrum disorder, dissociative disorder<br>❖ Research and clinician versions available |
| **Structured Clinical Interview for *DSM-5* Personality Disorders (SCID-5-PD)**<br>*First, Williams, Smith Benjamin, & Spitzer (2016)* | ❖ Adults<br>❖ 60–180 minutes | ❖ *DSM-5* personality disorders<br>❖ Diagnoses can be made categorically or dimensionally<br>❖ Includes optional self-report screening questionnaire (20 min) |
| **Diagnostic Interview Schedule for *DSM-IV* (DIS-IV)**<br>*Robins et al. (2000)* | ❖ Adults<br>❖ 90–150 minutes | ❖ *DSM-IV* Axis I (clinical disorders) and Axis II (personality disorders) Focuses on current and past (1 year) symptoms<br>❖ Used in epidemiological studies can be administered by lay interviewers<br>❖ Highly structured |
| **International Personality Disorder Examination (IPDE)**<br>*Loranger (1999)* | ❖ Adults<br>❖ 15 minutes self-report screening<br>❖ 90 minutes interview | ❖ Assesses *DSM-IV* and *ICD-10* personality disorders<br>❖ Specialized training designed for use by experienced clinicians |
| **Schedules for Clinical Assessment in Neuropsychiatry (SCAN), Version 2.1**<br>*Wing, Babor, Brugha, et al. (1990)* | ❖ Adults<br>❖ 60–140 minutes | ❖ Incorporates the updated Present State Examination (PSE10), the Item Group Checklist (IGC), the Clinical History Schedule (CHS), and the Glossary of Differential Definitions<br>❖ Developed within the framework of the World Health Organization |
| **Schedule for Affective Disorders and Schizophrenia (SADS)**<br>*Endicott and Spitzer (1978)* | ❖ Adults<br>❖ 90–150 minutes | ❖ Research diagnostic criteria for psychotic and affective disorders plus other select disorders (e.g., anxiety); current, lifetime, and change versions |

**Table 1.15 (Continued)**

| Interview *Authors (date)* | Population, Completion Time | Areas Covered, Additional Notes |
|---|---|---|
| **Diagnostic Interview Schedule for Children for *DSM-IV* (DISC-IV)** Shaffer, et al. *(2000)* | ❖ Children (6–17)<br>❖ 90–120 minutes<br>❖ Parent, youth, teacher versions | ❖ Six diagnostic sections (anxiety, mood, disruptive, substance use, Schizophrenia, and other disorders)<br>❖ Assesses presence of symptoms within past year, currently (past 4 weeks), and during lifetime |
| **Kiddie Schedule for Affective Disorders and Schizophrenia (K-SADS)** *Puig-Antich and Chambers (1978)* | ❖ Children (6–18)<br>❖ 60–75 minutes<br>❖ Administered to child and parent | ❖ Mood, psychotic, anxiety, and disruptive behavior disorders<br>❖ Versions available to assess present and/or lifetime symptoms and for epidemiological research<br>❖ Semistructured administered by clinicians |

In addition, structured interviews lessen opportunities to examine how clients organize and structure their behavior without the aid of the clinician (Hughes & Baker, 1990). Many structured interviews are also time-consuming to administer (C. Miller, 2010). Structured interviews that are closely linked to diagnostic classification systems need to be updated with classification system revisions (C. Miller, 2010).

Finally, highly structured interviews may be inappropriate to use with highly emotional clients or those in crisis. The decision to use structured or unstructured interview formats is not an either/or choice. An interviewer may decide to utilize a fairly unstructured format initially to gather certain pieces of information, put the client at ease, and establish rapport. Afterward, the interviewer might use a more structured modality to inquire about the presence, duration, and severity of specific symptoms. If you are using a highly structured interview format, you should inform the client how the interview will proceed. D. L. Segal et al. (2012) provide a more detailed discussion of the use of structured interviews for diagnostic purposes with adults. Angold, Costello, and Egger (2007) provide an excellent review of the use of structured interviews with children and adolescents.

## STRATEGIES AND TIPS FOR SUCCESS

Adequate preparation for the interview encompasses a review of information that is available about the client; a willingness to engage in self-reflection to identify potential biases, assumptions, and blind spots that may adversely affect rapport established with the client, understanding of the client's difficulties, and the quality of the information obtained; attention to the appropriateness of one's physical presentation and office surroundings; awareness of potential safety issues; gathering relevant paperwork; and knowledge of appropriate legal and ethical issues in the interview process. Adequate information will not be obtained in an intake interview if there is a failure to establish sufficient rapport with the client. Rapport is established through both nonverbal and verbal means and should be considered as a process that operates continuously throughout the intake.

Although interview content may be affected by theoretical orientation, it is useful to obtain information from the client in a number of standard areas, and more than one meeting may be necessary to gather this information based on the client's developmental and cognitive capacity, emotional state, and physical condition. The interview represents an opportunity not only to inquire about problems and potential pathology, but also to understand client resiliencies, strengths, and accomplishments. Presenting problems must be considered within the larger matrix of the client's ethnic, cultural, and religious background. The mental status examination provides a means for systematically evaluating dimensions of a client's cognition, emotions, and general behavior at the time of the interview, and is an important component of the interview process. Structured interviews can assist clinicians in obtaining information relevant to diagnosis and can help avoid biases that result in incomplete information; however, they may have limited application for clients in crisis and may hamper rapport and reduce opportunities to learn about unique aspects of a client's life.

Interviewing techniques must be modified when dealing with clients at either end of the age spectrum. Interviews with children, for example, include consultation with parents and observation of parent–child interactions, in addition to a direct interview with the child. Issues of confidentiality, developmental variations in children's cognitive processes, and the circumstances under which child clients come in for treatment (e.g., typically referred by others) are among the unique challenges clinicians face when conducting pediatric interviews. For older adult clients, the interview process may need to be adjusted for physical and sensory limitations, and the stigma of seeking professional help may be salient. Greater emphasis on understanding the impact of role changes, loss, and physical illness and decline is needed in interviewing older adult clients. Use of life cycle stage models can be useful in providing a framework for areas of inquiry when working with this population.

A final word of advice: If you want to become a skilled interviewer, the key is repeated practice. As is evident from reading this chapter, interviewers must possess a variety of skills and be able to accomplish multiple tasks at once. Skill in dealing with one client does not necessarily generalize across clients. Differences in presenting problems, verbal skills, insight, and cultural factors can all influence a client's manner of relating and the specific skill set required to conduct an effective interview. Thus, during one's training it is wise to take advantage of as many opportunities as possible to conduct supervised interviews with diverse clients in order to develop and maintain skills in this critical clinical domain.