

## Praise for Clinical Interviewing

"I'm a huge admirer of the authors' excellent work. This book reflects their considerable clinical experience and provides great content, engaging writing, and enduring wisdom."

—**John C. Norcross, Ph.D., ABPP**, Distinguished Professor of Psychology, University of Scranton

"This text is outstanding. Well-grounded in theory and research, it brings to life real challenges confronting mental health professionals. Especially impressive is the integration of cultural competence and cultural humility in the interview process. This is an awesome book."

—**Derald Wing Sue, Ph.D.** Department of Counseling and Clinical Psychology, Teachers College, Columbia University

"This is a 'must-have' resource that belongs on the bookshelf of every mental health counselor trainee and practitioner."

—**Barbara Herlihy, PhD, NCC, LPC-S**, University Research Professor, Counselor Education Program, University of New Orleans

### Fully-updated guide to proven, practical strategies for conducting effective interviews

*Clinical Interviewing* is the essential guide to conducting initial interviews, suicide assessment, mental status examinations, and psychotherapy skill development. The *Sixth Edition* includes:

- Updates focusing on latest trends in clinical interviewing research and practice
- Access to over 70 videos that show the authors discussing and demonstrating crucial interviewing techniques
- Online instructor's manual and resources to facilitate teaching

This edition also includes a unique Registration Code to access the Wiley Interactive E-Text (Powered by VitalSource), enhanced with dynamic content, including video, to further enrich student learning.

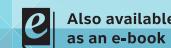
**JOHN SOMMERS-FLANAGAN, PhD**, is a clinical psychologist and professor of counselor education at the University of Montana. He is a long-time member of both the American Counseling Association (ACA) and the American Psychological Association (APA).

**RITA SOMMERS-FLANAGAN, PhD**, is professor emeritus at the University of Montana. As a clinical psychologist, she has worked with youth, families, couples, and women for many years.

Cover Design: Wiley  
Cover Image: ©Melamory/Shutterstock

Visit us at [wiley.com](http://wiley.com)

**WILEY**



Sommers-Flanagan  
Sommers-Flanagan

Clinical Interviewing

Sixth  
Edition

**WILEY**

# Clinical Interviewing

S i x t h   E d i t i o n

John Sommers-Flanagan

Rita Sommers-Flanagan

**WILEY**

Includes  
access code  
to online  
videos

Wiley E-Text  
Powered by VitalSource®  
Read, Search, Study, Share

#### **Download the e-textbook**

Come to class prepared. Study using the Wiley E-Text on your computer, tablet, or smartphone. Online or off, everything stays in sync. Available on Mac, Windows, iOS, and Android.

Download Now:

1. Go to: [www.vitalsource.com/download](http://www.vitalsource.com/download)
2. Download the Bookshelf® that is right for your computer.
3. Follow the installation instructions.
4. Complete all fields in the Registration Form.
5. Enter the code found under the scratch-off below in the Redemption Code field.
6. Click the Register button.
7. Double click on the downloaded title to open your Wiley E-Text.

Now Make it Mobile:

1. Download the VitalSource Bookshelf app to your smartphone or tablet.
2. Prepare for class anything, anywhere, on any device.

If you need help, go to [support.vitalsource.com](http://support.vitalsource.com)

Wiley E-Text  
ISBN: 9781119365082

# **CLINICAL INTERVIEWING**

Sixth Edition



# **CLINICAL INTERVIEWING**

Sixth Edition

**John Sommers-Flanagan  
Rita Sommers-Flanagan**

**WILEY**

Copyright © 2017 by John Wiley & Sons, Inc. All rights reserved.

Published by John Wiley & Sons, Inc., Hoboken, New Jersey.  
Published simultaneously in Canada.

No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopying, recording, scanning, or otherwise, except as permitted under Section 107 or 108 of the 1976 United States Copyright Act, without either the prior written permission of the publisher, or authorization through payment of the appropriate per-copy fee to the Copyright Clearance Center, Inc., 222 Rosewood Drive, Danvers, MA 01923, 978-750-8400, fax 978-646-8600, or on the Web at [www.copyright.com](http://www.copyright.com). Requests to the publisher for permission should be addressed to the Permissions Department, John Wiley & Sons, Inc., 111 River Street, Hoboken, NJ 07030, 201-748-6011, fax 201-748-6008, or online at [www.wiley.com/go/permissions](http://www.wiley.com/go/permissions).

**Limit of Liability/Disclaimer of Warranty:** While the publisher and author have used their best efforts in preparing this book, they make no representations or warranties with respect to the accuracy or completeness of the contents of this book and specifically disclaim any implied warranties of merchantability or fitness for a particular purpose. No warranty may be created or extended by sales representatives or written sales materials. The advice and strategies contained herein may not be suitable for your situation. You should consult with a professional where appropriate. Neither the publisher nor author shall be liable for any loss of profit or any other commercial damages, including but not limited to special, incidental, consequential, or other damages. Readers should be aware that Internet Web sites offered as citations and/or sources for further information may have changed or disappeared between the time this was written and when it is read.

This publication is designed to provide accurate and authoritative information in regard to the subject matter covered. It is sold with the understanding that the publisher is not engaged in rendering professional services. If legal, accounting, medical, psychological or any other expert assistance is required, the services of a competent professional should be sought.

For general information on our other products and services, please contact our Customer Care Department within the U.S. at 800-956-7739, outside the U.S. at 317-572-3986, or fax 317-572-4002.

Wiley publishes in a variety of print and electronic formats and by print-on-demand. Some material included with standard print versions of this book may not be included in e-books or in print-on-demand. If this book refers to media such as a CD or DVD that is not included in the version you purchased, you may download this material at <http://booksupport.wiley.com>. For more information about Wiley products, visit [www.wiley.com](http://www.wiley.com).

**Library of Congress Cataloging-in-Publication Data**

Names: Sommers-Flanagan, John, 1957- author. | Sommers-Flanagan, Rita, 1953- author.

Title: Clinical interviewing / John Sommers-Flanagan, Rita Sommers-Flanagan.

Description: Sixth edition. | Hoboken, New Jersey : John Wiley & Sons, Inc., [2017] | Includes bibliographical references and index.

Identifiers: LCCN 2016013760 (print) | LCCN 2016014706 (ebook) | ISBN 9781119215585 (paperback) | ISBN 9781119215608 (pdf) | ISBN 9781119215615 (epub)

Subjects: LCSH: Interviewing in mental health. | Interviewing in psychiatry. | BISAC: PSYCHOLOGY / Psychotherapy / General.

Classification: LCC RC480.7 .S66 2017 (print) | LCC RC480.7 (ebook) | DDC 616.89--dc23

LC record available at <http://lccn.loc.gov/2016013760>

Cover design by Wiley

Cover image: © Melamory/Shutterstock

Printed in the United States of America

SIXTH EDITION

PB Printing

10 9 8 7 6 5 4 3 2 1

# CONTENTS

Preface . . . . .	xiii
About the Authors . . . . .	xxi
<b>Part One: Foundations of Clinical Interviewing . . . . .</b>	<b>1</b>
<b>Chapter 1: An Introduction to the Clinical Interview . . . . .</b>	<b>3</b>
Learning Objectives. . . . .	3
Chapter Orientation . . . . .	3
Welcome to the Journey . . . . .	3
What Is a Clinical Interview? . . . . .	5
Clinical Interviewing versus Counseling and Psychotherapy . . . . .	7
A Learning Model for Clinical Interviewing . . . . .	13
Multicultural Competencies . . . . .	17
Multicultural Humility . . . . .	25
Summary . . . . .	28
Suggested Readings and Resources . . . . .	29
<b>Chapter 2: Preparation . . . . .</b>	<b>31</b>
Learning Objectives. . . . .	31
Chapter Orientation . . . . .	31
The Physical Setting . . . . .	31
Professional and Ethical Issues . . . . .	38
Multicultural Preparation . . . . .	55
Stress Management and Self-Care . . . . .	65
Summary . . . . .	68
Suggested Readings and Resources . . . . .	68
<b>Chapter 3: An Overview of the Interview Process . . . . .</b>	<b>71</b>
Learning Objectives. . . . .	71
Chapter Orientation . . . . .	71
Stages of a Clinical Interview . . . . .	71
The Introduction . . . . .	73
The Opening . . . . .	84
The Body . . . . .	90
The Closing . . . . .	95

Ending the Session (Termination) . . . . .	104
Summary . . . . .	107
Suggested Readings and Resources . . . . .	109
<b>Part Two: Listening and Relationship Development . . . . .</b>	<b>111</b>
<b>Chapter 4: Nondirective Listening Skills . . . . .</b>	<b>113</b>
Learning Objectives. . . . .	113
Chapter Orientation . . . . .	113
Listening Skills . . . . .	113
Adopting a Therapeutic Attitude . . . . .	114
Why Nondirective Listening Is Also Directive . . . . .	123
The Listening Continuum in Three Parts . . . . .	125
Nondirective Listening Behaviors:	
Skills for Encouraging Client Talk . . . . .	126
Ethical and Multicultural Considerations . . . . .	142
Not Knowing What to Say . . . . .	145
Summary . . . . .	146
Suggested Readings and Resources . . . . .	147
<b>Chapter 5: Directive Listening Skills . . . . .</b>	<b>149</b>
Learning Objectives. . . . .	149
Chapter Orientation . . . . .	149
Directive Listening Behaviors:	
Skills for Encouraging Insight . . . . .	150
Ethical and Multicultural Considerations	
When Using Directive Listening Skills . . . . .	175
Summary . . . . .	178
Suggested Readings and Resources . . . . .	179
<b>Chapter 6: Skills for Directing Clients Toward Action . . . . .</b>	<b>181</b>
Learning Objectives. . . . .	181
Chapter Orientation . . . . .	181
Readiness to Change . . . . .	181
Skills for Encouraging Action: Using Questions . . . . .	184
Using Educational and Directive Techniques . . . . .	192
Ethical and Multicultural Considerations	
When Encouraging Client Action . . . . .	204
Summary . . . . .	215
Suggested Readings and Resources . . . . .	216
<b>Chapter 7: Evidence-Based Relationships . . . . .</b>	<b>217</b>
Learning Objectives. . . . .	217
Chapter Orientation . . . . .	217

The Great Psychotherapy Debate . . . . .	217
Carl Rogers's Core Conditions . . . . .	218
Other Evidence-Based Relationship Concepts . . . . .	233
Evidence-Based Multicultural Relationships . . . . .	250
Summary . . . . .	253
Suggested Readings and Resources . . . . .	254
<b>Part Three: Structuring and Assessment . . . . .</b>	<b>255</b>
<b>Chapter 8: Intake Interviewing and Report Writing . . . . .</b>	<b>257</b>
Learning Objectives. . . . .	257
Chapter Orientation . . . . .	257
What's an Intake Interview? . . . . .	257
Identifying, Evaluating, and Exploring Client Problems and Goals . . . . .	259
Obtaining Background and Historical Information . . . . .	267
Assessment of Current Functioning . . . . .	276
Brief Intake Interviewing . . . . .	280
The Intake Report . . . . .	282
Do's and Don'ts of Intake Interviews with Diverse Clients. . . . .	298
Summary . . . . .	300
Suggested Readings and Resources . . . . .	301
<b>Chapter 9: The Mental Status Examination . . . . .</b>	<b>303</b>
Learning Objectives. . . . .	303
Chapter Orientation . . . . .	303
What Is a Mental Status Examination? . . . . .	303
Individual and Cultural Considerations . . . . .	305
The Generic Mental Status Examination . . . . .	308
When to Use Mental Status Examinations . . . . .	340
Summary . . . . .	342
Suggested Readings and Resources . . . . .	342
<b>Chapter 10: Suicide Assessment . . . . .</b>	<b>345</b>
Learning Objectives. . . . .	345
Chapter Orientation . . . . .	345
Facing the Suicide Situation . . . . .	345
Suicide Risk Factors, Protective Factors, and Warning Signs . . . . .	348
Building a Theoretical and Research-Based Foundation . . . . .	356
Suicide Assessment Interviewing . . . . .	360
Suicide Interventions . . . . .	380
Ethical and Professional Issues . . . . .	385
Summary . . . . .	389
Suggested Readings and Resources . . . . .	390

<b>Chapter 11: Diagnosis and Treatment Planning . . . . .</b>	<b>393</b>
Learning Objectives. . . . .	393
Chapter Orientation . . . . .	393
Modern Diagnostic Classification Systems . . . . .	393
Defining Mental Disorders. . . . .	396
Diagnostic Interviewing . . . . .	404
The Science of Clinical Interviewing:	
Diagnostic Reliability and Validity . . . . .	406
Less Structured Diagnostic Clinical Interviews . . . . .	409
Treatment Planning . . . . .	415
Case Formulation and Treatment Planning:	
A Cognitive-Behavioral Example . . . . .	423
Additional Cultural Modifications and Adaptations . . . . .	427
Summary . . . . .	428
Suggested Readings and Resources . . . . .	430
<b>Part Four: Special Populations and Situations . . . . .</b>	<b>431</b>
<b>Chapter 12: Challenging Clients and Demanding Situations . . . . .</b>	<b>433</b>
Learning Objectives. . . . .	433
Chapter Orientation . . . . .	433
Challenging Clients . . . . .	433
Motivational Interviewing and Other Strategies	
for Working Through Resistance . . . . .	436
Assessment and Prediction of Violence and Dangerousness . . . . .	451
Demanding Situations: Crisis and Trauma . . . . .	456
Cultural Competencies in Disaster Mental Health . . . . .	468
Summary . . . . .	470
Suggested Readings and Resources . . . . .	471
<b>Chapter 13: Interviewing Young Clients . . . . .</b>	<b>473</b>
Learning Objectives. . . . .	473
Chapter Orientation . . . . .	473
Considerations in Working With Young Clients . . . . .	473
The Introduction . . . . .	475
The Opening . . . . .	479
The Body of the Interview . . . . .	490
Closing and Termination . . . . .	503
Culture in Young Client Interviews . . . . .	506
Summary . . . . .	508
Suggested Readings and Resources . . . . .	508

<b>Chapter 14: Interviewing Couples and Families . . . . .</b>	<b>511</b>
Learning Objectives. . . . .	511
Chapter Orientation . . . . .	511
Challenges and Ironies of Interviewing Couples and Families . . . . .	511
The Introduction . . . . .	514
The Opening . . . . .	522
The Body . . . . .	528
Closing and Termination. . . . .	540
Special Considerations . . . . .	541
Diversity Issues . . . . .	546
Summary . . . . .	549
Suggested Readings and Resources . . . . .	550
<b>Chapter 15: Electronic and Telephonic Interviewing . . . . .</b>	<b>553</b>
Learning Objectives. . . . .	533
Chapter Orientation . . . . .	553
Technology as an Extension of the Self . . . . .	554
Definition of Terms and Communication Modalities . . . . .	557
Non-FtF Assessment and Intervention Research . . . . .	561
Ethical and Practical Issues: Problems and Solutions . . . . .	565
Conducting Online or Non-FtF Interviews . . . . .	573
Multicultural Issues: Culture and Online Culture . . . . .	575
Summary . . . . .	576
Suggested Online Training Resources . . . . .	577
<b>Appendix: Extended Mental Status Examination Interview Protocol .</b>	<b>579</b>
<b>References . . . . .</b>	<b>589</b>
<b>Author Index . . . . .</b>	<b>639</b>
<b>Subject Index. . . . .</b>	<b>655</b>



**This is for the many and diverse students who are choosing  
to dedicate their lives to helping others. May your skills develop  
throughout your lifetime, and may they always be used  
for improving the lives of individuals, couples, and families.**



## PREFACE

Clinical interviewing is the cornerstone of virtually all mental health work. It involves integrating varying degrees of psychological or psychiatric assessment and treatment. The first edition of this text was published in 1993. We remain in awe of the continuing evolution and broad practical application of clinical interviews in mental health settings.

### Language Choices

We live in a postmodern world in which language is frequently used to construct and frame arguments. The words we choose cannot help but influence the message. Because language can be used to manipulate (as in advertising and politics), we want to explain some of our language choices so that you can have insight into our biases and perspectives.

### Patients or Clients or Visitor

Clinical interviewing is a cross-disciplinary phenomenon. While revising this text, we sought feedback from physicians, psychologists, social workers, and professional counselors. Not surprisingly, physicians and psychologists suggested that we stick with the term *patient*, whereas social workers and counselors expressed strong preferences for *client*. As a third option, in the Mandarin Chinese translation of this text, the term used was *visitor*.

After briefly grappling with this dilemma, we decided to primarily use the word *client* in this text, except for cases in which *patient* is used in previously quoted material. Just as Carl Rogers drifted in his terminology from *patient* to *client* to *person*, we find ourselves moving away from some parts and pieces of the medical model. This doesn't mean we don't respect the medical model, but that we're intentionally choosing to use more inclusive language that emphasizes wellness.

## Sex and Gender

Sensitivity to multiple gender perspectives has complicated how gender is referred to in conversation and in writing. Consistent with tradition and contemporary perspectives, when possible, we used plural language (i.e., *them, their, they*). When speaking in the singular (as in case examples), we use *him or her*, based on the identified gender of the person in the case. As appropriate, we occasionally use the plural *they* when describing individuals whom we know or suspect wouldn't ascribe to a binary gender designation.

## Interviewer, Psychotherapist, Counselor, Therapist, Clinician, or Practitioner

Sometimes it feels as though there are far too many choices in life. Because this text was written for aspiring mental health professionals across several disciplines, we've chosen not to rein in our choices. Consequently, we alternate in a random and whimsical way from *therapist* to *clinician* to *interviewer* to *counselor* to *psychotherapist*, and occasionally we throw in *practitioner*. Our hope is for everyone to feel included.

## What's New in the Sixth Edition?

The sixth edition has new content and new citations, and is consistent with cutting-edge clinical interviewing research and practice. It's also 15% leaner than its predecessor. This trimming was in response to reviewer feedback. The outcome is increased clarity and instructional efficiency.

## Cultural Content

Because culture and diversity are ubiquitous, we have integrated culture and diversity throughout the text. Instead of finding multicultural content primarily in one chapter, you'll find it everywhere. In addition:

- The multicultural competencies are reworked to integrate the latest research and policy.
- Cultural humility, a new cultural orientation concept, is featured.
- More case examples reflect cultural diversity, including LGBTQ-related issues.

## Essential Skills, Reorganization, and Advanced Skills

This text has always taken a unique approach to bridging foundational clinical/counseling skills with advanced interviewing and assessment. From

our perspective, advanced assessment interviewing should always rest on a foundation of basic skills, and students should explicitly learn how the two are integrated. To help meet this instructional goal, we have made two organizational changes in this edition.

1. The former Chapter 6, An Overview of the Interview Process, has been moved to Chapter 3. This gives students an earlier view of the big interviewing picture.
2. We have divided the former Chapter 4, Directives: Questions and Action Skills, into two chapters. The result: expanded skills coverage in Chapter 5, Directive Listening Skills, and Chapter 6, Skills for Directing Clients Toward Action. This change strengthens and deepens coverage of specific clinical skills that facilitate client insight and action.

## Definitions and Clarity

The definition of clinical interviewing has been reworked and moved to the very beginning of Chapter 1. There's also a new and informative discussion of the difference between clinical interviewing and counseling or psychotherapy.

## Case Examples to Facilitate Learning

There are more short case examples than ever. These concrete examples help students "see" and apply interviewing skills and concepts.

## Learning Objectives

Every chapter has reformulated and rewritten learning objectives to facilitate active learning.

## Ethics

Ethical issues are more prominent and integrated throughout the text. New and updated discussions on clinician values, person-first versus disability-first language, and clinician social behavior are featured.

## Neuroscience

As appropriate, neuroscience concepts are discussed to help readers make deeper links between what might be happening in the brain and clinical interviewer and client behaviors.

## Technology

Chapter 15 includes updated information on technology-based interviewing. There's also a new section in Chapter 2 on using technology for note taking.

## Clinician Stress Management and Self-Care

We have included more information and resources pertaining to the importance of clinician self-care.

## Suicide Assessment

Consistent with contemporary research and practice, the suicide assessment chapter de-emphasizes suicide risk factors as a means for suicide prediction. Instead, there's a stronger emphasis on clinician-client relational factors as foundational to suicide prevention. In particular, methods for talking with clients about suicide ideation, previous attempts, and other suicide-related issues are clearer than anything we've seen in the literature.

## Diagnosis and Treatment Planning

*ICD-10-CM* and *DSM-5* are fully integrated into the diagnosis and treatment planning material. In addition, the treatment planning section features new evidence-based information on how to match client factors with treatment strategies and techniques. This information will help clinicians develop evidence-based treatment plans.

## Couple and Family Interviewing

New content and case examples consistent with emotionally focused couple therapy and the Gottman approach are provided.

## All Chapters

Every chapter has been revised and edited using feedback from dozens of graduate students and professors from various mental health disciplines throughout the United States. In addition, every chapter also has new citations and is updated to be consistent with the latest trends in clinical interviewing research and practice.

## Access to the Enhanced eBook

This edition comes with access to additional features via the enhanced ebook version, which contains dynamic content to further enrich your understanding of the text. Follow the instructions inside the back cover of the book for access details. This interactive e-text features the following interactivities:

### Videos

Every chapter is supported with an extensive set of new videos introduced by us and featuring counselors and clients demonstrating the techniques described in the text. We've provided them to help you "see" and apply interviewing techniques in different environments.

### Practice questions

At the end of each chapter within the etext, you will have the option to test your understanding of key concepts by going through the set of practice questions supplied. Each of these are tied back to the Learning Objectives listed at the start of each chapter.

## Using the Online Instructor's Manual and Ancillary Materials

This text has an online instructor's manual and ancillary materials to help make teaching clinical interviewing more pleasant and efficient. Through your John Wiley & Sons sales representative or via the Wiley website, adopting this text gives you access to the following instructional support:

- An online instructor's manual, with supplementary lecture ideas, discussion questions, and classroom demonstrations and activities
- A test bank with more than 40 test items for each chapter
- A downloadable set of generic PowerPoint slides geared to the textbook chapters

## Acknowledgments

Even on our bad days, we're aware of our good fortune as authors, professors, and therapists. We not only get to hang out with each other and write books but also get to publish with John Wiley & Sons. That's pretty close to being born on third base.

This is where we're supposed to thank, acknowledge, and honor everyone who made this book possible. But because this is the sixth edition of *Clinical Interviewing*, by now we're indebted to nearly everyone we've ever known. So we begin with a general thanks to the many people who have lightened our burdens, provided input and guidance, and offered emotional support.

More specifically, we want to thank our Wiley editors, Tisha Rossi and Rachel Livsey. You've both been steady, responsive, and immensely helpful. Thanks also to Stacey Wriston, Mary Cassells, Melissa Mayer, and other members of the Wiley publishing team. We've never had a question unanswered or a request denied.

In addition to our remarkable Wiley team, the following list includes individuals who have contributed to this or other editions in one significant way or another. You all rock.

- Roberto Abreu, MS, EdS, University of Kentucky  
Amber Bach-Gorman, MS, North Dakota State University  
Carolyn A. Berger, PhD, Nova Southeastern University  
Rochelle Cade, PhD, Mississippi College  
Sarah E. Campbell, PhD, Messiah College  
Anthony Correro, MS, Marquette University  
Carlos M. Del Rio, PhD, Southern Illinois University Carbondale  
Christine Fiore, PhD, University of Montana  
Kerrie (Kardatzke) Fuenhausen, PhD, Lenoir-Rhyne University  
Kristopher M. Goodrich, PhD, University of New Mexico  
Jo Hittner, PhD, Winona State University  
Keely J. Hope, PhD, Eastern Washington University  
David Jobes, PhD, Catholic University of America  
Kimberly Johnson, EdD, DeVry University Online  
Charles Luke, PhD, Tennessee Tech University  
Melissa Mariani, PhD, Florida Atlantic University  
Doreen S. Marshall, PhD, Argosy University-Atlanta  
John R. Means, PhD, University of Montana  
Scott T. Meier, PhD, University at Buffalo  
Teah L. Moore, PhD, Fort Valley State University  
Shawn Patrick, EdD, California State University San Bernardino

Jennifer Pereira, PhD, Argosy University, Tampa  
Gregory Sandman, MSEd, University of Wyoming  
Kendra A. Surmitis, MA, College of William & Mary  
Jacqueline Swank, PhD, University of Florida  
Christopher S. Taylor, MA, Capella University  
John G. Watkins, PhD, University of Montana  
Wesley B. Webber, MA, University of Alabama  
Ariel Winston, PhD, Professional School Counselor  
Janet P. Wollersheim, PhD, University of Montana  
Carlos Zalaquett, PhD, University of South Florida

Obviously, that's quite a list. We hope all that help translates into this being quite the book!



## ABOUT THE AUTHORS



Photo courtesy of Todd Johnson, University of Montana.

**John Sommers-Flanagan, PhD**, is a clinical psychologist and professor of counselor education at the University of Montana. John is the author or coauthor of more than 60 professional publications and a longtime member of both the American Counseling Association (ACA) and the American Psychological Association (APA). He regularly presents

professional workshops at the national conferences of both organizations, as well as at regional, national, and international continuing education gatherings. Having recently published chapters on clinical interviewing in the *APA Handbook of Clinical Psychology*, *The Encyclopedia of Clinical Psychology*, and the *SAGE Encyclopedia of Abnormal and Clinical Psychology*, John is a leading authority on the topic of clinical interviewing.

**Rita Sommers-Flanagan, PhD**, is professor emeritus at the University of Montana. Her diverse interests include professional ethics, women's issues, and spirituality and its connections to science and human well-being. She is the author or coauthor of more than 40 articles and book chapters, and most recently contributed a chapter titled "Boundaries, Multiple Roles, and Professional Relationships" to the *APA Handbook on Ethics in Psychology*. She is also a published poet, essayist, and clinical psychologist, and has worked with youth, families, couples, and women for many years.

John and Rita live and work in Montana. In their spare time, they write, irrigate, create art, garden, and restore old buildings on the family ranch. They hope to eventually establish a Stillwater River retreat center for writers, therapists, and peacekeepers.



# **CLINICAL INTERVIEWING**



PART ONE

## FOUNDATIONS OF CLINICAL INTERVIEWING



# AN INTRODUCTION TO THE CLINICAL INTERVIEW

## Chapter Orientation

*Clinical interview* is a common phrase used to identify an initial and sometimes ongoing contact between a professional clinician and client. Depending on many factors, this contact includes varying proportions of psychological assessment and biopsychosocial intervention. For many different mental health–related disciplines, clinical interviewing is the headwaters from which all treatment flows. This chapter focuses on the definition of clinical interviewing, a model for learning how to conduct clinical interviews, and multicultural competencies necessary for mental health professionals.

### VIDEO 1.1

## Welcome to the Journey

We took for granted that honesty and kindness were basic responsibilities of a modern doctor. We were confident that in such a situation we would act compassionately.

—Atul Gawande, *Being Mortal*, 2014, p. 3

Imagine you’re sitting face-to-face with your first client. You’ve carefully chosen your clothing. You intentionally arranged the seating, set up the video camera, and completed the introductory paperwork. In the opening moments of your session, you’re doing your best to communicate warmth and helpfulness through your body posture and facial expressions. Now, imagine that your client

- Immediately offends you with language, gestures, or hateful beliefs

## LEARNING OBJECTIVES

After reading this chapter, you will be able to:

- Define clinical interviewing
- Identify differences (and similarities) between clinical interviewing and counseling or psychotherapy
- Describe a model for learning how to conduct clinical interviews
- Apply four essential multicultural competencies
- Describe multicultural humility and why stereotyping is natural, but inadvisable

- Refuses to talk
- Talks so much you can't get a word in
- Asks to leave early
- Starts crying
- Says you can never understand because of your racial or ethnic differences
- Suddenly gets angry (or scared) and storms out

These are all possible client behaviors in a first clinical interview. If one of these scenarios occurs, how will you respond? What will you say? What will you do?

Every client presents different challenges. Your goals are to establish rapport with each client, build a working alliance, gather information, instill hope, maintain a helpful yet nonjudgmental attitude, develop a case formulation, and, if appropriate, provide clear and helpful professional interventions. Then you must gracefully end the interview on time. And sometimes you'll need to do all this with clients who don't trust you or who don't want to work with you.

These are no small tasks—which is why it's so important for you to remember to be patient with yourself. Conducting clinical interviews well is an advanced skill. No one is immediately perfect at clinical interviewing or anything else.

Becoming a mental health professional requires persistence and an interest in developing your intellect, interpersonal maturity, a balanced emotional life, counseling/psychotherapy skills, compassion, authenticity, and courage. Due to the ever-evolving nature of this business, you'll need to be a lifelong learner to stay current and skilled in mental health work. But rest assured, this is an exciting and fulfilling professional path (Norcross & Karpiak, 2012; Rehfuss, Gambrell, & Meyer, 2012). As Norcross (2000) stated:

The vast majority of mental health professionals are satisfied with their career choices and would select their vocations again if they knew what they know now. Most of our colleagues feel enriched, nourished, and privileged. (p. 712)

The clinical interview is the most fundamental component of mental health training in professional counseling, psychiatry, psychology, and social work (Jones, 2010; J. Sommers-Flanagan, 2016). It is the basic unit of connection between the helper and the person seeking help. It is the

beginning of a therapeutic relationship and the cornerstone of psychological assessment. It is also the focus of this book.

This text will help you acquire foundational and advanced clinical interviewing skills. The chapters guide you through elementary listening skills onward to more advanced, complex professional activities, such as mental status examinations, suicide assessment, and diagnostic interviewing. We enthusiastically welcome you as new colleagues and fellow learners.

For many of you, this text accompanies your first taste of practical, hands-on mental health training experience. For those of you who already possess substantial clinical experience, this book may help place your previous experiences in a more systematic learning context. Whichever the case, we hope this text challenges you and helps you develop skills needed for conducting competent and professional clinical interviews.

## What Is a Clinical Interview?

VIDEO  
1.2

Clinical interviewing is a flexible procedure that mental health professionals from many different disciplines use to initiate treatment. In 1920, Jean Piaget first used the words “clinical” and “interview” together in a manner similar to contemporary practitioners. He believed that existing psychiatric interviewing procedures were inadequate for studying cognitive development in children, so he invented a “semi-clinical interview.”

Piaget’s approach was novel at the time. His semi-clinical interview combined tightly standardized interview questions with unstandardized or spontaneous questioning as a method for exploring the richness of children’s thinking processes (Elkind, 1964; J. Sommers-Flanagan, Zeleke, & Hood, 2015). Interestingly, the tension between these two different interviewing approaches (i.e., standardized vs. spontaneous) continues today. Psychiatrists and research psychologists primarily use structured clinical interviewing approaches. Structured clinical interviews are standardized and involve asking the same questions in the same order with every client. Structured interviews are designed to gather reliable and valid assessment data. Virtually all researchers agree that if your goal is to collect reliable and valid assessment data pertaining to a specific problem (or psychiatric diagnosis), a structured clinical interview is the best approach.

Structured clinical interview  
vs  
Unstructured Clinical interview

In contrast, clinical practitioners, especially those who embrace postmodern and social justice perspectives, generally use unstructured clinical interviews. Unstructured clinical interviews involve a subjective and spontaneous relational experience. This relational experience is used to

collaboratively initiate a counseling process. Murphy and Dillon (2011) articulated the latter (less structured) end of this spectrum:

We mean a conversation characterized by respect and mutuality, by immediacy and warm presence, and by emphasis on strengths and potential. Because clinical interviewing is essentially relational, it requires ongoing attention to *how* things are said and done, as well as to *what* is said and done. The emphasis on the relationship is at the heart of the “different kind of talking” that is the clinical interview. (p. 3)

Research-oriented psychologists and psychiatrists who use structured clinical interviews for diagnostic purposes would likely view Murphy and Dillon’s description of this “different kind of talking” as a bane to reliable assessment. In contrast, clinical practitioners often view highly structured diagnostic interviewing procedures as too sterile and impersonal. Perhaps what’s most interesting is that despite these substantial conceptual differences—differences that are sometimes punctuated with passion—both structured and unstructured approaches represent legitimate methods for conducting clinical interviews. A clinical interview can be structured, unstructured, or a thoughtful combination of both. (See Chapter 11 for a discussion of semi-structured clinical interviews.)

Formal definitions of the clinical interview emphasize its two primary functions or goals (J. Sommers-Flanagan, 2016; J. Sommers-Flanagan, Zeleke, & Hood, 2015):

1. Assessment
2. Helping (including referral)

To achieve these goals, all clinical interviews involve the development of a therapeutic relationship or working alliance. Optimally, this therapeutic relationship provides leverage for obtaining valid and reliable assessment data and/or providing effective biopsychosocial interventions.

With all this background in mind, we define *clinical interviewing* as . . .

### Clinical Interviewing:

a complex and multidimensional interpersonal process that occurs between a professional service provider and client. The primary goals are (a) assessment and (b) helping. To achieve these goals, individual clinicians may emphasize structured diagnostic questioning, spontaneous and collaborative talking and listening, or both. Clinicians use information obtained in an initial clinical interview to develop a case formulation and treatment plan.

Given this definition, students often ask: “What’s the difference between a clinical interview and counseling or psychotherapy?” This is an excellent question that deserves a nuanced response.

## Clinical Interviewing versus Counseling and Psychotherapy

VIDEO  
1.3

During a clinical interview, clinicians simultaneously initiate a therapeutic relationship, gather assessment information, and, in most cases, begin therapy. It is the entry point for mental health treatment, case management, or any form of counseling. Depending on setting, clinician discipline, theoretical orientation, and other factors, the clinical interview may also be known as the (a) intake interview, (b) initial interview, (c) psychiatric interview, (d) diagnostic interview, or (e) first contact or meeting (J. Sommers-Flanagan, 2016).

Although it includes therapeutic dimensions, the initial clinical interview is usually considered an assessment procedure. However, beginning with Constance Fischer’s work on individualized psychological assessment in the 1980s and continuing with Stephen Finn’s articulation and development of therapeutic assessment in the 1990s, it’s also clear that, when done well, clinical assessment is or can be simultaneously therapeutic. (See Suggested Readings and Resources for works by Fischer and Finn.)

Some theoretical orientations ignore or de-emphasize formal assessment to such an extent that the initial clinical interview is transformed into a therapeutic intervention. In other cases, the clinical setting or client problem requires that single therapy sessions constitute an entire course of counseling or psychotherapy. For example,

In a crisis situation, a mental health professional might conduct a clinical interview designed to quickly establish . . . an alliance, gather assessment data, formulate and discuss an initial treatment plan, and implement an intervention or make a referral. (J. Sommers-Flanagan, Zeleke, & Hood, 2015, p. 2)

From this perspective, not only is the clinical interview always the starting point for counseling, psychotherapy, and case management, but, due to a variety of factors and choices, it also may be the end point.

There may be other situations where an ordinary therapy session must transform into a clinical assessment. The most common example of this involves suicide assessment interviewing (see Chapter 10). If clients begin talking about suicide, the standard practice for mental health and health care professionals is to shift the focus from whatever was happening to a state-of-the-art suicide assessment interview.

Thus, even though a clear demarcation might be preferable, everything that happens in a full course of counseling or psychotherapy may also occur within the context of a single clinical interview—and vice versa. The entire range of attitudes, techniques, and strategies you read about in this text are the same as what's necessary for conducting more advanced and theoretically specific counseling or psychotherapy. In addition, some practitioners refer to every therapy session as a clinical interview.

Several key dimensions of clinical interviews are described next:

1. The nature of a professional relationship
2. Client motivations for therapy
3. Collaborative goal-setting

## The Nature of an Ethical Professional Relationship

All professional relationships involve an explicit agreement for one party to provide services to another party. In counseling or psychotherapy, this explicit agreement is referred to as *informed consent* (Pease-Carter & Min-tton, 2012). Using an explicit informed consent process ensures that clients understand and have freely consented to treatment (Welfel, 2016). Informed consent is discussed later in this chapter.

Professional relationships typically include compensation for services (Kielbasa, Pomerantz, Krohn, & Sullivan, 2004). This is true whether the therapist receives payment directly (as in private practice) or indirectly (as when payment is provided by a mental health center, Medicaid, or other third party). In some situations, clinical services are provided on a sliding fee scale or at no charge. Professional and ethical practitioners provide consistent, high-quality services, even in situations in which clients are paying reduced fees or no fee at all.

Professional relationships involve power differentials; the professional is an authority figure with specialized expertise. Clients are in need of this expertise. The power differential can be heightened when professionals are from the dominant culture and clients are from less dominant cultures or social groups. Because clients often view themselves as coming to see an expert who will help them with a problem, they might be vulnerable to accepting unhelpful guidance, feedback, or advice. Ethical professionals are sensitive to power dynamics both inside and outside the therapy office (Patrick & Connolly, 2009).

Professional relationships imply some degree of emotional distance and objectivity. In fact, if you look up the word *professional*, you'll find the word "expert" as a possible synonym. Also, the word *clinical* is associated with

words like “scientific” and “detached.” But mental health professionals are generally not detached experts. Instead, the therapeutic relationship established also includes mutuality, respect, and warmth. This may cause you to wonder if it’s possible for a clinician to establish a professional relationship based on expertise and objectivity that also includes mutuality and warmth. The answer is yes; it’s possible, but not necessarily easy. Effective mental health professionals are experts at being respectful, warm, and collaborative with clients, while retaining the necessary professional distance and objectivity. Maintaining this balance is challenging and gratifying (see Putting It in Practice 1.1).

### **PUTTING IT IN PRACTICE 1.1: DEFINING APPROPRIATE RELATIONSHIP BOUNDARIES**

Although we don’t often think about them, boundaries define most relationships. Being familiar with role-related expectations, responsibilities, and limits is an important part of being a good therapist. Consider the following potential deviations from usual professional relationship boundaries. Evaluate and discuss the seriousness of each one with your classmates. Is it a minor, somewhat serious, or very serious deviation from a professional boundary?

- Having a coffee with your client at a coffee shop after the interview
- Asking your client for a ride to pick up your car
- Going to a concert with a client
- Asking your client (a math teacher) to help your child with homework
- Borrowing money from a client
- Sharing a bit of gossip with a client about someone you both know
- Talking with one client about another client
- Fantasizing about having sex with your client
- Giving your client a little spending money because you know your client faces a long weekend with no food
- Inviting your client to your church, mosque, or synagogue
- Acting on a financial tip your client gave you
- Dating your client
- Writing a letter of recommendation for your client’s job application
- Having your client write you a letter of recommendation for a job

## Why Clients Choose Therapy

Why do people seek mental health assessment and assistance? Usually, for one of the following reasons:

- The client is experiencing subjective distress, discontent, or a problem that's limiting in some way. (Note: Client distress might be in response to a relationship problem.)
- Someone, perhaps a spouse, relative, or probation officer, insisted on counseling. Usually this means the client has irritated others or broken the law.
- Personal growth and development.

When clients seek therapy because of subjective distress, they often feel demoralized because they haven't been able to fix their own problem or cope with their relationships (Frank, 1961; Frank & Frank, 1991). At the same time, the pain or cost of their problems may stimulate motivation for change. This motivation can translate into cooperation and hope.

In contrast, sometimes clients end up in therapy with little motivation. They may have been cajoled or coerced into scheduling an appointment. In such cases, the client's primary motivation may be to terminate therapy or be pronounced "well." Obviously, if clients are unmotivated, it will be challenging to establish and maintain a therapeutic relationship.

Clients seeking personal growth and development are usually highly motivated. Working with these clients can seem far easier than working with less motivated clients.

Solution-focused therapists use a similar three-category system to describe client motivation (Murphy, 2015). Their system consists of the following:

1. Visitors to treatment: Clients who attend therapy only when coerced. They have no interest in change.
2. Complainants: Clients who attend therapy at someone else's urging. They have a mild interest in change.
3. Customers for change: Clients who are especially interested in change—either to alleviate symptoms or for personal growth.

Many researchers and clinicians have written about subtle ways therapists can nurture client motivation (Berg & Shafer, 2004; W. R. Miller & Rollnick, 2013). In Chapter 3 and again in Chapter 12, we discuss client motivation, readiness for change, and the stages of change in counseling and psychotherapy (Prochaska & DiClemente, 2005). Understanding these concepts is essential to clinical interviewing.

## Collaborative Goal-Setting

**Collaborative goal-setting** is a common clinical practice that should occur within the course of an initial clinical interview (Tryon & Winograd, 2011). The positive outcomes associated with collaborative goal-setting likely involve interactive discussions with clients, not only about specific problems and worries but also about personal hopes, dreams, and goals (Mackrill, 2010). Depending on the therapist's theoretical orientation, this process may rely more or less on formal assessment and diagnosis.

From a cognitive-behavioral perspective, collaborative goal-setting is initiated when therapists work with clients to establish a problem list. Making a problem list helps illuminate client problems, provides an opportunity for empathic listening, and begins transforming problems into goals. J. Beck (2011) provided an example of how a cognitive-behavioral therapist might initially talk with clients about goal-setting:

Therapist: (*Writes "Goals" at the top of a sheet of paper.*) Goals are really just the flip side of problems. We'll set more specific goals next session, but very broadly, should we say: Reduce depression? Reduce anxiety? Do better at school? Get back to socializing? (p. 54)

J. Beck (2011) also noted that making a problem list with clients helps clients begin framing their goals in ways that include greater personal control.

Collaborative goal-setting is a process that contributes to positive treatment outcomes regardless of theoretical perspective. Mackrill (2010) described collaborative sensitivities required from an existential perspective:

The therapist needs to be sensitive to the isolation and perhaps vulnerability of the client who expresses goals for the first time. The therapist needs to be sensitive to the fact that considering the future may be new to the client. The therapist needs to be sensitive to the fact that focusing on goals and tasks may confront the client with his or her sense of self-worth or his or her sense of influence on the world. The therapist needs to be willing to talk about such challenges with the client, in the knowledge that this may be central to the therapy. (p. 104)

When client and therapist agree on client problem(s), establishing therapy goals is relatively easy. However, sometimes clients and therapists don't agree on goals. These disagreements may stem from a variety of sources, including (a) poor client motivation or insight; (b) questionable therapist motives or insight; and (c) social-cultural differences.

Throughout the process, both therapists and clients have expertise they contribute to their interactions.

### ***Therapist as Expert***

Therapists are culturally accepted experts in mental health and have the responsibility to evaluate clients professionally before proceeding with treatment. A minimal first-session evaluation includes an assessment of the client's presenting problems and problem-related situations or triggers, an analysis of client expectations or therapy goals, and a review of previous problem-solving efforts. In most cases, if an initial assessment reveals that a therapist is unable to help a client, a referral to a different therapist or agency may be provided. However, ethical referrals are typically offered when therapists are lacking skills or competence and not when therapists and clients have culture or values differences (Herlihy, Hermann, & Greden, 2014).

Several factors can lead clinicians to become more authoritative and less collaborative. Sometimes, after years of training and experience, clinicians become overconfident that their approach to counseling is the right approach. Other times, clinicians feel pressured to fix clients' problems quickly, and offer premature interventions based on inadequate assessment. In such cases, a number of negative outcomes might occur (Castonguay, Boswell, Constantino, Goldfried, & Hill, 2010):

1. Therapists may choose an inappropriate approach that's potentially damaging (e.g., client anxiety is increased rather than decreased).
2. Clients may feel misunderstood and rushed and could conclude that their problem is too severe or that the therapist isn't competent.
3. Clients may follow the therapist's narrow-minded or premature guidance and become disappointed and frustrated with therapy.
4. Therapists may recommend a remedy that the client had already tried without success. This can diminish therapist credibility.

Wise and effective therapists collaborate with clients. Collaboration involves establishing rapport, listening carefully, evaluating client problems and strengths, identifying reasonable goals, and soliciting client input before implementing specific change strategies.

### ***Client as Expert***

It's important to acknowledge and affirm that **clients are their own best experts on themselves and their experiences**. This is so obvious that it seems odd to mention, but, unfortunately, therapists can get wrapped up in their expertness and usurp the client's personal authority. Although

idiosyncratic and sometimes factually inaccurate, clients' stories and explanations about themselves and their lives are internally valid and therefore should be respected.

### CASE EXAMPLE 1.1: GOOD INTENTIONS

Recently, I (John) became preoccupied about convincing a client—who had been diagnosed years ago with bipolar disorder—that she wasn't really “bipolar” anymore. Despite my good intentions (it seemed to me that the young woman would be better off without a bipolar label), there was something important for her about holding on to a bipolar identity. As a “psychological expert,” I thought it obscured her many strengths with a label that diminished her personhood. Therefore, I tried valiantly to convince her to change her belief system. I told her that she didn’t meet the diagnostic criteria for bipolar disorder, but I was unsuccessful in convincing her to give up the label.

What’s clear about this case is that, although I was the diagnostic authority in the room, I couldn’t change the client’s viewpoint. She wanted to keep calling herself bipolar, and maybe that was a good thing for her. Maybe that label somehow offered her solace? Perhaps she felt comfort in a label that helped her explain her behavior to herself. Perhaps she never will let go of the bipolar label. Perhaps I’m the one who needed to accept that as a helpful outcome.

In recent years, practitioners from many theoretical perspectives have become more outspoken about the need for expert therapists to take a backseat to their clients’ lived experiences. Several different approaches emphasize respect for the clients’ perspective and deep collaboration. These include progress monitoring, client-informed outcomes, and therapeutic assessment (Finn, Fischer, & Handler, 2012; Meier, 2015).

When your expert opinion conflicts with your client’s perspective, it’s good practice to defer to your client, at least initially. Over time, you’ll need your client’s expertise in the room as much as your own. If clients are unwilling to collaborate and share their expertise, you’ll lose some of your potency as a helper.

## A Learning Model for Clinical Interviewing

**VIDEO  
1.4**

Clinical interviewing competence is based on specific attitudes and skills. We recommend that you learn, in the following order:

1. How to quiet yourself and listen well (instead of focusing on what *you* are thinking or feeling)

2. How to adopt a helpful and nonjudgmental attitude toward all clients
3. How to use specific clinical interviewing behaviors to help you establish rapport and develop working relationships with clients of different ages, abilities and disabilities, racial/cultural backgrounds, sexualities, social classes, and intellectual functioning
4. How to efficiently and collaboratively obtain valid, reliable, and culturally appropriate diagnostic or assessment information about clients and their problems, goals, and sense of wellness
5. How to individualize and apply counseling or psychotherapy interventions with cultural sensitivity
6. How to evaluate client responses to your counseling or psychotherapy methods and techniques (e.g., outcomes assessment)

This text primarily focuses on the first four skills listed. Although we intermittently touch on items 5 and 6, the implementation and evaluation of counseling or psychotherapy isn't the main focus of this text.

### **Quieting Yourself and Listening Well**

To be an effective clinician, you need to **quiet yourself and listen** to someone else. This is difficult. Giving advice or establishing a diagnosis is hard to resist, but it can usually wait. Instead, the focus needs to be on listening to clients and on turning down the volume of your own internal chatter and biases. Some students and clinicians find it helpful to arrive early enough to sit for a few minutes, clearing the mind, focusing on breathing, and being in the moment.

#### **PUTTING IT IN PRACTICE 1.2: LISTENING WITHOUT GIVING ADVICE**

Have you ever had trouble sitting quietly and listening to someone else without giving advice or sharing your own excellent opinion? We know many experienced mental health professionals (including ourselves) who also find it hard to sit and listen without directing, guiding, or advising. For many people, giving advice is second nature—even advice based solely on their own narrow life experiences. The problem is that the client sitting in front of you probably has had a very different slice of life experiences, so advice, especially if offered prematurely and without a foundation of empathic listening, usually won't go all that well. Remember how you felt when your parents (or other authority figures) gave you advice? Sometimes, it might have been welcome and helpful. Other times, you may have felt discounted or resistant. Advice giving is all about accuracy, timing, and delivery. The acceptability of advice giving as a therapeutic technique is also related to theoretical orientation and treatment goals. Focusing too much on advice giving is rarely, if ever, a wise strategy early in therapy.

If you can quiet yourself and listen, your clients will be empowered to find their voices and tell their stories. In most clinical interviewing situations, the best start involves allowing clients to explore their own thoughts, feelings, and behaviors. When possible, you should help clients follow their own leads and make their own discoveries (Meier & Davis, 2011). It's your responsibility, at least in the beginning, to *encourage* client self-expression. On the other hand, given time constraints commonly imposed on counseling and psychotherapy, you're also responsible for *limiting* client self-expression. Whether you're encouraging or limiting client self-expression, the big challenge is to do so skillfully and professionally. It's also important to note that listening without directing and facilitating client self-expression are not the same as behaving passively (C. Luke, personal communication, August 5, 2012). Listening well is an active process that requires specific attitudes and skills (see Chapters 3 and 4 and Putting It in Practice 1.2).

The following guideline may be useful for you: No matter how backward it seems, begin by resisting the urge to actively help or direct your client. Instead, listen as deeply, fully, and attentively as you can. Doing so will aid your client more than if you offer premature help (W. R. Miller & Rollnick, 2013; Rogers, 1961).

#### CASE EXAMPLE 1.2: I NEED SOMEONE TO LISTEN TO ME

Jerry Fest, a therapist in Portland, Oregon, was working at a drop-in counseling center for street youth (Boyer, 1988). One night, a young woman came in. She was agitated and in distress. Jerry knew her from other visits and greeted her by name. She said, "Hey, man, do I ever need someone to listen to me." He showed her to an office and listened to her incredibly compelling tale of difficulties for several minutes. He then made what he thought was an understanding, supportive statement. The young woman immediately stopped talking. When she began again a few moments later, she stated again that she needed someone to listen to her. The same sequence of events played out again. After her second stop and start, however, Jerry decided to take her literally, and he sat silently for the next 90 minutes. The woman poured out her heart, finally winding down and regaining control. As she prepared to leave, she looked at Jerry and said, "That's what I like about you, Jer. Even when you don't get it right the first time, you eventually catch on."

This young woman articulated her need to *be listened to, without interruption*. We offer this example not because we believe that sitting silently with clients is an adequate listening response. Instead, the case illustrates the complexity of listening, how clients who are sensitive or in crisis may need to have someone explicitly follow their directions, and how the nonverbal presence of a professional in the room can be powerfully meaningful.

## Adopting a Helpful and Nonjudgmental Attitude Toward All Clients

Having and holding a nonjudgmental attitude—toward all clients—is impossible. This is because clients will engage in behaviors and hold values in stark contrast to your behaviors and values. Some clients will report enjoying heavy use of alcohol and drugs. Others will tell you about sexual practices far outside your personal comfort zone. Still others will embrace and articulate personal belief systems (e.g., Satanism) that you may find abhorrent. Yet the expectation remains the same: Maintain a helpful and nonjudgmental attitude toward all clients.

In his classic 1957 article titled “The Necessary and Sufficient Conditions of Therapeutic Personality Change,” Carl Rogers identified sample statements characteristic of unconditional positive regard. These statements included the following:

- I feel no revulsion at anything the client says.
- I feel neither approval nor disapproval of the client and his statements—simply acceptance.
- I feel warmly toward the client—toward his weaknesses and problems as well as his potentialities.
- I am not inclined to pass judgment on what the client tells me.
- I like the client. (p. 98)

Even the best mental health professionals are intermittently judgmental. What’s important is to manage judgmental thoughts and feelings so that they don’t “pop out” as behaviors that contribute to negative outcomes. We address this essential attitudinal component of clinical interviewing throughout this book, but especially in Chapters 3 and 6.

## Developing Rapport and Positive Therapy Relationships

Establishing a positive working alliance with clients is the foundation on which all mental health interventions rest. This involves active listening, empathic responding, feeling validation, and other behavioral skills as well as cultural sensitivity and interpersonal attitudes leading to the development and maintenance of positive rapport (Rogers, 1957; Shea & Barney, 2015). Counselors and psychotherapists from virtually every theoretical perspective agree on the importance of developing a positive relationship with clients before using interventions (Norcross & Lambert, 2011). Some theorists refer to this as *rapport*—others use the terms “working alliance” or “therapeutic relationship” or “counseling relationship” (Bordin, 1979, 1994;

Wright-McDougal & Toriello, 2013). In Chapters 3 through 6 we cover the attitudes and skills needed to develop positive therapy relationships.

## Learning Diagnostic and Assessment Skills

All mental health professionals need training in assessment and diagnosis. This is true despite the fact that psychological assessment and psychiatric diagnosis are controversial (Hansen, 2013; Szasz, 1970).

The primary purpose of assessment and diagnosis is to aid in treatment planning necessary to help clients move from a problem state toward positive solutions or growth. However, the process of assessment + diagnosis + treatment plan = goal attainment isn't linear or unidimensional. If an authoritative clinician reaches diagnostic and treatment planning conclusions in isolation, then goal attainment is unlikely. It has become increasingly clear that effective assessment, diagnosis, and treatment planning work best when implemented in a collaborative and respectful manner (Meier, 2015; Norcross, 2011).

Even if only one session with a client is likely, clinicians should begin using specific interventions only after the following four conditions have been met:

1. They have quieted themselves and engaged in empathic listening.
2. They have adopted a helpful and nonjudgmental attitude.
3. They have developed a positive therapeutic relationship or working alliance.
4. They have used a collaborative, respectful, and culturally sensitive assessment and diagnostic process to identify their clients' individual needs and therapy goals.

### VIDEO 1.5

## Multicultural Competencies

The world is in the midst of a multicultural revolution that touches everyone and offers possibilities for a richer, more interesting, and sustainable future. (Hays, 2013, p. 2)

Much of the history of counseling, psychotherapy, and clinical interviewing has involved White heterosexual people of Western European descent providing services for other White heterosexual people of Western European descent. We're saying this in a way to be purposely blunt and provocative. Although there are Eastern and Southern influences in the practice and provision of mental health services, the foundation of this process is distinctively Western, heterosexual, and White.

This foundation has often served its purpose quite well. Over the years, many clients have been greatly helped by mental health providers. But, beginning in the 1960s and continuing to the present, there has been increasing recognition that counseling and psychotherapy theories were sometimes (but not always) racist, sexist, and homophobic in their application (J. Sommers-Flanagan & Sommers-Flanagan, 2012). We refer readers elsewhere for extensive information on the ways our profession has not always been sensitive, inclusive, and empowering of various minority groups (Brown, 2010; Shelton & Delgado-Romero, 2013; D. W. Sue & Sue, 2016).

Having a multicultural orientation is now a central principle and ethical requirement for all mental health practice. There are many reasons for this, including the fact that the United States continues to grow more diverse. In addition, several decades ago, it was reported that most minority clients dropped out of psychotherapy after only a single clinical interview (S. Sue, 1977). At the very least, these facts imply a poor fit between clinical interviewing as traditionally practiced and the needs or interests of minority clients.

Increased diversity in the United States constitutes an exciting and daunting possibility for mental health professionals: exciting for the richness that a diverse population extends to our communities and for the professional and personal growth that accompanies cross-cultural interaction; daunting because of increased responsibilities linked to learning and implementing culturally relevant approaches (Hays, 2013). The good news is that multicultural training for mental health professionals significantly improves service delivery and treatment outcomes for diverse clients (Griner & Smith, 2006; T. Smith, Rodriguez, & Bernal, 2011).

Multicultural competence should be front and center as an essential component in learning to conduct clinical interviews. You'll hear this message repeatedly in this text. We repeat this multicultural message because it's a message that's surprisingly easy to forget. Similarly, achieving multicultural incompetence is far easier than achieving multicultural competence. We hope you'll join us on this more difficult road.

## Four Principles of Multicultural Competence

Culture is ubiquitous. All humans are born to families or individuals embedded within a larger community and cultural context (Matsumoto, 2007). The membership, values, beliefs, location, and patterns of behavior within this community are generally referred to as *culture*. In this way, culture can be understood as the medium in which all human development

takes place. From a mental health perspective, answers to such questions as “What constitutes a healthy personality?” or “What should a person strive for in life?” or “Is this person deviant?” are largely influenced by the clinician’s and client’s cultural backgrounds (Christopher, Wendt, Marecek, & Goodman, 2014).

Over the past 20 years, many professional disciplines have established multicultural principles to guide teaching, research, and practice. Specifically, all three primary nonmedical mental health disciplines (professional counseling, psychology, and social work) have articulated at least four common multicultural practice competencies:

1. Clinician cultural self-awareness
2. Multicultural knowledge
3. Culture-specific expertise
4. Culture-sensitive advocacy

We briefly define these dimensions now and return to them throughout this text.

### ***Cultural Self-Awareness***

Those who have power appear to have no culture, whereas those without power are seen as cultural beings, or “ethnic.” (Fontes, 2008, p. 25)

Culture and self-awareness interface in several ways. Individuals from dominant cultures tend to be unaware of and often resistant to becoming aware of their invisible and unearned culturally based advantages. These “unearned assets” are often referred to as *White privilege* (McIntosh, 1998).

Developing self-awareness can be difficult, especially when it pertains to culture. One way of expressing this is to note, “We’re unaware of that which we’re unaware.” When someone tries to help us see and understand something about ourselves that has been outside our awareness, it’s easy to be defensive and resistant. Despite the challenges inherent in this process, we encourage you to be as eager for change and growth as possible, and offer three recommendations:

1. Be open to exploring your own cultural identity. It can be interesting to gain greater awareness of your ethnic roots.
2. If you’re a member of the dominant culture, be open to exploring your privilege (e.g., White privilege, wealth privilege, health privilege) as well as the sometimes hidden ways that you might judge or have bias toward minority populations (e.g., transgender, disabled).

3. If you're a minority group member, be open to discovering ways to have empathy not only for members within your group but also for other minorities and for the struggles that dominant cultural group members might have as they navigate the denial and guilt sometimes associated with increasing cultural awareness.

Multicultural theorists and experts believe that increasing cultural self-awareness is a precondition for moving from an ethnocentric, culturally encapsulated perspective to a truly multicultural orientation. Understanding other perspectives will help you avoid imposing your own cultural values on clients (Christopher et al., 2014). Multicultural Highlight 1.1 includes an activity to stimulate cultural self-awareness.

### **MULTICULTURAL HIGHLIGHT 1.1: EXPLORING YOUR CULTURAL BEING**

The first multicultural competency focuses on self-awareness. D. W. Sue, Arredondo, and McDavis (1992) expressed it this way:

Culturally skilled . . . [therapists] have moved from being culturally unaware to being aware and sensitive to their own cultural heritage and to valuing and respecting differences.  
(p. 482)

**For this activity, you should work with a partner.**

1. Describe yourself as a cultural being to your partner. What's your ethnic heritage? How did you come to know your heritage? How is your heritage manifested in your life today? What parts of your heritage are you especially proud or not so proud of? Why?
2. What do you think constitutes a "mentally healthy" individual? Can you think of exceptions to your understanding of this?
3. Have you ever experienced racism or discrimination? (If not, was there ever a time when you were harassed or prevented from doing something because of some unique characteristic that you possess?) Describe this experience to your partner. What were your thoughts and feelings related to this experience?
4. Can you identify a time when your thoughts about people who are different from you affected how you treated them? What beliefs about different cultural ethnicities do you hold now that you would consider stereotyping or insensitive? (C. Berger, personal communication, August 10, 2012).
5. How would you describe the "American culture"? What parts of this culture do you embrace? What parts do you reject? How does your internalization of American culture affect your definition of a "mentally healthy individual"?

At the conclusion of this activity, reflect on and possibly make a few journal entries about any new awareness you have about your cultural identity.

### ***Multicultural Knowledge***

Cultural self-awareness is a good start, but not enough. Cultural competence includes **actively educating yourself** regarding diverse cultural values, behaviors, and ways of being. It's not appropriate to be passive in this professional domain. It is also not acceptable to rely on clients to educate you about specific minority issues.

To help with your accumulation of multicultural knowledge, we've included multicultural highlight boxes and coverage of specific diversity-related issues throughout this text. We've also included outside resources focusing on multicultural knowledge in the Suggested Readings and Resources section at the end of every chapter.

Reading to acquire diverse cultural knowledge is a useful but limited approach. To become multiculturally sensitive and competent, you'll also need experiential learning. We recall an interaction that occurred at a recent grief conference that illustrated this limitation. During the conference, there was a question-and-answer period with a panel of local Native Americans. At one point, a White participant posed this question: "As a White person, how can I better understand and relate to Native American people?" One of the Native American panelists quickly quipped, "Get some Indian friends!" Laughter ensued, some of which probably stemmed from discomfort. But her message was delivered—along with what she referred to as Indian humor. As the discussion progressed, she continued to advocate for experiential cultural learning:

If you want to understand us, you'll need to spend time with us. You can read about pow-wows and Indian fry bread, but if you really want to experience Indian culture, you'll need to attend a pow-wow, actually eat the fry bread, and reach out to make Native American friends.

The more diverse interviewing, supervision, and life experiences you obtain, the more likely you'll be able to develop the broad knowledge base needed to understand clients from their own worldview and experience (D. W. Sue & Sue, 2016).

### ***Culture-Specific Expertise***

***Culture-specific expertise*** speaks to the need for clinicians to learn skills for working effectively with different minority populations. For example, learning the attitudes and skills associated with affirmative therapy is important for clinicians working with LGBTQ clients (Heck, Flentje, & Cochran, 2013). Similarly, integrating spiritual constructs into your work with African American, Latina(o), Native American, and traditionally religious clients is often essential (R. Johnson, 2013).

Stanley Sue (1998, 2006) described two general skills for working with diverse cultures: (a) **scientific mindedness** and (b) **dynamic sizing**.

*Scientific mindedness* involves forming and testing hypotheses about client culture, rather than coming to premature conclusions. Although many human experiences are universal, it's risky to assume you know the underlying meaning of your clients' behavior, especially minority clients. As Case Example 1.3 illustrates, culturally sensitive clinicians avoid stereotypical generalizations.

### CASE EXAMPLE 1.3: HAND SHAKING NOT ALLOWED

A young woman from Pakistan was studying physics at the graduate level in the United States. She attended a departmental party and, by her description, "had a frightening interaction with a male graduate student." She was upset and decided to go to the campus student health service for supportive counseling. A male counselor met her in the waiting room, introduced himself, and offered to shake hands. The Pakistani student shrank away. The counselor noted this, thinking to himself that she either was shy or had issues with men. As the student shared her story about the rude male student at the social gathering, the counselor considered the possibility that his hypothesis about her having "men issues" was correct, but he didn't come to that conclusion. Instead, he remained open to both possibilities and eventually concluded that her behaviors had more to do with her religion than issues with men.

*Scientific mindedness requires therapists to search for alternative cultural explanations before drawing conclusions about specific client behaviors.* Without using scientific mindedness and exploring less commonly known and understood explanations, the counselor wouldn't realize that for a Muslim woman, it's not proper to touch a male—even to shake hands. Her shrinking away had everything to do with her religion and nothing to do with the incident she came to talk about.

This case illustrates the importance of scientific mindedness as a clinical interviewing principle and practice. If he had not practiced scientific mindedness, the counselor in this case might have inaccurately concluded that his Pakistani client had "men issues." She was in fact behaving in a manner consistent with her religious beliefs.

*Dynamic sizing* is a complex multicultural concept that guides clinicians on when they should and should not make generalizations based on an individual client's belonging to a specific cultural group. For example, filial piety is a value associated with certain Asian families and cultures (Chang & O'Hara, 2013). *Filial piety* involves the honoring and caring for

one's parents and ancestors. However, it would be naïve to assume that all Asian people believe in or have their lives affected by this particular value; making such an assumption can inaccurately influence your expectations of client behavior. At the same time, you would be remiss if you were uninformed about the power of filial piety in some families and the possibility that it might play a large role in relationship and career decisions in many Asians' lives. When clinicians use dynamic sizing appropriately, they remain open to significant cultural influences, but they minimize the pitfalls of stereotyping clients.

Another facet of dynamic sizing involves therapists' knowing when to generalize their own experiences to their clients. S. Sue (2006) explained that it's possible for a minority group member who has experienced discrimination and prejudice to use this experience to more fully understand the struggles of those who have encountered similar experiences. However, having had experiences similar to a client may cause you to project your own thoughts and feelings onto that client—instead of facilitating an empathic response. Dynamic sizing requires that you know and understand and *not* know and *not* understand at the same time. We will return to dynamic sizing intermittently in this text.

### **Culture-Sensitive Advocacy**

There's general consensus that the dominant US culture consistently disadvantages, marginalizes, and sometimes oppresses minority group members. These discrimination experiences come in different shapes and sizes. For example, the Black Lives Matter movement in the United States is a response to repeated large-scale racial profiling and discrimination. While some individuals may argue about the intentionality underlying disproportionate shootings of African American youth, the existence of this discriminatory phenomenon is a shared reality.

Racial or minority discrimination also comes in smaller packages. One term for these smaller forms of discrimination is microaggression. *Micro-aggressions* are defined as

the brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial, gender, sexual orientation, and religious slights and insults to the target person or group. (D. W. Sue, 2010, p. 5)

Microaggressions are “brief and commonplace” and occur in everyday settings. It's not unusual to see them happening on the street, in the grocery

store, at the movies (on and off screen), and anywhere else where individuals with diverse backgrounds interact. Here's an example:

Three Latino males pull their car into a grocery store parking lot. As they get out of their vehicle, a 40-something White male makes eye contact, pulls out his car key, and pushes a button, automatically locking his car. For the White male, seeing the youth reminded him that he should lock his car. For the Latino males, this brief and commonplace behavior is viewed as a derogatory assumption that they're likely to break into unlocked cars.

Given that many minority clients probably experience intermittent macro- and microaggressions, clinicians need to be prepared to help clients deal with these discrimination experiences. Culturally sensitive advocacy has become a core multicultural competency (see Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2015). *Advocacy is a process through which clinicians become aware of social or cultural barriers that clients face, and work with clients to constructively address these barriers.*

Discrimination is disempowering. When minority clients experience discrimination, they may experience anger or sadness; they also may be at a loss for how to respond constructively. These experiences may involve government or institutional policies, employment situations, or interactions in schools and neighborhoods. For example, transgender individuals report a high frequency of being threatened in public restrooms. At minimum, clinicians need to display empathy for clients' discrimination experiences. Depending on clinicians' theoretical orientation, professional discipline, and other factors, it may be appropriate for them to take on an advocacy role within the context of a clinical interview.

#### CASE EXAMPLE 1.4: A CHRISTIAN COUNSELOR ADVOCATES FOR A BISEXUAL MALE

An openly Christian, conservative colleague (we'll call him Paul) who works at an inpatient youth training facility asked us to consult on a case of a young male who was exploring his bisexuality. The young male was also exploring his desire to be a "furry." Furry is a label that describes people who derive sexual satisfaction through role playing with other people—all of whom simultaneously play various animal roles. We imagined that Paul might be uncomfortable working with this young man. But instead, Paul was curious, open, and deeply invested in being an effective counselor and advocate for his client. There was no proselytizing and not a shred of evidence that Paul was judging the young man in any negative way. This example illustrates

that, using core attitudes of acceptance and empowerment, professionals with very conservative value systems can work with clients. We encourage you to stretch yourselves in ways that allow you to work effectively with a broad range of clients, as Paul did.

## Multicultural Humility

VIDEO  
1.6

To this point, consistent with the literature on multicultural counseling and psychology, we've been using the term "multicultural competence." However, **we have reservations about this because it implies that clinicians can reach a culturally competent end point**. In fact, it seems that as soon as clinicians grow too confident in their abilities to relate to and work with diverse peoples, they often lose their cultural sensitivities. We agree with Vargas (2004), who expressed similar concerns:

The focus on cultural competence also worries me. I very much try to be culturally responsive to my clients. But can I say that I am "culturally competent"? Absolutely not! I am still, despite my many and genuine efforts, "a toro (bull) in a China shop" with all the cultural implications of this altered adage intended. (p. 20)

For these and other reasons, we prefer the terms *multicultural sensitivity* and *multicultural humility* and refer to multicultural competencies with reservations (Stolle, Hutz, & Sommers-Flanagan, 2005).

Over the past decade, researchers and writers have begun making distinctions between cultural competence and cultural humility. Cultural humility is viewed as an overarching multicultural orientation or perspective that mental health providers may or may not hold. It springs from the idea that individuals from dominant cultures—or any culture—often have a natural tendency to view their cultural perspective as right and good and sometimes as superior. This tendency implies that attaining multicultural competence isn't enough for clinicians to be effective with culturally diverse clients. Clinicians need to be able to let go of their own cultural perspective and value the different perspective of their clients (Hook, Davis, Owen, Worthington, & Utsey, 2013).

Three interpersonal dimensions of multicultural humility have been identified:

1. An other-orientation instead of a self-orientation
2. Respect for others and their values and ways of being
3. An attitude that includes a lack of superiority

Cultural humility is closely aligned with multicultural competence, but is not the same thing. It's generally presented as a supplement to multicultural competence. It has its own research base and appears to independently contribute to clinician effectiveness. In a recent research study, when clients viewed therapists as having higher levels of cultural humility, they also endorsed higher ratings of the working alliance and perceived themselves as having better outcomes (Hook et al., 2013).

### **Why Stereotyping Is Natural, but Inadvisable**

Human brains are designed to organize and make sense of the apparent chaos and disorganization in the world. One process through which this happens is categorization, which involves abstraction and generalization. Examples of abstract generalizing abound. There are categories for fruits, vegetables, furniture, geographical settings, animals and breeds of animals, musical genres, trees, clouds, and, of course, people.

Humans naturally organize other humans into ethnic or cultural groups. This process can provide useful information. No doubt, evolutionary psychologists would claim that this "hard-wired" tendency exists due to its survival value. Generally, individuals perceived as similar to ourselves are judged as safer, and those who appear different may be categorized as dangerous.

Here's a simple stereotyping example: Many people think of Italians and Italian Americans as expressive and emotional. Knowing this general information can explain your experiences when attending a big family dinner with your Italian roommate. Interestingly, depending on your personal history and current attitudes, even if you have a stereotypical Germanic stoic demeanor, you may find yourself drawn to Italian culture. Alternatively, you may feel an aversion toward the full-on traditional Italian experience and avoid it whenever possible.

However and unfortunately, generalizing your knowledge of your Italian roommate and her family across all Italians is the foundation of stereotyping. This is where S. Sue's (1998) dynamic sizing comes into play. You may conclude that everyone with an Italian heritage is emotionally volatile. This might be based exclusively on your single experience from that one night with your Italian roommate's family. Or, as is often the case, you might take that single experience and add it to your preexisting ideas about Italian Americans, and end up with a firm and general stereotype. This involves moving from a concrete, situationally specific description (i.e., my friend's family behaved in ways that were gregarious and emotionally expressive on the night of my visit) to an abstract and general description (i.e., all Italians are gregarious and emotionally expressive). This generalization can easily

be fused with positive or negative attributions (i.e., I love the expressiveness of Italians vs. I hate the emotionally volatile nature of Italians). Finally, although these descriptions and assumptions may operate in ways that seem mostly harmless, when, as a professional, you sit down to meet with an Italian American immigrant and she turns out to be quiet, shy, and emotionally stoic, your broad stereotyping assumptions can quickly break down. Even worse, you may feel compelled to make her fit your Italian American stereotype—even if she doesn't. Alternatively, if your assumptions are correct, you may marginalize or oppress your client with your beliefs when, as she works herself into an emotional explosion, you think to yourself, “She's just showing her Italian side.”

To extend this example, imagine if we had used one of the following minority groups to illustrate stereotyping and dynamic sizing. As you read this list, linger on the different cultural groups and focus your awareness on your personal thoughts, feelings, and potential stereotyping in response to each group:

- Inner-city Black youth
- Inner-city White police officers
- Females whom you might describe as “Southern Belles”
- Rural Wyoming ranchers and farmers
- Gay males
- Ex-gay males
- Lesbian women
- Transgender females (male to female)
- Conservative Christians
- Liberal, contemplative Christians
- Muslims
- Mormons
- Atheists
- Jews
- Buddhists
- All First Nation peoples (aka Native Americans)
- Navajo Indian Americans
- All Latina(o) people
- Puerto Ricans
- Dominicans

- Cubans
- White South Africans
- Black South Africans
- All Asian people
- Chinese
- Japanese
- Hmong (Laotian)

Stereotyping may occur because of natural tendencies to categorize and generalize, and it may be more or less universal; nevertheless, allowing stereotypes to inform your interpersonal relationships or clinical work is inadvisable. Your goal is less about eliminating all stereotyping tendencies and more about continuing to work on self-awareness so that you can apply the multicultural skill of dynamic sizing in constructive and helpful ways with clients.

## **Summary**

The clinical interview is the most fundamental component of mental health training in professional counseling, psychiatry, psychology, and social work. It has its roots in a procedure that Piaget termed the semi-clinical interview. Piaget was interested in combining standardized and spontaneous questions as a means of assessing children's cognitive abilities. The tension between standardized and spontaneous approaches to clinical interviewing remains alive today.

Clinical interviewing is a complex and multidimensional process. It comprises two primary functions: (a) assessment and (b) helping. All clinical interviews involve a professional relationship between client and service provider. Clinicians use information obtained in an initial clinical interview to develop case formulations and treatment plans.

Clinical interviews are usually classified as assessment procedures. However, the complete range of skills and procedures used during longer-term counseling or psychotherapy may occur during a single clinical interview, and some professionals refer to any single psychotherapy session as a clinical interview. Also, at any point in the midst of psychotherapy or counseling, clinicians may shift into a more focused assessment procedure, such as a suicide assessment.

Clients are motivated to seek professional help for a variety of reasons. Whatever the reasons and level of motivation, clinicians should recognize and respect that **their clients are the best experts on themselves**. One way

this is accomplished is by using a collaborative goal-setting process with clients during a clinical interview.

This book is organized to emphasize a learning model that comprises the following steps: (a) quieting yourself and listening well, (b) adopting a helpful and nonjudgmental attitude toward all clients, (c) developing rapport and positive therapy relationships, and (d) learning diagnostic and assessment skills.

Developing cultural competence is a central foundational principle for contemporary mental health practice and clinical interviewing. Four principles of multicultural competence are self-awareness, multicultural knowledge, culture-specific expertise, and culture-sensitive advocacy. Although not considered one of the multicultural competencies, multicultural humility is an attitude that is independently related to positive therapy outcomes.

## Suggested Readings and Resources

The following resources provide a useful foundation for professional skill development and multicultural sensitivity.

Cormier, L. S., Nurius, P. S., & Osborn, C. J. (2017). *Interviewing and change strategies for helpers: Fundamental skills and cognitive-behavioral interventions* (8th ed.). Boston, MA: Cengage. This excellent text is similar to *Clinical Interviewing*, but has a stronger cognitive-behavioral perspective.

Fadiman, A. (1997). *The spirit catches you and you fall down: A Hmong child, her American doctors, and the collision of two cultures*. New York, NY: Farrar, Straus & Giroux. This book explores clashing cultures within the context of medical treatment. It contrasts the differences between a Hmong family's cultural beliefs about illness as compared to the contemporary medical paradigm.

Finn, S. E., Fischer, C. T., & Handler, L. (2012). *Collaborative/therapeutic assessment: A casebook and guide*. Hoboken, NJ: Wiley. This book applies the principles and practices of collaborative or therapeutic assessment to specific cases. Even if you don't read this whole book, you should go online and read Fischer's description of how she developed her interest in individualized and collaborative assessment.

Fischer, C. (1994). *Individualizing psychological assessment: A collaborative and therapeutic approach*. Hillsdale, NJ: Erlbaum. Originally published in 1985, this work by Constance Fischer paved the way for greater sensitivity and collaboration in psychological assessment.

Hays, P. A. (2013). *Connecting across cultures: The helper's toolkit*. Thousand Oaks, CA: Sage. In this practical text, Pamela Hays offers many concrete examples of how clinicians can develop a strong therapy alliance with diverse clients.

Lee, C. (Ed.). (2013). *Multicultural issues in counseling* (4th ed.). Alexandria, VA: American Counseling Association. This edited volume has chapters on

counseling specific minority populations, including American Indians, people of the African diaspora, Latina(o)s, Arab Americans, and many more.

Kottler, J. A. (2010). *On being a therapist* (4th ed.). Hoboken, NJ: Wiley. This book includes chapters on the therapist's journey, hardships, being imperfect, lies we tell ourselves, and many other topics. It offers one perspective on the road to becoming and being a therapist.

Ratts, M. J., Singh, A. A., Nassar-McMillan, S., Butler, S. K., & McCullough, J. R. (2015). *Multicultural and social justice counseling competencies*. Alexandria, VA: American Counseling Association. Also endorsed by the ACA, this web-based document is the Association for Multicultural Counseling and Development's latest version of multicultural competencies. It can be accessed at <http://www.counseling.org/knowledge-center/competencies>.

Sue, S. (2006). Cultural competency: From philosophy to research and practice. *Journal of Community Psychology*, 34(2), 237–245. Stanley Sue's concepts of scientific mindedness and dynamic sizing are featured in this article.

Yalom, I. (2002). *The gift of therapy*. New York, NY: HarperCollins. Renowned therapist Irvin Yalom describes his top 85 clinical insights about conducting psychotherapy. Each insight is a very short chapter of its own.

## PREPARATION

### Chapter Orientation

Preparation and planning are crucial to life in general . . . and clinical interviewing in particular. This chapter will help you think about all the things you might not ordinarily think about before you actually start meeting with clients. Even though new clinicians rarely feel completely ready, reading this chapter will help you feel more ready than you would otherwise.

#### VIDEO 2.1

### The Physical Setting

Perhaps the most important thing that has come out of my life is the discovery that if you prepare yourself at every point as well as you can, with whatever means you have . . . you will be able to grasp the opportunity for broader experience when it appears. Without preparation, you will not be able to do it.

—Eleanor Roosevelt, *The Autobiography of Eleanor Roosevelt*, 1937/1992, p. xix

Many environmental factors affect clinical interviewing process and outcome. This chapter will help you be conscious and intentional regarding your understanding and implementation of these factors.

### The Room

What type of room is most appropriate for clinical interviewing?

Your practice situation can dictate the room you use for interviewing. Some graduate programs may not have clinics with private offices. Professionals who work

#### LEARNING OBJECTIVES

After reading this chapter, you will be able to:

- Manage essential physical dimensions of the interview, such as seating arrangements, note taking, and video and audio recording
- Apply practical approaches for dealing with ethical issues, comprising how to present yourself to clients, time management, discussing confidentiality and informed consent, and documentation procedures
- Describe basic multicultural knowledge for working with First Nation peoples, Black or African Americans, Hispanic or Latina(o) Americans, Asian Americans, and clients from other minority groups
- List methods and strategies for personal stress management and self-care

in disaster or crisis situations conduct interviews in gyms or sitting on benches. Also, sometimes interviews happen in particular settings for clinical reasons. For example, behavior therapists take clients outside the office to anxiety-producing environments to implement exposure-based treatments (McKay & Ojserkis, 2015). Initial interviews and subsequent therapy sessions can take place outside—while jogging, walking, dancing, or sitting under a tree on a pleasant day. Despite these many exceptions, we recommend that you start with a room.

**Privacy is essential.** Professional décor is also important. People aren't inclined to reveal their deepest fears or secrets at the student union building over coffee—at least not to someone they've just met. Nor is it necessary to hide behind a massive desk with a background of framed professional degrees. When choosing a room, it's useful to strike a balance between professional formality and casual comfort. Consider the room an extension of your professional self. In an initial interview, your major purpose is to foster trust and hope, build rapport, and help clients talk openly. Your room choice reflects that purpose.

**Control is an important issue in setting up your counseling office.** The client may be given small choices such as chair selection. But overall, you should be in control of the surroundings.

One distinction between a clinical interview and other social encounters is that professional interviews should not be interrupted. An interruption costs time and disrupts session flow. It also can compromise confidentiality.

If you don't have access to rooms in which privacy is assured, place a DO NOT DISTURB OR SESSION IN PROGRESS sign on the door to reduce interruptions. Phone ringers, cell phones, and answering machines should be turned off. The last thing you want is your cell phone vibrating as your client begins a deeply personal disclosure.

Although you should take reasonable measures to ensure you're not interrupted, *do not* lock the door. If your impulse-ridden client gets angry, it's best to have a quick exit available. Similarly, you shouldn't sit between your client and the door. Both of you should be able to easily get up and leave.

Sometimes, despite your best efforts, interruptions occur. There are three main types of interruptions. First, there are inadvertent and brief interruptions. A new receptionist may knock on the door or enter without understanding the privacy issues. In such cases, gently inform the intruder that the meeting is private, and return to your interviewing business.

Second, there are legitimate interruptions that take time to manage. Perhaps your 10-year-old daughter's school telephones your office to tell

you that she's ill and needs to be picked up from school. Your receptionist informs you of this situation. Because you've planned for this, it might take a few minutes to contact a friend or family member to pick up your child. You can inform the client that a short break is necessary, apologize, and make the telephone call. On returning to the session, you can apologize again and offer restitution for the time missed from the session (e.g., "Can you stay an extra five minutes today?" or "Is it okay to make up the five minutes we lost at our next session?"). Then, as smoothly as possible, begin where you left off.

Third, an interruption may involve an emergency. In this case, you should apologize for having to end the session, reschedule, and provide the next session at no charge (or refund the client's payment for the interrupted session). An explanatory statement is important:

I'm sorry, but I need to leave because of an urgent situation. I hope you understand, but we'll need to reschedule. This is very unusual, and I'm terribly sorry for inconveniencing you.

Depending on theoretical orientation, personal preference, or office policy, you may or may not choose to disclose the specifics of the emergency.

To summarize, if an interruption occurs: (a) model calmness and problem-solving skills, (b) apologize for the interruption, and (c) compensate clients for lost time. Also, if you're taking notes when an interruption occurs, make certain the notes are secure before you leave.

## Seating Arrangements

There are many variations to professional seating arrangements. Some clinicians suggest face-to-face seating. Others (usually television therapists) like a desk between themselves and clients. Still others prefer sitting at a 90- to 120-degree angle so that client and therapist can look away from each other without discomfort. Some psychoanalytic psychotherapists still have clients lie on a couch (with the therapist seated behind and out of view).

Some training clinics have predetermined seating arrangements. Our former clinic had a single, soft reclining chair along with two or three austere wooden chairs. The soft recliner provided clients with a comfortable and relaxing place to stimulate free expression. The recliner was also excellent for hypnotic inductions and progressive muscle relaxation. Unfortunately, a designated seat for clients can produce discomfort. Clients at our training clinic nearly always avoided the cushioned recliners.

Several factors dictate seating arrangement choices, including theoretical orientation. You might try different arrangements to get a sense of

what's best for you. This doesn't mean that your instinctive choice is best, but discovering your preference may be enlightening. You should also remain sensitive to your clients' preferences.

Generally, we recommend that clinician and client sit at somewhere between a 90- and 150-degree angle to each other during initial interviews. Benjamin (1987) stated the rationale for this arrangement:

[I] prefer two equally comfortable chairs placed close to each other at a 90-degree angle with a small table nearby . . . The interviewee can face me when he [or she] wishes to do so, and at other times . . . can look straight ahead without my getting in [the] way. I am equally unhampered. The table close by fulfills its normal functions and, if not needed, disturbs no one. (p. 3)

The 90-degree-angle seating arrangement is broadly acceptable across many therapy settings. You may prefer a less extreme angle so that you can look at the client more directly but not quite face-to-face (perhaps a 120-degree angle).

Clients sometimes move chairs around and disrupt prearranged seating plans. It's usually wise to allow this, make a mental note of the behavior, and proceed with the interview.

An exception to this general rule can occur when a client (usually a child or adolescent) refuses to sit in an appropriate position, or even to sit down at all. Depending on your theoretical orientation or personal style, you may either let the client stand or sit wherever he or she chooses or gently suggest that the client choose between two or three acceptable seats (see Case Example 2.1).

#### **CASE EXAMPLE 2.1: I PREFER TO STAND, THANK YOU VERY MUCH**

I (Rita) was scheduled to meet with a 17-year-old girl living in a residential facility. We'd never met before. Consistent with her trauma history and strong personality, when she arrived for the appointment, she made it clear that she was opposed to the whole idea of having an interview with me. She stood in the doorway, announcing, "I'm not sitting!"

Instead of insisting on anything, I just thanked her for showing up and said, "Of course you don't have to sit if you don't want to." Then I gently explained the purpose of our meeting. She took a step into the room. Within five minutes, she had shut the door and taken her seat. Within 10 minutes, she was slumped in the chair, talking openly. Within 20 minutes, she was crying. At the end of the meeting, she got up and asked, "Can I give you a hug?"

## Office Clutter and Decor

One of us (John) sometimes dreams he's preparing for a therapy session, and just before it begins, he notices his office is a complete mess. There are piles of dirty laundry, books, DVDs, and papers strewn everywhere. At the last minute, he dashes around, stuffing papers and clothes under his desk in anticipation of his client's arrival. Unfortunately, the cleaning never gets finished, and when the client comes into the room, there's an embarrassing mess to explain.

Those of you inclined toward dream interpretation may assume John has excessive psychological baggage that leaks out during therapy sessions. Although this interpretation may be true, John also has the concrete problem of keeping his office neat and tidy (but he strongly denies keeping dirty laundry strewn about his office). The main point is to be intentional, disciplined, and tasteful in your office décor and clutter management.

**Your office represents your personality and values.** You can consciously arrange it more or less formally, more or less chic, and more or less self-revealing. It's important to strive for an office that a diverse range of individuals may find comforting. You should pay attention to the message that your office and waiting room send to clients. Intentionally providing reading materials that cater to various ethnic, racial, or sexual minority groups is good practice. For example, therapists working with Native American clients may want tasteful Native American art in their waiting room or office—although we should emphasize that multiculturally sensitive art is no substitute for adequate multicultural awareness, exposure, training, and supervision.

As a student, you may not have complete control over your office, but it's possible to make sure the office is neatly arranged. Some of our students bring along small décor items that they feel represent something important or that calms and centers them.

## Note Taking

**Note** taking is a topic of interest at many levels (Pipes & Davenport, 1999). Although some experts recommend that you write notes only after sessions are over, others point out that therapists don't have perfect memories and that an ongoing record of the session is desirable (Shea, 1998). Note taking may annoy some clients. In other cases, it can enhance rapport and credibility. Clients' reactions to note taking are usually a function of their interpersonal dynamics, previous experiences with note taking, and therapist tact. Providing an up-front explanation helps.

I frequently do not even pick up a clipboard until well into the interview. When I do begin to write, as a sign of respect, I often say to the patient, “**I’m going to jot down a few notes to make sure I’m remembering everything correctly. Is that alright with you?**” Patients seem to respond very nicely to this simple sign of courtesy. This statement of purpose also tends to decrease the paranoia that patients sometimes project onto note-taking, as they wonder if the clinician is madly analyzing their every thought and action. (Shea, 1998, p. 180)

Practicing interviews with and without taking notes is recommended.

### ***Technology and Note Taking***

Historically, note taking involved a clipboard, paper, and pen or pencil. However, times change; using technology is now a viable option for note taking.

In a recent study, researchers assigned intake interviewers to one of three note taking strategies: (a) pen and paper; (b) the Apple iPad (using a stylus); or (c) a laptop computer (Wiarda, McMinn, Peterson, & Gregor, 2014). Data were gathered to determine whether these different note taking strategies affected therapeutic alliance. The researchers reported that different note taking strategies had no effect on therapeutic alliance, but warned,

There are numerous ethical implications to technology use . . . with patient privacy and confidentiality being paramount . . . Technologies that psychotherapists use ought to enable them to comply with these acts without compromising ethical integrity. (Wiarda et al., 2014, p. 445)

As long as you take measures to maintain confidentiality, it appears that using technology is a matter of personal preference.

### ***Rules for Note Taking***

The following list summarizes general rules for note taking:

1. Don’t allow note taking to interfere with interview flow or rapport; always pay more attention to your client than you do to your notes.
2. Explain the purpose of note taking to clients. Usually a comment about not having a perfect memory suffices. Some clients are disappointed if you don’t take notes; if appropriate, explain why you’re not taking notes.

3. Never hide or cover your notes or act in any manner suggesting that your clients can't have full access.
4. Never write anything in your notes that you wouldn't want your client to read. Stick to the facts. If you write something you intend to keep to yourself, rest assured your client will want to read it. Some clients will be suspicious about what you've written and insist on reading your notes.
5. If clients ask to see what you've written, offer to let them read your notes and explore their concerns. When clients take you up on the offer, you'll be glad you followed rule 4.

## Video and Audio Recording

If you're recording a session, do so explicitly but unobtrusively. The more matter-of-fact you are in discussing the recording equipment, the more quickly clients become comfortable. This is easier said than done, because you may feel more nervous about being recorded than your client. Although you'll need a written consent-to-record form, you'll want to discuss this orally as well. You might say something like this:

The main reason I'm recording our session is so my supervisor can watch me working. It's to help make sure you get the best service possible and help me improve my counseling skills.

You must obtain your client's written and oral consent before turning on the equipment. Recording clients without their knowledge is an invasion of privacy and violates their trust. It's also important to explain possible future uses of recordings and how they'll be stored, handled, and eventually destroyed.

### CASE EXAMPLE 2.2: IS THAT CAMERA ON?

In an effort to obtain a recording of interactions from the very beginning of a session, an intern turned on the camera before the client entered the room. He hoped to preserve the important initial interactions and then obtain the client's permission. When the client discovered she was being recorded, she refused to continue the interview. Further, she delivered a punishing tirade about being recorded (and, of course, this tirade was conveniently recorded as well). The student had pinpointed an excellent method for destroying trust and rapport early in an interview: He failed to ask permission, in advance, to make a recording.

One final observation about recording sessions: Invariably, when you've conducted your best interview ever, you'll discover there was a technical glitch and your session didn't record properly. And, of course, when you've conducted a session you'd rather forget, the equipment will work perfectly and your supervisor will ask to watch that session first. Because of this particular manifestation of Murphy's Law, we recommend carefully testing the recording equipment before every session.

**VIDEO  
2.2**

## Professional and Ethical Issues

Practitioners from several different professional disciplines use clinical interviews to gather assessment information and initiate treatment. As with all professions, each of these disciplines (e.g., counseling, psychology, psychiatry, social work) has specific ethical codes. This section focuses on several professional and ethical issues related to clinical interviewing. Additional ethics-related information is integrated throughout this text. If you're in need of more specific ethics guidance, review your particular ethical code and confer with supervisors and colleagues.

### Self-Presentation and Social Behavior

**You are your own primary instrument for a successful interview.** Your self-presentation is an important part of professional clinical interviewing.

#### *Grooming and Attire*

Choosing professional clothing can be difficult. Some students ignore the issue; others obsess about selecting just the right outfit. The question of how to dress may reflect a larger developmental issue: How seriously do you take yourself as a professional? Is it time to take off the ripped jeans, remove the nose ring, cover the tattoo, or lose the spike heels? Is it time to don the dreaded three-piece suit or carefully pressed skirt? Don't worry. We're intentionally trying to push your fashion-freedom buttons. We're not really interested in telling you how you should dress or adorn your body. We are, instead, interested in convincing you to be conscious and deliberate in your professional attire. Even if you ignore your physical self-presentation, your clients—and supervisors—probably won't.

We knew a student whose distinctive style included closely cropped, multicolored hair; large earrings; and an odd assortment of scarves, vests, sweaters, runner's tights, and sandals. Imagine his effect on, say, a

middle-aged dairy farmer referred to the clinic for depression, or a mother-son dyad having trouble with discipline. Clothing, body art, and jewelry are not neutral; they're intended to communicate, and they do (Human & Biesanz, 2012). Potential negative effects of fashion statements can be overcome, but doing so may use up time and energy better devoted to other issues (see Putting It in Practice 2.1). As a therapist, you want to present yourself in a way that creates positive first impressions. This includes dress and grooming that foster rapport, trust, and credibility.

In one classic research study, Hubble and Gelso (1978) reported that clients experienced less anxiety and more positive feelings toward psychotherapists who were dressed slightly more formally than the client's usual attire. The take-home message from this research, along with common sense, is that it's better to err slightly on the neutral or conservative side, at least until you're certain that dressing more expressively won't have an adverse effect on your client population. As a professional colleague of ours tells her students, "A client should not walk away from your session thinking too much about what you wore" (S. Patrick, personal communication, June 27, 2015).

### ***Straight Talk About Cleavage and Crotches***

There aren't many professional or academic contexts where cleavage, crotches, and related matters are discussed openly. Our goal in this section is to break that norm and to encourage you to break it along with us. To start, we should confess that the whole idea of our bringing up this topic (in writing or in person) makes us feel terribly old and awkward. But we hope this choice might reflect the wisdom and perspective that comes with aging.

In recent years, we've noticed a greater tendency for female counseling and psychology students (especially younger females) to dress in ways that might be viewed as provocative. This includes low necklines that show considerable cleavage. We've also noted the tightening of men's trousers, more prominent tattoos, and trends in the display of body hair, or lack thereof. Male clothing choices can make clients uncomfortable, or be sexually provocative. Tight, stretchy pants or body positions that outline male genitalia create problems for clients, as can shirts or blouses unbuttoned too low, with chest hair or tattoos displayed.

Among other issues, cleavage and clothing were discussed in a series of postings on the Counselor Education and Supervision (CES) listserv in 2012. The CES discussion inspired many of the statements that follow.

Please read these bulleted statements and consider discussing them as an educational activity.

- Students have the right to express themselves via how they dress and should be able to dress any way they want.
- Commenting on how female students dress and/or making specific recommendations may be viewed as sexist.
- Agencies and institutions have rights to establish dress codes regarding how their paid employees and volunteers dress.
- Despite egalitarian and feminist efforts to free women from the shackles of a patriarchal society, how women dress is still interpreted as having socially constructed messages that often, but not always, pertain to sex and sexuality.
- Although efforts to change socially constructed ideas about women dressing “sexy” can include activities like campus “slut-walks,” a counseling or psychotherapy session is probably not the venue for initiating a discourse on social and feminist change.
- For better or worse, most middle school males and middle-aged men (and many “populations” in between) are likely to be distracted—and their ability to profit from a counseling experience may be compromised—if they have a close-up view of their therapist’s breasts. Similarly, middle school girls and women of all ages may find the outline of a man’s penis produced by his tight pants or body posture distracting as well.
- **It may be useful to watch a role-play counseling video of yourself, with the camera trained directly on you. Try to imagine the impression(s) your clothing, jewelry, and other physical choices might create in different types of clients.**

We don’t have perfect answers to the question of cleavage, tight slacks, or other potentially arousing clothing choices other than noting these interact with your professional development and your care for your clients. Guidelines depend, in part, on interview setting and specific client populations. At the very least, we recommend that you think about this dimension of professional attire and openly discuss these issues with fellow students, colleagues, and supervisors.

These issues are obviously laden with cultural stereotypes, norms, and expectations. In an effort to extend our coverage (no pun intended) of this topic, we went online and asked professionals and colleagues to give us feedback about this section. A summary of this feedback is included in Putting It in Practice 2.1.

### PUTTING IT IN PRACTICE 2.1: FEEDBACK ON CLEAVAGE AND CROTCHES

#### *A warning to male therapists:*

Male therapists need to watch their flirtatious behavior. They might consult with a female therapist friend to check out anything that might be questionable. I know, most males don't have cleavage issues, but they sometimes make provocative comments, such as, "You know, you should take that lovely sexuality of yours and use it to your advantage." I'm not making this up. Also, they might want to rein in, "You are so pretty. I'll bet this gets the guys going." I'm not making this up either. (J. Hocker, personal communication, June 27, 2015)

#### *Extending the conversation to male therapists:*

Curiously, I find that the conversation regarding appearance needs to take place with men. For example, male students who want to wear flip-flops, large jewelry, or "muscle" shirts. We also talk about whether or not to wear things that reveal tattoos, hair styles, and so on—so I think men are now as much a part of the conversation as women. (S. Patrick, personal communication, June 27, 2015)

#### *A message from a licensed school counselor:*

I know professionals in counseling and teaching who exhibit poor hygiene, dress, and might toss some cleavage out from time to time. Students do notice, and it's not cool. In my profession I want students to see me as casual, clean, and someone they're drawn to for a good ear and safe space. I don't want them to see cleavage ever. It's a distraction. Cleavage is sexy and draws attention no matter what. I'm not drawn to women sexually but I'm super distracted by cleav! I can't imagine how a person attracted to females would react! I find that when I'm not at work there are dates and social functions available that allow me to find my sexy self, but that self doesn't fit into the school counseling profession. Yes, women should be able to wear what they want, but the reality is if you sport cleav you'll receive notice by everyone and there's a time and place to celebrate our cleav; work may not be the place. (M. Robbins, personal communication, June 30, 2015)

#### *Sexual distraction is an equal opportunity:*

One thing that seems to go on in common discourse is an acceptance of the idea that men are more sexually focused than women. This is problematic on a couple fronts. Although research shows some increased arousal for men from visual stimuli compared to visual stimuli for women, BOTH men and women have been shown to be aroused by visual stimuli. BOTH women and men want sex for physical pleasure, not just as a relational tool. The difference is in degree to which these things are acknowledged by each sex, perhaps, but I haven't seen compelling evidence that there's actually a difference in the degree to which men and women can be sexually distracted by physical bodies. (C. Yoshimura, personal communication, June 28, 2015)

### ***Monitoring Social Behavior***

Beyond conscious or unconscious clothing choices that may be sexually suggestive, there are an array of other social behaviors that must also be considered. Standards for mental health professionals are high in the realm of social interaction. If you think about the setting and process, the high standards make sense. Clients often share deep emotional disclosures during clinical interviews. Both the act of revealing and the act of listening compassionately might arouse feelings related to sexual intimacy. In many social settings, behaviors move from friendly to slightly flirtatious without much conscious thought. As a mental health professional, you need to be fully conscious of this potential and censor any behaviors that might be interpreted as flirtatious. All ethical codes that pertain to professional counselors, psychologists, and social workers prohibit sexual contact between therapist and client. **The bottom line is that it's your responsibility, as a mental health professional or student therapist, to closely monitor your attire and behavior to make certain you're not directly or indirectly flirting with clients.**

### ***Is It Okay to Touch Clients?***

You may sometimes want to touch a client. This is natural. You may feel that impulse for several reasons. Perhaps the client is crying and you want to offer your hand or a hug, or perhaps you believe your touch will be a source of healing. You might be someone who tends to pat people on the back, hug, or otherwise offer supportive contact. But in therapeutic relationships, touch, like many other social impulses, must be examined and considered carefully.

Gazda, Asbury, Balzer, Childers, and Walters (1984) recommended that when counselors feel a desire to touch, they should ask themselves: **"Who is it for? Am I doing this for me, the other person, or to impress those who observe?"** (p. 111). This recommendation implies a guideline: *Before offering congruent touch, clinicians should explore motives underlying their behaviors.*

Touch shouldn't feel invasive or overbearing. You must make sure your touch won't be misinterpreted—which is difficult because clients with sexual abuse histories might interpret your touch in ways different from what you intended. If you have any doubts about how it will be interpreted, you shouldn't touch clients.

Welfel (2016) wrote, "Sexual attraction to clients is an almost universal phenomenon among therapists; however, most, of course, do not act on that attraction and work to handle their reactions in a responsible manner"

(p. 199). One reason that touch needs to be carefully scrutinized is that your client may experience your touch as intimate, romantic, or overtly sexual—regardless of your intent. Also, when therapists touch clients, it can move the relationship in a sexual direction, and sexual relations between therapist and client are always unacceptable, unethical, and often illegal. We agree with Pope's (1990) terminology for sexual relations between therapists and clients. He referred to it as *sexual abuse of clients*.

Consider this scenario: You're working with a client; you feel sexual attraction, so you say: "I feel sexually attracted to you." How do you suppose that disclosure might be interpreted? To speak of sexual attraction is nearly always laden with flirtation. And, since you're in a role with power, you're in a position to exploit clients. Bottom line: When you experience sexual attraction to a client, *don't* tell the client; instead, seek supervision and guidance (Murray & Sommers-Flanagan, 2014).

### **Presenting Your Credentials**

You may find it difficult to introduce yourself in a balanced way. Referring to yourself as "just a student" can bring forth spoken or imagined derogatory comments such as "So, I'm your guinea pig?" Our advice is to state your full name in a warm, clear voice and offer an accurate description of your training status. For example: "My name is Aalia Farran, and I'm in the graduate training program in clinical psychology," or "I'm working on my master's degree in mental health counseling," or "I'm enrolled in an advanced interviewing course." Pause after this description to provide clients a chance to ask questions, and then answer them directly. Always represent your status clearly and honestly, whether you're working with role-play volunteers or actual clients. It's an ethical violation to overstate your credentials. No matter how inexperienced or inadequate you feel, don't try to compensate through fraudulent misrepresentation.

Practicing your introductory statement is essential. Before reading further, formulate how you want to introduce yourself to new clients. You may want to write out your introduction or say it into a recorder. Practicing introductions helps you avoid sounding like this: "Well, I'm just a student and um, I'm taking this interviewing course, and I have to um, practice, so . . . uh, here we are."

There's nothing wrong with being a student and no need to apologize for your inexperience. An apologetic attitude can erode your credibility. If you feel guilt over "practicing" counseling skills with real clients, try a cognitive intervention on yourself: Remember, people usually enjoy a chance to talk about themselves. It's rare for people to receive 100% of someone else's

undivided attention. By listening well, you provide clients with a positive experience.

Student therapists are usually supervised. This information should be included when you present your credentials. To be clear about this, you might say:

Dr. Gutierrez supervises my work at this clinic. This means I'll be reviewing what we talk about with her to ensure you're receiving the best possible services. Dr. Gutierrez is a licensed professional. She'll keep what you say confidential just like I will.

When presenting your credentials, be forthright, honest, clear, and responsive to client questions or concerns.

## Time

One hallmark of professional service provision is that if your client is paying a fee, the fee is based on your time. Clinical interviewing is a rich, involved, and complex process; time is the most straightforward measure of what you're offering.

Clinical interviews typically last 50 minutes. This time period, though arbitrary, is convenient; it allows therapists to meet with clients on an hourly basis, with a few minutes at the end and beginning of each session to write notes and read files. Some situations warrant briefer contacts (e.g., school counseling). Other situations (e.g., initial intake or assessment interviews) are sometimes longer than 50 minutes because it's difficult to obtain the information needed to conceptualize a case and establish treatment goals in that short time period. Crisis situations also require flexibility.

### *Start the Session on Time*

Starting your interview on time is a top priority. If you're late, an apology and offer for compensation is appropriate. You could say: "I apologize for being late; I had an urgent phone call between sessions. Because I missed 10 minutes of our session, maybe we can extend this session or our next session an additional 10 minutes." If you're collecting fees, another option is to prorate the fee for whatever portion of the usual hour remains.

You should avoid beginning sessions early, even if you're available. Pipes and Davenport (1999) stated this succinctly: "Clients will show up early and may ask if you're free. The answer is no, unless there is a crisis" (p. 18).

**Punctuality communicates respect.** Clients appreciate professionals who begin sessions at the scheduled time. Often, our students have

discussed differences between psychotherapists and physicians (excluding psychiatrists) when it comes to punctuality. Many physicians are notoriously late for patient appointments; this lateness delivers a message about physician-patient relationships. In contrast, therapists explicitly show respect for clients' time.

When clients are late, you might feel like extending the session or punishing the client by canceling the session entirely. Neither option is desirable. Clients are responsible for being late, and should experience the natural consequence, which is an abbreviated session. This is true regardless of the reason for client lateness. The client may regret the lateness and ask for additional time. Be empathic but firm. Say something like:

I'm sorry this session has to be brief, but it's important for us to stick with our scheduled appointment time. I hope we can have a full session next week.

One option when clients arrive late is to offer an additional appointment later in the week. You might suggest, "If you want to make up the time we've lost today, we can schedule another appointment for later this week." Keep in mind, however, that when clients schedule an additional session (to make up for missed time), they sometimes complicate the problem by "no-showing" for their make-up appointment as well.

It's not unusual to feel anger or irritation toward clients who are late or who fail to keep appointments. As with many emotional reactions, it's good to notice and reflect on them, but not act on them. Even though you desperately want to leave the office after waiting 10 minutes for your chronically late client, you should resist that impulse. Instead, clarify your policy on lateness (e.g., "If you're late, I'll wait around for 20 minutes and then I may leave the office"). This information can be included in your informed consent. If clients completely miss appointments, you must decide whether to call to reschedule, send a letter asking if they want to continue therapy, or wait for clients to call for a new appointment. Some clinics or clinicians use email, texting, or another form of technology to communicate with clients. Be sure to discuss within your clinical setting whether you can use these communication modalities and still maintain confidentiality.

In some cases, your agency may have a policy of charging clients for a full hour if they don't cancel appointments 24 hours in advance. If so, clients should be informed of this policy up front. Similarly, inform volunteer clients of consequences associated with missing their scheduled appointments (e.g., loss of extra credit). You may not bill an insurance company for a missed hour; doing so is insurance fraud.

### ***End on Time***

Professional clinical interviews end on time. There are many excellent excuses for letting sessions run over, but these excuses rarely justify breaking prearranged time agreements. Some reasons we've heard from our students (and ourselves) include:

1. We were on the verge of a breakthrough.
2. She brought up a clinically important issue with only five minutes to go.
3. He just kept talking, and I felt uncomfortable cutting in.
4. I hadn't been very effective and felt the client deserved more time.
5. I forgot my watch and couldn't see the clock from my chair.

In most of the preceding situations, the therapist could have calmly and tactfully said something like:

I see our time is up for the day, but if you think it would be useful, we can continue with this topic at the beginning of our next session.

Be sure to sit in a position where you can see a clock. It's rude and distracting to glance at your watch or to look over your shoulder at the clock during an interview.

Very few situations warrant extending the clinical hour. These situations are usually emergencies. When clients are suicidal, homicidal, or psychotic, time boundaries may be modified. A colleague of ours once had a client hold him at gunpoint for about 40 minutes beyond the end of the session. This is certainly a situation in which time boundaries are irrelevant (although we know our colleague wished he could have simply said, "Well, it looks like our time is up for today" and had the client put the gun away and leave).

### ***Time and Culture***

As you read about how clinicians handle time boundaries, you may find yourself happy to be in a profession that's conscious and respectful of time boundaries. Or you may be struck by what feels like rigidity over starting and stopping on time. These different reactions are natural and may be related, in part, to culture (Trimble, 2010). For example, Native Americans tend to have more flexible attitudes toward time. Other cultural groups may want to engage in open-ended dialogue for as long as it takes to identify a solution to their problem. Diverse cultural attitudes toward time require clinicians to embrace Western time boundaries while remaining open to other cultural perspectives (Fontes, 2008). You may need to (a) include

in your informed consent your policy on lateness; (b) be ready to discuss time issues as needed; and (c) integrate reasonable flexibility around time boundaries into your work with clients from different ethnic backgrounds.

## Confidentiality

During a clinical interview, clients will entrust you with private and personal information. The general assumption is that whatever is shared in the therapy office stays in the therapy office.

*Confidentiality* refers both to an ethical duty to keep client identity and disclosures secret and a legal duty to honor the fiduciary relationship with the client. It is primarily a moral obligation rooted in the ethics code, the ethical principles, and the virtues that the profession attempts to foster. (Welfel, 2016, p. 117)

### **Limits to Confidentiality**

There are several limits to confidentiality (see Putting It in Practice 2.2). For example, a client might say:

I'm depressed and sick of life. I've decided to quit dragging my family through this miserable time with me . . . so I'm going to kill myself. I have a gun at home and plan to do it this weekend.

In this case, you're obligated to break confidentiality and report your client's suicidal plans to the proper authorities (e.g., police, county mental health professionals, or psychiatric hospital admission personnel) and possibly family members. However, laws and ethics change over time. Staying current with your local ethical and legal obligations is essential.

### **PUTTING IT IN PRACTICE 2.2: CONFIDENTIALITY AND ITS LIMITS**

The following guidelines may help you understand ethics and laws pertaining to confidentiality:

1. You cannot share personal client information without the client's permission. If someone telephones your office and asks if you're working with Jennifer Lawrence, you should say something like, "I'm sorry, my policy restricts me from saying whether someone by that name receives services here or not." If the person persists, you may politely add: "If you want to know if someone is being seen here, you need a signed release form so I can legally

*(Continued)*

provide you with information. Without a signed release, I can't even tell you if I've ever heard of anyone named Jennifer Lawrence." Further, upholding confidentiality requires keeping client records in a secure place (both physically and electronically).

2. In most states, you can break confidentiality in the following situations:
  - a. You have the client's (or his or her legal representative's) permission.
  - b. Your client is a danger to self.
  - c. The client is planning to engage in a behavior that's a serious and foreseeable danger to others.
  - d. The client is a child and you have evidence that leads you to suspect that there's sexual or physical abuse or neglect.
  - e. You have evidence suggesting that your client is abusing a minor.
  - f. You have evidence suggesting that elder abuse is occurring (either from working with an elderly client or because your client discloses information indicating a likelihood of abuse of an elderly person).
  - g. You have been ordered by the court to provide client information.
3. An explanation of these confidentiality limits should be provided in writing and orally at the beginning of every initial session.

*Note:* If you're interviewing a client who tells you about having engaged in an illegal activity involving an 18- to 64-year-old (i.e., a nonchild and nonelder) in the past—even if that illegal activity involved murder—in most circumstances, you're neither required nor allowed to disclose that information. Be sure to talk with a supervisor, and perhaps an attorney, to ascertain state and federal laws before taking any action.

### ***Introducing Confidentiality to Clients***

Ethical clinicians inform clients of the legal limits of confidentiality at the outset of the interview, both orally and in writing. It's important for clients to clearly understand this basic ground rule of the professional helping relationship.

Imagine a scenario where a client who wasn't initially informed of confidentiality limits begins talking about suicide. At that point, the clinician may suddenly feel compelled (and rightly so) to inform the client that he or she will be breaking confidentiality. However, informing clients *after* they begin talking about suicide that this information won't be held in confidence may feel like a betrayal to clients. This can cause serious damage to

the therapeutic relationship and erode the client's trust in mental health professionals in general. Of course, when clients understand confidentiality limits, they may be selective in their disclosures. This is a natural side effect of the legal and ethical limits of confidentiality.

Some clients may indicate that they already know the limits of confidentiality. Nevertheless, it is an ethical mandate that you define and discuss confidentiality with every new client. Sometimes, you'll need to remind ongoing clients about the nature of your confidential relationship. (Detailed samples of what you can say to introduce confidentiality to new clients is in Chapter 3.)

**Table 2.1** Confidentiality-Related Ethical Codes

From the American Psychological Association (APA, 2010a)
<b>Standard 4: Privacy and Confidentiality</b>
4.02 Discussing the Limits of Confidentiality
(a) Psychologists discuss with persons (including, to the extent feasible, persons who are legally incapable of giving informed consent and their legal representatives) and organizations with whom they establish a scientific or professional relationship (1) the relevant limits of confidentiality and (2) the foreseeable uses of the information generated through their psychological activities. (See also Standard 3.10, Informed Consent.)
(b) Unless it is not feasible or is contraindicated, the discussion of confidentiality occurs at the outset of the relationship and thereafter as new circumstances may warrant.
(c) Psychologists who offer services, products, or information via electronic transmission inform clients/patients of the risks to privacy and limits of confidentiality.
<b>From the American Counseling Association (ACA, 2014)</b>
<b>Section B: Confidentiality, Privileged Communication, and Privacy</b>
<b>B.1.a. Multicultural/Diversity Considerations</b>
Counselors maintain awareness and sensitivity regarding cultural meanings of confidentiality and privacy.
<b>B.1.c. Respect for Confidentiality</b>
Counselors protect the confidential information of prospective and current clients. Counselors disclose information only with appropriate consent or with sound legal or ethical justification.
<b>B.1.d. Explanation of Limitations</b>
At initiation and throughout the counseling process, counselors inform clients of the limitations of confidentiality and seek to identify situations in which confidentiality must be breached.
<b>B.2. Exceptions</b>
<b>B.2.a. Serious and Foreseeable Harm and Legal Requirements</b>
The general requirement that counselors keep information confidential does not apply when disclosure is required to protect clients or identified others from serious and foreseeable harm or when legal requirements demand that confidential information must be revealed. Counselors consult with other professionals when in doubt as to the validity of an exception. Additional considerations apply when addressing end-of-life issues.

*(Continued)*

**Table 2.1** (*Continued*)**From the National Association of Social Workers (NASW, 2008)****1.07 Privacy and Confidentiality**

- (a) Social workers should respect clients' right to privacy. Social workers should not solicit private information from clients unless it is essential to providing services or conducting social work evaluation or research. Once private information is shared, standards of confidentiality apply.
- (b) Social workers may disclose confidential information when appropriate with valid consent from a client or a person legally authorized to consent on behalf of a client.
- (c) Social workers should protect the confidentiality of all information obtained in the course of professional service, except for compelling professional reasons. The general expectation that social workers will keep information confidential does not apply when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or other identifiable person. In all instances, social workers should disclose the least amount of confidential information necessary to achieve the desired purpose; only information that is directly relevant to the purpose for which the disclosure is made should be revealed.

Note: The actual codes contain many more confidentiality-related statements. Information in this table represents only short excerpts from the complete APA, ACA, and NASW ethics codes. Their full codes can be viewed at

<http://www.apa.org/ethics/code/index.aspx>

<http://www.counseling.org/resources/aca-code-of-ethics.pdf>

<http://www.socialworkers.org/pubs/code/code.asp>

### ***The Vital Role of Consultation***

Professional consultation is a crucial component in all ethical decision-making models. Stated in the negative, *you shouldn't grapple with ethical dilemmas in isolation*. Suggestions for developing professional consultation skills and habits include the following:

- Periodically review confidentiality standards and laws associated with your professional discipline and state association.
- Discuss ethical standards with instructors, supervisors, and other students. It can be useful to brainstorm with your class specific cases where your need to break confidentiality might be unclear, and discuss what you should do in those situations.
- Seek professional relationships with colleagues you trust, looking to eventually establish a consultation group for mutual support on an ongoing basis.
- Professional associations at the national or state level often have staff dedicated to consulting with practitioners on ethical issues. For example, you can contact the American Psychological Association at 800-374-2721, the American Counseling Association at 800-422-2648, and the National Association of Social Workers at 800-638-8799.

### CASE EXAMPLE 2.3: CONFIDENTIALITY IN QUESTION

La Shell is a mental health counselor working in a public school. A teacher asks her to meet with Thomas, a male eighth-grade student, who came to school with a bruised and swollen eye and abrasions on his chin. The teacher tells La Shell that other students said Thomas's stepfather hit him. When Thomas meets with La Shell, he reports hitting his eye on the wall and scraping his chin while engaging in horseplay with his younger brother. No matter which way she inquires, Thomas denies violence. After Thomas returns to class, La Shell feels uncertain as to whether she should break confidentiality and contact her state Child Protective Services (CPS) office. Due to this uncertainty, La Shell decides to follow an ethical decision-making protocol. First, she contacts her supervisor. Unfortunately, her supervisor isn't available. Second, she consults with a colleague. Her colleague is also uncertain regarding whether La Shell should break confidentiality. Third, she calls an ethics help line sponsored by her national professional association. The expert consultant advises La Shell to call her state CPS office, describe the situation to the on-call social worker using "hypothetical" language, and follow the state CPS worker's guidance. La Shell does so; the CPS worker advises La Shell to report the incident. Then La Shell follows her agency's protocol for child abuse reporting:

1. She informs the school principal that she'll be making a child abuse report.
2. She has Thomas return to her office so she can gently inform him that she needs to call CPS about his injuries. She does her best to maintain a trusting relationship with Thomas, explaining her legal obligations as well as her concern for his safety and well-being.
3. She makes a good-faith effort to contact the parents and explain that she's required to make a report under these circumstances. She uses her listening and counseling skills to reassure the parent that this is standard procedure and that an investigation may lay concerns about violence to rest.
4. She contacts the CPS worker and provides the information requested.
5. She creates written documentation of her observations, consultations, and actions.
6. She stores this documentation in a highly secure manner.

### Informed Consent

*Informed consent* involves the ethical and sometimes legal mandate to inform clients about the nature of their treatment. When adult clients who are competent understand the proposed treatment, they can agree to or refuse treatment. Informed consent is more complicated with young clients or those who cannot consent for themselves.

Informed consent is challenging to offer and obtain. For many medical and mental health providers, it can be difficult to clearly describe client

problems and available treatment options. Often, professionals speak in jargon (e.g., “It looks like you need some systematic desensitization for your phobia”). In addition, clients are usually in physical or psychological distress and may consent to anything, even if they don’t fully understand the procedure.

At the very least, an informed consent form is provided to clients with two or three written paragraphs explaining, in plain language, your background, theoretical orientation, training, and the rationale for your usual techniques. The limits of confidentiality, use of diagnosis, potential inclusion of family members (especially in the case of marital work or work with minors), consultation or supervision practices, policies regarding missed appointments, and the manner in which you can be contacted in an emergency also should be included. Many professionals include a statement or two about the counseling process and emotional experiences that might accompany this process (R. Sommers-Flanagan & Sommers-Flanagan, 2007). In longer-term therapy, informed consent needs to be revisited over time.

A single written document cannot fully satisfy the spirit of informed consent, but it does start things off on the right foot. Written informed consent gives clients the message that they have important rights in the therapy relationship. It also helps educate clients about the therapy process. Well-written, readable, and personable consent forms increase the client’s impression of therapist expertise and attractiveness and may have a positive effect on counseling outcomes (Wagner, Davis, & Handelsman, 1998).

## Documentation Procedures

Engaging in responsible documentation probably won’t be the highlight of your day. On the other hand, failure to adequately document clinical work can ruin your day. (To really get the point, try imagining a grim-faced attorney shaking her head as you explain that you didn’t have time to write case notes.) Professionals need to clearly and carefully record what happens after each interaction with clients.

There are many positive aspects of taking good notes, including that you’re more likely to remember the details of what was said and planned. In addition, if you’re asked to send your notes to another professional or if your client wishes to review the notes, you’ll be glad that you have legible and coherent notes. If your interactions with clients take unexpected turns, you can go back through your notes and look for patterns. On a less positive note, if things don’t go well with a client and you’re accused of malpractice, your notes become an essential part of your defense.

**Table 2.2** Example of a SOAP Note

S: Joyce stated: "My head hurts, my nose is stuffy, and that's why I'm so f-ing irritated." She also said, "I wouldn't be so worn out and crabby except those Russian teachers danced so late. I can't say no. I wanted to go home, but they were fun and cute. It's my same old pattern."
O: Joyce arrived on time but appeared tired and distracted. She was dressed in jeans and a sweater but kept a scarf wrapped around her neck the entire session. She sneezed and rubbed her nose. She spoke of wishing for more peace and quiet in her life, but feeling unable to set limits without feeling guilty. She appeared distressed, both by her tiredness and her inability to set limits.
A: Joyce achieved further insight into the reasons she gives in so easily to others' demands. She began making a schedule that gave her free time every other day. Joyce's continued struggle with her need to please others was evident, but she also seemed determined to make changes.
P: Joyce will monitor in her notebook how she uses her time. We will analyze time use and further clarify her goals for more balance in her life. She made a goal of saying no to at least one social request and will report back on this next week.

### ***SOAP Notes***

Most experienced therapists have a favorite note taking format. Many use some rendition of the SOAP acronym. SOAP stands for **s**ubjective, **o**bjective, **a**ssessment, and **p**lan. SOAP notes include the following:

- S: The clients' subjective descriptions of their distress.
- O: The therapist's objective observations of the clients' dress, presentation, and so on.
- A: The therapist's assessment of progress.
- P: The plan for next contact, or comments regarding treatment progress.

Your note taking format is less important than regularity, inclusion of the right materials, and neutrality (see Table 2.2). Everything discussed during a session can't be included in the client's file. Therapists must discern key information from each session and record it in succinct, professional ways that are neither insulting nor overly vague. A colleague of ours recommended the ABCs of documentation: **a**ccurate, **b**rief, **c**lear (D. Scherer, personal communication, October 1998).

### ***Record-Keeping Guidelines***

The American Psychological Association (APA) has an online guide to record keeping for psychologists. For the full guide (and tons of fun), go to <http://www.apa.org/practice/guidelines/record-keeping.aspx>. A brief summary of the APA guide follows.

In its introduction, the APA emphasizes that clinical records are beneficial for clients and practitioners. When kept well, clinical records can

1. Document that planning has occurred.
2. Guide treatment services.

3. Allow providers to review and monitor their work.
4. Enhance continuity when there are treatment breaks or referrals to other providers.
5. Protect clients and providers during legal or ethical proceedings.
6. Fulfill insurance or third-party reimbursement requirements.

APA's document is a guide and not a mandate. APA notes that there's no significant empirical research foundation on which their guidelines are based. Instead, the guidelines are broadly based on APA policy, professional consensus, and other sources of ethics and legal information.

The following list paraphrases and summarizes APA's 13 guidelines.

1. *Responsibility.* Practitioners are responsible for the development and maintenance of their clinical records. This includes training staff in the appropriate confidential handling of client records.

2. *Record Content.* Records include information about the treatment being offered, including documentation of its nature, delivery, progress, outcomes, and fees. Information included is directly relevant to the clinical purpose of client contacts. Many factors influence the level of detail in a given note or report, including clients' wishes, referral sources or third-party payers, and the setting in which services occur.

3. *Confidentiality.* Maintenance of confidentiality is essential. In situations where it may be unclear who has access to records (e.g., in child custody conflicts), providers seek legal information to guide decision making.

4. *Informed Consent.* Practitioners provide clients with information regarding record-keeping procedures, including limits to confidentiality.

5. *Records Maintenance.* Records are organized to comply with federal law (HIPAA), and accuracy is maintained.

6. *Records Security.* Records are kept safe from physical damage. Access to records is controlled via a variety of methods, including locked cabinets, locked storage rooms, passwords, and data encryption.

7. *Records Retention.* Records are retained for a time period consistent with legal requirements. The general guide is seven years after the end of service for adults and three years after a minor reaches age 18 (whichever is later).

8. *Records Context.* Because client symptoms or conditions can vary with situational contexts, providers frame the content of client records within the appropriate historical context.

9. *Electronic Records.* The use and storage of electronic records present ongoing challenges. The best guidance is for practitioners to follow the

HIPAA Security Rule, conduct a security analysis, and consistently upgrade policies and practices to keep up with changes in technology.

10. *Records Within Agencies.* Practitioners must balance their professional ethical requirements and agency policy. The APA identifies three main areas: (a) conflicts between the agency and other requirements, (b) records ownership, and (c) records access.

11. *Multiple Client Records.* When providing couple, family, or group services, records management may become complex. You can consider creating separate records for all clients or identifying a primary client and keeping records for that person.

12. *Financial Records.* The nature of the fee agreement (including bartering agreements) as well as adjustments to account balances should be specified. Financial records include procedure codes, treatment duration, fees paid, fee agreements, dates of service, etc.

13. *Records Disposition.* In the case of unexpected events, there may be a need for records transfer or disposal. This implies a need for a records transfer and disposal policy, including information on how current and former clients will be informed if the policy needs to be enacted.

The APA guide is a comprehensive document that can guide practicing clinicians from many professional backgrounds.

## Multicultural Preparation

VIDEO  
2.3

The cross-disciplinary mantra for multicultural preparation is *awareness-knowledge-skill-advocacy*. In Chapter 1, we discussed cultural *awareness*. In this section, we focus on *knowledge* as it pertains to ethnic and other minority populations. Multicultural *skills* are discussed throughout the text. Intermittent, albeit minor, coverage of advocacy is also included in subsequent chapters. Additional resources are in the Suggested Readings and Resources section at the end of this and other chapters.

Cultural knowledge can be obtained in many ways. If you're not a member of a specific minority population that you wish to work with, we recommend a local cultural immersion project—known as a CIM (Hipolito-Delgado, Cook, Avrus, & Bonham, 2011). CIMs are based on the idea that significant and direct contact between different social groups over time can reduce tensions and misunderstandings (DeRicco & Sciarra, 2005). An appropriate CIM might require a three- to six-month commitment to work within a local community. Students who engage in these activities should have close ongoing and post-CIM multicultural supervision (Hipolito-Delgado et al., 2011).

Why do we need *knowledge* about other ethnic groups and cultures? Put simply, there's substantial historical and contemporary evidence that members of dominant and majority cultures tend to oppress individuals from minority groups (Bombay, Matheson, & Anisman, 2014; Nagata, Kim, & Nguyen, 2015). Your goal is to avoid this tendency. As mental health professionals, we have an ethical responsibility to (a) be aware of the potential to intentionally or unintentionally mistreat minority clients, and (b) have competence to work with diverse client populations. Obtaining knowledge about working effectively with those populations reduces the potential for misunderstandings or oppression.

You may feel it's too strong to use the word *oppress* to describe any aspect of the relationship between clinicians and clients. Synonyms for oppress include *tyrannize*, *persecute*, and *subjugate*. We seriously doubt whether anyone entering the mental health professions is doing so to persecute minority groups. Don't let this strong language put you off or push your buttons. Whether you hail from the dominant culture or a minority culture, there will be times when you feel misperceived and you or your clients may need strong language to articulate deep, painful, or partially understood feelings. One of the hallmarks of culturally competent clinicians is the ability to handle strong emotional language without losing compassion.

## First Nation Peoples Cultures

Yellow Bird (2001) wrote, "Indians, American Indians, and Native Americans are 'colonized' and 'inaccurate' names that oppress the identities of First Nation Peoples" (p. 61). In contrast, Dean (2003) held a different view: "In the United States, the most correct term for referring to indigenous people is Native American" (p. 62).

We've had the good fortune to work closely with graduate students and colleagues who are members of the Blackfeet, Crow, Salish, Kootenai, Northern Cheyenne, Navaho, Blood, Assiniboine (Nakota), Chippewa-Cree, Gros Ventre, and Ogalala Sioux Nations. Interestingly, when we've asked our First Nation colleagues, students, and clients over the years what they'd like to be called, most of them—in contradiction to Yellow Bird and Dean—say "Indian." After some discussion, we often hear something like, "As long as you say it respectfully, it doesn't matter whether you refer to us as Indians or Native Americans or First Nation peoples."

In this text, we use the terms Natives, Native Americans, as well as First Nation peoples, understanding that preferences for these terms vary among the peoples they represent. We also do our best to use these terms in ways that convey respect to this important minority group.

It's a mistake to assume more commonality among First Nation peoples than exists. At the same time, many Native people from different tribal backgrounds find common ground around genocidal practices they experienced at the hands of European settlers. The trauma, intergenerational grief, and despair associated with these experiences remain powerful forces in most tribal cultures. Poverty currently present on many reservations is another issue around which many Native people see common culturally oppressive experiences. Regardless of your cultural sensitivity and egalitarian values, some First Nation clients will perceive you as representative of a dominant culture that has and continues to encroach on the rights of Native peoples (Goodkind et al., 2011).

Understanding the following can help orient you to working with Native clients.

**1. Tribal identity.** Although it may reveal your unfamiliarity with the tribe named, respectfully asking about your client's tribal affiliation (including correct pronunciation and spelling) can be helpful. After clients identify their tribes, an easy follow-up is, for example, "Tell me the things you value most about being Assiniboine."

**2. Family roles.** Extended family is deeply important to Native peoples. Funerals, weddings, births, and community and family celebrations are of great import and often supersede other obligations. Sometimes, the family considers tribal elders and medicine people as family; it may be appropriate to include these individuals in clinical interviews (Sutton & Broken Nose, 2005).

**3. Humor.** Using humor with any client or minority group can be risky. However, if the opportunity arises, laughing together with Native clients can help deepen your therapeutic connection.

**4. Spirituality.** The spirit world is often significant. There are sacred connections among tribal members, living, dead, and those yet to be born; between nature and humans; and between Creator and created. Respect and honor are key values among Native peoples. When working with this minority group, it's especially important to show respect and honor for their spirituality.

**5. Sharing and material goods.** Sharing and gifting is a common culturally based act of honoring (Sutton & Broken Nose, 2005). Native American emphasis on generosity and nonmaterialism contrasts with capitalist values. These differences can create a clash of values for young Native people as they balance their cultural identity with life in the dominant culture. It's not uncommon for Native clients to give therapists gifts of appreciation. In general, ethical codes discourage accepting gifts, but in the interests of

cultural sensitivity, you should accept gifts graciously (R. Sommers-Flanagan & Sommers-Flanagan, 2007).

**6. Time.** Native clients are more oriented to the here and now and less oriented to the future (Sutton & Broken Nose, 2005). When a felt need for counseling is experienced in the present, it is sought. However, agreeing to an arrangement in the future may or may not work out, depending on what's happening when the future becomes the present.

**7. Communication styles.** Silence is a sign of respect. Listening carefully to another is a great compliment; not listening is seen as disrespectful. Questioning isn't viewed as listening and may be viewed as rude. In addition, you shouldn't expect many questions from Native clients. Pause liberally when you ask if clients have questions for you. They may want time to formulate one well-worded question rather than asking many. Arranging seating so that less direct eye contact is easy and natural may facilitate comfort and conversation. For some Native clients, note taking may be viewed as rude. If you take notes, explain their function and compensate for the distraction they represent.

## Black or African American Cultures

As is true for First Nation peoples, the relationship between African (Black) Americans and European settlers didn't begin as a mutual, voluntary relationship. Both of these now-minority cultures experienced destruction of family structure, severe illness, loss of property and custom, and loss of liberty in relationship with Whites. Between 1518 and 1870, approximately 15 million Africans were forcibly brought to serve as slaves in the New World (Black & Jackson, 2005). The resulting intergenerational trauma, role confusion, grief, and loss reverberate in the African American culture. There are spectacular success stories and examples of healing, depth, and wisdom throughout African American culture, but intergenerational trauma is still evident.

Also similar to First Nation peoples, the Black American population is very diverse. This diversity is frequently ignored in research and clinical practice (Bryant, Taylor, Lincoln, Chatters, & Jackson, 2008). Teah Moore, a faculty member at Fort Valley State University, wrote:

It's never stated in books, but it's offensive to compare African Americans with other people of African descent. We are so different. We experience a different type of racism. There is much diversity. Even Southern blacks and Northern blacks have different racial experiences.  
(Personal communication, August 11, 2012)

Understanding the following cultural factors can help orient you to working with African American/Black clients.

**1. Family roles.** Great importance is placed on the nuclear family and extended kinship systems. The family head may be the father, the mother, or older siblings. Unrelated community members (godparents, pastors, and close friends) may serve important familial roles. Although a genogram can help with assessment or treatment, African American kinship systems may contain information not openly acknowledged. You should carefully respect family privacy and maintain realistic expectations regarding openness and transparency.

**2. Religion and spirituality.** Many African Americans turn to their communities or clergy for support instead of professional service providers (Bell-Tolliver & Wilkerson, 2011). However, it's important not to stereotype all African Americans as religiously oriented (Hardy, 2012). Resources within African American communities, such as salons and barber shops, are also places where disclosures, consultation, and guidance are sought (T. Moore, personal communication, August 11, 2012). It's essential to be clear about confidentiality, because maintaining trust is especially helpful to intercultural relationships with service providers (Mattis & Grayman-Simpson, 2013).

**3. Couple and gender roles.** Franklin (2007) coined the term *invisibility syndrome*, referring to White culture's fear-based tendencies to marginalize Black males and treat them as if they were invisible. African American males also have a lower life expectancy than White males, primarily because of murder, incarceration, drug and alcohol abuse, and dangerous employment situations (Franklin, Boyd-Franklin, & Kelly, 2006). Service providers should be sensitive to societally driven health and safety issues within the Black male population. Black women occupy strong family roles; they may be family providers, function in an equal or dominant parenting role, and wield substantial power in family decision making—including decisions about whether to seek professional assistance.

**4. Assumptions.** Relationships between Black and White Americans are complex. This will be true whether the clinician or client is Black or White. White clinicians who hold a privileged place in society should be especially careful to behave respectfully toward Black clients who may be experiencing cultural oppression or repeated microaggressions (D. W. Sue 2010). Similarly, to avoid stereotyping members of the dominant culture, Black clinicians should use scientific mindedness when working with White clients.

## Hispanic/Latina(o) American Cultures

For the purposes of this chapter, we take our meaning of the term *Hispanic* from Marin and Marin (1991), who indicate that Hispanic people are “individuals who reside in the United States and who were born in or trace their family background to one of the Spanish-speaking Latin American nations or Spain” (p. 1). This term is not perfect, and Gallardo (2013) prefers using “Latina/o . . . as a culturally consistent term” (p. 44). Consistent with Gallardo’s perspective, some Mexican Americans prefer the term Latino because it does not harken back to the conqueror, Spain (Dana, 1993).

Hispanic or Latina(o) people represent many different countries, cultures, and sociopolitical histories. It can be important to begin a clinical interview by asking about the client’s country of origin. This is partly because “proclaiming their nationality is very important to Latinos” (Garcia-Preto, 1996, p. 142).

**1. Religion and belief systems.** The Catholic Church is influential. Mental health problems are sometimes seen as caused by evil spirits, so the church may be considered the logical place to seek assistance (Cuéllar & Paniagua, 2000). Mental health professionals may be contacted after all other avenues have been accessed. Some Hispanic/Latina(o)s believe that individuals bring on their own problems and that others can be inflicted with such problems by *mal de ojo* (the evil eye; Cuéllar & Paniagua, 2000). Such beliefs are related to fatalism (i.e., a belief that people can’t do much about their fate; Ho, Rasheed, & Rasheed, 2004). Confronting Hispanic/Latina(o)s regarding fatalistic beliefs or an external locus of control is ill-advised.

**2. Personalismo, respeto, and charlar.** Qualitative and quantitative research supports the use of personalismo, respeto, and charlar with Hispanic/Latina(o) clients (Gallardo, 2013). *Personalismo* refers to a personable and friendly demeanor; *respeto* refers to the expression of respect in relationships; *charlar* refers to small talk. During initial interactions, it’s important to use friendly small talk, but also to maintain formality. Using last names and acting with deliberate respect during the first interview can facilitate this process. One manifestation of personalismo can include gift giving, which should be handled with cultural sensitivity. A person who shows appropriate respeto for the right people is seen as someone who has been well educated or well reared (Guilamo-Ramos et al., 2007).

**3. Family roles.** Family is extremely important to Hispanic/Latina(o) people and is more broadly defined than traditional White American nuclear families. Family members have probably been consulted before a counseling appointment is scheduled; involving the family in a clinical

interview can be helpful. There is a strong emphasis on the family's (collectivist) needs over individual needs. Usually, family roles are clearly defined. The father is head of the household and is to be respected as such. The mother is the homemaker and cares for the children. Family obligation, honor, and responsibility run deep (Gibbs & Huang, 2003).

**4. Gender roles.** Machismo and mariанизmo are central notions that influence interpersonal relationships, especially between the sexes. *Machismo* denotes masculinity as evidenced in physical prowess, aggression, attractiveness to women, and familial protection. *Marianismo*, or traditional Hispanic/Latina womanhood, is based on the Catholic worship of the Virgin Mary. It connotes obedience, timidity, sexual abstinence until marriage, emotionality, and gentleness. According to Comas-Díaz (1994), the concept of mariанизmo includes a belief in the spiritual superiority of women, who endure all the suffering produced by men (Claudia L. Moreno, 2007; Vazquez & Clauss-Ehlers, 2005).

## Asian American Cultures

The idea that a prototypical Asian American client exists and will walk into your office for an interview is patently false. Chang and O'Hara (2013, p. 34) described the range of people classified as Asian:

Both the 2000 and 2010 U.S. census included several Asian-related categories . . . (a) Asian Indian, (b) Chinese, (c) Filipino, (d) Japanese, (e) Korean, (f) Vietnamese, or (g) Other Asian write-in category. Pacific Islander categories included (a) Native Hawaiian, (b) Guamanian or Chamorro, (c) Samoan, (d) or Other Pacific Islander write-in category. An additional challenge is that not all individuals from the Asian continent identify as Asian. For example, persons of Iranian, Indian, or Russian heritage may prefer to identify by region (e.g., South Asian, Middle Eastern) or country of origin. These examples underscore the fact that racial categories are fluid and that Asian Americans are heterogeneous both between and within subgroups.

The following information may be helpful in your work with the more than 40 disparate cultural groups represented under the term *Asian Americans*.

**1. Family roles.** Asian cultures are primarily collectivist. This leads to stronger, more inclusive family roles. For example, the strong achievement orientation often reported within Asian families is not exclusively for the self, but also to give honor and prestige to the family (Chang & O'Hara, 2013). Despite traces of individualism in the realm of achievement, decisions

affecting the family (which include most or all decisions) are generally family determined. The family also should be strong enough and wise enough, and have sufficient resources to handle problems encountered by the individual. Failing this task and seeking outside help in the form of counseling can be a shameful loss of face (C. M. Chao, 1992). Substantial stress may have prompted Asian clients to seek help (Chang & O'Hara, 2013). Similar to Hispanic/Latina(o) family structure, there can be strong hierarchical relationships inside and outside families, often based on sex/gender. The father is considered head of the household, mothers are more passive and subservient, and children are taught to value family harmony and respect authority (Chang & O'Hara, 2013). Many Asian families living in the United States are in an acculturation process. As children become bilingual, they assume power in the family that upsets traditional roles (Khanna, McDowell, Perumbilly, & Titus, 2009).

**2. Orientation toward authority.** Asian cultures are hierarchical (Matsumoto & Yoo, 2005; Negy, 2004). This is related to *filial piety*, which refers to the honor, reverence, obedience, and loyalty owed to those hierarchically above you (Cheung, Kwan, & Ng, 2006). Deference toward authority may manifest itself in a clinical interview. Asian American clients often expect clinicians to act with authority. In the same vein, verbal communication with a mental health professional may not be direct. This style, combined with a high valuing of harmonious relationships, makes it likely that Asian American clients, when faced with conflict or uncertainty in your office, will offer the most polite, affirmative response available. In addition, direct eye contact is viewed as invasive and disrespectful, especially when one is interacting with persons of higher status or authority (Fouad & Arredondo, 2007). Older Asian American clients may respond well to formality. Using Mr., Mrs., and Ms. and a last name signals respect and should not be discontinued until the client indicates otherwise. The concrete and tangible advice that many Asian American clients expect runs contrary to most training models; therefore, you may need to consider several options: (a) explain to clients that your approach doesn't involve giving direct advice; (b) explain to clients that you'll offer advice, but not until you've completed an assessment; or (c) prepare yourself to offer research-based advice that you believe can be helpful (C. Berger, personal communication, August 13, 2012).

**3. Spiritual and religious matters.** A reverence toward ancestors, and various beliefs regarding ancestral spirits, wishes, or presence in family matters can be central to individual and family functioning and decision making. Religious orientations are as varied as the countries from which

Asian Americans come, including such diverse belief systems as Buddhism, Islam, Hinduism, Christianity, and Jainism. Much has been written about the Western mind or worldview and the Eastern mind or worldview in religious and philosophical literature. Understanding these differences may provide insight.

## Clients from Other Minority Groups

Many additional minority groups exist in the United States. Most individuals within these groups have had experiences of being misunderstood, oppressed, or marginalized. Sometimes, but not always, these experiences are related to minority status. In fact, it's not unusual for White, male Christians in the United States to report feeling oppressed and marginalized. Although these feelings may be difficult to comprehend, it's not your job to judge the quality or quantity of an individual client's reported oppressive experiences; instead, your initial priorities include listening, offering empathic understanding, and assisting clients toward greater emotional adjustment and/or symptom reduction. These priorities also may include direct feedback, confrontation, and coaching on developing more adaptive personal coping strategies.

### ***Lesbian, Gay, Bisexual, Transgender, and Queer People***

Sexual identity and sexual orientation are intensely personal, central, and sometimes controversial. For many years, homosexuality was considered a mental disorder, and to this day, controversial treatments designed to "cure" homosexuals exist (Flentje, Heck, & Cochran, 2014). This is an affront to most of the lesbian, gay, bisexual, transgender, and queer (LGBTQ) community and has contributed to LGBTQ individuals and other sexual minorities distrusting mental health professionals.

Many LGBTQ individuals have endured verbal abuse, physical violence, and loneliness (Jeltova & Fish, 2005). To reduce their anticipation of harsh judgment and rejection, it can be helpful to have LGBTQ-affirming pamphlets or literature in the waiting room (Amadio & Pérez, 2008; Kort, 2008). It's also important to avoid using gender-specific words indicating assumptions of heterosexuality. When inquiring about intimate relationships, the term *romantic partner* rather than *boyfriend* or *girlfriend* should be used. This allows clients to reveal their partner's gender and sexual orientation when ready. Affirmative psychotherapy for LGBTQ clients is a major movement within counseling and psychotherapy (Heck, Flentje, & Cochran, 2013).

### ***Persons with Disabilities***

An extensive literature exists for therapists wishing to work with clients who have physical, developmental, or emotional disabilities (Dell Orto & Power, 2007). Graduate-level training programs in special education, rehabilitation counseling, and rehabilitation psychology are available. Having an open and accepting attitude is an essential prerequisite to this work, but compassionate attitudes need to be combined with competence (Falvo, 2011).

Sometimes, when interviewing clients with an obvious disability, professionals assume it's more polite to ignore crutches, missing limbs, wheelchairs, or even canes indicating blindness. However, asking directly about the "difference" is usually welcomed. Such questions as "Have you used a wheelchair all your life, or is it a more recent addition?" can open the door to a candid discussion of the disability. Specific disability information can also be obtained on registration forms as a means of initiating a discussion.

### ***The Religiously Committed***

There's a growing openness in counseling and psychology to integrate spiritual dimensions into therapy (R. Johnson, 2013). Despite this trend, religious individuals with more conservative values may be uncomfortable seeking secular help (Stern, 1985). For some deeply religious persons, an initial clinical interview may occur because of a family or personal crisis.

Although not visible, religious differences between counselor and client can be pronounced and unsettling, requiring awareness and specific clinical skills in this area (Onedera, 2008). You might be directly asked about your religious beliefs in an initial interview. We recommend a balanced response:

- Empathize with your client's concerns (e.g., "It sounds like you have concerns about the compatibility of our spiritual beliefs").
- Have an honest and carefully considered answer ready. Don't hide behind your professional role. Refusing to share a brief summary of your own spirituality will exacerbate client concerns.
- After your disclosure, return the topic to how it feels for the client to work with you.
- Never debate matters of faith.

Some mental health professionals identify their religious affiliations in their advertising, on their cards, or in their informed consent paperwork. Others develop specialties dealing with spiritual concerns. When working with religious clients, it can be useful to consult with religious leaders or mental health professionals whose practice focuses on spiritual issues (R. Johnson, 2013).

## Considerations for Minority Group Professionals

Graduate students from minority cultures are often highly valued for the diversity and insight they bring to their training programs. They also experience micro- and macroaggressions. If you're a member of a cultural minority group, you may feel pressure to subvert your cultural identity in favor of your professional credentials. In *Voices of Color: First-Person Accounts of Ethnic Minority Therapists*, Monika Sharma wrote, "I no longer strive to blend in and be invisible. Instead, I now stand up and want people to see me for the multifaceted Asian Indian American woman that I am" (Rastoqi & Wieling, 2004, p. 20).

For therapists of color, challenges of multicultural sensitivity are complex. If your client appears to be from the dominant culture, you may have to be on guard for instant countertransference, while simultaneously working to create a therapeutic alliance with a person from the culture that oppressed you. If your client appears to be from another minority culture, there may be other assumptions or stereotypes to overcome. Finally, if your client appears to be from the same cultural or racial background as you, given the vast diversity of experiences, assumptions of similarity may or may not be accurate or useful.

## Stress Management and Self-Care

VIDEO  
2.4

Clinicians who provide mental health services are working in a high-stress environment. Stress-related factors include:

- Working with clients (e.g., military personnel, sexual assault survivors, child abuse victims) who tell you trauma stories
- Working with families or individuals with severe mental health problems
- Working with clients who are suicidal and may require hospitalization
- Having the experience of a client dying by suicide
- Time management challenges associated with working for an agency or in private practice
- Dealing with billing, red tape, records requests, and other insurance-and managed care-related challenges
- Handling an excessively large counseling case load

Stress levels are also particularly high for student clinicians (El-Ghoroury, Galper, Sawaqdeh, & Bufka, 2012; Fuenfhausen & Cashwell, 2013).

Over the past several decades, it has become clear that clinician self-care is an ethical issue (Wise, Hersh, & Gibson, 2012). Although most

ethical codes don't prescribe self-care, there's a strong emphasis on professionals dealing with personal problems that might impair performance (e.g., alcohol abuse, personal traumas). If you're not coping well with your personal or work-related stress, you'll be unlikely to perform optimally as a mental health professional.

## Making Mistakes

You probably want to be a perfect interviewer. Or at least you have fear and dread about making mistakes and damaging clients. These fears have a basis in reality. Because you're human, perfection is unattainable. The challenge is to recognize your mistakes, recover from them, and use them for continued learning and growth. Sometimes, your mistakes can be humanizing for clients, because it shows them that even their highly esteemed therapist isn't perfect.

Shea (1998), a nationally renowned psychiatrist and workshop leader, commented on mistakes he makes while conducting interviews:

Mistakes were made, but I make mistakes every time I interview. Interviews and humans are far too complicated not to make mistakes . . . With every mistake, I try to learn. (p. 694)

We knew one student therapist who reported high anxiety and a tendency to pick at the skin around the edges of his fingers. During his first session, he picked at his fingers until he began feeling some moisture. He reported thinking, "I'm so nervous my fingers are sweating!" Eventually, he peeked down at his hands and discovered, much to his horror, that his finger had begun to bleed. He spent the rest of the session trying to cover up the blood and worrying that the client had seen his bleeding finger. Though this example is unusual, it illustrates how nervousness and anxiety can interfere with clinical interviewing. Managing stress effectively is an important professional issue.

## Approaches to Stress Management and Self-Care

There are many different approaches to stress management and self-care. Here's a nonexhaustive list of potential stress management categories and techniques.

- *Physical methods*, including physical exercise (e.g., cardio, weight lifting, yoga) and relaxation (e.g., progressive muscle relaxation, therapeutic massage)

- *Psychological or mental methods*, including traditional, mindfulness, and loving-kindness meditation; self-hypnosis; and personal counseling or psychotherapy
- *Social-cultural-emotional methods*, including talks with friends, attending culturally based activities (e.g., attending pow-wows), volunteer work, and emotional expression
- *Spiritual or nature-based methods*, including religious or spiritual services, prayer, chanting, and hiking/camping or communing with nature

These approaches all have either empirical or anecdotal support for their effectiveness. You probably know which ones are best for you, but it's also good practice to experiment with a range of different stress management and self-care approaches. Establishing a regular practice of one or more of these methods is essential for mental health providers who want to avoid burnout and work long into the future. For example, researchers have reported that regular mindfulness and loving-kindness meditation practice tends to have a modest but significant positive long-term effect on several different indicators of health and well-being (Creswell, Pacilio, Lindsay, & Brown, 2014). Consequently, we can't let ourselves end this chapter without strongly encouraging you to develop lifelong habits of self-care that help reduce the impact of your stressful professional work (Skovholt & Trotter-Mathison, 2011). See the Suggested Readings and Resources for specific stress management information.

#### CASE EXAMPLE 2.4: CONSULTATION AS STRESS MANAGEMENT

A client at a student health center periodically accused her therapist-in-training of being too unemotional. She said, "You never show any feelings. I'm pouring my heart out here, and you're stiff as a board. Don't you care about me?"

The therapist found this feedback disturbing. He shared it with the health center supervision group. They offered reassurance: "Don't worry about it. You're a very kind and caring person."

Soon afterwards, the therapist began seeing another female client. Ironically, this client told him that she thought he was "being too emotional."

The therapist was confused and upset. He turned to his supervisor. She observed that these women were both highly distressed, and seemed inclined toward misperceiving social cues. She also encouraged him to explore how he was reacting to them in session. As he began getting more in touch with his emotions, he saw how his reactions to these clients were exacerbating

(Continued)

their misperceptions. To some extent, they were right: He felt reluctant to emotionally engage with the first client, but felt deep compassion for the second.

The moral to this story is that although clients can, and will, have distorted perceptions of you, your reactions to them can add fuel to the fire. Getting feedback from peers and supervisors, and exploring your in-session emotional reactions can help you handle these issues more effectively. And yes, getting a little personal therapy can be an excellent idea.

## Summary

Before meeting with clients, therapists consider a number of practical, professional, and ethical factors. These factors include the room, seating arrangements, office clutter and décor, note taking, and video and audio recording. Professional and ethical issues include self-presentation and social behavior, maintenance of time boundaries, confidentiality, informed consent, and documentation procedures. These issues are basic and foundational; they support the interviewing activity, and without them the entire interviewing structure may suffer or collapse.

Multicultural knowledge is essential for contemporary clinicians. Four major cultural minority groups comprise First Nation peoples, Black or African Americans, Hispanic/Latina(o) Americans, and Asian Americans. Additional important minority groups include LGBTQ clients, clients with disabilities, and religious clients. Clinicians who are members of cultural minority groups face unique challenges when conducting clinical interviews.

Being a mental health professional involves high-stress work. It's crucial to accept imperfections and to use a variety of strategies for self-care and stress management.

## Suggested Readings and Resources

The following readings can provide you with insights into self-care, stress management, and microaggressions.

Goldfried, M. (2001). *How therapists change: Personal and professional recollections*. Washington, DC: American Psychological Association. This book gives you an insider's look into how professionals have undergone personal change. It gives you a feel for how the profession of counseling and psychotherapy might affect you personally.

- Hays, P. A. (2014). *Creating well-being: Four steps to a happier, healthier life*. Washington, DC: American Psychological Association. Pamela Hays is a prominent author and psychologist. She uses real-life examples and good humor to guide you through four scientifically based steps: (a) recognizing stressors, (b) avoiding negative thought-traps, (c) re-examining thinking, and (d) taking action.
- Kashdan, T. B., & Ciarrochi, J. (Eds.). (2013). *Mindfulness, acceptance, and positive psychology: The seven foundations of well-being*. Oakland, CA: Context Press. This edited volume focuses on how to achieve well-being from the perspectives of several different theoretical orientations. It includes chapters on love, self-compassion, committed action, perspective taking, and accepting guilt and abandoning shame—all of which can be useful for the developing mental health professional.
- Norcross, J. C., & Guy, J. (2007). *Leaving it at the office: A guide to psychotherapist self-care*. New York, NY: Guilford Press. This is a guidebook for therapists on how to focus on the positive parts of being a psychotherapist, engage in healthy physical and cognitive self-care, and set reasonable personal boundaries on psychotherapy practice.
- Shelton, K., & Delgado-Romero, E. A. (2013). Sexual orientation microaggressions: The experiences of lesbian, gay, bisexual, and queer clients in psychotherapy. *Psychology of Sexual Orientation and Gender Diversity*, 1, 59–70. This article focuses on the unique microaggression experiences of LGBTQ clients.
- Skovholt, T. M., & Trotter-Mathison, M. J. (2011). *The resilient practitioner: Burnout prevention and self-care strategies for counselors, therapists, teachers, and health professionals*. New York, NY: Taylor & Francis Group. This book is designed to help individuals in the highly interpersonal professions develop ongoing self-care skills and practice. Each chapter ends with self-reflective exercises designed to help with the acquisition of self-care skills.
- Sue, D. W. (2010). *Microaggressions in everyday life: Race, gender, and sexual orientation*. Hoboken, NJ: Wiley. In this book, Derald Wing Sue describes, explains, and offers solutions to problems of microaggressions against specific minority groups. This is an excellent book for facilitating multicultural awareness.
- Zeer, D., & Klein, M. (2000). *Office yoga: Simple stretches for busy people*. San Francisco, CA: Chronicle Books. This short book provides basic yoga stretching postures for busy professionals. It includes illustrations and easy-to-implement stress-reducing stretching exercises.



## AN OVERVIEW OF THE INTERVIEW PROCESS

### Chapter Orientation

Every interview has a beginning, middle, and end. As noted in Chapter 1, clinical interviews may be structured, unstructured, or somewhere in between. In this chapter, we examine the flow and pattern inherent in all interviews. The primary goal is to help you understand how to integrate many essential interviewing tasks smoothly into the beginning, middle, and end of a single clinical hour.

#### VIDEO 3.1

### Stages of a Clinical Interview

It is good to have an end to journey towards; but it is the journey that matters, in the end.

—Ursula K. LeGuin,  
*The Left Hand of Darkness*, 1969, p. 109

Learning to conduct a clinical interview is similar to learning other new skills, such as juggling or dancing. You can read all about how to juggle or tango, but when you first start performing the skill, you feel awkward and need to keep reminding yourself of what comes next.

Like juggling or dancing, the clinical interview also has a more or less step-by-step format (but this clinical interviewing guidebook is somewhat longer than the instructions that came with your juggling set). After reading this and other chapters, you may find yourself worrying about engaging in the proper interviewing step at the proper time. You might catch yourself thinking, “I need to establish rapport here . . . Now it’s time to elicit information . . . Time to prepare for closing.”

#### LEARNING OBJECTIVES

After reading this chapter, you will be able to:

- Identify the stages of a clinical interview
- List and apply interviewing skills that facilitate the introduction stage, comprising phone contact, initial meetings, building rapport, putting clients at ease, the use of small talk (charla), and clarifying expectations
- List and apply interviewing skills that facilitate the interview’s opening stage, consisting of your opening statements, the client’s opening response, and responding therapeutically to clients
- List and apply interviewing skills to perform assessment tasks and intervention techniques associated with the body of an interview
- List and apply interviewing skills that facilitate the closing stage of an interview, such as how to support clients, revisit role induction, summarize crucial issues and themes, provide an initial case formulation, guide and empower clients, monitor progress, instill hope, and tie up loose ends before ending a session

(Continued)

**LEARNING OBJECTIVES**  
**(Continued)**

- List and apply interviewing skills that facilitate the ending or termination stage of an interview, including time boundaries, managing session-ending activities, facing termination, and dealing with client feelings about ending(s)

Organizing the clinical interview into stages is like having a map that tells you where you are and where you should turn next so that you can smoothly and efficiently reach your destination. Shea (1998) identified the following stages of a clinical interview:

1. The introduction
2. The opening
3. The body
4. The closing
5. The termination

Shea's model is generic and atheoretical. It can be applied to virtually all interviewing situations. Similarly, Foley and Sharf (1981) wrote about five sequential tasks common to interviews:

1. Putting the patient at ease
2. Eliciting information
3. Maintaining control
4. Maintaining rapport
5. Bringing closure

Foley and Sharf's model is also atheoretical, but it provides a descriptive glimpse of your general tasks during each stage.

Although many other theory-based interviewing models exist, for now, our focus is on the atheoretical. This is because being a cognitive-behavioral or narrative or feminist therapist will change the content of your interview, but regardless of your theoretical orientation, the process or stages remain the same.

It's your job to guide clients through the five interview stages. If you use a more unstructured approach, you'll allow your clients to rush or linger on a given topic as needed (K. D. Jones, 2010). In contrast, if you use a structured or semi-structured approach, your protocol will determine—for the most part—what your clients talk about. Regardless of the amount of structure, you are responsible for managing the hour, smoothly integrating interview elements, staying within time limits, and covering essential components.

## The Introduction

VIDEO  
3.2

Shea (1998) defined the *introduction stage* as follows:

The introduction begins when the clinician and the patient first see one another. It ends when the clinician feels comfortable enough to begin an inquiry into the reasons the patient has sought help. (p. 58)

The introduction stage begins the helping relationship. Your first task is to put clients at ease so they're ready to engage in an open and collaborative discussion of the issues that prompted them to seek therapy.

### First Contact

The introduction stage may begin online or via telephone. Handled well, the online or telephone response, the paperwork, and the clarity and warmth with which clients are greeted can begin putting them at ease. Handled poorly, these same elements can confuse and intimidate. First contact, whether with you, your web page, or your office manager, begins the clinician-client relationship.

The following transcript illustrates an initial telephone contact:

**Therapist:** Hello, I'm trying to reach Bob Johnson.

**Client:** That's me.

**Therapist:** Bob, this is Chelsea Brown. I'm a student-therapist at the University Counseling Center. I understand you're interested in counseling. I'm calling to see if you'd like to set up an appointment.

**Client:** Yeah, I filled out a questionnaire.

**Therapist:** Right. If you're still interested, we should set up a time to meet. Do you have particular days and times that work best?

**Client:** Tuesday or Thursday is best for me . . . after two . . . but before six.

**Therapist:** How about this Thursday, the 24th, at four?

**Client:** That's fine with me.

**Therapist:** Do you know how to find the center?

**Client:** Yep. I was there to fill out the questionnaire.

**Therapist:** Good. If you could come 10 minutes before 4 P.M. and check in, that would be great. The receptionist will give you more forms to fill out, and that way you can finish them before we start our meeting at four. Is that okay?

**Client:** Sure, no problem.

**Therapist:** Great. I look forward to meeting you Thursday, the 24th, at 4 p.m.

**Client:** Okay, see you then.

Several points in this dialogue deserve explanation. First, scheduling the initial appointment is a collaborative process. Collaboration is needed from the start; it foreshadows the evidence-based process of clinician and client forming an alliance and working together to solve problems (see Chapter 7; J. Sommers-Flanagan, 2015). If you can't amicably collaborate on finding an appointment time, it's probably a bad sign for your chances of working effectively together on bigger issues. The preceding dialogue illustrates a straightforward scheduling experience. Being clear about your available times before initiating the phone call will make the process smoother.

Second, the clinician identifies herself, her status (i.e., student-therapist), and her place of employment. Clarity and specificity are essential. Be very careful not to misrepresent yourself. You can't call yourself a psychologist or a counselor unless you're licensed and have that professional status.

Third, the clinician checks to make sure the client knows how to get to the interview location. Even though many clients will get a map to your location via the Internet, you should be ready before making the call to provide directions. It's also helpful when agencies provide a map with directions or instructions for public transportation.

Fourth, the clinician asks the potential client what days and times work best. This is a reasonable question only if you have a flexible schedule. If your schedule is tight, you should begin by identifying your openings. Whatever the case, specific information about why you can't meet at a particular time is unnecessary. During an initial phone call it's too much to say, "Oh, I can't meet then because I have to pick up my daughter from school" or "I'm in class then."

Fifth, the clinician closes by repeating the appointment time and indicates she's looking forward to meeting the client. She also clarifies what the client should do when arriving at the center (i.e., check in with the receptionist). It's good to avoid saying things like, "Check in with the receptionist and I'll be right out to meet you," because you don't know when the client will arrive. If he arrives 25 minutes early, you're stuck—either you meet him 25 minutes early or you end up not following through with what you said on the phone.

Be sure to practice telephone conversations in class or with supportive friends or family members. Invite them to throw you a few curves so that you can practice handling a question or two you weren't prepared for. If you've practiced, you'll be more able to smoothly work together to schedule an appointment.

## Initial Face-to-Face Meeting

Most agencies have public waiting rooms. It's more difficult to keep a client's identity anonymous in these settings than it is for single clinicians in private practice. If you work in a public setting, consider how to best respect client privacy. One option is to have the receptionist point out a new client so that you can walk up and say the client's name in a quiet, friendly voice, not easily overheard by others in the room. A handshake may or may not be appropriate (more on this later). You can say something like, "It's nice to meet you" and "Come back this way" and then lead the client to your office.

When you meet, you and your client are simultaneously sizing up each other and the situation. To be consistent, you might want to follow an introductory ritual that includes some or all of the following:

1. Shaking hands (warning: this can be culturally inappropriate, for example, with Muslim women or Orthodox Jewish women and men who have religious reasons for not shaking hands with the opposite sex)
2. Offering tea, coffee, or water if available in your setting
3. Chatting about a neutral topic while walking to the office

Greeting clients in a consistent manner frees you to be more observant. Standardization strengthens your ability to make inferences from your observations (see Putting It in Practice 3.1). However, many therapists prefer an individualized response to each client. Lazarus (1996) referred to this as being an *authentic chameleon*. Sometimes, this is a firm handshake and/or comforting social banter. Other times, no handshake and less banter are used. Our advice is to begin with a standard routine and then vary as needed.

### PUTTING IT IN PRACTICE 3.1: STANDARDIZED INTRODUCTIONS

Standardization is a part of good assessment science (Groth-Marnat, 2009). A standard approach increases the reliability, and potential validity, of your observations. If you vary your introduction routine based on your moment-to-moment mood, whatever you observe will be more about your mood and less about your clients.

At the same time, however, you don't want to come across as mechanical. It's important to respond not only to each client's unique individual characteristics but also to typical differences found in social or cultural groups. Using the same approach with male adolescents and female senior citizens wouldn't be appropriate. Individuals in these two groups have different relational

(Continued)

styles. To treat them identically would be a mistake. Also, excess standardization may adversely affect rapport. When introducing yourself, two general guidelines can help:

1. Go with the base rates: Greet people in a manner consistent with their basic demographics, including culture, age, and gender.
2. Choose the least offensive alternative: If you make a mistake, make it a minor mistake.

You might be put off by standardization and routine. Shouldn't we give each client a unique and human response? The answer is no and yes. No, it's not necessary to give each client a different response just to avoid routine. And yes, we should give each client a human response. Just because you've said the same thing dozens of times doesn't mean you're operating on autopilot.

The final point is to be intentional. If you don't want your session to begin in the waiting room, don't greet your client with a socially spontaneous, "How are you?" The way you greet clients is an extension of the intentionality you need when conducting a clinical interview.

How should you address clients? In some situations, it's best to use first names. In other situations, it's best to use Mr., Ms., Mrs., or Dr. It can be difficult to tell which title to use with which person. If you're comfortable with Spanish and are working with a Latina(o) client, beginning with Señor, Señora, or Señorita is reasonable. When in doubt, go with the client's first and last name while making eye contact, but not too much eye contact. Later, if you're not sure you got it right, you can ask, "How would you like me to address you?" If you sense you used the wrong greeting strategy, check with your client, correct yourself, and apologize ("Would you prefer I call you Mrs. Rodriguez? Okay. Sorry about that."). The effort to address clients as they want to be addressed communicates culturally sensitive respect (*respeto*) and is a specific way you can communicate acceptance.

## Establishing Rapport

*Rapport* is defined as having an especially harmonious connection with another person; this connection may occur immediately or require extended interaction. Many technical responses discussed in Chapter 4 help with developing rapport (e.g., paraphrase, reflection of feeling, and feeling validation). When you're working across cultures or with young clients, rapport building may depend on acceptance of diverse communication styles, language use, and personal values (Hays, 2013).

## Sensitivity to Common Client Fears and Doubts

Clients naturally have fears and doubts about therapy. Being aware of these can help with rapport. Common concerns include the following:

- Is this therapist competent?
- Can this person help *me*?
- Will this therapist understand me, my culture, my religion, and my problems?
- Am I going crazy?
- Can I trust this person?
- Will I be pressured to say things I don't want to say?

All mental health professionals are authority figures. Clients may believe they should treat you the way they treat other authority figures, such as physicians and teachers. They may expect you to behave as previous authority figures in their lives have behaved. This can range from warm, caring, wise, and helpful to harsh, cold, and rejecting. Because clients come to counseling with both conscious and unconscious assumptions about authority figures, you may need to be explicit about your intent to collaborate. It's useful to say something about the developing partnership between you and your client. Examples include:

- I'm looking forward to working with you today.
- Since we don't know each other well, counseling can feel awkward at first, but hopefully we'll start getting comfortable together today.
- Because this is our time to start getting to know each other, I may ask more questions today than I usually do.
- I hope you'll feel free to ask me any questions you want as we talk together today.

### CASE EXAMPLE 3.1: AN EARLY INVITATION FOR COLLABORATION

Sophia, a 26-year-old mother of two, was referred for counseling by her children's pediatrician. When she sat down with her counselor, she stated:

I don't believe in this counseling thing. I'm stressed, that's true, but I'm a private person, and I believe very strongly that I should take care of myself and not have anyone take care of my problems for me. Besides, you look like you might be 18 years old, and I doubt you're married or have children. So I don't see how this is supposed to help.

(Continued)

It's easy to be shaken when, at the beginning of the first session, clients like Sophia pour out their doubts about therapy and about you. Our best advice: (a) Be ready for it. (b) Don't take it personally; Sophia is speaking of *her* doubts, so don't let them become *yours*. (c) Be ready to respond directly to the client's core message. (d) End your response with an invitation for collaboration. An *invitation for collaboration* is a clinician statement that explicitly offers your client an opportunity to work together. In some cases, an invitation for collaboration is a time-limited "let's try this out" offer.

Here's a sample counselor response to Sophia:

**Counselor:** I hear you loud and clear. You don't believe in counseling, you're a private person, and you're concerned that I don't have the experiences needed to understand or help you.

**Sophia:** That's right. [Sometimes when the counselor explicitly reflects the client's core message (in this case, "you're concerned I don't have the experience needed to understand or help you"), the client will retreat from this concern and say something like, "Well, it's not that big of a deal." But that's not what Sophia does.]

**Counselor:** Well then, I can see why you wouldn't want to be here. And you're right, I don't have a lot of the life experiences you've had. But I do have knowledge and experience working with people who are stressed and concerned about parenting, and I'd very much like to have a chance to be of help to you. How about since you're here, we try out working together today, and then toward the end of our time together, I'll check back in with you, and you can be the judge of whether this might be helpful or not.

**Sophia:** Okay. That sounds reasonable.

In this case, the counselor responded directly and empathically to Sophia and then offered an invitation for collaboration. As the session ends, Sophia may or may not accept the counselor's invitation. But either way, the counselor's skillful response provides an opportunity for a collaborative relationship to develop.

It's also important to provide clients with support and reassurance. However, generic reassurance ("Don't worry, everything will be okay") or premature reassurance ("I'm sure you don't have any serious problems") can be viewed as inaccurate and patronizing. Instead, use reassurance in ways that promote a sense of universality. Carl Rogers wrote, "The only type of reassurance which has any promise of being helpful is that which relieves the client's feeling of peculiarity or isolation" (1942, p. 165). Be sure to refrain from reassurance unless or until you see or hear evidence that

reassurance might be appropriate. The following are examples of appropriate (universalizing) reassurance:

- Lots of people who come for counseling feel uncomfortable at first. It usually gets more comfortable as we work together.
- Many clients have concerns similar to yours, and they usually find that counseling is helpful.

## Putting Clients at Ease

After explaining confidentiality, you may wish to use a statement similar to the following:

Counseling is unique to every individual. This first meeting is a chance for us to get to know each other. My main goal is to understand your hopes and concerns. Sometimes I'll listen. Other times I'll ask questions. This is also a chance for you to see how I work in counseling. If you have questions, feel free to ask them.

This introduction rephrased in your own words can help put clients at ease. It acknowledges the fact that therapist and client are “getting to know each other” and gives clients permission to ask questions.

## Conversation and Small Talk

Conversation and informal chatting are common methods to help put clients at ease.

- You must be Steven Green. [initial greeting]
- Do you like to be called Steven, Steve, or Mr. Green? [clarifying how the client would like to be addressed, or how to pronounce his name]
- Were you able to find the office [or a place to park] easily? [small talk and empathic concern]
- How was the traffic on the way here? [acknowledgment of challenges associated with transportation]
- [With children or adolescents] I see you've got a Miami Heat hat on. Are you a Heat fan? [small talk; an attempt to connect with the client's world]

Chatting may or may not be important with adult clients. In contrast, with children, adolescents, or with clients from different cultures, initial casual conversation can make or break an interview. Interviews with young

people may succeed partly because, at the beginning of the first session, you take time to discuss the client's favorite music, television shows, video games, toys, foods, hobbies, and sports teams.

### **Personalismo and Cultural Connections**

When working with clients from diverse cultures, remember the Latina(o) principle and practice of personalismo. Personalismo connotes a relational emphasis on informal social connection and can be crucial for rapport with clients from many different cultures. For African Americans, this informal personal interaction is called *person-to-person connection*, and American Indians sometimes refer to it as *respect and reciprocity* (Hays, 2008).

To create personalismo, therapists need to speak casually and informally about social commonalities (Ayón & Aisenberg, 2010). This may involve conversations about the weather, recent news, traffic, parking availability, sports teams, jewelry, clothing, and other topics. However, even comments about the weather may not be without baggage, so caution is recommended. (John regularly gets himself in trouble when expressing his idiosyncratic views on the weather.)

Engaging in personalismo helps transform the therapist from an authority figure within a dominant cultural setting into a real person who deals with traffic and is curious or observant about clothing and other issues. In certain cross-cultural situations, it also creates a connection to share that you have (or don't have) children, depending on the situation and purpose of your disclosure. Because self-disclosure is a technique, it's important to be thoughtful and purposeful when making these disclosures (see Chapter 5).

### **Self-Disclosure: Striking a Balance**

A clinical interview isn't a normal social situation. In the context of therapy, the purpose of self-disclosure is to build rapport, rather than to build a friendship. Beginning an interview with too much self-disclosure or small talk can misguide clients into thinking that the interview is a social encounter. We encourage you to experiment with reasonable and limited self-disclosure under your supervisor's guidance. As Weiner (1998) wrote, limiting your first session disclosures is good practice:

Just as a patient will have difficulty identifying the real person in a therapist who hides behind a professional facade and never deviates from an impersonal stance, so too he will see as unreal a therapist who ushers him into the office for a first visit saying, "Hi, my name is

Fred, and I'm feeling a little anxious because you remind me of a fellow I knew in college who always made me feel I wasn't good enough to compete with him." (p. 28)

## Role Induction and Evaluating Client Expectations

*Role induction* involves educating clients about their role and what to expect in the assessment and treatment process. When implemented well, role induction not only educates clients but also facilitates an interactive discussion about client expectations. Role induction is similar to psychoeducation (see Chapter 6), but focuses primarily on client expectations and the treatment process. Current practice is to integrate role induction into the initial clinical interview (Strassle, Borckardt, Handler, & Nash, 2011). Role induction also continues intermittently throughout psychotherapy.

Role induction is needed because many clients don't understand what a clinical interview, or counseling, entails. Clients benefit from knowing what to expect and how to act in therapy (Walitzer, Dermen, & Conners, 1999).

Clients are less likely to drop out if their therapist engages in "role induction" and provides education about the therapy process. (Teyber & McClure, 2011, p. 52)

During the introduction stage, role induction includes keeping clients informed as to what will happen next. As the session starts, you might begin with a review of client registration forms (including informed consent):

Before we get started, we have some paperwork to review and talk about.

Role induction is part of the informed consent process. It should be straightforward and interactive—and should occur even if your client already filled out and signed a lengthy informed consent form. Remember: No mound of paperwork is a substitute for a conversation about therapy (J. Sommers-Flanagan & Sommers-Flanagan, 2007b).

A conversation similar to the following is recommended:

**Counselor:** Have you heard of *confidentiality* before?

**Client:** I think so.

**Counselor:** Let me briefly describe what counselors mean by confidentiality. It means, what you say here stays here. I'll keep what you say to me private and confidential. However, there are also limits to your privacy. I tell everyone who comes to see me about those limits. If you

share information that leads me to think that you're suicidal or homicidal, I can't keep that information private. Also, if you share information about child abuse or elder abuse, I can't keep that private either. It's not that I suspect that's the case for you; I tell this same thing to everyone up front. Finally, if you give me written permission to release your records to a professional or I'm served with a court order for your records, I'll cooperate with those requests. Do you have any questions about confidentiality?

It's important to be comfortable describing confidentiality. Taking the preceding verbiage and practicing it using your own words can help. Also keep in mind that you'll need to shift your language depending on your individual client's age, culture, language skills, and other factors.

In some cases after a confidentiality explanation, clients will make a joke—usually an awkward one (e.g., “Well, I’m not planning to kill my mother-in-law or anything”). Other times, they’ll respond with specific questions (e.g., “Will you be keeping records about what I say to you?” or “Who else has access to your files?”). When clients ask questions about confidentiality, they may be expressing curiosity, or they may be especially worried about trust. They may have suicidal or homicidal thoughts and want to clarify the limits of what they should and shouldn’t say. Whatever the case, it’s best to respond to questions directly and clearly: “Yes, I’ll be keeping records of our meetings, but only my office manager and I have access to these files. And the office manager will also keep your records confidential.”

If you’re being supervised and your supervisor has access to your case notes and recordings, make that clear as well. For example:

Because I’m a graduate student, I have a supervisor who checks my work. Sometimes we discuss my work with a small group of other graduate students. However, in these situations, the purpose is to help me provide you with the best services possible. Other than the exceptions I mentioned, no information about you will leave this clinic without your permission.

Role induction is also used to inform and affirm the purpose of the interview. For example, if a primary care physician has referred a client for a diagnostic assessment, you might say:

**Clinician:** As you know, Dr. Singh referred you to me because he wanted more information about the symptoms you’ve been experiencing. He asked about your anxiety and depression symptoms, but he also wanted a general assessment of anything that might be bothering you. Is that consistent with your understanding of our meeting?

**Client:** Yes. I haven't been myself lately. I need to understand what's going on.

**Clinician:** Okay. It sounds like you're ready to get to work. I like to start by having you talk a bit, and later I'll start asking lots of questions about your life and your symptoms and whatever else seems important. Does that sound okay with you?

**Client:** Absolutely. Let's go for it.

The explanation you provide varies depending on the type of interview you're conducting. A general statement regarding the interview's purpose clarifies client expectations about what will happen during the session. It can also help clarify client and therapist roles and behaviors. A psychologist who routinely conducted assessment interviews of prospective adoptive parents made the following statement:

The purpose of this interview is for me to help the adoption agency evaluate how you would be as adoptive parents. I like to start this interview in an open-ended way by having you describe why you're interested in adoption and having each of you talk about yourselves, but eventually I'll get more specific and ask about your childhoods. Finally, toward the end of the interview, I'll ask very specific questions about your approach to parenting. Do you have questions before we begin?

In our work as mental health consultants at Job Corps, we often interviewed new students with emotional or behavioral issues. Many of these youth were unhappy about meeting with a mental health professional. We had to be clear about our role and purpose:

Before we start, let me tell you what I know about you and why we're meeting. Your counselor asked me to meet with you because he said you have a history of depression. He wanted me to check in on how you're adjusting here. So, I'm going to spend time getting to know you and then I'll ask you questions about depression and other stuff. Also, just so you know, my job is to help you be successful here. You're not in any trouble. I meet with lots of students. Even though I'll ask you lots of questions today, I hope you feel free to ask me whatever you want to ask.

Another issue to clarify during the introduction stage is the time length of the session. Even if this is in the paperwork, it's crucial to state the session's time limits to your client.

Just to be clear, we've got 50 minutes together today. We started at 2 p.m. and we'll be ending at ten minutes to 3 p.m. Okay?

**Table 3.1** Checklist for Introduction Stage

<b>Therapist Task</b>	<b>Evidence-Based Relationship Factors (see Chapter 7 for more on these)</b>
<input type="checkbox"/> 1. Schedule a mutually agreed-on meeting time.	Working alliance, positive regard, mutuality
<input type="checkbox"/> 2. Introduce yourself.	Congruence, attractiveness, positive regard
<input type="checkbox"/> 3. Identify how the client likes to be addressed.	Positive regard, empowerment
<input type="checkbox"/> 4. Engage in conversation or small talk.	Empathy, rapport
<input type="checkbox"/> 5. Direct the client to an appropriate seat (or let the client choose).	Expertness, empathy, rapport
<input type="checkbox"/> 6. Present your credentials or status (as appropriate).	Expertness
<input type="checkbox"/> 7. Explain confidentiality.	Trustworthiness, working alliance
<input type="checkbox"/> 8. Explain the purpose of the interview.	Working alliance, expertness
<input type="checkbox"/> 9. Check client expectations of the interview for similarity to and compatibility with your purpose.	Working alliance, mutuality, empowerment
<input type="checkbox"/> 10. Clarify time limits.	Working alliance, expertness

Whenever we've forgotten to explicitly provide key role induction information to clients—even if only about the session's length—we've always ended up regretting the oversight. (See Table 3.1 for a checklist of the introduction tasks.)

## VIDEO 3.3

### The Opening

The *opening* is a nondirective or unstructured interview stage lasting about five to eight minutes (Shea, 1998). During this stage, attending skills and nondirective listening responses are used to encourage client disclosure. Your main task is to listen and stay out of the way so that clients can begin telling their stories.

### Your Opening Statement

An opening statement signals to clients that small talk, introductions, and informed consent procedures are over and it's time to begin the interview. An *opening statement* is your first direct inquiry into the client's concerns. The statement is delivered in a calm, easy manner, so it doesn't interrupt interview flow, but occasionally you'll need to assertively cut in to start the interview.

Most clinicians use a standard opening statement. This consists of an open question or prompt designed to get clients to share their concerns.

One common opening is “What brings you here?” A more detailed version is “Tell me what brings you to counseling [or therapy] at this time.” This version comprises the following elements:

- *Tell me.* The therapist is expressing interest in hearing what the client has to say and makes it clear that the client will be doing the telling.
- *What brings you.* This guides the client toward talking about precipitating events or concerns.
- *To counseling.* This phrase acknowledges that coming for counseling is a distinct goal-oriented or help-seeking behavior. It links “the problem” to counseling as a solution.
- *At this time.* Seeking help is based not only on causes but on timing. This part of the prompt implies, “Why now?”

You may or may not be comfortable with these particular words; just be sure to consciously decide on your opening statement.

Alternative openings abound. You can say whatever you like, but it’s useful for your opening statement to include either an open question (i.e., a question beginning with *What* or *How*) or a gentle prompt. The opening statement at the beginning of this section is a gentle prompt—a directive that begins with the words “Tell me.” Other possibilities include:

- What brings you here?
- Where would you like to start?
- How can I be of help?
- Maybe you could begin by telling me things about yourself, or your situation, that you believe are important.
- What are your goals for our meeting?

These first two openings are unstructured; the structure or direction increases as you go down the list. Some clients will respond better to structured openings, while others will appreciate less structure and more freedom of expression.

Your opening statement guides how clients begin talking about themselves and their problems. Odds are, if you ask about something, you’ll hear about it. If you ask, “How’s it going?” you’ll probably get a more casual social report. If you ask, “How has your week been?” you’ll get a description of the past week. (By the way, we never advise opening a session this way, unless your goal is to talk about last week, which is a fairly rare counseling goal.) In contrast, “How can I be of help?” communicates an assumption that the client needs help and that you’ll be functioning as a helper. No opening is without baggage. In general, the purpose of the opening statement is to help

clients talk freely about the personal concerns that caused them to seek professional assistance.

## The Client's Opening Response

Immediately after your opening statement, the spotlight shifts to the client. Listening closely to your client's opening response is an excellent assessment opportunity. Will he or she take your opening and run with it, or hesitate, struggle for the right words, and ask for more direction?

Clients' responses to an unstructured opening (e.g., "What brings you here?") can provide a clue about how they respond to less structured situations. Psychodynamic or interpersonally oriented clinicians consider this initial behavior crucial in understanding client interpersonal patterns or personality dynamics (Teyber & McClure, 2011). Cabaniss, Cherry, Douglas, and Schwartz (2011) described why openings should be . . . open:

Openings should be just that—open—and should generally consist of open-ended questions. The beginning of the session is a time for the patient to speak freely and your opening should encourage this. Let the patient speak in his/her own way for a little while—perhaps 5 minutes or so. This will help you to hear the patient's speech pattern and thought process. It will also let you see where the patient begins and what he/she prioritizes. (p. 100)

## *Rehearsed Client Responses*

Some clients will sound as though they've rehearsed their part.

- Well, let me begin with my childhood.
- Currently, my symptoms include . . .
- I have a list of three things I want to talk about.

There are advantages and disadvantages to working with clients who come prepared for their first interview. The advantages are that these clients have thought about their personal problems and immediately focus on why they've come for therapy. If they're insightful and have a good grasp of why they want help, the interview should proceed smoothly.

Alternatively, client openings that imply a "rehearsed interview" (Shea, 1998, p. 76) can lack spontaneity. Clients might be providing stock interview responses as a defense. They may act emotionally remote or distant. When clients have a rehearsed and emotionally distant start, it may (or may not) be a sign that emotional engagement is part of their problem.

## ***Helping Clients Who Struggle With Self-Expression***

Clients struggle to express themselves for many reasons. It could be the therapist's fault (i.e., lack of clarity in an opening statement). It could be that an unstructured opening was the last thing the client expected. It could be related to cultural issues. Or it could be that taking the initiative and engaging in self-expression will emerge as central therapy issues or goals.

How therapists handle clients who struggle with an opening often depends on theoretical orientation. For now, consider the following evidence-based relationship guidelines.

*Express empathy and positive expectations.* If your client says, "I don't know what I'm supposed to talk about," try, "It can be hard to decide what to talk about right at the beginning, but that's okay . . . give yourself a moment to think of where you'd like to begin."

*Articulate positive expectations about the helpfulness of therapy.* When your client falters, consider saying, "It can be hard to talk about certain topics, but facing and talking about hard things can be helpful."

*Encourage the client to take the lead.* If your client asks, "What should I talk about?" begin nondirectively with something like, "I'll be asking questions later, but to start, whatever you'd like to talk about is fine with me." It's useful to let clients pick where to start because they're the best experts in their own lives.

*Emphasize collaboration.* Let clients know that you're flexible in how you work: "Sometimes it's good to start our session very open ended, with you saying whatever you like. Other times it's good for me to ask specific questions. I can either be quiet and listen or ask you questions, or I can use a combination of listening and questioning. Which way would you like to start?"

*Make adaptations as needed.* Clients may need or want a more structured opening. One reason might be related to culture. Multicultural researchers recommend that culturally competent therapists make adaptations as needed (T. Smith, Rodriguez, & Bernal, 2011). Cultural adaptations might include having an interpreter, inviting the family for an initial interview, serving tea, spending more time with small talk (aka *charlar* in Spanish), using self-disclosure, and other variations on the traditional clinical interview (Hays, 2008). Or you might offer a self-disclosure (family therapists would refer to this as "joining") and combine it with increased structure: "I often find the beginning of a session can be challenging because

it's hard to know what to talk about first. How about if we start by drawing a family tree [genogram]? That way I can get to know a bit more about your family background."

Every client will arrive at your office with different needs and goals. Some clients are uncomfortable talking about the past. Other clients are unwilling to talk about their feelings in the here and now. Sometimes a simple, structured, and casual opening works best with a tongue-tied client. Try something like, "How about if you begin by telling me how your day has been going so far?"

### ***Other Client Responses to Your Opening Statement***

Ideal client responses to your opening statement usually reflect thoughtfulness and the initiation of a working alliance. For example:

I'm not sure of all the reasons I'm here or why I chose to come right now. I've been pretty overwhelmed with stress at work lately, and it's affecting my family life. I guess I'll start by telling you about work and family, and as I go along, maybe you can tell me if I'm talking about the things you need to know about me.

In this case, even though the client isn't perfectly insightful, her start implies motivation and openness to engaging in a therapeutic process.

Some clients will begin interviews in unusual ways that immediately trigger concerns. Imagine the following client responses:

- I've come because the others told me to come. You will be my witness.
- At this point, I've lost the will to live.
- It's by the grace of God that I'm sitting before you right now. May I pray before we begin?

It's obvious that the preceding opening client statements mean something, but what they mean in particular is less obvious. The first client might be psychotic or delusional, the second appears suicidal, and the third seems highly religious. However, it's usually standard practice to proceed with caution when using client introductory statements for assessment purposes. This means that, consistent with the principles of scientific mindedness (see Chapter 1), you can formulate hypotheses, but avoid firm conclusions. Initial client verbalizations can be illuminating, but more data and more time are needed to confirm your first impressions.

## Evaluating and Responding to Client Behavior During the Opening

As clients begin talking, ideally you'll observe their responses and modify your approach accordingly. With clients who are very verbal, you may need to interject yourself into the interview early and often. You might:

1. Progressively ask more closed questions to interrupt the client's monologue. (See Chapter 5 for more information on using questions.)
2. Use psychoeducation (see Chapter 6) to explain that you'll be occasionally interrupting to make sure you're tracking accurately.
3. Avoid open-ended or exploratory questions.

Another client style you might notice is the tendency to use an internal frame of reference when describing problems. For example:

I feel anxious in groups. It feels like everyone's staring at me. I've been this way forever. And I'm depressed about it because I can't get myself to do some things I'd like to do. I'm just a total mess.

Clients who use an internal frame tend to self-criticize and self-blame. They may start the session with self-criticism and not stop until the end. They're sometimes referred to as *internalizers* because they describe their problems as having internal causes. Internalizing clients seem to be saying, "There's something wrong with me."

Other clients are described as *externalizers*. They communicate the message, "I'm fine, but everybody else in my life has a problem." A client who tends to externalize might say:

My problem is that I have a ridiculous boss. He's rude, stupid, and arrogant. In fact, men in general are insensitive, and my life would be fine if I never had to deal with another man again. My daughter thinks I'm rude, but she's the rude one, and so are my coworkers.

Clients with externalizing tendencies believe that their troubles stem from others. Although there may be truth to this, it can be difficult to get them to accept responsibility and focus on their own feelings, thoughts, and behavior.

Realistically, client problems usually derive from a combination of personal (internal) and situational (external) factors. It's useful, especially during the opening stage, to listen for whether your clients seem to be taking too much or too little responsibility for their problems.

Table 3.2 lists tasks for the opening stage of the interview.

**Table 3.2** Checklist for Opening Stage

Therapist Task	Technical Approaches
<input type="checkbox"/> 1. Continue working on rapport.	Nondirective listening
<input type="checkbox"/> 2. Focus on the client's view of life and problems.	Open-ended questioning, gentle prompting
<input type="checkbox"/> 3. Provide structure and support if necessary.	Reflections of feeling, clarifying the purpose of opening stage, narrowing the focus of opening question
<input type="checkbox"/> 4. Help clients adopt an internal rather than external frame of reference if culturally appropriate.	Nondirective listening, therapeutic questioning
<input type="checkbox"/> 5. Evaluate how the interview is proceeding and think about what approaches might be most effective during the body.	Paraphrasing, summarizing, role induction, therapeutic questioning

**VIDEO  
3.4**

## The Body

All clinical interviews include continuous and varying degrees of assessment and/or helping. If you think back to first contact during the introduction stage, you'll recall that it involves assessment (i.e., data gathering) and helping (initiating collaboration to build a working alliance). If you look forward, you'll see (soon) that assessment and helping are also part of the closing and termination interview stages.

The *body* is the longest clinical interviewing stage. It's where most of the assessment and helping activities are implemented. At least four factors drive the content and process during the body of the interview: (a) the purpose of the interview, (b) your setting, (c) your theoretical orientation, and (d) the client's problems or needs. Although the body is the core of your interview, your assessment data will be more valid and your interventions more efficacious if you do a good job addressing tasks associated with the other interview stages (see Case Example 3.2).

### CASE EXAMPLE 3.2: ADMINISTERING THE STRUCTURED CLINICAL INTERVIEW FOR DSM-5—CLINICIAN VERSION (SCID-5-CV)

Malik is employed as a psychology intern at a veteran's hospital. He and other interns are responsible for administering, as a part of the hospital's intake process, the Structured Clinical Interview for DSM-5—Clinician Version (SCID-5-CV) to new patients within 72

hours of admission. For every new patient assigned to his assessment caseload, he finds the patient in the hospital, introduces himself (making first contact), and schedules the appointment. He then meets with each patient to administer the SCID-5-CV. During his meeting, he opens the session, discusses the limited nature of confidentiality, explains the SCID-5-CV administration process (i.e., provides a role induction), administers the SCID-5-CV, and then takes care of tasks associated with the interview closing and schedules a follow-up appointment to give the patient feedback and assign the case to a hospital clinician. Although the bulk of time during the interview involves administration of the SCID-5-CV, Malik's sensitivity to all interview stages helps his patients understand the process and reap greater benefits.

## Assessment

When assessing clients, clinicians are making a series of judgments about a number of issues, including the following:

- Whether clients are normal or deviant
- The level and sophistication of clients' social or interpersonal skills
- How much distress clients are experiencing
- What sorts of coping skills clients have in their repertoire
- Whether clients are more or less likeable, hostile, self-absorbed, obsessive, internalizing, externalizing
- What theoretical orientation might be the best fit for clients and their presenting problem(s)

A primary problem with the whole assessment process is that we all have biases and blind spots. As human beings, we're subjective, and we filter information not only through our own senses but through our own experiences. This makes it easy for assessments to be in error.

To mitigate the problem of subjectivity in assessment, clinicians use scientific principles. In particular, we use standardized procedures that reduce individual variability and bias. This facilitates data collection that's consistent (reliable) and true (valid). In addition, when possible, data collected are compared with appropriate population norms. Generally, more structured (standardized) clinical interviews produce more reliable and valid data. (See Chapter 11 for specific information and guidance on diagnostic interviewing.)

Even when clinicians use standardized methods to produce reliable and valid data and normative samples, all efforts to know the complete truth

about someone else will fall short. Cultural differences further impede the ability to make firm conclusions about individual clients based on standardized assessment procedures (Hardin, Robitschek, Flores, Navarro, & Ashton, 2014). To compensate for this, it's extremely important for clinicians to remain humble and collaborative during the assessment process and when reporting assessment results.

## Defining Mental Disorders

Sometimes the exclusive function of a clinical interview is to provide a psychiatric diagnosis. Although checklists and decision trees are available to help make diagnostic decisions, understanding how to make distinctions between normal/healthy functioning and disturbed/disordered functioning will serve you well. Further, when conducting a diagnostic assessment interview, being familiar with the *International Classification of Diseases*, 10th edition (*ICD-10*; World Health Organization, 2004) and the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*; American Psychiatric Association, 2013) is essential.

The fact that the *ICD-10* and *DSM-5* provide authoritative guidance for diagnosing mental disorders shouldn't be used to dismiss the long and continuing struggle over how to best define mental health problems. This struggle is intermittently political—as illustrated in the roiling controversies associated with publication of the *DSM-5* (Frances & Widiger, 2012). A basic question imbedded in the psychiatric diagnostic process is, “How can we best judge whether an individual is experiencing a mental disorder?”

Some prominent scholars and practitioners take the position that mental illness does not exist (Szasz, 1970). This position is technically correct; no one is ever diagnosed as having a mental illness. Although mental illness is a popular term in contemporary society, mental health professionals who are charged with the responsibility for psychiatric diagnoses don't use that term. “Mental disorder” is standard terminology for assigning psychiatric diagnoses (see Chapter 11).

## General Criteria for Mental Disorders

To deepen your understanding of psychiatric diagnosis, it can be helpful to temporarily put aside the *DSM* and *ICD* diagnostic criteria. Even without the *DSM* and *ICD* systems, whether specific human behaviors or conditions qualify as mental disorders can be examined using four questions:

1. Does the behavior or condition interfere with important social or occupational functioning? This is the *impairment or disability criterion* (e.g., attention-deficit/hyperactivity disorder or social anxiety disorder).
2. Does the behavior cause significant personal distress? This is the *distress criterion* (e.g., panic disorder or major depression).
3. Do other people consistently find the behavior disturbing? This is the *disturbance criterion* (e.g., conduct disorder, antisocial personality disorder, or substance-related disorders).
4. Is the behavior rationally or culturally justifiable, or caused by a medical condition? These are *universal exclusion criteria* and speak to the importance of context in diagnosis. If rational thought, cultural context, or a medical condition explains the behaviors in question, then a mental disorder should not be diagnosed.

We hope you noticed that the preceding list doesn't include behavior that's statistically deviant from the norm as a criterion for mental disorder. This is an interesting issue. Technically, although statistically deviant behavior is "abnormal," abnormal behavior isn't diagnosable unless it causes impairment, distress, or disturbance.

## Applying the Four Principles

These four principles can be applied to almost any clinical observation that takes place during an interview. For example, if a client exhibits symptoms of depression or sadness, you could consider the following questions:

1. Is the sadness adversely affecting the client's interpersonal relationships, ability to function at work, or enjoyment of recreational activities?
2. Is the sadness disturbing or upsetting to the client?
3. Is the sadness particularly disturbing to other people in the client's environment?
4. Is there a rational or cultural or medical explanation for the client's sadness? For example, was there an event that's logically associated with your client's sadness (e.g., the death of a loved one or a series of failures)?

The preceding guidelines are designed to aid you in your thinking about psychopathology or mental disorders. They also can help with identifying client goals or your therapy focus. Of course, you shouldn't rely solely on any one of these criteria to determine the presence or absence of a mental disorder. Each criterion—when applied in isolation—has substantial shortcomings.

### MULTICULTURAL HIGHLIGHT 3.1: WHERE DOES THE PROBLEM RESIDE? EXPLORING SOCIETY'S CONTRIBUTIONS TO CLIENT PROBLEMS

Renowned family therapist Salvador Minuchin gathered research and clinical data on eating disorders and asthma in children and adolescents (Minuchin, Rosman, & Baker, 1978). He found that successful interventions for physical problems could involve the entire family, rather than just the afflicted individual. He concluded that the locus of pathology for these problems was not *in the individual*, but instead centered within families.

In contrast to Minuchin, the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* defines mental disorders as residing within individuals (American Psychiatric Association, 2013).

If you were aware of only the *DSM*'s and Minuchin's perspectives, you might think they're on opposite ends of a conceptual continuum. In reality, both the *DSM* and Minuchin represent "moderate" etiological perspectives. Proponents of biological psychiatry hold more extreme views; they believe that mental disorders are biogenetically predestined within the individual (Horwitz & Wakefield, 2007).

In contrast, clinicians operating with feminist, multicultural, or social justice roots view oppressive social and cultural factors as causing individual problems. They believe that mental disorders aren't caused by genes or families or individuals; disturbed and disturbing social factors are the root causal factors.

Biological psychiatrists might even claim that the words *mental disorder* are inaccurate (and *mental illness* more accurate), whereas Thomas Szasz (1970) and William Glasser (2003) claimed that there's no such thing as mental illness. Table 3.3 describes these four viewpoints.

**Table 3.3** Four Explanations for Mental Health Problems

Biological Psychiatry	DSM-5	Minuchin	Feminist or Multicultural
Client problems are a product of individual biogenetics.	Client problems reside in the individual, but can be provoked or maintained by cultural factors.	Client problems are a function of family and environmental contexts.	Client problems are caused by social and cultural oppression.

Where do you fall in this debate? Do you find one of these explanations for human problems more compelling than others? Or do you think all these viewpoints have merit?

## Interventions

During the body of the interview, therapists can use interventions to facilitate client change. Ideally, most interventions will be applied after a suitable assessment has been completed. However, in many cases, assessment and intervention happen simultaneously.

From a solution-focused or constructive perspective, assessments and interventions are inseparable. This is because of the underlying philosophy that all change is founded on linguistic construction. Consequently, when constructive theorists say, “Therapists are not just taking history; they’re making history,” they’re referring to the likelihood that change begins based on the way the therapist and client talk about the client’s lived experiences and potential future.

Whatever your theoretical orientation, after you have established a therapeutic relationship and obtained adequate background information, the body of the interview is where you’ll actively work for change. Behavior therapists will use reinforcement, response cost, participant modeling, and exposure during this stage. Cognitive therapists will question maladaptive thoughts and explore core client schemata. Person-centered therapists will use the therapeutic relationship to enable clients to engage in deeper encounters with the self. Psychoanalytic therapists will listen and interpret. Constructive therapists will use therapeutic questions. Feminist therapists will focus on how power and social forces are linked to client distress.

The body of the interview is where the therapeutic action resides. However, of equal importance is the transition out of the body and into the closing . . . and regardless of your theoretical orientation, you’ll move into the closing stage. Tasks for the body stage of the interview are listed in Table 3.4.

**Table 3.4** Checklist for the Body Stage

Therapist Task	Therapist Tools
<input type="checkbox"/> 1. Transition from nondirective to more directive listening.	Use role induction; explain this shift of style to the client.
<input type="checkbox"/> 2. Gather information.	Use open and closed questions (see Chapter 5).
<input type="checkbox"/> 3. Obtain diagnostic information.	Use the <i>DSM</i> , <i>ICD-10</i> , or a structured diagnostic interview protocol.
<input type="checkbox"/> 4. Apply appropriate interventions.	Use interpretation, confrontation, therapeutic questions, or other interventions depending on your theoretical orientation.
<input type="checkbox"/> 5. Shift from information gathering or intervention to preparation for closing.	Acknowledge that time is passing; explain and discuss the need to summarize major issues.

## The Closing

As time passes during an interview, you may begin feeling pressure. It can start to feel like a race to see if you can fit everything into a 50- or 90-minute session. Chad Luke (personal communication, August 10, 2012)

**VIDEO  
3.5**

suggests that a key to a smooth closing is to begin a process of reflecting on the session about halfway through, with a question like, “We’re about half-way through our session, and I’m wondering how you’re feeling about our time together so far today?” This gives clients an opportunity to provide feedback and serves as a marker to gauge the passing of time (Lambert & Shimokawa, 2011). Another key to a smooth closing is to consciously stop gathering new information somewhere between 5 and 10 minutes before your interview time is over. Shea (1998) noted, “One of the most frequent problems I see in supervision remains the over-extension of the main body of the interview, thus forcing the clinician to rush through the closing” (p. 130).

Clients also may feel increasing tension as time passes. They might worry about whether they’ve expressed themselves adequately and if they can be helped. Clients also sometimes feel worse than when the interview started because they’ve spent most of an hour talking about their problems. Leaving ample time for closure will allow you to address these possible issues.

### **Reassuring and Supporting Your Client**

Clients need reassurance and support in at least two main areas. First, they need to have their expressive capabilities noticed and supported. Nearly all clients who seek professional assistance do the best they can during the interview. The first contact can be challenging and sometimes anxiety provoking. Comments such as the following can help:

- You covered lots of ground today.
- I appreciate your efforts in telling me about yourself.
- First sessions can be difficult because there’s so much to cover and so little time.
- You did a nice job describing yourself in a very short time period.
- Thanks for being open and sharing so much with me.

These comments acknowledge that interview situations can be difficult and commend clients for their efforts.

Second, most clients have ambivalent feelings about therapy; they have hope for help, but fear the experience. Therefore, you should support the client’s decision to seek professional services, siding with the hopeful part of that decision. For example:

- You made a good decision when you decided to come for an appointment.
- Congratulations on getting here today. Coming to counseling can be hard. Getting help is a sign of strength.

These statements acknowledge the reality of how difficult it can be to seek professional help.

Even when clients behave defensively and avoid disclosing information, you should recognize and acknowledge that they're doing their best. It can be useful to comment on the difficulty of the task or on how the client seemed to be reluctant to talk. Expressing anger or disappointment should be avoided. Maintain an optimistic frame:

I know it was hard for you to talk today. That's not surprising; after all, we don't really know each other yet. Usually this counseling thing gets easier over time and as we both get more comfortable.

## Role Induction, Revisited

It's not unusual to return to role induction during the closing stage. For example, imagine that toward the end of her first session, a client tells you about her feelings of insecurity:

I'm not sure if I should bring this up. But because you let me talk about a lot of different things, I'm not sure I talked about what I was supposed to talk about.

This statement reflects at least three possibilities:

1. The client truly doesn't know what's okay and what's not okay to talk about in therapy and needs instruction or reassurance about what's important.
2. The client is exhibiting self-doubt and has maladaptive cognitions about her performance. She needs to have this gently reflected back and put in context.
3. The client is experiencing an initial transference reaction. She knows she talked about what she wanted to talk about, but is worried about what her therapist thinks of her.

In all three cases, it's best to begin with a statement supportive of client openness. Your role induction might sound like either of the following:

- I'm glad you shared your worries. That's an important part of counseling. I hope you can always speak openly here, because if you don't speak openly, it will be harder for me to know how to be helpful.
- Whenever you start wondering whether you should say something or not, you should just go ahead and say it. Then we can decide together whether we should talk about it in greater depth.

If, in this situation, you were working from a cognitive-behavioral perspective, you could provide psychoeducation (see Chapter 6) about automatic thoughts:

What you just said is important. It shows me that you're having some negative automatic thoughts about yourself and counseling. This is exactly the kind of thing we'll be talking about because, although counseling may or may not be helpful, it's too soon for either of us to jump to a conclusion that your situation is hopeless and counseling won't be helpful.

Another possibility in the preceding situation is that, after spending 45 minutes talking about her challenging life, the client is feeling even more discouraged or demoralized than when she walked into the office. If so, the following psychoeducation would be appropriate:

Sometimes just talking about your problems can temporarily make you feel worse. It's like when you're cleaning house, and right when you start, it feels overwhelming and hopeless. But, just like housecleaning, if you stick with counseling, it feels much better when you're finished.

When clients are uncertain about the counseling process and whether they're doing it "right," it's your job to reduce the confusion.

### **Summarizing Crucial Themes and Issues**

Perhaps the most important closing task is "solidifying the patient's desire to return for a second appointment or to follow the clinician's referral" (Shea, 1998, p. 125). An excellent method for enhancing clients' motivation to return is to accurately summarize their therapy goals:

Based on what you said today, it seems you're here because you want to feel less self-conscious when you're in social situations. You'd like to feel more positive about yourself. You said, "I want to believe in myself," and you also talked about how you want to figure out what you're feeling inside and how to share your emotions with others you care about.

If you can summarize the specific ways in which clients want to improve their lives, they'll be more likely to return to see you or follow your recommendations. Providing this summary also shows clients that you've heard and understood them.

## Providing an Initial Case Formulation

Case formulation or case conceptualization is a cornerstone of effective treatment (Persons, 2008). *Case formulation* involves integrating assessment information with a theoretically supported or evidence-based approach to guide subsequent therapeutic work. To place this in context: the treatment plan focuses on *what* you and your client will do together to address client problems; the case formulation is the explanation for *why* you've chosen your particular treatment plan.

Nearly a century ago, Alfred Adler (1930) emphasized that client insight enhances motivation. More recently, it has become clear that collaboratively developing a treatment plan is an empirically supported therapy component (Tryon & Winograd, 2011). If you can describe your clients' central problem(s) and explain how they can address this problem in therapy, clients will often experience (a) insight, (b) the sense of being known or understood, (c) enhanced motivation, and (d) hope for change.

It's too much to expect beginning therapists to smoothly articulate a comprehensive case formulation and treatment plan at the end of an initial session. Even experienced therapists sometimes wait until their second or third session before providing a clear treatment plan (Ledley, Marx, & Heimberg, 2010). However, if you're ready to provide a plan, it fits well into the closing stage of the interview.

At the least, you should provide a summary of the client's problem combined with a tentative explanation of the likely treatment approach (and how it fits well with the presenting problem). Asking clients for permission facilitates this process:

Is it okay if I just go ahead and share with you my thoughts about your main concerns and how we might address these concerns in counseling?

In virtually every case, clients will respond affirmatively to this request.

After obtaining your client's permission, you can offer an initial case formulation. During a closing with a client who had anger management issues, the following case formulation was offered (adapted from J. Sommers-Flanagan & Sommers-Flanagan, 2004):

We talked a lot about anger today. I've been struck by how your anger is related to your high standards for yourself and others. If I were to try to describe it in a word, I'd say you seem *perfectionistic*. It seems like your perfectionism is linked to your anger. And so as we work together, it could be very helpful to focus on the thoughts and expectations you

have for yourself and how they set you up to get angry in different situations. How does that sound to you?

Or, with a client who presents with depressive symptoms, you might offer the following initial case formulation.

You told me about how depressed you feel sometimes. Is it okay with you if I share with you some of what I'm thinking about you and your tendency to feel depressed? [Client responds affirmatively].

One thing that seems to increase your down feelings is that you have an automatic thought process that comments—very often, very quickly, and very negatively—on you and your behavior. When you're in social situations, those thoughts flood into your head, and you think negatively about what you're wearing, you believe you're saying stupid things, and you tell yourself no one could ever like you. It's no big surprise that you don't enjoy yourself and feel miserable after the social event. Does this make sense to you? [Client says, "Absolutely it does."]

Good. I'm glad this makes sense. One part of our plan, if it's okay with you, will be to develop strategies to interrupt these automatic thoughts. We might do it with mindfulness activities or with gentle questioning of the validity of your thoughts or with specific behaviors that help you get that negative voice out of your head. How does that sound? [Client says, "That works for me."]

Initial case formulations should be simple, straightforward, and light on the jargon. They also should be brief, based on what you've been talking about, and not especially deep. If your initial session goes well, you'll have chances to go deeper later.

### **CASE EXAMPLE 3.3: HOW CULTURAL FACTORS CAN INFLUENCE SYMPTOMS, CASE FORMULATION, AND TREATMENT PLANNING**

Although the body of an interview can include an intervention, during initial interviews the body mostly involves assessment and information gathering that leads to case formulation and treatment planning. This case example illustrates how culturally sensitive assessment leads to case formulation and the development of a culturally appropriate treatment plan.

A young Puerto Rican man was living with his mother in the United States, dating a woman, and planning to get married. He started having hallucinations of a large white ghost visiting him

while he was sleeping or lying in bed with his girlfriend. The ghost would sit on his chest and prevent him from breathing. Many Western-trained professionals might link these symptoms with the onset of a psychotic disorder.

The young man came for an intake interview. There, he began talking about feeling attracted to men, but not to his girlfriend. A part of him was telling him that he was gay, but another part was telling him to fight that image—because being gay wasn't culturally acceptable. He believed his mother would die if he came out as gay.

During the interview, he reported that the ghost visited him only when he was in bed with his girlfriend. Through further exploratory questioning, the clinician discovered that the ghost-visiting phenomenon wasn't uncommon in this young man's home culture, especially when people were experiencing internal conflict.

Over the course of the interview, the clinician's hypotheses about what was happening in this case transformed dramatically. Initially, he was concerned about psychotic symptoms or sleep-onset-related hallucinations. Later, he became concerned about internal conflicts generating excessive stress. In the end, he recognized that the ghost was not a hallucination, but represented a cultural manifestation of the conflict. Eventually, his case formulation informed his treatment plan. Instead of referring the client to a psychiatrist for a medication evaluation, treatment involved supporting the client in arranging a visit to his home country, finding a gay-friendly clergyperson to speak with, and eventually breaking up with his girlfriend. The ghost visits subsided and became an interesting footnote in this client's personal history.

## Guiding and Empowering Clients

You've spent 40 to 45 minutes with someone you've never met before, and listened to fears, pain, confusion, problems, and goals. You hope you've listened well, summarized along the way, and, when necessary, guided your client to talk about important material. Regardless of how accepting you've been, it's natural for your client to worry about your judgments. No matter how many invitations for collaboration you've offered, your client may still feel the experience was one-sided; after all, you know a fair amount about your client, but your client knows very little about you. Therefore, it's useful to explicitly empower your client during the closing stage. You might say, for example,

- I've asked you a lot of questions. Do you have questions for me that you'd like to ask before we close?
- Has this interview been as you expected it to be?

- Are there any areas that you feel we've missed or that, if we meet again, you'd like to discuss at greater length?
- What do you want to remember from our time together today?

Although you want to keep control toward the end of an interview, it's also important to share that control. In most cases, clients won't jump in with lots of questions or comments; however, offering collaboration again during the closing is empowering. Questions, comments, and feedback from clients also can push you in ways that augment your professional growth.

## Progress Monitoring

The addition of progress monitoring data to any therapeutic approach appears likely to decrease treatment failures, thus meeting the need for increased accountability. (Meier, 2015, p. 3)

At this point it should be clear: If you want to be a clinician who follows the contemporary literature on treatment outcomes, collaboration is in, and authoritative approaches that minimize client input are out.

*Progress monitoring* (PM) is an evidence-based approach that involves using brief symptom-oriented questionnaires to elicit client feedback about therapy progress. Researchers have consistently reported that formal progress monitoring is linked to fewer treatment failures and more positive treatment outcomes immediately after therapy and at six-month follow-up (Byrne, Hooke, Newnham, & Page, 2012; Meier, 2015). PM empowers clients to provide feedback to clinicians about their symptoms, usually toward the end of each therapy session.

Formal PM is likely to be introduced during the initial clinical interview's closing stage. You might say:

Research has shown that it's very important for you to tell me how therapy is going and whether you're feeling better, worse, or the same. One method we have for that is for me to just directly ask you . . . and I'll do that from time to time. But it's also important for you to take a short questionnaire after most of our sessions. This questionnaire is sort of like when a doctor takes your blood pressure and temperature at the beginning of every appointment. Today, you'll take the questionnaire at the end of our appointment, but from here forward, I'll have you take the questionnaire just before we meet every week. That way,

in addition to what you tell me face-to-face, I'll have a consistent measure of how you're doing. Is that okay with you?

Some clients will resist formal PM assessments. If they do, you should regularly and informally ask for feedback about their ongoing symptoms and treatment progress. In addition to symptom-oriented PM, many clinicians now also use short instruments for evaluating and monitoring the quality of the therapy relationship during the closing stage of each session (Meier, 2015).

## Instilling Hope

Accurately summarizing why your client has sought professional assistance and making an initial case formulation statement can implicitly instill hope in clients. However, because hope has long been shown to be a central force in treatment outcomes, it also makes sense to make hopeful or positive statements explicitly about counseling (Frank & Frank, 1991; J. Sommers-Flanagan, Richardson, & Sommers-Flanagan, 2011). These hopeful statements can be very brief. For example, "You've made a wise decision to try counseling. I think this will help."

Hopeful statements can also be integrated into your initial case formulation:

This anger has been troubling you for some time, and you've made valiant efforts to deal with it. But I think that if we dig down into your perfectionism and then build a concrete plan for how you can deal with both the perfectionism and the anger, we'll be successful in our work together.

If you believe therapy can help, part of your job is to communicate that belief. Many clients are naïve about the potential benefits (and detriments) of psychotherapy. Of course, you should only make positive and hopeful statements if you actually believe them.

## Tying Up Loose Ends

The final formal task is to clarify whether there will be further professional contact. This involves concrete steps, such as scheduling the next appointment, dealing with fee payment, and handling other administrative issues linked to your particular setting. Table 3.5 is the checklist for the closing stage.

**Table 3.5** Checklist for the Closing Stage

Therapist Task	Therapist Tools
<input type="checkbox"/> 1. Reassure and support the client.	Reflection of feeling; validation; open appreciation of your client's efforts at expression
<input type="checkbox"/> 2. Summarize crucial themes and issues.	Summarizing; use of interpretation to determine client's insight and ability to integrate themes and issues
<input type="checkbox"/> 3. Provide an initial case formulation.	Questions; summarizing; psychoeducation
<input type="checkbox"/> 4. Instill hope.	Suggestion; explanation of counseling process and how it is usually helpful
<input type="checkbox"/> 5. Guide and empower your client.	Questions; asking client for comments or questions of you
<input type="checkbox"/> 6. Tie up loose ends.	Questions; clarification; collaborative scheduling of next appointment

**VIDEO  
3.6**

## Ending the Session (Termination)

Some professionals believe that the end of each session is an unconscious reminder of all things that end, including life itself. Although comparing an interview's end with death is a bit dramatic, it does point out how important endings are in our lives. For many, saying goodbye is difficult. Some of us bolt away, avoiding the issue altogether; others linger, hoping it won't happen; still others have emotional responses such as anger, sadness, or relief. The way that clients cope with a session's end may foreshadow eventual termination of therapy. Responses to termination may also represent our own or our clients' psychodynamics regarding separation and individuation, cultural differences, or situational stressors. Termination (aka ending) is an essential and often overlooked component of clinical interviewing.

## Watching the Clock

You shouldn't literally, or at least overtly, watch the clock. However, you're responsible for ending sessions on time; this means being very aware of time passing. Your goal is to experience a smooth closing and ending. If your client is from a culture with a less linear conception of time, it may be necessary to acknowledge those differences and apologize for the fact that your clinical situation requires observing formal time boundaries (Hays, 2013).

The ideal is to finish with all clinical business on time so that the client's termination behavior can be observed. When it's time to end the session, clients often begin thinking, feeling, and behaving in ways that give you clues regarding interpersonal dynamics, therapy issues, psychopathology,

and diagnosis (see Putting It in Practice 3.3). Some client behaviors at the ending require immediate attention, whereas others simply require a firm but kind statement, such as “I’m glad you mentioned that. Let’s start there next week.”

## Guiding or Controlling the Ending

*Termination* or *the ending* of the clinical interview occurs as both parties acknowledge that the meeting is over. This may involve escorting clients out, along with a comfortable farewell ritual. One of our colleagues always says, “Take care” in a kind voice but with a tone of finality. Some clinicians like to set up the next appointment and finish with “See you then.” We also recall, with some chagrin, a colleague who would peek her head out of her office as the client was leaving and say, “Hang in there!”

It’s worth considering in advance how you’d like to end your sessions. It’s also wise to practice various endings ahead of time with colleagues. Find a comfortable method of closing sessions firmly and gently.

### **PUTTING IT IN PRACTICE 3.3: DOORKNOB STATEMENTS**

*Doorknob statements* are statements that clients make just as they’re getting up to leave or as they walk out the door. In a small group or with a partner, review the following doorknob statements and actions and discuss their potential significance.

- Thanks so much for your time today. You’re the best! [Imagine this accompanied by a handshake or an attempt to give you a hug at the end of every session.]
- By the way, my thoughts about killing myself have really intensified these past few days. [Clients sometimes wait until the final minute of a session to mention suicidal thoughts.]
- Do you think we could get together for coffee sometime?
- So that’s it? When will I start feeling better?

Sometimes clients will proactively end the session. We’ve had clients closely watch the clock and then, 2, 5, or even 15 minutes before their time is up, stand up abruptly, and say, “I’m done talking for today” or “I guess our time is up.”

As a rule, interview sessions have a designated ending time, and clients shouldn’t be automatically excused early (although certain clients, such as adolescents, commonly claim that they have nothing else to talk about and request to be “let out” early). When adult clients want to leave early, it may be a sign of anxiety; the desire to leave may be a defense—conscious or

otherwise—designed to avoid experiencing and talking about something difficult. It can also be an indirect way of expressing anger or disappointment in the counseling experience or in you.

Exploring what motivated your client to terminate a session early can be worthwhile, although because there may be deeper emotional or interpersonal dynamics, you should do so sensitively. Sometimes a gentle clarification of the time boundary and an offer to summarize are effective.

Actually, we've got about six minutes left, so if it's okay with you, I'd like to use that time talking about what you thought was most and least helpful about our meeting today.

Following are several other strategies you can use when you encounter clients who want to terminate an interview early:

- Use the time to solicit feedback from clients on their perception of the session and of your work together.
- Consult your notes or an outline to check whether you've covered all the issues you wanted to cover during the interview (e.g., "Let me look through my notes to see if there's anything to check back in on").
- Let clients know there's no hurry by saying something like, "We still have plenty of time left," and then keep working on your closure tasks.

Your client may be desperate to leave early. Engaging in a power struggle to keep clients in the room is a bad idea. Instead, accept the client's choice, making a note to explore leaving early if you have a next meeting. If your client is leaving early and seems to have no intention of ever coming back, you can make a statement suggesting that, sometime in the future, he or she might come back for another meeting or visit a different professional. For example:

I can see you really want to leave right now, even though we still have plenty of time remaining. Maybe you've talked about everything you wanted to talk about, or maybe you don't want to go deeper into personal issues. I don't want to force you to stay and talk. But I hope you'll come back and meet with me or someone else in the future if or when you'd like to talk more.

## Facing Termination

Our own issues can affect how we handle termination. If we're characteristically worried and hurried, it can show in the way we say goodbye. If we're

unsure of ourselves or not convinced we did a good job, we may linger and “accidentally” go overtime. If we’re typically assertive and the client keeps trying to share just “one more thing,” we might abruptly usher her from the room.

Time limits are important from a practical and an interpretive perspective. For your own professional survival, you should begin and end on time. At a deeper level, sticking with time boundaries models for your clients that, like life, therapy is bound in time, place, and real-world demands. You’re not omniscient; you can’t give clients extra time to compensate for the difficult lives they’ve had. Your time with clients, no matter how good, must end. You must stand firm when clients push time boundaries.

Students sometimes feel guilty for firmly ending sessions on time. They allow clients to go on and break the rules just a little. This doesn’t serve clients well in the end, even though they may feel special or believe they got a little extra for their money. In fact, wishing for or demanding special status may be what they need to face and work on. Limitations of the real world aren’t easy, and neither is ending an interview. By doing so in a kind, timely, professional manner, the message you give your client is, “I play by the rules, and I believe you can, too. I’ll be here next week. I hold you in positive regard and am interested in helping you, but I can’t work magic or change reality.”

Table 3.6 lists the tasks for this final stage of the interview.

**Table 3.6** Checklist for the Ending Stage

Therapist Task	Therapist Methods
<input type="checkbox"/> 1. Watch the clock.	Place a clock where you can see it. Paraphrase. Make feeling reflections.
<input type="checkbox"/> 2. Observe for client’s significant doorknob statements.	Explain that time is nearly up.
<input type="checkbox"/> 3. Guide or control termination.	Use a standardized ending. Make a warm and comfortable termination statement. Discuss termination and time boundaries with your client.
<input type="checkbox"/> 4. Face termination.	Evaluate your own response to ending sessions. Stay within time boundaries.

## Summary

Researchers and clinicians use various models to describe the temporal and process structure of what occurs during a clinical interview. A generic

model used in this chapter consists of five stages: (a) introduction, (b) opening, (c) body, (d) closing, and (e) ending (or termination).

The introduction stage begins with first contact. This may involve online, telephone, or face-to-face contact. It's important to plan how to handle first contacts with prospective clients. Although it's recommended that therapists follow a standard procedure when first meeting clients, flexibility is also desirable. During the introduction, therapists educate clients on key issues such as confidentiality and the interview's purpose. There are many different tactics or strategies therapists use to establish an initial rapport with clients. These strategies include education, reassurance, courteous introductions, light conversation, and flexibility. When working with clients from cultural minority groups, a personal approach with friendly small talk can be helpful.

The opening stage of an interview begins when therapists make their first open-ended inquiry into the client's condition. The opening stage includes several components, comprising therapists' opening statements, the clients' opening responses, and therapists' observations of client behavior. The opening stage ends when therapists have listened carefully to the main reasons why clients have sought professional assistance.

The body of an interview focuses primarily on information gathering, but also can include interventions. Information is gathered to contribute to case formulation and treatment planning. The body of an interview sometimes focuses exclusively on the diagnosis of mental disorders. The general criteria for mental disorders include whether they cause clients impairment or distress, significantly disturbs others, and isn't rationally or culturally justifiable.

During the closing stage, there's a shift from information gathering to activities that prepare clients for the termination of the interview. Clients and therapists may feel pressured during this part of the interview because time is running short, and there's usually much more information that could be obtained or additional feelings that could be discussed. Therapists should summarize key issues discussed in the session, provide an initial case formulation, introduce progress monitoring, instill hope, and empower clients by asking them if they have questions or feedback.

Ending the interview can bring important separation or loss issues to the surface for both clients and therapists. Clients may express anger, disappointment, relief, or other strong emotions at the end of an interview. These emotions may reflect unresolved feelings that the client has concerning previous separations from important people. Time management is crucial. It's important that therapists plan how they can most effectively end their interviews.

## Suggested Readings and Resources

This chapter contains numerous topics woven together to form the structure and sequence of the clinical interview. The following readings may help further your understanding of these issues.

Carlson, J., Watts, R. E., & Maniacci, M. (2006). *Adlerian therapy: Theory and practice*. Washington, DC: American Psychological Association. This text orients you to the stages of interviewing and counseling from an Adlerian theoretical perspective.

O'Donohue, W. T., & Cucciare, M. (Eds.). (2008). *Terminating psychotherapy: A clinician's guide*. New York, NY: Routledge. In this edited book, a variety of authors drill down into the nuts and bolts of termination. Chapters include "Managed Care and Termination" and "Terminating Psychotherapy Therapeutically."

Shea, S. C. (1998). *Psychiatric interviewing: The art of understanding* (2nd ed.). Philadelphia, PA: W. B. Saunders. Chapter 2 of Shea's book is titled "The Dynamic Structure of the Interview" and provides a thorough and practical discussion of the temporal structure typical of most diagnostic clinical interviews.

Teyber, E., & McClure, F. H. (2011). *Interpersonal process in therapy: An integrational model* (6th ed.). Belmont, CA: Brooks/Cole. This text spells out the basic ways in which interpersonal process—the dynamics between therapist and client—can be used to facilitate therapist and client insights.



**PART TWO**

**LISTENING AND RELATIONSHIP DEVELOPMENT**



# NONDIRECTIVE LISTENING SKILLS

## Chapter Orientation

Most people know a good listener when they meet one. It's less easy to figure out exactly what good listeners do to make it possible for others to talk openly and freely. This chapter analyzes the mechanics of effective attending and listening skills.

### VIDEO 4.1

## Listening Skills

The theory I have presented would see no essential value to . . . techniques [such] as interpretation . . . free association, analysis of dreams . . . hypnosis, interpretation of life style, suggestion, and the like.

—Carl R. Rogers, “The Necessary and Sufficient Conditions of Therapeutic Personality Change,” in *Journal of Consulting Psychology*, 1957, pp. 102–103

In this chapter (and the next two), we describe and illustrate the technical skills therapists can employ during a clinical interview. Our goal is for you to understand and practice these skills so that you can help clients

- Talk openly about themselves, their problems, and their hopes
- Have insights or new ideas about what they can do to manage their problems and achieve greater wellness
- Begin engaging in positive behavior change

These technical skills are referred to as facilitative behaviors, helping skills, microskills, facilitation skills, counseling behaviors, and more (Hill, 2014; Ivey, 1971; M. E. Young, 2013).

### LEARNING OBJECTIVES

After reading this chapter, you will be able to:

- Explain the difference between therapist skill and therapist attitude
- Adopt a therapeutic attitude in your work with clients
- Organize your listening behaviors into three general categories
- List and apply nondirective listening behaviors in your clinical interviews, consisting of therapeutic silence, paraphrasing, clarification, reflection of feeling, and summarizing
- Modify your listening skills to fit male and female clients and clients from different cultural backgrounds

As we focus on skill building, we simultaneously feel discomfort—discomfort stemming from awareness that the great Carl Rogers would NOT AGREE IN THE LEAST with what we're writing. For Rogers, the special ingredients that make therapy work were *not techniques or skills or behaviors*. Instead, he insisted that successful therapy (even a one-session clinical interview) is based on *therapist attitude*—and the subsequent development of a “certain type of relationship” (Rogers, 1942, 1957, 1961; more on this in Chapter 6).

It's difficult to argue with Carl Rogers. His gentle, caring, and reflective voice keeps urging us to abandon skill development in the service of empathy training. His point is valuable and profound. Many contemporary therapists, academics, and others don't understand the essence of person-centered therapy (J. Sommers-Flanagan, 2007). Too often Rogers's ideas are reduced to simplistic reflection skills (e.g., paraphrasing and reflection of feeling). The consequence is that far too many helping professionals-in-training end up learning parroting skills that can be quite annoying (unless you're an actual parrot) and not especially therapeutic.

As we open this chapter, we cannot in good conscience risk having you conclude that all you need to do is learn a couple dozen behavioral skills to become a good therapist. Rogers was right; that's just not how it works.

## VIDEO 4.2

### Adopting a Therapeutic Attitude

Back in the 1940s, 1950s, and 1960s, Rogers wrote extensively about core conditions (aka counselor attitudes) that he believed were necessary and sufficient for therapeutic change. If he were alive today, he would likely fight the modern emphasis on teaching microskills, noting that nothing clinicians do can be therapeutic unless clinicians experience and express the core attitudes of congruence, unconditional positive regard, and empathic understanding.

Although the core conditions may not be all that is needed, if they're absent, therapeutic change is unlikely. For the most part, research on counseling and psychotherapy has supported Rogers's claims that the core conditions are necessary (Malin & Pos, 2015; Norcross, 2011). Even contemporary neuroscience research is broadly supportive of Rogers's ideas.

### Neurogenesis and Listening With Empathy

*Neurogenesis* refers to the birth of neurons and is one of the biggest recent revelations in brain research. Although neurogenesis primarily occurs during prenatal brain development, recent findings show that humans can generate new neurons (brain cells) throughout the life span. When

adult neurogenesis occurs, new neurons are integrated into existing neurocircuitry.

Over 25 years ago, researchers demonstrated that repeated tactile experiences produced functional reorganization in the primary somatosensory cortex of adult owl monkeys (Jenkins, Merzenich, Ochs, Allard, & Guk-Robles, 1990). This finding and subsequent research supporting neurogenesis underscore a commonsense principle: Whatever behavior you practice or repeat is likely to stimulate neural growth and strengthen skills in that area. This is our explanation and prescription for how you can become more like Carl Rogers.

Researchers have recently developed theories about what's happening in different brain regions during an empathic experience. To summarize a large body of research, it appears that various brain regions and structures are activated when individuals experience empathy. In particular, the insula or *insular cortex* is a small structure residing deep within the fissure that separates the temporal lobe from the frontal and parietal lobes. It has been linked to empathy experiences, self-regulation, and other compassionate counseling-type responses.

Compassion meditation (aka lovingkindness meditation) is associated with neural activity and structural development (or thickening) of the insula. Specifically, researchers reported that individuals who engage in extensive compassion meditation have thicker insula, and when they view or hear someone in distress, they experience more insula-related neural activity than individuals without compassion meditation experience (Hölzel et al., 2011). Other researchers have conducted meta-analyses and written reviews indicating that during cognitive-emotional perception, regulation, and response, several brain structures are activated, and the relationships among them are highly complex. In describing the role of the anterior insular cortex in empathic responding, Mutschler, Reinbold, Wankerl, Seifritz, and Ball (2013) wrote:

Accumulating evidence indicates a crucial role of the insular cortex in empathy: in particular the anterior insular cortex (AIC)—a brain region which is situated in the depth of the Sylvian fissure and anatomically highly interconnected to many other cortical regions. (p. 1)

At the risk of oversimplifying a complex neurological process, it appears generally safe to conclude that compassion meditation and other human activities related to empathic experiencing may contribute in some way to the thickening of the insula and subsequently enhance empathic responsiveness.

Although our knowledge about what's actually happening in the brain is limited, these findings imply that you should engage in rigorous training to strengthen and grow your insula—as well as some of its empathic and self-regulating buddies like the middle cingulate cortex and pre-supplementary motor area (Kohn et al., 2014). This “training regimen” might contribute to your becoming more empathic and therapeutic. In addition to practicing lovingkindness meditation, such a regimen could include:

1. Committing to the intention of becoming a person who can listen to others in ways that are accepting, empathic, and respectful.
2. Developing an empathic listening practice. This could involve any form of regular interpersonal experience where you devote time to using the active listening skills described in this chapter. As you engage in this practice, it's important to have listening with compassion as your primary goal.
3. Engaging in the active listening, multicultural, and empathy development activities sprinkled throughout this text, offered in your classes, and obtained from additional outside readings.
4. When watching television, reading literature, and obtaining information via technology, lingering on and experiencing the emotions that these normal daily activities trigger.
5. Reflecting on these experiences and then . . . repeating . . . repeating . . . and repeating some more.

Rogers wrote in personal ways about his core conditions for counseling and psychotherapy. Contemplating his perspective is part of our prescription for developing an empathic orientation toward the variety of individuals with whom you will work.

I come now to a central learning which has had a great deal of significance for me. I can state this learning as follows: *I have found it of enormous value when I can permit myself to understand another person.* The way in which I have worded this statement may seem strange to you. Is it necessary to *permit* oneself to understand another? I think that it is. Our first reaction to most of the statements which we hear from other people is an immediate evaluation or judgment, rather than an understanding of it. When someone expresses some feeling or attitude or belief, our tendency is, almost immediately, to feel “That's right”; or “That's stupid”; “That's abnormal”; “That's unreasonable”; “That's incorrect”; “That's not nice.” Very rarely do we permit ourselves to *understand* precisely what the meaning of his [or her] statement is to him [or her]. I believe this is because understanding is risky. If I let

myself really understand another person, I might be changed by that understanding. (Rogers, 1961, p. 18; italics in original)

### MULTICULTURAL HIGHLIGHT 4.1: A HETEROSEXUAL INTERN WORKS WITH A GAY CLIENT, BY GREGORY SANDMAN

In the following essay, a doctoral student at the University of Wyoming shares his experiences as he embraces the attitudes associated with Rogers's core conditions while working with a Gay client.

\* \* \*

Understanding cultural differences between therapist and client is essential for positive counseling relationships. Although interesting in theory, this became a reality for me during my internship at an LGBTQ clinic.

My supervisor initially recommended that unless it became important therapeutically, there was no reason to disclose my sexual orientation (SO) to clients. Some may disagree with this, and certainly there are times when counselors need to disclose personal information. During my first interview at the LGBTQ clinic, the client insisted on knowing my SO. When I asked how this information would be helpful, he became agitated and insistent. I finally disclosed that I was straight, and the client wadded up the informed consent papers, threw them in my face, and stormed out!

This experience led me to question my supervisor again about disclosing my SO. He felt we should proceed according to the original plan. My SO came up again during future counseling sessions, but fortunately only after I had time to develop a working relationship. After learning I was straight, one client stated, "If I had known before we started meeting that you were straight, I wouldn't have come. But this has been very helpful, and I've benefited from our sessions a lot."

To better understand how Gay male clients experience working with straight male therapists, I conducted an IRB-approved case study with a former client. "Chris" (a pseudonym) had only seen one other straight therapist, a woman. When making his first appointment with me, he asked if his therapist would be straight or Gay, but the policy was to not disclose SO. Chris reported feeling apprehension, anxiety, nervousness, and shame about working with a straight man. His concerns centered around whether a straight male could understand his experiences. He worried about judgment that might stem from me not being "Gay informed" (Kort, 2008).

Chris described my demeanor as different from what he expected from straight men. He said I didn't have the "face of judgment" that he'd seen before. He stated that not feeling judged allowed him to open up and go deeper than he had with previous therapists. He expressed appreciation for feedback, even simple nodding or "uh huhs." He said his previous straight

(Continued)

therapists sat silently, staring at him. Finally, Chris stated, "You shook my hand." Chris was HIV-positive. He explained that many people wouldn't enter a room with him if they knew his HIV status. Chris became emotional talking about how much it meant to him to have someone physically shake his hand and treat him with respect and dignity.

From working with Chris and other Gay males, I realized that we have the opportunity to provide a powerful therapeutic experience simply by being a friendly, positive person. Many clients haven't had affirming people in their lives, and it's our honor to provide that part of the therapeutic experience.

## Communication Is Always Two-Way

Meryt listened in stillness, watching my face as I recounted my mother's history, and the story. . . My friend did not move or utter a sound, but her face revealed the workings of her heart, showing me horror, rage, sympathy, compassion. (Diamant, 1997, p. 93)

Human communication involves sending and receiving information. It's a two-way highway; messages are traveling both directions at the same time.

When someone sends out information, your goal is to be a good listener, or receiver. But of course, even if you listen intently and manage to keep your mouth shut, you're still simultaneously sending information. This is what communication professors mean when they say *You cannot not communicate*. Human communication involves constant and interactive sending and receiving of verbal and nonverbal messages.

No matter what you say (even if you say nothing), you're communicating something. Recall a time when you were talking with a friend on the phone. Perhaps you said something, and your statement was followed by silence. What did you think at that moment? Most people fill in the blank and conclude that the pause in communication meant something.

Your clients' impressions of you will include what they observe as they're speaking. Your behavior is a message to clients—a message that, ideally, is interpreted as an invitation to speak freely. This section focuses on how you can learn to look, sound, and act like a good listener.

It may seem disingenuous to suggest that you practice *looking like* a good listener. Nevertheless, good therapists consciously and deliberately engage in specific behaviors that most clients will interpret as signs of

interest and concern. These behaviors are referred to as *attending behaviors* (Ivey, Normington, Miller, Morrill, & Haase, 1968).

## Attending Behavior

*Attending behaviors* are the foundation of active listening. They comprise nonverbal and minimal verbal behaviors that assure clients you're listening. Attending behaviors are sometimes referred to as *minimal encouragers* because when they're displayed, clients are encouraged to talk.

To be successful, therapists must communicate respect and interest. The importance of positive attending behaviors is recognized across disciplines and theoretical orientations; it's spectacularly uncontroversial (Cormier, Nurius, & Osborn, 2017; Wright & Davis, 1994).

Attending behavior is primarily nonverbal. Anthropologist and cross-cultural researcher Edward T. Hall (1966) claimed that communication is 10% verbal and 90% "a hidden cultural grammar" (p. 12). Others have said that 65% or more of a message's meaning is nonverbal (Birdwhistell, 1970). Usually, if verbal and nonverbal messages conflict, people will believe the nonverbal message. This is why being aware of and using nonverbal channels is so important when communicating with clients.

Ivey, Ivey, and Zalaquett (2010, p. 65) described four categories of attending behavior that have been studied across cultures.

1. Visual/eye contact
2. Vocal qualities
3. Verbal tracking
4. Body language

### *Visual/Eye Contact*

Norms for *eye contact* vary across cultures. What constitutes appropriate and inappropriate eye contact also varies from individual to individual within the same culture. For some therapists, sustaining eye contact during an interview is natural. For others, it can be difficult; there may be a tendency to look down or away from the client's eyes because of respect, shyness, or cultural dynamics. The same is true for clients: Some prefer more intense and direct eye contact; others prefer looking at the floor, the wall, or anywhere but into your eyes.

Generally, you should maintain eye contact most of the time with White clients. In contrast, Native American, Asian, and some African American clients may prefer less eye contact (for more information, see Multicultural Highlight 4.2). It's usually appropriate to maintain more eye contact as clients speak and less eye contact when you speak.

### MULTICULTURAL HIGHLIGHT 4.2: EYE CONTACT! DIFFERENT PERSPECTIVES

The following contrasting comments about eye contact come from two Black/African American professors.

**Teah Moore, PhD, Associate Professor, Fort Valley State University, Robins, GA:**

I had a supervisor who would stare you right in the eyes while talking to you. Normal people glance away every once in a while but not her. It was distracting and unnerving to talk with her. As an African American I found myself looking away or finding a spot on her shirt to stare at. I heard about the same experience from other African Americans. (Personal communication, August 11, 2012)

**Kimberly Johnson, EdD, Senior Executive Advisor/Advocate, DeVry University Online:**

As a Black female, I was taught to always look a person in the eye when speaking. To not do so displays lack of confidence, untruth, shyness, and/or uncertainty. Eye contact is requested or solicited in our culture when focus is required. Culturally we believe the eyes tell a story regarding interpretation. (Personal communication, July 28, 2012)

\* \* \*

Even though two people appear similar based on surface characteristics or ethnic identity, they may have had different cultural, familial, and educational experiences. Individual experiences—even within the same culture—can result in different beliefs and perspectives.

This is a great example of why Stanley Sue emphasized dynamic sizing as a multicultural skill. *Dynamic sizing* (see Chapter 1) involves determining whether a particular cultural characteristic “fits” for an individual member of that culture. S. Sue and Zane (2009) wrote:

We believe that cultural knowledge and techniques . . . are frequently applied in inappropriate ways. The problem is especially apparent when therapists and others act on insufficient knowledge or overgeneralize what they have learned about culturally dissimilar groups. (p. 5)

In conclusion: Making assumptions about other people is a bad idea. As Dr. Teah Moore and Dr. Kimberly Johnson described two individuals with apparently similar ethnic and cultural backgrounds may have different interpersonal styles or preferences. Further, never assume that less eye contact indicates poor self-esteem, dishonesty, disrespect, or anything other than normal cultural variation in eye contact.

### **Vocal Qualities**

Have you ever listened very closely and tried to describe someone’s voice? If so, you probably described the person’s paralinguistics. *Paralinguistics* consist of voice loudness, pitch, rate, rhythm, inflection, and fluency. Think about how these variables might affect clients. Interpersonal influence is often determined not so much by *what* you say but by *how* you say it.

Effective therapists use vocal qualities to enhance rapport, communicate interest and empathy, and emphasize specific issues or conflicts. As with body language, it's useful to follow the client's lead, speaking in a volume and tone similar to the client's. Meier and Davis (2011) refer to this practice as "pacing the client" (p. 9).

You also can use voice tone and speech rate to lead clients toward particular content or feelings. For example, speaking in a soft, slow, and gentle tone encourages clients to explore feelings more thoroughly, and speaking with increased rate and volume may help convince them of your credibility or expertise (Ekman, 2001).

### ***Verbal Tracking***

*Verbal tracking* involves restating some portion of the content of your client's speech; it doesn't include adding your personal or professional opinion about the content. Verbal tracking is a pacing response. You need to stick closely to the client's speech content and avoid leading.

Accurate verbal tracking can be challenging, especially when clients are talkative. You may become distracted by what the client is saying and drift into your own thoughts. For example, a client may mention recent travel experiences, abortion, legalizing marijuana, pornography, political leanings, divorce, or other topics about which you have personal opinions or emotional reactions. To verbally track effectively, you must minimize your internal and external personal reactions; your focus remains on the client. This is also true with more advanced active listening techniques, such as clarification, paraphrasing, and summarizing.

### ***Body Language***

Body language is another important dimension of human communication. Two aspects of body language are kinesics and proxemics (Knapp, Hall, & Horgan, 2013). *Kinesics* has to do with physical features and physical movement of any body part, such as eyes, face, head, hands, legs, and shoulders. *Proxemics* refers to personal space and environmental variables such as the distance between two people and whether any objects are between them. As you know from personal experience, a great deal is communicated through simple and subtle body movements. When we discussed client-therapist seating arrangements in Chapter 2, we were analyzing proxemic variables and their potential effect on the interview.

Positive body language includes (from Walters, 1980):

- Leaning slightly toward the client
- Maintaining a relaxed but attentive posture

- Placing your feet and legs in an unobtrusive position
- Keeping your hand gestures unobtrusive and smooth
- Minimizing the number of other movements
- Matching your facial expressions to your feelings or the client's feelings
- Sitting approximately one arm's length from the client
- Arranging the furniture to draw you and the client together

These examples of positive body language are based on Western cultural norms. In practice, you'll find individual and cultural variations on these behaviors.

*Mirroring*, as an aspect of body language, involves synchrony or consistency between clinician and client. When mirroring occurs, the clinician's physical movements and verbal activity are in sync with the client's. Mirroring is a nonverbal technique that potentially enhances rapport and empathy, but when done poorly can be disastrous (Maurer & Tindall, 1983). If mirroring is obvious or overdone, clients may think you're mocking them. Therefore, intentional mirroring is best used in moderation. Mirroring is probably more of a natural product of positive rapport than a causal factor in establishing it.

## Negative Attending Behaviors

Positive attending behaviors open up communication and encourage free expression. Negative attending behaviors tend to inhibit client talk. When it comes to identifying positive and negative attending behaviors, there are few universals. What works with one client may not work with the next. The way you pay attention to clients will vary depending on each client's individual needs, personality style, and family and cultural background.

One of the most common ways to engage in negative attending behaviors is to overdo positive attending behaviors. It can be disconcerting when someone listens too intensely. For example:

- *Head nods.* Excessive head nods can be bothersome. After a while, clients may look away to avoid watching their therapist's head bob. After spending time with an enthusiastic nodding therapist, a child stated, "I thought her head was attached to a wobbly spring instead of a neck."
- *Saying "uh huh."* Both novices and professionals can overuse this verbal encourager. Our response to excessive "uh huhs" (and the response of many clients) is to stop talking to force the person to say something besides "uh huh."
- *Eye contact.* Too much eye contact can cause people to feel scrutinized. Imagine a therapist relentlessly staring at you while you're talking about

something deeply personal . . . or while you're crying. Eye contact is crucial, but too much is too much. This varies with culture.

- *Repeating the client's last word.* Some therapists use a verbal tracking technique that involves repeating a single key word, often the last word, from what the client said. Overusing this pattern can cause clients to feel overanalyzed, because therapists reduce 30- or 60-second statements to a single-word response.

Researchers have reported that clients perceive the following therapist behaviors as negative (Cormier et al., 2017; Smith-Hanen, 1977):

- Infrequent eye contact
- Turning 45 degrees or more away from the client
- Leaning back from the waist up
- Crossing legs away from the client
- Folding arms across the chest

As suggested in the previous chapter, it's often difficult to know how you're coming across to others. Getting feedback on your attending behaviors is essential.

## Why Nondirective Listening Is Also Directive

VIDEO  
4.3

Attention is usually rewarding. When listening nondirectively, you may inadvertently, or purposefully, pay closer attention when clients discuss certain issues. For example, if you want a client to talk about his relationship with his mother, you can use eye contact, head nodding, verbal tracking, and positive facial expressions whenever the client mentions his mother. Conversely, you can look disinterested and use fewer verbal tracking responses when he discusses something other than his mother. From a behavioral perspective, you're using social reinforcement to influence the client's verbal behavior. This selective attending probably occurs frequently in clinical practice, linked to conscious theoretical preference and less conscious interests of the therapist.

Even if you're determined to keep your theoretical leanings and personal interests out of the equation while listening, you will still end up guiding clients. Clients talk about such a wide range of topics that it's impossible to pay equal attention to every issue. Selection is necessary. Imagine a case where a young woman begins a session by saying,

We didn't have much money when I was growing up, and that frustrated my father. He beat us five kids. He's dead, but to this day, my

mom says we needed the discipline. I hated it then and swore I'd never be like him. Now that I'm grown and have kids of my own, I'm doing okay, but sometimes I feel I need to discipline my kids more and harder . . . do you know what I mean?

What if you were this woman's therapist? Which issues would you focus on? And remember, all this—being poor, being beaten by her father, her father's death, having a mom who continues to claim that the client needed to be beaten, swearing that she never wants to be like her father, doing okay now, and feeling as though she needs to discipline her children more severely—was expressed in the session's first 30 seconds.

To be truly nondirective, you would respond equally to every piece of this client's message. That's obviously unrealistic. As a professional, you'll choose to pay attention to some part of what was presented, leaving other parts disregarded—at least temporarily. Because directing clients is inevitable, the wise therapist is aware of when, why, and how to use nondirective listening behaviors directly.

Techniques described in the rest of this chapter mostly involve clients talking and therapists listening. This is simple enough. But consider this example (adapted from Walsh, 2015):

You're sitting with three friends watching a documentary on the Supreme Court's same-sex marriage decision. A portion of the show has Justice Anthony Kennedy speaking at about 10:10 a.m. on June 26, 2015. He rises and states, "These considerations lead to the conclusion that the right to marry is a fundamental right inherent in the liberty of the person, and under the Due Process and Equal Protection Clauses of the Fourteenth Amendment, couples of the same sex may not be deprived of that right and that liberty. The court now holds that same-sex couples may exercise the fundamental right to marry."

A few minutes later, Chief Justice John Roberts is shown, offering his dissent. You hear these words: "From the dawn of human history, marriage has been a social institution. . . . But today five lawyers have ordered the state to change their definition of marriage. Just who do we think we are? I have no choice but to dissent."

Following the documentary, you and your friends engage in a rousing discussion. Somewhat surprisingly, you discover that although you were all sitting in the same room and listening to the same words, not only do your opinions on the issues differ, but your memory differs. How can this be? How can four people listening to the same words take away different messages?

Humans bring their own unique preferences, interests, distractions, hopes, and personal history into what they hear. This is why there's no such thing as complete objectivity. As you pursue graduate training in the helping professions, there's another factor that will increasingly influence what you hear when your clients talk: your theoretical orientation. A dozen therapists could listen to the same recording of a client and, depending on their theoretical orientations, come away with a dozen different versions of what the client said. These therapists could also construct a dozen different (and reasonable) treatment plans.

Although this isn't a book on counseling and psychotherapy theory, it's important to acknowledge how theory will inevitably influence the way you conduct a clinical interview. We refer to this influence as your *listening focus*. For every theoretical orientation, there's a slightly different listening focus. Psychodynamic therapists focus on past and present interpersonal relationship patterns. Behavior therapists listen for reinforcement contingencies. As you develop your theoretical orientation, try to be conscious and intentional in your listening focus.

## The Listening Continuum in Three Parts

**VIDEO  
4.4**

Nondirective listening behaviors give clients the responsibility for choosing what to talk about. Consistent with person-centered approaches, using these behaviors is like handing your clients the reins to the horse and having them take the lead and choose where to take the session. In contrast, directive listening behaviors (Chapter 5) and directive action behaviors (Chapter 6) are progressively less person centered. These three categories of listening behaviors (and the corresponding chapters) are globally referred to as *the listening continuum*. To get a visual sense of the listening continuum, see Table 4.1.

**Table 4.1** The Listening Continuum

<b>Nondirective Listening Behaviors on the LEFT Edge (Chapter 4)</b>	<b>Directive Listening Behaviors in the MIDDLE (Chapter 5)</b>	<b>Directive Action Behaviors on the RIGHT Edge (Chapter 6)</b>
Attending behaviors or minimal encouragers	Feeling validation	Closed and therapeutic questions
Therapeutic silence	Interpretive reflection of feeling	Psychoeducation or explanation
Paraphrase	Interpretation (classic or reframing)	Suggestion
Clarification	Confrontation	Agreement/disagreement
Reflection of feeling	Immediacy	Giving advice
Summary	Open questions	Approval/disapproval
		Urging

The ultimate goal is for you to have behavioral skills along the whole listening continuum. Further, we want you to be able to apply these skills *intentionally* and with *purpose*. That way, when you review a video of your session with a supervisor, and your supervisor stops the recording and asks, “What exactly were you doing there?” you can respond with something like this:

I was doing an interpretive reflection of feeling. The reason I chose an interpretive reflection is that I thought the client was ready to explore what might be under his anger.

Trust us; this will be a happy moment for both you and your supervisor.

Hill (2014) organized the three listening continuum categories in terms of their primary purpose:

1. Nondirective listening behaviors facilitate *client talk*.
2. Directive listening behaviors facilitate *client insight*.
3. Directive action behaviors facilitate *client action*.

**VIDEO  
4.5**

## Nondirective Listening Behaviors: Skills for Encouraging Client Talk

We hope you still (and will always) remember the Rogerian attitudes and have placed them firmly in the center of your developing therapeutic self. In addition, at this point we hope you understand the two-way nature of communication, the four different types of attending behaviors, and how your listening focus can shift based on a variety of factors, including culture and theoretical orientation.

Next, we begin coverage of the technical skills you’ll need to conduct a clinical interview. See Table 4.2 for a summary of nondirective listening behaviors and their usual effects. Having already reviewed attending behaviors, we now move to therapeutic silence.

### Therapeutic Silence

Most people feel awkward about silence in social settings. Some researchers have described that therapists-in-training view silence as a “mean” response (Kivlighan & Tibbits, 2012). Despite the angst it can produce, silence can also be therapeutic.

*Therapeutic silence* is defined as well-timed silence that facilitates client talk, respects the client’s emotional space, or provides clients with an

**Table 4.2** Summary of Nondirective Listening Behaviors and Their Usual Effects

Listening Response	Description	Primary Intent/Effect
Attending behavior	Eye contact, leaning forward, head nods, facial expressions, etc.	Facilitates or inhibits spontaneous client talk.
Therapeutic silence	Absence of verbal activity	Allows clients to talk. Provides “cooling off” time. Allows the clinician to consider next response.
Paraphrase	Reflection or rephrasing of the content of what the client said	Assures clients that you hear them accurately and allows them to hear what they said.
Clarification	Restating a client’s message, preceded or followed by a closed question (e.g., “Do I have that right?”)	Clarifies unclear client statements and verifies the accuracy of what the clinician heard.
Reflection of feeling	Restatement or rephrasing of clearly stated emotion	Enhances clients’ experience of empathy and encourages further emotional expression.
Summary	Brief review of several topics covered during a session	Enhances recall of session content and ties together or integrates themes covered in a session.

opportunity to find their own voice regarding their insights, emotions, or direction. From a Japanese perspective,

Silence gives forgiveness and generosity to human dialogues in our everyday life. Without silence, our conversation tends to easily become too clever. Silence is the place where “shu” . . . (to sense the feeling of others, and forgive, show mercy, absolve, which represents an act of benevolence and altruism) arises, which Confucius said was the most important human attitude. (Shimoyama, 1989/2012, p. 6; translation by Nagaoka et al., 2013, p. 151)

Silence also allows clients to reflect on what they just said. Silence after a strong emotional outpouring can be therapeutic and restful. In a practical sense, silence also allows therapists time to intentionally select a response rather than rush into one.

In psychoanalytic psychotherapy, silence is used to facilitate free association. Psychoanalytically oriented therapists explain to clients that psychoanalytic therapy involves free expression, followed by occasional therapist comments or interpretations. Explaining therapy or interviewing procedures to clients is always important, but especially so when therapists are using potentially anxiety-provoking techniques, such as silence (Meier & Davis, 2011).

### CASE EXAMPLE 4.1: EXPLAIN YOUR SILENCE

While on a psychoanalytically oriented internship, I (John) noticed one supervisor had a disturbing way of using silence during therapy sessions (and in supervision). He would routinely begin sessions without speaking. He would sit down, look at his client (or supervisee), and lean forward expectantly. His nonverbal behavior was unsettling. He wanted clients and supervisees to free associate and say whatever came to mind, but he didn't explain, in advance, what he was doing. Consequently, he came across as intimidating and judgmental. The moral of the story: If you don't explain the purpose of your silence, you risk scaring away clients.

#### *Examples of How to Talk About Silence*

Part of the therapist's role involves skilled explanations of both process and technique. This includes talking about silence. Case Example 4.1 is a good illustration of how both therapist and client would have been better served if the therapist had taken time to explain why he started his sessions with silence.

Here's another example of how a clinician might use silence therapeutically:

Katherine is conducting a standard clinical intake interview. About 15 minutes into the session the client begins sobbing about a recent romantic relationship break-up. Katherine provides a reflection of feeling and reassurance that it's okay to cry, saying, "I can see you have sad feelings about the break-up. It's perfectly okay for you to honor those feelings in here and take time to cry." She follows this statement with about 30 seconds of silence.

There are several other ways Katherine could handle this situation. She might prompt her client,

Let's take a moment to sit with this and notice what emotions you're feeling and where you're feeling them in your body.

Or she might explain herself and her purpose more clearly.

Sometimes it's helpful to sit quietly and just notice what you're feeling. And sometimes you might have emotional sensations in a particular part of your body. Would you be okay if we take a few moments to be quiet together so you can tune in to your emotions and where you're feeling them?

In each of these scenarios, the counselor explains, at least briefly, her use of silence. This is crucial because when clinicians are silent, pressure is placed on clients to speak. When silence continues, the pressure mounts, and client anxiety may increase. In the end, clients may view their experience with an excessively silent therapist as aversive, lowering the likelihood of rapport and a second meeting.

### ***Guidelines for Using Silence Therapeutically***

At first, using silence therapeutically may feel uncomfortable. With practice, you'll increase your comfort level. Consider the following suggestions and guidelines:

- When a client pauses after making a statement or after hearing your paraphrase, let a few seconds pass rather than jumping in verbally. Given an opportunity, clients can move naturally into important material without guidance or urging.
- As you're waiting for your client to resume speaking, tell yourself that this is the client's time for self-expression, not your time to prove you can be useful.
- Try not to get into a rut regarding silence. When silence occurs, sometimes wait for the client to speak next and other times break the silence yourself.
- Be cautious with silence if you believe your client is confused, experiencing an acute emotional crisis, or psychotic. Excessive silence and the anxiety it provokes can exacerbate these conditions.
- If you feel uncomfortable during silent periods, use attending skills and look expectantly toward clients. This helps them understand that it's their turn to talk.
- If clients appear uncomfortable with silence, give them instructions to free associate (e.g., "Just say whatever comes to mind"). Or you can use an empathic reflection (e.g., "It's hard to decide what to say next").
- Remember, sometimes silence is the most therapeutic response available.
- Read the interview by Carl Rogers (Meador & Rogers, 1984) listed at the end of this chapter. It includes examples of how Rogers handled silence from a person-centered perspective.
- Remember to monitor your body and face while being silent. There's a vast difference between a cold silence and an accepting, warm silence. Much of this difference results from body language and an attitude that welcomes silence.

- Use your words to explain the purpose of your silence (e.g., “I’ve been talking quite a lot, so I’m just going to be quiet here for a few minutes so you can have a chance to say whatever you like”). Clients may be either happy or terrified at the chance to speak freely.

## Paraphrase (or Reflection of Content)

The paraphrase is a cornerstone of effective communication. It lets others know you’ve heard what they said and allows them to hear how they’ve been perceived. This can further facilitate clarity and expression.

*Paraphrasing* involves restating or rewording another person’s verbal communication. The paraphrase is sometimes referred to as a *reflection of content* or, more simply, a *reflection*. Paraphrases reflect the content of what clients are saying, but not feelings or emotions. As you’ll soon see, although paraphrases are typically a reflection of what clients said, there’s also room for subjectivity. Some reflections are more leading than others. A good paraphrase is accurate and brief.

You may feel awkward as you begin using paraphrases because it might seem as if you’re just restating the obvious. In fact, if you simply parrot back to clients what they said, it can come off as rigid, stilted, and, at times, offensive. As W. R. Miller and Rollnick (1991) wrote, “Reflective listening is easy to parody or do poorly, but quite challenging to do well” (p. 26). Over time and with practice, you will find it easier to use paraphrases creatively and to view them as a flexible technique that enhances rapport and empathy and affects clients in different ways.

### *The Simple Paraphrase*

The simple paraphrase doesn’t add meaning or direction. The therapist rephrases, rewards, and reflects what the client said. The following are two examples:

**Client 1:** Yesterday was my day off. I just sat around the house doing nothing. I had errands to run, but I couldn’t make myself get up off the couch and do anything.

**Therapist 1:** You had trouble getting going on your day off.

**Client 2:** I do this with every assignment. I wait until the last minute and then whip the paper together. I end up doing all-nighters. I don’t think the final product is as good as it could be.

**Therapist 2:** Waiting until the last minute has become a pattern for you, and you think it makes it so you don’t do as well as you could on your assignments.

As clients talk more, reflective listening grows more complex. You may have difficulty tracking exactly what the client said. Although it's important to stay accurate, sometimes reflective listening is like a verbal dance. If you miss something important, the client will make a correction. Or if you include something the client didn't say, the client will edit you. Notice in the next exchange, the therapist misses a piece of what the client says, so the client repeats that part of his message. This gives the therapist a second chance.

**Client 3:** If I want to lose weight, I should get to bed earlier, even though I hate going to bed early. That way I won't snack into the night, and I can get up earlier and exercise in the morning.

**Therapist 3:** So you think it would be better for you to get up earlier in the morning.

**Client 3:** It might be better, but I'm a night person and I hate going to bed early.

**Therapist 3:** You like to stay up.

**Client 3:** Yeah. I like to stay up and talk on the phone and go online and do Facebook.

The simple paraphrase rephrases the client's core message but doesn't retain everything that was originally said. It's simple, but it's not so simple as an echo or a parrot. Remember this: Paraphrasing never includes your opinion, reactions, or commentary, whether positive or negative. If you offer anything from your perspective, then you're not using a paraphrase.

### ***The Sensory-Based Paraphrase***

In the 1970s, Richard Bandler and John Grinder developed an approach to counseling and psychotherapy called *neurolinguistic programming* (NLP). Among other things, NLP emphasized a concept referred to as *representational systems* (Bandler & Grinder, 1975; Grinder & Bandler, 1976). Representational systems refer to the sensory system—usually visual, auditory, or kinesthetic—that individual clients use when experiencing their world. It was hypothesized that by tuning into clients' representational systems and using language that speaks to clients more directly, clinicians could have more influence. Bandler (2008) reflected on how he learned about language use and matching representational systems from watching great therapists—in this case, Virginia Satir:

[A client] might say: "I just feel everything's getting on top of me and I can't move forward or back. I just don't see a way through this." She

would reply: "I feel the weight of your problems is stopping you from finding your direction, and the best route you can take isn't clear yet." (2008, p. 31)

If you listen closely to your clients' words, you'll notice that some clients rely primarily on visually oriented words (e.g., "I see" or "It looks like"), others on auditory words (e.g., "I hear" or "It sounded like"), and others on kinesthetic words (e.g., "I feel" or "It moved me"). Although research in this area is very limited, some evidence suggests that when therapists speak through their client's representational system, empathy, trust, and desire to see the therapist again are increased (Hammer, 1983; Sharpley, 1984).

Listening for your client's sensory-related words is the key to using sensory-based paraphrases. Examples of sensory-based paraphrases follow, with the sensory words italicized:

**Client 1:** My goal in therapy is to get to know myself better. I think of therapy as a *mirror* through which I can *see* myself, my strengths, and my weaknesses more *clearly*.

**Therapist 1:** You're here because you want to *see* yourself more *clearly*, and you believe therapy can really help you with that.

**Client 2:** I just got *laid off* from my job, and I don't know what to do. My job is so important to me. I *feel* lost.

**Therapist 2:** Your job has been so important to you, you *feel* adrift without it.

Listening for sensory words is a skill development activity. It can improve your sensitivity to the subtle communications coming from clients. As you get better at tuning in to sensory words, you also get better at listening well, and your clients may benefit. Pomerantz (2011) noted, "Clients whose therapists literally 'speak their language' tend to feel relaxed and understood" (p. 153).

### ***The Metaphorical Paraphrase***

Therapists can use metaphor or simile to capture their client's central message. For instance, often clients come to therapy because of feeling stuck and not making progress in terms of personal growth or problem resolution. In such cases, you might paraphrase, "It seems like you're spinning your wheels" or "Dealing with this has been a real uphill battle." Additional examples follow:

**Client 1:** My sister is so picky. We share a room, and she always bugs me about picking up my clothes, straightening my dresser, and everything

else, too. She watches every move I make and criticizes me every chance she gets.

**Therapist 1:** It's like you're in the army and she's your drill sergeant.

**Client 2:** I miss my son terribly. When I see his friends or classmates, I can't help but wish they had died, not him. It's been especially hard lately because the anniversary of his death is coming up.

**Therapist 2:** You're saying it's usually very painful, but right now and the next few weeks feel like an especially rough road.

### ***Intentionally Directive (or Theoretically Informed) Paraphrases***

Reflective listening is so flexible that it can be adapted for use with all different theoretical orientations. In the next examples, the therapists are paraphrasing, but include language consistent with their theoretical orientations.

**Client 1:** Lots of times I get really nervous when I'm expected to speak in class. I want to speak, but I freeze.

**Therapist 1:** It's like you're saying to yourself, "I want to speak up," but for some reason, on the inside you feel anxiety or nervousness about that.

**Client 1:** Definitely . . . And when I try to force myself to speak up if I'm not ready . . . I feel like my throat's closing and I get a red face.

**Therapist 1:** You're trying to speak, but at the same time you're thinking, "I'm not ready for this," and then your anxiety gets more physical.

**Client 2:** I constantly focus on possible tragedies that could happen because my life has been so easy. I especially worry about tragedy striking my kids. I wish I could just live like a normal person and not have all these doom-and-gloom thoughts in my head. I wonder, as I'm talking about this, if maybe I always live with a little anxiety.

**Therapist 2:** You're saying "I have this underlying anxiety" even though life's been easy. It seems constant to you, this underlying fear that something big might go wrong . . . something bad might happen . . . there could be a tragedy coming up . . .

In these two examples, the therapists use paraphrases (aka reflective listening) in ways that fit with their underlying theoretical orientations. Therapist 1 is operating from a cognitive-behavioral perspective. You can see this in his language. When he paraphrases "you're saying to yourself"

and “you’re thinking,” he’s focusing on self-talk or cognition, and his reflection “the anxiety gets more physical” is consistent with a cognitive-behavioral case formulation that distinguishes between cognitive and physical manifestations of anxiety.

Therapist 2 sounds more existential or psychodynamic. By repeating the anxiety-provoking words, the therapist is encouraging her client to focus on what might be under the anxiety. These examples provide a glimpse into the flexibility and sophistication of paraphrasing. They show why clinicians from all therapy orientations can and do use this clinical skill.

In contrast to the therapists in the preceding examples, solution-focused therapists use paraphrasing to intentionally highlight or emphasize client strengths and de-emphasize problems. For example, O’Hanlon (1998) described a variation on paraphrasing called “Carl Rogers with a twist.” This technique is a method for showing empathy and compassion, while simultaneously helping clients shift from a more negative to a less negative perspective. The following are some examples:

**Client 3:** I feel like cutting myself.

**Therapist 3:** You’ve felt like cutting yourself (O’Hanlon, 1998, p. 47). [In this example, the therapist validates the client, but shifts the negative impulse from the present to past tense.]

**Client 4:** I have flashbacks all the time.

**Therapist 4:** So you have flashbacks a lot of the time. [The therapist transforms the client’s verbal disclosure from a global to a partial perception.]

**Client 5:** I’m a bad person because I was sexually abused.

**Therapist 5:** You’ve gotten the idea that you’re bad because you were sexually abused. [The therapist shifts the client’s words from factual to perceptual (J. Sommers-Flanagan & Sommers-Flanagan, 2012).]

For another example of how paraphrasing can be selective and directive, see Putting It in Practice 4.1.

#### **PUTTING IT IN PRACTICE 4.1: SELECTIVELY PARAPHRASING THE POSITIVE**

Insoo Kim Berg was famous for her ability to focus on, magnify, and paraphrase very small positive client statements—even if the statement was surrounded by or covered up with negative content (I. K. Berg & DeJong, 2005). For Berg, deciding what to paraphrase was easy. She believed that all therapists lead their clients, so they may as well intentionally lead their clients in positive

directions. Weiner-Davis (1993) articulated this perspective: "Since we cannot avoid leading, the question becomes, 'Where shall we lead our clients?'" (p. 156).

If we return to a nondirective listening example from early in this chapter and you focus on Berg's philosophy of leading clients to the positive, you might be able to identify what Berg would say in response to a specific client statement.

Read the following excerpt again:

We didn't have much money when I was growing up, and I suppose that frustrated my father. He beat us five kids all the time. He's dead now, but to this day, my mom says we needed the discipline. But I hated it then and swore I'd never be like him. Now that I'm grown and have kids of my own, I'm doing okay, but sometimes I feel I need to discipline my kids more . . . harder . . . do you know what I mean?

Take a moment to imagine what positive part of this statement Berg might choose to paraphrase. Perhaps Berg would have said something like, "Now that you're grown and have your own kids, you see yourself as doing okay!" or "So, you swore you'd never be like your father, and clearly, you aren't!" or "You've worked long and hard and successfully at being different than your father." Similar to Carl Rogers with a twist, these strength-focused reflections intentionally lead clients toward the positive. There are many different names for these intentionally leading responses, including positive reconstruction, finding the exception, or focusing on sparkling moments (J. Sommers-Flanagan & Sommers-Flanagan, 2012).

## Clarification

There are several approaches to clarification. They all serve a common purpose: to make clear for yourself and the client precisely what was said. The first approach to clarification consists of a restatement of what the client said and a closed question, in either order. Rogers was a master at clarification:

If I'm getting it right . . . what makes it hurt most of all is that when he tells you you're no good, well shucks, that's what you've always felt about yourself. Is that the meaning of what you're saying? (Meador & Rogers, 1984, p. 167)

The second approach to clarification consists of a restatement imbedded in a double question. A *double question* is an either-or question including two or more choices of response for the client. For example:

- Do you dislike being called on in class—or is it something else?
- Did you get in the argument with your husband before or after you went to the movie?

Using clarification as a double question provides more control of what clients say during an interview. It involves guessing a client's potential response by providing possible choices.

The third approach to clarification is the most basic. It's used when you don't quite hear what a client said and you need to recheck.

- I'm sorry, I didn't quite catch that. Could you repeat what you said?
- I couldn't make out what you said. Did you say you're going home after the session?

There will be times during interviews when you don't understand what clients are saying. There also will be times when your clients are confused about what they're trying to say. Sometimes, the appropriate response is to wait for understanding to come. Other times, it's necessary to clarify precisely what your client is talking about.

Brammer (1979) provided two general guidelines for clarifying. First, admit your confusion over what the client has said. Second, "try a restatement or ask for clarification, repetition, or illustration" (p. 73). Asking for a specific example can be especially useful because it encourages clients to be concrete and specific rather than abstract and vague.

There are two main factors to consider when deciding whether to use clarification. First, if the information appears trivial and unrelated to anything therapeutic, then you might wait for the client to move on to a more productive area (or prompt the client to talk about something different). There's no need to waste time clarifying minor details that aren't related to your interview goals. For example, suppose a client says,

My stepdaughter's grandfather on my wife's side of the family usually has little or no contact with my parents.

This presents an excellent opportunity to listen quietly. To attempt a clarification might result in a lengthy entanglement with distant family relationships that takes the interview off course. In fact, sometimes clients will tell long and confusing stories to avoid deeper topics. Seeking to clarify can prolong avoidance.

Second, if the information seems important but isn't articulated clearly, you have two choices: Wait to see if clients can independently express themselves clearly, or immediately use a clarification. For example:

I don't know, she was different. She looked at me differently than other women. Others were missing . . . something, you know, the eyes. Usually you can tell by the way a woman looks at you, can't you? Then again, maybe it was something else, something about me that I'll understand someday.

An appropriate clarification would be: "She seemed different; it may have been how she looked at you or something about yourself you don't totally understand. Is that what you're saying?"

## Reflection of Feeling (aka Empathy)

The primary purpose of a *reflection of feeling* is to let clients know, through an emotionally focused paraphrase, that you're tuned in to their emotional state. Nondirective reflections of feeling encourage further emotional expression. Consider the following example of a 15-year-old male talking about his teacher:

**Client:** That teacher pissed me off big time when she accused me of stealing her watch. I wanted to punch her.

**Counselor:** You were pretty pissed off.

**Client:** Damn right.

In this example, the feeling reflection focuses only on what the client clearly articulated. This is the rule for nondirective feeling reflections: Restate or reflect *only* the emotional content that you *clearly* heard the client say. It doesn't involve probing, interpreting, or speculation. Although we might guess at the underlying emotions causing this boy's fury, a nondirective feeling reflection focuses on the obvious emotions.

Emotions are personal. Any attempt to reflect feelings is a move toward closeness or intimacy. Some clients who don't want the intimacy associated with a counseling relationship may react negatively to reflections of feeling. You can minimize potential negative reactions to reflections of feeling by phrasing them tentatively, especially during an initial interview:

When using reflection to encourage continued personal exploration, which is the broad goal of reflective listening, it is often useful to understate slightly what the speaker has offered. This is particularly so when emotional content is involved. (W. R. Miller & Rollnick, 2002, p. 72)

Emotional accuracy is your ultimate goal. However, if you miss the emotional target, it's better to miss with an understatement than an overstatement. If you overstate emotional intensity, clients will often backtrack or deny their feelings. As we'll discuss in Chapter 12, there's a proper time for intentionally overstating client emotions. Generally, however, you should aim for accuracy while proceeding tentatively and understating rather than overstating your client's emotional intensity. Rogers (1961) would sometimes use clarification with clients after giving a reflection of feeling (e.g., "I'm hearing sadness and pain in your voice . . . am I getting that right?").

If you underestimate a reflection of feeling, your client may correct you.

**Client:** That teacher pissed me off big time when she accused me of stealing her watch. I wanted to punch her.

**Counselor:** Seems like you were a little irritated about that. Is that right?

**Client:** Irritated, hell—I was pissed.

**Counselor:** You were more than irritated. You were pissed.

In this example, a stronger emotional descriptor is more appropriate because the client obviously expressed more than irritation. However, any adverse effect of “missing” the emotion is minimized because the counselor phrased the reflection tentatively with “Seems like . . .” and then added a clarifying question at the end. Then, perhaps most important, when the client corrected the counselor, the counselor repaired the reflection to fit with the client’s emotional experience. From a psychoanalytic perspective, the repairing of emotional mirroring or empathy is the most therapeutic part of listening (Kohut, 1984; see Putting It in Practice 4.2 to practice emotional responses to clients).

### PUTTING IT IN PRACTICE 4.2: ENHANCING YOUR FEELING VOCABULARY

There are many ways to enhance your feeling vocabulary. Carkhuff (1987) recommended the following activity. Identify a basic emotion, such as anger, fear, happiness, or sadness, and then begin associating to other feelings in response to that emotion. For instance, state, “When I feel sad . . .” and then finish the thought by associating to another feeling and stating it; for example, “I feel cheated.” An example follows:

When I feel joy, I feel fulfilled.

When I feel fulfilled, I feel content.

When I feel content, I feel comfortable.

When I feel comfortable, I feel safe.

When I feel safe, I feel calm.

When I feel calm, I feel relaxed.

This feeling association process can help you discover more about your emotional life. Conduct this exercise individually or in dyads using each of the 10 primary emotions identified by Izard (1982):

Interest-excitement	Disgust
Joy	Contempt
Surprise	Fear
Distress	Shame
Anger	Guilt

## Summary

A *summary* is an expanded paraphrase. It demonstrates accurate listening, enhances client and therapist recall of major themes, helps clients focus on important issues, and extracts or refines the meaning behind client messages. Depending on how much your clients talk, you will summarize intermittently throughout a session and again at the end.

**Therapist:** You've said a lot in the past 10 minutes, so I want to make sure I'm tracking your main concerns. You talked about the conflicts between you and your parents, about how you've felt angry and neglected, and about how it was a relief, but also a big adjustment, to be placed in a foster home. You also said you're doing better than you thought you'd be doing. Does that cover what you've talked about so far?

**Client:** Yeah. That about covers it.

Coming up with a summary can be difficult. Your memory of what your client said will sometimes fade quickly, leaving you without complete recollection. Also, sometimes therapists take on too much responsibility:

You've mentioned four main issues today. First, you said you don't remember much about your childhood because of moving so often, which you hated. Second, your military experience has caused you to struggle with issues of trust. Third, you would very much like to find a partner to share your life with, but are frightened of intimacy. And fourth, uh, fourth [long pause], uh, sorry, I forgot the fourth one—but I'm sure it'll come to me.

Inviting clients to summarize with you is a wiser practice. As our colleague Carlos Zalaquett (personal communication, August 25, 2012) noted, an interactive approach will highlight your clients' perspective on what's important during an interview or serve as a check on their understanding of homework. Instead of your taking on responsibility for accurately summarizing everything your client said, collaboration honors your clients' values and perspectives, gives them the responsibility to determine what's important, and models respect and teamwork.

### ***Guidelines for Summarizing***

When summarizing content from an interview, be informal, collaborative, supportive, and balanced:

- Informal

Instead of saying, "Here's my summary of what you said," say, "Let's make sure I'm keeping up with what you've been talking about."

Instead of numbering your points, simply state them one by one. That way you won't be embarrassed by forgetting a point.

- Collaborative

Instead of taking the lead, ask clients to summarize (e.g., "What seemed most important to you during our meeting?"). This allows you to hear your client's view before offering your own. You can always add what you thought was important later.

If you take the lead in summarizing, pause intermittently so your client can agree, disagree, or elaborate.

At the end of your part of the summary, ask if what you've said seems accurate (e.g., "Does that seem to fit with what you recall?").

Using a collaborative approach can feel empowering to clients. You might say, "I'm interested in what *you* feel has been most important of all you've covered today" or "How would you summarize the homework we've been talking about?"

- Supportive

It can be very supportive to acknowledge your client's efforts. For example, summarizing your observations by stating things like "You've said a lot" or "I appreciate your openness today" are reassuring and supportive summary statements that help clients feel good about what they've shared. Of course, you should only make these supportive statements when they are consistent with behaviors your client has displayed in the session.

It's also supportive to note topics that seemed difficult for your clients, stating something like, "I noticed you shared some of your sadness with me."

- Balanced

When summarizing, be intentional. Although it's important to be accurate, it's also important to balance the summary so that it highlights difficult content as well as client strengths, or reasons for hope. In fact, therapists who adhere to a solution-focused perspective will avoid summarizing anything negative. Instead, they'll highlight the positive and hopeful (e.g., "Throughout this session, I heard you talking about different skills or strengths you've used to cope with the loss of your relationship partner. I respect how hard you've worked at this").

Your summary style will be tied to your theoretical orientation. For instance, psychodynamic clinicians provide summaries that emphasize repetitive relationship patterns. In contrast, cognitive therapists summarize

distorted or maladaptive thinking patterns and eventually package this information into a case formulation to share with clients (Epp & Dobson, 2010).

As you reflect on this section, consider both your natural inclinations and your theoretical orientation. Will your summaries be more positive and upbeat, or more focused on what is going wrong or what feels bad in your client's life? Recognizing your tendencies will help you find a balanced style.

## The Pull to Reassurance

Taken together, attending skills and nondirective listening techniques could be considered polite behaviors. They involve listening attentively, indicating interest, tuning in to feelings, and demonstrating caring behaviors. Such behaviors make people attractive and popular. However, in the context of therapy, these behaviors are not just a way of being nice. They're techniques. Two other common and positive social behaviors are complimenting and reassuring.

If you're listening well, you also may feel a pull to offer compliments or reassurance during clinical interviews. However, it's important to know that, strictly speaking, complimenting or reassuring clients is a directive technique.

From a behavioral perspective, complimenting clients may function as positive reinforcement. Also, when you compliment, you're expressing *your* taste and *your* approval, which is a form of self-disclosure—another therapeutic technique that must be consciously and skillfully managed. Compliments or self-disclosure in any form is a *technique* to be used in moderation (Farber, 2006; Zur, 2007). Reassurance, too, is a technique. Clients may behave in ways that tug on your impulse to say something reassuring. They want to know whether they're good parents, whether they did the right thing, or whether their sadness will lift. At some point you're likely to feel the pull to tell them they're doing just fine.

Premature or global reassurance isn't recommended. When you issue blanket reassurance, you're assessing a situation and/or a person's coping abilities and declaring that things will improve or come out for the better. Even though that might be what you hope for, such an outcome can't be guaranteed. In this sense, reassurance is misleading. In another sense, global reassurance might discount the client's difficulties. You're not in a position to know how bad things are or how much work will be involved in making changes. Empathy and reassurance aren't interchangeable.

Therapists should use reflective, empathic listening regularly, whereas reassurance, compliments, and self-disclosure should come in small, carefully considered doses.

**VIDEO  
4.6**

## Ethical and Multicultural Considerations

It's likely that each client will respond to you and your listening skills differently. Some clients will love having you as a listener. They'll be instantly impressed with your excellent interviewing skills. Other clients will be neutral. Still others will think (and possibly tell you) that your education and training are worthless and that they resent having to spend time with you.

### The Ethics of Not Directing

Listening well is an essential therapeutic skill, but many clients don't come for counseling looking for an excellent listener. They come because they want an expert. They desire guidance. They may even want to be told what to do and how to do it.

The desire for an authoritative counselor may be particularly salient within ethnic and cultural groups. For example, Asian American clients tend to want more direct guidance from their counseling professionals (Chang & O'Hara, 2013). Of course this is a generalization, but knowing that some Asian clients want an expert and will be disappointed if you don't act in more directive ways is valuable information.

Some problems, such as those present in crises or severe mental disorders, also might require more active and directive interventions. Cultural and personal expectations, presenting problem(s), and theoretical orientations can call for more directive, authoritative interactions. If so, it might be unethical for you to persist with nondirective listening and not advance to the skills and techniques described in Chapters 5 and 6. See Case Example 4.2 for an illustration.

### CASE EXAMPLE 4.2: WHEN BEING NONDIRECTIVE MIGHT BE UNETHICAL

While reading the referral information, you discover that your new client is a 17-year-old Chinese American female with a history of cutting and parasuicidal behavior. Early in the interview she tells you, "I want to stop cutting." This is especially good news because you know something about skills training for clients who cut. Although your active listening provides an excellent foundation, if you *only* listen to her, you'll be doing her a disservice. The point is this: If you know about something that fits with your client's specific condition and you withhold it without an exceptionally good rationale, you're in ethical hot water. In this case, you *should* actively begin teaching your client alternative emotional management skills.

In another situation, you could make a case for withholding your advice and being less direct. For example, if your client is Native American and rapport development is slow and you're not certain that she's motivated to stop cutting, you would have a solid rationale for maintaining a nondirective listening stance with plenty of self-disclosure and a focus on developing a working alliance. Staying less direct with Native clients and respecting their process are reasonable strategies. Your client might not be ready or willing to work on developing alternative coping strategies until Session 2 or 3 or 4. If you were to jump in too soon with advice on how to stop cutting, your client might not show up for Session 2.

## Gender, Culture, and Emotion

Imagine that you're in an initial clinical interview with a Latino male. Your impression is that he's angry about his wife's employment outside the home. You're aware that some Latina(o)s have more traditional ideas about male and female roles in the home. This knowledge provides you with evidence to support your hypothesis about your client's emotional state. So you intentionally use a reflection of feeling to focus in on your client's anger:

I'm getting the sense that you're a little angry about your wife deciding to go back to work.

He responds,

Nah. She can do whatever she wants.

You hear his words. He seems to be empowering his wife to do as she pleases. But his voice is laden with annoyance. This leads you to try again to connect with him on a deeper level. You say,

Right. But I hear a little annoyance in your voice.

This reflection of feeling prompts an emotional response, but not the one you had hoped for.

Sure. You're right. I am annoyed. I'm fucking annoyed with you and the fact that you're not listening to me and keep focusing on all this feelings shit.

This is a dreaded scenario for many clinicians. You take a risk to reflect what seems like an obvious emotion, and you get hostility in

return. For several possible reasons, your emotional sensitivity backfires. The client moves to a defensive and aggressive place, and a relationship rupture occurs (see Chapter 7 for more on dealing with relational ruptures).

It's tempting to use culture and gender to explain this client's negative reaction to your reflection of feeling. But it's not that simple.

Although culture, gender, race, and other broad classification-based variables can sometimes predict whether a specific client will be comfortable with emotional expression, individual client differences are probably more substantial determinants. In particular, comfort in expressing emotion is often a function of whether the client comes from a family-neighborhood-cultural context where emotional disclosure was a norm. For example, Knight (2014) reported that Black and Latino males who were unlikely to disclose to their peers attributed this tendency directly to their experiences living in violent communities. These young men had learned that emotional expression and trusting others were bad ideas in their neighborhoods. Conversely, emotional disclosure is more likely to be in the comfort range of Black and Latino males who are raised in safer community environments. This makes good common sense: Whether clients perceive you as safe to talk with about emotional concerns probably has more to do with the clients' background and past experiences than it has to do with you.

Overall, it's likely that clients' willingness to tolerate feeling reflections is based on a mix of their cultural, gender, and individual experiences. To move these ideas toward application, if you have reason to suspect that your client is less comfortable focusing on emotions, you should avoid words that are emotionally specific and therefore more provocative. Examples of emotionally specific words include *angry, sad, scared, and guilty*.

Instead of using emotionally specific words, you can initially substitute words that are emotionally vague (and less intense). Later, as trust develops, it may be possible to use more specific emotional words. Consider the following phrases:

- You found that frustrating.
- It seems like that bothered you a bit.
- It's just a little upsetting to think about that.

Putting It in Practice 4.3 lists examples of emotionally vague words you might use instead of emotionally specific words.

**PUTTING IT IN PRACTICE 4.3: USING VAGUE AND EMOTIONALLY SAFE WORDS**

Emotionally Specific Words	Substitute (Safer) Words
Angry	Frustrated, upset, bothered, annoyed
Sad	Down, bad, unlucky, "that sucked"
Scared	Bothered, "didn't need that," "felt like leaving"
Guilty	Bad, sorry, unfortunate, "bad shit"
Embarrassed	Less than comfortable, bugged, annoyed

*Note:* These words may work as substitutes for more emotionally specific words, but they also may not. It will be more effective for you to work with your classmates or work setting to generate less emotionally threatening words and phrases that are culturally and locally specific.

## Not Knowing What to Say

As a beginning therapist, you wish, quite naturally, for a perfect guide so that you always know the right thing to say and when you shouldn't say anything. However, one factor that makes our profession both exhilarating and complex is that the unique relationship between each therapist and client—and the interviewing process itself—is too dynamic for any preset formula. Differences among clients make it impossible to reliably predict their reactions to various interviewing responses. Some clients react positively to therapist behaviors that seem inadequate or awkward; others react negatively to what you thought was a perfect paraphrase. Knowing when to apply a particular technical skill is the artful side of interviewing. Good timing requires sensitivity and experience as well as other intangibles, such as having patience with yourself.

Not knowing what to say or when to say it can be disconcerting. Over time you'll get more comfortable with pausing during sessions to reflect on what to say next. Meier and Davis (2011) advised: "When you don't know what to say, say nothing" (p. 11). And Luborsky (1984) noted: "Listen . . . with an open receptiveness to what the patient is saying. If you're not sure of what is happening and what your next response should be, listen more and it will come to you" (p. 91).

At some point, you'll likely experience self-doubt. Margaret Gibbs (1984) expressed this distress in a chapter titled "The Therapist as Imposter":

Once I began my work as a therapist . . . I began to have . . . doubts. Certainly my supervisors seemed to approve of my work, and my patients improved as much as anybody else's did. But what was I actually supposed to be doing? I knew the dynamic, client-centered and behavioral theories, but I continued to read and search for answers. I felt there was something I should know, something my instructors had neglected to tell me, much as cooks are said to withhold one important ingredient of their recipes when they relinquish them. (p. 22)

The missing ingredient Gibbs was seeking could have been experience. Ironically, however, experience doesn't guarantee that therapists will know the *right* thing to say. Instead, what it probably does best is help take the edge off the anxiety associated with not knowing what to say.

Part of being an honest professional is to admit and tolerate that sometimes you don't know what to say. Gibbs ended her chapter with the following:

Strategies can cover up, but not resolve, the ambiguities of clinical judgments and interventions. Imposter doubts need to be shared, not suppressed, in the classroom as elsewhere. [There is] evidence to support the idea that uncertainty and humility about the accuracy of our clinical inferences is an aid to increased accuracy. I find this notion enormously comforting. (p. 32)

For you to become an effective clinician, it's essential that you understand and be able to apply the skills in this chapter. But being comfortable with uncertainty and developing humility are also central parts of becoming a competent clinician.

## Summary

Nondirective listening skills include attending behaviors and a range of different technical skills that facilitate listening. These technical skills are referred to as facilitative behaviors, helping skills, microskills, facilitation skills, counseling behaviors, and more. Although this chapter focuses on listening skills, Carl Rogers, who developed the nondirective approach, viewed clinician attitudes as more important than specific skills or techniques.

Adopting a therapeutic attitude includes Rogers's core conditions of congruence, unconditional positive regard, and accurate empathy.

According to recent neuroscience research, it appears likely that clinicians can develop their therapeutic attitude through repeated practice, as well as mindfulness meditation. It's important to remember that communication between therapist and client is always two-way.

Attending behavior is primarily nonverbal and consists of culturally appropriate eye contact, body language, vocal qualities, and verbal tracking. Positive attending behaviors open up and facilitate client talk, whereas negative attending behaviors tend to shut down client communication. Even when clinicians are engaging in attending behaviors and nondirective listening, they're leading or directing clients by paying more and less attention to the content of client speech. Considerable cultural and individual differences exist among clients regarding the amount and type of eye contact, body language, vocal qualities, and verbal tracking they prefer.

The whole range of skills available to clinicians can be placed on a listening continuum, with less directive listening on the left and more directive, action-oriented interventions on the right. This chapter focuses on the least directive listening skills, with more directive approaches covered in Chapters 5 and 6.

Nondirective listening behaviors consist of therapeutic silence, paraphrasing (or reflection of content), clarification, reflection of feeling, and summarizing. Nondirective listening behaviors are primarily designed to facilitate client self-expression.

Being nondirective can have ethical and cultural implications. In cases where clients are ready for education and clinicians have concrete problem-solving and change methods to offer, it can be unethical to withhold this information. In addition, effective clinicians are aware that client gender and culture may influence whether more or less directive clinician behaviors are appropriate.

## Suggested Readings and Resources

The following readings offer additional information on attending skills, empathic communication, neuroscience, and person-centered therapy.

Agosta, L. (2015). *A rumor of empathy: Resistance, narrative, and recovery in psychoanalysis and psychotherapy*. London, England: Routledge. This book is a look at empathy from the psychoanalytic perspective. In particular, Agosta examines the fascinating reasons for ambivalence, reluctance, and resistance to empathic connection.

Decety, J., & Ickes, W. (2009). *The social neuroscience of empathy*. Cambridge, MA: MIT Press. Much of the foundational research and thinking on empathy is covered in this edited book. If you want an intellectual and practical read, this book

is a good choice because it includes not only sections on research-informed dimensions of empathy and evolutionary and neuroscience perspectives, but also a substantial section on clinical perspectives on empathy.

Gibbs, M. A. (1984). The therapist as imposter. In C. M. Brody (Ed.), *Women therapists working with women: New theory and process of feminist therapy* (pp. 21–33). New York, NY: Springer. This chapter is a strong appeal to therapists to acknowledge their insecurities and inadequacies. It provides insights into how experienced professionals can and do feel inadequate.

Kabat-Zinn, J. (2012). *Mindfulness for beginners: Reclaiming the present moment—and your life*. Boulder, CO: Sounds True. If you’re thinking about starting a mindfulness practice, there are literally hundreds of options, but we recommend Kabat-Zinn’s work. His early work, *Full Catastrophe Living*, was a major force in contemporary integration of mindfulness into psychotherapy.

Krznaric, R. (2015). *Empathy: Why it matters and how to get it*. New York, NY: Perigee. This popular press book on empathy describes six habits of highly empathic people. Despite the book’s neglect of empathy pioneers such as Alfred Adler and Carl Rogers and its overemphasis on empathy as a “recent” scientific discovery, the habits are solid, and the quotations are marvelous.

Meador, B., & Rogers, C. R. (1984). Person-centered therapy. In R. J. Corsini (Ed.), *Current psychotherapies* (3rd ed., pp. 142–195). Itasca, IL: Peacock. This chapter in Corsini’s third edition (if you can find it) contains a fabulous excerpt of Rogers’s classic interview with the “silent young man.”

Rogers, C. R. (1951). *Client-centered therapy*. Boston, MA: Houghton Mifflin. This text includes Rogers’s original discussion of feeling reflections.

Satel, S., & Lilienfeld, S. O. (2013). *Brainwashed: The seductive appeal of mindless neuroscience*. New York, NY: Basic Books. Neuroscience continues to grow in its immense popularity. This book analyzes popular neuroscience, grounds it in real science, and provides an excellent foundation for evaluating neuroscience breakthroughs that are likely to occur in the future.

Sommers-Flanagan, J., & Sommers-Flanagan, R. (2012). *Counseling and psychotherapy theories in context and practice: Skills, strategies, and techniques* (2nd ed.). Hoboken, NJ: Wiley. Of the many “theories” texts out there, this is our personal favorite.

## CHAPTER 5

# DIRECTIVE LISTENING SKILLS

### Chapter Orientation

As a mental health professional, you'll need to move beyond listening and be more active in structuring and directing the interview. This will involve using questions for assessment and therapeutic purposes. Although clinical interviews are never investigations, at times you'll want to engage clients with questions to track down symptoms and search for diagnoses. Other times you'll encourage clients to engage in self-examination designed to lead to insight or improved problem management. In this chapter, we describe and illustrate a range of different directive listening skills, including questions.

If you're like many students, you may have found the non-directive listening emphasis in Chapter 4 frustrating. It may have left you chomping at the metaphorical bit. You might have felt a longing to exert your influence or offer advice or confront clients on their inconsistencies. But none of those behaviors were discussed (or permitted) in Chapter 4.

Not to worry. In this chapter, we reward you (a little) for your patience. The skills in this chapter include sophisticated strategies for influencing clients. These skills are in the middle of the listening continuum. They don't include direct advice giving, but they do provide you exciting tools for gently guiding clients toward ideas and issues that you believe are therapeutic.

The directive listening behaviors and skills in this chapter are the stuff of nuance. They allow you to do a bit of nudging . . . but no pushing yet. We'll get to the pushing in Chapter 6. This chapter is about subtle directing, guiding, and probing that lead clients toward a self-examination process that might inspire new perspectives or insight.

### LEARNING OBJECTIVES

After reading this chapter, you will be able to:

- Describe the nature and purpose of directive listening behaviors
- Describe and apply directive listening behaviors, including interpretive reflections of feeling, interpretations, feeling validations, and confrontations
- Describe and apply direct questioning in an ethical manner, empowering clients to explore specific actions, rather than pushing them in culturally or values-based directions
- Identify ethical and cultural issues that can arise when using directive listening skills

**VIDEO  
5.1**

## Directive Listening Behaviors: Skills for Encouraging Insight

If we are the stories we tell ourselves, we had better choose them well.

—James Orbinski, *An Imperfect Offering*, 2008, p. 4

*Directive listening behaviors* are advanced interviewing techniques that encourage clients to examine and possibly change their thinking or behavior patterns or choose new stories to tell about themselves. They can be used for assessment, exploring client issues, and facilitating insight. The following are specific directive listening behaviors:

- Feeling validation
- Interpretive reflection of feeling
- Interpretation (psychoanalytic or reframing)
- Confrontation
- Immediacy
- Questions

Directive listening behaviors (aka skills) work best after you've established an initial alliance with clients.

Using directive listening skills places you in an expert role. The therapist's behaviors in this chapter range from being mostly client centered to mostly therapist centered. Client-centered directives zero in on what the client is *already talking about*, but are aimed to take clients deeper. Directives that are therapist centered are designed to shift clients toward what they're *not yet talking about*. Directive listening behaviors operate on the assumption that clients will benefit from guidance or direction.

### Feeling Validation

Reflections of feeling (discussed in Chapter 4) are often confused with feeling validation. The difference is that reflections of feeling are more purely client centered, whereas feeling validation includes your opinion, approval, or validation of client emotions. A *feeling validation* is an emotion-focused technique that acknowledges and validates your client's stated feelings. It's a message that communicates, "What you're feeling is a natural or normal emotional response."

The difference between reflecting feelings versus validating feelings may seem subtle, but it provides an excellent example of the complexities

of skillful interviewing. Skilled interviewers intentionally use reflection of feeling as a method to prompt clients to evaluate their own emotions. In contrast, they use feeling validation as a method to support and reassure clients. Novice interviewers may not know or understand the difference.

Psychoanalytically oriented clinicians distinguish between supportive and expressive psychotherapy techniques. Based on this distinction, feeling validation is a supportive technique, and feeling reflection is an expressive technique. Clients usually feel supported and more normal when you validate their emotions. Clients may experience greater stress if you use reflections of feeling to have them examine and judge the validity of their own emotions.

Supportive techniques like feeling validation are *outside-in* self-esteem boosters. What this means is that they're based on the therapist (as an outside authority) saying something like "Your anger in response to being unfairly accused of stealing something seems pretty natural." One drawback of outside-in self-esteem boosters is that they involve reassurance from an outside source; they don't empower self-discovery. Thus the boost that comes from external emotional validation may be temporary and not lead to real or lasting client change. In addition, if clients come to rely on external validation of their feelings, it can lead to dependency.

All approaches to feeling validation give clients the message, "Your feelings are acceptable, and you have permission to feel them." In fact, sometimes you might even use feeling validation to suggest to clients that they *should* be having particular feelings.

**Client 1:** I've been so sad since my mother died. I can't seem to stop myself from crying. (*Client begins sobbing*)

**Therapist 1:** It's okay to feel sad about losing your mother. That's perfectly normal. Crying in here as you talk about it is a natural response.

The preceding exchange involves validation. This is no longer a person-centered response. By openly stating that feeling sad and crying is normal, the therapist takes on an expert role.

Another way to provide feeling validation is through self-disclosure:

**Client 2:** I get so anxious before tests, you wouldn't believe it! All I can think about is how I'm going to freeze up and forget everything. Then, when I get to class and look at the test, my mind just goes blank.

**Therapist 2:** You know, sometimes I feel the same way about tests.

In this example, the therapist uses self-disclosure to validate the client's anxiety. Although using self-disclosure to validate feelings can be

reassuring, it's not without risk. Clients may wonder if therapists can be helpful with anxiety symptoms if they have similar anxieties. Of course, self-disclosure can also enhance therapist credibility, as a client may think, "Hmm. If my therapist went through test anxiety too, maybe he'll understand and be able to help me." Using self-disclosure to validate client emotions can diminish or enhance therapist credibility—depending on the client and the therapeutic relationship.

Therapists can also use universality to validate or reassure clients.

**Client 3:** I always compare myself to everyone else—and I usually come up short. I wonder if I'll ever really feel confident.

**Therapist 3:** You're being too hard on yourself. I don't know anyone who feels a complete sense of confidence.

Clients may feel validated when they observe or are informed that nearly everyone else in the world (or universe) feels similar emotions. Yalom provided a personal example:

During my own 600-hour analysis I had a striking personal encounter with the therapeutic factor of universality . . . I was very much troubled by the fact that, despite my strong positive sentiments [towards my mother], I was beset with death wishes for her, as I stood to inherit part of her estate. My analyst responded simply, "That seems to be the way we're built." That artless statement not only offered considerable relief but enabled me to explore my ambivalence in great depth. (Yalom & Leszcz, 2005, p. 7)

Feeling validation is a common technique. People like to have their feelings validated; and, often, counselors like validating their clients' feelings. However, open support, such as feeling validation, can reduce client exploration of important issues (i.e., clients assume they're fine if their therapist says so) and diminish the likelihood that clients will independently develop positive attitudes toward themselves.

Potential effects of feeling validation include:

- Enhanced rapport
- Increased or reduced client exploration of the problem or feeling (this could go either direction)
- Reduction in client anxiety, at least temporarily
- Enhanced client self-esteem or feelings of normality (perhaps only temporarily)
- Possible increased client-therapist dependency

## Interpretive Reflection of Feeling (aka Advanced Empathy)

*Interpretive reflections of feeling* are emotion-focused statements that go beyond the client's obvious emotional expressions. This technique is sometimes referred to as advanced empathy (Egan, 2014). It's based on Rogers's (1961) idea that sometimes person-centered therapists work on emotions that are barely within the client's awareness.

The goal of an interpretive reflection of feeling is to go deeper than surface feelings or emotions, uncovering underlying emotions and potentially producing insight (i.e., the client becomes aware of something that was previously unconscious or partially conscious). Whereas nondirective reflections of feeling focus on obvious, clear, and surface emotions, interpretive reflections target partially hidden, deeper emotions.

Consider again the 15-year-old boy who was so angry with his teacher.

**Client:** That teacher pissed me off big time when she accused me of stealing her watch. I wanted to punch her.

**Counselor:** So you were pretty pissed off. (*reflection of feeling*)

**Client:** Damn right.

**Counselor:** I also sense that you have some other feelings about what your teacher did. Maybe you were hurt because she didn't trust you. (*interpretive reflection of feeling*)

The counselor's second statement probes deeper feelings that the client didn't directly articulate.

An interpretive reflection of feeling may stimulate client defensiveness. As described later, interpretations require good timing (Fenichel, 1945; Freud, 1949). That's why, in the preceding example, the counselor initially used a nondirective reflection of feeling and then, after that reflection was affirmed, used a more interpretive response. W. R. Miller and Rollnick (2002) made this point in *Motivational Interviewing*:

Skillful reflection moves past what the person has already said, though not jumping too far ahead. The skill is not unlike the timing of interpretations in psychodynamic psychotherapy. If the person balks, you know you've jumped too far, too fast. (p. 72)

Interpretive reflections of feeling can have many effects; the most prominent include the following:

- If offered prematurely or without a good rationale, they may feel foreign or uncomfortable; this discomfort can lead to client resistance, reluctance, or denial.

- When well stated and used within the context of a positive therapy relationship, interpretive reflections of feeling may feel supportive because therapists are “hearing” clients at a deeper emotional level; this can lead to enhanced therapist credibility and strengthening of the relationship.

Use of interpretive reflections of feeling is a subtle technique that can produce significant therapeutic breakthroughs. Gestalt therapist Fritz Perls often engaged clients in experiments to help them get in touch with the deeper emotions underneath surface feelings. For example, when clients claimed feelings of guilt, he would have them continue talking about guilt, but have them substitute the word “resentment” for “guilt.” This strategy sometimes helped clients become aware of anger and resentment underlying their guilt.

Keep in mind the following principles when using interpretive reflections of feeling.

- Wait until:
  - You have good rapport.
  - Your clients know that you can accurately hear their surface emotions.
  - You have evidence (e.g., nonverbal signals, previous client statements) that provide a reasonable foundation for your interpretation.
- Phrase your interpretive statement:
  - Tentatively (e.g., “If I were to guess, I’d say . . .”)
  - Collaboratively (e.g., “Correct me if I’m wrong, but . . .”)

The principle of phrasing statements tentatively and collaboratively is equally true when using any form of feedback or interpretation. Many different phrasings can be used to make such statements more acceptable.

- I think I’m hearing that you’d like to speak directly to your father about your sexuality, but you’re afraid of his response.
- Correct me if I’m wrong, but it sounds like your anxiety in this relationship is based on a deeper belief that she’ll eventually discover you’re unlovable.
- If I were to guess, I’d say you’re wishing you could find your way out of this relationship. Does that fit?
- This may not be accurate, but the way you’re sitting seems to communicate not only sadness but also a little irritation.

**CASE EXAMPLE 5.1: NOTICING THE SHAME UNDER THE ANGER**

A 24-year-old Black female referred herself for counseling. She reported having explosive anger reactions that, in her words, “are way out of line. I mean, I might deserve to be a little bit annoyed, but I’ll go off like a bomb.” Her therapy goals were to understand her rage and to control it better.

As a part of the intake interview, the clinician explored anger triggers with the client. She reported extreme anger in response to “somebody criticizing or lecturing me” and “somebody trying to make a fool of me in public.”

Toward the end of the intake, the clinician made the following interpretive reflection of feeling:

You’re very in touch with the angry feelings that rise up in you when you’re criticized or made to look like a fool in public. But when you described these situations, I heard another emotion lurking under the anger. It seems to me, but you should tell me if this seems right, that there’s some shame or embarrassment mixed in there too, and those feelings make your anger bigger than it might be otherwise.

In response, the client acknowledged deep and long-standing feelings of shame. The clinician’s interpretive reflection of feeling became a central factor in helping the client understand the nature of her rage and improve her anger management skills.

## Interpretation

*Interpretations* are used to produce client insight and help clients perceive reality more accurately. As Fenichel (1945) stated long ago, “Interpretation means helping something unconscious to become conscious by naming it at the moment it is striving to break through” (p. 25). When therapists provide an interpretation, they’re offering feedback that links past emotional or relationship patterns to current emotional or relationship patterns.

### *Psychoanalytic or “Classical” Interpretations*

An interpretation is based on the psychoanalytic theoretical principle that unconscious processes influence behavior. By pointing out unconscious conflicts and patterns, therapists help clients develop greater self-awareness and improved functioning. This doesn’t imply that insight alone produces behavior change. Instead, insight begins moving clients toward more adaptive ways of feeling, thinking, and acting.

Consider, one last time, our angry 15-year-old student.

**Client:** That teacher pissed me off big time when she accused me of stealing her watch. I wanted to punch her.

**Counselor:** So you were pretty pissed off. (*nondirective reflection of feeling*)

**Client:** Damn right.

**Counselor:** You know, I also sense you have some other feelings about what your teacher did. Maybe you were hurt because she didn't trust you. (*interpretive reflection of feeling*)

**Client:** (pauses) Yeah, well, that's a dumb idea . . . it doesn't hurt anymore . . . after a while when no one trusts you, it's no big surprise to get accused again of something I didn't do.

**Counselor:** So when you respond to your teacher's distrust of you with anger, it's like you're not just reacting to her, but also to those times in the past when your parents haven't trusted you. (*interpretation*)

In this exchange, the boy demeans the counselor's interpretive feeling reflection ("that's a dumb idea"), but then affirms it by noting "it doesn't hurt anymore." With this phrase, the boy gives the counselor a signal that there may be relevant past experiences (i.e., the word *anymore* is a reference to the past). This is consistent with psychoanalytic theory in that accurate interpretations are seen as often producing *genetic* material (i.e., material from the past). Thus the counselor perceives the client's signal and proceeds with an interpretation.

Classical interpretations work best if you have knowledge of clients and their past and present relationships. In the previous example, the counselor knows from earlier in the interview that the boy perceived himself as unjustly punished by his parents. The counselor could have made the interpretation after the boy's first statement, but waited until after the boy responded positively to the first two interventions. This illustrates the importance of timing when using interpretations. As Fenichel (1945) wrote, "The unprepared patient can in no way connect the words he hears from the analyst with his emotional experiences. Such an 'interpretation' does not interpret at all" (p. 25).

Within the context of an initial clinical interview, it's rarely appropriate to use a classical psychoanalytic interpretation to get deep into personal issues. That's because a single interview rarely provides enough rapport or relationship to explore client psychodynamics. However, it's not unusual for psychoanalytic clinicians to use trial or test interpretations during an initial interview to gather assessment data.

A *trial interpretation* is a statement that tentatively connects present behavior to past behavior. The focus is usually on repeating interpersonal relationship patterns. Theoretically, a trial interpretation deepens client awareness of a repeating maladaptive behavior pattern that warrants further analysis and possibly modification.

Trial interpretations are used to evaluate how clients are likely to respond to insight-oriented treatments. They should be stated tentatively and offered collaboratively. If clients respond to trial interpretations with interest, then an insight-oriented approach might be appropriate. If the response is hostile or defensive, or goes nowhere, it could mean your timing is off or that a concrete and practical behavioral approach is more suitable.

The simplest and least threatening trial interpretation involves *noticing a pattern*. You don't need to identify a meaning associated with the repeating pattern, only that a pattern seems to exist. It's also helpful to ask permission.

**Therapist:** Do you mind if I comment on something I noticed?

**Client:** Sure. Go for it.

**Therapist:** I just noticed what might be a pattern in how you describe yourself. I think at least three times you've described yourself or something you've done as "dumb" or "stupid."

If you ask permission, receive permission, and then use a trial interpretation, your client will likely respond in one of two ways: open and positive or closed and negative. Here's a closed and negative response:

**Client:** I do that because what I did or said was dumb or stupid. I don't believe in mincing words. It is what it is.

**Therapist:** You're just calling it as you see it.

In contrast, here's an open and positive response to the trial interpretation:

**Client:** I noticed that too. I suppose it might be related to the fact that my dad called me "dumb-ass" all the time. Somehow I believe that's true, and so I say it myself because that's safer than risking having you judge me as stupid.

**Therapist:** It's something you heard a lot from your dad. And it sounds like sometimes you use it proactively . . . to protect yourself from possible judgment from others.

In the first case, the client dismisses the therapist's observation. In the second case, the client is interested in the observation and begins talking about possible origins of the pattern. As in these examples, whether the

client's response is positive or negative, therapists should provide a paraphrase as a means of accepting the client's reaction.

Much has been written about the technical aspects of psychoanalytic interpretation: what to interpret, when to interpret, and how to interpret (Fenichel, 1945; Greenson, 1965; Weiner, 1998). Reading basic psychoanalytic texts, enrolling in psychoanalytic therapy courses, and obtaining supervision are prerequisites to using classical interpretations. As with interpretive reflections of feeling, poorly timed interpretations usually produce resistance and defensiveness.

### ***Reframing or Postmodern Interpretations***

Instead of bringing unconscious processes into awareness, nonpsychoanalytic practitioners use interpretation to shift how clients view their problems. Family systems, solution-focused, existential, and cognitive-behavioral therapists label this approach *reframing* or *cognitive reframing* (D'Zurilla & Nezu, 2010; de Shazer, 1985; Frankl, 1967).

Reframing is used when clinicians believe that their clients are viewing the world in a manner that's inaccurate or maladaptive. Consider the following counselor-client exchange:

**TJ:** If I ask for help or show any emotion, that's just a sign of weakness.

**Counselor:** You've mentioned before that you were raised to believe that having emotions like sadness or fear means you're weak. I think of it differently. For you, being able to face and deal with your sad feelings is a sign of strength. Doesn't it take strength to face and talk about things that make you uncomfortable, instead of avoiding them?

Although TJ may or may not accept this weakness-into-strength reframe, the counselor has offered an alternative viewpoint that may eventually sink in. Reframes like this one push an alternative reality into the client's perceptual field.

Here's a more playful example of a clinician using a reframe to comment on the relationship between two members of an outpatient group for youth who have gotten in legal troubles:

**Peg:** He's always bugging me. He insults me. And I think he's a jerk. I want to make a deal to quit picking on each other, but he won't do it.

**Dan:** She's the problem. Always thinks she's right. She's never willing to back down. No way am I gonna make a deal with her. She won't change.

**Counselor:** I notice you two are sitting next to each other again today.

**Peg:** So! I'd rather not be next to him.

**Counselor:** You two almost always sit next to each other, and you're always sparring back and forth. I think you might actually like each other, even though you act like you hate each other.

**Others:** Wow. That's it. We always thought so.

These teenagers were consistently harassing each other in group. This pattern led the clinician to suggest that the two teens were expressing mutual attraction rather than mutual irritation. Although the teens denied the reframe, other group members agreed that attraction was a possibility.

Effective reframing should be based on a reasonable alternative hypothesis. Here are some other examples:

- *To a client with depressive symptoms:* When you make a mistake, you see it as evidence for failure, but you could also see it as evidence of effort and learning. After all, most successful people experience many failures before succeeding.
- *To a young girl with oppositional behaviors:* You think that saying something nice to your parents is brown-nosing. I wonder if sometimes saying something positive to your mom or dad might just be an example of you giving them honest feedback (J. Sommers-Flanagan & Sommers-Flanagan, 2007b).
- *To a client with social anxiety:* When people don't say hello, you think they're rejecting you. It could be that they're having a bad day or have something else on their minds.

Cognitive reframes may be met with denial, but having clients practice viewing their problems in a new way can reduce anxiety, anger, or sadness. Reframing promotes perceptual flexibility. Similar to all forms of interpretation, reframes work best when you have credibility or a positive relationship with clients, when you offer a reasonable rationale, and when you make the statement collaboratively.

## Confrontation

Clients often have an inaccurate or unhelpful view of others, the world, and themselves. These inaccuracies usually manifest themselves as incongruities or discrepancies. Imagine a client with clenched fists and a harsh, angry voice saying,

I wish you wouldn't bring up my ex-wife. I've told you before, that's over! I don't have any feelings toward her. It's all just water under the bridge.

Obviously, this client still has strong feelings about his ex-wife. Perhaps the relationship is over and the client wishes he could put it behind him, but his nonverbal behavior—voice tone, body posture, and facial expression—tells you he's still emotionally involved with her.

*Confrontation* is a reflection or feedback statement that articulates clients' perceptual inaccuracies or inconsistencies. The intention is to help clients perceive themselves and others in a manner that's more adaptive and accurate.

Confrontation works best when you have a working relationship with clients and ample evidence to demonstrate their emotional or behavioral discrepancies. In the preceding example, we wouldn't recommend using confrontation unless there was additional evidence indicating that the client has unresolved feelings about his ex-wife. If there was supporting evidence, the following confrontation might be appropriate:

You mentioned last week that every time you think of your ex-wife, you want revenge. Today, you say you don't have any feelings about her. But judging by your clenched fists, voice tone, and what you just said about her "screwing you over," it seems like you still have very strong feelings about her. Perhaps you *wish* those feelings would go away, but it looks like they're still there.

In this situation, the clinician believed that the client would benefit from admitting to and dealing with his unresolved feelings toward his ex-wife. The clinician used confrontation to push the client to see the issue. To increase the likelihood that the client will admit to the discrepancy between his nonverbal behavior and his internal emotions, the clinician stated the confrontation gently and supported it with evidence.

Confrontations range from gentle to harsh. For example, take the case of a young, newly married man who, 35 minutes into his psychotherapy session, has not yet mentioned his wife (despite the fact that she left two days earlier to return to school about 2,000 miles away). The young man, while discussing a rise in his anger and frustration, was mildly confronted by his therapist, who observed, "I noticed you haven't mentioned anything about your wife leaving."

In this situation, the therapist used a reflection of content (or lack of content) to help the client connect his wife's departure to his irritable mood. This is an example of a gentle confrontation.

Firmer confrontations are sometimes useful. However, when therapists use aggressive confrontations, they risk evoking client resistance (W. R. Miller & Rollnick, 2013). Here's an example of a firm confrontation with a substance-abusing client.

**Client 1:** Doc, it's not a problem. I drink when I want to, but it doesn't have a big effect on the rest of my life. I like to party. I like to put a few down on the weekends; doesn't everybody?

**Therapist 1:** I agree that you like to party and that putting down a few on the weekend is mostly normal. But you've had two DUIs [tickets for driving under the influence], three different jobs, and a half dozen fights over the past year. That's looking like a problem. I think you'll be better off if you admit that alcohol is getting you in trouble, and we start working together to figure out how to deal with it.

Many people incorrectly believe that confrontations must be aggressive. This is simply not true.

There is, in fact, no persuasive evidence that aggressive confrontational tactics are even helpful, let alone superior or preferable strategies in the treatment of addictive behaviors or other problems. (W. R. Miller & Rollnick, 1991, p. 7)

Although stronger confrontations may be needed with some clients, it's more therapeutic and sensible, and less likely to produce resistance, if you begin with gentle confrontations. You can always get more assertive later.

A final example of an incongruity worthy of confrontation involves a 41-year-old married man who's describing how he picked up a 20-year-old woman over the Internet. The client's statement is followed by three potential confrontations, each progressively more assertive:

**Client 2:** I met this girl in a chat room. My marriage has been dead for 10 years, so I need to do something for myself. She's only 20, but I'm all set to meet her next week in Dallas, and I'm like a nervous Nellie. I've got a friend who's telling me I'm nuts, but I need some action in my life again.

**Confrontation A:** You're thinking that having a rendezvous with this young woman, rather than working on your relationship with your wife of 15 years, might help you feel better.

**Confrontation B:** Your plans seem a little risky. It sounds like you're valuing a possible quick sexual encounter with someone you've never met over your 15-year marriage. Have I got that right?

**Confrontation C:** I think you're playing out a midlife fantasy. You've never seen this girl, you don't know if she's really 20, whether she's got an STD, or if she plans to rob you blind. You think getting together with her will

help you feel better, but you're just running from your problems. Getting together with her will probably only make you feel worse in the long run.

Your client's response is the best gauge of your confrontation's effectiveness. Clients may blatantly deny the accuracy of your confrontation, partially accept it, or completely accept it.

Pure confrontations don't contain explicit prescriptions for change. They just bring together two inconsistent statements or behaviors, dropping the incongruity into the client's lap. Instead of a prescription for change, it implies that the incongruity should be addressed and that action may be necessary (but doesn't specify or prescribe any actions). In the next chapter, we review techniques that explicitly suggest or prescribe action.

### **Immediacy (aka Self-Disclosure)**

*Immediacy* involves an integration of here-and-now self-disclosure, feedback, and confrontation. In his work, Carl Rogers typically used himself and his experience in the session as a vehicle for providing feedback. In one well-known case, he stated:

I don't understand it myself, but when you start talking on and on about your problems in what seems to me a flat tone of voice, I find myself getting very bored. (R. C. Berg, Landreth, & Fall, 2006, p. 209)

This immediate disclosure provided the client feedback about how he was affecting Rogers, and subsequently, the client behaviors linked to Rogers's feelings in the session and within the relationship could be explored. You can probably sense the confrontation imbedded in Rogers's in-the-moment disclosure.

Immediacy shares many of the risks that accompany confrontation. Also, it can easily be more about the therapist and less about the client. In the preceding example, one rationale Carl Rogers used to explain why he shared his feelings of being bored was that having such feelings was very unusual for him. Depending on your background in psychology and counseling, you may recognize that immediacy can involve processing what psychoanalytic therapists refer to as countertransference as a means of exploring interpersonal dynamics emerging between therapist and client (see Chapter 7 for more on countertransference).

Immediacy is a flexible therapist response that can be used for many different purposes (Hill, 2014; Mayotte-Blum et al., 2012). For example, it can be used as a way of expressing support:

As I listen to you talk about the abuse you've experienced, I feel admiration for the strength I hear in your voice and in your stories.

Immediacy also can be primarily confrontational:

You say you want your roommate to be neater and more respectful of you and your space, and yet as you talk about it in here, it feels almost like you're a helpless child instead of the competent and resourceful adult I've come to know.

And immediacy can be used to lead clients toward specific action:

What I hear is that you're really unhappy in your job . . . and it makes me feel dissatisfaction right along with you . . . which then makes me want to get out and explore other employment options, but I don't hear you doing that.

Of all the different directive listening behaviors available to therapists, immediacy is perhaps the best illustration of how person-centered and therapist-centered behaviors are integrated into a single therapy intervention. As you can see from the preceding examples, immediacy involves relatively equal parts client observation and therapist disclosure in a way that provides both client and therapist with therapeutic grist for the mill.

## Questions

Imagine digging a hole without a shovel or building a house without a hammer. For many clinicians, conducting an interview without using questions constitutes an analogous problem: How can you complete a task without using your most basic tool?

VIDEO  
5.2

Despite the central role of questions in clinical interviewing, we've avoided discussing them until now. Similarly, when teaching clinical interviewing skills, we usually prohibit question asking for a significant portion of the course (J. Sommers-Flanagan & Means, 1987). Questions are easy and often misused. Also, because questioning isn't the same thing as listening, our goal is for students to develop alternative information-gathering strategies. Asking questions can get in the way of gathering important information from clients. *The Little Prince* expresses a fundamental problem with excessive questioning.

Grown-ups love figures. When you tell them that you have made a new friend, they never ask you any questions about essential matters. They never say to you, "What does his voice sound like? What games does he love best? Does he collect butterflies?" Instead, they demand: "How old is he? How many brothers has he? How much does he weigh?

"How much money does his father make?" Only from these figures do they think they have learned anything about him. (de Saint-Exupéry, 1943/1971, p. 17)

Unfortunately, the questions you ask may be of no value to the person being asked. Ideally, your questions should focus on the heart of what seems most important to clients.

Despite our reservations about excessive questioning, questions are a diverse and flexible interviewing tool; they can be used to

- Stimulate client talk
- Inhibit client talk
- Facilitate rapport
- Show interest in clients
- Show disinterest in clients
- Gather information
- Confront clients
- Focus on solutions
- Ignore the client's viewpoint

There are many forms or types of questions. Differentiating among them is important because different question types produce different client responses. In this section, we describe open, closed, swing, indirect, and projective questions. Chapter 6 covers therapeutic questions. Although we distinguish between general question types and therapeutic questions, all questioning can be used for assessment or therapeutic purposes.

### ***Open Questions***

*Open questions* are used to facilitate talk; they pull for more than a single-word response. Open questions ordinarily begin with either *How* or *What*. Sometimes questions that begin with *Where*, *When*, *Why*, and/or *Who* are classified as open, but such questions are only partially open because they don't facilitate talk as well as *How* and *What* questions (Cormier, Nurius, & Osborn, 2017). The following hypothetical dialogue illustrates how using questions traditionally classified as open may or may not stimulate client talk:

**Therapist:** When did you first begin having panic attacks?

**Client:** In 1996.

**Therapist:** Where were you when you had your first panic attack?

**Client:** I was just getting on the subway in New York City.

**Therapist:** What happened?

**Client:** When I stepped inside the train, my heart began to pound. I thought I was dying. I just held on to the metal post next to my seat because I was afraid I would fall over and be humiliated. I felt dizzy and nauseated. Then I got off the train at my stop, and I've never been back on the subway again.

**Therapist:** Who was with you?

**Client:** No one.

**Therapist:** Why haven't you tried to ride the subway again?

**Client:** Because I'm afraid I'll have another panic attack.

**Therapist:** How are you handling the fact that your fear of panic attacks is so restrictive?

**Client:** Not so good. I've been slowly getting more and more scared to go out. I'm afraid that soon I'll be too scared to leave my house.

As you can see from this example, open questions vary in their openness. They don't uniformly facilitate depth and breadth of talk. Although questions beginning with *What* or *How* usually elicit the most elaborate responses from clients, that's not always the case. More often, what's important is the way a particular *What* or *How* question is phrased. For example, "What time did you get home?" and "How are you feeling?" can be answered very succinctly. The openness of a particular question should be judged primarily by the response it usually elicits.

Questions beginning with *Why* are unique in that they commonly elicit defensive explanations. Meier and Davis (2011) stated, "Questions, particularly 'why' questions, put clients on the defensive and ask them to explain their behavior" (p. 23). *Why* questions frequently produce one of two responses. First, as in the preceding example, clients may respond with a form of "Because!" and then explain, sometimes through detailed and intellectual responses, why they're thinking or acting or feeling in a particular manner. Second, some clients defend themselves with a "Why not?" response. Or, because they feel attacked, they respond confrontationally with "Is there anything wrong with that?" This is the rationale for therapists' minimizing *Why* questions—they exacerbate defensiveness and intellectualization and diminish rapport. In contrast, if rapport is good and you want your client to speculate or intellectualize about something, then a *Why* question may be appropriate and useful in helping your client take a closer, deeper look at an issue.

### ***Closed Questions***

*Closed questions* are questions that can be answered with a yes or no response. Although sometimes classified as open, questions that begin with *Who*, *Where*, or *When* direct clients toward very specific information; therefore, they should be considered closed questions (see Putting It in Practice 5.1).

Closed questions restrict verbalization and lead clients toward specific responses. They can reduce or control how much clients talk. Restricting verbal output is useful when working with clients who talk excessively. Closed questions also can clarify specific behaviors and symptoms and are commonly used when conducting diagnostic interviews. (For example, in the preceding example about a panic attack on the New York subway, a diagnostic interviewer might ask, “Did you feel lightheaded or dizzy?” This question would help confirm or disconfirm the presence of a panic disorder.)

#### **PUTTING IT IN PRACTICE 5.1: OPEN AND CLOSED QUESTIONS**

The four sets of questions that follow are designed to obtain information pertaining to the same topic. Put yourself in the position of a client and imagine how these questions might *feel* different and lead you to answer them differently.

1. (Open) “How are you feeling about being in therapy?”  
(Closed) “Are you feeling good about being in therapy?”
2. (Open) “After you walked onto the subway and you felt your heart pounding, what happened next?”  
(Closed) “Did you feel lightheaded or dizzy after you walked onto the subway?”
3. (Open) “What was it like for you to confront your father after having been angry with him for so many years?”  
(Closed) “Was it gratifying for you to confront your father after having been angry with him for so many years?”
4. (Open) “How do you feel?”  
(Closed) “Do you feel angry?”

Notice and discuss with your classmates the differences in how you (and clients) might be affected by open versus closed questioning.

Sometimes, therapists inadvertently or intentionally transform open questions into closed questions with a tag query. For example, you might start with, “What was it like for you to confront your father after all these years” . . . and then tag “was it gratifying?” onto the end.

Transforming open questions into closed questions limits client elaboration. Unless clients faced with such questions are expressive or assertive, they’re likely to focus solely on whether they felt gratification when confronting their father (as in the preceding example). Clients may or may not elaborate on feelings of fear, relief, resentment, or anything else they’ve experienced.

Closed questions usually begin with words such as *Do*, *Does*, *Did*, *Is*, *Was*, or *Are*. They’re useful if you want to solicit specific information. Traditionally, closed questions are used later in the interview, when rapport is established, time is short, and efficient questions and short responses are needed (Morrison, 2007).

If you begin an interview using a nondirective approach, but later change styles to obtain more specific information through closed questions, it’s wise to use role induction to inform your client of this shift in strategy. You might say,

We have about 15 minutes left, and I have a few things I want to make sure I’ve covered, so I’m going to start asking you more specific questions.

Beginning therapists are sometimes advised to avoid closed questions. This is good advice because closed questions are frequently interpreted as veiled suggestions. For example:

**Client:** Ever since my husband came back from Afghanistan, he’s been moody, irritable, and withdrawn. This makes me miss him terribly, even though he’s home. I just want my old husband back.

**Therapist:** Have you told him how you’re feeling?

In this case, the client could believe her therapist’s question as a suggestion that she open up to her husband about her feelings (see also Case Example 5.3 later in the chapter). Although this may be a reasonable idea, using a closed question instead of an open question pulls the client in a specific direction. An open question like “How have you been dealing with these feelings?” allows the client to tell you what’s she’s been doing, before you imply or offer a suggestion. Overall, closed questions are a helpful interviewing tool—as long as they’re used intentionally and in ways consistent with their purpose.

### ***Swing Questions***

*Swing questions* can function as either closed or open questions; they can be answered with yes or no, but they also invite more elaborate discussion of feelings, thoughts, or issues (Shea, 1998). Swing questions usually begin with *Could*, *Would*, *Can*, or *Will*. For example:

- Could you talk about how it was when you first discovered you were pregnant?
- Would you describe how you think your parents might react to finding out you're leaving?
- Can you tell me more about that?
- Will you tell me what happened in the argument between you and your daughter last night?

Ivey, Ivey, and Zalaquett (2011) believe that swing questions are the most open of all questions: "Could, can, or would questions are considered maximally open and contain some advantages of closed questions. Clients are free to say 'No, I don't want to talk about that'" (p. 85).

For swing questions to function effectively, you should observe two basic rules. First, avoid using swing questions unless rapport has been established. If rapport isn't adequately established, a swing question may backfire and function as a closed question (i.e., the client responds with a shy or resistant yes or no). Second, avoid using swing questions with children and adolescents, especially early in the relationship. This is because children and adolescents often interpret swing questions concretely and may respond oppositely (J. Sommers-Flanagan & Sommers-Flanagan, 2007b). The two following examples illustrate this potential problem:

**Counselor 1:** Would you tell me more about the fights you've been having with your classmates?

**Young Client 1:** No.

**Counselor 2:** Could you tell me about how you felt when your dad left?

**Young Client 2:** No.

Using swing questions with young clients (especially if you don't have positive rapport) can produce an awkward and unhelpful interaction.

### ***Indirect or Implied Questions***

Indirect or implied questions usually begin with *I wonder* or *You must* or *It must* (Benjamin, 1987). They're used when therapists don't want to directly

ask or pressure clients to respond. The following are examples of indirect or implied questions:

- I wonder how you're feeling about your upcoming wedding.
- I'm wondering about your plans after graduation.
- I'm curious if you've given any thought to searching for a job.
- You must have some thoughts or feelings about discovering your son is transgender.
- It must be hard for you to cope with your wife being shipped out to serve overseas.

There are many other indirect sentence stems that imply a question or prompt clients to speak about a topic. Common examples include "I'd like to hear about . . ." and "Tell me about . . ."

Indirect or implied questions can be useful early in interviews or when approaching delicate topics. Like immediacy, they can contain a supportive self-disclosure of interest. They're gentle and noncoercive, so they may be especially useful as an alternative to direct questions with clients who seem reticent (C. Luke, personal communication, August 7, 2012). It should also be noted that when overused, indirect questions can seem sneaky or manipulative; after repeated "I wonder . . ." and "You must . . ." probes, clients may start thinking, "And I'm wondering why you don't just ask me whatever it is you want know!"

### ***Projective or Presuppositional Questions***

*Projective questions* are used to ask clients to imagine particular scenarios and help them identify, explore, and clarify unconscious or unarticulated conflicts, values, thoughts, and feelings. Solution-focused therapists refer to projective questions as presuppositional questions (Murphy, 2015). These questions typically begin with some form of *What if* and invite client speculation. Projective questions can be used to trigger mental imagery and help clients explore thoughts, feelings, and behaviors they might have if they were in a particular situation. For example:

- What would you do if you were given one million dollars?
- If you had three wishes, what would you wish for?
- If you needed help or were really frightened, or even if you were just totally out of money and needed some, who would you turn to right now? (J. Sommers-Flanagan & Sommers-Flanagan, 1998, p. 193)
- What if you could go back and change how you acted during that party (or other significant life event): What would you do differently?

Projective questions are also used for evaluating client values, decision making, and judgment. For example, a therapist can analyze a response to the question “What would you do with one million dollars?” to indirectly glimpse client values and self-control. Projective questions are sometimes included as a part of mental status examinations (see Chapter 9 and the Appendix).

### CASE EXAMPLE 5.2: PROJECTIVE QUESTIONING TO ELICIT VALUES

Your use of projective questions is limited only by your creativity. John likes to use projective questions to explore relationship dynamics and values. For example, with a 15-year-old male client who had an estranged relationship with his father and was struggling in school, John asked, “If you did really well on a test, who’s the first person you would tell?” The client responded, “My dad.” After hearing this response, John used the information (that the boy continued to value his father’s approval) to encourage the boy and his father to meet together for counseling to improve their communication and relationship.

Table 5.1 summarizes the various types of questions and usual client responses.

### Benefits and Liabilities of Questions

Therapists vary in their beliefs and habits with regard to questions. To explore this, sometimes we assign students the task of conducting a brief interview in which they only ask questions (no paraphrasing allowed!). Some students really like this assignment, whereas others hate it. We get

**Table 5.1** Question Classification

Word(s) the Question Begins With	Type of Question	Usual Client Responses
What	Open	Factual and descriptive information
How	Open	Process or sequential information
Why	Partially open	Explanations and defensiveness
Where	Minimally open	Information pertaining to location
When	Minimally open	Information pertaining to time
Who	Minimally open	Information pertaining to a person
Do/Did	Closed	Specific information
Could/Would/Can/Will	Swing	Diverse info, sometimes rejected
I wonder/You must/I’d like to hear	Indirect	Exploration of thoughts and feelings
What if	Projective or presuppositional	Information on judgment and values

similar responses when the assignment is to use predominantly solution-focused questions. Student reactions have included:

- I felt more in control.
- I felt more pressure.
- It was like I was asking the same question (about positive goals) over and over again.
- It was hard to think of questions while I was trying to listen to the client, and it was hard to listen to the client while I was thinking of what might be a good question to ask next.
- I seemed to have less patience. I just wanted to get to my next question and kept cutting in to ask more questions.
- I felt less pressure. I really liked asking questions!

As an assessment or therapy tool, questions have benefits and liabilities. Whether a given question functions in a positive or negative way depends on many factors, including therapist skill and client sensitivity. Table 5.2 includes potential benefits and liabilities of questions.

**Table 5.2** Potential Benefits and Liabilities of Questions

Benefit	Liability
Clients can have an experience of being led to discuss their thoughts and feelings in depth and detail.	Therapists may begin focusing too much on their own interests and values and too little on what their clients want to talk about.
Therapists are able to gather specific client information efficiently.	Clients may feel that their perspective is devalued.
Clients may feel relieved and understood when their therapists lead and ask important questions.	Therapists can get put in a position of being too much of an expert.
Therapists can use questions to encourage clients to focus on strengths and possible positive outcomes.	Clients may feel pressured to respond to probing questions.
Therapists can obtain specific, concrete examples of client behavior.	Clients can become less spontaneous and more passive.

## Guidelines When Using General Questions

To optimize your use of questions, we offer the following guidelines.

### *Prepare Clients for Questions*

A simple technique that reduces negative fallout is to warn clients when intensive questioning is coming. This often helps clients be less defensive and more cooperative. You can forewarn clients by saying,

I need to get some specific information from you. So, for a while, I'll be asking you lots of questions to help me get that information. Some of the questions may seem odd, but I promise, there's a reason behind them.

### ***Don't Use Questions Without Nondirective Listening***

Generally speaking, questions should be combined with less directive listening skills. This is true whether the questions are used for assessment or for therapeutic purposes. Be sure to follow your client's response to your query, at least occasionally, with a listening response:

**Interviewer:** What happened when you first stepped onto the subway?

**Client:** When I got inside the train, I felt my heart begin to pound. I thought I was going to die. I just held onto the metal post as hard as I could because I was afraid I would fall over and be humiliated. Then I got off the train at my stop, and I've never been back on the subway again.

**Interviewer:** It sounds like that was a frightening experience. You were doing everything you could to stay in control. Was anyone with you when you went through this panicky experience?

Unless listening skills are used in combination with repeated questions, clients are likely to feel bombarded or interrogated. W. R. Miller and Rollnick (2002) recommended that therapists avoid asking more than three questions consecutively.

### ***Make Questions Relevant to Client Concerns and Goals***

Clients are more likely to view you as competent and credible if you focus on their major concerns and/or goals. Aim your queries directly at what clients believe is important.

It may be hard for clients to understand the purpose of certain diagnostic or mental status questions. For example, when interviewing depressed clients, the following questions would be relevant:

- How has your appetite been?
- Have you been sleeping through the night?
- Have you had trouble concentrating?
- Do you find yourself interested in sex lately?

Imagine how a depressed client who is irritable and psychologically naïve, and who believes, somewhat accurately, that her bad mood is related to 10 years of emotional abuse from her domestic partner, might perceive such a series of questions. She might think, "I couldn't believe that counselor! What do my appetite, sex life, and concentration have to do with why I came to see her?" Unless clients can see their relevance, questions can decrease rapport and reduce client interest in therapy. (See Chapter 11 for more information on diagnostic interviewing.)

Similarly, from a solution-focused perspective, presuppositional questions will make more sense to clients when those questions focus on the client's

goals. For example, asking a teenage client, “What would it look like if you imagine yourself getting along great with your teacher” is more effective when the student has identified “getting along with the teacher” as a therapy goal.

### ***Use Questions to Elicit Concrete Behavioral Examples***

Perhaps the best use of questions is to obtain clear, concrete, past, present, or future behavioral examples from clients. Instead of relying on abstract client descriptions, you can use questions to obtain specific behavioral examples:

**Client:** I have so much trouble with social situations. I guess I’m just an anxious and insecure person.

**Interviewer:** Could you give me an example of a recent social situation when you felt anxious and thought you were insecure?

**Client:** Yeah, let me think. Well, there was the party at the frat the other night. Everyone else seemed to be having a great time, and I just felt left out. I’m sure no one wanted to talk with me.

In this exchange, although the therapist asks a swing question to obtain specific information, the client remains somewhat vague. Keep in mind that it’s often difficult for clients to be specific when describing their problems. In this situation, reassurance may be helpful (e.g., “Sometimes it can be hard to come up with a specific example”). After offering reassurance and support, you may need to ask repeated open and closed questions to help clients be more specific and concrete in describing their anxiety. For example:

- What exactly was happening when you felt anxious and insecure at the party?
- Who was standing near you when you had these feelings?
- What thoughts were going through your mind?
- What would you have done differently in this situation if you could do it over?

It’s also helpful for therapists to track verbal material with an occasional question as clients tell their stories. For example, when clients leave gaps in a story, it’s best to ask an open-ended question such as “What happened then?” rather than a close-ended question like “Did you go visit your mother?” Well-timed open-ended questions asked as clients tell a story will usually keep clients talking productively.

### ***Approach Sensitive Areas Cautiously***

Be especially careful when questioning clients about sensitive topics. As Wolberg (1995) noted, it’s important to avoid immediately questioning new

clients in sensitive areas (e.g., appearance, status, sexual difficulties, failures). Wolberg suggested that clients be allowed to talk freely about sensitive topics, but if blocking occurs, questioning should be avoided until the relationship is better established because relationship building is usually a higher priority than information gathering.

Despite Wolberg's (1995) generally good advice, sometimes the therapy relationship must share the front seat with information gathering. This is especially true when conducting an intake interview, when a client is in crisis, or when the setting demands a speedy assessment. For example, if a client is suicidal or homicidal, gathering assessment data for clinical decision making is top priority—along with relationship building. If you're in a clinical situation and unsure about whether it's acceptable to pursue a specific and sensitive area of questioning, you can always ask, "Is it okay with you if I ask you a few personal questions?" or state your intentions while giving the client permission for privacy (e.g., "I'm going to ask you some personal questions, but you don't have to answer them if you don't want to").

See Table 5.3 for a summary of directive listening behaviors.

**Table 5.3** Summary of Directive Listening Behaviors and Their Usual Effects

Listening Response	Description	Primary Intent/Effect
Feeling validation	Statements that support, affirm, approve of, or validate client feelings.	Enhances rapport. Temporarily reduces anxiety. May cause therapists to be viewed as expert.
Interpretive reflection of feeling	Statements that explore feelings that therapists believe are underlying their client's thoughts or actions.	May enhance empathy and encourage emotional exploration and insight.
Interpretation	Statements that express what therapists believe a client's emotions, thoughts, and/or actions might represent; often includes references to past experiences.	Encourages reflection and self-observation of clients' emotions, thoughts, and actions. Promotes client insight or perceptual shift.
Confrontation	Statements ranging from gentle to aggressive that point out or identify a client incongruity or discrepancy.	Encourages clients to examine themselves and their patterns of thinking, feeling, and behaving. May result in personal change and development.
Immediacy	Statements that integrate here-and-now therapist experiences and disclosures; can be used for confrontation, support, or guidance.	Initiates an examination or exploration of the here-and-now therapeutic relationship; focuses on how the client is affecting the therapist or being perceived by the therapist.
Open questions	A sentence or phrase designed to obtain a broad range of information from clients. Open questions commonly begin with the words <i>What</i> and <i>How</i> .	Encourages clients to speak openly about one general topic of the therapist's choosing. Open questions prompt clients to speak in an exploratory manner.
Closed questions	A sentence or phrase that seeks specific information from a client and can generally be answered in one or two words. Closed questions commonly begin with words like <i>Do</i> , <i>Are</i> , <i>Does</i> , and <i>Is</i> .	Closed questions usually limit clients to a yes or no response. Interviewers use closed questions to direct or control what clients talk about.

## Ethical and Multicultural Considerations When Using Directive Listening Skills

VIDEO  
5.3

In general, the more you use questions, the more you highlight your power and authority. This can be good: Ethical clinicians are aware of the power, responsibility, and authority inherent in their professional training and status, and strive to not abuse it. Ethical clinicians also use collaborative strategies to implicitly and explicitly share power with clients.

If you use many questions, you may be perceived as an investigator or interrogator. Frequent questioning will put you in charge of the interaction, directing and controlling the interview process. Benjamin (1987) commented on excessive question use:

Yes, I have many reservations about the use of questions in the interview. I feel certain that we ask too many questions, often meaningless ones. We ask questions that confuse the interviewee, that interrupt him. We ask questions the interviewee cannot possibly answer. We even ask questions we don't want the answers to, and consequently, we do not hear the answers when forthcoming. (p. 71)

Benjamin was an advocate for nondirective interviewing. His concerns about questioning are well articulated, but practitioners from other theoretical orientations disagree with his perspective. In fact, some clients prefer to be asked questions because questions provide clear guidelines for what's expected in the interview (D. W. Sue & Sue, 2016). Although sometimes overused, questions are an unparalleled tool for gathering information, exploring client symptoms, and focusing on client strengths.

## Curiosity, Culture, and Professional Ethics

We've often noticed in ourselves and in our students an urge to ask inappropriate questions. Inappropriate questions are more about the clinician's curiosity and less about what's professionally best for clients. For example, if a client mentions growing up somewhere you're familiar with, you may feel an impulse to ask,

- Where did you go to high school?
- Did you ever go to that great bakery on Third Street?
- Did you play any sports?

These questions satisfy your curiosity rather than elicit diagnostic or treatment planning information. They also can give the interview a social, rather than therapeutic, flavor and even confuse clients. Further, if you give in

to your curiosity, you might also give in to inappropriate self-disclosure (“Yeah, one night I was out drinking with a couple buddies, and . . .”). You can imagine where that disclosure might go. Everything you do, including the questions you ask, should focus on your client’s welfare (Bloomgarden & Mennuti, 2009).

In contrast to our preceding point, there may be a time, place, and purpose for therapists to use social curiosity as a way to create connections. For example, in a qualitative study of Latina(o) therapists, many of the therapists specifically spoke to the value of charlar (small talk) when providing clinical services to Latina(o) clients. Gallardo wrote:

While the idea of “small talk” is not an “official” component in “traditional” training, in working with Latinas/os using charlar facilitates the establishment of the therapeutic relationship, while creating a foundation for future work. (2013, p. 47)

In this and other areas, ethical and effective interviewing behaviors may involve a balancing act. Even social chitchat must be considered as it pertains to best serving your clients and the therapeutic relationship.

If you freely follow certain impulses and ask inappropriate questions, ethical problems related to relationship boundaries may surface. An ethical dilemma popularized by Lazarus (1994) focused on whether it’s acceptable, at the end of a therapy hour, for a therapist to ask a client for a ride somewhere (provided the client is going that direction anyway). Our position is that mental health professionals should get their personal needs met outside therapy, even supposedly innocuous needs—such as catching a ride or satisfying a bit of hometown curiosity. Of course, it’s possible to be too rigid in your application of this principle, but we generally avoid boundary violations because they can lead to more frequent inappropriate impulses and eventual ethical violations (R. Sommers-Flanagan, Elliott, & Sommers-Flanagan, 1998).

## The Ethics of Directing Clients

In court, attorneys can object to leading questions. In assessment and therapy settings, some questions are so leading that they are objectionable and border on unethical. Consider the following:

- Have you thought about leaving your husband?
- I wonder if you’ve considered sex-change surgery?
- What’s the worst thing that could happen if you tell your daughter what you really think about her sexuality?

- Given the stress you've been talking about, I can't help but wonder if your life might be better if you walked away from the military?

These questions lead clients toward specific action. In the right context and with the right frame, they can be used ethically. However, if asked out of context or in ways that are inappropriately leading, they can be unethical. When using questions to lead clients, consider three key issues:

- Are you leading your client toward acting in a way that's consistent with *your* personal values? (This form of questioning could be ethically problematic.)
- Are you collaboratively working *with* your client to explore emotions and consequences associated with potential actions that the client is considering? (This questioning approach stimulates consequential thinking and is a part of an evidence-based problem-solving approach [Bell & D'Zurilla, 2009]; it's on solid ethical ground.)
- If your colleagues (or some attorneys) were listening, would they consider your questions appropriate or inappropriate? (When in doubt, consultation or supervision is a reasonable, and sometimes essential, option.)

In Case Example 5.3, the clinician frames his questions as part of a balanced and person-centered problem-solving approach.

#### CASE EXAMPLE 5.3: ETHICAL QUESTIONING IN A PROBLEM-SOLVING CONTEXT

Maria is a 21-year-old White college student. She begins the initial interview complaining about feeling stressed and depressed. She's living with a man she describes as immature. Maria explains that she's going to school full-time and holding down two part-time jobs, while her boyfriend is unemployed and mostly hanging out in their basement playing online computer games. Yesterday she came home and found that he had left to go out drinking with his buddies, neglecting to walk their dog, which she says is his only household responsibility. She bursts into tears and says, "I have to do something to change this situation. It's driving me crazy."

Nelson is the 27-year-old Black intern meeting with Maria. His first thought is that Maria seems like a nice, hardworking young woman who should get out of this one-sided relationship. However, instead of letting his values guide his questioning, he stays emotionally neutral:

I hear you saying that there are parts of your living situation that are upsetting you right now. If it's okay with you, I'd like to hear about the different ideas that you've had about how you might handle it.

(Continued)

Nelson is using good judgment. He's focusing on possible actions and trying to initiate a problem-solving process.

Many professionals don't use good judgment in this situation. Instead, they blithely jump in and ask a leading question: "Have you talked with your partner about how you feel about his not contributing equally to your home situation?" Although this seems like a reasonable question, it implies that Maria should talk with her boyfriend about her feelings. Here's the problem with that: If the counselor isn't familiar with the client's cultural context, her relationship history, or her boyfriend's ability or willingness to listen to her—then the whole idea of her initiating an open discussion about her needs and desires is premature and could disastrously backfire (e.g., leading to verbal or physical abuse and termination of counseling).

Once Nelson has established a problem-solving frame and Maria shares her ideas, then Nelson can guide Maria to think about the pros and cons of each possible action.

Maria, one of the thoughts you've had is to just talk directly with your boyfriend about your feelings and what you want in your relationship. Since you know him much better than I do, how do you think he'll respond to that sort of talk?

And later:

You said you've thought about leaving. Let's make a list: What keeps you in this relationship, and what makes you want to leave? And then let's have you answer the question, What will your life be like in a year if you choose to leave ... and if you choose to stay?

As you can see, using a problem-solving frame allows you to ethically ask a balanced array of leading questions.

Within the therapeutic realm, questions that lead clients toward action are ethical as long as they're accompanied with a rich discussion of the pros and cons associated with the specific actions. Put another way, questions that are collaborative and that empower clients to explore potential actions are acceptable.

## Summary

Directive listening behaviors are advanced interviewing techniques that encourage clients to examine and possibly change their thinking or behavior patterns. Using directive listening skills places clinicians in an expert role. These skills operate on the assumption that clients will benefit from guidance or direction.

Directive listening behaviors (or skills) discussed in this chapter include (a) feeling validation, (b) interpretive reflection of feeling, (c) interpretation, (d) confrontation, (e) immediacy (aka self-disclosure), and (f) questions. Having an initial rapport or working alliance is important to the effective use of these skills.

Many types of questions are available to therapists, ranging from maximally open (*What* or *How*) to minimally open (*Where*, *When*, and *Who*) to closed (can be answered with yes or no) questions. Swing questions, beginning with the words *Could*, *Would*, *Can*, or *Will*, require adequate rapport, but often yield in-depth responses. Indirect questions, beginning with *I wonder* or *You must*, are implied questions that allow clients to respond or not respond. Projective or suppositional questions usually begin with *What if* and invite client speculation.

Asking questions of clients comes with benefits and liabilities. Benefits include greater therapist control, potentially deeper exploration, and efficiency in gathering information. Liabilities include setting the therapist up as expert, focusing on the therapist's interests instead of the client's, and inhibiting client spontaneity. To maximize the effectiveness of questions, therapists should (a) prepare clients, (b) mix questions with less directive therapist responses, (c) use questions relevant to client problems, (d) use questions to elicit concrete behavioral information, and (e) approach sensitive areas cautiously.

Although sometimes overused, questions are an unparalleled tool for gathering information, exploring client symptoms, and focusing on client strengths. Clinicians should be careful to avoid questioning clients to fulfill their own curiosity. When the therapist directs clients toward action, it's most ethical to do so in ways that are collaborative and culturally respectful.

## Suggested Readings and Resources

The following readings offer additional information on therapy techniques from various theoretical orientations.

Bloomgarden, A., & Mennuti, R. B. (2009). *Psychotherapist revealed: Therapists speak about self-disclosure in psychotherapy*. New York, NY: Routledge. This edited volume provides a balanced perspective on self-disclosure. The editors and authors write openly about their self-disclosure experiences, and reading these honest and reflective chapters will tend to help you become more reflective and intentional with regard to your own use of self-disclosure.

Farber, B. A. (2006). *Self-disclosure in psychotherapy*. New York, NY: Guilford Press. Farber describes the costs and benefits of self-disclosure and how therapists can use self-disclosure to strengthen the therapy relationship.

- Greenson, R. R. (1967). *The technique and practice of psychoanalysis* (Vol. 1). New York, NY: International Universities Press. This classic work provides extensive ground rules for the use of interpretation.
- Hill, C. E. (2014). *Helping skills: Facilitating exploration, insight, and action* (4th ed.). Washington, DC: American Psychological Association. Chapter 14 of Hill's basic text focuses exclusively on interpretation.
- Jordan, J. (2010). *The power of connection: Recent developments in relational-cultural theory*. New York, NY: Routledge. Clinicians who employ a relational-cultural theoretical approach are likely to liberally use empathy and immediacy to facilitate change.
- Messer, S. B., & McWilliams, N. (2007). *Insight in psychodynamic therapy: Theory and assessment*. Washington, DC: American Psychological Association. This text includes excellent advanced information on how to facilitate insight through interpretation.
- Nezu, A. M., Nezu, C. M., & D'Zurilla, T. (2013). *Problem-solving therapy: A treatment manual*. New York, NY: Guilford Press. This book is a comprehensive treatment manual for students and practitioners interested in applying an evidence-based, problem-solving approach. It includes toolkits for addressing specific problems and key training points to keep you focused on how to use this approach effectively.
- Van Deurzen, E. (2013). *Existential counseling and psychotherapy in practice* (3rd ed.). London, England: Sage. Existential therapists tend to use self-disclosure extensively in an effort to connect with clients, foster awareness, and stimulate change.
- Wubbolding, R. (2011). *Reality therapy*. Washington, DC: American Psychological Association. Wubbolding provides an impressive array of questions that are gently confrontational and can be used to help clients engage in self-evaluation.

## SKILLS FOR DIRECTING CLIENTS TOWARD ACTION

### Chapter Orientation

*Directive interviewing techniques* (directives) are persuasion techniques used to encourage clients to change the way they think, feel, or act. Using directives places responsibility on clinicians for determining what client changes might be desirable. This is true even when you're working collaboratively, because, for example, you're the one who decides what advice to offer and when to offer it. Although clients ultimately decide whether to apply your suggestions or advice to their lives, your role as a mental health professional still imbues you with authority and responsibility. In this chapter, we review, illustrate, and analyze therapeutic questions, psychoeducation, suggestion, agreement-disagreement, giving advice, self-disclosure, urging, approval-disapproval, and other action-oriented clinical interviewing techniques.

#### VIDEO 6.1

### Readiness to Change

I see no evidence of an inner world of mental life . . .

The appeal to cognitive states and processes is a diversion which could well be responsible for much of our failure to solve our problems. We need to change our behavior . . .

—B. F. Skinner, “Why I Am Not a Cognitive Psychologist,” *Behaviorism*, p. 10

In an ideal world (or during an ideal clinical interview), clients would arrive at your office filled with motivation for positive change. Even better, you'd be filled with wisdom, and clients would listen attentively to your words,

### LEARNING OBJECTIVES

After reading this chapter, you will be able to:

- Explain how stages-of-change principles operate in a clinical interviewing context
- Describe and apply therapeutic questions to help shift client attitudes and behaviors
- Describe and apply directive action techniques, comprising psychoeducation, suggestion, agreement-disagreement, advice, self-disclosure, urging, and approval-disapproval
- Identify ethical and cultural issues related to clinician values, cross-cultural advice giving, and self-disclosure

go out into the world, and make just the right changes to live happy, fulfilled lives. Of course, if you believe that the preceding is likely, then you're probably having grandiose delusions (see Chapter 9, The Mental Status Examination).

Directives are more effective when clients are ready to change. In fact, researchers have found that using directives can stimulate resistance (Beutler, 2011). Consequently, before describing specific directive techniques, we look at how and why individual clients might respond differently to clinicians' directives (W. R. Miller & Rollnick, 2013).

The interviewing techniques in this chapter in general and this section in particular explicitly push clients toward making positive personal change. But, as implied in the previous paragraph, the extent to which these techniques work depends on at least two basic factors:

1. Your clients' motivation for change
2. The quality of guidance you have to share with them

There's no guarantee that clients will be motivated for positive change. In fact, client motivation is highly variable. Some clients are exceptionally motivated and cooperative, while others won't acknowledge the accuracy of your paraphrases and quickly dismiss your guidance. It's especially interesting that clients (and sometimes our friends and ourselves) actively resist obviously good advice (e.g., to stop smoking or to exercise more). In Chapter 12, we focus on specific interviewing strategies to use with clients who have little motivation. For now, we briefly review how clients' readiness to change can affect how they respond to questions and directives.

James Prochaska (1979) originally developed the transtheoretical model, a complex, integrative, and multidimensional system that helps clinicians understand how clients change (Prochaska & DiClemente, 2005). Although Prochaska's theory initially focused on how people change, he later formulated a theoretical component called "the stages of change" (Prochaska, Norcross, & DiClemente, 1994, p. 38). This particular component of the transtheoretical model has proven useful and popular.

In the stages-of-change component of the transtheoretical model, it's hypothesized that humans approach change in five relatively distinct stages, as follows:

1. *Precontemplation*: no particular interest in changing
2. *Contemplation*: occasional thoughts about making positive changes and some self-examination or self-evaluation
3. *Preparation*: thinking that positive change is possible and desirable, but no significant action yet

4. *Action*: actively involved in enacting positive change
5. *Maintenance*: adjusting to positive changes and actively practicing new skills to maintain change

Prochaska hypothesized that clients respond more positively or more negatively to the same counseling technique depending on which stage of change they're in. As you can imagine, this concept is very important for clinical interviewing. According to Prochaska's stages of change, clients further along the stages-of-change continuum (i.e., the action and maintenance stages) will be less interested in paraphrasing and summarizing and more eager for psychoeducation and advice. In contrast, clients in the pre-contemplation stage will often react negatively to the directive techniques covered in this chapter and can even display strong negative reactions to mildly directive therapist behaviors such as interpretation. Therapists may find it helpful to choose techniques that match the clients "readiness" or stage of change (see Putting It in Practice 6.1).

### **PUTTING IT IN PRACTICE 6.1: A GUIDE TO USING STAGES-OF-CHANGE PRINCIPLES IN CLINICAL INTERVIEWING**

Here we pose and answer four questions about how to apply stages-of-change principles in a clinical interviewing context.

**Q1:** When should I use directive techniques like psychoeducation or advice?

**A1:** When clients are in the action or maintenance stage, you can be more directive (provided you have useful information that fits your client's problem).

**Q2:** When should I use less directive listening responses like paraphrasing, reflection of feeling, and summarizing?

**A2:** When clients are in the precontemplation or contemplation stage, you should use nondirective listening skills to stimulate motivation for change. These are (a) attending behaviors, (b) paraphrasing, (c) clarification, (d) reflection of feeling, and (e) summarizing. Many questions, especially open questions and solution-focused or therapeutic questions, also may be appropriate for clients who are in the precontemplation or contemplation stage. Your best strategies will be based on person-centered, solution-focused, and motivational interviewing approaches.

**Q3:** How do I know what stage of change my client is in?

**A3:** We're tempted to say you'll know it when you see it . . . and there's truth to that. If you make an action-oriented intervention and clients respond defensively, you may be moving too fast, and it's advisable to retreat to reflective listening. Conversely, if your client seems frustrated

*(Continued)*

with nondirective listening and expresses interest in change, then you should try more directive approaches. Also, we recommend using George Kelly's (1955) credulous approach (i.e., just ask your clients what they want). For example, when working with parents, we say:

This is your consultation. And so if I'm talking too much, just tell me to be quiet and listen and I will. Or, if you start feeling like you want more advice and suggestions, let me know that as well. (J. Sommers-Flanagan & Sommers-Flanagan, 2011, p. 60)

There are also standard measures for assessing clients' readiness for change. Most of these involve asking clients questions about their motivation to change, how difficult they expect change to be, and how ready they are to change (all of which are in the spirit of George Kelly's credulous approach; see also Chung et al.'s 2011 study on the predictive validity of four measures assessing client readiness to stop smoking cigarettes).

**Q4: Is the stages-of-change concept empirically supported?**

**A4:** The data are mixed on whether using interventions that fit your clients' stage of change makes a difference. Some researchers report support for gearing techniques to clients' stage of change (Johnson et al., 2008). Others contend that such interventions do no better than others (Salmela, Poskiparta, Kasila, Vähäsranta, & Vanhala, 2009). We recognize that this isn't the clear and decisive research outcome you might hope for, but such is the nature of our profession.

## VIDEO 6.2

### Skills for Encouraging Action: Using Questions

There are several approaches to questioning clients in ways that can stimulate therapeutic action.

#### Therapeutic Questions

All questions can serve assessment and/or therapeutic purposes, but some questions are linked to specific theories and designed to stimulate change. In the next paragraphs, we describe several theory-based questions. The guidance and cautions regarding general questions (discussed in Chapter 5) are relevant to these theory-driven questions as well.

#### *The Question*

Alfred Adler believed that all human behavior is purposeful (Carlson, Watts, & Maniaci, 2006). He applied this belief to adaptive (healthy) and maladaptive (unhealthy) behaviors. Ever the creative interviewer, Adler developed "the question" to uncover the purpose of unhealthy client behaviors. The

question encourages clients to articulate what they might lose if they gave up an unhealthy behavior; it's phrased as "What would be different if you were well?"

Although the goal of Adler's question is somewhat different, it's often considered a precursor to the solution-focused miracle question, described later in this chapter (de Shazer, 1985). Both of these questions help clients envision their lives without their problem(s). Adler's emphasis was more on what has been termed "secondary gain." He was interested in understanding what underlying purpose or motive was sustaining unhealthy behaviors. According to Adlerian theory, clients may be engaging in unhealthy behaviors for attention, power and control, or revenge, or to maintain a pattern of inadequacy so that others take care of them.

### ***Four Big Reality Therapy Questions***

Practitioners who use choice theory and reality therapy emphasize four main questions. These questions may or may not be asked directly. Wubbolding (2011) summarized the four big questions of reality therapy using the acronym WDEP (**wants, doing, evaluation, planning**):

1. What do you want?
2. What are you doing?
3. Is it working?
4. Should you make a new plan?

Wubbolding (2011) has written extensively about these and many additional questions that can be used to help clients identify goals, engage in self-evaluation, and develop plans for goal attainment. These questions are flexible and should be modified for different cultural populations (Wubbolding et al., 2004). His work with Japanese clients led him to suggest that, rather than asking direct questions pertaining to whether a particular behavior is working (evaluation), counselors should phrase the question differently (e.g., "Is that a plus or a minus for you?").

Adler and Glasser (and now Wubbolding) emphasized the purpose of client behavior. This emphasis focuses clinicians on whether clients are behaving in ways that are consistent with their own best interests (Glasser, 1998, 2000). These questions have been integrated into many different therapeutic systems and even popularized in the talk-therapy entertainment industry. For example, when Dr. Phil asks guests on his television show, "How's that working for you?" he's using an Adlerian or choice theory approach to help them self-evaluate the usefulness of their behavior.

## Narrative and Solution-Focused Therapeutic Questions

Narrative and solution-focused approaches rely heavily on questioning (De Jong & Berg, 2008; Madigan, 2011). De Shazer and Dolan (2007) articulated the practical and theoretical significance of questions from the solution-focused perspective:

SFBT [Solution-Focused Brief Therapy] therapists . . . make questions the primary communication tool, and as such they are an overarching intervention. SFBT therapists tend to make no interpretation, and rarely make direct challenges or confrontations to a client . . . The questions that are asked . . . are almost always focused on the present or on the future. This reflects the basic belief that problems are best solved by focusing on what is already working, and how a client would like his or her life to be, rather than focusing on the past and the origin of problems. (pp. 4–5)

Narrative and solution-focused therapists believe that therapists should intentionally lead clients toward positive thoughts, feelings, behaviors, and solutions. For narrative and solution-focused therapists, there's less distinction between assessment and intervention. Consequently, you'll notice that the following therapeutic questioning strategies include questions with both assessment and intervention qualities. These questions share a common core: They focus clients on positive, hopeful, and constructive themes in their lives.

### ***The Pretreatment Change Question***

Clients sometimes begin improving between the time they call for an appointment and when they initially meet with their therapist (De Vega & Beyebach, 2004). Solution-focused therapists take advantage of this tendency by asking clients to elaborate on their spontaneous improvements. They recommend asking the following question near the beginning of the first session:

What changes have you noticed that have happened or started to happen since you called to make the appointment for this session?  
(de Shazer & Dolan, 2007, p. 5)

If clients report no noticeable improvements, solution-focused therapists are likely to move on and open the session with something like “What would you like to have happen during our meeting that would make our time together successful today?” Or, if clients indicate that “nothing has

changed,” the solution-focused response might be “How have you been able to keep things from getting worse?”

If clients report positive improvements (e.g., “Yeah, after I called I decided to get together with an old friend, and we talked and had a good time”), the clinician begins asking questions like these:

- What was good about seeing your friend?
- How did you manage to come up with the excellent idea of getting together with your friend?
- What other excellent ideas have you had since you went out with your friend?

These questions frame and highlight the client’s abilities to initiate positive change—even without therapy. They also empathically acknowledge the courage and commitment it takes for clients to seek therapy. This strategy begins the process of having clients engage in “solution talk” instead of “problem talk” (de Shazer & Dolan, 2007).

### ***Scaling Questions***

*Scaling questions* focus clients on what needs to change for an improvement to be noticeable. From the constructive perspective, the more that therapists keep clients focused on positive outcomes, the more likely it is for positive change to occur. Here’s an example:

**Counselor:** On a scale of 1 to 10, with 1 being the “very worst possible” and 10 being the “very best possible,” how would you rate how well you’ve been handling your anger this past week?

**Client:** Oh, I guess about a 4.

**Counselor:** Okay. Let’s say next week you improved your rating to a 5. What, exactly, would be different if you came in next week and told me that you’re handling your anger at a 5?

**Client:** I think the biggest thing is that I’d stop yelling so much.

**Counselor:** What would that look like? How much would you need to stop yelling to get your rating up to a 5?

Another form of scaling question is the percentage question.

**Counselor:** You’ve been telling me about how depressed you’ve been feeling, and that sounds hard. I’m wondering, how exactly would your life be different if you were 1% less depressed?

**Client:** I might be able to get out of bed in the morning.

**Counselor:** Excellent. So that’s what a 1% improvement would look like. How about if you were 10% less depressed? What would that look like?

**Client:** I'd be able to get up in the morning and also get out and start looking for a job.

**Counselor:** Great. How about if you were 50% less depressed? What would that look like?

**Client:** It would look pretty good.

**Counselor:** Exactly how good would it look, sound, feel, and even smell?

What's most important to observe in the preceding example is how the clinician systematically keeps the client focusing on the appearance, sound, feel, and smell of success or improvement. This can be difficult and requires more extensive interactions than illustrated here, because clients may not immediately be able to articulate what small changes would look like. From a cognitive therapy perspective, scaling and percentage questions provide an intervention for the black-and-white thinking associated with depressive symptoms (J. Beck, 2011).

### ***Unique Outcomes or Redescription Questions***

Narrative therapists use a collaborative process to analyze and reconstruct their client's personal narrative. The goal is to help clients to develop more positive or strength-based narratives. Michael White (1988) originally developed unique outcomes or redescription questions to achieve this goal. Clients are prompted to explain how they've accomplished a specific positive task. Winslade and Monk (2007) described the counselor's focus while using unique outcomes questions:

The counselor selects for attention any experience, however minute and insignificant to the client, that stands apart from the problem story. These fragments of experience are the raw material from which the new story can be fashioned. By asking questions about these "unique outcomes," the counselor inquires into the client's influence on the life of the problem. (p. 10)

The following are examples of unique outcomes and redescription questions (J. Sommers-Flanagan & Sommers-Flanagan, 2012, p. 384):

- How did you beat the fear and go out shopping?
- How did you manage to stay calm?
- What did you do that helped you get yourself out of bed and in here for this appointment despite the depression?
- You just stopped drinking last week cold turkey! How did you accomplish that?

Unique outcome and redescription questions can be used whenever clients report individual accomplishments, no matter how small. This question-based intervention turns the tables on traditional problem-focused interviewing. Problem-focused approaches encourage clients to analyze their problems with questions like these:

- What were you thinking when you had that panic attack?
- What usually leads to the fights and abuse in your family?

In contrast, unique outcome questions focus on strengths and facilitate a deeper analysis of success:

- What were you thinking when you were able to stay calm and fight off your anxiety?
- What helps you and your family keep the peace?

Although there's great appeal in systematically and persistently focusing on client strengths, being able to do so in ways that clients are willing to accept is challenging. Many clients strongly identify with their symptoms and prefer talking about negative experiences. This is one of several reasons why using solution-focused and narrative techniques isn't always straightforward and requires practice, supervision, and feedback.

### ***Presuppositional Questions***

*Presuppositional questions* are virtually the same as projective questions (see Chapter 5), but are used with a solution-focused frame. They *presuppose* that a positive change has already occurred and ask clients to elaborate on those changes. During an interview, constructive therapists use presuppositional questions along with individualized goal setting. Similar to scaling and percentage questions, presuppositional questions orient clients toward success. Examples include:

- Who will be most surprised in your family when they hear that your grades have improved? Who will be the least surprised? (Winslade & Monk, 2007, p. 58).
- What do you imagine will have changed when you start staying calm even when other students try to make you mad?
- Let's suppose two years have passed, and now you're living your life free from alcohol. What are you doing every day to keep yourself sober?

### ***The Miracle Question***

The miracle question is the most famous of all solution-focused questions. It's a therapeutic question that, like most solution-focused questions, aids

clients in initiating and maintaining a positive vision for the future. It also facilitates the analysis of what factors might contribute to that positive future. Insoo Kim Berg initially stumbled on the idea when a client, in apparent desperation, said that only a miracle would help (De Jong & Berg, 2008). Subsequently, the miracle question was phrased by Berg's colleague, Stephen de Shazer (1988), as:

Suppose you were to go home tonight, and while you were asleep, a miracle happened and this problem was solved. How will you know the miracle happened? What will be different? (p. 5)

A more detailed version of the miracle question was described by Berg and Dolan (2001) and is included in Putting It in Practice 6.2, where we discuss the hypnotic or suggestive nature of the miracle question.

The miracle question is a flexible intervention that focuses on positive expectations and on goal attainment (Reiter, 2010). Many therapists have expanded on or slightly revised the miracle question to fit their work with different client populations. For example, when working with youth, Bertolino (1999) recommended substituting the word "strange" for "miracle." Similarly, a different version of the miracle question was proposed for use with mandated clients (Tohn & Oshlag, 1996; see also J. Sommers-Flanagan & Sommers-Flanagan, 2012).

### ***Externalizing Questions***

Traditional diagnostic interviewing procedures include a series of questions that identify and clarify the presence or absence of specific psychiatric symptoms. These symptoms are then used to determine a diagnosis and subsequent treatment. As you know, there are other ways to think about the origins, location, and perpetuation of human psychological distress. From a constructive viewpoint, psychiatric conditions are socially, culturally, and individually constructed. From a narrative therapy perspective, if individuals view their life challenges and problems as internal disorders or failures, these problems will become more internalized and ingrained.

Narrative and solution-focused counselors use nontraditional approaches to questioning clients about symptoms. This is radically different from traditional diagnostic interviewing in that it involves externalizing—placing psychiatric symptoms outside the self.

For example, if you're working with a young client with a reputation for being a troublemaker, instead of asking about ways he or she gets into trouble, you might ask "When did [Mr.] Trouble at school first come along?" and eventually follow this with "Do you think [Mr.] Trouble is getting more

or less strong?" and "Does it interest you more to stay on the side that is trying to defeat old [Mr.] Trouble, or would you prefer to let [Mr.] Trouble carry you along with him sometimes?" (Winslade & Monk, 2007, pp. 6–7, 9, 12, with "Mr." added). In this example, "trouble" was transformed from an internal character trait within the teenager to an external force that's oppressing him and that he might begin battling against.

When therapists are working with depressed clients, externalizing questions may be used to help clients fight back against depression, or depressive symptoms. For example, depression can be described in a symbolic way (e.g., as a cloud, fog, blackness, tunnel, pit, or heaviness; Corcoran, 2005). Externalizing questions for clients with depressive symptoms might include the following:

- How might you fight back against that black cloud the next time it tries to take over your life?
- What are you doing when you're free from that fog of depression?
- Who are you with when you feel lighter and happier and like you've thrown off the weight of that depression?
- How might you tell the depression thank-you and goodbye?

### ***Exception Questions***

A central practice in solution-focused therapy is to ask clients questions that focus on exceptions to the problem. Guterman (2013) described this concept:

It is our job as counselors to focus on identifying and amplifying the exceptions to clients' problems rather than focus on the problems themselves. (p. 5)

Narrative therapists have a similar emphasis, but refer to positive exceptions as "sparkling moments" or "unique accounts" (J. Sommers-Flanagan & Sommers-Flanagan, 2012). In keeping with the theoretical position that only small changes are needed to instigate larger changes, exception questions seek minor evidence that the client's problem isn't always huge and overbearing. The following questions (adapted from Corcoran, 2005, p. 12) can be used to help clients elaborate on their exceptions:

**Who:** Who's present when the exception occurs? What are they doing differently? What would they say you are doing differently?

**What:** What's happening before the exception occurs? What is different about the behavior during the exception period? What happens afterwards?

**Where:** Where is the exception occurring? What are the details of the setting that contribute to the exception?

**When:** What time of day does the exception occur? How often is the exception happening?

**How:** How are you making this exception happen? What strengths, talents, or qualities are you drawing on?

Solution-focused therapists use exception sequences to highlight pre-existing client strengths and resources. These sequences build or reconstruct new and more adaptive client story lines in contrast to less adaptive problem-saturated story lines.

## VIDEO 6.3

### Using Educational and Directive Techniques

Providing education and direction is one of the most efficient means of stimulating client change.

#### Psychoeducation

*Psychoeducation* is an educational process that focuses on information for clients about their diagnosis, treatment, prognosis, and intervention strategies. Psychoeducation is sometimes used as an intervention in and of itself (Bond & Anderson, 2015). In some ways, psychoeducation is similar to role induction (see Chapter 3), but focuses more specifically and in greater depth on educating clients about diagnosis and treatment implementation.

When clients experience mental health problems, they usually have puzzling or disturbing symptoms. For example, clients with anxiety disorders often think they're "going crazy" or "dying." These symptoms are extremely distressing, despite the fact that the prognosis for most anxiety disorders is positive (Lebowitz, Pyun, & Ahn, 2014). Psychoeducation can be used to educate clients with anxiety disorders (or other disorders) about their symptoms:

I know you think there's something wrong with your mind, because what you're feeling is very frightening. But, based on your personal history, your family history, and the symptoms you described, I can tell you that you're not going crazy. Professionals usually refer to your symptoms, including the thoughts that you might die, as symptoms of panic disorder. And the good news is that panic symptoms respond very well to counseling.

Here's another example where the clinician focuses less on symptoms and more on providing instructions for a homework intervention:

**Client:** I don't know what causes my depression. It comes out of nowhere. Is there anything I can do to get more control over the overwhelming sadness that just comes over me?

**Therapist:** The first step in managing depression usually involves keeping a journal of your emotions and the situations, thoughts, and behaviors linked to them. I have a handout for you on this that places these different parts of your depressive experiences into columns. And we'll want to track your happy experiences too. Before you leave today, I'd like for us to practice filling it out together. Would that be okay with you?

In this case, a cognitive-behavioral therapist is giving instructions for a self-monitoring assignment. When providing psychoeducational instructions, you should always intermittently ask if your client has questions (e.g., "Do you have any questions about how to track your emotions?").

Your theoretical orientation and practice environment will determine the psychoeducational information you provide. If your interview focus is diagnostic, then you'll offer educational information about the diagnosis and associated treatment process. In medical settings, this might involve discussing psychotropic medications, side effects, and coping strategies. If you're working with students who have academic problems in a university counseling center, your initial interview might include a short psychoeducational intervention on study skills and a description of campus resources.

## Suggestion

Suggestion is an interesting directive technique that's not very directive. Although most textbooks classify suggestion as a mild form of advice, it has roots in the hypnotic literature (Erickson, Rossi, & Rossi, 1976). Suggestion and advice are two distinct therapist behaviors. To *suggest* means to bring before a person's mind indirectly or without plain expression, whereas to *advise* is to give counsel to or offer an opinion worth following. Offering advice is more directive than using suggestion.

A *suggestion* is a therapist statement that directly or indirectly suggests, implies, or predicts that a particular phenomenon will occur. Suggestion is designed to move clients consciously or unconsciously toward engaging in a particular behavior, changing their thinking patterns, or experiencing a specific emotion. Suggestion is used much more often than most people

realize. In fact, the miracle question is a form of suggestion. In addition, nearly every relaxation or visual imagery procedure involves suggestion:

Just let yourself relax and allow your eyes to close if you like. When you let your eyes close, you can let go of the stress and strain and just go inside yourself and take a break.

Although suggestions are often given when clients are in a trance state, they may also be given when clients are fully alert and awake. For example:

**Client:** I've never been able to stand up to my mother. It's like I'm afraid of her. She's always had her act together. She's stronger than I am.

**Therapist:** Let's take a moment to reflect on ways you're just as strong as your mother . . . or even stronger. What comes to mind?

Another way to use suggestion is for therapists to suggest that clients will dream about a particular issue. This example is classic in the sense that psychoanalytic therapists use suggestions to influence unconscious processes:

**Client:** This decision is really getting to me. I have two job offers but don't know which one to take. I'm frozen. I've analyzed the pros and cons for days and just swing back and forth. One minute I want one job and the next minute I'm thinking of why that job is totally wrong for me.

**Therapist:** If you relax and think about the conflict as clearly as possible in your mind before you drop off to sleep tonight, perhaps you'll have a dream to clarify your feelings about this decision.

In this example, suggestion is mixed with advice. The therapist advises the client to relax and clearly think about the conflict before falling asleep and suggests that a clarifying dream will subsequently occur.

Suggestion can be used with young clients who exhibit delinquent behaviors (J. Sommers-Flanagan & Sommers-Flanagan, 1998). We use the following technique when discussing behavioral alternatives with young clients:

**Client:** That punk is such a loser. He deserved to have me beat him up.

**Therapist:** Maybe so. But you can do better than resorting to violence in the future. I know you can do better than that.

From an Adlerian perspective, this suggestion could be viewed as a method for encouraging clients (Adler, 1930).

Suggestion should be used carefully. It can be viewed as manipulative. Sometimes suggestion backfires and evokes opposition. Each suggestion

used in examples from this section could backfire, producing the following results:

- The client resists the suggestion to relax and experiences irritation and animosity.
- The woman continues to insist that her mother is stronger.
- The client doesn't recall his dreams or is unable to make any connections between dreams and decision making.
- The delinquent boy insists that physical violence is his best option.

### **PUTTING IT IN PRACTICE 6.2: ON MIRACLES AND SUGGESTIONS**

We lament the name “miracle question” because it erroneously implies that something quick, easy, and miraculous is happening—sort of like snapping your fingers and reciting the Tarantallegra incantation from the Harry Potter series. You can try it that way, but it won’t work . . . because you won’t be manifesting an understanding of the incantation.

It shouldn’t be surprising that the miracle question requires sophisticated verbal behavior. Insoo Kim Berg and Steven de Shazer (the developers of the miracle question) were strongly influenced by the renowned hypnotherapist Milton Erickson. This may be one reason why, when done well, the miracle question resembles a hypnotic induction. De Shazer noted that it might take an entire therapy session to ask and explore the miracle question.

We include here one of the more detailed versions of the miracle question (Berg & Dolan, 2001). As you read this example, remember: The miracle question should be spoken slowly, there should be repeated pauses, and the therapist should deeply believe in the solution-focused principle that all clients already possess the inherent competence to produce positive life changes . . . because that’s how you build a good hypnotic suggestion. Here’s the question:

I am going to ask you a rather strange question [pause]. The strange question is this: [pause] After we talk, you will go back to your work (home, school) and you will do whatever you need to do the rest of today, such as taking care of the children, cooking dinner, watching TV, giving the children a bath, and so on. It will become time to go to bed. Everybody in your household is quiet and you are sleeping in peace. In the middle of the night, a miracle happens and the problem that prompted you to talk to me today is solved! But because this happens while you are sleeping, you have no way of knowing that there was an overnight miracle that solved the problem [pause]. So, when you wake up tomorrow morning, what might be the small change that will make you say to yourself, “Wow, something must have happened—the problem is gone!” (Berg & Dolan, 2001, p. 7, brackets and italics in original)

## Agreement-Disagreement

Agreement is an appealing interviewing response. Most of us like to be in agreement with others and to have others be in agreement with us.

*Agreement* occurs when a clinician makes a statement indicating harmony with a client's opinion. Agreement feels validating to both clinician and client, partly because people like to be with others who have attitudes similar to their own (Yalom & Leszcz, 2005).

As with other directives, you should think about why you're inclined to agree with clients. Is agreement being used therapeutically, or are you agreeing because it feels good to let someone else know that your opinions are similar? Are you agreeing with clients to affirm their viewpoint or yours?

Using agreement has several potential effects. First, agreement can enhance rapport. Second, if your clients think you're a credible authority, agreement enhances their belief in the correctness of their opinion ("My therapist agrees with me, so I must be right!"). Third, agreement puts you in an expert role, and your opinion is likely to be sought in the future. Fourth, agreement can reduce client exploration ("Why explore my beliefs any longer; after all, my therapist agrees with me").

Wherever there's agreement, there can also be disagreement. Although it's simple, rewarding, and natural to express agreement, disagreeing is less socially desirable. People sometimes muffle their disagreement, either because they're unassertive or because they fear conflict or rejection.

In a clinical interview, however, you're in a position of power and authority. You might find yourself losing your inhibition and openly expressing disagreement. Depending on the issue, the result can be devastating to clients and disruptive to therapy, and may constitute abuse of power and authority (see Case Example 6.1).

### CASE EXAMPLE 6.1: RESISTING DISAGREEMENT

Imagine the following scenario summarized from a case involving one of our interns:

**Client:** I'm feeling very angry about the presidential election, but I don't suppose I should talk about that in here.

**Counselor:** I'd like you to be able to talk about whatever you want to talk about.

**Client:** I hate Obama. I'm just hoping he gets assassinated.

**Counselor:** Whatever your political beliefs may be, I think what you just said is completely inappropriate, and it's totally unpatriotic too.

As you can see from this interaction, it's possible for a counselor-client interaction to deteriorate into a disagreement or argument about social or political issues. Our main point is that disagreement will often either shut down clients or escalate into conflict. Either way, the assessment or therapeutic value of the interaction is lost. For example, if the counselor is concerned that her client is expressing a threat toward the president, then it's crucial to remain neutral and to explore the client's violent impulses. In this case, expressing disagreement would interfere with the assessment function of the clinical interview. Similarly, disagreement also will interfere with the therapeutic function of an interview.

Disagreement may also be subtle (Herlihy, Hermann, & Greden, 2014). Silence, lack of head nodding, folding one's arms, or clinician neutrality is sometimes interpreted as disagreement or disapproval. It's good to monitor your reactions to clients so that you know if you're nonverbally or inadvertently communicating disagreement or disapproval.

The purpose of disagreement is to change client opinion. The problem with disagreement is that countering one opinion with another opinion may deteriorate into an argument, resulting in increased defensiveness by both parties. In general, it's wise to avoid using disagreement as a therapeutic intervention. The cost is too high, and the potential benefit can be achieved through other means.

Two basic guidelines apply when you feel the desire to disagree with clients:

1. If you have an opinion different from a client regarding a philosophical issue (e.g., abortion or sexual behavior), remember, it's not your job to change your clients' opinions; it's your job to help them with maladaptive thoughts, feelings, and/or behaviors.
2. If, in your professional judgment, a client's belief or behavior is maladaptive (e.g., dangerous or causing stress), then you may choose to confront and provide factual information to facilitate client change toward more adaptive beliefs or behaviors. You're better off providing psychoeducation than disagreement.

A good example of a situation in which a clinician should employ psychoeducation instead of disagreement is in the area of child rearing. Clients often use ineffective child-rearing techniques and then support such techniques by citing their opinion or experience. You should avoid bluntly rushing in and telling clients that research exists indicating that their opinion is "wrong." Instead, you can encourage clients to examine whether using a

particular parenting strategy is helping them consistently accomplish their discipline goals:

**Client:** I know some people say spanking isn't good. But I was spanked when I was young, and I turned out just fine.

**Counselor:** (*At this point, the counselor resists an impulse to disagree with the client and uses a paraphrase instead.*) You feel that being spanked as a child didn't have negative effects on you.

**Client:** Right. I'm doing okay.

**Counselor:** It's true that many parents spank and many parents don't. Maybe, instead of looking at whether spanking is good or bad, we should look at your goals for parenting your son. Then we can talk about what strategies, including spanking, might best help you accomplish your parenting goals.

Researchers have consistently reported that physical punishment may produce undesirable consequences (Gershoff, 2013; Lee, Altschul, & Gershoff, 2015). Numerous professional groups (the American Psychological Association and the American Academy of Pediatrics, among others) recommend that parents avoid physical punishment with children. Eventually, the counselor may discuss these potential undesirable consequences of physical punishment. Generally, this discussion should focus on the client's child-rearing goals and objectives, rather than on whether the counselor does or doesn't "believe in spanking." An exception to this guideline occurs when a therapist suspects that the client is physically abusing a child. However, even in cases when child abuse is suspected and reported, the decision is based on violation of a legal standard, rather than on therapist-client philosophical disagreements.

## Giving Advice

*Giving advice* is a therapist-centered, directive activity that includes a common central message: "Here's what I think you should do." Giving advice casts you in an expert role.

It's important to avoid advice giving early in interviews because giving advice is easy, common, and sometimes coolly received. Friends and relatives freely give advice to one another, sometimes effectively, other times less so. You may wonder, if advice is readily available outside therapy, why would therapists bother using it?

There are two main answers to this question:

1. People desire advice—especially expert advice.
2. Sometimes giving advice is a helpful therapeutic change technique.

Giving advice remains controversial; some therapists frequently give advice, while others passionately avoid it (Benjamin, 1987; Rogers, 1957). Many professionals believe that Publius Syrus was correct in 42 BC when he claimed, “Many seek advice, few profit from it”; see also Jing-ying, 2013).

Clients will sometimes try to get quick advice during an initial session. However, premature problem solving or advice in a clinical interview is often ineffective. Typically, giving advice is more effective after rapport is established, empathy is offered, and permission is granted. It also helps when clients collaborate in problem-solving processes because then they have more ownership or investment in the solution (Hill, 2014). An exception to these rules may occur if the counselor or psychotherapist has guru-like status—in which case, sometimes clients will, for better or worse, follow the advice without reflection (Meier & Davis, 2011). A more reasonable approach for most of us non-gurus is to thoroughly explore a specific issue with a client before offering advice. During the exploration process, clients may develop their own ideas about how to approach their problem. Before jumping in with advice, you would be wise to find out everything your client has tried.

Sometimes it's difficult to resist giving advice. Imagine working with a client who tells you,

I'm pregnant, and I don't know what to do. I just found out two days ago. No one knows. What should I do?

You may have good advice for this young woman. Maybe you've gone through a similar experience or know someone who struggled with an unplanned pregnancy. The woman in this scenario may desperately *need* constructive advice (as well as basic information). However, this is speculation, because given what she said, you have no knowledge of her need for information or advice. All that's known is that she “doesn't know what to do.” If she discovered she was pregnant two days ago, she's probably spent nearly 48 hours thinking about her available options. Immediately advising her on what to do would be insensitive and inappropriate.

Giving premature advice can shut down further exploration of the problem and possible solutions. Starting with paraphrases and reflections of feeling is recommended; you can always provide advice later.

So you haven't told anyone about the pregnancy. And if I understand you correctly, you're feeling like you should take a particular action, but you're not sure what.

Some clients will push hard for advice and keep asking, “But what do you think I should do?” If so, you can use role induction and an open-ended

question to allow you to continue listening and formulating potential advice. For example:

Before we talk about what you should do, let's talk about what you've been thinking and feeling about your situation. Then we can talk together about options; but first, tell me what you've thought about and felt since discovering you're pregnant.

Or an open-ended question might be adequate:

What options have you thought of already?

When you do offer advice, it should almost always be advice about how to obtain the resources or information the client needs to make a decision. In the preceding example, rather than advising the young woman to take a certain action, you should focus your advice on how she can analyze her immediate options and longer-term consequences.

### **PUTTING IT IN PRACTICE 6.3: A LITTLE ADVICE ON GIVING ADVICE**

We'd like to offer you advice about giving advice. Consider the following questions.

When you feel like giving advice, is it

1. Just to be helpful?
2. Because you have limited sessions and feel pressured?
3. To prove you're competent?
4. Because you had the same problem and think you know the answer?
5. Because you think you have better ideas than your client?
6. Because you think your client will never come up with any constructive ideas?

Your responses to these questions can help determine your advice-giving motives. On the one hand, we're not strong advocates of advice. On the other hand, we believe well-timed advice from the proper person can be tremendously powerful. Timing and relationship are central.

In conclusion, when it comes to giving advice, our advice is (a) be aware of why you're giving it, (b) wait for the appropriate time to deliver it, (c) avoid moralistic or value-laden advice, and (d) avoid giving advice the client has already received from someone else.

Clients are usually complex, thoughtful, and full of constructive solutions. They're also often more resourceful than *they* think they are. One way to honor their inner wisdom is to use solution-focused questioning to

emphasize client skills and resources and get clients to generate their own advice:

- How have you made good decisions before?
- What would you tell a friend to do in this situation?
- Let's focus on what you think is your best possible goal . . . and then build a plan to help you get there.

Providing *redundant advice* (i.e., advice to take an action that others have previously suggested or that clients have already tried) can damage credibility and the therapeutic alliance. To avoid this, ask clients what advice they've already received from friends, family, and past counselors (see also Putting It in Practice 6.3).

## Self-Disclosure

*Self-disclosure* is a complex and flexible interviewing response that can be used for many purposes. In Chapter 5, we discussed how it might be used in the form of a here-and-now immediacy response. However, self-disclosure can also be used as a means of sharing your perspective and revealing more about yourself to clients.

Hill (2014) encourages helpers to use self-disclosure to lead clients toward greater insight. She suggests a brief self-disclosure focused on the client's central issue, followed by an indirect question ("I wonder") to check in with the client. She gives the following examples:

Yes, I do that too. I notice that I have a tendency to regress to being dependent unless I am careful. I wonder if that's true for you? (p. 279)

I've also struggled in thinking about my role as a professional woman and possibly having children. For me it's related to not being sure that I want both. I wonder if you experience any ambivalence about wanting both a career and a family? (p. 279)

As you can see from these examples, self-disclosure can be used to lead clients. In each case, the clinician isn't only implying commonality, but also implying that the way she thinks about or handles her own life may be a model for her client. Therapists may feel good about managing their in-laws, finances, conscience, or many other inter- and intrapersonal issues and therefore believe they have just the right ideas for their clients. Obviously, there are problems with this presumption—especially when it comes to working with clients with different cultural, ethnic, and sexual identities. This leads to the conclusion that self-disclosure is an advanced and complex

technique worthy of personal reflection, class discussion, and supervision time to explore its appropriate and inappropriate uses.

### **Urging**

*Urging* is a step beyond advice giving. It involves pressuring clients to take specific action. When therapists urge clients to take action, they're using a direct power approach to facilitating change.

Urging clients isn't common during clinical interviews, but there are situations when urging may be appropriate. These situations primarily involve crisis (e.g., when the client is in danger or is dangerous). For example, in child abuse cases, if you're interviewing parents or caretakers suspected of abuse, you may urge them to contact the local child protection agency. By urging clients to make the report themselves (with you present for support and encouragement), you might preserve the therapy relationship and facilitate a better child-protection outcome.

In domestic or intimate partner violence situations, sometimes therapists will want to urge victims or potential victims to leave an abusive partner and move to a shelter for safety. Even this seemingly rational advice may be inappropriate, partly because it's important to respect a potential victim's instincts and intuition about safety. Urging a potential victim to leave a partner could result in escalating violence and even murder. It's better to work collaboratively with clients to explore their options even when they're exposed to danger (Rolling & Brosi, 2010).

In noncrisis situations, urging is even less common. One noncrisis situation in which urging may be appropriate is in the treatment of anxiety. This is because clients with anxiety disorders tend to reinforce their fears by avoiding anxiety-producing situations. They become increasingly incapacitated by fearful expectations and avoidance behaviors. A major component of treatment involves graduated exposure to previously anxiety- or fear-producing situations. People suffering from anxiety disorders often need their therapists to actively encourage them to face their fears (Hayes-Skelton, Roemer, & Orsillo, 2013).

### **Approval-Disapproval**

*Approval* refers to a therapist's sanction of client thoughts, feelings, or behavior. To give approval is to render favorable judgment. Approval and disapproval place significant power in the therapist's hands. Depending to some degree on theoretical orientation and presenting problems, therapists often prefer that clients judge, accept, and approve of their own thoughts, feelings, and behavior rather than relying on external evaluation. To use

approval and disapproval as interviewing techniques, you must have the knowledge, expertise, and sensitivity necessary for rendering judgments on your clients' ideas and behavior.

Many clients seek approval from their therapists. In this regard, clients are vulnerable; they need or want a professional's stamp of approval. As therapists, we must ask whether we should accept the responsibility, power, and moral authority that needy and vulnerable clients give us. Who are we to decide which feelings, thoughts, or behaviors are good or bad? Perhaps more important, disapproving of clients' behavior on the basis of your personal values is unethical (Herlihy et al., 2014). Instead, it might be more acceptable to restrict approval to your clients' adaptive behaviors and disapproval to maladaptive behaviors.

Some therapists freely give approval to clients and see it as perfectly appropriate. Therapists often say "Good job!" when clients complete homework assignments, and therapists who work with children liberally offer high fives or fist bumps in approval. If approval is provided as a technique, it is best that it be used intentionally, explicitly, and for therapeutic purposes. The following excerpt of a single-session interview between solution-focused therapist Yvonne Dolan (de Shazer & Dolan, 2007) and a young client offers a positive perspective on using approval as a form of encouragement:

**Yvonne:** Um. I just want to say I really believe in you. I just have this instinct. And every once in a while I meet a young person and I kind of say to myself afterwards, and I probably wouldn't say it if I was going to see you again. Maybe I'd say it if I ran into you in a year or two. But since I am probably only going to see you once in my lifetime, I'm going to just say: There's something about you. You're one of those young people that . . . you give me hope in the next generation. I just have that feeling. I want you to know that. (p. 33)

Providing approval to clients can be powerful. Explicit approval can enhance rapport and increase client self-esteem. It can also foster dependent relationships. When a client's search for approval is rewarded, the client is likely to solicit approval when or if the insecure feelings begin again. Some clients will present as even more "needy" and continuously seek your approval.

Sometimes you'll experience feelings of disapproval. It's especially difficult to maintain professional neutrality if your client is talking about child abuse, intimate partner violence, sexual assault, murderous thoughts and impulses, or deviant sexual practices. Keep in mind the following:

- Clients who engage in deviant or abusive behavior have been disapproved of before, usually by people who mean a great deal to them and

sometimes by society. External disapproval hasn't stopped them from engaging in deviant or abusive behavior.

- Your disapproval may alienate you from a client who needs your help.
- By maintaining objectivity and neutrality, you're not implicitly approving of your client's behavior. There are other techniques besides disapproval (e.g., explanation and confrontation) to show your client you believe change is needed.
- Disapproval is associated with reduced rapport, feelings of rejection, and early termination of counseling.

Similar to agreement and disagreement, approval and disapproval can be communicated subtly. For example, responding with the words *okay* or *right* can be interpreted as approval—even when you're using these words as a verbal tracking response. Be aware that your verbal and nonverbal behavior may communicate disapproval and has been cited in legal proceedings as evidence of mistreatment (*Walden v. Centers for Disease Control and Prevention*, No. 10-11733 [11th Cir. Feb. 7, 2012]).

Some therapist behaviors not discussed here, such as scolding and rejection, are even more therapist centered than approval and disapproval and should be avoided (see Benjamin, 1987). Others, such as humor, are difficult to place on the listening continuum. Table 6.1 is a summary of directives described in this section.

## VIDEO 6.4

### Ethical and Multicultural Considerations When Encouraging Client Action

Clinicians who emphasize the nondirective techniques described in Chapter 4 are unlikely to get themselves in trouble for using their personal values to judge clients. That's because these clinicians are using paraphrasing and reflecting techniques and not expressing their own ideas or making values-based recommendations. Their primary focus is to be like a mirror, and their goal is to help clients explore personal emotions, thoughts, and behaviors.

Clinicians who use the directive listening techniques discussed in Chapter 5 are also unlikely to express their personal values. They'll be using questions, confrontation, and interpretation to guide clients toward important emotions and issues.

In contrast, the techniques described in this chapter can be boldly directive. Clinicians who use these techniques will be using professional opinion to guide treatment. Of course, professional opinion should always be grounded in empirical evidence and clinical knowledge.

**Table 6.1** Summary of Directive Action Techniques and Their Usual Effects

Directive Action Response	Description	Primary Intent/Effect
Therapeutic questions	Theory-based questions that orient clients toward engaging in positive change	Focuses clients on motivation or positive and therapeutic outcomes, making such outcomes more likely.
Psychoeducation	Statement providing factual information about clients' symptom or diagnosis; it can be the primary treatment	Helps clients understand their condition and implement recommended treatment.
Suggestion	Therapist statement that directly or indirectly suggests or predicts that a particular phenomenon will occur	May help clients engage consciously or unconsciously in a particular behavior or thinking process.
Agreement-disagreement	Statement indicating harmony or disharmony of opinion	Agreement may affirm or reassure a client, enhance rapport, or shut down the need for exploration.  Disagreement can produce conflict and stimulate arguments or defensiveness.
Giving advice	A recommendation to clients to act, think, or feel in a specific manner	Provides clients with new ways to act, think, or feel. If given prematurely, can be ineffective and can damage credibility.
Self-disclosure	Sharing personal thoughts or feelings with the client	May increase intimacy or decrease client confidence in the clinician.
Urging	Pressuring or pleading with clients to engage in specific actions	May produce the desired change or backfire and stimulate resistance. May be considered offensive.
Approval-disapproval	Favorable or unfavorable judgment of clients' thoughts, feelings, or behaviors	Approval may enhance rapport and foster client dependency. Disapproval may reduce rapport and incite shame.

All this points to an emerging ethical issue: When clinicians freely use professional opinion to guide assessment and treatment, there's risk that the lines between professional opinion and personal values can become blurred. Further, given the heavy weight and culturally influenced nature of disapproval, ethical professionals need to closely examine their potential use of values-based disapproval.

### Checking Your Values at the Door

All clinicians have personal values. These values run deep and are often directly linked to specific religious or philosophical beliefs about what matters in life. Unfortunately, if given free expression, your personal values,

opinions, or religious beliefs can harm clients. Attending to the client's welfare and doing no harm are central tenets of all ethics codes in the helping professions.

Over the past 15 years, several legal cases and state legislation have focused on conflicts between clinicians' religious values and client behaviors. In particular, practicing clinicians and graduate students in counseling programs have objected to working with LGBTQ clients. These objections have been based on specific Christian beliefs, but could also reflect beliefs held by other religious groups. In some cases, these objections have been framed as a "refusal" to work with LGBTQ clients; other times, they have been framed as the desire to refer clients because of an expressed lack of competence (Hermann & Herlihy, 2006; Kocet & Herlihy, 2014). Before summarizing recent legal issues, we'll briefly look at how the American Psychological Association and American Counseling Association address clinician values in their respective ethical codes.

### ***How the American Psychological Association (APA) Addresses Psychologist Values***

The APA is clear that client welfare is of highest ethical priority. The ethical principles of beneficence (i.e., decisions should be made on the basis of doing good and being of help to others) and nonmaleficence (i.e., people should strive to do no unjustified harm) are deeply integrated into the APA code. However, the code doesn't explicitly address clinicians' personal values. Instead, it focuses on the positive, emphasizing awareness, respect, and eliminating bias (American Psychological Association [APA], 2010a; see Principle E: Respect for People's Rights and Dignity in the Ethical Principles of Psychologists and Code of Conduct). However, and of great import, the APA code includes the following statement:

Psychologists have or obtain the training . . . necessary to ensure the competence of their services or they *make appropriate referrals*. (APA, 2010a, p. 5, *italics added*)

This language clearly indicates that the APA supports referring clients when psychologists lack competence.

The APA also includes language implying that psychologists prevent their personal biases from adversely affecting clients:

Psychologists exercise reasonable judgment and take precautions to ensure that their potential biases, the boundaries of their competence,

and the limitations of their expertise do not lead to or condone unjust practices. (APA, 2010a; Principle D: Justice)

Finally, consistent with the APA's emphasis on scientific methodology, its code articulates science and knowledge as foundational to decision making: "Psychologists' work is based upon established scientific and professional knowledge of the discipline" (APA, 2010a; code 2.04: Bases for Scientific and Professional Judgments).

In summary, the APA code makes the following points regarding psychologists' values, biases, competence, and referral practices:

- Psychologists are expected to practice in ways that respect all minority groups or vulnerable populations.
- Psychologists will be competent to provide services to diverse cultural groups or obtain training to become competent.
- Psychologists will manage their biases and personal and professional limits in ways that protect clients from unjust practices.
- Psychologists may "make appropriate referrals" based on limitations in training and/or competence.
- Psychologists' work is based on scientific knowledge.

Paprocki (2014) summarized the ambiguity in the APA ethics code: "Given this wording, it is reasonable to assume that in some cases referring out based on a demographic characteristic is appropriate, and in other cases it is inappropriate" (p. 281). Our summary is similar: According to the APA ethics code, psychologists *probably* cannot remain ethical if they *always* refer members of a particular minority group to alternative providers.

### ***How the American Counseling Association (ACA) Addresses Counselor Values***

In contrast to the APA, the ACA is more explicit in mandating that its members not "impose" personal values on clients. Under Section A: The Counseling Relationship, subsection 4.b., the ACA Code of Ethics reads:

Counselors are aware of—and avoid imposing—their own values, attitudes, beliefs, and behaviors. Counselors respect the diversity of clients, trainees, and research participants and seek training in areas in which they are at risk of imposing their values onto clients, especially when the counselor's values are inconsistent with the client's goals or are discriminatory in nature. (American Counseling Association [ACA], 2014)

This content has stimulated some controversy among ACA members. As a clarification, Richard Yep, executive director of the ACA, posted this statement:

As has been pointed out . . . , the ACA Code of Ethics does not speak to the personally held beliefs of the counselor. Rather, it focuses on behaviors that are in the client's best interest. Section A.4.b states that counselors avoid imposing their personal values, attitudes, beliefs, and behaviors on a client. The focus of A.4.b is on a behavior—imposing—and does not speak to any particular personal values held by the counselor. So counselors can hold any personal values and belief system that they choose as long as they do not impose them on a client.

Yep was emphasizing that the ACA views the verb *impose* as a behavior that could potentially cause client harm (i.e., violating nonmaleficence). This position seems similar to the APA's language around not allowing service provision to "lead to or condone unjust practice."

The ACA Ethics Revision Task Force also endorsed a qualitative research-based bracketing procedure for handling personal values. Kocet and Herlihy (2014, p. 182) defined *ethical bracketing* as:

the intentional separating of a counselor's personal values from his or her professional values or the intentional setting aside of the counselor's personal values in order to provide ethical and appropriate counseling to all clients, especially those whose worldviews, values, belief systems, and decisions differ significantly from those of the counselor.

More information on ethical bracketing is in Case Example 6.2.

### **The Law (in Process)**

To date, four legal cases have examined the issue of whether it's acceptable for clinicians with Christian-based religious values to refer, rather than work with, LGBTQ clients. Two cases involved practicing clinicians who were working within agencies. The other two cases involved student counselors filing suit to protect religious freedoms. In all four cases, the plaintiffs wanted to refer LGBTQ clients to other providers. They also were generally opposed to receiving additional multicultural training or remediation to enhance their competency in working with LGBTQ clients.

The outcomes of these legal cases were mixed, and reflect the heat and depth of this particular conflict. In addition, at least one state legislature established a law to protect students from being summarily expelled on the basis of personal values. Obviously, the intersection between deeply

held philosophical or religious beliefs and professional services will continue to be fraught with ambiguity, strong emotion, and future legal rulings. As we discuss next, your task is to integrate ethics codes, the law, and your own belief systems into your work, without harming clients. There's no substitute for ongoing education, consultation, and supervision to help you address these difficult issues.

### ***Implications for Students and Clinicians***

The ACA and APA ethical codes, recent legal decisions, and new statutory law have implications for counseling and psychotherapy practice. We offer the following summary statements with the caveat that all student and professional clinicians should stay current with future legal and ethical developments.

- *Don't inform clients of your values conflicts.* The first consistent thread in this tapestry of information is that it's unacceptable to directly tell clients that you're referring them because your value system doesn't allow you to support LGBTQ sexual behavior. This is true for practicing clinicians and student therapists. Doing so is potentially harmful to clients. Citing your religious beliefs doesn't legally protect you from your duty to nonmaleficence. Although some ethics scholars recommend engaging clients in a collaborative discussion about values-based conflicts, current case law indicates that doing so raises legal risks (S. Anderson & Handelsman, 2010; Kocet & Herlihy, 2014).
- *Don't systematically refer all clients based on class.* This is especially true if your client is a minority or a member of a legally protected class. Although you can't refuse to counsel a whole class of clients (e.g., LGBTQ clients), in some cases it may be ethical to work collaboratively and respectfully with clients who have specific concerns to find them a counselor who is a better fit. If you're a student, any steps you take toward referral should be reviewed and approved by your university supervisor.

Making referrals based on lack of competence may be acceptable. This practice is consistent with the ACA and APA ethical codes. Herlihy et al. (2014) wrote:

At this point in time, it is probably accurate to state that counselor educators generally agree that referring a client due to a lack of competence is acceptable. (p. 152)

However, as emphasized previously, if students or practicing counselors show a pattern of referring all Muslim clients, all Black clients, all LGBTQ

clients, all Christian clients, or all of any other class of clients, then pleading incompetence can and should raise legitimate concerns. This is because doing so is in conflict with the ethical mandate that psychologists and counselors obtain training for working with diverse or minority clients.

As a counterpoint, the research evidence in support of ethnic matching and psychotherapy outcomes makes referring clients somewhat more complex. For example, a case can be made for Muslim clinicians to work with Muslim clients and for Black clinicians to work with Black clients. If there's a competent student or professional clinician available who is a diversity match, this could provide an additional rationale for a respectful and collaborative referral.

Referring clients to other providers is acceptable when clients are referred on the basis of their presenting problem (e.g., an eating disorder or addiction problem). In addition, a case can be made for referring clients if you don't possess competence in a specific treatment modality that the client desires (e.g., clinical hypnosis, graduated exposure). Finally, some demographic categories can be a legitimate reason for competence-related referral (e.g., children and geriatric populations, or referrals to clinicians who specialize in men's or women's issues or spiritual/religious-based counseling).

### ***Implications for Professors and Training Programs***

At this time, legal precedence and statutory law indicate that mental health professional training programs and faculty *generally* have the right to (a) abide by their profession's ethical codes and (b) judge students on their competence in providing professional services. However, when the Sixth Circuit Court remanded the *Ward v. Wilbanks* case back to trial, an important caveat emerged. The Sixth Circuit wrote:

Ward was willing to work with all clients and to respect the school's affirmation directives in doing so. That is why she asked to refer gay and lesbian clients (and some heterosexual clients) if the conversation required her to affirm their sexual practices. What more could the rule require? Surely, for example, the ban on discrimination against clients based on their religion (1) does not require a Muslim counselor to tell a Jewish client that his religious beliefs are correct if the conversation takes a turn in that direction and (2) does not require an atheist counselor to tell a person of faith that there is a God if the client is wrestling with faith-based issues. Tolerance is a two-way street. Otherwise, the rule mandates orthodoxy, not anti-discrimination. (Retrieved June 4, 2016 from [www.ca6.uscourts.gov/opinions.pdf/12a0024p-06.pdf](http://www.ca6.uscourts.gov/opinions.pdf/12a0024p-06.pdf))

This analysis implies that a university may not compel students to affirm client behavior or beliefs when those behaviors or beliefs are inconsistent with the clinician's religious values. The Sixth Circuit accepts that discrimination is illegal, while noting that individual students *shouldn't have to speak out against their own beliefs*. The practical problem with this ruling for professional training programs is that "affirmative" counseling for LGBTQ clients is a generally accepted approach to working with this population (Heck, Flentje, & Cochran, 2013). Consequently, it may be that Christian, Muslim, or other students holding faith-based values can claim "incompetence" rather than discrimination because they're unable to affirm LGBTQ sexual attitudes and behaviors. This would allow for ethical referral procedures based on lack of competence.

## Solutions

Most ethics scholars recommend using either an ethical decision-making model or ethical bracketing to address values-based conflicts between clinicians and clients. To supplement usual ethical decision-making models, Kocet and Herlihy (2014) designed the Counselor Values-Based Conflict Model (CVCM) to help students and clinicians engage in self-examination around values issues. This model includes the following steps (summarized from Kocet & Herlihy):

1. Determine the nature of the value-based conflict: Is the conflict personal or professional?
2. Explore core issues and potential barriers to providing an appropriate standard of care: What personal (e.g., religious biases) and/or professional (e.g., skill deficits or countertransference) issues are affecting the counseling process?
3. Seek assistance/remediation for providing an appropriate standard of care: This might involve consulting ethics codes, colleagues, or supervisors; obtaining necessary training; using ethical bracketing; obtaining personal counseling; and identifying methods for maintaining personal beliefs while providing effective treatment.
4. Determine and evaluate possible courses of action: This might involve examining the rationale for a possible referral, assessing the usefulness of the remediation plan, and determining if referral to another provider is ethical.
5. Ensure that proposed actions promote client welfare: This involves a reexamination of whether the clinician's action (to continue treatment or make a referral) is in the client's best interest.

## CASE EXAMPLE 6.2: ETHICAL BRACKETING

### Resisting Disagreement

Ethical bracketing is recommended as a method counselors can use to set aside their personal values and remain helpful to diverse clients (Kocet & Herlihy, 2014). The following is an example of how ethical bracketing might be employed.

Peter, a graduate student in counselor education, was also a lay minister in a Greek Orthodox church. In his role as a minister, he was dedicated to upholding the sanctity of marriage. During class and in supervision, he shared that if he was working with a couple and the couple decided to divorce, he would refer them to another provider. His reasoning was that he can't support divorce.

Peter's supervisor worked with him on bracketing his religious values so that he could work with all couples, even those considering or completing a divorce. Peter was provided with extra training and resources, and with processes couples can use to accomplish an amicable divorce. Further, his supervisor engaged in role plays with him in which Peter practiced using nondirective problem-solving procedures (emphasizing paraphrasing and open questions) with clients seeking separation and divorce. Finally, to help him deepen his empathy for individuals who feel compelled to divorce, Peter was assigned to attend five sessions of a divorce support group.

In the end, Peter reported that he felt capable of counseling couples through divorce, despite the fact that he maintained his belief in the sanctity of marriage. In fact, he was able to satisfy (in a bracketed manner) his moral values by developing and offering marriage strengthening and enhancement courses in his community.

### *Client Welfare*

Although all analogies are inevitably insufficient, refusal to work with a specific class of individuals can be viewed through the lens of other professions. For example, imagine this scenario within a physician's medical practice. When so doing, it's difficult to support individual physicians who refuse to provide medical treatment for Black or Christian or LGBTQ patients. Can you imagine a Muslim physician who works in an emergency room suddenly discovering that the patient is Christian and then stepping back and saying, "I'm sorry, I'm unable to treat this patient because the patient's lifestyle and beliefs are in conflict with mine."

Physicians make a clear and unwavering commitment to the health, well-being, and medical treatment of all patients. The idea that they would break that commitment with some patients is virtually unthinkable. The

commitment of professional counselors, psychologists, and social workers to their clients' welfare should be just as deep.

The bottom line is that both clients and counselors have certain rights (e.g., freedom of speech and freedom of religion). However, ethical helping professionals must find ways to practice that are consistent with their values without imposing them on those they help. Muslim, Jewish, Buddhist, or atheist clinicians have no more right to impose their beliefs on clients than do Christian counselors—despite the fact that legal precedence thus far has centered on conflicts that specific Christian counselors have experienced.

In closing, it's important to note that there are many practice settings throughout the United States and abroad that specifically provide faith-based clinical services. In addition, there are numerous colleges and universities that explicitly include faith-based commitments in their statements of purpose and mission. As educators, service providers, and professionals, we appreciate the existence of these training and practice settings. Their ability to serve students and clients who prefer a faith-based experience constitute a critical resource within society. That said, in our opinion, it's essential for public institutions to ensure that all classes of individuals within a civil society have equal and fair access to training and to medical, health, and psychological services.

## Cross-Cultural Advice Giving

Cross-cultural advice giving has many hazards because cultural differences are linked to values-based differences. What someone from one culture values deeply can seem silly or pathological to someone from another culture. Several examples help illustrate risks in offering cross-cultural advice and why you should seek a cultural consultation before doing so.

*Example 1:* A Muslim couple brings their teenage daughter to you for counseling. The issue they bring is whether they should allow their daughter to attend college. They're seeking counseling because their daughter has refused to speak with them unless they bring her to a counselor to discuss college. The parents tell you they're deeply committed to Islam and that they want to arrange a marriage for their daughter rather than allow her to go to college. Your culture-based values support women's rights to education. Should you advise the parents to let their daughter go to college? What if you do and she goes to college, and during her first week of classes she's sexually assaulted?

*Example 2:* A Native American mother comes to you because she wants her 17-year-old son to stop smoking. You realize that tobacco use has spiritual or ceremonial value among some tribes. The mother uses tobacco

ceremonially and wants her son to do the same. Considering your cultural values and knowledge about tobacco, nicotine, and addiction, you believe that the best advice is for the mother to support complete abstinence from tobacco for her son. Should you provide that advice?

*Example 3:* You're working with an African American male. During his initial interview, he describes difficulty with his coworkers. He says the problems stem from his being Black. He reports that he's the only person of color in his office. On the basis of your cognitive-behavioral theoretical perspective, your own personal experiences, and his initial description of the problem, you believe he's "catastrophizing" and overreacting to imagined discrimination. At the end of the interview, how much do you empathize with his situation, and how much do you recommend treatment to help him change his expectations for how his coworkers treat him?

### Ethics, Diversity, and Self-Disclosure

Most multicultural experts recommend using thoughtful self-disclosure with clients from different cultures (Barnett, 2011). Self-disclosures can make you more approachable and facilitate trust building. However, as with all interviewing techniques, the effectiveness of self-disclosure depends on how (and why) you use it.

Self-disclosure for the purpose of joining or connecting is generally appropriate. For example, recently, when working with a young woman from the Crow tribe, one of us shared that we might both know the same individual. This disclosure was offered in a neutral or slightly positive manner: "We have a few students in my school counseling program from the Crow tribe. Her name is Salena." The client's affective response was positive; then she briefly reflected on someone from her family who might know the student, and we moved on.

In contrast, when used as a means of providing advice or suggestions, self-disclosure with culturally diverse clients can damage relationships. Imagine, for example, a counselor from the dominant culture noting to an African American male that sometimes he feels invisible at work and wonders if the client feels the same. Given the depth and pain associated with the invisibility complex among Black men, this disclosure could further the client's belief that his counselor has no clue about what it's like to be a Black man in the workplace (Franklin, 2007).

Generally, any cross-cultural self-disclosure that implies someone from a dominant cultural group knows the inner feelings and struggles of someone from a less dominant cultural group has a good chance of being poorly received. Instead, you're better off citing research or quoting others from

the culture when exploring client issues. Instead of relying on his personal experiences of feeling invisible, the counselor would be more effective if he were to mention the research and writing of Anderson Franklin about invisibility experiences of Black Americans and then check to see if the client has had similar experiences (Franklin, 2004, 2007; Franklin, Boyd-Franklin, & Kelly, 2006). If you're interviewing a Native American woman from the Crow tribe who was separated from her children, it's better for you to share what you've read about Chief Plenty Coup's view on children rather than sharing your own feelings (Linderman, 2002). Overall, although personal self-disclosure can be effective, it's no substitute for cultural knowledge.

## Summary

Directive interviewing techniques (directives) are persuasion techniques used to encourage clients to change the way they think, feel, or act. Directives are more effective when clients are ready to change. The stages-of-change component of Prochaska's transtheoretical model is one approach for determining whether clients are ready for action-oriented directive techniques.

There are many interviewing techniques that facilitate action. Assessment questions based on Adlerian or choice theory and on narrative/solution-focused approaches are especially geared toward helping clients change. These questions comprise (a) the question, (b) the four big questions of choice theory, (c) pretreatment change, (d) scaling, (e) percentage, (f) unique outcomes or redescription, (g) presuppositional, (h) the miracle question, (i) externalizing, and (j) exception.

Directive interviewing techniques also consist of explanation, suggestion, agreement-disagreement, giving advice, self-disclosure, urging, and approval-disapproval. Each of these techniques involves clinician judgment and provides clients with guidance that implies action.

Using directive techniques can bring up ethical and cultural issues. Several recent legal cases have addressed the issue of whether counseling providers can refuse to offer services to LGBTQ clients. Although it's possible to make ethical referrals based on lack of competence, student therapists and licensed providers are acting unethically if they systematically discriminate against any specific class of clients.

Cross-cultural advice giving and self-disclosures across cultures can also be problematic. Advice or disclosures from dominant-culture therapists toward minority clients can be poorly received. Instead, it's better practice for therapists to cite research or quote others from the culture when exploring client issues.

## Suggested Readings and Resources

The following readings offer additional information and exercises on using questions, directive action skills, and therapeutic techniques from different theoretical orientations.

- de Jong, P., & Berg, I. K. (2008). *Interviewing for solutions*. Belmont, CA: Thomson. This book reviews, describes, and provides examples of an array of helping responses from the solution-focused perspective.
- de Shazer, S., Dolan, Y., Korman, H., McCollum, E., Trepper, T., & Berg, I. K. (2007). *More than miracles: The state of the art of solution-focused brief therapy*. New York, NY: Haworth Press. This is the most recent solution-focused work from the late Steve de Shazer.
- Glasser, W. (2000). *Counseling with choice theory*. New York, NY: HarperCollins. In this book, William Glasser, the originator of choice theory and reality therapy, describes several cases during which he uses active and directive choice theory interviewing approaches.
- Herlihy, B. J., Hermann, M. A., & Greden, L. R. (2014). Legal and ethical implications of using religious beliefs as the basis for refusing to counsel certain clients. *Journal of Counseling & Development*, 92(2), 148–153. This state-of-the-law article describes four recent cases and articulates the dangers of counselors discriminating against one class of clients.
- Kocet, M. M., & Herlihy, B. J. (2014). Addressing value-based conflicts within the counseling relationship: A decision-making model. *Journal of Counseling & Development*, 92(2), 180–186. doi:10.1002/j.1556-6676.2014.00146.x. This article describes the values-oriented ethical decision-making model mentioned in this chapter.
- Welfel, E. R. (2016). *Ethics in counseling and psychotherapy: Standards, research, and emerging issues* (6th ed.). Belmont, CA: Thomson Brooks/Cole. This is an excellent contemporary ethics text.

## EVIDENCE-BASED RELATIONSHIPS

### Chapter Orientation

Virtually all clinicians and researchers agree that successful counseling and psychotherapy outcomes are more likely if clinicians establish and maintain a positive working relationship with clients right from the beginning. In this chapter, we examine many different dimensions of what has come to be known as evidence-based relationships.

### The Great Psychotherapy Debate

The medical model of psychotherapy that Wampold so meticulously deconstructs in *The Great Psychotherapy Debate* has led us to accept a view of clients as inert and passive objects on whom we operate and whom we medicate.

—Gene V. Glass, in *The Great Psychotherapy Debate*, 2001, p. ix

In a 1957 publication in the *Journal of Consulting Psychology*, Carl Rogers boldly declared:

1. No psychotherapy techniques or methods are needed to achieve psychotherapeutic change.
2. Diagnostic knowledge is “for the most part, a colossal waste of time” (1957, p. 102).
3. All that is *necessary* and *sufficient* for change to occur in psychotherapy is a certain type of relationship between psychotherapist and client.

These revolutionary statements refocused the profession. Until Rogers, therapy was primarily about theoretically based methods, techniques, and interventions.

### LEARNING OBJECTIVES

After reading this chapter, you will be able to:

- Describe the great psychotherapy debate as a context for the development of “evidence-based therapy relationships”
- List and apply evidence-based relationship factors based on Carl Rogers’s core conditions of congruence, unconditional positive regard, and accurate empathy
- List and apply evidence-based relationship factors derived from other theoretical foundations (e.g., psychoanalytic, behavioral, feminist)
- Describe how the evidence-based relationship factors apply to clients with diverse cultural orientations

After Rogers, writers and practitioners began debating the possibility that it might be the relationship between client and therapist—not the methods and techniques employed—that produce positive changes.

This debate continues and has been referred to as “the great psychotherapy debate” (Wampold, 2001; Wampold & Imel, 2015). It can be boiled down to a dichotomy captured by the question “Do treatments cure disorders or do relationships heal people?” (Norcross & Lambert, 2011, p. 4).

Supporters of the psychotherapy-as-relationship position have written of manualized technical procedures as the “rape” of psychotherapy, while those who believe psychotherapy should only involve empirically validated procedures lament practitioners who ignore important empirical research. The empirically oriented group promotes new terminology (i.e., “psychological clinical scientists”) to distinguish clinicians who base their interventions on science from other clinicians (T. Baker & McFall, 2014, p. 482; Fox, 1995). This heated controversy continues, in part, because we live in a world with limited health care dollars. Clearly, the fight to determine which therapies are “valid” and, therefore, reimbursable will continue (J. Sommers-Flanagan, 2015).

In this chapter, we focus on an early version of the controversy that’s no longer controversial. Over the past two decades, research has settled at least one dimension of the argument: Positive psychotherapy relationships contribute to positive outcomes across all therapies and settings (Laska, Gurman, & Wampold, 2014; Norcross & Lambert, 2011). The question is no longer whether psychotherapy relationships matter, but how much they matter. To bring this point home, the psychotherapy-as-relationship proponents now refer to these relationship factors as “evidence-based therapy relationships” (Norcross & Lambert, 2011).

## VIDEO 7.1

### Carl Rogers's Core Conditions

Carl Rogers (1942) believed that three core conditions were necessary and sufficient to produce change in psychotherapy: (a) congruence, (b) unconditional positive regard, and (c) empathic understanding. In his words:

Thus, the relationship which I have found helpful is characterized by a sort of transparency on my part, in which my real feelings are evident; by an acceptance of this other person as a separate person with value in his own right; and by a deep empathic understanding which enables me to see his private world through his eyes. When these conditions are achieved, I become a companion to my client, accompanying him in the frightening search for himself, which he now feels free to undertake. (Rogers, 1961, p. 34)

## Congruence

*Congruence* means that a person's thoughts, feelings, and behaviors match. As Rogers (1957) emphasized, congruence is *less a skill and more an experience*.

Congruence is complex. It has been described as "abstract and elusive" (Kolden, Klein, Wang, & Austin, 2011, p. 187). The ability to be congruent includes an internal dimension that involves clinicians being in touch with their inner feelings or *real self*, and an external or expressive dimension that allows them to articulate their internal experiences in ways clients can understand. Congruent therapists are authentic and comfortable with themselves. Congruence can include spontaneity and honesty; it's usually associated with the clinical skill of immediacy and involves limited self-disclosure (see Chapters 5 and 6). The following excerpt from Rogers's work illustrates these internal and external dimensions of experiencing and expressing congruence:

We tend to express the *outer edges* of our feelings. That leaves *us* protected and makes the other person unsafe. We say, "This and this (which *you* did) hurt me." We do not say, "This and this weakness of mine *made me* be hurt when you did this and this."

To find this inward edge of my feelings, I need only ask myself, "Why?" When I find myself bored, angry, tense, hurt, at a loss, or worried, I ask myself, "Why?" Then, instead of "You bore me," or "this makes me mad," I find the "*why*" *in me* which makes it so. That is always more personal and positive, and much safer to express. Instead of "You bore me," I find, "I want to hear more personally from you," or, "You tell me what happened, but I want to hear also what it all meant to you." (1967, pp. 390–391)

Rogers also emphasized that congruent expression is important even when the attitudes, thoughts, or feelings don't, on the surface, appear conducive to a good relationship. He suggested that it's acceptable—and even growth promoting—to speak about things that are difficult to talk about. However, as you can see from the preceding excerpt, Rogers expected therapists to look inward and transform their negative feelings into positive and constructive expressions of congruence.

### ***The Evidence Base for Congruence***

In a meta-analysis, Kolden and colleagues (2011) analyzed 16 research studies and 863 participants. Most of the research was conducted prior to 1990. Overall, they reported an effect size (ES) of 0.24. Using Cohen's (1977)

standards, 0.24 is considered a medium ES; it indicates that, for the studies reviewed, congruence accounted for about 6% of treatment variance.

Kolden et al. (2011) also included analyses based on disaggregation of the data. Studies described as client centered, interpersonal, or eclectic had significantly higher ES ( $r = 0.36$ ) than studies described as psychodynamic ( $r = 0.04$ ). Further, results varied as a function of therapy setting. The researchers reported the following effect sizes:

- School counseling centers: ES = 0.43
- Inpatient settings: ES = 0.27
- Mixed settings: ES = 0.23
- Outpatient mental health settings: ES = -0.02

In conclusion, a small but significant evidence base supports the positive influence of congruence during clinical interviews. In addition, there's robust theoretical and anecdotal support for congruence or authenticity as facilitative of helping relationships (Grafanaki, 2013; Rogers, 1961). Given the importance of congruence, we now turn to how to apply this "abstract and elusive" concept in clinical interviews.

### ***Guidelines for Using Congruence***

Students often have questions about how congruence sounds and looks in a clinical interview. Common questions (and brief answers) follow:

- **Does congruence mean I say what I'm really thinking in the session?**

Usually not. Your thoughts may mean something important and may warrant being shared at some point, but initial spontaneous thoughts and reactions to clients should stimulate personal reflection, not immediate disclosure.

- **What if I dislike something a client says or does? Am I being incongruent if I don't express my dislike?**

No. If you have an aversion to something your client says or does, reflect on it, rather than reacting with judgment. As Rogers (1967) recommended, if you have a negative reaction, try to think about it as your issue, instead of blaming the client. For example, if you feel put off in response to a client's anger, you can focus on your discomfort with the anger and say something like, "When you're so angry I want to retreat, but I also realize that I want to hear more about the feelings under your anger."

- **If I feel sexually attracted to a client, should I be "congruent" and share my feelings?**

Absolutely not. As discussed in Chapter 2, you should never share feelings of sexual attraction with clients. Doing so is manipulative and unethical. Deal with your sexual issues and attractions in supervision and on your own time.

One general guideline for determining when and how to be transparent or congruent is to ask, *Would the disclosure help facilitate my client's work?* Making this decision involves relying on your clinical judgment—which is difficult for everyone, but especially for new clinicians. Too much self-disclosure—even in the service of congruence or authenticity—can muddy the assessment or therapeutic focus. The key is to maintain balance; self-disclosure in the service of congruence should be limited, purposeful, and based on solid theoretical foundations (Ziv-Beiman, 2013).

Rogers (1957) was wary about excessive self-disclosure:

Certainly the aim is not for the therapist to express or talk about his own feelings, but primarily that he should not be deceiving the client as to himself. At times he may need to talk about some of his own feelings (either to the client, or to a colleague or supervisor) if they are standing in the way. (p. 98)

Imagine that you're working with a client and you feel the impulse to self-disclose in the spirit of being congruent. If you're not confident that your comment will be facilitative or will *keep the focus on the client*, then you shouldn't disclose. Given the challenges inherent in deciding *how* to be congruent, you should discuss struggles with self-disclosure with peers or supervisors. This can deepen your understanding of how to be therapeutically congruent.

On the basis of recommendations from the literature (Farber, 2006; Kolden et al., 2011; Ziv-Beiman, 2013) and our own clinical experiences, we offer the following guidelines for self-disclosures:

- Examine your motives for the self-disclosure you have in mind. Is it more about you or more about your client?
- Ask yourself whether the disclosure is likely to be facilitative.
- Ask yourself whether the comment will keep the focus on the client or will distract from the client's process and issues.
- Consider the possibility of a negative reaction. Could your client respond in a negative or unpredictable manner?
- Remember, congruence doesn't mean you say whatever comes to mind; it means that when you do speak, you do so with honesty and integrity.

### CASE EXAMPLE 7.1: CONGRUENCE ACROSS CULTURES

Cultural identity has many dimensions (Collins, Arthur, & Wong-Wylie, 2010). In this example, during an initial clinical interview with an African American male teenager, the clinician uses congruence across several different cultural domains.

**Client:** This is stupid. What do you know about me and my life?

**Clinician:** I think you're saying that we're very different, and I totally agree. As you can probably guess, I've never been in a gang or lived in a neighborhood like yours. And you can see that I'm not a Black teenager, and so I don't know much about you and what your life is like. But I'd like to know. And I'd like to be of help to you in some way during our time together.

This clinician is being open and congruent and speaking about obvious differences that might interfere with the clinician-client relationship. It would be nice to claim that being open like this always improves clinician-client connection, but nothing *always* works. However, as researchers have reported, congruence tends to facilitate improved treatment process and also contributes to positive outcomes, at least in small ways (Kolden et al., 2011; Tao, Owen, Pace, & Imel, 2015).

### Unconditional Positive Regard

Rogers (1961) defined *unconditional positive regard* as follows:

To the extent that the therapist finds himself experiencing a warm acceptance of each aspect of the client's experience . . . he is experiencing unconditional positive regard . . . it means there are no conditions of acceptance, no feeling of "I like you only if you are thus and so." It means a "prizing" of the person, as Dewey has used that term. . . It means a caring for the client as a separate person. (p. 98)

Unconditional positive regard implies that clients are the best authority on their own experiences. Therapist judgments are always based on inadequate information; we haven't lived with our clients, we haven't been with them long, and we can't directly know their internal motives, thoughts, or feelings.

For Rogers, unconditional positive regard was based on an underlying belief that consistent warmth, acceptance, and prizing of clients facilitated clients' growth toward their potential. He stated, "the safety of being liked and prized as a person seems a highly important element in a helping relationship" (1961, p. 34). Positive, accepting feelings toward clients allow clients to feel safe enough to explore self-doubts, insecurities, and weaknesses. That idea not only jibes with common sense but also has research support.

### ***The Evidence Base for Unconditional Positive Regard***

Farber and Doolin (2011) conducted a meta-analysis of 18 treatment outcome studies involving 1,067 clients. These studies all included measures of unconditional positive regard. Their overall finding was an aggregate ES of 0.27 across all 18 studies. This indicates a medium positive effect, with unconditional positive regard accounting for about 7% of treatment outcomes.

The results also showed a weak, but statistically significant, tendency for studies with greater numbers of racially diverse clients to have more positive outcomes. Farber and Doolin (2011) speculated:

We tentatively hypothesize that therapists' provision of positive regard may be a salient factor in treatment outcome when non-minority therapists work with minority clients. In such cases, the possibility of mistrust and of related difficulties . . . may be attenuated by clear indications of the therapist's positive regard, in turn facilitating the likelihood of a positive outcome. (p. 182)

This interpretation of the findings is consistent with multicultural theory and practice (D. W. Sue & Sue, 2016). When working with minority clients, it's especially crucial to show unwavering positive regard.

### ***How to Communicate Unconditional Positive Regard***

Technically, according to Rogers (1957), unconditional positive regard is an experience and not a skill. As noted earlier, he wrote: "To the extent that the therapist finds himself [or herself] experiencing a warm acceptance of each aspect of the client's experience . . . he is experiencing unconditional positive regard" (p. 98). Nevertheless, it's useful to discuss how unconditional positive regard might look during interactions between therapist and client. A question our students frequently ask is "How can I express or demonstrate unconditional positive regard?"

It's tempting to try expressing positive feelings directly to clients through hugs or pats on the back, or with such statements as "I like [or love] you," "I care about you," "I will accept you unconditionally," or "I won't judge you in here." However, expressing unconditional positive regard directly to clients can backfire. Direct expressions of caring may be interpreted as phony or inappropriately intimate and may violate ethical boundaries by implying you want a friendship or loving relationship (R. Sommers-Flanagan, 2012). Also, as a human being, you will sooner or later have negative feelings toward your clients; if you explicitly claim "unconditional acceptance," you're promising the impossible.

If it's not appropriate to communicate unconditional positive regard directly, then how might you express positive regard, acceptance, and respect to clients *indirectly*? Here are several general principles, followed by examples:

1. You arrive on time, ask your clients how they like to be addressed (and then remember to address them that way), listen sensitively, show compassion, and carefully guard the time boundaries around appointments.
  - How would you like me to address you? Do you prefer Mrs., Ms., or something else?
2. You allow clients freedom to talk about themselves in their natural manner.
  - I have information about you from your physician. She said you're experiencing anxiety, but I'd like to hear from you what that anxiety has been like.
3. By remembering your clients' stories, you communicate interest and a valuing of what they're telling you.
  - Earlier today you mentioned wishing your roommate respected you. And now I hear you saying again that you find her behavior disrespectful.
4. When you respond with compassion or empathy to clients' emotional pain without judging the content of that pain, clients can feel accepted.
  - The loss of your job really has you shaken up right now. You're feeling lost about what to do next.
5. Because clients are sensitive to your judgments and opinions, by simply making a sincere effort to accept and respect your clients, you're communicating a message that may be more powerful than any other therapy technique.
  - I know you're saying I can't understand what you've been through, and you're right about that. But I'd like to try to understand, and hear as much about your trauma as you're willing to share.
6. Although direct expression of unconditional positive regard is ill-advised, research suggests that direct expressions of encouragement and affirmation for specific behaviors can have a positive effect.
  - "I didn't see you as submissive or weak. In fact, since showing emotion is so difficult for you, I saw it as quite the opposite." (Farber & Doolin, p. 173)
  - I have confidence in your ability to do this.
  - Thank you for sharing so much about yourself with me.

7. Use the concept and technique of radical acceptance from Linehan's (1993) work (see Chapter 12 for examples).

Even Rogers (1957) recognized that therapists can't constantly experience unconditional positive regard. He referred to the phrase as "an unfortunate one" (p. 98), noting that it was more accurate to say that therapists intermittently experience unconditional positive regard. He also emphasized that therapists sometimes experience conditional positive regard, or even negative regard for their clients—although when therapists feel negative regard, it's likely to be associated with ineffective therapy. Rogers's core message is that clinicians should strive toward *experiencing unconditional positive regard*, recognizing that it's impossible to constantly feel accepting toward your clients (W. B. Webber, personal communication, August 13, 2015; see Case Example 7.2).

#### CASE EXAMPLE 7.2: INTERMITTENT UNCONDITIONAL POSITIVE REGARD AND PARALLEL PROCESS

Abby is a 26-year-old graduate student. She identifies as a White heterosexual female. After an initial clinical interview with Jorge, a 35-year-old who identifies as a male heterosexual Latino, she meets with her supervisor. During the meeting, she expresses frustration about her judgmental feelings toward Jorge. She tells her supervisor that Jorge sees everyone as against him. He's extremely angry at his ex-wife, and he's returning to college following his divorce and believes his poor grades are due to racial discrimination. Abby tells her supervisor that she just doesn't get Jorge. She thinks she should refer him instead of having a second session.

Abby's supervisor listens empathically and is accepting of Abby's concerns and frustrations. The supervisor shares a brief story of a case where she had difficulty experiencing positive regard toward a client who had a disability. Then she asks Abby to put herself in Jorge's shoes and imagine what it would be like to return to college as a 35-year-old Latino man. She has Abby imagine what might be "under" Jorge's palpable anger toward his ex-wife. The supervisor also tells Abby, "When you have a client who views everyone as *against him*, it's all the more important for you to make an authentic effort to be *with him*." At the end of supervision, Abby agrees to meet with Jorge for a second session and to try to explore and understand his perspectives on a deeper level. During their next supervision session, Abby reports great progress at experiencing intermittent unconditional positive regard for Jorge and is enthusiastic about working with him in the future.

One way to enhance your ability to experience unconditional positive regard is to have a supervisor who accepts your frustrations and intermittent judgmentalness. If the issues that arise in therapy are similar (or parallel) to the issues that arise in supervision, it's referred to as parallel process (Searles, 1955). This is one reason why when you get a dose of unconditional positive regard in supervision, it may help you pass it on to your client.

## Empathic Understanding

Rogers (1980) defined *empathy* as

the therapist's sensitive ability and willingness to understand the client's thoughts, feelings, and struggles from the client's point of view. [It is] this ability to see completely through the client's eyes, to adopt his frame of reference [p. 85]. . . It means entering the private perceptual world of the other . . . being sensitive, moment by moment, to the changing felt meanings which flow in this other person. . . It means sensing meanings of which he or she is scarcely aware. (p. 142)

Rogers's definition of empathy consists of several components.

- Therapist ability or skill
- Therapist attitude or willingness
- A focus on the client's thoughts, feelings, and struggles
- Adopting the client's frame of reference or perspective
- Entering the client's private perceptual world
- Moment-to-moment sensitivity to felt meanings
- Sensing meanings of which the client is barely aware

As with congruence and unconditional positive regard, the complexity of Rogers's definition has made research on empathy challenging. Nevertheless, there's a substantial body of empirical research supporting the positive effects of empathy.

### *The Evidence Base for Empathy*

In a meta-analysis of 47 studies including over 3,000 clients, Greenberg, Watson, Elliot, and Bohart (2001) reported a correlation of .32 between empathy and treatment outcome. Although this isn't a large correlation, they noted that "empathy . . . accounted for almost 10% of outcome variance," and "Overall, empathy accounts for as much and probably more outcome variance than does specific intervention" (p. 381).

Elliot, Bohart, Watson, & Greenberg (2011) conducted a more recent meta-analysis. This sample included 57 studies with 3,599 clients and "224 separate tests of the empathy-outcome association" (p. 139). They concluded (based on a weighted  $r$  of 0.30) that empathy accounts for about 9% of outcomes variance.

On the basis of their meta-analysis and an analysis of various theoretical propositions, Greenberg et al. (2001) identified five ways in which empathy contributes to positive treatment outcomes:

1. *Empathy improves the therapeutic relationship.* When clients feel understood, they're more likely to stay in therapy and be satisfied with their therapist.
2. *Empathy contributes to a corrective emotional experience.* When clients expect emotionally painful interactions in therapy, but instead experience acceptance and understanding, a corrective emotional experience can occur.
3. *Empathy facilitates client verbal, emotional, and intellectual self-exploration and insight.* Rogers (1961) articulated this: "It is only as I see them (your feelings and thoughts) as you see them, and accept them and you, that you feel really free to explore all the hidden nooks and frightening crannies of your inner and often buried experience" (p. 34).
4. *Empathy moves clients in the direction of self-healing.* When clients have a deeper understanding of themselves, they can take the lead in their personal change process.
5. *Empathy is strongly linked to positive treatment outcomes.* Some authors have suggested that empathy is the basis for all effective therapeutic interventions: "Because empathy is the basis for understanding, one can conclude that there is no effective intervention without empathy and all effective interventions have to be empathic" (Duan, Rose, & Kraatz, 2002, p. 209).

### ***A Deeper Look at Empathy***

There are many different definitions of empathy (A. Clark, 2010; Duan et al., 2002; Gonzalez-Liencres, Shamay-Tsoory, & Brüne, 2013). According to Elliott et al. (2011), recent advances in neuroscience suggest that empathy consists of three core subprocesses:

1. *Emotional stimulation:* This happens when one person experientially mirrors another's emotions. Think of when you "tear up" in response to hearing another person in emotional pain. Emotional stimulation involves mirror neurons, structures within the limbic system, neurochemicals, and other factors (e.g., bilateral dorsomedial thalamus, insula, and oxytocin).
2. *Perspective taking:* This happens when you try to "see" the world from another person's perspective. It requires intellectual inference. Perspective taking is considered a cognitive or intellectual foundation for

empathy and appears to involve the prefrontal and temporal cortices (Stocks, Lishner, Waits, & Downum, 2011).

3. *Emotion regulation:* Therapists must cope with and process their own emotions and then provide an empathic response. This process involves reappraisal and soothing of your own emotional reactions. It's a springboard for a helping response. The most common technical responses during this process include reflection of feeling or feeling validation, but nearly every potential interviewing behavior can include verbal and non-verbal components that include empathy. Emotional regulation may involve the orbitofrontal cortex and prefrontal and right inferior parietal cortices.

Empathy is a multidimensional interpersonal process that requires experiencing, inference, and action. However, as with all neuroscience models, it's likely that any single dimension of empathic responding involves more of the whole brain than the specific regions identified. For example, if you're empathically attuned to your client and experience emotional stimulation, you might simultaneously notice multiple physical reactions (e.g., your breathing slows, tears well up, your eyes shift downward). This awareness could trigger a cognitive reflective process (e.g., "What's going on with me?"), judgment ("I'm feeling too much and need to pull back emotionally"), and distress. It's also not unusual for clients' emotional state to trigger your memories. This could include hippocampal activation and associated cognitive (frontal lobe), physical (motor cortex), and visual (occipital lobe) dimensions linked to your experience (Gonzalez-Liencres et al., 2013; Messina et al., 2013).

Simple guides to experiencing and expressing empathy can strengthen empathic abilities, but there's no single strategy to help you develop the complete array of skills associated with the whole empathy package. For example, Carkhuff (1987) referred to the intellectual or perspective-taking part of empathy as "asking the empathy question" (p. 100). He wrote:

By answering the empathy question we try to understand the feelings expressed by our helpee. We summarize the clues to the helpee's feelings and then answer the question, How would I feel if I were Tom and saying these things? (p. 101)

Carkhuff's empathy question is a useful tool for tuning into client feelings, but it oversimplifies the empathic process. First, it assumes that you have a perfectly calibrated internal affective barometer. Unfortunately, this isn't the case. Just because *you* would feel a particular way if you were in the client's shoes doesn't mean the client feels as you would. If you rely exclusively on Carkhuff's empathy question, you risk projecting your own feelings onto clients.

Consider what might happen if a therapist tends toward pessimism, whereas her client usually puts on a happy face. The following exchange might occur:

**Client:** I don't know why my dad wants us to come to therapy now and talk to each other. We've never been able to communicate. It doesn't even bother me anymore. I've accepted it. I wish he would accept it too.

**Therapist:** It must make you angry to have a father who can't communicate effectively with you.

**Client:** Not really. Like I said, it doesn't bother me. I'm letting go of my relationships with my parents.

In this case, asking the empathy question “How would I feel if I could never communicate well with my father?” may produce angry feelings in the therapist. This process consequently results in the therapist projecting angry feelings onto the client, even if the client isn’t angry. Accurate empathic responding stays close to client word content and nonverbal messages. If this client had previously expressed anger or was looking upset or angry (e.g., angry facial expression, raised voice), the therapist might choose to reflect anger. Instead, the therapist’s comment is inaccurate and rejected by the client. The therapist could have stayed closer to what her client expressed by focusing on key words.

Coming into therapy now doesn’t make much sense to you. Maybe you used to have feelings about your lack of communication with your dad, but it sounds like at this point you feel pretty numb about the whole situation and just want to move on.

This second response is more accurate. It touches on how the client felt before, what she presently thinks, and the numbed affective response. The client may well have unresolved sadness, anger, or disappointment, but for the therapist to connect with these buried feelings involves a more interpretive intervention. Recall from Chapter 5 that interpretations and interpretive reflections of feeling require supporting evidence.

To help with the intellectual process of perspective taking, instead of focusing exclusively on what you’d feel if you were in your client’s shoes, you can expand your repertoire in at least three ways:

1. Reflect on how other clients have felt or might feel.
2. Reflect on what your friends or family might feel and think in response to this particular experience.
3. Read and study about experiences similar to your clients’.

Using Rogers's writings as his rationale, A. Clark (2010) referred to intellectual approaches to expanding your empathic understanding as objective empathy. *Objective empathy* involves using "theoretically informed observational data and reputable sources in the service of understanding a client" (p. 349). Objective empathy is based on the application of external knowledge to the empathic process—this can expand your empathic responding beyond your own personal experiences.

Rogers (1961) also emphasized that reflections of feeling should be stated tentatively so that clients can freely accept or dismiss them. Elliot et al. (2011) articulated the tentative quality of empathy: "Empathy should always be offered with humility and held lightly, ready to be corrected" (p. 147).

A second way in which Carkhuff's (1987) empathy question is simplistic is that it treats empathy as if it had to do *only* with accurately reflecting client feelings. Although accurate feeling reflection is an important part of empathy, empathy also involves *thinking* and *experiencing* with clients (Akhtar, 2007). Rogers's use of empathy with clients frequently focused less on emotions and more on meaning. Recall that in his original definition, Rogers wrote that empathy involved "being sensitive, moment by moment, to the changing felt meanings which flow in this other person" (p. 142). Empathic understanding isn't simple: it involves feeling with the client, thinking with the client, sensing felt meanings, and reflecting all this and more back to the client with a humility that acknowledges deep respect for the validity of the client's experiences.

### ***Misguided Empathic Attempts***

Sometimes you can try too hard to express empathy, completely miss your client's emotional point, or otherwise stumble in your empathic efforts. Classic statements that beginning therapists often use, but should avoid, include the following (J. Sommers-Flanagan & Sommers-Flanagan, 1989):

1. "I know how you feel" or "I understand."

Clients may respond with: "No. *You* don't understand how I feel," and they would be absolutely correct. "I understand" is a condescending response that should be avoided. However, saying "I want to understand" or "I'm trying to understand" is acceptable.

2. "I've been through the same type of thing."

Clients may respond with skepticism or ask you to elaborate on your experience. Suddenly the roles are reversed: The interviewer is being interviewed.

3. “Oh my God, that must have been terrible.”

Clients who have experienced trauma are sometimes uncertain about how traumatic their experiences really were. You need to monitor whether you’re leading or tracking the client’s emotional experience. If clients give you an indication that they feel “terrible” about their experience, reflecting that the experience “must have been terrible” is empathic. Even then, a better empathic response would remove the judgment of “must have” and get rid of the “Oh my God” and say something like, “Sounds like you feel terrible about what happened.”

### CASE EXAMPLE 7.3: WHAT AND HOW TO VALIDATE: EMPATHIC RESPONDING TO TRAUMA AND ABUSE

Empathy often includes emotional validation. But sometimes clients have ambivalent feelings about their own experiences, which makes the validation process more complex. This is especially true when trauma or abuse survivors experience victim guilt—feeling as though they caused their own trauma.

**Therapist:** Can you think of a time when you felt unfairly treated? Perhaps punished when you didn’t deserve it?

**Client:** No, not really. (15-second pause) Well, I guess there was one time. I was supposed to clean the house for my mother while she was gone. It wasn’t done when she got back, and so she broke a broom over my back.

**Therapist:** She broke a broom over your back? (*stated with a slight inflection, indicating possible disapproval or surprise with the mother’s behavior*)

**Client:** Yeah. I probably deserved it, though. The house wasn’t cleaned like she had asked.

In this situation, the client expressed mixed feelings about her mother. Although her mother was violent, the client felt guilty for not following her mother’s directions. The therapist tried a nuanced empathic response using voice tone and inflection. This was used because focusing too strongly on the client’s pain or anger might prematurely shut down exploration of her guilty feelings. Despite the minimal empathic expression, the client defended her mother’s physical abuse anyway. This suggests that the client had accepted (by age 11, and still accepted at age 42) her mother’s negative evaluation of her. From a person-centered or psychoanalytic perspective, a supportive statement like “That’s just abuse; mothers should never break brooms over their daughters’ backs” may have closed off exploration of the client’s victim guilt about the incident.

(Continued)

Alternatively, this is a situation in which gentle, open, and empathic questioning might deepen the therapist's understanding of the client's unique experience and help her explore other feelings, such as anger. For example, the therapist could ask:

I hear you saying that maybe you deserved to be hit by your mother in that situation, but I also wonder what other feelings you might have?

Or the therapist might use a third-person question to help the client have empathy for herself:

What if you had a friend who experienced something like what you experienced? What would you say to your friend?

In the first version of this interaction, the therapist used a nondirective model. He didn't openly criticize the mother's violence. Do you think he might have been too nondirective? Perhaps the client might have been able to explore her anger toward her mother if the therapist had led her in that direction with an empathic self-disclosure?

When I imagine myself in your situation, I can feel the guilt, but also, a part of me feels angry that my mother would care so much about housecleaning and so little about me.

This self-disclosure is empathic and leading. Do you think it's too leading? Or do you think it's a better response than the neutrality often emphasized in psychoanalytic therapies?

### ***Concluding Thoughts on Empathy***

Empathy is a vastly important, powerful, and complex interpersonal phenomenon. People can simultaneously express conflicting meanings and emotions. Rogers believed that experiencing empathy decreased his interest in judging clients and put inhibitions around his congruence. Empathy, unconditional positive regard, and congruence are not competing individual constructs; they complement and influence one another.

Greenberg et al. (2001) discussed the challenges of being empathic:

Certain fragile clients may find expressions of empathy too intrusive, while highly resistant clients may find empathy too directive; still other clients may find an empathic focus on feelings too foreign. Therapists therefore need to know when—and when not—to respond empathetically. Therapists need to continually engage in process diagnoses to determine when and how to communicate empathic understanding and at what level to focus their empathic responses from one moment to the next. (p. 383)

The preceding description of constantly attuning your empathic responding to individual clients sounds formidable . . . and it should. When we add cultural diversity to the empathic mix, the task becomes even more daunting. Nevertheless, we encourage you to embrace the challenge with hope, optimism, and patience. As discussed in Chapter 4, sitting with people as they struggle to express their emotional pain and suffering contributes to your own empathic neurological development.

## Other Evidence-Based Relationship Concepts

VIDEO  
7.2

The following theoretically and empirically supported relationship factors are derived from a variety of theoretical perspectives. We begin with relational concepts linked to psychodynamic treatment approaches.

### Transference

Freud (1949) defined *transference* as a process that occurs when “the patient sees in his analyst the return—the reincarnation—of some important figure out of his childhood or past, and consequently transfers on to him feelings and reactions that undoubtedly applied to this model” (p. 66). Transference is especially important in psychoanalytic and interpersonal therapy because a major goal is to help clients gain awareness of repeating maladaptive relationship patterns. By gaining greater awareness or insight into repeating relationship patterns, clients can begin changing those patterns. Awareness or insight is viewed as a prerequisite to change.

Transference generally feels inappropriate, such as when a client responds to you with actions, thoughts, or feelings that are too intense, too extreme, and too capricious, and that are held on to with tenacity (Greenson, 1967). Transference “exceeds anything that could be justified on sensible or rational grounds” (Freud, 1912/1958, p. 100). Sometimes, but not always, intense and obvious transference can surface early in an interview. For example, an angry young man had a negative reaction to his female counselor and became verbally aggressive during an initial screening interview. He repeatedly stated,

You f--ing women can't understand where I'm coming from. No way.  
Women just don't get me. You don't get me.

Because the counselor's behavior hadn't warranted a strong reaction, it's likely this client was displacing “feelings, attitudes, and behaviors” based on previous interactions he had experienced with important females in his life (Gelso & Hayes, 1998, p. 51).

### ***The Evidence Base for Transference***

Researchers have reported that transference reactions during sessions can be reliably and validly measured (Kivlighan, 2002). There's also evidence that measures of transference (e.g., the core conflictual relationship theme, or CCRT) in therapy can identify patterns that are highly similar to contemporary relationship patterns observed outside therapy (Zilcha-Mano, McCarthy, Dinger, & Barber, 2014). Finally, researchers have reported that working directly with transference using psychoanalytic models can produce positive treatment outcomes (Shedler, 2010). For example, in a meta-analysis of 10 studies focusing on long-term psychoanalytic treatment, an ES of 0.78 was reported (Driessen et al., 2010). As a comparator, a meta-analysis of medications for major depression produced an ES of 0.31 (E. Turner, Matthews, Linardatos, Tell, & Rosenthal, 2008).

These findings have implications for the beginning clinical interview. It's possible that during initial and follow-up interviews, clients will display behaviors representing transference. Although dealing with these behaviors therapeutically requires extensive training, you may want to explore with your supervisor the possibility of using trial interpretations with clients (see Chapter 5 for guidelines for trial interpretations).

### ***Examples of Transference***

Transference is often abstract, vague, and elusive. Clients may subtly react in ways that are more emotional than the situation warrants, they may make assumptions about you that have little basis in reality, or they may express unfounded and unrealistic expectations regarding you or therapy.

One common example of transference occurs when clients expect you to judge them negatively. For example, a client expressed anxiety regarding her psychological testing performance and her out-of-session homework. She stated tentatively,

Um . . . you know, I think some things that personality test says about me don't seem accurate. I must have done something wrong when I took the test.

This comment is revealing. Usually when clients get inaccurate psychological test feedback, they question the test's validity, rather than their own performance. In a similarly tentative way, she later stated, "I did the assignment, but I'm not sure I had the right idea." She made this statement despite the fact that she had done exactly as instructed. Her self-doubt was triggered because she viewed her therapist as an authority figure who might evaluate her negatively. Her expectation of criticism suggested that she may have experienced harsh criticism in the past. In this sense, her reaction is

similar to that of a child who flinches when approached by an adult whose arm is extended. The child may flinch because of previous physical abuse; the flinch may be an automatic and unconscious response. Similarly, clients who have been exposed to excessive criticism may have automatic and unconscious tendencies to prepare themselves (or flinch) when exposed to evaluative situations. This is an example of transference.

Transference may manifest itself in positive (e.g., affectionate, liking, loving) or negative (hostile, rejecting, cold) attitudes, feelings, or behaviors. Working through either form of transference as therapy progresses can be productive. However, during an initial clinical interview, the wisest course is for you to be an astute observer, noticing patterns of client responses that seem inappropriate and may stem from past relationships in the client's life. Commenting on these patterns can wait for later (see the section on interpretation in Chapter 5).

### ***Noticing and Exploring Transference***

Working with client transference requires advanced skills and firm theoretical grounding. However, the following four principles and practices can be your first steps in noticing and exploring client transference:

1. Be aware of the possibility that repeating transference reactions may occur during an interview.
2. Notice repeating patterns internally and then if a pattern becomes clear, notice it with an explicit comment that acknowledges your subjectivity and is stated tentatively:
  - I could be wrong, but I've noticed you seem to get angry when we talk about your father.
  - It's just an observation, but several times you've made some pretty negative comments about yourself.
3. Collaboratively explore repeating patterns that may be significant:
  - What do you make of your tendency to get angry when we talk about your father?
  - When have you felt similar feelings in the past?
4. Keep in mind that too much linking of your transference observations to your clients' out-of-session relationships can have negative effects (Safran, Muran, & Eubanks-Carter, 2011). Consequently, only make those links infrequently and tentatively:
  - It feels like this pattern of expecting to be punished for expressing yourself might also be happening in your relationships outside. Is that possible?

Remember, although transference gives you a special opportunity to glimpse the converging nature of your client's past, present, and in-session relationships, you don't want to focus too much on transference early in psychotherapy.

## Countertransference

Freud had a negative view of countertransference (CT). He wrote: "No psychoanalyst goes further than his own complexes and internal resistances permit" (1910/1957, p. 145). Later psychoanalytic practitioners have contributed to four different ways of thinking about CT (Gelso & Hayes, 2007).

1. *Classical*. This is Freud's view. Client transference triggers analysts' unresolved childhood conflicts. This triggering results in analysts' acting out in ways consistent with the unresolved conflicts. This CT is negative and should be "overcome."

2. *Totalistic*. This CT refers to all reactions the therapist has toward the client. These reactions are meaningful, and should be studied, understood, and used to enhance therapy process and outcome.

3. *Complementary*. This CT emanates from specific client interaction patterns that "pull" therapists to respond in ways that others (outside therapy) respond to the client. Good therapists inhibit their reactive impulses, seek to understand the nature of the transaction, and use this knowledge to frame interventions to modify the client's maladaptive relational style.

4. *Relational*. This CT is constructed from the combination or integration of the unmet needs and conflicts of both client and therapist.

Most contemporary theorists and therapists have moved beyond Freud's negative view of CT and hold one or more of the other perspectives.

### ***The Evidence Base for Countertransference***

Researchers have found that CT reactions can teach therapists about their own important underlying conflicts as well as client interpersonal dynamics (Betan, Heim, Conklin, & Westen, 2005; Fatter & Hayes, 2013). Betan et al. conducted a survey of 181 psychiatrists and clinical psychologists, and reported:

Patients not only elicit idiosyncratic responses from particular clinicians (based on the clinician's history and the interaction of the patient's and the clinician's dynamics) but also elicit what we might call average expectable countertransference responses, which likely resemble responses by other significant people in the patient's life. (p. 895)

This conclusion is consistent with the view that CT is a natural phenomenon and a useful source of information that can contribute to therapy process and outcome.

J. Hayes, Gelso, and Hummel (2011) conducted a meta-analysis of 10 quantitative studies that measured CT and outcomes. They reported a small negative overall effect for CT on outcomes (weighted  $r = 0.16$ ), indicating that CT is associated with slightly poorer treatment outcomes.

J. Hayes et al. (2011) conducted a meta-analysis focusing on whether CT management reduced negative outcomes. Their study rationale was stated as follows: "A fundamental concept in this literature is that if CT is to be a help rather than a hindrance, the therapist must do something to, with, or about CT" (p. 251). They identified 11 quantitative studies where an effort was made to manage or control CT. Overall, they reported a small effect, suggesting that efforts to manage CT were associated with reduced manifestations of CT (weighted  $r = -0.14$ ).

In a third meta-analysis, J. Hayes et al. (2011) examined the relationship between CT management and treatment outcomes. Their question was whether or not CT management might contribute to improved outcomes. On the basis of seven quantitative studies, they reported a "significant and large" effect (weighted  $r = 0.56$ ). It appears that when therapists actively manage their CT reactions to clients, it can contribute to more positive treatment outcomes.

### ***Examples of Countertransference***

There are an unlimited number of potential CT behaviors, considering that nearly any behavior or emotional response may represent CT. For example,

- Reaching out and touching a client or drawing back from a client who wants to shake your hand or give you a hug
- Talking too much in a session; feeling inhibited and unable to speak freely in a session
- Feeling bored; feeling aroused
- Joking too much; feeling unable to shake negative and depressive thoughts and feelings
- Dreaming about your client; dreading your client's arrival

Clinicians from various theoretical orientations have acknowledged the reality of CT. From a behavioral perspective, Goldfried and Davison (1976) advised: "The therapist should continually observe his own behavior and emotional reactions, and question what the client may have done to bring about such reactions" (p. 58). Similarly, Beitman (1983) suggested

that even technique-oriented counselors may fall prey to CT. He wrote: “Any technique may be used in the service of avoidance of CT awareness” (p. 83). For example, clinicians may repetitively apply a particular technique to clients (e.g., progressive muscle relaxation, mental imagery, or thought stopping) without realizing they’re applying the techniques to address their own needs, rather than their clients’ needs (see Case Example 7.4).

### ***Countertransference Management***

Using the totalistic CT definition, CT is defined as all therapist emotional and behavioral reactions to clients. Imagine a therapist who lost his mother to cancer as a child. His father’s grief was severe. As a consequence, the father offered little emotional support when the therapist was a child. The situation eventually improved, his father recovered, and the therapist’s conscious memory consists of a general sense that losing his mother was very difficult. Now, years later, he’s a graduate student, conducting his first interviews. Things are fine until a depressed middle-aged man comes in because he recently lost his wife. What reactions might you expect from the therapist? What reactions might catch him by surprise?

CT reactions may be more or less conscious. These reactions, if unmanaged, can negatively affect therapy. The following guidelines can assist you in coping with CT reactions:

- Recognize that CT is normal and inevitable. If you experience strong emotional, cognitive, or behavioral reactions to a client, it doesn’t mean you’re a “bad” therapist.
- CT reactions can signal the need to do personal work. This work can be self-guided and focused on awareness, especially at first.
- If you have disturbing reactions to a client, consult with a colleague or supervisor.
- Do additional CT reading. Reading about the problems your clients are manifesting (e.g., eating disorders, depression, antisocial behavior) can help you view client problems and your emotional reactions from a more intellectual perspective.
- If you establish a regular meditation practice, you may be able to lower your reactivity to clients and improve CT management (Fatter & Hayes, 2013).
- If CT persists despite your best efforts, consider referring your client and/or getting personal psychotherapy. As J. Hayes et al. (2011) noted, “Personal therapy for the therapist seems especially important when dealing with chronic CT problems” (p. 255).

### CASE EXAMPLE 7.4: CLINICIAN CONTRIBUTIONS TO COUNTERTRANSFERENCE

Client behavior is the trigger for CT. Sometimes clients treat their therapists with such open hostility or admiration that therapists are quickly caught up in a transference-countertransference dance. This can cause you to behave in ways that are very unusual for you. For example, at a psychiatric hospital, a patient unleashed an unforgettable accusation against her therapist:

You are the coldest, most computer-like person I've ever met. You're a robot! I talk and you just sit there, nodding your head like a machine. I bet if I cut open your arms, I'd find wires, not veins!

On the surface, this accusation might be considered pure transference. Perhaps the client was responding to her therapist in this way because important male figures in her past were emotionally unavailable. On a deeper level, as the saying goes, it takes two to tango; the therapist also needed to examine his possible contributions to this particular interaction.

The therapist consulted with colleagues and a supervisor, engaged in self-reflection, and came to several conclusions. First, he realized that he was behaving more coolly with her than he did with other clients. Second, he became aware that he was frightened of her intense emotional intimacy demands. He began recognizing that being more robotic was a protective response. Third, his supervisor reassured him that he wasn't the first clinician to experience CT. Finally, he worked to respond to the client more therapeutically, rather than reacting to his own fears.

### The Working Alliance (aka the Therapeutic Relationship)

The idea that therapist and client collaborate in ways that support positive outcomes originated with Freud (1912/1958). Later, psychoanalytic theorists introduced the terms *therapeutic alliance* and *working alliance* (Greenson, 1965; Zetzel, 1956). Greenson (1965, 1967) distinguished between the two, viewing the working alliance as the client's ability to cooperate with the analyst on psychoanalytic tasks, and the therapeutic alliance as the bond between client and analyst. Eventually, Bordin (1979, 1994) introduced a pantheoretical model that he referred to as the working alliance. Bordin's model consists of three dimensions:

1. Goal consensus or agreement
2. Collaborative engagement in mutual tasks
3. Development of a relational bond

Bordin's model is dominant today. Throughout this text, we use the terms *working alliance*, *therapeutic alliance*, and *alliance* interchangeably.

The working alliance has become a frequent clinical research topic. Horvath, Re, Flückiger, and Symonds (2011) noted that when searching electronic research databases for the keywords *alliance*, *helping alliance*, *working alliance*, and *therapeutic alliance* in 2010, they obtained more than 7,000 hits. This voluminous research indicates that there's strong consensus that all therapists from all theoretical orientations should intentionally and systematically make efforts to establish and maintain a working alliance (Constantino, Morrison, MacEwan, & Boswell, 2013; Safran, Muran, & Rothman, 2006). Further, emerging empirical evidence indicates that a positive working alliance is linked to more positive outcomes with minority group clients (Asnaani & Hofmann, 2012).

Several researchers have noted that clients' ability to establish an alliance is predictive of their potential to benefit from psychotherapy. If clients can't or won't engage in a working alliance, there's little hope for change, but the more completely clients enter into such a relationship, the greater their chances for positive change (Falkenström, Granström, & Holmqvist, 2013; Hardy, Cahill, & Barkham, 2007). Ironically, it appears that those most in need of a therapeutic relationship may be those least able to enter into one.

### ***The Evidence Base for the Working Alliance***

Therapists vary in their ability to form an alliance (Baldwin, Wampold, & Imel, 2007). In a meta-analysis, Ackerman and Hilsenroth (2003) found that clinicians who were best able to form and sustain an alliance were warm, flexible, experienced, and trustworthy. These clinicians also used reflective and affirming techniques that facilitated emotional expression and focused directly on their client's experiences.

Horvath et al. (2011) conducted a meta-analysis on the working alliance in psychotherapy. On the basis of "190 independent alliance-outcome relations representing over 14,000 treatments" (p. 47), they reported a medium ES ( $r = 0.275$ ). Across many different therapies, higher alliance ratings were related to better treatment outcomes. These results are consistent with previous reviews and more recent research (Falkenström et al., 2013; Martin, Garske, & Davis, 2000).

Bordin's working alliance model includes collaboration and goal consensus components. Tryon and Winograd (2011) conducted a meta-analysis on the relationship between these two alliance dimensions and treatment outcomes. They reviewed 15 studies focusing on goal consensus with an overall sample of 1,302 clients. There was a medium ES ( $r = 0.34$ ) for goal consensus. They also analyzed 19 collaboration studies with 2,260 clients and reported a similar ES ( $r = 0.33$ ).

When clinicians explicitly solicit feedback from clients on therapy progress (i.e., progress monitoring), both the working alliance and treatment outcomes tend to improve (see Chapter 3 for more information on progress monitoring). Specifically, Lambert and Shimokawa (2011) conducted a meta-analysis on client feedback procedures and reported a variety of effect sizes, depending on the particular feedback measure employed. Overall, all measures showed a positive relationship to outcome, with effect sizes ranging from  $r = 0.23$  to  $r = 0.54$ .

Developing a working alliance and engaging in collaboration, goal consensus, and feedback or progress monitoring are substantially associated with positive treatment outcomes. The strength of association between these variables and outcomes is greater than that of any specific therapy techniques (Wampold & Imel, 2015). Horvath and colleagues (2011) wrote: “The magnitude of this correlation makes it one of the strongest and most robust predictors of treatment success that research has been able to document” (p. 56). There’s little doubt that integrating this knowledge into your repertoire can improve your clinical work.

### ***Recommendations for Developing a Positive Working Alliance***

Therapists who want to develop a positive working alliance (and that should include everyone) will employ alliance-building strategies beginning with first contact. Using Bordin’s (1979) model, alliance-building strategies focus on (a) collaborative goal setting, (b) engaging clients in mutual therapy-related tasks, and (c) developing a positive emotional bond. Progress monitoring is also recommended. The following list includes alliance-building concepts and illustrations:

1. Initial interviews and early sessions are especially important to alliance building. Many clients will be naïve about psychotherapy. This makes role induction essential. Here’s a cognitive-behavioral therapy (CBT) example:

For the rest of today’s session, we are going to be doing a structured clinical interview. This interview assesses a range of different psychological difficulties. It is a way to make sure that we “cover all of our bases.” We want to see if social anxiety is the best explanation for your problems and also whether you are having any other difficulties that we should be aware of. (Ledley, Marx, & Heimberg, 2010, p. 36)

2. Asking clients direct questions about what they want from counseling and then integrating that information into your treatment

plan help build the alliance. In CBT, this includes making a problem list (J. Beck, 2011).

**Clinician:** What brings you to counseling, and how can I be of help?

**Client:** I've just been super down lately. You know. Tough to get up in the morning and face the world. Just feeling pretty crappy.

**Clinician:** Then we definitely want to put that on our list of goals. Can I write that down? (*Client nods assent.*) How about for now we say, "Find ways to help you start feeling more up?"

**Client:** Sounds good to me.

3. Engaging in collaborative goal-setting to achieve goal consensus is central to alliance building. In CBT, this involves transforming the problem list into a set of mutual treatment goals.

**Clinician:** So far I've got three goals written down: (1) Find ways to help you start feeling more up, (2) Help you deal with the stress of having your sister living with you and your family, and (3) Improving your attitude about exercising. Does that sound about right?

**Client:** Totally. It would be amazing to tackle those successfully.

4. Problem lists and goals are a good start, but clients engage with clinicians better when they know the treatment plan (TP) for moving from problems to goals. The TP includes specific tasks that will happen in therapy and may begin in the first clinical interview. Here's an example of a "devil's advocacy" technique where the clinician takes on the client's negative thoughts and then has the client respond (Newman, 2013). You'll notice that collaboratively engaging in mutual tasks offers spontaneous opportunities for deeper connection and clinician-client bonding:

**Clinician:** You said you want a romantic relationship, but then you start thinking it's too painful and pointless. Let's try a technique where I take on your negative thinking and you respond with a reasonable counter-argument. Would you try this with me?

**Client:** Sure. I can try.

**Clinician:** Excellent. Here we go: "It's pointless to pursue a romantic relationship because they always come to a painful end."

**Client:** That's possible, but it's also possible to have some good times along the way toward the painful end.

**Clinician:** (*smiles, breaks from role*) That's the best comeback ever.

5. Soliciting feedback from clients from the first session onward to monitor the quality and direction of the working alliance contributes to

the alliance. Although you can use an instrument for this, you can also ask directly:

We've been talking for 20 minutes, so I want to check in with you on how you're feeling about our time together so far. How are you doing with this process?

6. Making sure you're able to respond to client anger without becoming defensive or counterattacking is essential to positive working relationships. We usually apply radical acceptance (Linehan, 1993). Here's an excerpt from an initial session with an 18-year-old male in which the clinician accepted the client's aggressive message and transformed it into a relational issue:

**Clinician:** I want to welcome you to therapy with me, and I hope we can work together in ways you find helpful.

**Client:** You talk just like a shrink. I punched my last therapist in the nose. (*Client glares at therapist and awaits a response.*) (J. Sommers-Flanagan & Bequette, 2013, p. 15).

**Clinician:** Thanks for telling me that. I'd never want to have the kind of relationship with you where you felt like hitting me. And so if I ever say anything that offensive, I hope you'll just tell me, and I'll stop.

## Repairing Relationship (Alliance) Ruptures

Robust scientific support for the working alliance as an important therapeutic factor has stimulated research on relationship ruptures. *Relationship ruptures* are defined as tensions or breakdowns in the clinician-client collaborative relationship (Safran & Muran, 2006). Concepts similar to relationship rupture include empathic failures and therapeutic impasse (Kohut, 1984; Safran et al., 2011). The idea is that if clinicians can weather relationship storms, it may strengthen the working alliance and improve outcomes.

Like the working alliance, the concept of relationship rupture and repair has roots in the psychoanalytic tradition (Kohut, 1984). However, similar to the working alliance, rupture and repair in psychotherapy are now considered pantheoretical concepts. From a CBT perspective, Newman (2013) wrote: "The importance of the therapist's competency in managing strains or ruptures in the therapeutic relationship cannot be overstated" (p. 57).

The reality is that all clinicians, regardless of theoretical orientation, will experience relationship strains and ruptures. Sometimes these ruptures will be hardly noticeable; other times they'll be large and obvious.

Whether small or large, ruptures can disrupt therapy process, lead to negative outcomes, and cause clients to drop out of treatment (Safran & Kraus, 2014). Having rupture resolution skills is essential. There is little doubt that ruptures will occur, and repairing them can improve treatment outcomes.

### ***The Evidence Base for Rupture Repair***

Safran and colleagues (2011) conducted a meta-analysis on the relationship between rupture repair episodes and treatment outcomes. They comprised three studies with 148 total clients and reported an “aggregated correlation” of  $r = 0.24$ , indicating that rupture repair episodes were significantly associated with positive outcomes ( $p = .002$ ).

Safran et al. also conducted a meta-analysis on the effects of rupture resolution training or supervision on treatment outcomes. Again, they reported positive results. According to the results of seven studies with control group comparisons, therapists with rupture resolution training obtained slightly more positive outcomes ( $r = .15$ ,  $p = .01$ ). The researchers concluded that “rupture resolution training/supervision leads to small but statistically significant patient improvements relative to treatment by therapists who did not [receive] such training” (Safran et al., 2011, p. 84).

### ***Examples of Relationship Ruptures***

Relationship ruptures have been organized into two types: withdrawal ruptures and confrontation ruptures (Safran & Kraus, 2014). *Withdrawal ruptures* involve client silence, topic shifts, and explicit overcompliance. A palpable sense of disengagement may signal a withdrawal rupture:

**Clinician:** You've been talking about wanting to focus on career goals.

That's a good idea. But based on our time together today, it seems like your anxiety is what's stopping you from moving forward with your career. And so my recommendation is that we start with anxiety reduction and then move on to focusing on your career later.

**Client:** (10 seconds of silence) . . . Okay.

**Clinician:** You don't seem very enthused with that plan.

**Client:** Oh, no, that's okay.

**Clinician:** Do you have any thoughts or reactions to the plan?

**Client:** No.

In contrast to withdrawal ruptures, confrontation ruptures usually include aggressive statements. Clients may express discontent or

resentment. Clients also commonly accuse their therapists of incompetence or make disparaging comments (e.g., “The whole idea of therapy working for me is ridiculous”). For example:

**Client:** I've read half a dozen books on anxiety reduction and came to the conclusion months ago that those psychobabble techniques aren't worth my time and effort.

In most cases, withdrawal and confrontation rupture behaviors have different underlying dynamics. Withdrawal is often a product of anxiety or fear and linked to expectations that the therapist will reject what the client is feeling and thinking. This leads to conscious or unconscious vulnerability and withdrawal or avoidance. For many clients, it's safer to avoid expressing disappointment than to risk rejection and/or a punitive therapist response.

Confrontation ruptures are often surface anger expressions that cover deeper disappointment and hurt. They can be seen as an aggressive form of the message, “You don't get me.” When clinicians manage client anger and engage in deeper exploration with clients, it's not unusual to uncover disappointment and a wish for nurturance.

### ***Rupture Repair: General Guidelines and Specific Strategies***

Rupture repair can be direct or indirect. Directly addressing ruptures may involve various interviewing techniques including self-disclosure/immediacy, gentle questioning, acknowledgment of an empathic failure, and concession to the client's perspective. The following are some examples of clinician statements:

- *Self-disclosure/immediacy:* I recall one time when I was in therapy and my therapist started going in a direction I didn't care for. I remember feeling I should just keep my mouth shut and not say what I really thought. I'm worried that's happening with us. And so if you're feeling even the least bit of doubt about focusing on anxiety in our counseling, I hope you'll tell me.

- *Gentle questioning:* You seem more quiet than usual. I'm wondering what you really think about focusing on anxiety before moving on to career goals. I would love to hear your genuine perspective—even if you're disappointed or angry—and I'm open to changing directions based on what you want.

- *Acknowledgment of an empathic failure:* You know what . . . I think I missed the significance of what you were saying earlier about your anxiety. I'd like to revisit that and try listening better to your thoughts and feelings this time around.

- *Conceding to the client's perspective:* My sense is that you're more enthused about working on your career goals. If it's okay with you, how about we reverse the order? Let's work on career goals first and then if it seems necessary, we can shift to anxiety later.

Indirect rupture repair occurs when you don't comment on the rupture, but instead shift your focus to what you missed or where you think the client would rather go. In the case involving anxiety reduction versus career goals, the therapist could simply switch direction. ("I'm sorry. I've rethought your situation, and now I think we should go with your career goals. Is that okay?") Similarly, as a clinician, you may decide to change your therapeutic task (e.g., "Today let's try visual imagery instead of progressive muscle relaxation") or unilaterally accept responsibility for an empathic failure ("I'm sorry. I think you were saying you feel numb and not so much anxious.").

Although steps toward rupture resolution can vary depending on theoretical orientation and clinician style, Safran et al. (2011) identified six generic steps.

### **1. Repeating the therapeutic rationale**

One way to think of this is as providing a *role re-induction*. This involves restating the reasons why it makes sense to proceed in a particular manner.

Even though it's terribly difficult to face anxiety directly, one thing we know for sure from research and clinical practice is that avoiding anxiety will only give anxiety more control over you.

### **2. Changing tasks or goals**

"Let's cross that off our goal list" or "Let's put that into a new list of what we might talk about in the future if we decide to."

It seems like when I just ask you to talk openly about whatever you like, that doesn't work very well for you. How about if I ask you a few more questions to help us both focus, and we'll see if that seems better?

### **3. Clarifying misunderstandings at a surface level**

When I said I think we should put anxiety first, I wasn't meaning that we *have* to put it first on our list. I'm open to working on the career goals first . . . or simultaneously.

### **4. Exploring relational themes associated with the rupture**

This is just a hunch on my part, but my feeling is that part of the reason you stay quiet and don't share your thoughts openly with me is

because you anticipate that I'll judge you in some negative way. Does that seem true to you?

### 5. Linking the alliance rupture to common patterns in a patient's life

Are there any times in your daily life when you're hesitant and don't share openly even with people who would be likely to accept and try to understand your feelings/perspective?

How about if we look at situations and people in your life and make some first guesses about who you can trust to listen to you if you want to talk and who you should continue to hesitate with?

### 6. New relational experience

Inside therapy:

I noticed you spoke your feelings directly to me just now. How did that feel?

Outside therapy:

You just told me a story about being assertive and speaking up for yourself, and it sounds like the outcome was pretty darn good. What are your thoughts on being able to do that and have a good outcome?

Rupture repair occurs on multiple levels. Often, clients aren't completely aware of the reasons underlying their rupture-related withdrawal or aggression. From the psychoanalytic perspective, therapist efforts to repair ruptures are soothing unconscious communications that say, "It's okay. We can talk about this, and we can work through painful emotions together." From the behavioral perspective, it's also possible to view rupture repair as the therapist's modeling effective, open communication as a means of facing uncomfortable feelings.

## Therapist Modeling

*Modeling* is a powerfully ubiquitous force in contemporary psychology. The fact that humans learn through modeling was articulated in Mary Cover Jones's early work with phobic children and later became a cornerstone of Bandura's social learning theory (J. Sommers-Flanagan & Sommers-Flanagan, 2012). Modeling is considered a form of treatment in its own right; it's an empirically supported approach used extensively in treating anxiety disorders and skill deficits (Spiegler & Guevremont, 2016). However, for the

purposes of this chapter, modeling is viewed as a phenomenon that occurs within the therapist-client relationship.

Psychoanalytic and object relations theorists use the terms *identification* and *internalization* to describe what behaviorists consider modeling (Safran et al., 2011). Individuals *identify* with others whom they love, respect, or view as similar. Through this identification process, individuals begin to incorporate or internalize unique and specific ways in which that loved or respected person thinks, acts, and feels.

No one knows the precise psychological dynamics that cause people to imitate or model their behavior after someone else. It could involve the identification-internalization process. Or it could be caused by other factors (see Case Example 7.5).

### CASE EXAMPLE 7.5: MODELING OR INTERNALIZATION?

Imagine the following scenario: A young adult's probation officer refers her to a mental health professional after several minor criminal convictions. The client arrives for the initial clinical interview, but is reluctant to talk openly. Eventually the client begins to like the therapist and enjoys spending time with him. They talk about specific triggers that have gotten the client in trouble in the past as well as how to stop and reflect before acting impulsively. Therapy is successful, and in the final session the therapist asks the client what she found most helpful. Although they've worked together on cognitive-behavioral strategies such as problem solving and consequential thinking, the client describes her success as based on something else.

I guess I think it was two things, Doc. You're a good guy, and at some point in my time with you I started thinking I wouldn't mind being more like you. And then, when I faced situations where I would usually make a bad decision, it was like your voice popped into my head and then I thought, hmm, I wonder what the doc would do? And then I did what I thought you would do instead of what I would usually do.

According to psychoanalytic theory, identification is the precursor to internalization. Decades ago, object relations theorists hypothesized that as we develop, we internalize components of various caretakers and others in our early environment. These internalizations serve as the basis for how we feel about ourselves and how we interact with others (Fairbairn, 1952). If we internalize "bad objects" (i.e., abusive parents, neglectful caretakers, vengeful siblings), we may experience disturbing self-perceptions and interpersonal relationships. Psychotherapy involves a relationship that can replace

maladaptive internalizations with adaptive or positive internalizations. Strupp (1983) summarized this: “Since the internalization of ‘bad objects’ has made the patient ‘ill,’ therapy succeeds to the extent that the therapist becomes internalized as a ‘good object’” (p. 481).

Clients may improve because of identification and internalization, or they may improve because of observational learning. Either way, when therapists are positive, respectful, and reflective people whom clients can identify with and/or imitate, it contributes to positive outcomes.

### Mutuality and Mutual Empathy

Feminist approaches emphasize egalitarian relationships between clients and therapists (Worell & Remer, 2003). These relationships involve mutuality and empowerment. Although feminists endorse and embrace the person-centered core conditions (Rogers, 1957), feminists also focus on social and cultural factors, gender dynamics, and power differentials that impact how clients experience themselves and their worlds (L. Brown, 2010).

*Mutuality* refers to a sharing process; it means that power, decision making, goal selection, and learning are shared. Although other psychotherapies consider treatment a mutual process wherein clients and therapists are open and human with one another, nowhere are egalitarian values and the concept of mutuality emphasized more than in feminist therapy (Evans, Kincade, & Seem, 2011). In addition, mutual empathy has been identified as a therapeutic factor in relational cultural therapy. *Mutual empathy* is defined as clients seeing-experiencing-knowing their emotional effect on their therapists within a safe environment. When achieved, it allows clients to see their therapists experiencing empathic resonance. This connection—as opposed to the withdrawing-isolation-punishment that caregivers often have in response to their children’s deep emotions—is viewed as healing in and of itself and as promoting self-acceptance of painful emotions (see Case Example 7.6).

#### CASE EXAMPLE 7.6: MUTUAL EMPATHY—A FEMINIST RELATIONSHIP FACTOR

Chantelle, a 25-year-old woman attending community college, came to the student health service for counseling. She was intermittently tearful as she described her abusive childhood. Her counselor, a 25-year-old female counseling intern, listened, paraphrased, offered reflections of feeling, and stayed connected with Chantelle through the stories and tears. At one point, the client expressed hate for herself and then described repeated scenarios where she felt coerced

(Continued)

into providing sexual favors for males in her household in order to have access to transportation and food. With tears of empathic resonance in her eyes, the therapist said, "I have this image of you in prison and the men who are in control only hand you the keys to go on leave if they shame you into giving them sexual gratification."

The client noticed her counselor's emotion. In response she had a powerful emotional outpouring. Later, when asked about what was helpful in her work with the counseling intern, the client identified her counselor's tears. She said that her mother and sisters always minimized and humiliated her for "complaining" about living in a home where she had food and shelter. For the client, the whole idea and experience of someone else having an empathic emotional response to her shame and self-revulsion played a big role in her healing.

When therapists encourage mutuality, they do so to empathically resonate with and empower clients. Although mutuality doesn't alter the fact that authority rests with the counselor, feminist therapists place the power for change in their clients' hands. They respect the client's authority, and actively work to help clients respond to the dominant social discourse with the authority of their own voices. This includes a focus on client assertiveness and a deep valuing of self. Feminist therapists believe respectful, reciprocal interactions—including mutual empathy—can develop personal power in clients; empirical data support this claim (Neff & Harter, 2003).

## VIDEO 7.3

### Evidence-Based Multicultural Relationships

In 2001, the Institute of Medicine (IOM) defined evidence-based medicine as "the integration of the best research evidence with clinical expertise and patient values" (p. 147). Somewhat later, the American Psychological Association's Task Force on Evidence-Based Practice (2006) extended the IOM's statement to evidence-based practice (EBP) in mental health treatment. The task force wrote: "[EBP is] the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences (p. 273)."

These definitions acknowledge the essential relevance of addressing client or patient culture within all evidence-based approaches. Morales and Norcross (2010) wrote: "Clinical practice without attending to culture cannot be characterized as EBP" (p. 824). However, the sad truth is that despite the fact that all therapists should attend to client culture as a part of

practicing EBP, there's very little quantitative research evidence specifically focusing on EBP with minority cultures.

This leaves us with a conundrum. How do we follow the IOM and APA guidelines when we have minimal research on which to base clinical decision making? The answer: Without more nuanced data to depend on, the best clinical approaches for using evidence-based relationships when working across culture is to focus on the relationship variables discussed in this chapter. The caveat: You should do so in a manner consistent with (a) the multicultural competencies (Chapter 1), (b) available qualitative and anecdotal information, and (c) existing quantitative research.

Clinical researchers have used several approaches to adapt evidence-based techniques for working with diverse clients. These approaches all tend to emphasize intercultural relationships and the multicultural competencies. For example, researchers have solicited culturally valuable information from focus groups, tribal leaders, and cultural consultants (Baker-Henningham, 2011; Bernal, Jiménez-Chafey, & Rodríguez, 2009; Morsette, van den Pol, Schuldberg, Swaney, & Stolle, 2012). The following paragraphs represent an integration of ideas for connecting with cultures along with evidence-based relationship factors.

**Congruence.** Clinical practitioners, multicultural experts, and qualitative data all indicate that when clinicians are open and genuine with clients from minority cultures, rapport is enhanced and outcomes are likely to be better. In a qualitative study, Gallardo (2013) reported that Latina(o) clients viewed charlar (small talk) as a positive therapy factor.

**Unconditional positive regard (UPR).** Another word that can be used instead of UPR is *respect*. Of all relationship variables, respect has possibly the most universal utility. According to quantitative and qualitative research and clinical anecdotes, it appears safe to say that clients from all minority groups respond better when they have unequivocal respect from members of the dominant culture (Farber & Doolin, 2011). The tricky part is how to express respect to individual clients with diverse cultural, sexual, and ability status. The solution probably involves following the multicultural competency guidelines: Develop your multicultural awareness, knowledge, and skills (see Chapter 1).

**Empathic understanding.** Empathy across cultural divides should never be presumptive; it should be expressed with maximum tentativeness and humility. Rogers (1957, 1961) should be your guide, and he would have you tread gently in the emotional world of others. Tentative phrases like the following are recommended: "If I'm getting this right . . ." or "Tell me if I'm wrong about this, but it seems like . . ." or "Could it be that you're feeling . . ."

**Transference.** Regardless of your racial or cultural identity, your clients may have an immediate transference reaction to you. If you're an Asian therapist and you're meeting with a Vietnam-era veteran, the client's reaction to you may have nothing to do with you as a person and everything to do with your appearance and the client's history. Techniques such as charlar, self-disclosure, and making a statement about your purpose, combined with professionalism, are all recommended (Gallardo, 2013).

**Countertransference.** Countertransference triggers related to race and culture abound. If you're an Iraq War veteran and your client is a bearded man named Abdul from Iraq, you may need to steady your emotional self. Working with your supervisor to openly reflect on and cope with your reactions to clients from minority cultures is strongly recommended (Ponton & Sauerheber, 2014).

**Working alliance.** There is quantitative evidence that the working alliance is modestly associated with positive outcomes in psychotherapy with Canadian Aboriginal clients (Shaw, Lombardero, Babins-Wagner, & Sommers-Flanagan, *in press*). This outcome is consistent with expectations based on clinical practice. What remains in question is how clinicians can best foster a working alliance with culturally diverse clients. A good beginning is to provide clients with a clear statement of purpose individualized to specific cultural orientations. For example, with a client who has a collectivist orientation: "My goal is to provide the best help I can to you and your family."

**Rupture repair.** It should be assumed that when therapy relationships extend across cultures, they may be more fragile and ruptures may be more frequent. This implies that culturally effective clinicians attend to potential relationship ruptures and provide reparative statements as needed. At minimum, repair statements should include a clear apology along with a commitment to not make the same mistake again.

**Modeling.** To assume that clients from minority cultural groups should automatically view clinicians from the dominant culture as positive role models is presumptuous and unacceptable (D. W. Sue & Sue, 2016). Minority clients need their own role models. That said, it's still acceptable to join with minority clients and have similar thoughts and feelings in response to specific issues. For example, even if clients don't acknowledge an emotional reaction to discrimination, you might use modeling to imply that emotional expression with you is acceptable: "I don't know if this is how it affects you, but when I hear about the racial insults you've experienced, I feel angry and sad."

**Mutual empathy.** Although there's no empirical research on how mutual empathy operates when counseling across cultures, it makes logical and intuitive sense that showing minority clients your genuine and empathic emotional responses to their experiences might facilitate the development of positive relationship bonds. It's recommended that you use genuine expressions of empathic compassion to allow opportunities for mutual empathy to develop (Jordan, 2010).

## Summary

Carl Rogers (1942, 1957) initially articulated the importance of relationship variables in psychotherapy. He claimed that therapy techniques were irrelevant and that change occurred as a function of a special type of relationship between therapist and client. Contemporary researchers and practitioners still debate whether relationships or techniques are more important to therapy. Therapeutic relationship factors are now referred to as "evidence-based relationships" (Norcross, 2011).

Rogers identified three core conditions that he believed were necessary and sufficient for effective therapy: (a) congruence, (b) unconditional positive regard, and (c) accurate empathy. Congruence is synonymous with genuineness or authenticity and generally means that the therapist is open and real with clients. Unconditional positive regard involves accepting and respecting clients. Accurate empathy is a complex and multidimensional concept that involves feeling feelings right along with clients. Empirical research indicates that Rogers's original core conditions contribute to positive therapy outcomes.

Several relationship factors derived from other theoretical perspectives also have been linked to positive therapy outcomes. These comprise transference, countertransference, the working alliance, repairing relationship ruptures, therapist modeling, mutuality, and mutual empathy. Relationship factors, such as building the therapy alliance, are important from the initial clinical interview onward.

Evidence-based practice in counseling and psychotherapy includes sensitivity to and consideration of cultural factors. This is somewhat problematic in that there's only minimal empirical research available that focuses on how evidence-based relationship factors work with specific cultural minority groups. At this point, the best guide for practice is to use the evidence-based relationship factors described in this chapter along with the multicultural competencies.

## Suggested Readings and Resources

The following readings offer additional information on relationship factors that have scientific support and theoretical roots.

- Evans, K., Kincade, E. A., & Seem, S. R. (2011). *Introduction to feminist therapy: Strategies for social and individual change*. Thousand Oaks, CA: Sage. This is a well-organized and well-written introduction to feminist theory and therapy.
- Freud, S. (1949). *An outline of psychoanalysis* (J. Strachey, Trans.). New York, NY: Norton. This quick read provides a succinct description of psychoanalytic principles in Freud's own words.
- Jordan, J. (2010). *Relational-cultural therapy*. Washington, DC: American Psychological Association. Jordan is a prominent feminist therapist and author. In this book, she articulates a feminist approach to therapy that emphasizes relational mutuality as a healing force.
- Miller, S. D., Duncan, B., Wampold, B. E., & Hubble, D. (Eds.). (2010). *The heart and soul of change: Delivering what works in therapy* (2nd ed.). Washington, DC: American Psychological Association. This book focuses on common factors associated with positive change in counseling and psychotherapy. It provides practical suggestions for integrating common factors into your interviewing practice.
- Newman, C. F. (2013). *Core competencies in cognitive-behavioral therapy: Becoming a highly effective and competent cognitive-behavioral therapist*. New York, NY: Routledge. There are many CBT books available. This one is relationally sophisticated and includes two whole chapters on the therapeutic alliance.
- Norcross, J. C. (Ed.). (2011). *Psychotherapy relationships that work: Evidence-based responsiveness*. New York, NY: Oxford University Press. This book is the compilation of the findings of the task forces from Divisions 12 (Clinical Psychology) and 29 (Psychotherapy) of the American Psychological Association. It includes 21 chapters that report data on the contribution of relationship factors to psychotherapy outcomes.
- Rogers, C. R. (1961). *On becoming a person*. Boston, MA: Houghton-Mifflin. This text contains much of Rogers's thinking regarding congruence, unconditional positive regard, and empathy.

**PART THREE**

**STRUCTURING AND ASSESSMENT**



## INTAKE INTERVIEWING AND REPORT WRITING

### Chapter Orientation

Mental health treatment nearly always begins with an intake interview. Clinicians are faced with the daunting task of simultaneously and efficiently gathering nuanced information about clients while also establishing and maintaining rapport. This chapter reviews the nuts and bolts of conducting an intake interview and provides information about preparing intake reports.

#### VIDEO 8.1

### What's an Intake Interview?

Now I would be less satisfied to treat the fears of . . . anyone . . . without . . . an appreciation of him [or her] as a tantalizingly complex person with unique potentials for stability and change.

—Mary Cover Jones, 1975, p. 186

The *intake interview* is the first meeting between client and therapist. It can be face-to-face, telephonic, or online. In many ways, the purpose of the intake interview is to gain an appreciation of the “tantalizingly complex person” who is becoming your client. More formally, the intake is an assessment interview that involves gathering information to facilitate (a) problem identification (or diagnosis), (b) goal-setting, (c) case formulation, and (d) treatment planning. Some agencies use intake interviews to assign clients to specific therapists. For example, if the intake worker identifies a client as having an eating disorder, that client can be assigned to a therapist specializing in eating disorders. Before initiating counseling, psychotherapy, or psychiatric treatment, it’s usually necessary and always wise to conduct an intake interview.

### LEARNING OBJECTIVES

After reading this chapter, you will be able to:

- Define the intake interview as well as its nature and objectives
- Describe and apply methods for identifying, evaluating, and exploring client problems and goals
- Describe and apply methods for obtaining background or historical information about clients and evaluating their interpersonal behavior
- Describe and apply methods for assessing clients' current level of functioning
- Apply brief intake interviewing procedures for working with clients in time-limited models
- Write a well-organized, professional, and client-friendly intake report

Over the past two decades, managed health care and third-party payers began significantly reducing how many reimbursed therapy sessions are allowed. These limits have changed the nature of counseling and psychotherapy. Decades ago, graduate students were taught that several 50-minute interviews were needed to provide a diagnosis, develop a treatment plan, and initiate treatment. This was true even for cognitive-behavioral therapy (CBT).

Despite consistent research data indicating that longer-term treatment is more efficacious (Lambert, 2007; Lopes, Gonçalves, Fassnacht, Machado, & Sousa, 2015), many employee assistance programs and managed care insurance plans set strict limits on the number of therapy sessions available per year. This means that practitioners must be faster and more efficient in identifying client problems, establishing treatment goals, and outlining treatment plans. It also means that treatments are more educational and less depth oriented. Speed and brevity are the order of the day. Treatment goals are modest in depth and breadth.

Although it's reasonable for therapists to become more efficient in making treatment decisions, brevity doesn't necessarily enhance efficiency. When you're pressured to work faster, it doesn't matter whether you're baking cakes, building cabinets, repairing automobiles, or doing intake interviews—the outcome is similar: Quality can be compromised.

This chapter describes an intake procedure that's more comprehensive than is usually expected or tolerated. It's important to learn what *can* be accomplished in the context of an intake interview, even though it may not reflect what ordinarily *will* be accomplished. Also, insurance companies are profit-driven organizations that regulate therapy services; they don't have expertise for determining how mental health professionals should conduct intake interviews or formulate treatment plans (Schoenholtz, 2012). It would be unethical to educate prospective mental health professionals using exclusively a "bare bones" intake-assessment approach. Trimming back and becoming more efficient is best done from a broad and thorough understanding of the process. However, we're also pragmatic; if you're in graduate school today, chances are you'll work in settings that limit the number of counseling sessions. Therefore, toward the end of this chapter, we provide an outline and checklist for conducting brief intake interviews.

## VIDEO 8.2

### Three Overarching Objectives

Broadly speaking, the three objectives of an intake interview are:

1. Identifying, evaluating, and exploring the client's chief complaint or problem (and associated therapy goals)

2. Obtaining data related to the client's interpersonal behavior and psychosocial history
3. Evaluating the client's current life situation and functioning

This information is used for case formulation and treatment planning. In many cases, it also leads to an initial diagnosis.

In most mental health settings, you'll conduct the intake interview and then write or dictate an *intake report* (Zuckerman, 2010). The process and content of intake reports are covered later in this chapter.

## Identifying, Evaluating, and Exploring Client Problems and Goals

Zeroing in on your client's chief complaint is your first objective. The *chief complaint* is the client's reason for seeking help. It usually consists of one or more emotionally painful or distressing symptoms. It's the answer to the question: "Why are you here?"

Your opening statement or question leads you to the chief complaint (e.g., "What brings you here?" or "How can I be of help?"; see Chapter 3). After the opening statement, about 5 to 15 minutes are spent listening and trying to understand what your client wants from therapy. In some cases, clients quickly identify their reasons for seeking help; in other cases, they're vague and unclear.

Client problems are intrinsically linked to goals (A. Thomas, Kirchmann, Suess, Bräutigam, & Strauss, 2012). Many clients who come to therapy are unable to see past their problems. You may need to help them orient toward appropriate goals or solutions.

Anxiety, phobias, depression, and relationship conflicts are among the most common problems that bring adults to counseling. Others include alcohol and drug use, eating disorders, trauma, social skill deficits, work-related issues, and insomnia. Remember, every problem has an inherent goal. Early in the intake, you can encourage clients to reframe problem statements into goal statements:

I hear you talking about nervousness and anxiety. If I understand you correctly, you'd like to feel calm and in control more often. So, one therapy goal might be to feel calm more often and to be able to bring on those calm feelings yourself. Do I have that right?

Reframing client problems into goals facilitates hope and initiates a positive goal-setting process (Wollburg & Braukhaus, 2010). That doesn't mean you should always frame problems as goals. Sometimes clients will

want to talk about their problems and label them as such. Using goal-setting reframes is one way to articulate the direction of therapy.

## Prioritizing and Selecting Client Problems and Goals

It might be nice (though a bit intimidating) if your client started the first session like this:

I have a social phobia. When in public, I worry about being scrutinized and judged. My anxiety is manifest through sweating, worries about being inadequate, and avoidance of most, but not all, social situations. What I'd like to do in therapy is build my self-confidence, increase my positive self-talk, and learn to calm myself down when I'm starting to get upset.

Most clients come to intake interviews with either a number of interrelated complaints or with general vague symptoms. Sometimes they will share a real, but less emotionally significant concern to "test out" how the therapist responds. Later, if you pass the test, you may begin hearing about deeper concerns or problems (C. Myers, personal communication, October 14, 2012).

After you've listened to your client and sorted through symptoms for the first 5 to 15 minutes, your job is to make a list of primary problems and goals. This first summary of client problems and goals signals a transition from general nondirective listening to a more directive approach. Transitioning from client free expression to more structured interactions allows you to check for additional problems that may be important and begins the process of problem prioritization, selection, and goal setting:

**Therapist:** So far, you've talked mostly about how you've been feeling sad, how it's hard for you to get up in the morning, and how your usually fun activities aren't much fun lately. I'm wondering if you have other concerns you haven't mentioned yet.

**Client:** As a matter of fact, I do. I get big butterflies. I feel so scared sometimes. Mostly I feel scared about my career . . . or maybe my lack of career.

In the preceding exchange, the therapist used an indirect question to explore for additional problems.

Because all problems can't be addressed simultaneously, therapists and clients choose together which problem(s) need attention during an intake. This is called *problem prioritization*. Problem prioritization should be collaborative.

**Therapist:** So far we could summarize your major concerns as your depressed mood, anxiety over your career, and shyness. Which of these would you say is currently most troubling?

**Client:** They all bother me, but I guess my mood is worst. When I'm in a really bad mood and don't get out of bed all day, I never face those other problems anyway.

This client identified depression as the biggest concern. An alternative formulation of the problem is that social inhibition and anxiety produce the depressed mood and should be dealt with first. However, it's usually (but not always) best to follow the client's lead and explore the chief complaint first. In this example, all three symptoms may eventually be linked anyway. You can explore depression first and anxiety and shyness symptoms later.

If you want to explore a different issue from what the client identified (e.g., alcohol use), it's best to wait and listen carefully to the client's perspective first. You should avoid labeling the client's concern as a "problem" if the client doesn't define it as such (e.g., substance abuse). In time-limited circumstances, empathic responses are usually brief and intermittent because of the need to quickly transition from problems to goal-setting.

## Analyzing Client Problems and Goals

Once you've identified a primary problem, your next step is to thoroughly analyze that problem, including emotional, cognitive, interpersonal, and behavioral components. Using questions similar to the following is useful:

### Antecedent or Triggering Questions

- When did the problem or symptoms first occur? (Explore the symptom's origin and more recent development and maintenance.)
- Where were you and what was happening when you first noticed the problem? (What was the setting, who was there, etc.?)
- Are there any situations, people, or events that usually precede this problem? (What are the current antecedents?)

### Questions Focusing on the Problem Experience

- How frequently do you experience this problem?
- What exactly happens when the problem or symptoms begin?
- What thoughts or images go through your mind when it's occurring?
- What physical sensations do you have before, during, or after the problem occurs?
- What do you feel in your body? Describe it as precisely as possible.

- How long does it last?
- How does it usually end (or what makes it finally stop)?

### Coping Questions

- What have you already tried to deal with this problem?
- What has been most helpful?
- What else has been helpful?

### Questions That Stimulate Client Reflections on the Problem

- Does the problem interfere with any important activities in your life? How so?
- Describe the worst experience you've had with this symptom. What thoughts, images, and feelings came up then?
- Describe the best experience you've had with this problem, a time when you handled it well. What thoughts, images, and feelings came up then?
- Have you ever expected the symptom to occur and were surprised that it didn't occur, or it occurred only for a few moments and then disappeared?
- If you were to rate the severity of your problem, with 0 indicating no distress and 100 indicating so much distress that it's going to cause you to kill yourself or die, how would you rate it today?
- What rating would you have given your symptom on its worst day ever?
- What's the lowest rating you would ever have given your symptom?
- Has it ever been completely absent?
- As we have discussed your symptom during this interview, have you noticed any changes? (Has it gotten any worse or better as we've focused on it?)
- If you were to give this symptom and its effects on you a title, like the title of a book or play, what title would you give it?

These are sample questions designed to give you a taste of problem-focused questions you could ask. You may have noticed that these questions primarily use internalizing or problem-saturated language (Gonçalves, Matos, & Santos, 2009). Solution-focused or narrative therapists would use questions that externalize the problem or identify exceptions (J. Murphy, 2015). For example, instead of asking, "What thoughts or images go through your mind when [the problem is] occurring?" a solution-focused therapist might ask, "What thoughts or images go through your mind when the problem is gone?"

You can reword these questions to be more solution focused or to fit your theoretical orientation, add and delete questions, and create a question set that meets your interviewing goals. Through practice, you can develop a sense of how much you can cover in a single interview, and you may even memorize a question list that flows well for you.

Even best-laid plans can fail. Clients can skillfully draw you off track. And at times it may be important to be drawn off track because deviating from your planned questions can lead to a more important area (e.g., reports of sexual or physical abuse or suicide ideation). While focusing on your planned task, use empathic statements such as paraphrases, feeling validation, and nondirective reflections of feeling. Remain flexible to avoid overlooking important clues about other significant problem areas.

## Using Questionnaires and Rating Scales

There are a plethora of specific questionnaires and rating scales that can be used during intake interviews. The traditional approach is to have clients complete an instrument prior to or after the interview (e.g., the Minnesota Multiphasic Personality Inventory-2 or MMPI-2-RF, the Beck Depression Inventory-2, or the Outcome Questionnaire-45; A. Beck, Steer, & Brown, 1996; Greene, 2000; Mueller, Lambert, & Burlingame, 1998). Information gleaned from these instruments is used to assist in the formulation of client goals, diagnosis, and treatment plans.

Traditionally, clients were not necessarily privy to their test results, and little time was spent discussing test results with clients. Beginning in the 1950s and moving forward, Constance Fischer and Stephen Finn have advocated for a more collaborative and therapeutic approach to psychological assessment (Finn, Fischer, & Handler, 2012). Their collaborative/therapeutic approach is growing in popularity, but traditional approaches to assessment remain dominant. However, because the traditional administering of a questionnaire and using that information to guide treatment require no particular clinical interviewing skills, this section focuses specifically on Fischer and Finn's practice of using assessment data collaboratively and therapeutically.

Fischer (1994) emphasized several core principles.

- *The clinician collaborates.* Clinicians and clients aren't two people passing in the night. They should collaborate throughout the assessment process. Clients are the best experts on their own experiences and therefore should be fully involved in all phases of psychological assessment.

- *Data are contextualized.* Assessment data aren't separate from a client's situations, problems, and solutions. For the clinician to use assessments as a vehicle for understanding and change, assessment data—even a simple forced true-false response to an MMPI-2-RF item—should be viewed within the context of the client's whole life situation.
- *Assessment is intervention.* Under most circumstances, classifying a client's present state isn't the end goal of psychological assessment. Instead, the purpose of assessment is "to assist clients in discovering new ways of thinking and being" (Finn et al., 2012, p. 3). The purpose of assessment is to facilitate treatment.
- *Clients are described, not labeled.* Labeling clients as depressed, anxious, impulsive, or angry is limiting and can inhibit change. Instead, assessments can be used to describe clients, their condition and their situation, "using the client's own words whenever possible" (Finn et al., 2012, p. 3). This process helps engage clients and leads to a deeper understanding.
- *Clinicians respect client complexity.* Reducing clients' lives to a variable or simple explanation misses the richness of the person. Clinicians should strive to understand and not simply explain clients' behavior. This deeper engagement builds interpersonal connection and leverage for change.

Finn has written extensively about therapeutic assessment (Finn et al., 2012; Finn & Martin, 2013; Finn & Tonsager, 2002). He urges clinicians to organize assessment results by levels, with each level corresponding to clients' current self-schema. Clinicians then share information in the following order (Finn et al., 2012, p. 5):

*Level 1:* Begin with information consistent with or close to the client's current self-schema . . . and then . . .

*Level 2:* Move to information that's "mildly discrepant" from their current ways of viewing themselves . . . and finally . . .

*Level 3:* Introduce information that's "highly discrepant from the ways they already thought about themselves."

See Case Example 8.1 for an application of these principles.

Collaborative/therapeutic assessment is an approach that requires sophisticated clinical skills. Sometimes clients will forcefully dispute assessment results. Other times they'll dispute the process before the assessment starts. Case Example 8.1 gives you a sense of the delicate, tentative, and interactive flavor of collaborative/therapeutic assessment.

### CASE EXAMPLE 8.1: THERAPEUTIC ASSESSMENT

This is an example of how to use Fischer's and Finn's ideas about therapeutic assessment.

Mark is a 25-year-old biracial heterosexual male (Puerto Rican and White). Prior to intake, he completed the MMPI-2-RF. You reviewed the results from this testing before meeting. You start the session and tell him that about halfway through, you'll share his MMPI results and discuss how they may be helpful in therapy.

Marcus reports several aggressive episodes that cost him financially and relationally. Although his MMPI profile shows elevations on the restructured clinical scales 2 (Low Positive Emotions) and 7 (Dysfunctional Negative Emotions), he doesn't disclose depression or anxiety problems during the less structured portion of his interview. Instead, he views himself (self-schema) in a manner consistent with his gender and cultural identities.

On the basis of 25 minutes of an intake interview and knowledge of his MMPI profile, you tentatively offer this feedback:

*Level 1 feedback:* Your assessment results are consistent with your description of yourself. When things don't go the way you think is fair and right, you get quite angry and sometimes explode to set things right. Does that fit? [Marcus responds affirmatively, and you have an in-depth discussion about the predictable anger triggers in his current situation.]

*Level 2 feedback:* One thing that might contribute to your anger is a wish for control. If I were to guess, it seems like you want control over certain situations, and when you don't feel in control, you have a grinding discomfort that's undesirable. Bottom line: Sometimes you want so badly to relieve yourself from this discomfort that exploding—even though the outcomes aren't good—feels better than sitting and doing nothing. What do you think of that idea? [Marcus admits that he hates sitting and doing nothing when something's not right. You suggest, "When we do anger management, we should identify ways you can be active, so you're not just sitting around feeling bad." Marcus endorses this idea.]

*Level 3 feedback:* This last result is something you never mentioned today, but it might be important. The MMPI indicates that you're not very happy with your life and yourself right now. One way that might be related to anger is that unhappiness causes irritability and makes getting angry easier. I don't know what feels unhappy for you. I know sometimes it's not cool for men to talk about sadness, and so if you don't want to, you don't have to . . . but the test results are what they are . . . so I hope you'll tell me more about what might be making you unhappy. [Marcus opens up about his mother's death two years ago. You talk through this, and formulate ideas for addressing his unresolved grief in ways comfortable for him.]

## The Behavioral ABCs

Behavioral theorists and practitioners focus on antecedents and consequences as causal factors in the development and maintenance of problems. Working from this perspective, clinicians analyze clients' environments to explain, predict, and control specific symptoms. Behaviorists refer to this as the *ABC model* and focus on (a) behavioral antecedents, (b) the behavior or problem itself, and (c) consequences (Thoresen & Mahoney, 1974). The following questions represent the behavioral ABCs:

- What events, thoughts, and experiences precede the identified problem?
- What's the operational definition of the problem (i.e., what behaviors and symptoms constitute the problem)?
- What events, thoughts, and experiences follow the identified problem?

### **PUTTING IT IN PRACTICE 8.1: DON'T LET YOUR PHILOSOPHICAL BELIEFS MAKE YOU LESS PROFESSIONALLY COMPETENT**

Over the years, we've noticed that students sometimes eschew what they view as the cold and rigid application of behavior therapy. This is problematic for two reasons.

First, behavioral science isn't cold and rigid. When applied to human clients, it can—and should be—warm and flexible. The idea that behaviorally informed therapists must be cold and rigid is patently false. They can be, but then they're just being bad therapists.

Second, behavioral principles are operating everywhere all the time and shouldn't be ignored. We've come to label behavioral ignorance as "backward behavior modification" (J. Sommers-Flanagan & Sommers-Flanagan, 2011, p. 39). *Backward behavior modification* occurs when undesirable behavior is reinforced and desirable behavior is ignored or punished. This often happens with parents and families and within individuals. When working with a certain type of anxious client, we occasionally feel an urge (which we valiantly control) to point out: "Of course you're having trouble controlling your anxiety...it's BECAUSE YOU KEEP REWARDING YOURSELF FOR BEING ANXIOUS!!"

There's nothing wrong with being broadly existential or compassionately person centered or dogmatically eclectic. You can be those and more. We're not saying everyone should become behavior therapists. Our point: Don't ignore one of the foundational sources of knowledge in the helping professions. If you ignore behavioral principles out of an allegiance to an alternative philosophical perspective, you do so at the expense of your own competence. Even worse, you do so at the expense of your clients' welfare.

## Obtaining Background and Historical Information

Clients are more than a set of symptoms. When symptoms occur, they occur within an individual, and that individual hails from a unique family system, neighborhood, and ethnic culture. Consequently, although clients can have similar symptoms or diagnoses, each client simultaneously holds multiple intersecting individual and collective identities (Hays, 2008). As a clinician, you'll need to know about more than the presenting problem or symptoms. You'll also need to know how the problem is situated in the client's larger framework and to generally get a sense of who clients are . . . in the specific contexts of their lives. Two information sources are useful:

1. The client's personal or psychosocial history
2. Observations and reports of client interpersonal behavior

### Shifting to the Personal or Psychosocial History

Exploring the presenting complaint should give you an initial idea of why clients are seeking counseling. A possible bridge from problem exploration to personal or psychosocial history is the *Why now* question:

I'm clear on why you've come for counseling, but I'd like to know more about *why* you've chosen to come for counseling *now*.

This question helps determine the precipitating event. The *precipitating event* is the immediate incident or circumstance that stimulated the client to seek professional help now (and not before or later). Responses to the *Why now* question shed light on client motivation for treatment; you'll gain a sense of whether your client is a willing participant or was coerced to attend counseling.

If the client balks at your *Why now* question, you can pursue it through alternative means:

- You didn't come in a few months ago when you were first jilted by your girlfriend. Why now and not then?
- You've had these symptoms a long time. What prompted you to seek counseling now?
- You said that in the past you would "tough it out." What's different this time?

After your client responds to the *Why now* question (and after you've summarized or paraphrased the response), you can shift from a focus on the *problem* to a focus on the *person*:

We've spent most of our time talking about what led you to come for counseling. Now I'd like to try to get a better sense of you. Is it okay if I ask you some questions about your past?

Although the *Why now* question is useful and interesting, it's not essential. You might already have a good sense of why the client has sought help now, so there's no point in being redundant. Either way, you'll need to transition from a symptom-oriented interview to a history-oriented interview. As you make this shift, you can use a nondirective lead or a structured history-taking approach.

### Nondirective Historical Leads

*Nondirective leads* are open questions or prompts that give clients control over what they talk about. The advantage of this approach is that what clients choose to talk about and choose to avoid talking about can be revealing. The disadvantages include that it can evoke anxiety in clients and be time consuming.

In addition to the classic initial interview line, "Let's begin with your childhood," you might try:

- What do you remember about your childhood?
- What's important from your growing-up years that I should know about?

Many clients are hesitant to talk about their childhood; they may ask for structure and guidance. If you're using a psychodynamic or person-centered approach, you'll resist giving structure and guidance, at least briefly. This is because if you immediately start asking specific questions, you spoil your chance to know your client's spontaneous response. If your client presses you for structure, you can state directly:

I'll ask specific questions soon, but right now I'm interested in whatever past experiences and memories come to mind.

Personal histories can be traumatic and disturbing. Historical events may be hard to recall. Sometimes clients will actively try not to think about specific childhood events. They may claim, "I can't remember much of my past" or "My childhood is a blank." If this happens, supportive psychoeducation can help:

Memory is a funny thing. Sometimes bits will pop up here and there for different reasons. And most of us have memories we'd rather not

recall because they're unpleasant. I don't want to force you into talking about your past, but I do want you to talk about whatever past events you think are important.

Intake interviews don't usually include direct questioning about specific trauma experiences. However, clients may open up and share about trauma spontaneously (Goodman & Epstein, 2008). The goal is to give clients an opportunity to disclose past traumatic events, but not dive too deeply into details until an adequate therapy relationship has been established.

Many students have asked, "What if my client has been sexually abused?" or "What if my client's parents died when she was a young child; what do I do then?" When you explore your client's history, you should anticipate hearing emotionally charged material. When this happens, the best thing is to listen well. What a traumatized client needs first is a supportive and empathic ear. Comments that track your client's experience, such as "Sounds like that was an especially difficult time" or "You were really in a tough place back then," are potentially therapeutic.

Some clients have trouble pulling themselves out of emotionally distressing memories. In such cases, distinctions can be made between what happened then and what's happening now. Solution-focused approaches that explore, identify, and emphasize how clients coped and survived during a difficult past situation can be helpful. You may have a chance to point out ways your client was strong during a difficult time:

You've been through very hard times. No doubt about that. And yet, as I listen, I hear that when things were at their worst, you reached out and got help to get yourself back on your feet again.

It's also useful to gradually lead clients back to the present. For example, "When your daughter was born, your family wasn't very supportive. How old is she now?" As you move into the present, your clients may gain distance from painful past experiences. Other times, clients will stay in their negative emotions. Trauma memories are powerful. When clients get stuck in negative memories, especially in an intake interview, they can feel stress or panic. Strategies for assessing and managing clients who are overwhelmed with negative or suicidal thoughts are covered in Chapter 10. Approaches for moving clients into more positive emotional states are in Putting It in Practice 8.2.

## **Directive Historical Leads**

Even if you use a nondirective historical lead to start, eventually you'll need to become more directive and structured. This is because a lifetime of client

historical material is available. Selecting which areas to focus on is necessary. One place to begin a directive inquiry into the past is with an earliest recollection question (Adler, 1930; Clark, 2002):

**Counselor:** What's your earliest memory—the first thing you remember from your childhood?

**Client:** I remember my brothers trying to get me to get into my dad's pickup. They wanted me to pretend I was driving. They were laughing. I got into the cab and somehow got the truck's brake off, because it started rolling. My dad got mad. My brothers were always trying to get me to do outrageous things.

**Counselor:** How old were you?

**Client:** About four or five.

Early memories can represent major themes or issues clients are currently struggling with (Sweeney, 2009). For example, the client who revealed the preceding memory believed he was always putting on performances in his life. He felt addicted to doing outrageous things for attention and approval.

All clients have positive and negative childhood memories. Some theorists hypothesize that clients who remember mostly negative childhood experiences may be suffering from a depressive disorder, whereas clients who never mention negative experiences may be using defense mechanisms of denial, repression, or dissociation (Mosak, 1989). When clients exclusively share only positive or only negative memories, you might prompt for the opposite:

**Client:** I remember breaking a plate trying to set the table. I must have been about five. My mom was really mad. And then I pulled the car out of neutral and it backed into the neighbor's fence. My parents freaked.

**Counselor:** Sounds like those were some negative times when you got in trouble. Can you think of an early memory of something more positive?

**Client:** Yeah. My memories of playing with my older sister are great. She used to let me wear her dresses.

**Counselor:** Do you remember a specific time?

**Client:** Uh . . . yeah. She had one dark blue silky dress. I loved it, and put it on and danced around. But then I ripped the hem. She got really angry.

Sometimes, even when you ask for a positive or negative client memory, you won't get what you ask for. Early in therapy, it's wise to simply note the pattern and move on. Later, you can explore patterns in more depth.

Another method for exploring childhood is to ask clients to provide three words to describe their parents (or caregivers).

**Counselor:** Give me three words to describe your mother.

**Client:** What do you mean?

**Counselor:** When you think of your mother and what she's like, what three words best describe her?

**Client:** I suppose . . . clean . . . and proper, and uh, intense. That's it, intense.

Stumbling into affectively charged memories is especially possible when exploring parent-child relationships. Words clients use to describe parents may require follow-up. You can ask for specific examples:

You said your mother was intense. Can you give me an example of something she did that fits that word?

A natural history-taking flow is: (a) first memories, (b) memories of parents/caregivers and siblings (if any), (c) school and peer relations, (d) work or employment, and (e) other areas. (Table 8.1 includes a comprehensive list of content that might be covered in a psychosocial history. In a typical intake, you'll be selective. It's impossible to cover everything.)

Because it's often difficult to choose which domains to explore during a brief intake interview, agencies and individual clinicians often use registration forms or intake questionnaires for new clients. These forms provide you with client information in advance and can help you choose your interview focus.

## Evaluating Interpersonal Behavior

Interpersonal behavior is central in the development and maintenance of client problems. Some theorists claim that all client problems have their root in relationship problems (Glasser, 1998). Evaluating client interpersonal behavior is an essential part of an intake interview.

Intake interviewers have five potential data sources pertaining to client interpersonal behavior.

1. Client self-report. This includes self-report of (a) past relationship interactions (e.g., childhood) and (b) contemporary relationship interactions.
2. Clinician observations of client interpersonal behavior during the interview.
3. Formal psychological assessment data.
4. Information from past psychological records/reports.
5. Information from collateral informants.

**Table 8.1** Psychosocial History Interview Sample Questions

<b>Content Areas</b>	<b>Questions</b>
First memories	What's your first memory? How old were you then?
Descriptions and memories of parents	Give me three words to describe your mother (or father). With which parent did you spend more time? What did your parents do for discipline? What recreational activities did you do with your family?
Descriptions and memories of siblings	Did you have brothers or sisters? (If so, how many?) What memories do you have with your siblings? Who was your closest sibling and why? Who were you most similar/dissimilar to in your family?
Elementary school experiences	How was school for you? (Did you like school?) What was your favorite (or best) subject in school? What subject did you like least (or were worst at)? Do you have any vivid school memories? Describe the worst trouble you were ever in when in school. Were you in any special or remedial classes?
Peer relationships (in and out of school)	Did you have many friends in school? What did you do for fun with your friends? Did you get along better with boys or girls? What positive (or negative) memories do you have with school friends?
Middle school, high school, and college experiences	What positive (or negative) memories do you have from high school? How was high school for you? (Did you like high school?) What was your favorite (or best) subject in high school? What subject did you like least (or were worst at)? Do you have any vivid high school memories? Describe the worst trouble you were ever in when in high school. What was your greatest high school achievement? Did you go to college? What were your reasons for going (or not going) to college? What was your major field of study in college?
First employment and work experience	What was your first job or the first way you ever earned money? How did you get along with coworkers? What positive and negative job memories do you have? Have you ever been fired from a job? What is your ultimate career goal?

Content Areas	Questions
Military history and experiences	Were you ever in the military? What branch? How did you choose to enter the military? Tell me about your most positive (or most negative) experiences in the military. Final rank? Honorable discharge? Were you ever disciplined? What was your offense?
Romantic relationship history	Have you ever had romantic feelings for someone? What do you think makes a good romantic relationship? What do you look for in a romantic (or marital) partner? What first attracted you to your spouse (or significant other)?
Sexual history (including first sexual experience)	What did you learn about sex from your parents (or school, siblings, peers, television, or movies)? What do you think is most important in a sexual relationship? Have you had any difficult sexual experiences (e.g., rape or incest)?
Aggressive history	What are you like when angry? Have you ever been in a fight? Tell me about a time when you got too angry and regretted it later. When was your last fight? Have you ever used a weapon in a fight? What's the worst you've ever hurt someone (or been hurt)?
Medical and health history	Did you have any childhood diseases? Any medical hospitalizations? Any surgeries? Do you have any current medical concerns or problems? Are you taking any prescription medications? When was your last physical examination? Have you ever been unconscious? Are there any major illnesses that run in your family? Tell me about your usual diet. Do you have any major allergies? What are your exercise patterns?
Psychiatric or counseling history	Have you ever been in counseling? What was the purpose of your counseling? How long did you go? Do you remember anything your previous counselor did that was particularly helpful (or particularly unhelpful)? Did counseling help with the problem? If not, what did help? Have you ever been hospitalized for psychological reasons? Have you ever taken medication for psychiatric problems? Has anyone in your family been hospitalized for psychological reasons or had mental health problems? Can you remember that person's problem or diagnosis?

(Continued)

Content Areas	Questions
Alcohol and drug history	When did you have your first drink of alcohol (or pot or other substance)? When was your most recent drink (and how much)? How many drinks do you have each day (or week or month)? What's your drink/drug of choice? Have you had medical, legal, family, or work problems related to alcohol? What benefits do you get from drinking?
Legal history	Have you ever been arrested or ticketed for something illegal? Have you been issued a ticket for driving under the influence? Any other legal issues or involvement?
Recreational history	What's your favorite recreational activity? What recreational activities do you hate or avoid? How often do you engage in your favorite (or best) activity? What prevents you from engaging in this activity more often?
Developmental history	What's the story of your conception? Was your mother's pregnancy normal? What was your birth weight? Did you have any health or medical problems? When did you sit, stand, and walk?
Spiritual or religious history	What's your religious background? What are your current religious or spiritual beliefs? Do you attend church, pray, or participate in religious activities? Any other spiritual activities?

Although some behaviorists and in-home family therapists also observe clients outside the office (e.g., in school, home, and work environments), it's unusual to have those data available prior to an intake.

Evaluating interpersonal behavior is difficult. Each of the preceding data sources can be suspect. For example, client self-report may be distorted or biased; often clients cast their interpersonal behaviors in a favorable light, or they may excessively blame themselves for negative interpersonal experiences. Clinician observations are also subjective. When you're evaluating client interpersonal behavior, it's wise to use several basic assessment principles to temper your conclusions:

1. Single observations are often unreliable. This is partly because interpersonal behavior can shift dramatically from situation to situation. Multiple observations of behavior patterns (e.g., interpersonal aggression or interpersonal isolation) are more reliable.

2. Just as construct validity is established through multimethod, multi-trait assessments (Campbell & Fiske, 1959), interpersonal assessments are more valid when you have converging data from more than one source (e.g., self-report plus clinician observation).
3. The literature is replete with theory-based models for interpersonal assessment. When clinicians hold strong theoretical beliefs, confirmation bias is more likely (in other words, you will make observations that confirm your theoretical stance or hypothesis). Therefore, you should regularly question conclusions about client interpersonal behavior that are based on your preexisting ideas.

One of the most popular models for conceptualizing interpersonal behavior is attachment theory. Adherents to this perspective believe that early caregiver-child relationship interactions create internal working models about how relationships work. Essentially, this leaves clients with consistent (and sometimes rigid) interpersonal expectations and reactions. For example, clients with insecure attachment styles may expect or anticipate rejection or abandonment, while clients with ambivalent attachment styles alternate between pushing others away and clinging to them. Typically, maladaptive components of client internal working models are activated during the early stages of new relationships or during times of significant stress, when support and reassurance are needed (O'Shea, Spence, & Donovan, 2014).

Interpersonal assessment based on attachment theory is a psychodynamic approach and involves a depth-oriented assessment process. However, the idea that individuals have internal working models that guide their interpersonal behaviors is consistent across many different theoretical perspectives. Specifically,

- Cognitive therapists emphasize client schema or schemata that shape what clients expect in interpersonal relationships (Young, Klosko, & Weishaar, 2003).
- Adlerian therapists use the term *lifestyle assessment* to refer to the evaluation of client expectations about the self, the world, and others (Carlson, Watts, & Maniacci, 2006).
- Psychoanalytic therapists refer to the client's core conflictual relational theme (CCRT) as a target for treatment (Luborsky, 1984).
- The whole emphasis of the empirically supported interpersonal psychotherapy for depression is based on addressing problematic interpersonal relationship dynamics (Markowitz & Weissman, 2012).

It's always advisable to attend to feelings and reactions that clients elicit in you (Teyber & McClure, 2011). For example, some clients may trigger

boredom, arousal, sadness, or annoyance. These personal and emotional reactions can be viewed as countertransference (Luborsky & Barrett, 2006). However, if there's convergent evidence that reactions the client is evoking in you are also evoked in others, it's likely that the client's interpersonal behavior is the culprit. If your reactions are unique, then your countertransference reaction may be more about you and less about the client.

Evaluating a client's personal history and interpersonal behaviors is a formidable task that could easily take several sessions. Expecting that you should have a precise sense of your client's interpersonal style after a single interview is unrealistic. A better goal is to have a few working hypotheses about your client's interpersonal behavior patterns (see Case Example 8.2).

### CASE EXAMPLE 8.2: DESCRIBING INTERPERSONAL OBSERVATIONS

The following intake note focuses on interpersonal observations and, consistent with a collaborative/therapeutic assessment model, uses a descriptive rather than a labeling approach.

Miriam, a 36-year-old White, married female, described herself as suffering from tension and stress in her marital relationship. She reported, "My husband always calls me controlling, and I hate that, but sometimes he's right." During our session, Miriam repeatedly (about five times) asked for more information, complaining that she "really needed" to understand exactly what counseling was about before she could be sure she wanted to proceed. As we discussed her husband's comments in greater detail, Miriam noted that she believed her "need for control" was related to anxiety. Together we identified several triggers that elicit anxiety and are then followed by self-identified controlling behaviors. These comprised (a) new situations (like counseling), (b) her husband leaving the house without telling her his plans, and (c) when she feels neglected by her husband. Overall, these triggers may be related to an internal working model where Miriam's sense of relational security is threatened. Consequently, one of our first therapy tasks is for Miriam to engage in a self-monitoring homework assignment to help further refine our understanding of the interpersonal triggers that activate her "controlling" behaviors.

### Assessment of Current Functioning

After exploring historical and interpersonal issues, therapists should shift to current functioning. The shift to current functioning is both a symbolic and a concrete return to the present.

The following statements and questions facilitate client talk about areas of current functioning:

- We've talked about your major concerns and a bit about your past. I'd like to shift to what's happening in your life right now.
- Describe a typical day in your life.
- How much time do you spend at work?
- About how much time do you spend with your partner (spouse)?
- What do you and your partner do together? How often do you do these activities?
- Do you spend time alone?
- What do you most enjoy doing all by yourself?

Some clients have difficulty shifting from talking about their past to talking about the present. This can be especially true for clients who had difficult or traumatic childhoods. If clients become upset during an intake interview, two main strategies are recommended: (a) validate the client's feelings and (b) instill hope for positive change. For example, consider a mother who comes to counseling shortly after losing her child to a tragic accident. You might state:

Losing your son has been terribly painful, and your feelings are totally natural. Most people consider losing a child to be the most emotionally painful experience possible. Also, I want you to know how smart it is for you to come and talk with me about your son's death and your feelings. It won't make your sad feelings magically go away, but talking about grief is almost always the right thing to do. It will help you move through the grieving process.

Feeling validation involves accepting clients' emotions as natural (see Chapter 5). This technique is an appropriate tool toward the end of an intake when a client is experiencing painful or disturbing feelings. The following is a more general example of what you might say to a client in emotional pain or distress toward the end of an intake:

I notice that you're still feeling sad about what we talked about. It's natural to have sad or upset feelings. Many people who come in for counseling leave with mixed feelings. That's because it's hard to talk about problems without having uncomfortable feelings, but it's good too. What you're feeling is normal.

Offering reassurance is an essential part of a therapeutic closing (see Putting It in Practice 8.2).

### **PUTTING IT IN PRACTICE 8.2: HELPING CLIENTS REGAIN EMOTIONAL CONTROL**

It's natural for clients to experience emotional distress during an intake. Clients usually pull themselves together and are in reasonably good emotional shape at the interview's end. However, sometimes clients remain emotionally distraught and need assistance to regain emotional control before leaving. Although no strategies guarantee emotional reconstitution, the following techniques, combined with empathetic statements, can help.

*Focus or refocus on the present and immediate future.* "What are your plans for the rest of the day? What will you do right after you leave here? Is there anything you can do that you'd find especially emotionally comforting?"

*Ask clients about what they usually do for emotional soothing.* "When you feel upset at home or outside therapy, what do you usually do to help yourself feel better? What usually helps you feel better?"

*Change the subject back to a more positive issue.* "Earlier when we were talking about your job, I was impressed with how you've been handling your work stress."

*Give a compliment and suggestion.* "It takes lots of strength to be as open as you've been with me today. I hope you recognize that."

*Acknowledge the negative reality and then have the client review some positives.* "It's hard to get refocused on the positive, so I'm going to ask a few questions to help move you in that direction. What were the most positive things you'll take from our meeting today?"

*Engage in a centering activity.* "Before we end our time together, let's take a few moments to breathe deeply and be mindful of this moment." (You can use centering activities from specific therapy models, such as Acceptance and Commitment Therapy; S. Hayes, 2004.)

### **Reviewing Goals and Monitoring Change**

Clients come to therapy because they want change, and change involves the future. This is why many therapists pose future-oriented questions toward the end of an intake:

- Let's say therapy is successful and you notice positive change in your life. What will have changed?
- How do you see yourself changing in the next several years?
- What kind of personal (or career) goals are you striving toward?

Discussing therapy goals during an intake interview or in early therapy sessions provides a foundation for termination. Through establishing clear visions of desired change, clients and therapists can jointly monitor progress and determine when therapy might end. Using a progress monitoring

system is an evidence-based strategy that can start in the first session (see Chapter 3).

## Factors Affecting Intake Interview Procedures

VIDEO  
8.3

To conduct an intake that covers each area described in this chapter in 50-minutes is impossible. You must choose what to emphasize, what to de-emphasize, and what to ignore. Several factors affect your choices.

### ***Client Registration Forms***

Client registration forms allow you to gather detailed information without extending the clinical hour. Registration forms can include space to list previous therapists, primary care physicians, and demographic information (e.g., date of birth, age, gender identity, birthplace, educational attainment).

Although intake questionnaires are useful, when used excessively they can offend or intimidate clients. When using questionnaires that include personal questions about sex, trauma, suicide, or the past, you should first explain their purpose. It's also appropriate to include standardized symptom checklists or behavioral inventories as a part of a pretherapy questionnaire battery. An ethics point: Never forget to look at intake information *before* clients leave. If they've indicated past trauma or suicidality or murderous rage, this needs to be assessed and addressed before they leave.

### ***Institutional Setting***

Information obtained in an initial interview is partly a function of agency or therapist policy. Some institutions, such as psychiatric hospitals, require diagnostic or historical information; other settings, such as health maintenance organizations, place greater emphasis on problem or symptom analysis, goal setting, and treatment planning. Your intake approach will vary depending on your setting.

### ***Theoretical Orientation***

Theoretical orientation strongly influences *what* information is obtained during an intake session and *how* it's obtained. Practitioners using CBT focus on current problems, whereas psychoanalytic therapists downplay analysis of current problems in favor of gathering historical information. Person-centered therapists focus on the current situation and client emotions. Solution-focused therapists emphasize the future and potential solutions rather than examining past or current problems. Feminist therapists ask about potentially oppressive social and cultural factors. Traditional psychoanalytic, person-centered, and existential therapists are less likely to

make use of detailed client registration forms, computerized interviewing procedures, or standardized questionnaires.

### ***Professional Background and Affiliation***

Your professional background and discipline influence what information you obtain in an intake interview. Usually, this interacts with your setting and institutional expectations. Depending on whether your professional training is in clinical psychology, counseling, psychiatry, or social work, you may be more or less oriented toward biological, social, individual, or systems information. All of these areas are important, and none should be completely ignored.

#### **VIDEO 8.4**

### **Brief Intake Interviewing**

Given cost containment in health care, conducting abbreviated intakes is often a mandate. Although intake interview objectives are the same within a limited-session philosophy, you'll need to condense your approach and:

- Rely on registration forms and questionnaires to gather information from clients before meeting.
- Use more questions and allocate less time for client-directed self-expression.
- Reduce time spent obtaining information about psychosocial history and interpersonal behavior.

Because using registration forms and questionnaires and asking more questions are straightforward modifications, the following discussion focuses on how to briefly obtain psychosocial history and interpersonal behavior information.

### **Obtaining Information on Psychosocial History and Interpersonal Behavior**

Time-limited mental health philosophy places responsibility for client well-being back on the client (M. Hoyt, 1996). This model empowers clients to make greater contributions to their own mental health. You might say the following:

We have only a few minutes to discuss your childhood and your past.  
So, very briefly, tell me, what are the most essential things I need to know about your past?

Often, when given this assignment, clients successfully identify a few critical incidents in their developmental history.

Information pertaining to client interpersonal behavior is minimally relevant when you have a limited number of available sessions. This is because time-limited work restricts your focus to symptom management; there's little time for interpersonal process work.

Nevertheless, even in brief therapy formats, you may be immediately aware that your client has distinct or troubling interpersonal behavior patterns. In some cases, these interpersonal behaviors may be related to a personality disorder (Dimaggio, 2015); it may be appropriate to use a diagnostic manual to determine whether a client exhibits interpersonal behaviors consistent with one or more of the three personality disorder clusters and then document these features using the appropriate diagnostic nomenclature (i.e., *ICD-10-CM* or *DSM-5*).

## A Brief Intake Checklist

A managed care or limited-session intake outline is in Table 8.2.

**Table 8.2 A Brief Intake Checklist**

- Obtain presession or registration information from the client in a sensitive manner. Explain: "This information will help us tailor the treatment to you."
- Inform clients of session limits at the beginning of treatment. This information can also be on the registration materials. All policy information and informed consent should be given to clients in advance of meeting with their therapist.
- Allow clients a brief time period (not more than 10 minutes) to introduce themselves and their problems to you. Begin asking specific questions toward the 10-minute mark, or before.
- Summarize clients' major problem (and sometimes a secondary problem) and obtain an agreement to work on these problems.
- Help clients reframe their primary problems into realistic treatment goals.
- Do a brief problem history. Also ask for a review of what informal and formal treatments have been used previously.
- Identify problem antecedents and consequences, but also ask about problem exceptions. For example: "Tell me about times when your problem isn't occurring. What helps you get rid of the problem?"
- Tell clients that their personal history is important, but that there isn't time to explore their past. Instead, ask them to tell you two or three critical events that they believe you should know. Also, ask them about (a) sexual abuse, (b) physical abuse, (c) traumatic experiences, (d) suicide attempts, (e) episodes of violent behavior or loss of personal control, (f) brain injuries or pertinent medical problems and treatments, and (g) current suicidal or homicidal impulses.
- Emphasize goals and solutions rather than problems and causes.
- Give clients a homework assignment to complete between sessions. This can include, for example, CBT self-monitoring or a solution-oriented exception assignment.
- After the initial session, write up a treatment plan that you can review with clients and have them sign at the beginning of the second session.

**VIDEO  
8.5**

## The Intake Report

Report writing is a unique challenge. Before you begin, consider the areas described next.

### Remembering Your Audience

When you write an intake report, are you writing it for yourself, your client, your supervisor, or your client's insurance company? The answer: All of the above. As you write, imagine a diverse audience with various perspectives is peering over your shoulder.

If you imagine that you're writing for your supervisor, you might want to emphasize your diagnostic skills through a sophisticated discussion of client psychopathology; you also might use CBT jargon like "consequential thinking," "response cost," and "behavioral rehearsal." In contrast, if you imagine your client as your primary audience, you should avoid the CBT jargon—and de-emphasize complex discussions of psychopathology.

The complete answer to "Who's looking over your shoulder?" might expand (at least) to the following list of people and agencies:

- Your client
- Your supervisor
- Your agency administrator
- Your client's attorney
- Your client's former spouse
- Your client's insurance company
- Your professional colleagues
- Your professional association's ethics board
- Your local, state, or professional ethics board

After reviewing this list, some beginning therapists throw up their hands in frustration and consider writing multiple versions of the same report. This solution might be fine, except that it requires extra work, and, legally, the people on this list could access both reports anyway. Writing a good report is a challenging process; it deserves your close attention to detail and articulate expression. For an intake report structure, see Putting It in Practice 8.3.

**PUTTING IT IN PRACTICE 8.3: THE INTAKE REPORT OUTLINE****Confidential Intake Report**

Note that this outline is an initial guide for writing a thorough intake report. In real-life clinical situations, you'll want to follow your agency guidelines.

NAME:	DATE OF BIRTH:
AGE:	DATE OF INTAKE:
INTAKE INTERVIEWER:	DATE OF REPORT:

**I. Identifying Information and Reason for Referral**

- A. Client name
- B. Age
- C. Sex and gender identity
- D. Racial/ethnic information
- E. Marital status
- F. Referral source (and telephone number, when possible)
- G. Reason for referral (why has the client been sent to you for a consultation/intake session?)
- H. Information sources (e.g., include here files reviewed, length of interview, informants consulted, specific assessment instruments used, etc.)
- I. Presenting complaint (use a quote from the client to describe the complaint)

**II. Behavioral Observations (and/or Mental Status Examination)**

- A. Appearance (including hygiene, body posture, and facial expression)
- B. Quality and quantity of speech and responsiveness to questioning
- C. Client description of mood (use a quote in the report when appropriate)
- D. Affect (your observations of client emotion quality and range)
- E. Primary thought content (including presence or absence of suicide ideation)
- F. Client cooperation or attitude toward the interview
- G. Estimate of adequacy of the data obtained

**III. History of the Current Problem(s) (or Illness)**

- A. Include one paragraph describing the client's presenting problems and associated current stressors.
- B. Include one or two paragraphs outlining when the problem initially began and the course or development of symptoms.

*(Continued)*

- C. Repeat, as needed, paragraph-long descriptions of additional current problems identified during the intake interview. (Client problems are often organized using diagnostic—*ICD* or *DSM*—groupings; however, suicide ideation, homicide ideation, relationship problems, and other symptoms or problems may be listed.)
- D. Follow, as appropriate, with relevant negative or rule-out statements. (For example, with a clinically depressed client, it's important to rule out mania: "The client denied any history of manic episodes.")

#### **IV. Past Treatment History and Family Treatment History**

- A. Include a description of previous problems or episodes not included in section III. (For example, if the client presents with an anxiety problem, but has a history of treatment for an eating disorder, note the eating disorder here.)
- B. Description of previous treatment received, including hospitalization, medications, psychotherapy or counseling, and case management.
- C. List psychiatric and substance abuse disorders in all blood relatives (i.e., parents, siblings, grandparents, and children, but also possibly aunts, uncles, and cousins).
- D. List significant major medical disorders in blood relatives (e.g., cancer, diabetes, seizure disorders, thyroid disease).

#### **V. Relevant Medical History**

- A. List past hospitalizations and major medical illnesses (e.g., asthma, HIV-positive status, hypertension).
- B. Describe the client's current health status (use client or physician quote).
- C. List current medications and dosages.
- D. List primary care physician (and/or specialty physician) and telephone.

#### **VI. Developmental History** (This section is optional and is most appropriate for inclusion in child/adolescent cases.)

#### **VII. Social and Family History** (use categories as needed)

- A. Early memories/experiences
- B. Educational history
- C. Employment history
- D. Military history
- E. Romantic relationship history
- F. Sexual history
- G. Aggression/violence history

- H. Alcohol/drug history (if not previously covered as a primary problem area)
- I. Legal history
- J. Recreational history
- K. Spiritual/religious history

**VIII. Current Situation and Functioning**

- A. A description of typical daily activities
- B. Self-perceived strengths and weaknesses
- C. Ability to complete normal activities of daily living

**IX. Formal Assessment Data**

- A. Self-report questionnaires and rating scales
- B. Projective testing
- C. Data from direct observation or informant (e.g., teacher, parent) ratings
- D. Other formal assessment data

**X. Diagnostic Impressions**

- A. Brief discussion of diagnostic issues
- B. Diagnostic code and label from *ICD-10* or *DSM-5*

**XI. Case Formulation and Treatment Plan**

- A. Case formulation: Include a paragraph description of how you conceptualize the case.
- B. Treatment plan: Include a paragraph description (or list) of recommended treatment procedures and goals.

## The Ethics of Report Writing

Report writing involves the same ethical principles and practices as record keeping and documentation in general (see Chapter 2). If you have an explicit records management policy included in your informed consent, use secure records storage, and closely manage records requests, you're already handling most ethical issues. However, intake reports bring three additional ethical challenges to the forefront: (a) collateral information and informants, (b) using nondiscriminatory language, and (c) sharing reports with clients.

### ***Collateral Information and Informants***

*Collateral information* is information or data obtained through a third party. This information can be obtained via a separate interview or through

written documentation (e.g., file review). Individuals who provide you with information are typically referred to as *collateral informants*. Common collateral information sources include:

- Parent or teacher interviews
- Interviews with spouse or other family members
- Psychiatric hospital discharge summary
- Records from probation or parole officers
- School testing records
- Previous psychological evaluations
- Military discharge records

Written permission is required to obtain collateral information. The only exception to this is if you're working in an agency that has preexisting client information. In these cases, the client probably already signed an informed consent document allowing therapists employed at the agency to have access to records. The permission will be in place, and you won't have to obtain it yourself. For example, if you're working in a medical clinic or mental health center and a physician already has seen the client, you may automatically have access to an electronic records database or paper records before seeing the client. This probably will be assumed, but you should still inform your clients that you have read their medical/psychological records. (*Please note:* Organizations and individuals relying on electronic systems for maintaining confidential records must closely adhere to the Health Insurance Portability and Accountability Act of 1996 [HIPAA]. Information about HIPAA compliance is available on the Internet and in many books and journals.)

If you're interviewing a collateral informant, you'll need an informed consent document that articulates the nature and purpose of the interview. This is true even if your client is in the room during the collateral interview. For example, if you're interviewing the spouse of an extremely depressed client and the spouse is in the room, you should repeat the informed consent information:

Thanks for coming in to share information about your partner. Hearing your perspective is very important. Before we begin, I want to let you know that because what you say today may help with goal setting and guide our counseling, I'll be including information you provide in my intake report and noting that I received it from you. Also, unless I have your partner's written permission, I won't share any details of her treatment with you. Of course, she can choose to tell you about her

therapy, but I wanted to let you know that today is all about me listening to your perspective and not about me sharing information about her with you. Does that make sense?

If the spouse (client) isn't present, you might add:

Although what you say is confidential and I won't share it outside this office, because your partner is my main client, anything you say to me, I may share with her. I wanted to make that clear before we start.

The purpose of collateral information is to enhance assessment, diagnosis, and treatment planning. For example, when clients present with a complex array of mental health symptoms, reading about their previous diagnoses and reviewing their treatment records can prevent you from making mistakes that other practitioners have already made. Similarly, because clients aren't always skilled at articulating their symptoms, having information from a family member can be invaluable as you develop a diagnosis and treatment plan.

### ***Using Nondiscriminatory Language***

No matter how careful and sensitive writers try to be, it's still possible to offend someone. Writing with sensitivity and compassion toward all potential readers is difficult, but mandatory.

The publication manual of the American Psychological Association (APA) provides guidance regarding nondiscriminatory language:

APA is committed both to science and to the fair treatment of individuals and groups, and this policy requires that authors who write for APA publications avoid perpetuating demeaning attitudes and biased assumptions about people in their writing. Constructions that might imply bias against people on the basis of gender, sexual orientation, racial or ethnic group, disability, or age are unacceptable. (American Psychological Association, 2010b, pp. 70–71)

Avoiding bias and demeaning attitudes is mostly straightforward. In addition to following the APA's guidance and writing for a multidimensional audience, the best advice we have is to encourage you to conceptualize and write your intake report collaboratively. This means:

1. At the beginning and toward the end of your session, speak directly with your client about the content you plan to include in the report.
2. Rather than surprising clients with a diagnosis, be explicit about your recommended diagnosis and diagnostic rationale.

3. Discuss your treatment plan openly with clients. Doing so serves the dual purpose of providing clients with advance information and getting them more invested in treatment.
4. If you're not clear about how your client would like to be addressed in the report (Mr., Ms., etc.), ask directly. If you're working with a client who has a physical disability, check to see if person-first or disability-first language is preferred (see Multicultural Highlight 8.1).

### **MULTICULTURAL HIGHLIGHT 8.1: PERSON-FIRST OR DISABILITY-FIRST LANGUAGE?**

Since at least the early 1980s, there has been a strong movement within education, rehabilitation, and psychology toward using person-first language (Wright, 1983). *Person-first language* emphasizes the person rather than impairments or disabilities. The goal is to "preserve disabled people's humanity while promoting their individuality" (Dunn & Andrews, 2015, p. 258). For example, instead of referring to an individual as "a visually impaired client," person-first language is "a client with a visual impairment."

Person-first language has strong supporters and dissenters (Bickford, 2004; Jensen et al., 2013). The APA advocates person-first language: "The guiding principle for 'nonhandicapping' language is to maintain the integrity of individuals and human beings. Avoid language that equates persons with their condition" (2010b, p. 69). However, speaking from the disability-first perspective, the National Federation of the Blind wrote:

We believe that it's respectable to be blind, and although we have no particular pride in the fact of our blindness, neither do we have any shame in it. To the extent that euphemisms are used to convey any other concept or image, we deplore such use. We can make our own way in the world on equal terms with others, and we intend to do it. (quoted in Bickford, 2004, p. 121)

To make matters more complex, Bickford (2004) reported that people with disabilities often have either no preference for person-first versus disability-first language or prefer disability-first language. And a recent article in the *American Psychologist* strongly advocated for disability-first language (Dunn & Andrews, 2015).

As advocates for individuals in need of mental health services, we find this debate fascinating on many levels. Although language can shift attitudes and increase consciousness, individuals with disabilities (aka disabled individuals) have a right to reject person-first language and claim their disabilities as a central part of their identities.

The issue may be less controversial with regard to mental health labels. Even though mental health diagnosis-first language is easier (e.g., "the depressed child") than person-first language

(e.g., “the child with depression”), the difference is crucial. Using diagnosis-first language suggests chronicity and identity. Being a depressed client leaves less possibility for positive change and growth than being a client with depression.

In the end, although we lean toward using person-first language with individuals who are experiencing mental disorders, we also remain open to respecting their views on the topic and collaborating with them on the best language to use.

### ***Sharing Intake Reports With Clients***

Clients have a legal right to access their medical-psychological-counseling records. You or your agency should have policies and procedures in place for releasing reports directly to clients. This reduces the likelihood that clients will misunderstand or misinterpret what you’ve written.

In most cases, the following guidelines are recommended:

- Inform clients at the outset of counseling that you keep records and that they have access to them.
- When appropriate, inform clients that portions of their records (e.g., diagnostic information, testing results) are written to communicate with other professionals; consequently, the records may not be easy to read or understand.
- If possible, meet with clients, free of charge, to review the records before releasing them.
- If clients are no longer seeing you, are angry with you, or refuse the free appointment, you can (a) release records without a meeting (and hope they’re not misinterpreted) or (b) offer to release the records to another licensed professional (who can review them with the client).
- Remember, you have to release the records—one way or another. Therefore, be polite and collaborative throughout the records request process.
- If you have a supervisor or work at an agency, defer to your supervisor’s authority or agency policy (both of which should be spelled out in the informed consent document).

When clients request their records, remain calm, acknowledge their rights, and follow your records-sharing procedures. Most clients will be satisfied if you treat them with compassion and respect *and* if your records are written in a compassionate and respectful manner.

## Choosing the Structure and Content of Your Report

Intake report structure varies depending on professional affiliation, clinical setting, and personal preference. For instance, social workers usually write longer sections on psychosocial history, whereas psychiatrists emphasize medical history, mental status, and diagnosis. The following structure (and outline in Putting It in Practice 8.3) won't please everyone; you should modify it to suit your needs and interests. Also, keep in mind that the following structure errs on the side of thoroughness; abbreviated intake reports may be preferred.

### ***Identifying Information and Reason for Referral***

After listing the client's name and other essential information, most intake reports begin with a narrative section to orient the reader to the report. This section is one or two short paragraphs and includes identifying information and a summary of the reasons for referral. Psychiatrists label this initial section "Identifying Information and Chief Complaint," but the substance is similar:

John Smith, a 53-year-old married male of Euro-American descent, was referred for psychotherapy by his primary care physician, Emil Rodriguez, MD (509-555-5555). Dr. Rodriguez described Mr. Smith as "moderately depressed" and as suffering from "intermittent anxiety, insomnia, and distress associated with recent job loss." During his initial session, Mr. Smith confirmed these problems and added that "troubles at home with the wife" and "finances" were furthering his discomfort and "shame."

### ***Behavioral Observations (and Mental Status Examination)***

After the initial section, the intake report turns to specific behavioral observations. Depending on your institutional setting, these observations may or may not include a complete mental status report. If you're in a medical setting, inclusion of a mental status examination (MSE) is likely and possibly required. However, because we discuss MSEs in the next chapter, the following example includes the therapist's behavioral observations, with minor references to mental status.

Mr. Smith is a short and slightly overweight man who looks approximately his stated age. He has a European-American lineage. At the time of the interview, his hair was unkempt and he had

slight body odor. Mr. Smith's eyes were intermittently downcast. He engaged in frequent hand wringing. His crossed legs bounced continuously. He spoke deliberately and responded directly to all questions. He described himself as feeling "pathetic" and "hyper." He acknowledged suicide ideation, but denied intent, stating, "I've thought about ending my life, but I'd never do it." Mr. Smith was cooperative with the interview and testing procedures. As a consequence, the following information is likely an adequate representation of his past and present condition.

### ***History of the Current Problem(s) (or Illness)***

This section is for reporting the client's particular problem in detail, along with its unique evolution. The history and description of several problems may be included. Medically oriented practitioners use "illness" when titling this section.

Mr. Smith reported feeling "incredibly down" for the past 6 weeks, after being laid off from his job as a millworker at a local wood-products company. For about two weeks after receiving his notice, he aggressively campaigned against termination and, along with several co-workers, consulted an attorney. After it became apparent that he had no legitimate claim against the company, he went for two job interviews, but reported "leaving in a panic" during the second interview. Subsequently, he began having difficulty sleeping, started snacking all day and night, and quickly gained 10 pounds. He also reported difficulty concentrating, feelings of worthlessness, and suicide ideation. He stated: "I've lost my confidence. I got nothing to offer anybody. I don't even know myself anymore."

Mr. Smith indicated he had "Never!" had previous depressive or anxiety symptoms. He denied recurrent panic attacks and minimized the significance of his "panic" during the job interview, claiming "I was just getting in touch with reality. I don't have much to offer an employer."

### ***Past Treatment (Psychiatric) History and Family Treatment (Psychiatric) History***

This section may be brief or extensive. It often includes reference to previous records. Unless there's something about the previous treatment

that warrants specification (e.g., a particular form of treatment, such as “dialectical behavior therapy”), you might simply make a summary statement:

This client was seen previously by a number of mental health providers for the treatment of posttraumatic stress disorder, substance abuse, and depression.

Family history of psychiatric problems is also included in this section (although some report writers devote a separate section to this topic).

Mr. Smith has never received mental health treatment previously. His physician reported that Mr. Smith was offered antidepressant medications, but refused them in favor of a trial of psychotherapy.

Initially, Mr. Smith reported that no one in his family had ever seen a mental health professional, but later admitted his paternal uncle suffered from depression and received “shock therapy” back in the 1960s. He didn’t know the nature of his uncle’s problem. He denied other family-related mental health problems.

### ***Relevant Medical History***

Depending on how much information you received from your client’s physician and on how closely you covered this area during the intake, you may or may not have much medical history to include. At minimum, ask your client about (a) general health, (b) any recent or chronic physical illnesses or hospitalizations, (c) prescription medications, and (d) most recent physical exam.

Mr. Smith’s primary care physician did not provide a medical history. During the interview, Mr. Smith described himself as in good health. He denied major illnesses or hospitalizations during his youth. He noted he “rarely gets sick” and that his employment attendance was excellent. His only reported major medical problems and associated treatments were for kidney stones (1999 and 2010) and removal of a benign polyp from his colon (2008). He reported currently taking vitamins, but not prescription medications. Mr. Smith’s primary care physician is Dr. Emil Rodriguez.

## ***Developmental History***

The developmental history begins before birth and focuses primarily on developmental milestones. A developmental history is used primarily when working with child or adolescent clients.

## ***Social and Family History***

Writing a social and family history can be like writing a novel. Everyone's life takes twists and turns; your goal is to condense the client's life into a tight narrative. Be brief, relevant, and organized, and include essential highlights only. The depth, breadth, and length of your social/developmental history depend on the purpose and setting.

Mr. Smith was born and raised in Kirkland, Washington, a Seattle suburb. He was the third of five children born of Edith and Michael Smith. His parents, now in their late 70s, are married and live in Kirkland. Mr. Smith remains close to them, visiting several times a year. He expressed concern about their declining health. He reported no significant conflicts or problems in his relationships with his parents or siblings.

Mr. Smith characterized his early childhood memories as "normal." He described his parents as "loving and strict." He denied sexual or physical abuse in his family of origin.

Mr. Smith graduated from Lake Washington High School in Kirkland in 1980. He described himself as "an average student." He had minor disciplinary problems, including numerous detentions (usually for failing to turn in his homework) and one suspension (for fighting on school grounds).

Following graduation, Mr. Smith moved to Spokane, Washington, and briefly attended Spokane Falls Community College. During this time, he met his eventual wife and decided to seek employment, rather than pursue college. He worked briefly at a number of jobs, eventually obtaining employment at the local wood-products plant where he worked for 31 years. Mr. Smith never served in the military.

In terms of demeanor, Mr. Smith indicated he has always been (until recently) "friendly and confident." He dated in high school. He met Irene, the woman he married, in 1981, at age 19. He described her as "the perfect fit" and reported being "a happily married man." He denied sexual difficulties, but acknowledged diminished sexual interest and desire over the past month.

Mr. Smith and his wife have been married 35 years. They have three children (two sons and one daughter; ages 26 to 32), all of whom live within 100 miles of Mr. and Mrs. Smith. According to Mr. Smith, all of his children are doing well. He reported regular contact with his children and five grandchildren.

*(Continued)*

Mr. Smith occasionally got in “fights” or “scuffles” during his school years, but emphasized that such behavior was “normal.” He denied ever using a weapon in a fight and reported that his most recent physical altercation was just after quitting college, “back when I was about 20.”

Mr. Smith drank recreationally in high school and college. He also went out with his buddies for “beers” every Friday after work. He briefly experimented with marijuana while in college, but claimed, “I didn’t like it.” He’s never experimented with “harder” drugs and denied problems with prescription drugs, stating: “I avoid ‘em when I can.”

Other than a few speeding tickets, Mr. Smith denied legal problems. In college he was cited once for “disorderly conduct” outside a bar with a group of friends. He had to pay a small fine and write a letter of apology to the business owner.

Mr. Smith’s favorite recreational activities are bowling, fishing, and duck hunting. He and his wife enjoy gambling at a local casino. He denied ever losing significant money. He doesn’t consider his gambling to be a problem. He has diminished interest in recreational activities subsequent to losing his job.

Mr. Smith was raised Catholic and reported attending church “off and on” for most of his life. He is currently in an “off” period. He hasn’t attended for about nine months. His wife continues to attend regularly. He considers himself a “Christian” and a “Catholic.”

### ***Current Situation and Functioning***

This section focuses on three main topics:

1. Usual daily activities
2. Client self-perception of personal strengths
3. Ability to perform age-appropriate activities of daily living (ADLs)

You can expand on this section with a description of client psychological functioning, cognitive functioning, emotional functioning, or personality functioning. This is a chance to include your subjective appraisal of current client functioning in a variety of areas.

During a typical day, Mr. Smith rises at 7 a.m., has coffee and breakfast with his wife, reads the newspaper, and then moves to the living room to watch the morning news. He reads the “classified” section closely for job opportunities, circling positions of potential interest. However, he

doesn't follow up. Instead he watches television or "putters around" in his garage or backyard. He eats lunch and then continues putting. At about 5:30 p.m., his wife returns home from her job as an administrator at a local nonprofit corporation. Occasionally, she reminds him of his plans to get a new job, but Mr. Smith indicated that he usually responds with irritation ("It's like I try to bite her head off"). She retreats to the kitchen and makes dinner. After dinner, he continues watching television late into the night. His usual routine is interrupted on the weekends, often by visits from his children and grandchildren and sometimes when he and his wife venture out to a local casino to "spend a few nickels." (However, he indicated their weekend activities are limited because of tightening finances.)

Mr. Smith sees himself as having several strengths. He considers himself an honest, hard-working, and devoted husband and father. He believes he's a good friend. He reported: "I was fun to be around back when I was working and had a life." In terms of intelligence, Mr. Smith claimed he is "no dummy" but that he is having some trouble concentrating and remembering anything lately. When asked about personal weaknesses, Mr. Smith stated, "I hope you got lotsa ink left in that pen of yours, Doc," but primarily focused on his current state of mind, which he described as "being a problem of not having the guts to get back on that horse that bucked me off."

Despite poor hygiene and lack of productiveness, Mr. Smith seems capable of adequately performing most activities of daily living. He reported occasionally cooking dinner, fixing the lawnmower, and taking care of other household and maintenance tasks. He perceives himself as less efficient with most tasks because of distractibility and forgetfulness. His interpersonal functioning appears limited, as he described relatively few current outside involvements.

### ***Formal Assessment Data***

When intake interviews include substantial psychological testing, this section may be long and detailed. More typically, clinicians either administer a broad-based symptom-focused questionnaire to be used for monitoring treatment response (e.g., the Outcome Questionnaire-45; Mueller et al., 1998). Alternatively, if clinicians know the client's presenting problem in advance, a more focused questionnaire might be employed (e.g., the Beck Depression Inventory-II; A. Beck et al., 1996).

Scale scores and descriptive statements about test results should be included in the intake report. Validity concerns also should be included. Limiting interpretative statements is especially important with diverse clients.

Mr. Smith was administered a Beck Depression Inventory-II (BDI-II) prior to his appointment. His total score was 22, which is in the lower end of the “moderate depression” range. Consistent with his presentation during the interview, he endorsed several items consistent with anhedonia, self-deprecation, and sleep disturbances. He did not endorse any suicidality or suicidal intent items. Mr. Smith agreed to complete the BDI-II every week prior to his appointment as one method for monitoring his depressive symptoms.

### ***Diagnostic Impressions***

Most intake reports include a discussion of diagnostic issues, even if you only discuss broad diagnostic categories (e.g., depression, anxiety, substance use). Clients may need a diagnosis to access insurance benefits. Although simply listing a final diagnosis is sometimes acceptable, providing a brief discussion of diagnostic issues followed by an *ICD-10-CM* or *DSM-5* diagnosis is preferred. The brief discussion orients readers to your diagnostic considerations. In the following excerpt, we use Morrison’s (2007) guideline of assigning the least severe label to explain the symptom pattern.

This 53-year-old male meets diagnostic criteria for an adjustment disorder. Although he also meets diagnostic criteria for major depression, because his depressive symptoms are associated with recent life changes and he has no personal and minimal family history of a mood disorder, an initial diagnosis of adjustment disorder seems more appropriate. Mr. Smith is also experiencing several anxiety symptoms. These symptoms may be more central than his depressive symptoms in interfering with his ability to seek new employment. Similarly, a case could also be made for assigning him an anxiety disorder diagnosis, but again, the abrupt onset of these symptoms in direct association with job loss suggests that his current mental state is better accounted for with a less severe diagnostic label.

His *ICD-10-CM* diagnosis follows:

Axis I:	F43.23 (ICD) Adjustment Disorder with Mixed Anxiety and Depressed Mood (Provisional)
Rule Out (R/O)	F32.0 (ICD) Major Depressive Disorder, Single Episode, Mild

*Note:* The “provisional” tag and a “rule out” diagnostic possibility (major depressive disorder) are methods for expressing diagnostic uncertainty.

### ***Case Formulation and Treatment Plan***

The *case formulation* (or case conceptualization) is your description of factors contributing to the presenting problem. This provides an opportunity

to articulate how you view the case and how that logically relates to your treatment plan. You should keep your theoretical jargon to a minimum so that your client can understand this section.

Mr. Smith is a stable and reliable man who is experiencing an adjustment reaction to sudden unemployment. For many years, much of his identity was associated with his work life. He feels depressed and anxious without the structure of his usual workday. His depression and anxiety symptoms have shaken his confidence. He currently feels unable to pursue employment. This further reduces his confidence and self-respect.

Psychotherapy with Mr. Smith should focus on two simultaneous goals. First, it's crucial that Mr. Smith begin making a consistent effort to seek employment. The treatment objectives associated with this general goal are the following:

1. Analyze factors preventing Mr. Smith from following through on job prospects.
2. Develop physical anxiety coping strategies (including relaxation and daily exercise).
3. Develop and implement cognitive coping strategies (including cognitive restructuring and self-instructional techniques).
4. Develop and implement social coping strategies (including peer or spousal support for job-seeking behaviors).
5. Develop and implement social-emotional coping strategies. (Mr. Smith needs to learn to express his feelings about his personal situation to close friends and family without pushing them away through irritable or socially aversive behaviors.)
6. Help Mr. Smith reframe his goal from (a) securing employment to (b) completing job applications and doing his best during job interviews.

The second general goal for Mr. Smith is to help him expand his identity beyond that of a man who is a long-term employee at a wood-products company. Objectives associated with this second goal are:

1. Helping Mr. Smith recognize valuable aspects of relationships and activities outside employment
2. Helping Mr. Smith identify how he would talk with a person in a similar situation, and then have him translate that attitude and "talk" into a self-talk strategy with himself
3. Exploring with Mr. Smith eventual plans for retirement

Although Mr. Smith's therapy will be individually oriented, his spouse could accompany him to some sessions for assessment and support purposes. It might prove beneficial for them to work together to help him cope more effectively with this difficult and sudden life change.

*(Continued)*

Overall, it's important to encourage Mr. Smith to use his already existing positive personal skills and resources to address this new challenge in his life. We will monitor his depressive symptoms weekly with the BDI-II. After 10 sessions using this approach, we will formally evaluate his progress in therapy.

### Writing Clearly and Concisely

Writing a clear and concise intake report takes time and effort. Don't expect to sit down and write the report perfectly the first time. It may take several drafts before you want anyone to see it. We have several recommendations for making the writing process more tolerable.

- Write the report as soon as possible. (Immediately following the session is ideal; the longer you wait, the harder it is to reconstruct the session.)
- Write an immediate draft without worrying about perfect wording or style; then store it in a secure location and return to it for editing.
- Closely follow an outline; following any outline is better than rambling on about the client.
- Try to get clear information from your supervisor or employer about intake report writing expectations. If a standard format is available, follow it.
- If your agency has sample reports available, look them over and use them as models for your report.
- Like any skill, report writing becomes easier with practice; many seasoned professionals dictate a full intake report in 10 minutes—someday you may do so as well.

Another issue associated with writing concisely involves choosing what information to put into your intake report. How brief and how detailed should you be? How much deeply personal information should be included? Consult with your supervisor on this issue, and remember, sometimes less is better.

### VIDEO 8.6

### Do's and Don'ts of Intake Interviews With Diverse Clients

You'll have many opportunities to conduct intake interviews with clients who are different from you. These differences may involve culture, race, ethnicity, religion, sexuality, or other life experiences. The applicability and

relevance of the following suggestions will vary depending on your particular clinical situation.

#### **When engaging in open inquiry . . .**

- Do ask about tribal, ethnic, or background differences that are obvious or are made obvious by information the client provides.
- Don't insist on a more thorough exploration of these differences than is offered.
- Do realize that acculturation and cultural identity are fluid and developmental.
- Don't assume that all members of a given family group or couple have the same cultural identity or the same experiences interfacing with the dominant culture.

#### **When working with families . . .**

- Do recognize that in many or most nondominant cultures, family is central to identity. Therefore, be attuned to family matters with heightened awareness and sensitivity.
- Don't impose strict definitions of family on your client. Simply be open to the client's sense of family.
- Do graciously allow family members to attend part of an initial interview if requested.

#### **When it comes to communication styles . . .**

- Do remember that patterns of eye contact, verbalizing problems, storytelling, and note taking all have culturally determined norms.
- Do chat, but don't assume an overly familiar style. Strive to show respect.
- Do ask for clarification if something isn't clear.
- Don't ask for clarification in a manner that blames clients for your misunderstanding.

#### **Regarding religious and spiritual matters . . .**

- Do accept the client's beliefs regarding sources of distress: ancestral disapproval, the evil eye, God's wrath, or trouble because of misbehavior in another life. Use approaches that broadly fit within the client's belief system.
- Don't assume you're being told the whole story regarding faith or belief systems. Trust takes more time than you think it will.

- Do take advantage of links to meaningful spiritual or religious beliefs or connections that may help address your client's distress.
- Don't hesitate to allow input from respected religious or spiritual persons.

## Summary

The intake interview is an assessment that involves gathering information to facilitate (a) problem identification (or diagnosis), (b) goal-setting, (c) case formulation, and (d) treatment planning. This chapter described an intake procedure that's more comprehensive than is usually expected or tolerated in a managed care environment.

Three primary objectives of an intake interview are (a) identifying, evaluating, and exploring the chief complaint or problem (and associated therapy goals); (b) obtaining data related to interpersonal behavior and psychosocial history; and (c) evaluating the current life situation and functioning.

Client problems are intrinsically linked to goals. Client problems and goals need to be prioritized and selected for potential therapeutic intervention. Many theory-based assessment systems are available to help analyze and conceptualize client symptoms. Formal assessment can also be used. When formal assessments are used in conjunction with a clinical interview, a collaborative or therapeutic approach is recommended.

Clinicians need to know about the unique context of the client's problems and goals. This can involve personal history taking and an evaluation of the client's interpersonal behaviors. Personal history flows from early memories and descriptions of parents and family experiences to school and peer relationships and employment. Therapists must be selective and flexible regarding client history taking because there's always far more historical information than can be covered in a single interview.

The intake also focuses on the client's current functioning. Therapists should focus on current functioning toward the interview's end because it helps bring clients back in touch with their current situation. The end of the interview should emphasize client personal strengths and environmental resources and should focus on the future, goal setting, and progress monitoring.

Several different factors affect the intake interviewing process. Client registration forms, intake questionnaires, and institutional setting can help determine the focus of an intake. Theoretical orientation and professional background and affiliation also guide the focus of intake interviews.

Insurance-related cost containment can limit the time available for intake interviewing and assessment. When you're conducting brief intakes, the focus is primarily on symptom or diagnostic assessment, treatment planning, and symptom relief. The chapter included a brief intake checklist.

Writing the intake report is challenging. When preparing an intake report, consider: your audience, ethical issues, the structure and content of your report, and use clear and concise writing. It can be useful to interview collateral informants, but when doing so, maintaining confidentiality remains crucial. The chapter included the do's and don'ts of interviewing cultural minority clients.

## Suggested Readings and Resources

The following readings offer additional information about intake interviewing, report writing, and other issues related to the content of this chapter.

- Carlat, D. (2012). *The psychiatric interview* (3rd ed.). Philadelphia, PA: Lippincott, Williams & Wilkins. Coming from a medical model perspective, this book vividly articulates many different dimensions of the psychiatric interview (aka the clinical interview). It has a strong section on the psychiatric history.
- Davis, S. R., & Meier, S. T. (2001). *The elements of managed care: A guide for helping professionals*. Belmont, CA: Thomson Brooks/Cole. Davis and Meier provide counselors and psychotherapists with excellent guidance for navigating the often turbulent seas of managed care and third-party payers.
- Lichtenberger, E. O., Mather, N., Kaufman, N. L., & Kaufman, A. S. (2004). *Essentials of assessment and report writing*. Hoboken, NJ: Wiley. Part of Wiley's "essentials" series, this book will guide you through contemporary assessment and report writing.
- Zuckerman, E. L. (2010). *The clinician's thesaurus: The guide to conducting interviews and writing psychological reports* (7th ed.). New York, NY: Guilford Press. This extensive resource has a substantial section on psychological report writing.



# THE MENTAL STATUS EXAMINATION

## Chapter Orientation

Historically, the mental status examination (MSE) has held a revered place in psychiatry and medicine. In recent years, professional competence in conducting MSEs has expanded to include all mental health professionals. Overall, the MSE offers physicians, psychotherapists, and counselors a unique method for evaluating clients' (or patients') mental condition.

As a mental health professional, you'll need knowledge and skills to understand, administer, and communicate MSEs. This chapter focuses on the basic components of an MSE.

### VIDEO 9.1

## What Is a Mental Status Examination?

A careful analysis of the process of observation in atomic physics has shown that the subatomic particles have no meaning as isolated entities, but can only be understood as interconnections between the preparation of an experiment and the subsequent measurement. . . In atomic physics, we can never speak about nature without at the same time speaking about ourselves.

—Fritjof Capra, *The Tao of Physics*, 1975, p. 19

The *mental status examination* (MSE) is a semi-structured interviewing procedure designed to facilitate and organize clinical observations pertaining to mental status or mental condition. The primary purpose of the MSE is to evaluate current cognitive processes (Strub & Black, 1977; Zuckerman, 2010). Many different approaches

## LEARNING OBJECTIVES

After reading this chapter, you will be able to:

- Describe a mental status examination (MSE) and brief MSE reports
- Identify and manage individual and cultural issues during MSEs
- List and describe the basic components of an MSE: client appearance; behavior; attitude; affect and mood; speech and thought; perceptual disturbances; orientation and consciousness; memory and intelligence; and client reliability, judgment, and insight
- Identify when you do and don't need to administer a complete MSE

to evaluating mental status exist. Some approaches focus on psychiatric symptoms; others focus primarily on neurological symptoms. In a quick PsycINFO search over the past several years, we found a variety of MSE interview protocols, including: (a) the Mini-Mental State Examination, (b) the Modified Mini-Mental State Examination, (c) the Saint Louis University Mental Status Examination, and (d) the Autism Mental Status Examination (Brown, Lawson, McDaniel, & Wildman, 2012; Grodberg, Weinger, Kolevzon, Soorya, & Buxbaum, 2012; Zimmer, Chovan, & Chovan, 2010). Rather than following a strict structured protocol, the MSE described in this chapter is a generic psychiatric model that focuses more on potential mental disorders and less on neurological functioning. Other chapters in this text are devoted to the related topics of intake interviewing (Chapter 8), suicide assessment (Chapter 10), and diagnosis and treatment planning (Chapter 11).

For psychiatrists, the MSE is similar to the physical examination in general medicine. In hospitals, psychiatrists sometimes request daily MSEs for acutely disturbed patients. Results are reported in concise descriptions of approximately one medium-length paragraph per patient (see Putting It in Practice 9.1). Anyone seeking employment in the medical domain should be competent in communicating mental status. This is why physician, psychotherapist, and counselor training all now include MSE skill development. MSEs and short mental status reports allow communication of important information in a format commonly understood among health professionals.

### **PUTTING IT IN PRACTICE 9.1: MENTAL STATUS EXAMINATION REPORTS**

A good report is brief, clear, and concise, and addresses the areas described in this chapter.

#### **Mental Status Report 1**

Gary Sparrow, a 48-year-old heterosexual White male, was disheveled and unkempt upon arriving at the hospital emergency room. He wore dirty khaki pants, an unbuttoned golf shirt, and white shoes. He appeared slightly younger than his stated age. He looked agitated, frequently standing up and changing seats. He was impatient and sometimes rude. Mr. Sparrow reported that today was the best day of his life, because he had decided to join the professional golf circuit. His affect was labile, but appropriate to the content of his speech (i.e., he became tearful when reporting he had “bogeyed number 15”). His speech was loud, pressured, and overelaborative. He exhibited loosening of associations and flight of ideas; he unpredictably shifted the topic of conversation from golf to the mating habits of geese to the likelihood of extraterrestrial life. Mr. Sparrow described grandiose delusions regarding his sexual and athletic performances.

He reported auditory hallucinations. (God had told him to quit his job to become a professional golfer.) He was oriented to time and place, but claimed he was the illegitimate son of Jack Nicklaus. He denied suicide and homicide ideation. He refused to participate in intellectual- or memory-related portions of the examination. Mr. Sparrow was unreliable and had poor judgment. Insight was absent.

### Mental Status Report 2

Ms. Audrey George, a 77-year-old African American female, was evaluated during routine rounds at Cedar Springs Nursing Home. She was 5 feet tall, wore a floral print summer dress, held tight to a matching purse, and appeared approximately her stated age. Her grooming was adequate, and she was cooperative. She reported her mood as “desperate” because she had recently misplaced her glasses. Her affect was characterized by intermittent anxiety, generally associated with having misplaced items or with difficulty answering the examiner’s questions. Her speech was slow, halting, and soft. She repeatedly became concerned with her personal items, clothing, and general appearance, wondering where her scarf “ran off to” and occasionally inquiring about whether her appearance was acceptable (e.g., “Do I look okay? I have lots of visitors coming by later”). Ms. George was oriented to person and place, but indicated the date as January 9, 1981 (today is July 8, 2015). She was unable to calculate serial sevens and after recalling zero of three items, became briefly anxious and concerned, stating “Oh my, I guess you pulled another one over me, didn’t you, sonny?” She maintained a pleasant style, stating “And you’re such a gem for coming to visit me again.” Her proverb interpretations were concrete. Judgment, reliability, and insight were significantly impaired.

## Individual and Cultural Considerations

VIDEO  
9.2

If you’re regularly conducting MSEs, it’s easy to become overconfident in your ability to make quick judgments about clients’ mental health. Thinking about objectivity and being aware of the dangers of single-symptom overgeneralization can help temper the strength of your conclusions.

### Thinking About Objectivity

To assume that another human’s mental status can be quickly evaluated is both exciting and presumptuous. The excitement comes from being able to objectively analyze and rate another person’s mental status in a wise and helpful way. But the idea that anyone can fully and accurately assess the mental functioning of someone else—and do so quickly—is rather presumptuous. For better or worse, however, sometimes mental health

professionals must make judgment calls in situations that don't allow for the development of a long-term relationship. In those situations, it's crucial to have a structured or semi-structured interview protocol for evaluating clients and a standard format for communicating evaluation results to other professionals.

Total objectivity requires emotional neutrality. In the opening quotation, Capra (1975) articulated why neither objectivity nor neutrality is possible. Similar to the subatomic particles that were the subject of Capra's observations, mental status examiners aren't completely separate from their examinees. When conducting an MSE, you're simultaneously participant and observer. It's impossible to completely detach yourself and objectively observe and evaluate clients. For example, we're certain you can recall a time when someone's mood, or something someone said to you, affected you emotionally or even physically. And we're equally certain you've had similar effects on the mood or behaviors of others. Such is the nature of human interaction.

Objectively evaluating clients becomes even more complex when you consider this: Your mood or beliefs not only can interfere with objective mental status evaluations but also can help you be a better evaluator! This is because it's possible to *use* your emotional connection and emotional reactions to more completely understand the person with whom you're working. Understanding how and why clients affect you can be illuminating and helpful. The challenge of MSEs is to balance emotional sensitivity with appropriate objective detachment.

Like all assessment procedures, MSEs are vulnerable to error. This is especially the case if an examiner lacks multicultural knowledge, sensitivity, and humility. To claim that client mental states are partly a function of culture is an understatement; culture can *determine* an individual's mental state. As captured by the following excerpt from Nigerian novelist Chinua Achebe (1994), perceptions of madness depend on one's cultural perspective:

After the singing the interpreter spoke about the Son of God whose name was Jesu Kristi. Okonkwo, who only stayed in the hope that it might come to chasing the men out of the village or whipping them, now said:

"You told us with your own mouth that there was only one god. Now you talk about his son. He must also have a wife, then." The crowd agreed.

"I did not say He had a wife," said the interpreter, somewhat lamely...

The missionary ignored him and went on to talk about the Holy Trinity. At the end of it Okonkwo was fully convinced that the man was mad. (pp. 146–147)

Specific cultural beliefs, especially spiritual beliefs, can sound like madness (or delusions) to outsiders. The same can be said about beliefs and behaviors associated with physical illness, recreational activities, and marriage and family rituals. In some cases, fasting might be considered justification for involuntary hospitalization, whereas in other cases, fasting—even extended fasting—is associated with spiritual or physical practices (Polanski & Hinkle, 2000). Overall, interviewers must sensitively consider individual and cultural issues before coming to conclusions about a client's mental state. (For more on this, see Multicultural Highlight 9.2 toward the end of this chapter.)

### The Danger of Single-Symptom Generalization

As you read this chapter and gain knowledge about the potential diagnostic meaning of specific symptoms, you may be tempted to make sweeping judgments about clients based on minimal information. This is a natural temptation, and like many temptations, it should be resisted. For example, in a book titled *The Mental Status Examination and Brief Social History in Clinical Psychology*, H. F. I. Smith (2011) stated:

A Fu-Manchu mustache suggests the wearer doesn't mind being thought of as "bad," whereas a handlebar mustache tells you the person may be somewhat of a dandy or narcissist. (p. 4)

After reading the preceding excerpt, we decided to conduct a small research study by surveying men in Montana with Fu-Manchu mustaches. Whenever we saw men sporting a Fu-Manchu, we asked them to rate (on a 7-point Likert scale) whether they minded being thought of as "bad." In contrast to H. F. I. Smith's (2011) observations, we found that most men with Fu-Manchus reported wearing their mustache in an effort to look good and be more attractive. Of course we didn't really conduct this survey, but the fact that we *thought* about doing it and *imagined* the results carries about the same validity as the wild assumption that a mental status examiner can quickly "get into the head" of all clients with Fu-Manchu (or handlebar) mustaches and accurately interpret their underlying personal beliefs or intentions or, even worse, assign a personality disorder diagnosis.

Although we're poking fun at H. F. I. Smith's (2011) overgeneralizations, our intent is to note how easy it is to grow overconfident when

making mental status judgments. Like Smith, we've sometimes made speculative assumptions about the pathological meaning of specific behaviors. (For example, John reluctantly admits to developing his own theory about tanning behaviors and narcissism years ago.) The key to dealing with this natural tendency toward overconfidence is to use Stanley Sue's (2006) scientific-mindedness concept. Symptoms should be viewed as hypotheses worthy of further exploration.

Another example from H. F. I. Smith (2011) is illuminating. He stated: "If the person is unshaven, this may be a sign of depression, alcoholism, or ... poor ability at social adaptation" (p. 4).

Smith may be correct in his hypotheses about unshaven clients. In fact, if a research study were conducted on diagnoses or symptoms commonly associated with unshavenness, it might show a small correlation with depressive symptoms, partly because poor hygiene can be associated with depression. However, in the absence of additional evidence, an unshaven client is just an unshaven client. And when it comes to social adaptation, we know many young men (as well as a variety of movie stars) who consider the unshaven look desirable and sexy. This could lead to an equally likely hypothesis that an unshaven client is particularly cool or has an especially high level of social adaptation.

We encourage you to adopt the following three guidelines to avoid making inappropriate overgeneralizations based on single symptoms:

1. When you spot a single symptom or client feature of particular interest, engage your scientific mindedness.
2. Remember that hypotheses are not conclusions; they're guesses that require additional supporting evidence.
3. Don't make wild inferential leaps without first consulting with colleagues and/or supervisors; it's easier to make inappropriate judgments when working in isolation.

Keep these preceding guidelines in mind as you review the nine generic MSE domains.

## VIDEO 9.3

### The Generic Mental Status Examination

The main categories covered in a generic psychiatrically oriented MSE vary slightly among practitioners and settings (R. Baker & Trzepacz, 2013). This chapter consists of the following:

1. Appearance
2. Behavior/psychomotor activity

3. Attitude toward examiner (interviewer)
4. Affect and mood
5. Speech and thought
6. Perceptual disturbances
7. Orientation and consciousness
8. Memory and intelligence
9. Reliability, judgment, and insight

During an MSE, observations are organized to establish hypotheses about the client's *current mental or cognitive functioning*. Although MSEs provide important diagnostic information, and research on the reliability and validity of specific MSE protocols exists, an MSE is not primarily or exclusively a diagnostic procedure, nor is it considered a formal psychometric assessment (Polanski & Hinkle, 2000; Zuckerman, 2010). MSEs are best classified as semi-structured assessment interviews.

## Appearance

Mental status examiners take note of their clients' general appearance. Observations are limited primarily to physical characteristics, but demographic information is sometimes included.

Physical characteristics commonly noted on an MSE include personal grooming (including the presence of particular mustache styles), dress, pupil dilation/contraction, facial expression, perspiration, make-up, body piercing, tattoos, scars, height, weight, and physical signs possibly related to medical status (Daniel & Gurczynski, 2010). Examiners should closely observe not only how clients look but also how they physically react or interact. For example, Shea (1998) wrote: "The experienced clinician may note whether he or she encounters the iron fingers of a Hercules bent upon establishing control or the damped palm of a Charlie Brown expecting imminent rejection" (p. 9).

A client's physical appearance is at least partially a manifestation of mental state. Physical appearance also may be linked to a mental disorder diagnosis. For example, dilated pupils are sometimes associated with drug intoxication, and pinpoint pupils with drug withdrawal. Of course, dilated pupils aren't conclusive evidence of drug intoxication. Further evidence is needed.

Client sex, age, race, and ethnic background are also noted during an MSE. These factors can be related to psychiatric diagnosis and treatment planning. As Othmer and Othmer (2002) noted, the relationship between appearance and biological age may have significance. There are

many reasons why clients might appear older than their stated age. An older appearance could be related to drug or alcohol abuse, severe depression, chronic illness, or a long-term mental disorder.

In a mental status report, a client's appearance might be described as follows:

#### **SAMPLE APPEARANCE DESCRIPTION**

Maxine Kane, a 49-year-old single, self-referred, Australian American female, appeared much younger than her stated age. She was tall and thin and arrived for the evaluation wearing sunglasses, a miniskirt, spike heels, heavy makeup, and a contemporary bleached-blond hairstyle.

A client's physical appearance may also be a manifestation of his or her environment or situation (Paniagua, 2010). In the preceding example, it would be important to know that Ms. Kane came to her evaluation appointment directly from her place of employment—the set of a television soap opera.

#### **Behavior or Psychomotor Activity**

Mental status examiners watch for physical movements, such as excessive or reduced eye contact (keeping cultural differences in mind), grimacing, excessive eye movement (scanning), odd or repeated gestures, and posture. Clients may deny experiencing particular thoughts or emotions (e.g., paranoia or depression), although their body movements suggest otherwise (e.g., vigilant posturing and scanning or slowed psychomotor activity and lack of facial expression).

Excess body movements may be associated with anxiety, drug reactions, or the manic phase of bipolar disorder. Reduced movements may represent an organic brain condition, catatonic schizophrenia, or drug-induced stupor. Depression can manifest either via agitation or psychomotor retardation, although severe depression is more likely to include psychomotor retardation (Buyukdura, McClintock, & Croarkin, 2011). Clients with paranoid symptoms may scan their visual field to be on guard against external threat. Repeated motor movements (such as dusting off shoes) may signal the presence of obsessive-compulsive disorder. Repeated picking of imagined lint or dirt off clothing or skin can indicate delirium or toxic reactions to drugs/medications.

Each of these single symptoms or observations may or may not be linked to psychopathology. Many contextual factors, including the interview itself, can contribute to behaviors that look as though they could represent a diagnostic condition. Another example from H. F. I. Smith (2011) helps illustrate the importance of symptom context.

I have noticed, for example, that virtually every patient who has a rapid bob of the foot when she is in the exam, has a high degree of pathology. (p. 5)

In this situation, the client could be nervous simply because her therapist has an unusually large handlebar mustache.

#### SAMPLE BEHAVIOR/PSYCHOMOTOR ACTIVITY DESCRIPTION

The client scratched at her legs, back, and stomach throughout the interview. When asked about the scratching, she said, "Oh, you wouldn't believe the mosquito storm I got caught in when I took out the garbage last night. I think I counted 57 bites."

### Attitude Toward Examiner (Interviewer)

*Attitude toward the examiner* refers to how clients *behave* in relation to the interviewer. *Attitude* can be described as a settled way of thinking about a person or thing and is usually evidenced through overt or subtle behavior. Attitudes have affective components that may be linked to the client's evaluation of the situation or the examiner. Considering the range of attitudes clients can exhibit during an interview (e.g., aggressive, oppositional, seductive) provides you with a sense of the complex cognitive, affective, and interpersonal components of an attitude.

Physical characteristics and movements provide a foundation for evaluating client attitude. Also, observations regarding client responsiveness to interviewer questions—including nonverbal factors such as voice tone, eye contact, and body posture, as well as verbal factors such as response latency, and directness or evasiveness of response—all help interviewers determine client attitude. Later in the chapter, we'll discuss speech and voice qualities.

Judgments about client attitude are susceptible to interviewer subjectivity. For example, a heterosexual male interviewer may infer seductiveness from the behavior of an attractive female because he wishes her to behave seductively, rather than because she engaged in actual seductive

behavior. What's judged as seductive by an examiner may not fit the client's view of seductive. Individual or cultural backgrounds can cause differences in perception and judgment.

When describing client attitude, it's especially helpful to identify the observations supporting your description. In mental health settings, clinicians may be encouraged to use the concept of "as evidenced by" (AEB) to support their statements (J. Swank, personal communication, August 7, 2012).

### SAMPLE ATTITUDE TOWARD THE EXAMINER DESCRIPTION

The client's attitude toward the examiner was hostile as evidenced by (AEB) repeated eye-rolls, sarcastic comments, and intermittent use of the word "duh."

Table 9.1 lists words for describing client attitude toward the examiner.

**Table 9.1** Potential Descriptors of Client Attitude

**Aggressive:** The client attacks the examiner physically or verbally or through grimaces and gestures. The client may "flip off" the examiner or simply say something like "That's a stupid question."

**Cooperative:** The client responds directly to interviewer comments or questions. There's an effort to work with the interviewer to gather data or solve problems. Frequent head nods and receptive body posture are common.

**Guarded:** The client is reluctant to share information. When clients are mildly paranoid, they may guard against personal disclosure or affective expression.

**Hostile:** The client is indirectly nasty or biting. Sarcasm, rolling of the eyes, or staring into space may represent subtle, or not so subtle, hostility. This behavior pattern can be more common among young clients.

**Impatient:** The client is on the edge of his seat. The client is not tolerant of pauses or of times when interviewer speech becomes deliberate. He or she may make demands about wanting answers immediately.

**Indifferent:** The client's appearance and movements suggest lack of concern or interest in the interview. The client may yawn, drum fingers, or become distracted by irrelevant details.

**Ingratiating:** The client is overly solicitous of interviewer approval. He or she may try to present as overly positive, or may agree with everything the interviewer says. There may be excessive head nodding, eye contact, and smiles.

**Manipulative:** The client tries to use the examiner. Examiner statements may be twisted to represent the client's best interests. Statements such as "His behavior isn't fair, is it, Doctor?" may represent manipulation.

**Open:** The client openly discusses problems and concerns. The client may also have a positive response to examiner ideas or interpretations.

**Oppositional:** The client opposes what the examiner says. There may be disagreements with paraphrases or summaries that appear accurate. The client may refuse to answer questions or may be silent. This behavior is also called oppositional.

**Seductive:** The client may move in seductive or suggestive ways. He or she may expose skin or make efforts to be "too close" to or to touch the examiner. The client may make flirtatious and suggestive verbal comments.

**Suspicious:** The client may repeatedly look around the room (e.g., checking for hidden microphones). Squinting or looking out of the corner of one's eyes also may be interpreted as suspiciousness. The client may ask questions about the examiner's notes or about why such information is needed.

## Affect and Mood

*Affect* is the visible moment-to-moment emotional tone that you (the examiner) observe. Observations of affect are typically based on nonverbal behavior. Affect is also referred to as an individual's outward expression of emotion (K. Hope, personal communication, October 7, 2012). In contrast, *mood* is the client's internal, subjective, verbal *self-report* of mood state (Serby, 2003).

### *Affect*

Affect is usually described in terms of its (a) content or type, (b) range and duration (also known as variability and duration), (c) appropriateness, and (d) depth or intensity.

### Affective Content

Affective content indicators consist of facial expression, body posture, movement, and voice tone. For example, if you see tears, a downcast gaze, and minimal movement (psychomotor retardation), you'll likely conclude that your client has a "sad" affect. In contrast, clenched fists, gritted teeth, and strong language suggest an "angry" affect.

Although people use many different feeling words in conversation, affect content usually can be accurately described using one of the following:

Angry	Guilty or remorseful
Anxious	Happy or joyful
Ashamed	Irritable
Euphoric	Sad
Fearful	Surprised

### Range and Duration

Being able to experience, identify, and express a variety of emotions is associated with positive mental health (Pennebaker & Ferrell, 2013). However, in some cases, affective or emotional expression can become too variable. For example, clients with mania or histrionic traits may quickly shift from happiness to sadness to anger and back again. Clients with highly variable emotional patterns are described as having a *labile affect*.

Sometimes clients exhibit little or no affect during an interview. It's as if their emotional life has turned off. The absence of emotional display is referred to as a *flat affect*. Flat affect may be present in clients diagnosed with schizophrenia, severe depression, or neurological conditions such as Parkinson's disease. College students often report this after a particularly long and boring lecture.

When clients are taking antipsychotic medications, it's not unusual for them to show diminished affect. This condition, similar to flat affect, is described as *blunted affect* because an emotional response appears present under the surface, but is muted. In contrast, the term *constricted affect* is used when individuals appear to be constricting their own affect. Some individuals with compulsive personality traits may intentionally constrict their emotions because they don't like feeling or expressing emotion.

### **Appropriateness**

Affect is judged as appropriate or inappropriate based on client speech content and/or life situation. Most often, inappropriate affect is observed in clients suffering from severe mental disorders such as schizophrenia or bipolar disorder. Clients diagnosed with autism spectrum disorder also can exhibit inappropriate affect.

Determining appropriateness of client affect is subjective. If a client is speaking about a tragic incident (e.g., the death of his child) and giggling and laughing without rational justification, there would be evidence for concluding that the client's affect was "inappropriate with respect to the content of his speech." However, some clients have idiosyncratic reasons for smiling, laughing, or crying in situations where it seems inappropriate. For example, when a loved one dies after a long and protracted illness, it may be appropriate to smile or laugh, for reasons associated with relief or religious beliefs. Similarly, clients from diverse cultures may be uncomfortable expressing emotion in a professional's presence and thus appear unemotional. Judging the appropriateness of clients' affect, especially diverse clients, is best done with caution (Hays, 2013).

Some clients exhibit emotional indifference. This condition, in which clients speak about profound physical or situational problems with the emotional intensity that college students feel when reading certain textbooks, is referred to as *la belle indifference* (French for "lofty indifference"). La belle indifference is most commonly associated with conversion disorder, somatization disorder, dissociative disorder, and/or neurological deficits (J. Stone, Smyth, Carson, Warlow, & Sharpe, 2006).

### **Depth or Intensity**

Client affect is also described in terms of depth or intensity. Some clients appear profoundly sad; others seem sad on the surface. Determining depth of client affect can be difficult, because many clients prefer not to be emotional with a professional. However, through close observation of client voice tone, body posture, facial expressions, and ability to quickly move (or not move) to a new topic, you can gather evidence regarding client

affective depth or intensity. We recommend limiting affective intensity ratings to situations when clients are obviously deeply emotional or incredibly superficial.

It's not necessary to discuss every possible affective dimension in mental status reports. Most commonly, affect content, range, and duration are described. Affective appropriateness and affective intensity are included as needed. A typical mental status report of affect in a client with depressive symptoms might be stated this way:

#### SAMPLE AFFECT DESCRIPTION I

Throughout the examination, Ms. Brown's affect was occasionally sad, but often constricted. Her affect was appropriate with respect to the content of her speech.

In contrast, a client (Mr. Johnson) who presents with manic symptoms might display the following affective signs:

*Euphoric* (content or type): based on behavior suggestive of mania. For example, the client claims omnipotence, exhibits increased psychomotor activity, and has exaggerated gestures.

*Labile* (range and duration): refers to a wide band of affective expression over a short time. For example, the client shifts quickly from tears to laughter.

*Inappropriate with respect to speech content and life situation* (appropriateness): For example, the client expresses euphoria over job loss and marital separation; client's affective state is not rationally justifiable.

*Shallow* (depth or intensity): referring to little depth of emotion. For example, the client claims to be happy because "I smile" and "smiling takes care of everything."

#### SAMPLE AFFECT DESCRIPTION II

Throughout the examination, Mr. Johnson exhibited a labile, primarily euphoric, inappropriate, and shallow affect. He shifted from tears to laughter several times during the session.

### **Mood**

*Mood* is defined as clients' self-report regarding their prevailing emotional state (Serby, 2003). Mood should be evaluated directly through a simple open-ended question such as, "How have you been feeling lately?" or "How would you describe your mood?" rather than a closed and leading question that suggests an answer: "Are you depressed?"

When asked about their emotional state, some clients respond with a description of their physical condition or a description of their current life situation. If so, simply listen and then follow up with, "And how about emotionally? How are you feeling about [the physical condition or life situation]?"

Your client's response to the mood question should be included verbatim in your MSE report. This makes it easier to compare a client's self-reported mood on one occasion with self-reported mood on another occasion. In addition, it's important to compare self-reported mood with client affect, especially because although mood is a more prevailing emotional state, many clients will note that their mood shifts somewhat rapidly. Self-reported mood should also be compared with self-reported thought content, because thought content may account for the predominance of a particular mood. (This is discussed in the next section.)

Mood can be distinguished from affect on the basis of several features. Mood tends to last longer than affect. Mood changes less spontaneously than affect. Mood constitutes the emotional background. Clients report mood, whereas interviewers observe affect (Othmer & Othmer, 2002). Put another way (for you analogy buffs), mood is to affect as climate is to weather.

In the MSE report, client mood is typically a client quotation.

#### **SAMPLE MOOD DESCRIPTION I**

The client reported, "I feel miserable, unhappy, and angry most of the time."

Mood also can be evaluated in greater detail using scaling techniques (see the Appendix). After obtaining a general mood description, you ask clients to rate their (a) current mood, (b) their normal mood, (c) their lowest mood in the past two weeks, and (d) their highest mood in the past two weeks. To initiate a scaling assessment, you might ask:

On a scale from 0 to 10, where 0 is the worst possible mood you could experience and 10 is the best possible mood, what would you rate your mood right now?

Follow-up questions consistent with *ICD-10-CM* or *DSM-5* depressive disorder diagnostic criteria can be integrated into this portion of the MSE.

After obtaining mood ratings, you may ask additional follow-up questions, such as, “What’s going on right now that makes you rate your mood as a 4?” or “What’s happening that makes you so happy [or sad] right now?” Even when conducting an MSE, you should respond with empathy during this process. When you’re writing the mental status section on mood, it also may be appropriate (depending on your setting, the client’s symptoms, and your inclination) to include a more detailed description of client mood, as in the following example.

### SAMPLE MOOD DESCRIPTION II

The client’s current mood rating was a 4 on a 0–10 scale. He reported his two-week low as a 3 and his two-week high as a 5 and noted that this range of 3 to 5 is pretty normal for him. He described his low mood as “irritable” rather than sad.

## Speech and Thought

Mental status examiners observe and evaluate thought process and content primarily through client speech. There are, however, other ways to observe and evaluate thought processes. Nonverbal behavior, sign language (in hearing-impaired clients), and writing samples also provide valuable information about thinking processes. Speech and thought are evaluated both separately and together.

### *Speech*

*Speech* is described in terms of rate and volume. *Rate* refers to the observed speed of a client’s speech. *Volume* refers to loudness. Both rate and volume can be categorized as:

- High (fast or loud)
- Normal (medium or average)
- Low (slow or soft)

Client speech is usually described as pressured (high speed), loud (high volume), slow or halting (low speed), or soft or inaudible (low volume). When no speech problems are present, you should write, “The client’s speech was of normal rate and volume.”

Speech that occurs with minimal direct prompting or questioning is described as spontaneous. Clients with *spontaneous* speech provide easy access to their internal thought processes. However, some clients are naturally less verbal or may resist speaking openly. When clients provide little verbal material, they're described as exhibiting *poverty of speech*. Clients who respond slowly to questions are described as having *response latency*. Although increased speech rate and volume may be associated with mania or aggression, and decreased speech rate and volume may be linked to depression or passivity, there are other possible explanations. Both age (e.g., older clients may process questions more slowly) and language fluency (in cases where clients are speaking a second or third language) can reduce speech rate and volume.

Distinct speech qualities or speech disturbances also should be noted. These may include accents, high or low pitch, and poor or distorted enunciation. Specific speech disturbances consist of the following:

- *Dysarthria*: problems with articulation (e.g., mumbling) or slurring
- *Dysprosody*: problems with rhythm, such as mumbling or long pauses or latencies between syllables
- *Cluttering*: rapid, disorganized, and tongue-tied speech
- *Stuttering*: halting speech with frequent repetition of sounds

Dysarthria, dysprosody, and cluttering can be associated with specific brain disturbances or drug toxicity; for example, mumbling may occur in patients with Huntington's chorea, and intoxicated patients may exhibit slurring of speech. Many other distinctive deviations from normal speech are possible, including a rare condition referred to as "foreign accent syndrome." Individuals with this syndrome speak with a nonnative accent. There's some question about whether the individual really has adopted a "foreign" accent or whether the individual's pitch and prosody have been affected in ways that lead others to perceive a particular foreign accent (Kanjee, Watter, Sévigny, & Humphreys, 2010).

### ***Thought Process***

Observation and evaluation of thought are divided into two broad categories: thought process and thought content. *Thought process* refers to how clients express themselves. In other words, does thinking proceed in an organized and logical manner? It's useful to obtain a verbatim speech sample to capture psychopathological processes. The following sample is from a client's letter to his therapist, who was relocating to seek further professional education.

Dear Bill:

My success finally came around and I finally made plenty of good common sense with my attitude and I hope your sister will come along just fine really now and learn maybe at her elementary school whatever she may ask will not really develop to bad a complication of any kind I don't know for sure whether you're married or not yet but I hope you come along just fine with yourself and your plans on being a doctor somewhere or whatever or however too maybe well now so. I suppose I'll be at one of those inside sanitarians where it'll work out . . . and it'll come around okay really, Bye for now.

This client's letter illustrates a thought process dysfunction. His thinking is disorganized and minimally coherent. Initially, his communication shows loosening of association. Interestingly, after writing the word *doctor*, the client decompensates into incoherent word salad. (See Table 9.2 for common MSE thought process descriptors.)

**Table 9.2** Thought Process Descriptors

**Blocking:** Sudden cessation of speech in the midst of a stream of talk. Blocking may indicate that the client was (a) approaching an uncomfortable topic or (b) experiencing the intrusion of delusional thoughts or hallucinations.

**Circumstantiality:** When clients provide excessive and unnecessary detail. Very intellectual people (e.g., college professors) can become circumstantial; they eventually make their point, but don't do so efficiently. Circumstantiality or overelaboration can signal defensiveness or be associated with paranoid thinking. (It can also be a sign that the professor was not well prepared for the lecture.)

**Clang associations:** The combining of unrelated words or phrases with similar sounds. Usually, this is manifest through rhyming or alliteration; for example: "I'm slime, dime, do some mime" or "When I think of my dad, rad, mad, pad, lad, sad." Clanging usually occurs among very disturbed clients (e.g., those with psychotic disorders). As with all psychiatric symptoms, cultural norms may prompt the behavior. (For example, clang associations among rappers are normal.)

**Flight of ideas:** Speech in which clients "fly" from one idea to another. In contrast to loose associations (see below), there are logical connections in the client's thinking. However, unlike circumstantiality, the client never gets to the point. Clients with flight of ideas often appear overactive or overstimulated (e.g., mania or hypomania). Many normal people—including one of the authors—exhibit flight of ideas after excessive caffeine intake.

**Loose associations:** Nearly, but not completely, random thinking process (e.g., "I love you. Bread is life. Haven't I seen you in church? Incest is horrible"). In this example, the client thinks of love, then of God's love expressed through communion, then of church, and then of an incest presentation he heard in church. Tracking the links is difficult. Loose associations are usually linked to psychotic or prepsychotic disorders. Extremely creative people also exhibit loose associations, but find socially acceptable ways to express their ideas.

**Mutism:** Lack of responsive speech. Mutism can be general or selective. General mutism is linked to autism or schizophrenia, catatonic subtype. Selective mutism occurs when clients can speak responsively in some situations, but not others, and may be anxiety based.

**Neologisms:** Coining or inventing new words. Neologisms in psychiatry are usually linked to psychotic disorders and are products of the moment rather than thoughtfully creative. We've heard "slibber," "temperaturific," and others. You should check with clients about word meaning and origin. Unusual words may be taken from the Internet or television, or be a product of combining languages.

**Perseveration:** Involuntary repetition of a single response, idea, or movement. Examples include echolalia and obsessional behaviors. Perseveration is different from persistence: perseveration involves being stuck, and persistence is intentional. Perseveration is mostly associated with neurological disorders, autism, and psychotic disorders.

(Continued)

**Table 9.2** (Continued)

---

*Tangential speech:* Similar to loose associations, but connections between ideas are even less clear. Tangential speech is different from flight of ideas because flight of ideas involves pressured speech.

---

*Word salad:* A series of unrelated words. Word salad indicates extreme disorganized thinking. Clients who exhibit word salad are incoherent. (See the second half of the preceding "Dear Bill" letter for an example of word salad.)

---

Sometimes clients from nondominant cultures have difficulty responding to MSE questions. For example, as noted by Paniagua (2001), "Clients who are not fluent in English would show thought blocking" (p. 34). If you ignore culture and language issues, you might incorrectly conclude that response latency indicates anxiety, schizophrenia, or depressive symptoms. This conclusion would be inaccurate for many cultural groups.

### ***Thought Content***

*Thought content* refers to *what* clients talk about. What clients talk about can give interviewers valuable information about mental status.

Several specific content areas are explored in MSEs. These are delusions, obsessions, and suicidal or homicidal thoughts or plans. Because we cover suicide assessment in Chapter 10, this section focuses on evaluating for delusions and obsessions.

*Delusions* are false beliefs. They're not based on facts or on real events or experiences and thus represent a break from reality. For beliefs to be delusional, they must be outside the client's cultural, religious, and educational background. Examiners should not directly dispute delusional beliefs. Instead, a question that explores the belief may be useful: "How do you know the CIA is monitoring your phone?" (Robinson, 2007).

There are different types of delusions. *Delusions of grandeur* are false beliefs pertaining to ability or status. Clients with delusions of grandeur believe they have extraordinary mental powers, physical strength, wealth, or sexual potency. They're usually unaffected by discrepancies between their beliefs and objective reality. Grandiose clients may believe they're a specific historical or contemporary figure. (Napoleon, Jesus Christ, and Joan of Arc are common historical figures.)

Clients with *delusions of persecution* or *paranoid delusions* hold false beliefs that others are out to get them. They may falsely believe they're being followed. Clients with paranoid delusions often have *ideas of reference*, erroneous beliefs that unrelated events refer to them—for example, beliefs that the television, newspaper, or radio is referring to them. One hospitalized patient complained bitterly that the television news was broadcasting his life story every night and humiliating him in front of the rest of the patients.

Clients who believe they're under the control or influence of an outside force or power are experiencing *delusions of alien control*. Symptoms usually involve disowning personal volition. A client might report feeling as if he or she is a puppet and unable to assert personal control. In years past, it was popular to report being controlled by the Russians or Communists; in recent years, the Russians are out, and we've observed a greater frequency of delusions about being possessed or controlled by supernatural or alien forces.

*Somatic delusions* involve false beliefs about medical or physical conditions. Somatic delusions may involve traditional illnesses (e.g., AIDS or pregnancy) or an idiosyncratic physical condition. A case reported in the literature involved a man who "believed that his internal organs were not functioning, that his heart stopped beating, and that his heart was displaced to the right side of his chest" (Kotbi & Mahgoub, 2009, p. 320). Like all delusions, somatic delusions can incorporate current events or recent medical discoveries (Hegarty, Catalano, & Catalano, 2007).

About 25% of hospitalized patients with depression and 15% of outpatients diagnosed with depression report delusions (Maj, 2008). These often include *delusions of self-deprecation*. Clients with depression may hold tightly to the belief that they're the "worst case ever" or that their skills and abilities are grossly impaired (even when they're not impaired). Common self-deprecating comments include statements about sinfulness, ugliness, and stupidity.

It may or may not be important to seek factual evidence to determine the validity of a client's apparent delusions. Whether such information is sought depends primarily on the clinical and diagnostic situation. Clients suspected of having somatic delusions should be referred for medical examinations.

Exploring delusional beliefs can help you develop hypotheses about psychodynamics underlying client symptoms. For example, a client who claims that "alien forces" are making him shout obscenities at his parents may feel controlled by them and finds it less threatening to disown his angry impulses. Similarly, a grandiose client may feel unimportant and compensate with a belief (delusion) of having special importance (e.g., "I am Jesus Christ"). Interpersonal dynamics combined with client genetic and biological predispositions may produce unique delusional content.

Sometimes, however, client delusions are primarily a function of biogenetic factors rather than psychological dynamics. For example, the young man who believes that the aliens are forcing him to shout obscenities at his parents may have Tourette's disorder and an otherwise positive relationship with his parents.

### ***Obsessions***

*Obsessions* are recurrent and persistent ideas, thoughts, and images. True obsessions are involuntary, cause distress or impairment, and are viewed as excessive or irrational *even by those who experience them*.

Clients may worry or intentionally ruminate about many issues, but obsessions are beyond normal worry. One obsessive-compulsive client with whom we worked had intrusive obsessive thoughts that his car would roll away even when parked in a flat parking lot. To deal with these thoughts, he developed ritualistic *compulsions* wherein he would check and reset his parking brake seven times before leaving his car.

More typically, individuals with compulsions exhibit *washing* or *checking* behaviors. Clients who engage in compulsive washing are usually responding to thoughts or fears of infection or contamination. Clients who engage in compulsive checking behavior are usually responding to thoughts or fears about an intruder, gas leak, kitchen fire, and the like. Obsessions often include a sense of doubt:

- Are my hands clean?
- Have I been contaminated?
- Did I remember to lock the front door?
- Did I remember to turn off the oven (lights, stereo, etc.)?

Everyone experiences occasional obsessive thoughts, but the thoughts may or may not be clinically or diagnostically significant. Information is of *clinical* significance if it contributes to the treatment plan; information is of *diagnostic* significance if it contributes to the diagnostic evaluation. During an MSE, it's important to evaluate obsessions, because they reveal what the client spends time thinking about. Such information may be clinically significant; it may enhance empathy and treatment planning. However, the same obsessions may or may not be diagnostically significant. For example, if a client describes occasional obsessions or compulsions—such as always feeling compelled to count the number of stairs climbed—but these compulsions don't interfere with the ability to function at work, school, home, or play, they may not be diagnostically significant. These are referred to as "normal obsessions" (Rassin, Cougle, & Muris, 2007; Rassin & Muris, 2007).

Questions to assess for obsessive thoughts include the following:

- Do you have repeated thoughts that are difficult to get out of your mind?
- Do you engage in repeated behavior to calm your anxiety, such as checking the locks of your house or washing your hands?
- You know how sometimes people get a song or tune stuck in their head and can't stop thinking about it? Have you had that kind of experience?

Anxiety is at the heart of obsessive-compulsive disorder. Anxiety, followed by obsessive and compulsive behavior, can indicate obsessive-compulsive disorder or another anxiety-based condition. For example, clients who experience trauma (e.g., sexual assault) sometimes display obsessive anxiety and engage in compulsive behavior to feel safe. These clients may (or may not) experience significant anxiety reduction as a function of their compulsive behaviors. In such instances, the client is likely experiencing posttraumatic stress and not an obsessive-compulsive disorder.

#### SAMPLE SPEECH AND THOUGHT DESCRIPTION

The client's speech was loud and pressured. Her communication was sometimes incoherent; she exhibited flight of ideas and neologisms as evidenced by her inability to stay on topic and use of words such as "whaddingy" and "ordinarrational." She didn't respond coherently to questions about obsessions, but appeared preoccupied with the contents of a small notebook.

## Perceptual Disturbances

Perceptual disturbances involve difficulties in the perception and interpretation of sensory input. Understanding the nature of clients' perceptual disturbances can help establish a diagnosis. The next sections describe three major perceptual disturbances: hallucinations, illusions, and flashbacks. (See Table 9.3 for characteristics of perceptual disturbances.)

### *Hallucinations*

*Hallucinations* are false sensory impressions or experiences. Hearing voices in the absence of auditory sensory input is the most common hallucination type. Hallucination content may be diagnostically relevant. Clients experiencing depressive states can have hallucinations that repeatedly offer an insulting commentary (e.g., "You're nothing but worthless scum. You should just die").

Hallucinations occur in any sensory modality: visual, auditory, olfactory, gustatory, and tactile. Auditory hallucinations are commonly associated with mood disorders (extreme mania, severe depression) or schizophrenia. However, auditory hallucinations also may be linked to chemical intoxication or acute traumatic stress. In less severe cases, clients may report having especially good hearing, or they may report listening to their own "inner voice." Although such reports are worth exploring, they're not necessarily perceptual disturbances.

**Table 9.3** Characteristics of Different Perceptual Disturbances

	<b>Hallucinations</b>	<b>Illusions</b>	<b>Flashbacks</b>
Definition	False sensory experiences	Perceptual distortions	Sensory-laden recollections of previous experiences
Diagnostic Relevance	Auditory hallucinations are usually associated with schizophrenia, bipolar disorder, or severe depression; tactile or visual hallucinations are often linked to neurological or substance-related problems.	Illusions are more common among clients who have vivid imaginations, who believe in the occult, or have other schizotypal personality disorder symptoms.	Flashbacks are most common among clients with PTSD.
Useful Questions	<p>Do you ever hear or see things that other people can't see or hear?</p> <p>When and where do you usually see or hear these things? [checking for hypnagogic or hypnopompic experiences]</p> <p>Does the radio or television ever speak directly to you?</p> <p>Has anyone been trying to steal your thoughts or read your mind?</p>	<p>What was happening in your surroundings when you saw [or experienced] what you saw [or experienced]?</p> <p>Did the vision [or image or sounds] come out of nowhere, or was there something happening?</p>	<p>Have you had any similar experiences before in your life?</p> <p>Sometimes when people have had very hard or bad things happen to them, they keep having those memories come back to them. Does that happen to you?</p> <p>Was there anything happening that triggered this memory or flashback to the past?</p>

Visual or tactile hallucinations are usually linked to organic conditions (Tombini et al., 2012). These conditions include drug intoxication or withdrawal, brain trauma, Parkinson's, or other brain-based diseases. Clients in acute delirious states may pick at their clothes or skin to remove hallucinated objects or organisms. They may see insects crawling on their skin. Similarly, clients may reach out or call out for people or objects that don't exist. When clients report these experiences or you observe these perceptual disturbances, the disorder is usually serious and disabling.

Odd perceptual experiences can occur during sleep onset or upon awakening. A common example involves seeing someone at the foot of the bed when falling asleep, sometimes accompanied by feelings of paralysis. Although frightening, these perceptual disturbances are naturally occurring phenomena during the hypnagogic (sleep onset) or hypnopompic (sleep termination) sleep stages (Cheyne & Girard, 2007). When evaluating for hallucinations, you should determine *when* such experiences usually occur. If they're linked to sleep onset or termination, they're less diagnostically relevant.

### ***Illusions***

*Illusions* are perceptual distortions. They're based on sensory input and technically involve misperceptions. For example, if you misperceive a coat

hanging on the back of a door for an intruder, you're experiencing an illusion. Illusions can be more persistent or more transient—as in the case when you quickly realize that the feared intruder isn't actually an intruder, but instead a harmless coat hanging on the door.

Although auditory hallucinations are typically associated with mood disorders or schizophrenia, illusions are more difficult to link with specific mental disorders. This might be because many people within the normal range of functioning have unusual beliefs and experiences that involve their creative imaginations.

### ***Flashbacks***

*Flashbacks* are a core symptom of posttraumatic stress disorder (PTSD). They consist of sudden and vivid sensory-laden recollections of previous experiences. Flashbacks are typically triggered by immediate sensory input (Muhtz, Daneshi, Braun, & Kellner, 2010). It's not unusual for war veterans to have flashbacks when they hear or see firecrackers or fireworks. Similarly, survivors of sexual abuse may experience flashbacks in response to certain touch, smells, or voice tones. Flashbacks may be fleeting and mild; but they also can be lengthy, dissociative episodes wherein an individual acts as if he or she were reliving the traumatic experience for “several hours or even days” (see *DSM-5*, p. 275).

Flashbacks are typically related to trauma, so distinguishing between flashbacks and other perceptual disturbances (illusions or hallucinations) is diagnostically important. Flashbacks are commonly associated with other PTSD symptoms, such as nightmares, hyperarousal, emotional numbing, avoidance of triggering stimuli, and high anxiety levels.

### ***Asking Clients About Perceptual Disturbances***

Clients can be reactive to inquiries about delusions, hallucinations, or flashbacks. Sensitivity in exploring these experiences is recommended. Robinson (2007) suggested a three-part approach:

1. *Greasing the wheels* to help the patient feel comfortable sharing information
2. *Uncovering the logic* associated with the delusional material
3. *Determining the client's insight* and how much distance he or she has from the symptom

The following are sample questions in these three areas (Robinson, 2007, pp. 239–240, parenthetical information added):

- I'm interested in what you just said; please tell me more. (greasing the wheels)

- How did this all start? (greasing the wheels)
- What has happened so far? (uncovering the extent and logic)
- Why would someone want to do this to you? (uncovering the extent and logic)
- How do you know that this is the situation? (determining distance)
- How do you account for what has taken place? (determining distance)

The following dialogue is an example of how you might help a client talk about suspected delusions or bizarre experiences:

**Interviewer:** I'm going to ask a few questions about unusual experiences.  
These questions may or may not fit for you.

**Client:** Okay.

**Interviewer:** Sometimes radio or television news or shows can feel personal, as if the people in them are speaking directly to you. Have you ever thought a radio or television program was talking about you or to you personally?

**Client:** That program the other night was about my life. It was about me and Taylor Swift.

**Interviewer:** How do you know Taylor Swift?

**Client:** She wrote a song about me, and so I got in touch with her.

This next portion models an evaluation for auditory perceptual disturbances, with a similar check for visual hallucinations or illusions:

**Interviewer:** I've noticed you seem pretty observant. Is your hearing especially good?

**Client:** Yes, as a matter of fact, I have better hearing than most people.

**Interviewer:** Really? What can you hear that most people can't hear?

**Client:** I can hear voices right now, coming through the wall.

**Interviewer:** Really. What are the voices saying?

**Client:** They're talking about me and Taylor . . . about our sex life.

**Interviewer:** How about your vision? Do your eyes ever play tricks on you?

The next dialogue models methods for exploring client flashbacks:

**Interviewer:** It's not unusual for individuals who have been through very difficult circumstances, like you, to have thoughts or images from the past come into the present. Have you noticed this?

**Client:** It's terrible. Sometimes it's like I was there all over again with my buddy, and we're getting jumped and shot and stabbed.

**Interviewer:** Sometimes it feels like you're back in your gang days. Does that just come out of nowhere, or are there certain triggers that take you back there?

**Client:** Mostly it starts if somebody's talking smack to me. I get pissed and scared and ready to go on the attack.

Notice how the interviewer in these examples normalizes possible pathology with statements like “you seem pretty observant” or “It’s not unusual” and then inquiring about possible symptoms. These techniques illustrate how to approach unusual perceptual experiences delicately. Interestingly, researchers reported that 50 consecutive patients responded openly and 26% reported visual hallucinations when asked the question, “Do your eyes ever play tricks on you?” (Jefferis, Mosimann, Taylor, & Clarke, 2011).

#### SAMPLE PERCEPTUAL DISTURBANCES DESCRIPTION

The client spontaneously reported hearing voices in a variety of different settings. These voices usually tell him to “crawl” or “get to your knees” because he is “bad.” He did not report illusions or flashbacks.

### Orientation and Consciousness

Mental status examiners routinely evaluate whether clients are oriented to person, place, time, and situation. This is usually done early in the exam:

1. What is your name?
2. Where are you (i.e., what city, or where in a particular building)?
3. What is today’s date?
4. What’s happening right now? [or] Why are you here?

If a client answers these queries correctly, you document it with “O × 4” (oriented times four) in your note or report. Evaluating client orientation is a direct way to assess confusion or *disorientation*. There are many reasons why clients are unable to respond accurately to one or more of these questions. For example, questions about the date or day of the week may be irrelevant to individuals who are long retired or living in extended care settings (J. Winona, personal communication, September 16, 2012).

In some cases, resisting (or refusing to answer) questions about orientation implies disorientation. In the following example, a hospital patient with a recent head trauma was interviewed regarding orientation:

**Interviewer:** I'm going to ask you a few questions. Just give the best answers you can. Tell me, what day is it today?

**Client:** They told me I was riding my bike and that I didn't have my helmet on.

**Interviewer:** That's right. I'm still curious, though. What day is it today?

**Client:** Could I get a glass of water?

Although the interaction begins with a simple orientation-to-time question, the patient didn't answer directly. When the question is repeated, the patient continues evasive tactics. When patients avoid answering orientation questions, it may be because they don't know the answers.

Orientation can be pursued in greater or lesser depth. Clients can be asked what county they're in, the name of the governor of the state, and the name of the local newspaper. They also can be asked if they recognize hospital personnel, visitors, and family. Some orientation questions require greater cultural immersion or are values based, such as the names of elected officials or the name of a local football team.

When clients become disoriented, they usually lose awareness of the situation first, then their sense of time, then their sense of place, and finally their identity. Orientation is recovered in reverse order (person, place, time, situation). Disorientation is usually associated with an organic process (e.g., head injury, drug toxicity, Alzheimer's).

Fully oriented clients may view questions about their orientation as offensive. Being required to answer simple questions can feel belittling. Cognitively impaired clients may also act indignant, perhaps from embarrassment or to cover their disorientation. It helps to inform clients that orientation questions are routine and to express empathy with the client's uncomfortable feelings.

Elderly clients, particularly those in acute and chronic care settings, may experience delirium. *Delirium* consists of diurnally shifting consciousness, attention, perception, and memory lasting from a few minutes to several days (Moraga & Rodriguez-Pascual, 2007). Several formal mental status assessment tools are available for evaluating delirium, including the Mini-Mental State Examination (Edlund et al., 2006), the Organic Brain Syndrome Scale (Edlund et al., 2006), and the Richmond Agitation-Sedation Scale (Peterson et al., 2006). Delirium is usually associated with toxicity, blood electrolytes, and brain injury or disease. With delirium, patients may experience a gradual clearing of consciousness.

Questions on the following list can be used in combination with more chatty questions to assess client orientation.

- Self/Person

What is your full name? Where are you from?

Where do you currently live?

Are you employed? [if so] What do you do for a living?

Are you married? [if so] What is your spouse's name?

Do you have any children? [if so] What are their names?

- Place

There's been a lot happening these past few days [or hours]; I wonder if you can describe where we are now?

What city are we in?

What's the name of the building we're in right now?

- Time

What's today's date? [If client claims not to recall, ask for an estimate; estimates can help assess level of disorientation.]

What day of the week is it?

What month [or year] is it?

How long have you been here?

Do you know what holiday is coming soon?

- Situation

Do you know why we're here?

How did you get here?

What's your best guess as to what we'll be doing next?

*Consciousness* is evaluated along a continuum from alert to comatose. Although consciousness and orientation are related, they're not identical. As you observe clients' responses and behaviors during an interview, you select a descriptor of consciousness:

- Alert
- Confused
- Clouded
- Stuporous
- Unconscious
- Comatose

The orientation and consciousness section might read as follows:

### SAMPLE ORIENTATION AND CONSCIOUSNESS DESCRIPTION

The client's consciousness was clouded; she was oriented to person (O x 1), but incorrectly identified the year as "1999" instead of 2016 and was unable to identify our location or the purpose of the interview.

## Memory and Intelligence

MSEs include a cursory assessment of client cognitive abilities. This consists of assessments of memory, abstract reasoning, and general intelligence.

### *Memory*

An MSE can provide a quick memory screening, but not definitive information. Formal neuropsychological assessment is needed to specify the nature and extent of memory impairments.

*Memory* is broadly defined as the ability to recall experiences. Three types of memory are assessed in an MSE: remote, recent, and immediate. *Remote memory* refers to recall of events, information, and people from the distant past. *Recent memory* refers to recall of events, information, and people from the prior week or so. *Immediate memory* refers to retention of information or data to which one was just exposed.

Remote memory questions can be integrated into the psychosocial history portion of the intake. This involves questioning about time and place of birth, names of schools attended, date of marriage, age differences between client and siblings, etc. Basing an assessment of remote memory on self-report is problematic because you can't verify the client's accuracy. This problem reflects the main dilemma in assessment of remote memory impairment: the possibility of confabulation.

*Confabulation* refers to spontaneous and sometimes repetitive memory fabrication or distortion (Gilboa & Verfaellie, 2010). Confabulation occurs during recall and typically involves memory retrieval problems (Metcalf, Langdon, & Coltheart, 2007). To some extent, confabulation is normal (Gilboa & Verfaellie, 2010). In fact, we've found that intense marital disputes can occur when memories of key events fail to jibe.

Human memory is imperfect, and, as time passes, events are subject to reinterpretation. This is especially the case if clients feel pressured into responding to specific questions and is one reason why coercive questioning

techniques are contraindicated when interviewing witnesses in legal situations (Stolzenberg & Pezdek, 2013). For example, clients may be able to recall only a portion of a specific memory, but when pressured to elaborate, they may confabulate. Here's an example of confabulation on a test of remote memory.

**Interviewer:** I'm going to ask you a few questions to test your memory.  
Ready?

**Client:** Yeah, I guess.

**Interviewer:** Name five US presidents since 1950.

**Client:** Right. There was, uh, Obama . . . and Ronald Reagan . . . uh, yeah there's uh, Bush and Bush again. I've got another one on the tip of my tongue.

**Interviewer:** You're doing great. Just one more.

**Client:** Yeah, I know. I can do it.

**Interviewer:** Take your time.

**Client:** Washington. That's it, William Washington.

In this case, the examiner's support and enthusiasm may have been perceived as performance pressure. When pressuring occurs, through either positive or coercive means, humans tend to make things up to relieve the pressure.

The preceding example pertains to memory of historical fact. In contrast, it may be impossible to confirm or disconfirm your client's personal memories. If a client claims to have been "abducted" as a child, it may be difficult to judge the accuracy of that claim.

Client responses to personal history questions nearly always contain minor inaccuracies or confabulation. That's how memory works. It's the examiner's responsibility, within reason, to determine whether clients are accurately reporting personal history events. Pursuing truth can be a challenging experience!

When confabulation or memory impairment is suspected, it may be helpful to ask clients about objective past events. This usually involves inquiring about significant and memorable social or political events (e.g., Who was president when you were growing up? What countries were involved in the Gulf War? What music was popular when you were in high school?). Asking social and political questions may be unfair to cultural minorities, so you should exercise caution when using such strategies.

If the accuracy of a client's historical report is questionable, it may be useful (or necessary) to call on the client's friends or family for confirmation. This can be complicated because legal documents must be signed to

interview collateral informants (see Chapter 8). In addition, friends and family members may not be honest with you or may have impaired memories themselves. Although verification of client personal history is recommended, it's not a problem-free strategy.

Clients may acknowledge memory problems; this is referred to as *subjective memory complaints* (Kurt, Yener, & Oguz, 2011). However, subjective memory complaints don't constitute evidence of memory impairment. In fact, clients with brain injury or damage may be more likely to deny memory problems and try to cover them up through confabulation. Conversely, depressed clients may exaggerate the extent to which their cognitive skills have diminished, complaining to great lengths that something is wrong with their brain (Othmer & Othmer, 2002).

Nevertheless, clients with depression sometimes experience cognitive impairment. The term *pseudodementia* (Dunner, 2005) is used when depressed clients with no organic impairment suffer from emotionally based memory problems. Once the depression is alleviated, memory problems are often resolved. However, research suggests that reversible pseudodementia tends to be a positive predictor of later dementia (Sáez-Fonseca & Walker, 2007).

Evaluating recent and immediate memory is simpler than evaluating remote memory because experiences of the recent past are more easily verified. If the client has been hospitalized, questions can be asked pertaining to reasons for hospitalization, treatments received, and hospital personnel with whom the client had contact. Clients may be asked what they ate for breakfast, what clothes they wore the day before, and whether they recall the prior week's weather.

There are several methods for evaluating immediate memory during an MSE. The most common are serial sevens, recall of brief stories, and digit span (Folstein, Folstein, & McHugh, 1975). Each of these methods engage clients in activities that require sustained attention and concentration.

To administer *serial sevens*, clients are asked to "begin with 100 and count backward by 7" (Folstein et al., 1975, p. 197). Clients who can sustain attention (and adequate math skills) can perform serial sevens without difficulty. However, anxiety—sometimes in clients who have anxiety disorders, but also in clients who have a history of math difficulties—may interfere with concentration and impair performance. Clients of diverse cultural backgrounds also struggle with this task, partly because of difficulty comprehending and lack of experience participating in such activities (Paniagua, 2001). The research on using serial sevens to evaluate cognitive functioning is weak (Spencer et al., 2013). Anxiety level, cultural and educational background, distractibility, and potential invalidity of the

procedure should all be considered when evaluating a client's memory or attention span using serial sevens.

*Digit span* is a subtest on the Weschler intelligence scales, but is often administered separately within an MSE. When administering the digit span, a preset series of numbers is read to patients at one-second intervals. Care should be taken to use a standardized procedure and number list to enhance reliability and validity (Woods et al., 2011). You begin with a short series of numbers and then proceed to longer lists:

**Interviewer:** I want to do a simple test with you to check your ability to concentrate. First, I'll say a series of numbers. Then, when I'm finished, you repeat them back to me. Okay?

**Client:** Okay.

**Interviewer:** Here's the first series of numbers: 6–1–7–4.

**Client:** 6 . . . 1 . . . 7 . . . 4.

**Interviewer:** Okay. Now try this one: 8–5–9–3–7.

**Client:** Um . . . 8 . . . 5 . . . 9 . . . 7 . . . 3.

**Interviewer:** Okay, here's another set: 2–6–1–3–9. (The examiner doesn't point out the client's incorrect response, but simply provides another set of five numbers. When clients get one of two trials correct, they can proceed to the next level, until both trials are incorrect.)

After completing digit span forward, it's common to administer digit span backward.

**Interviewer:** Now I'm going to have you do something a little different. I'll read another short list of numbers, but this time when I'm finished I'd like you to repeat them back in reverse order. For example, if I said: 7–2–8, what would you say?

**Client:** Uh . . . 8 . . . 2 . . . 7. That's pretty hard.

**Interviewer:** But I think you've got it. Now try this: 4–2–5–8.

Clients may become sensitive about their performance on specific cognitive tasks. Their responses can range from overconfidence (e.g., "Sure, no problem, what a silly question") to excuse making (e.g., "Today's not a good day for me!") to open acknowledgment of performance concerns (e.g., "I'm afraid I got that one wrong. I'm just horrible at this"). The way clients respond to cognitive performance tests may reveal important clinical information, such as grandiosity, rationalizing or excuse making for poor performance, or a tendency toward self-deprecation. However, as always, these observations provide only tentative hypotheses about client behavior patterns. Digit span performance, like all cognitive assessments, may

be strongly affected by education level, native language, and cultural background (Ostrosky-Solís & Lozano, 2006).

When clients are referred specifically because of memory problems, an initial MSE is appropriate, but should be followed by further clinical assessment. When assessing memory problems, it's recommended that you obtain appropriate legal releases so that you can interview family members or other knowledgeable parties. You should ask family members specific questions about their perceptions of the onset, duration, and severity of memory problems.

Many other forms of memory have been studied extensively. These include *episodic memory* (memory for events), *semantic memory* (memory for facts), *skill memory* (memory for activities), and *working memory* (holding multiple pieces of information in memory at one time). The study of memory is fascinating and worth additional reading (Gluck, Mercado, & Myers, 2013).

### ***Intelligence***

Evaluation of intellectual functioning is controversial, perhaps especially so when evaluation takes place during a brief clinical interview (Mackintosh, 2011). Despite this controversy, general statements about intellectual functioning are usually made in an MSE report. Statements about intellectual functioning should be phrased broadly and tentatively.

Few people agree on a single definition of *intelligence*. Wechsler (1958) defined it as a person's "global capacity . . . to act purposefully, to think rationally, and to deal effectively with his environment" (p. 35). Although general, this definition is still useful. Put as a question, it might be "Is there evidence that the client is resourceful and functions adequately in a number of life domains?" or "Does the client make mistakes in life that appear due to limited 'intellectual ability' rather than clinical psychopathology?"

It may be more reasonable to view intelligence as a composite of several specific abilities rather than as a general adaptive tendency (H. Gardner, 1999; Sternberg, 2005). However, the idea of multiple intelligences has been widely criticized, due to lack of empirical support (Waterhouse, 2006). Nevertheless, for the purposes of MSEs, the lack of empirical evidence supporting these theories is less important than the reminder that people can express intellectual abilities in different ways. This reminder may prevent you from inappropriately concluding on the basis of a single intellectual dimension (e.g., language/vocabulary use) that minority clients or clients from lower socioeconomic backgrounds are unintelligent.

Intelligence can be measured during an MSE using several methods:

1. Intelligence is inferred from education level. This method overvalues academic intelligence.
2. Intelligence is inferred from language comprehension and use (i.e., vocabulary or verbal comprehension). This method is biased in favor of the formally educated over cultural minorities (Ortiz & Ochoa, 2005).
3. Intelligence is inferred from responses to fund-of-knowledge questions. Fund of knowledge is often a by-product of a stimulating educational background, and questions used to assess knowledge are culturally biased.
4. Intelligence is measured through responses to questions related to abstract thinking ability. These questions require sophisticated knowledge of language and an understanding of the intent of the questions.
5. Questions designed to measure social judgment are used to evaluate intellectual functioning. Individuals who are impulsive or don't quickly understand hypothetical scenarios are at a disadvantage on these questions.
6. Intelligence is inferred from observations of responses to tests of other cognitive functions (e.g., orientation, consciousness, and memory).

Statements about intellectual functioning should be phrased tentatively, especially when they pertain to minority clients. (See Multicultural Highlight 9.1 for sample questions on fund of knowledge, abstract thinking, and social judgment.)

#### SAMPLE MEMORY AND INTELLIGENCE DESCRIPTION

This client's intellectual ability is probably at least in the above-average range. He completed serial sevens and other concentration tasks without difficulty. His response to social judgment and abstraction questions were sophisticated and nuanced. His remote, recent, and immediate memory appeared intact.

### Reliability, Judgment, and Insight

It's clear in the preceding sections that all portions of the MSE involve examiner subjectivity. Subjectivity is perhaps even more prevalent when assessments focus on reliability, judgment, and insight.

### ***Reliability***

*Reliability* refers to credibility and trustworthiness. Reliable informants carefully present their life histories and current personal information honestly and accurately. In contrast, some clients are highly unreliable; for one reason or another, they distort, confabulate, or blatantly lie about their life circumstances and personal history.

It's often difficult to determine when clients are being truthful. Over the years, we've had clients tell us they don't use substances (when they do), that they have children who passed away (when there's no evidence that a child ever existed), that they recently won a lawsuit for a million dollars (when they're penniless), that they've captured the spirit of a demon in a crystal (when they don't own a crystal), and that their nine-month-old child knows martial arts and speaks in complete sentences (despite the developmental impossibility of those behaviors).

Perhaps what's most interesting about these situations is not so much that lies were told, but that the clients had good reasons to tell their lies. Dishonesty and unreliability may be manifest during an MSE due to distrust in the process or distrust in the examiner. Unreliability also occurs due to long-standing patterns of compulsive lying or other unknown factors. Because it's so difficult to sort the truth from fiction, statements about client reliability should be phrased tentatively.

Estimates of reliability are based on several observable factors. Clients with good attention to detail and who give spontaneous and elaborate responses to your questions are likely to be reliable informants. In contrast, clients who answer questions in a vague or defensive manner or who appear to be exaggerating or storytelling have a greater probability of being unreliable. In some cases, you'll have a clear sense that clients are intentionally omitting or minimizing parts of their history.

If a client behaves in ways that are guarded or defensive, it can be helpful to address the issue directly by stating something like "You seem uncomfortable with this process. Is there anything I can do to help you feel more comfortable?" When you suspect a client is unreliable, it's useful to contact family, employers, or other client associates for potential corroboration. This step involves obtaining client consent, but it can help with verifying facts. Concerns about client reliability are noted in the mental status report.

### ***Judgment***

People with good judgment consistently make adaptive decisions that affect their lives in positive ways. Client judgment can be evaluated by exploring their activities, relationships, and vocational choices. Regular participation

in illegal activities, destructive relationships, and life-threatening behaviors constitutes evidence that an individual is exercising poor judgment.

Adolescent clients frequently exercise poor judgment. A 17-year-old with whom we worked quit his job as a busboy at an expensive restaurant simply because he found out an hour before his shift that he was assigned to work with an employee whom he didn't like. Six months later, still complaining about lack of money and looking for a job, he continued to defend his impulsive move, despite the fact that it appeared to be an example of shortsightedness.

Some clients, especially impulsive adolescents or adults in the midst of a manic episode, may exhibit grossly impaired judgment. They may profoundly overestimate or underestimate their physical, mental, and social prowess. For example, manic patients often exhibit extremely poor judgment in financial affairs, spending large amounts of money on sketchy business ventures or gambling schemes. Similarly, driving while intoxicated, engaging in unprotected sex, or participating in poorly planned criminal activity are all behaviors considered as evidence of poor judgment.

In addition to evaluating judgment on the basis of clients' reports of specific behaviors, you can assess judgment by having clients respond to hypothetical scenarios. Sample scenarios are provided in Multicultural Highlight 9.1, under the Judgment category.

### MULTICULTURAL HIGHLIGHT 9.1: SAMPLE MENTAL STATUS EXAMINATION QUESTIONS USED TO ASSESS INTELLIGENCE

#### Part One

Many questions used to assess intelligence during an MSE are copyrighted. The following questions are for purposes of illustration.

#### Fund of Knowledge

Name six large US cities.

What is the direction you go when traveling from New York to Rome?

Who was president of the United States during the Vietnam War?

Which president "freed the slaves"?

What poisonous chemical substance is in automobile emissions?

What is Jay Z's profession?

(Continued)

What does the phrase “macking on the girls” mean?

### Abstract Thinking

In what way are a pencil and a typewriter alike?

In what way are a whale and a dolphin alike?

What does this saying mean? People who live in glass houses shouldn’t throw stones

What does this saying mean? A bird in the hand is worth two in the bush

### Judgment

What would you do if you discovered a gun hidden in the bushes of a local park?

If you won a million dollars, what would you do with it?

How far would you estimate it is from Los Angeles to Chicago?

If you were stuck in a desert for 24 hours, what would you do to survive?

How would you handle it if you discovered that your best friend was having an affair with your boss’s spouse?

### Part Two

After reviewing this list of “intelligence questions,” gather in small groups and discuss potential individual or cultural biases associated with each question. Some questions are clearly biased against younger clients, others against older clients, and still others against clients not born in the United States. In many cases, mental health professionals show bias against clients who respond poorly to fund-of-knowledge questions. This bias includes judging such individuals as having intellectual deficits even though they simply lacked educational opportunities, so you should discuss this issue as well. Also, analyze each question with your group and try to come up with better questions for briefly assessing client intelligence. Are there any perfect intellectual assessment questions?

*Note:* These items were developed for illustrative purposes. You should consult published, standardized testing materials when conducting formal evaluations of intelligence. It’s inappropriate to make conclusive statements about client intellectual functioning based on just a few interview questions.

### *Insight*

*Insight* refers to clients’ understanding of their problems. Take, for example, the case of a male client who presented with symptoms of exhaustion. During the interview, he was asked if he sometimes experienced anxiety and tension. He insisted, despite shallow breathing, flushing on the neck, and clenched fists, that he had no problems with tension, so learning to relax would be useless. On further inquiry about whether there might be, in some cases, a connection between his chronically high levels of tension and his exhaustion,

his response was a terse “No, and anyway I told you I don’t have a problem with tension.” This client displayed no insight into a probable problem area.

It can be useful to ask clients to speculate on the cause or causes of their symptoms. Some clients respond with powerful insight, while others begin discussing a physical illness they may have contracted (e.g., “Maybe I have mono?”). Still others have no ideas about potential underlying causes or dynamics.

Clients who are insightful are able to intelligently discuss the possibility of emotional or psychosocial factors contributing to their symptoms. In contrast, clients with little or no insight become defensive when faced with possible psychosocial or emotional factors; in many cases, clients without insight blatantly deny having any problems.

Four descriptors are used to describe client insight:

- *Absent*: Clients with a lack of insight don’t admit to having problems. They may blame someone else for their treatment or hospitalization. If you suggest a problem exists, these clients become defensive.
- *Poor*: Clients with poor insight may admit to minor problems, but primarily rely on physical, medical, or situational explanations for their symptoms. If they admit that a problem exists, they’re likely to rely on medications, surgery, or getting away from people they blame for their problems as their preferred treatment.
- *Partial*: Clients with partial insight may seek help for a problem, but leave treatment prematurely. These clients occasionally articulate how situational or emotional factors contribute to their condition and how their own behavior may contribute to their problems, but they’re reluctant to directly focus on such factors. Gentle reminders can motivate them to work with nonmedical treatment approaches.
- *Good*: Clients with good insight readily admit to having problems that may benefit from psychosocial treatments. These clients take personal responsibility for modifying their life situation. They articulate and use psychosocial treatment approaches independently. They may be creative in addressing their problems through nonmedical methods.

#### SAMPLE RELIABILITY, JUDGMENT, AND INSIGHT DESCRIPTION

Overall, this client appeared forthright and reliable. He was open about his drug abuse history and expressed interest in obtaining help. His responses to social judgment questions were positive; he described social relationships based on empathy and rational decision making. His insight and judgment were good.

**VIDEO  
9.4**

## When to Use Mental Status Examinations

Formal MSEs are not always appropriate. Here's a good basic guideline: MSEs become more necessary as client psychopathology increases. If clients appear well adjusted and you aren't working in a medical setting, it's unlikely you'll conduct a full MSE. However, if you have questions about diagnosis or client psychopathology and are working in a medical setting, a formal MSE is usually recommended (see Table 9.4 for an MSE checklist).

Some practitioners have suggested that it's nearly always inappropriate to use a traditional MSE with cultural minority clients (Paniagua, 2001). This is because evaluative judgments made during MSEs can be culturally insensitive and/or biased. (To help mitigate this problem, see Multicultural Highlight 9.2.)

**Table 9.4** Mental Status Examination Checklist

Category	Observation	Hypothesis
Appearance		
Behavior/ psychomotor activity		
Attitude toward examiner		
Affect and mood		
Speech and thought		
Perceptual disturbances		
Orientation and consciousness		
Memory and intelligence		
Judgment, reliability, and insight		

### MULTICULTURAL HIGHLIGHT 9.2: CULTURAL DIFFERENCES IN MENTAL STATUS

#### Part One

Cultural norms must be considered in MSE evaluations. Read through the following MSE categories and observations, then contemplate the invalid conclusion along with the explanation. Notice that without considering culture, it's easy to use your observations and come to invalid conclusions.

Category	Observation	Invalid Conclusion	Explanation
Appearance	Numerous tattoos and piercings	Antisocial tendencies	Comes from a region or subculture where tattoos and piercings are the norm

Behavior/psychomotor activity	Eyes downcast	Depressive symptom	Culturally appropriate eye contact
Attitude toward examiner	Uncooperative and hostile	Oppositional-defiant or personality disorder	Has experienced abuse in the dominant culture
Affect and mood	No affect linked to son's death	Inappropriately constricted affect	Expression of emotion about death is unaccepted in client's culture
Speech and thought	Fragmented or incoherent speech	Possible psychosis	Speaks English as third language and is under extreme stress
Perceptual disturbances	Reports visions	Psychotic symptom	Visions are consistent with Native culture
Orientation and consciousness	Inability to recall three objects or do serial sevens	Attention deficit or intoxication	Misunderstands questions due to language problem
Memory and intelligence	Cannot recall past presidents	Memory impairment	Immigrant status
Reliability, judgment, and insight	Lies about personal history	Poor reliability	Does not trust White examiner

## Part Two

For each category addressed in a traditional MSE, think of cultures that would behave differently but still be within "normal" parameters for their cultural or racial group. Examples include differences in cultural manifestations of grief, stress, humiliation, or trauma.

Work with a partner to generate possible MSE observations in addition to those listed in part one of this Multicultural Highlight that might lead you to an inappropriate and invalid conclusion regarding client mental status.

Category	Observation	Invalid Conclusion	Explanation

All evaluation procedures, including MSEs, are culturally biased in one way or another. For example, researchers from India noted that affect and mood have different definitions across cultures and nations (Manjunatha, Saddichha, Sinha, & Khess, 2008). These results imply the obvious: We cannot and should not assume that an Asian Indian mental health professional can accurately evaluate individuals from the dominant US culture; neither can we assume the reverse. Culture is a variable within the MSE that refuses

to remain static. As is the case with all interviewing procedures, respect for client individuality, cultural background, other identity factors, and significant recent events (e.g., stressors or trauma) should be factored into your conclusions.

## Summary

Mental status examinations (MSEs) are a way of organizing clinical observations to evaluate current mental status. Administration of an examination is common in medical settings. Although mental status information is useful in the diagnostic process, MSEs are not primarily diagnostic procedures.

Culture is a powerful determinant of clients' mental states. Consequently, the validity of clinical observations in an MSE can be compromised when examiners are insensitive to cultural factors. Similarly, although it can be tempting for examiners to leap to conclusions based on single symptoms, such temptations should be resisted.

Complete MSEs require therapists to observe and/or query client functioning in nine areas: (a) appearance; (b) behavior or psychomotor activity; (c) attitude toward examiner (therapist); (d) affect and mood; (e) speech and thought; (f) perceptual disturbances; (g) orientation and consciousness; (h) memory and intelligence; and (i) reliability, judgment, and insight.

MSEs are usually administered when significant psychopathology is suspected. If clients are getting help on an outpatient basis for problems associated with daily living, a mental status evaluation is less important. As in all evaluation procedures, client cultural background, age, significant events, and other identity and situational factors should be considered and integrated into evaluation reports.

## Suggested Readings and Resources

The MSE is a complex and nuanced process that requires substantial knowledge and skill. The following resources can help further development of your knowledge and skills in this important area.

Baker, R. W., & Trzepacz, P. T. (2013). Conducting a mental status examination. *Psychologists' desk reference* (3rd ed., pp. 17–22). New York, NY: Oxford University Press. doi:10.1093/med:psych/9780199845491.003.0002. This is a brief description of a model for conducting MSEs, from the perspective of psychologists.

Folstein, M. E., Folstein, S. E., & McHugh, P. R. (1975). "Mini-mental state": A practical method for grading the cognitive state of patients for the clinician. *Journal of Psychiatric Research*, 12, 189–198. This article presents a quick and commonly

used method for evaluating client mental state. The mini-mental state is often used in psychiatric and geriatric settings.

Garcia-Barrera, M., & Moore, W. R. (2013). History taking, clinical interviewing, and the mental status examination in child assessment. In D. H. Saklofske, C. R. Reynolds, & V. L. Schwean (Eds.), *The Oxford handbook of child psychological assessment* (pp. 423–444). New York, NY: Oxford University Press. If you're interested in how to conduct interviews and MSEs with children, this is a good resource.

Gluck, M., Mercado, E., & Myers, C. E. (2013). *Learning and memory: From brain to behavior*. New York, NY: Worth. See Chapter 3 for an excellent review of episodic and semantic memory.

Morrison, J. (2007). *The first interview: A guide for clinicians* (3rd ed.). New York, NY: Guilford Press. This text includes two chapters discussing the MSE. It's especially helpful in giving guidance regarding potential diagnostic labels associated with specific mental status symptoms.

Othmer, E., & Othmer, S. C. (2002). *The clinical interview using DSM-IV-R: Vol. 1. Fundamentals*. Washington, DC: American Psychiatric Press. Chapter 4 of this text, "Three Methods to Assess Mental Status," contains useful information about mental status evaluation.

Paniagua, F. A. (2001). *Diagnosis in a multicultural context*. Thousand Oaks, CA: Sage. Paniagua provides many examples of appropriate and inappropriate diagnostic and assessment procedures and conclusions with multicultural patients.

Polanski, P. J., & Hinkle, J. S. (2000). The mental status examination: Its use by professional counselors. *Journal of Counseling and Development*, 78, 357–364. This brief article, published in a major counseling journal, illustrates the central place MSEs have taken with regard to client assessment in all mental health professions.

Robinson, D. J. (2001). *Brain calipers: Descriptive psychopathology and the psychiatric mental status examination* (2nd ed.). Port Huron, MI: Rapid Psychler Press. This book provides an overview of the MSE with examples, sample questions, and discussions of the relevance of particular findings. It uses an entertaining approach complete with illustrations, humor, mnemonics, and summary diagrams. It also has a helpful chapter on the Mini-Mental State Examination.

Strub, R. L., & Black, W. (1999). *The mental status examination in neurology* (4th ed.). Philadelphia, PA: F. A. Davis. This is a popular and classic MSE training text for medical students. It provides excellent practical and sensitive methods for determining client mental status, along with some norms for evaluating patient performance on specific cognitive tasks.

Zuckerman, E. L. (2010). *The clinician's thesaurus: The guide to conducting interviews and writing psychological reports* (7th ed.). New York, NY: Guilford Press. This comprehensive resource includes three chapters focusing on the MSE.



# SUICIDE ASSESSMENT

## Chapter Orientation

Suicide is an issue many people don't like to talk or think about. But within the context of a clinical interview, talking about suicide is essential. In this chapter, we outline and discuss state-of-the-art methods for conducting suicide assessment interviews.

### VIDEO 10.1

## Facing the Suicide Situation

The primary thought disorder in suicide is that of a pathological narrowing of the mind's focus, called constriction, which takes the form of seeing only two choices; either something painfully unsatisfactory or cessation.

—Edwin Shneidman, “Aphorisms of Suicide and Some Implications for Psychotherapy,” in *American Journal of Psychotherapy*, 1984, pp. 320–321

Working with clients who are suicidal is one of the most stressful tasks mental health professionals face (Fowler, 2012). It takes little imagination to conjure up the stress. Consider this: *Your new client tells you he's thinking of suicide . . . you try to develop a treatment plan to keep him safe . . . he assures you that he'll be fine and thanks you for your concern . . . but, during the subsequent week, he ends his life.*

This sequence of events can be personally and professionally devastating.

### LEARNING OBJECTIVES

After reading this chapter, you will be able to:

- Recite recent statistical trends in national suicide rates
- Describe the benefits and limits of using suicide risk factors, protective factors, and warning signs in determining suicide risk
- Discuss theoretical and research-based foundations for contemporary suicide assessment and intervention
- Conduct a thorough and clinically informed suicide assessment interview
- Apply specific suicide interventions, including safety planning
- Describe ethical and professional issues for working with suicidal clients

When mental health professionals discover that a client is suicidal, the law is clear: You have a professional *duty to protect*. Jobes and O'Connor (2009) wrote:

All states . . . have explicit expectations of a duty to protect that requires clinical recognition of the severity of clients' emotional and behavioral problems when these struggles pose an imminent danger to self. (p. 165)

The duty to protect is both an ethical and legal mandate (*Tarasoff v. Board of Regents of California*, 1974; *Tarasoff v. Regents of the University of California*, 1976). If you determine that a client is actively suicidal, you become legally responsible to initiate safety planning (Pabian, Welfel, & Beebe, 2009).

It's not possible to know in advance if your next client will be suicidal, so all clinicians should prepare themselves to work with suicidal clients (J. Sommers-Flanagan & Sommers-Flanagan, 1995a). In this chapter, we explore professional and personal issues associated with working with suicidal clients. We also outline state-of-the-art suicide assessment interviewing approaches that all prospective therapists should master.

## Personal Reactions to Suicide

In 1949, Edwin Shneidman, a suicidology pioneer, was working at the Los Angeles Veteran's Administration. He was asked to write condolence letters to two widows of soldiers who died by suicide, and he stumbled on a vault of suicide notes at the L.A. county coroner (Leenaars, 2010). In retrospect, he wrote:

The fulcrum moment of my suicidological life was not when I came across several hundred suicide notes in a coroner's vault while on an errand for the director of the VA hospital, but rather a few minutes later, in the instant when I had a glimmering that their vast potential value could be immeasurably increased if I did not read them, but rather compared them, in a controlled blind experiment, with simulated suicide notes that might be elicited from matched nonsuicidal persons. My old conceptual friend, John Stuart Mill's Method of Difference, came to my side and handed me my career. (Leenaars, 1999, p. 247)

Shneidman became a determined advocate for suicide prevention. His work enabled him to vividly describe the inner world of individuals with suicidal thoughts and impulses:

Suicide always involves an individual's tortured and tunneled logic in a state of inner-felt, intolerable emotion. In addition, this mixture of constricted thinking and unbearable anguish is infused with that individual's conscious and unconscious psychodynamics (of hate, dependency, hope, etc.), playing themselves out within a social and cultural context, which itself imposes various degrees of restraint on, or facilitations of, the suicidal act. (Leenaars, 2010, p. 8)

Shneidman's description of the suicidal mind is provocative. Reading his ideas and this chapter, as well as practicing suicide assessment interviewing in class, can evoke challenging emotions. These reactions are especially likely if you've had someone close to you attempt or complete suicide, or if you, like many people, have contemplated suicide at some point in your life. We recommend that you discuss your reactions to this chapter with colleagues, instructors, or a personal counselor. At the chapter's end, we turn again to a discussion of the emotional ramifications of suicide for mental health professionals.

## Suicide Statistics

Every year, the Centers for Disease Control and Prevention (CDC) provide national statistics on death by suicide. These data are available through the CDC's Web Based Injury Statistics Query and Reporting System (WISQARS; [www.cdc.gov/injury/wisqars/index.html](http://www.cdc.gov/injury/wisqars/index.html)).

Suicide rates are commonly reported in terms of number of deaths per 100,000 individuals. Using this metric, suicide rates in the United States are generally stable from year to year. However, over the past 14 years, death by suicide in the United States has consistently edged upward, increasing over 30% (from 10.0 per 100,000 individuals in 1999 to 13.4 deaths per 100,000 individuals in 2014). The current suicide rate in the United States is the highest in recent history.

Suicide is a major national health concern. The numbers are tragic, but statistically speaking, death by suicide occurs at a very low base rate (13.4 per 100,000). This low base rate poses a prediction problem. Robert Litman (1995), a renowned suicidologist, wrote:

At present it is impossible to predict accurately any person's suicide. Sophisticated statistical models . . . and experienced clinical judgments are equally unsuccessful. When I am asked why one depressed and suicidal patient commits suicide while nine other equally depressed and equally suicidal patients do not, I answer, "I don't know." (p. 135)

For clinicians, Litman's prediction problem translates into a prevention problem. Predicting which 13.4 individuals of every 100,000 will die by suicide is virtually impossible. The good news is that since Litman's (1995) statement, research that might aid in the prediction and prevention of death by suicide has accumulated. However, there's also bad news: the CDC's suicide data over the past 15 years indicate that there's no evidence that our ability to predict and prevent suicide has improved. This has led to calls for new approaches to understanding and preventing suicide (M. Silverman & Berman, 2014; Tucker, Crowley, Davidson, & Gutierrez, 2015).

**VIDEO  
10.2**

## **Suicide Risk Factors, Protective Factors, and Warning Signs**

Over the past 20-plus years, hundreds of risk factors and dozens of warning signs have been identified in the research literature (Tucker et al., 2015). Individual studies consistently uncover new links to suicidal behavior and give hope to the possibility of improved suicide prediction and prevention (Bernert, Turvey, Conwell, & Joiner, 2014).

Unfortunately, a close analysis of suicide risk factors or assessments of warning signs don't appear especially helpful to clinicians (Lester, McSwain, & Gunn, 2011; Tucker et al., 2015). There are many reasons for this, including (a) the overwhelming number of risk factors and warning signs available; (b) the extremely low base rate of death by suicide (and the proliferation of false positive predictions); and (c) the fact that even the best risk factors and warning signs don't effectively distinguish between suicidal and nonsuicidal individuals (Bolton, Spiwack, & Sareen, 2012; Tucker et al., 2015).

Although we cover risk factors and warning signs next, this coverage is abbreviated. We then move to information that will provide you with a more nuanced awareness of the multidimensional and multidetermined nature of suicide. As you read this section, remember that although knowing suicide risk factors and warning signs can be intellectually stimulating, developing a positive working alliance with potentially suicidal clients is far more important (Jobes, Au, & Siegelman, 2015). And also note this essential fact: *An absence of risk factors and warning signs in individual clients is no guarantee of safety from suicidal impulses.*

### **Risk Factors**

A *suicide risk factor* is a measurable demographic, trait, behavior, or situation that has a positive correlation with suicide attempts and/or death by

suicide. In the past, researchers and clinicians have developed strategies for remembering and systematically assessing the presence or absence of suicide risk factors within individual clients. In our opinion, the proliferation of suicide risk factor checklists isn't particularly helpful (Warden, Spiwak, Sareen, & Bolton, 2014). Instead—and we recognize that we're advocating only a subtle shift in perspective—what's important is to spend time *understanding suicide risk factors* and how and why they contribute to suicide risk.

### ***Mental Disorders and Psychiatric Treatment***

Suicide prevention websites and resources often emphasize that over 90% of individuals who die by suicide have a diagnosable mental disorder. Although the 90% number sounds impressive, this statistic is basically meaningless, as nearly 100% of clients you'll see in clinical settings will have diagnosable mental disorders. However, some specific mental disorders, symptom clusters, and psychiatric treatments do confer greater risk, and this information is important.

**Depression.** The relationship between depression and suicidal behavior is well established (Bolton, Pagura, Enns, Grant, & Sareen, 2010). Clients with clinical depression *and* one or more of the following symptoms are at significant risk (Fawcett, Clark, & Busch, 1993; Marangell et al., 2006):

- Hopelessness
- Severe anxiety
- Panic attacks
- Severe anhedonia
- Alcohol abuse
- Substantially decreased ability to concentrate
- Global insomnia
- Repeated deliberate self-harm
- History of physical/sexual abuse
- Employment problems
- Relationship loss

**Posttraumatic stress disorder.** In a file review of 200 outpatients, child sexual abuse was a better predictor of suicidality than depression (Read, Agar, Barker-Collo, Davies, & Moskowitz, 2001). Similarly, data from the National Comorbidity Survey ( $n = 5,877$ ) showed that women who were sexually abused as children were two to four times more likely to attempt suicide than nonabused females, and men sexually abused as children were

4 to 11 times more likely to attempt suicide than nonabused males (Molnar, Berkman, & Buka, 2001). Overall, trauma is more predictive of suicide when it occurs earlier in life and is assaultive, chronic, and severe (Wilcox & Fawcett, 2012).

**Bipolar disorder.** Researchers (Azorin et al., 2009; Cassidy, 2011) have identified many specific risk factors among clients with bipolar disorder that predict increased suicidality:

- Multiple hospitalizations
- Depressive or mixed polarity of first episode
- Presence of stressful life events before illness onset
- Younger age at onset
- No symptom-free intervals between episodes
- Being female
- Greater number of previous episodes
- Cyclothymic temperament
- Family suicide history
- History of cocaine or benzodiazepine abuse

**Substance abuse or dependence.** Research unequivocally links alcohol and drug use to suicide (Sher, 2006). Suicide risk increases even more substantially when substance abuse is associated with other risk factors, such as depression and social isolation. Because alcohol and substances reduce inhibition, they increase immediate suicide risk.

**Schizophrenia.** A diagnosis of schizophrenia generally increases suicide risk, but among individuals diagnosed with schizophrenia, the specific factors that increase risk include the following (Hor & Taylor, 2010):

- Age (being younger)
- Sex (being male)
- Higher education level
- Number of prior suicide attempts
- Depressive symptoms
- Active hallucinations and delusions
- Having insight into one's problems
- Family history of suicide
- Comorbid substance misuse

**Anorexia nervosa.** Anorexia is linked to higher suicide rates, but also has the unpleasant distinction of being a mental disorder that can directly

cause death. This has led some to contend that anorectic symptoms represent low-grade, chronic suicidality. Researchers report that purging and depressive features increase suicidality in some clients, while anxiety along with restricting symptoms increases suicide risk in others (Forcano et al., 2011).

**Borderline personality disorder.** Clients with a borderline personality diagnosis are well known for engaging in repeated self-harm or parasuicidal behavior. They're also at higher risk for death by suicide. Training in dialectical behavior therapy (DBT) and in using a DBT suicide risk assessment and management protocol is vital to working effectively with this population (Linehan et al., 2015).

**Conduct disorder.** Youth diagnosed with conduct disorder are at higher suicide risk. This is especially true if depression and/or substance abuse or dependence is also present. It may be that the impulsiveness, poor family relations, and other factors linked to misconduct contribute to heightened suicide risk (Vander Stoep et al., 2011).

**Insomnia.** Insomnia in the context of other mental disorders has long been known to increase suicide risk. More recently, however, data have accumulated indicating that insomnia is an independent risk factor. In one study of young adults in the military, self-reported insomnia was more significant than several traditional suicide risk factors (e.g., hopelessness, PTSD diagnosis, depression severity, alcohol and drug abuse; Ribeiro et al., 2012).

**Post-hospital discharge.** Psychiatric patients are at increased risk for suicide immediately following hospital discharge. This is particularly true of individuals with additional risk factors, such as previous suicide attempts, lack of social support, and chronic mental disorders (Links et al., 2012).

**Serotonin specific reuptake inhibitors (SSRIs).** All SSRI medication labels in the United States include a black box warning (US Food and Drug Administration, 2007). The warning states:

Antidepressants increased the risk compared to placebo of suicidal thinking and behavior (suicidality) in children, adolescents, and young adults in short-term studies of Major Depressive Disorder (MDD) and other psychiatric disorders. Patients of all ages who are started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber.

Agitation and violent thoughts are most likely to be stimulated following recent administration of SSRIs (after 30 minutes and until

30 days have passed; Healy, 2009; D. Healy, personal communication, February 17, 2004).

### ***Social, Personal, Contextual, and Demographic Factors***

Many social, personal, and contextual factors are linked to increased suicide risk. A list and brief description of these factors follow.

**Social isolation/loneliness.** Divorced, widowed, and separated people are at higher risk of suicide. Single, never-married individuals have a suicide rate nearly double that of married individuals (Van Orden et al., 2010). Researchers have reported that factors traditionally linked to loneliness (e.g., social scapegoating, unemployment, physical incapacitation) probably contribute most strongly to suicide when combined with hopelessness (Hagan, Podlogar, Chu, & Joiner, 2015).

**Previous attempts.** Suicide risk is higher for people with previous suicide attempts (Fowler, 2012). Van Orden et al. (2010) refer to previous attempts as “one of the most reliable and potent predictors of future suicidal ideation, attempts, and death by suicide across the lifespan” (p. 577).

**Non-suicidal self-injury (NSSI).** NSSI or self-mutilation is generally considered a means of emotional regulation and not indicative of increased suicide risk. However, repeated self-harm also predicts eventual suicide, especially in young women (Zahl & Hawton, 2004). Specifically, when self-harm progressively rises to single or repeated hospitalization, it may constitute an experimental or practicing behavior that leads to death by suicide.

**Physical illness.** Many decades of research have established the link between physical illness and suicide. Specific illnesses that confer increased suicide risk include brain cancer, chronic pain, stroke, rheumatoid arthritis, hemodialysis, and dementia (Jia, Wang, Xu, Dai, & Qin, 2014).

**Unemployment or personal loss.** Individuals who suffer personal loss are at higher suicide risk. Unemployment is a particular loss-related life situation linked to suicide attempts and death by suicide. The increased risk may arise, in part, because individuals experience a sense of being a burden on others (Joiner, 2005). Other losses that increase risk include (a) status loss, (b) loss of a loved one, (c) loss of physical health or mobility, (d) loss of a pet, and (e) loss of face through shameful events (Hall, Platt, & Hall, 1999; Mandal & Zalewska, 2012).

**Military personnel and veteran status.** Data on military personnel and veteran status are difficult to interpret. However, veteran status in general, and being a young veteran in particular, appear to confer substantially higher suicide risk. The reasons for this may include (a) post-traumatic stress, (b) access to firearms, (c) difficulties adjusting to civilian life, and (d) reluctance to acknowledge emotional problems or seek help.

**Sexual orientation and sexuality.** Reports are mixed as to whether lesbian, gay, bisexual, transgender, or queer (LGBTQ) individuals are a high suicide risk group. A 2011 publication in the *Journal of Homosexuality* reported no clear evidence that LGB individuals die by suicide at a rate greater than the general population (Haas et al., 2011). However, LGBTQ populations have significantly higher suicide attempt rates. In particular, parental rejection, depression, hopelessness, sexuality-related verbal abuse, and previous suicide attempts substantially increase suicide risk for this population (D'augelli et al., 2005; Mustanski & Liu, 2013).

**Firearms availability.** Firearms constitute a highly lethal suicide method. This may be why more than 50% of deaths by suicide in the United States involve firearms. Access to firearms is a suicide risk factor within the United States and in other countries (Runyan, Brown, & Brooks-Russell, 2015). Firearms safety and restriction are associated with reduced suicide rates, especially among males (T. Hoyt, & Duffy, 2015; Rodríguez Andrés & Hempstead, 2011).

**Suicide contagion.** *Suicide contagion* is defined as indirect or direct passing on of suicidal behavior from one person to another. Researchers report that suicide contagion operates in conjunction with other preexisting suicide risk factors (Lake & Gould, 2014). Whether there is a local suicide or a highly publicized suicide (e.g., Robin Williams), individuals with a history of depression and suicide attempts are at the highest risk of contagion (A. Cheng et al., 2007).

**Abuse and bullying.** Social trauma and bullying can be a distinct contextual factor linked to suicide ideation, attempts, and death by suicide. Bullying and abuse can occur online (cyberbullying), in school, or outside school. Some researchers describe a phenomenon referred to as “spontaneous, unplanned adolescent suicides” that appear unrelated to depression and other traditional risk factors and may be a function of social relationship dynamics (K. Reed, Nugent, & Cooper, 2015, p. 128).

**Demographics.** Age, sex, and race are not strong predictors of suicide, but some clinicians find that having knowledge about higher- and lower-risk groups is helpful. Table 10.1 summarizes major trends.

## Protective Factors

*Protective factors* against suicide are personal or contextual factors that have been shown to decrease suicide risk or aid in resisting suicide impulses. Researchers have identified two types of protective factors: (a) factors empirically linked to reduced suicide risk in the general US population;

**Table 10.1** Demographics and Suicide\***Sex and Gender**

The rate of male suicide is nearly four times the rate of females:

Males = 20.2/100,000

Females = 5.5/100,000

Females attempt suicide about four times more often than males.

**Age**

Suicide is extremely rare for children under age 14 years: 0.7/100,000.

Rates are low among 15- to 24-year-olds: 10.9/100,000.

Rates are highest in the 45- to 64-year-old range: 19.1/100,000.

**Race/Ethnicity**

Whites have the highest suicide rate: 14.2/100,000.

American Indians have the next highest rate: 11.7/100,000.

Blacks, Asian/Pacific Islanders, and Hispanic/Latina(o)s are all below 6.0/100,000.

**Combination Demographics**

Among Whites, especially White males, risk tends to increase with age, especially when other risk factors are present (e.g., illness, being single).

Suicide rates are higher among young (15- to 24-year-old) Native American populations and decrease with age, but rise among adult Alaskan Natives.

Adult Black females have the lowest rates at about 2.0/100,000.

\*All numbers are based on the CDC's 2013 data.

(b) factors that protect against suicide for individuals within specific populations (e.g., military personnel, transgender individuals, Native American youth).

General suicide protective factors include the following:

- Reasons for living (e.g., being a role model for others, having children or loved ones)
- Higher global functioning (i.e., individuals who score higher on overall life functioning tend to have lower suicide rates)
- Social support (e.g., reporting many friendships)
- Life evaluations (e.g., viewing life as meaningful)
- Frequent religious service attendance
- Suicide-related beliefs (e.g., believing that suicide is an unacceptable life choice)

Specific protective factors include:

- Connectedness to parent (for adolescents)
- Neighborhood safety (for adolescents)
- Academic achievement (for adolescents)
- Supportive school climate (for sexual minority youth)
- Coming out/disclosing (for transgender adults)

Similar to risk factors, suicide protective factors offer clinicians no detectable statistical or predictive advantage. However, knowing and thinking about protective factors can deepen your understanding of what might help protect individuals from suicide. Further, if you understand protective factors, you're better prepared to work collaboratively with individual clients to expand on the unique protective factors they find most personally meaningful and relevant.

## Warning Signs

In 2003, the American Association of Suicidology (AAS) brought together a group of expert suicidologists to develop an evidence-based list of suicide warning signs (Juhnke, Granello, & Lebrón-Striker, 2007). The purpose was to provide an alternative to risk factor assessment. The hope was to use suicide warning signs in a manner similar to how warning signs are used for heart attacks; signals of immediate suicide risk could guide medical interventions.

The AAS work group reviewed hundreds of warning signs in the research literature and on public Internet sites. They distilled these to their 10 top suicide-specific warning signs. The acronym IS PATH WARM was used to facilitate recall of the warning signs:

I = Ideation

S = Substance use

P = Purposelessness

A = Anxiety

T = Trapped

H = Hopelessness

W = Withdrawal

A = Anger

R = Recklessness

M = Mood change

IS PATH WARM is referred to as evidence based because the AAS work group based their decision making on empirical research. Unfortunately, subsequent research hasn't supported IS PATH WARM. In one study, the only warning sign that distinguished between individuals who made a suicide attempt and those who had suicide ideation—but didn't make an attempt—was anger/aggression (Gunn, Lester, & McSwain, 2011). Another study showed that IS PATH WARM failed to discriminate between genuine and simulated suicide notes (Lester et al., 2011). Although these studies don't spell the end of IS PATH WARM, they illustrate some of the frustrations of trying to predict or anticipate suicidal behavior. Although we encourage you to experiment to see if using IS PATH WARM helps improve your suicide assessment process, you shouldn't mistakenly consider it an empirically supported approach. There is no empirically supported assessment approach that utilizes suicide warning signs or risk factors (Bolton et al., 2012).

**VIDEO  
10.3**

## **Building a Theoretical and Research-Based Foundation**

If suicide risk factors and warning signs aren't empirically supported approaches, then what reasonable options can you use as your guide? There's currently no great answer to this question; but for now, using broad theoretical models to inform a practical, client-friendly strategy probably constitutes a better approach than overreliance on statistical models.

### **Shneidman's Theory**

Shneidman posited three factors that directly contribute to suicidality:

1. Psychache
2. Mental constriction
3. Perturbability

Shneidman used the term *psychache* to describe the intense personal pain, anguish, shame, and other negative emotions associated with suicidal crises. He believed that as psychache increases and becomes intolerable, suicide emerges as a potential solution. Not only is the intensity of psychache important, but the degree to which psychache is experienced as unrelenting and permanent also drives suicidal behavior. Psychache plus hopelessness creates higher suicide risk.

*Mental constriction* is a problem-solving deficit that occurs when there is a narrowing of thought so that suicidal individuals cannot see beyond two alternatives: (a) continued psychache and misery or (b) cessation of life

to eliminate psychache. Researchers have reported that as depression and suicide ideation increase, problem-solving ability becomes impaired (Ghahramanlou-Holloway, Bhar, Brown, Olsen, & Beck, 2012). This implies that suicide interventions should include active and collaborative problem solving (Quiñones, Jurska, Fener, & Miranda, 2015).

*Perturbability* is a state of agitation or heightened arousal; it's characterized by an inner drive to act or "do something." When psychache is present, perturbability drives clients toward stopping the associated pain and misery. Researchers have also referred to this as agitation, arousal, or overarousal, noting that "acute states of heightened arousal—in particular, sleep disturbance and agitation—have been repeatedly linked to suicidal behavior" (Ribeiro, Silva, & Joiner, 2014, p. 106).

Shneidman's three factors should inform all suicide assessment interviewing and intervention models. As mental health professionals, we should be thinking about how we can assist clients in reducing their pain, improving their problem-solving skills, and coping with agitation/arousal.

### Joiner's Interpersonal Theory

Many risk and protective factors fall under the broad umbrella of Thomas Joiner's interpersonal theory of suicide (Joiner & Silva, 2012). Joiner (2005) theorized that two interpersonal factors can be proximal causes of suicidal intent:

- Thwarted belongingness (social isolation)
- Perceived burdensomeness

There are well over 50 empirical studies indicating that social isolation contributes to suicide risk and, conversely, that social support functions as a protective factor. One of your primary goals should be to establish an empathic interpersonal connection with clients who have suicidal ideation.

### New Empirical and Conceptual Approaches

Scientific knowledge about suicide and suicide prevention naturally changes over time; well-meaning practitioners sometimes operate on old, outdated information. Knowing the latest research and practice information for working with suicidal clients is essential. (See Table 10.2 for a summary of old suicide myths and new suicide narratives.)

#### ***Beyond the Medical Model: A Constructive Approach***

The *medical model* refers to the diagnosis and treatment of illness. The approach of focusing in on illness, identifying or naming it, and then

**Table 10.2** A Summary of Old Suicide Myths and New Narratives

Old Myth or Method	New Narrative and Approach
We look for pathology.	We look for strengths.
We view suicide ideation as deviance.	We normalize suicide ideation and view it as a communication of distress or psychache.
We emphasize risk factor assessment and diagnostic interviewing.	We balance risk factor assessment with protective factor assessment and recognize that diagnosis is nearly irrelevant.
We implement treatments on clients and establish no-suicide contracts.	We engage clients empathically in a collaborative process of assessment, treatment, and safety planning.

applying treatments to make it go away is a good fit for many health conditions. However, emphasizing illness isn't a good fit for suicide assessment and treatment.

Contemporary practitioners began integrating a constructive (narrative and solution-focused) perspective into suicide prevention work in the 1990s. This perspective holds that, at least to some extent, individuals construct their own personal meaning and reality (J. Sommers-Flanagan & Sommers-Flanagan, 2012).

Constructive theorists posit that whatever we consciously focus on, be it relaxation or anxiety or depression or happiness, shapes our individual reality (Gergen, 2009; S. Hayes, 2004). What this means for suicide assessment and treatment going forward is that *clinicians should move away from illness-based weaknesses, deficits, and limitations and instead adopt a stronger emphasis on clients' strengths, resources, and potentials*.

### ***Suicide Ideation: A Sign of Distress, Not Deviance***

Historically, suicidal thoughts and behaviors were viewed as representing a deviant mental state. However, this perspective is inaccurate and impractical. It's inaccurate because suicide ideation occurs at a high rate among the general US population. For example, the annual prevalence of suicide ideation among college students is approximately 21% (Center for Collegiate Mental Health, 2015; Farabaugh et al., 2015). Thus suicide ideation is not a deviation from normal. Many people share this experience.

Viewing suicide ideation as deviance is also impractical, because suicide ideation is primarily a means of communicating emotional pain and distress. When clients talk about suicide, they're articulating psychache and communicating a need for assistance and support (Shneidman, 1980).

Holding the belief that suicide ideation is pathological creates distance between clinician and client. If clients sense negative judgments, they'll be less open and honest about their suicidal thoughts. In one study, 78% of

patients who died by suicide in hospitals denied suicidal thoughts during their last professional contact (Busch, Fawcett, & Jacobs, 2003). Viewing suicide ideation as a natural means of communicating distress allows both clinician and client to work more effectively on the problems leading to the suicidal impulses.

### ***Emphasizing Protective Factors Over Risk Factors and Wellness Over Diagnosis***

The medical model's focus on what's wrong or diseased is a compelling perspective. Pursuing a mental disorder diagnosis can be hard to resist. Doing so can translate to an overemphasis on risk factor assessment. For example, your focus might be too negative:

- Have you ever tried to kill yourself?
- When was the last time you used drugs or alcohol?
- Has anyone in your family ever committed suicide?

Similarly, when performing a diagnostic assessment for clinical depression, clinicians can place an excessive emphasis on the negative:

- Over the past two weeks, have you felt down or depressed most of the day and nearly every day?
- How often do you feel worthless or very guilty about something?
- Do you have any difficulty sleeping or problems waking up and getting up in the morning?

Many studies have illustrated how easy it is to get humans to experience low and depressive moods (Lau, Haigh, Christensen, Segal, & Taube-Schiff, 2012; Teasdale & Dent, 1987). Focusing exclusively on risk factors and diagnostic criteria during a clinical interview can activate or exacerbate your client's depressive mood state and potentially impair problem solving. This is an example of how an illness-oriented perspective can inadvertently facilitate an iatrogenic process (A. Horwitz & Wakefield, 2007).

Rather than continually drilling down into your clients' depressive and suicidal symptoms, balancing risk factor and diagnostic assessments with wellness-oriented questions is recommended. Forgetting to ask your client about positive experiences is like forgetting to go outside and breathe fresh air.

### ***Collaborating With Clients Who Are Suicidal***

The idea that health care professionals must take an authoritarian role when evaluating and treating suicidal clients has proven problematic.

Authoritarian clinicians can activate oppositional or resistant behaviors (W. Miller & Rollnick, 2013). If you try arguing clients out of suicidal thoughts and impulses, they may shut down and become less open.

For decades, *no-suicide contracts* were a standard practice for suicide prevention and intervention (Drye, Goulding, & Goulding, 1973). These contracts consisted of signed statements like “I promise not to commit suicide between my medical appointments.” In a fascinating turn of events, during the 1990s, no-suicide contracts came under fire as coercive and as focusing more on practitioner liability than client well-being (Edwards & Sachmann, 2010; Rudd, Mandrusiak, & Joiner, 2006). Suicide experts no longer advocate their use.

Instead, collaborative approaches to working with suicidal clients are strongly recommended. One such approach is called the *collaborative assessment and management of suicide* (CAMS; Jobes, 2016). The CAMS emphasizes suicide assessment and intervention as a humane encounter honoring clients as experts regarding their suicidal thoughts, feelings, and situation. Jobes, Moore, and O’Connor (2007) wrote:

CAMS emphasizes an intentional move away from the directive “counselor as expert” approach that can lead to adversarial power struggles about hospitalization and the routine and unfortunate use of coercive “safety contracts.” (p. 285)

Consistent with Shneidman’s theory, Jobes (2016) recommended viewing clients’ suicidal thoughts and behaviors as efforts to cope with and manage their personal pain and suffering. Using the CAMS model, therapist and client collaborate to monitor suicide ideation and develop an individualized treatment plan (Jobes et al., 2004). From first contact, treating clients with suicide potential now emphasizes a collaborative therapy alliance (see Chapter 7).

All of the preceding information about personal reactions to suicide, suicide statistics, risk factors, protective factors, warning signs, suicide theory, and suicide myths was designed to build a foundation for your primary suicide assessment and intervention assignment: to perform a state-of-the-art (and science) collaborative suicide assessment interview.

## VIDEO 10.4

### Suicide Assessment Interviewing

A comprehensive and collaborative suicide assessment interview is the professional gold standard for assessing suicide risk. Suicide assessment scales and instruments can be a valuable supplement—but not a substitute—for suicide assessment interviewing (see Putting It in Practice 10.1).

A comprehensive suicide assessment interview includes the following components:

- Gathering information about suicide risk and protective factors. This should be done in a manner that emphasizes your desire to understand the client and not as a checklist to estimate risk.
- Asking directly about possible suicidal thoughts.
- Asking directly about possible suicide plans.
- Gathering information about client self-control and agitation.
- Gathering information about client suicide intent and reasons to live.
- Consultation with one or more professionals.
- Implementation of one or more suicide interventions, including, at the very least, collaborative work on developing an individualized safety plan.
- Detailed documentation of your assessment and decision-making process. (Table 10.3 includes an acronym—RIP SCIP—to help you recall the components of a comprehensive suicide assessment interview.)

**Table 10.3** RIP SCIP—A Suicide Assessment Acronym

**R** = Risk and Protective Factors

**I** = Suicide Ideation

**P** = Suicide Plan

**SC** = Client Self-Control and Agitation

**I** = Suicide Intent and Reasons for Living

**P** = Safety Planning

## Exploring Suicide Ideation

Unlike many other risk factors (e.g., demographic factors), suicide ideation is directly linked to potential suicidal behavior. It's difficult to imagine anyone ever dying by suicide without having first experienced suicide ideation.

Because of this, you may decide to systematically ask every client about suicide ideation during initial clinical interviews. This is a conservative approach and guarantees you won't face a situation where you should have asked about suicide but didn't. Alternatively, you may decide to weave questions about suicide ideation into clinical interviews as appropriate. At least initially, for developing professionals, we recommend using the systematic

approach. However, we recognize that this can seem rote. From our perspective, it is better to learn to ask artfully by doing it over and over than to fail to ask and then regret it.

The nonverbal nature of communication has direct implications for how and when you ask about suicide ideation, depressive symptoms, previous attempts, and other emotionally laden issues. For example, it's possible to ask: "Have you ever thought about suicide?" while nonverbally communicating to the client, "Please, please say no!" Therefore, before you decide how you'll ask about suicide ideation, you need to adopt the right attitude about asking the question.

Individuals who have suicidal thoughts can be extremely sensitive to social judgment. They may have avoided sharing suicidal thoughts out of fear of being judged as "insane" or some other stigma. They're likely monitoring you closely and gauging whether you're someone to trust with this deeply intimate information. To pass this unspoken test of trust, it's important to endorse and directly or indirectly communicate the following beliefs:

- Suicide ideation is normal and natural, and counseling is a good place for clients to share those thoughts.
- I can be of better help to clients if they tell me their emotional pain, distress, and suicidal thoughts.
- I want my clients to share their suicidal thoughts.
- If my clients share their suicidal thoughts and plans, I can handle it!

If you don't embrace these beliefs, clients experiencing suicide ideation may choose to be less open.

### ***Asking Directly About Suicide Ideation***

Asking about suicide ideation may feel awkward. Learning to ask difficult questions in a deliberate, compassionate, professional, and calm manner requires practice. It also may help to know that, in a study by Hahn and Marks (1996), 97% of previously suicidal clients were either receptive or neutral about discussing suicide with their therapists during intake sessions. It also may help to know that you're about to learn the three most effective approaches to asking about suicide that exist on this planet.

**Use a normalizing frame.** Most modern prevention and intervention programs recommend directly asking clients something like "Have you been thinking about suicide recently?" This is an adequate approach if you're in a situation with someone you know well and from whom you can expect an honest response.

A more nuanced approach is to ask about suicide along with a normalizing or universalizing statement about suicide ideation. Here's the classic example:

Well, I asked this question since almost all people at one time or another during their lives have thought about suicide. There is nothing abnormal about the thought. In fact it is very normal when one feels so down in the dumps. The thought itself is not harmful. (Wollersheim, 1974, p. 223)

Here are three more examples of using a normalizing frame:

1. I've read that up to 50% of teenagers have thought about suicide. Is that true for you?
2. Sometimes when people are down or feeling miserable, they think about suicide and reject the idea, or they think about suicide as a solution. Have you had either of these thoughts about suicide?
3. I have a practice of asking everyone I meet with about suicide, so I'm going to ask you: Have you had thoughts about death or suicide?

A common fear is that asking about suicide will put suicidal ideas in clients' heads. There's no evidence to support this (Jobes, 2016). More likely, your invitation to share suicidal thoughts will reassure clients that you're comfortable with the subject, in control of the situation, and capable of dealing with the problem.

**Use gentle assumption.** On the basis of more than two decades of clinical experience with suicide assessment, Shawn Shea (2004; Shea & Barney, 2015) recommended using a framing strategy referred to as *gentle assumption*. To use gentle assumption, the interviewer presumes that certain illegal or embarrassing behaviors are already occurring in the client's life, and gently structures questions accordingly. For example, instead of asking, "Have you been thinking about suicide?" you would ask:

When was the last time you had thoughts about suicide?

Gentle assumption can make it easier for clients to disclose suicide ideation.

**Use mood ratings with a suicidal floor.** It can be helpful to ask about suicide in the context of a mood assessment (as in an MSE). Scaling questions such as those that follow can be used to empathically assess mood levels (see also Case Example 10.1).

1. Is it okay if I ask some questions about your mood? (This is an invitation for collaboration; clients can say no, but rarely do.)

2. Please rate your mood right now, using a 0 to 10 scale. Zero is the worst mood possible. In fact, 0 would mean you're totally depressed and so you're just going to kill yourself. At the top, 10 is your best possible mood. A 10 would mean you're as happy as you could possibly be. Maybe you would be dancing or singing or doing whatever you do when you're extremely happy. Using that 0 to 10 scale, what rating would you give your mood right now? (Each end of the scale must be anchored for mutual understanding.)
3. What's happening now that makes you give your mood that rating? (This links the mood rating to the external situation.)
4. What's the worst or lowest mood rating you've ever had (or in the past 2 weeks)? (This informs the interviewer about the lowest lows.)
5. What was happening back then to make you feel so down? (This links the lowest rating to the external situation and may lead to discussing previous attempts.)
6. For you, what would be a normal mood rating on a normal day? (Clients define their normal.)
7. Now tell me, what's the best mood rating you think you've ever had? (The process ends with a positive mood rating.)
8. What was happening that helped you have such a high mood rating? (The positive rating is linked to an external situation.)

The preceding protocol assumes that clients are at least minimally cooperative. More advanced interviewing procedures can be added when clients are resistant (see Chapter 12). The process facilitates a deeper understanding of life events linked to negative moods and suicide ideation. This can lead to formal counseling or psychotherapy, as well as safety planning.

### ***Responding to Suicide Ideation***

Let's say you broach the question, and your client openly discloses the presence of suicide ideation. What next?

First, remember that hearing about your client's suicide ideation is good news. It reflects trust. Also remember that depressive and suicidal symptoms are part of a normal response to distress. Validate and normalize:

Given the stress you're experiencing, it's not unusual for you to sometimes think about suicide. It sounds like things have been really hard lately.

This validation is important because many suicidal individuals feel socially disconnected, emotionally invalidated, and as if they're a social

burden (Joiner, 2005). Your empathic reflection may be more or less specific, depending on how much detailed information your client has given you.

As you continue the assessment, collaboratively explore the frequency, triggers, duration, and intensity of your client's suicidal thoughts.

- *Frequency:* How often do you find yourself thinking about suicide?
- *Triggers:* What seems to trigger your suicidal thoughts? What gets them started?
- *Duration:* How long do these thoughts stay with you once they start?
- *Intensity:* How intense are your thoughts about suicide? Do they gently pop into your head, or do they have lots of power and sort of smack you down?

As you explore the suicide ideation, strive to emanate calmness and curiosity, rather than judgment. Instead of thinking, “We need to get rid of these thoughts,” engage in collaborative and empathic exploration.

Some clients will deny suicidal thoughts. If this happens, and it feels genuine, acknowledge and accept the denial, while noting that you were just using your standard practice.

Okay. Thanks. Asking about suicidal thoughts is just something I think is important to do with everyone.

If the denial seems forced, however, or is combined with depressive symptoms or several risk factors, you'll still want to use acknowledgment and acceptance, but then find a way to return to the topic later in the session.

### ***Exploring Depressive Symptoms***

You may be in a clinical situation where it's your role to conduct a formal diagnostic assessment for depression. If so, you should use a diagnostic assessment procedure or protocol (see Chapter 11). When possible, however, using a balance of positively and negatively oriented questions is recommended. Following are sample questions that focus on different dimensions of depression.

**Mood-related symptoms.** Open-ended questions are useful:

- How have you been feeling lately?
- Would you describe your mood for me?

In response, clients may or may not use diagnostically clear words like “sadness” or “irritability.” Instead, you might hear “I've just been feeling really nasty lately.” If that's the case, paraphrase with language similar to your client's (see Case Example 10.1).

**CASE EXAMPLE 10.1: USING A MOOD RATING WITH A SUICIDE FLOOR**

Open-ended questions are useful for obtaining a *qualitative sense* of a client's mood. In this example, the mood rating with a suicide floor is illustrated to get a *quantitative* mood rating.

**Therapist:** You said you've been feeling down and nasty. Is it okay if I ask you more questions about your mood to get a better feel for how down and nasty you're feeling?

**Client:** Yeah. Sure.

**Therapist:** Okay. Thanks. On a scale of 0 to 10, with 0 being the worst possible—so totally depressed that you're going to kill yourself—and with 10 being absolute perfect happiness, how would you rate how sad or how nasty you're feeling right now?

**Client:** Guess I'm at about a 3.

**Therapist:** What's happening right now to make your mood at a 3?

**Client:** I have to be here, and I know I'm down, and I don't like talking to shrinks much.

**Therapist:** How about over the past two weeks? On that same scale, what's the *very worst* you've felt?

**Client:** Last weekend I was at a 2. That's the worst I've ever felt.

**Therapist:** That sounds miserable (you could go deeper here).

**Client:** It was.

**Therapist:** What do you think was your best mood rating over the past two weeks?

**Client:** Last weekend I was a 5, I think.

**Therapist:** What was happening then?

**Client:** My daughter and grandkids came over to visit. That was pretty nice.

**Therapist:** It sounds like you enjoy time with them.

**Client:** Usually I do.

**Therapist:** How about your normal mood, when you're not feeling down or depressed or having to meet with me? What rating would you give your normal mood, outside of the past two weeks or this particular down time?

**Client:** Usually I'm a pretty happy person. My normal mood is about a 6 or 7.

In this exchange, the therapist obtained valuable assessment information. Using a simple rating scale, she now has a sense of her client's current mood, the range and triggers over the past two weeks, and the client's normal mood.

To maintain balance, it's useful to ask mood-related questions with a positive focus:

- What's happening in your life when you feel happy or joyful?
- When have you felt especially good?
- Some people feel especially good when they do something nice for someone else . . . does that help put you in a good mood, too?

Positive mood questions can pull clients toward more happy moods. If the client brightens, then you're seeing positive mood reactivity. If the questions don't work, the depressive condition may be deeper and more difficult to change.

Anhedonia is a specific mood-related symptom of major depressive disorder that involves a loss of interest or pleasure in usually enjoyable activities. Literally, *anhedonia* means "without pleasure." Positive questions about anhedonia include the following:

- What recreational activities do you enjoy?
- What do you do for fun?
- Who do you look forward to spending time with?

**Physical or neurovegetative symptoms.** Clients with depression frequently experience physical symptoms related to eating and sleeping. Psychiatrists refer to these symptoms as *neurovegetative signs* and consider them cardinal features of biological depression. Positive neurovegetative questions include:

- When do you sleep best?
- What thoughts help you get to sleep?
- What thoughts keep you awake?
- When was the last time you had your normal appetite?

**Cognitive symptoms.** Negative cognitions are a hallmark of depression and often center around Beck's (1976) cognitive triad: negative thoughts about the (a) self, (b) others, and (c) the future.

One especially important cognitive symptom linked to suicidality is hopelessness (Van Orden et al., 2010). Depending on your affinity for numbers and your client's tolerance of rating tasks, you could repeat the mood rating task but focus on hopelessness:

On that same scale from 0 to 10 that we talked about before, this time with 0 meaning you have no hope at all that your life will improve and

10 being that you're full of hope that things will improve and you'll start feeling better, what rating would you give?

Hopelessness may be expressed in different ways, such as "I don't see how things will ever be different" or "I've felt like this for as long as I can remember." A client's ability to make constructive or pleasurable future plans is an important gauge of hopefulness. Future-oriented questions include:

- What plans do you have for tomorrow?
- What do you think you'll be doing five years from now?
- What would help you feel hopeful again? (C. del Rio, personal communication, August 15, 2012)

Questions that require clients to reflect on past successes or third-person situations can be useful for evaluating whether hopefulness can be stimulated:

- I know you've been down before. What have you done in the past that helped you bring yourself back up?
- What advice would you give to a good friend going through the very same experience as you? [To set this question up well, it's important to have clients identify a close friend and build up a concrete and personal scenario.]

**Social/interpersonal symptoms.** Clients with depressive symptoms may not be fully aware of their isolation. If you believe you don't have the whole picture, you may need a release of information to speak with family or friends. It's helpful to listen for statements indicating that the client has changed and become more distant, hard to reach, despondent, or exceptionally touchy or irritable.

Even though you're trying to be helpful, some potentially suicidal clients will treat you with hostility. The basic principles for dealing with this are to (a) take nothing personally, (b) only go as deep as needed, (c) respond to everything with compassion and empathy, and (d) maintain your helpful demeanor.

## Assessing Suicide Plans

Once rapport is established and the client has talked about suicide ideation, it's appropriate to explore suicide plans. Exploration of suicide plans can begin with a paraphrase and a question:

You said sometimes you think it would be better for everyone if you were dead. Some people who have similar thoughts also have a plan for

committing suicide. Have you planned how you would kill yourself if you decided to follow through on your thoughts?"

Many clients respond to questions about suicide plans with reassurance that they're not really thinking about acting on their suicidal thoughts; they may cite religion, fear, children, or other reasons for staying alive. Typically, clients say something like "Oh, yeah, I think about suicide sometimes, but I'd never do it. I don't have a plan." Of course, sometimes clients will deny having a plan even when they do. If they do admit to a plan, further exploration is crucial.

When exploring and evaluating a client's suicide plan, assess four areas (M. Miller, 1985): (a) *specificity* of the plan; (b) *lethality* of the method; (c) *availability* of the proposed method; and (d) *proximity* of social or helping resources. These four areas of inquiry are easily recalled with the acronym SLAP.

### ***Specificity***

*Specificity* refers to the plan's details. Has the person thought through details necessary to die by suicide? Some clients outline a clear suicide method, others avoid the question, and still others say something like "Oh, I think it would be easier if I were dead, but I don't really have a plan."

If your client denies a suicide plan, you have two choices. First, if you believe your client is being honest, you may be able to drop the topic. Alternatively, if you suspect that your client has a plan but is reluctant to speak about it, you can use the normalizing frame discussed previously.

You know, most people who have thought about suicide have at least had passing thoughts about how they might do it. What kinds of thoughts have you had about how you would commit suicide if you decided to do so? (Wollersheim, 1974, p. 223)

### ***Lethality***

*Lethality* refers to how quickly a suicide plan could result in death. Greater lethality is associated with greater risk. Lethality varies depending on the way a particular method is used. If you believe that your client is a very high suicide risk, you might inquire not simply about your client's general method (e.g., firearms, toxic overdose, or razor blade), but also about the way the method will be employed. For example, does your client plan to use aspirin or cyanide? Is the plan to slash his or her wrists or throat with a razor blade? In both of these examples, the latter alternative is more lethal.

### ***Availability***

*Availability* refers to availability of the means. If the client plans to overdose with a particular medication, check on whether that medication is available. (Keep in mind this sobering thought: Most people keep enough substances in their home medicine cabinets to die by suicide.) To overstate the obvious, if the client is considering suicide by driving a car off a cliff and has neither car nor cliff available, the immediate risk is lower than if the person plans to use a firearm and keeps a loaded gun in an unlocked location.

### ***Proximity***

*Proximity* refers to proximity of social support. How nearby are helping resources? Are other individuals available who could intervene and rescue the client if an attempt is made? Does the client live with family or roommates? Is the client's day spent mostly alone or around people? Generally, the further a client is from helping resources, the greater the suicide risk.

If you're working on an ongoing basis with clients, you should check in periodically regarding plans. One recommendation is for collaborative reassessment at every session until suicidal thoughts, plans, and behaviors are absent in three consecutive sessions (Jobes et al., 2007).

## **Assessing Client Self-Control**

Asking directly about self-control and observing for agitation/arousal are the main methods for evaluating client self-control.

### ***Asking Directly***

If you want to focus on the positive while asking directly about self-control, you can ask something like this:

What helps you stay in control and stops you from killing yourself?

If you want to explore the less positive side, you could ask:

Do you ever feel worried that you might lose control and try to kill yourself?

Exploring both sides of self-control (what helps with maintaining self-control and what triggers a loss of self-control) can be therapeutic. This is done together with your client in an effort to understand the client's

perception of self-control. When clients express doubts about self-control that cannot be addressed therapeutically, then hospitalization should be considered. Hospitalization can provide external controls and safety until the client feels more internal control.

Here's an example of a discussion that shows (a) an interviewer focusing on the client's fear of losing control and (b) an indirect question leading the client to talk about suicide prevention.

**Client:** Yes, I often fear losing control late at night.

**Therapist:** Sounds like night is the roughest time.

**Client:** I hate midnight.

**Therapist:** So, late at night, especially around midnight, you're sometimes afraid you'll lose control and kill yourself. I wonder what has helped keep you from doing it.

**Client:** Yeah. I think of the way my kids would feel when they couldn't get me to wake up in the morning. I just start bawling my head off at the thought. It always keeps me from really doing it.

A brief verbal exchange, such as this, isn't a final determination of safety or risk. However, this client's love for her children is a mitigating factor that may work against a loss of self-control.

### ***Observing for Arousal/Agitation***

*Arousal* and *agitation* are contemporary terms used to describe what Shneidman originally referred to as perturbation. As he noted, perturbation is the inner push that drives individuals toward a suicide act. Arousal and agitation are underlying components of several other risk factors, such as akisthisia associated with SSRI medications, psychomotor agitation in bipolar disorder, and command hallucinations in schizophrenia.

Arousal or agitation adversely effects self-control. Unfortunately, systematic methods for evaluating arousal are lacking. This leaves clinicians to rely on four approaches to assessing arousal:

1. Subjective observation of client increased psychomotor activity (as in an MSE)
2. Client self-disclosure of feeling unsettled, unusually overactive, or impulse ridden
3. Questionnaire responses or scale scores indicating agitation (e.g., an elevated scale 9 on the MMPI-2-RF)
4. Historical evidence of agitation-related suicide gestures or attempts

## Assessing Suicide Intent

*Suicide intent* is defined as how much an individual wants to die by suicide. Suicide intent is usually evaluated *following* a suicide attempt (Hasley et al., 2008; Horesh, Levi, & Apter, 2012). Higher suicide intent is linked to more lethal means, more extensive planning, a negative reaction to surviving the act, and other variables. In a small, longitudinal research study, suicide intent, as measured by the Beck Suicide Intent Scale (BSIS), was a moderate predictor of death by suicide (Stefansson, Nordström, & Jokinen, 2012).

Assessing suicide intent *prior to* a potential attempt is more challenging and less well researched. The question can be placed on a scale and asked directly:

On a scale from 0 to 10, with 0 being you're absolutely certain you want to die and 10 that you're absolutely certain you want to live, how would you rate yourself right now?

It's also possible to infer intent based on the SLAP assessment of client suicide plans. This has some evidence base, as suicide-planning items on the BSIS are the strongest predictors of death by suicide (Stefansson et al., 2012).

Obtaining detailed information about previous attempts is important from a medical-diagnostic-predictive perspective, but unimportant from a constructive perspective, where the focus is on the present and future. Whether to explore past attempts or to stay focused on the positive is a dialectical problem in suicide assessment protocols. On the one hand, as D. Clark (1998) and others (Packman, Marlitt, Bongar, & Pennuto, 2004) noted, suicide scheduling, rehearsal, experimental action, and preoccupation indicate greater risk and, therefore, are valuable information. On the other hand, to some extent, detailed questioning about intent, plans, and past attempts involves a deepening preoccupation with suicide planning.

Balance and collaboration are recommended. As you inquire about intent, continue to integrate positively oriented questions into your protocol:

- How do you distract yourself from your thoughts about suicide?
- As you think about suicide, what other thoughts spontaneously come into your mind that make you want to live?
- Now that we've talked about your plan for suicide, can we talk about a plan for life?
- What strengths or inner resources do you tap into to fight back those suicidal thoughts?

Eventually you may reach the point where directly asking about and exploring previous attempts is needed.

## Exploring Previous Attempts

Previous attempts are considered the strongest of all suicide predictors (Fowler, 2012). Information about previous attempts is usually obtained through the client's med-psych records or an intake form, or while discussing depressive symptoms (see Case Example 10.2). It's also possible that you won't have information about previous attempts, but you decide to ask directly:

Have there been any times when you were so down and hopeless that you tried to kill yourself?

Once you have or obtain information about a previous attempt or attempts, you have a responsibility to acknowledge and explore it, even if only via a solution-focused question.

You've tried suicide before, but you're here with me now . . . What has helped?

If you're working with a client who is severely depressed, it's not unusual for your solution-focused question to elicit a response like this:

Nothing helped. Nothing ever helps.

One error clinicians often make at this point is to venture into a yes-no questioning process about what might help or what might have helped in the past. Again, if you're working with someone who is extremely depressed and experiencing the problem-solving deficit of mental constriction, your client will respond in the negative and insist that nothing ever has helped and that nothing ever will help. This constant negative response requires a different assessment approach. Even the most severely depressed clients can, if given the opportunity, acknowledge that every attempt to address depression and suicidality isn't equally bad. Using a continuum where severely depressed and mentally constricted clients can rank intervention strategies (instead of a series of yes-no questions) is a better approach:

**Therapist:** It sounds like you've tried many different things to help you through your depressed feelings and suicidal thoughts. Let's take a look at all of them. I'm guessing they haven't all been equally bad. I'm sure that some of them are worse than others. For example, you've tried physical exercise, you've tried talking to your brother and sister and one friend, and you've tried different medications. Let's list these out and see which of these has been the worst and which have been a bit less bad.

**Client:** The meds were the worst. They made me feel like I was already dead inside.

**Therapist:** Okay. Let's put meds down as the worst option you've experienced so far. So, which one was a little less worse than the meds?

You'll notice the therapist emphasized that some efforts at dealing with depression/suicide were *worse than others*. This language resonates with the negative emotional state of depressed clients. It will be easier to begin by identifying the most worthless of all their strategies and build from there to strategies that are "a little less bad." Building a personal and unique continuum of helpfulness for your client is the goal. Then you can add new ideas that you suggest or that the client suggests and put them in their appropriate place on the continuum. If this approach works well, you'll have several ideas (some new and some old) that are worth experimenting with in the future.

### **Using Outside Information to Initiate Risk and Protective Factor Assessment**

Outside of the formal suicide assessment interview, three main sources of information can be used to initiate a discussion with clients about suicide risk and protective factors:

1. Client records
2. Assessment instruments
3. Collateral informants

#### ***Client Records***

If available, your client's previous medical or mental health (med-psych) records are a quick and efficient source of client risk and protective factor information. Many risk factors listed in this chapter won't be in your client's records, but you should look closely for salient factors, such as previous suicide ideation and attempts, a history of a depression diagnosis, and familial suicide. After your standard intake interviewing opening and rapport building, you can use the records to broach these issues.

I saw in your records that you attempted suicide back in 2012. Could you tell me what was going on in your life back then to trigger that attempt?

When exploring previous suicide attempts, it's important to do so in a constructive manner that can contribute to treatment (see Case

Example 10.2). Using psychoeducation to explain to clients why you're asking about the past helps frame and facilitate the process.

The reason I'm asking about your previous suicide attempt is that the latest research indicates that the more we know about the specific stressors that triggered a past attempt, the better we can work together to help you cope with that stress now and in the future.

Don't forget to balance your questioning about previous suicide attempts with a focus on the positive.

Often, after a suicide attempt, people say they discovered some new strengths or resources or specific people who were especially helpful. How about for you? Did you have anything positive you discovered in the time after your suicide attempt?

It may be difficult to identify protective factors in your client's med-psych records. However, if you find evidence of protective factors or personal strengths, you should bring them up in the appropriate context during a suicide assessment interview. For example, when interviewing a client who's talking about despair associated with a current depressive episode, you might say something like this:

I noticed in your records that you had a similar time a couple years ago when you were feeling very down and discouraged. And, according to your therapist back then, you worked very hard and managed to climb back up out of that depressing place. What worked for you back then?

Strive to use information from your client's records collaboratively. As illustrated, you can use the information to broach delicate issues (both positive and negative).

#### CASE EXAMPLE 10.2: EXPLORING PREVIOUS ATTEMPTS AS A METHOD FOR UNDERSTANDING CLIENT STRESSORS AND COPING STRATEGIES

Exploring previous suicide attempts is an assessment process. It can illuminate past stressors, but it's equally useful for helping clients articulate past, present, and future coping responses.

**Therapist:** You wrote on your intake form that you attempted suicide about a year-and-a-half ago. Can you tell me a bit about that?

**Client:** Right. I shot myself in the head. It's obvious. You can see the scar right here.

*(Continued)*

**Therapist:** What was happening in your life that brought you to that point?

**Client:** I was getting bullied in school. I hated my stepfather. Life was shit, so one day after school I took the pistol out of my mom's room, aimed at my head, and shot.

**Therapist:** What happened then?

**Client:** I woke up in the hospital with a bad fucking headache. And then there was rehab. It was a long road, but here I am.

**Therapist:** Right. Here you are. What do you make of that?

**Client:** I'm lucky. I'm bad at suicide. I don't know. I suppose I took it to mean that I'm supposed to be alive.

**Therapist:** Have you had any thoughts about suicide recently?

**Client:** Nope. Nada. Not one.

**Therapist:** I guess from what you said that getting bullied or having family issues could still be hard for you. How do you cope with that now?

**Client:** I've got some friends. I've got my sister. I talk to them. You know, after you do what I did, you find out who really cares about you. Now I know.

### ***Assessment Instruments***

Suicide assessment instruments are an efficient means of collecting extensive and reliable information regarding many different suicide dimensions (Hughes, 2011). Some clients find it easier to be open about their suicidal thoughts and past when filling out a questionnaire. These instruments have the advantage of providing a substantial amount of suicide-related information rather quickly, in a standardized format.

The disadvantages of assessment instruments lie primarily in their impersonalness and standardized consistency. They don't flex or pause and give clients an empathic look or word of encouragement. They don't directly contribute to your therapeutic alliance. Also, although you have a great deal of information at your fingertips, that information is useful only if clients respond honestly and only if you review the instrument before the session. One danger is to quickly scan questionnaire responses, potentially missing meaningful client disclosures. Many researchers and some practitioners advocate using very short suicide screening questionnaires with clinical interviews to follow. Several different suicide assessment questionnaires and scales are briefly described in Putting It in Practice 10.1.

Assessment instruments alert you to potential suicide risk. If a client endorses a questionnaire item indicating suicidality, you should note this in a way that models transparency and collaboration:

The reason I had you fill out those questionnaires was to help focus our time together. When I reviewed your responses, I noticed several things to discuss. First, you indicated you have high stress in your life right now. Second, you mentioned you've had thoughts about suicide. Third, the way you filled out the questionnaire suggests you're feeling pretty angry. I've listed these three issues for us to talk about. What else should we discuss?

Suicidal thoughts and impulses don't immediately constitute an emergency. When clients endorse suicide-related questionnaire items, there's no need to overreact. The recommended approach is to acknowledge and accept suicidal thoughts and impulses as just one of many important discussion topics.

### **PUTTING IT IN PRACTICE 10.1: SUICIDE ASSESSMENT INSTRUMENTS AND SCALES**

Suicide assessment instruments are a unique and efficient way to gather extensive information pertaining to client suicidality. In the context of a clinical interview, it would be extremely difficult to have clients respond to numerous suicide-related items using a 5-, 6-, or 7-point Likert scale. This is nuanced and important information. However, even in automated scenarios, it's necessary for clinicians to interpret questionnaire results and follow up with a clinical interview and debriefing. To whet your appetite regarding the multitude of potentially useful measures, we've listed and described several here:

*The Reasons for Living Inventory* (RFL; Linehan, Goodstein, Nielsen, & Chiles, 1983). The RFL is a 48-item inventory. When introduced in the literature, it was unique in that it focused exclusively on protective factors (i.e., reasons for living) instead of risk factors. It comprises six factors: (a) survival and coping, (b) responsibility to family, (c) child-related concerns, (d) fear of suicide, (e) fear of social disapproval, and (f) moral objections (Linehan et al., 1983, p. 283). A briefer version is also available (Ivanoff, Jang, Smyth, & Linehan, 1994).

*The Beck Hopelessness Scale* (BHS; Beck & Steer, 1988). This 20-item true-false self-report questionnaire focuses on hopelessness. The item content includes negative and positive beliefs about the future. It has high reliability (.87 to .93) and has been shown to predict suicide attempts and death by suicide (G. Brown, Beck, Steer, & Grisham, 2000).

(Continued)

*The Cultural Assessment of Risk for Suicide* (CARS; Chu et al., 2013). This 39-item scale is new. Initial data indicate that this instrument may be especially useful for Asian, Latina(o), African American, and LGBTQ individuals (Chu et al., 2013). Reading through the items on this culturally oriented scale can help enhance your sensitivity to culturally unique suicide risk factors.

*Suicide Ideation Scale* (SIS; Rudd, 1989). This is a 10-item self-report scale that measures suicidal thoughts on a 5-point Likert scale. Rudd (1989) reported that the SIS can discriminate between people who have attempted and not attempted suicide.

Many new scales are being developed, including the Affective States Questionnaire (ASQ; Hendin, Maltsberger, & Szanto, 2007) and the Suicidal Affect-Behavior-Cognition Scale (SABCs; K. Harris et al., 2015).

### ***Collateral Informants***

Collateral informants (see Chapter 8) represent an unparalleled source of information about client risk and protective factors. However, in addition and of greater import, collateral informants represent a potential source of social support.

Informants can provide information before, during, or after your initial clinical interview. Due to legal/ethical issues, you must have a release of information to share anything about clients. However, even without a release of information, you can listen to what collateral informants say. Consider the following telephone scenario.

**Therapist:** Hello. This is Rita Sommers-Flanagan.

**Informant:** Hi Rita. My name is Megan McClure. I'm calling about a friend of mine, Kristin Eggers. She's coming to see you today, and I have something you should know.

**Therapist:** Okay. Thanks for telling me that. Of course, I can't even tell you if I know anyone by that name without a release of information.

**Informant:** Right. Well, I'm her good friend, and I know she's seeing you today because she told me.

**Therapist:** Here's the deal. I can't tell you anything. But I can listen. Then, if it turns out I see someone with the name you mentioned and it seems like the right thing, I could get a release of information signed so we can talk again.

**Informant:** Oh. I don't care about all that. I just want to tell you that she's been talking about suicide and I'm very concerned about her. I'm just not sure how open she'll be, so I wanted you to know.

**Therapist:** Thanks for that information. Whether or not I ever see someone of that name, I want to say that you're a dedicated and concerned friend . . . which is very nice.

This therapist chose to listen to and receive information about the client. You may not always make this choice, but if you do, it includes a subsequent cascade effect of ethical decision making. In this case, the caller (Megan) has no professional relationship with the therapist and therefore there's no confidentiality obligation. It may be appropriate, when Kristin arrives for counseling, to tell her early in the session that Megan called and what Megan said. Alternatively, the therapist could have immediately told Megan,

Before you share anything, I should tell you that my policy is to discuss phone calls like this one with clients directly.

If the therapist shares about Megan's telephone call, Kristin may feel either supported or betrayed. If she feels supported, there may be ways to weave Megan, as Kristin's friend, into the counseling to provide support if suicide risk escalates. However, if Kristin feels betrayed at any point in the process, it may cause an alliance rupture between the therapist and Kristin (which can be dealt with using the rupture and repair guidelines in Chapter 7).

#### MULTICULTURAL HIGHLIGHT 10.1: CULTURALLY SENSITIVE SUICIDE RISK ASSESSMENT

Although suicide rates vary across cultural groupings (e.g., Native Americans) and minority status (e.g., LGBTQ), most suicide assessment instruments and protocols operate with an assumption of cultural universality. This leaves clinicians with little guidance regarding how to sensitize existing instruments or interview protocols to detect suicide risk and protective factors unique to cultural minority groups.

Joyce Chu and colleagues are addressing this gap in the research literature. She refers to her approach as the *cultural theory and model of suicide*. She's in the process of evaluating the psychometrics of an instrument (the Cultural Assessment of Risk for Suicide; CARS) that includes four culturally distinct suicide-relevant categories and eight factors that appear relevant and meaningful for Asian, Latina(o), African American, and sexual minority clients (Chu et al., 2013). Chu's categories and sample items representing factors from her questionnaire follow:

**Social Discord.** This category focuses on "alienation, conflict, or lack of integration with one's family, community, or friends" 2013, p. 426). For example, family conflict within Asian families is linked to higher suicide risk.

*Family Conflict item:* "There is conflict between myself and members of my family" (p. 429).

(Continued)

*Social Support item:* "I have access to many resources in my community" (p. 429).

**Minority Stress.** This category focuses on stresses unique to individuals who identify as being within single or multiple minority groups (e.g., mistreatment or harassment associated with cultural or sexual identity).

*Sexual Minority Stress item:* "The decision to hide or reveal my sexual or gender orientation to others causes me significant distress" (p. 429).

*Acculturative Stress item:* "Adjusting to America has been difficult for me" (p. 429).

*Nonspecific Minority Stress item:* "People treat me unfairly because of my ethnicity, sexual, or gender identity" (p. 429).

**Idioms of Distress.** This category focuses on cultural variations in how suicidality is expressed and potential suicide methods. (For example, Latinos are viewed as expressing suicidality via high-risk behaviors.)

*Idioms of Distress item (Emotional/Somatic):* "When I get angry at something or someone, it takes me a long time to get over it" (p. 429).

*Idioms of Distress item (Suicidal Actions):* "I have thought of my household possessions as things that could be used to commit suicide" (p. 429).

**Cultural Sanctions.** This category focuses on cultural values or practices about the acceptability of suicide and the shame or acceptance that cultural minority clients might feel about specific life events that could increase suicide risk.

*Cultural Sanctions item:* "Suicide would bring shame to my family" (p. 429).

This short summary of Chu's research provides a glimpse into how suicide risk can be unique within specific cultural groups. When working with cultural minorities, you may find it helpful to use Chu's instrument or to integrate content from her questionnaire into your suicide assessment interview. For example, when you're interviewing clients with collectivist cultural orientations, gently asking questions about the presence or absence of family conflict and closeness is recommended. Similarly, when you're interviewing sexual minorities, asking about emotional or psychological pain (or relief) associated with closeting or coming out regarding sexual identity is crucial.

## VIDEO 10.5

### Suicide Interventions

The following guidelines provide basic ideas about suicide intervention options during a suicide crisis. These guidelines are consistent with Shneidman's (1996) excellent advice for therapists working with suicidal clients: "Reduce the pain; remove the blinders; lighten the pressure—all three, even just a little bit" (p. 139).

## Listening and Being Empathic

The first rule of working therapeutically with suicidal clients is to listen empathically. Your clients may have never openly discussed their suicidal thoughts and feelings with another person. Using basic attending behaviors and listening responses (e.g., paraphrasing and reflection of feeling) to show your empathy for the depth of your clients' emotional pain is a solid foundation.

## Establishing a Therapeutic Relationship

A positive therapy relationship is important to successful suicide assessment and effective treatment. In crisis situations (e.g., on a suicide telephone hotline), there's less time for establishing therapeutic relationships and more focus on applying interventions. However, whether you're working in a crisis or therapy setting, you should still use relationship-building counseling responses as much as possible given the constraints of your setting.

Within the CAMS approach, assessment is used to help therapists understand "the idiosyncratic nature of the client's suicidality, so that both parties can intimately appreciate the client's suicidal pain and suffering" (Jobes et al., 2007, p. 287). At some point after you've "intimately appreciated" your client's suicidality, you may then make an empathic statement to facilitate hope:

I hear you saying you're terribly depressed. Despite those feelings, it's important for you to know that most people who get depressed get over it and eventually feel better. The fact that we're meeting today and developing a plan to help you deal with your emotional pain is a step in the right direction.

Clients who are depressed or emotionally distressed may have difficulty remembering positive events or emotions (Lau, Segal, & Williams, 2004). Therefore, although you can help clients focus on positive events and past positive emotional experiences, you also need empathy with the fact that it isn't easy for most clients who are suicidal to recall anything positive.

**Clinician:** Can you think of a time when you were feeling better and tell me what was happening then?

**Client:** (*in a barely audible voice*) No. I don't remember feeling better.

**Clinician:** That's okay. It's perfectly natural for people who are feeling depressed to not be able to remember positive times.

Suicidal clients also may have difficulty attending to what you're saying. It's important to speak slowly and clearly, occasionally repeating key messages.

## Safety Planning

Helping clients develop practical plans for coping with and reducing psychological pain is central to suicide intervention. This plan can include relaxation, mindfulness, traditional meditation practices, cognitive restructuring, social outreach, and other strategies that increase self-soothing, decrease social isolation, improve problem solving, and decrease feelings of being a social burden.

Instead of traditional no-suicide contracts, contemporary approaches emphasize obtaining a commitment-to-treatment statement from clients (Rudd et al., 2006). These treatment statements or plans go by various names, including commitment to intervention, crisis response plan, safety plan, and safety planning intervention (Jobes, Rudd, Overholser, & Joiner, 2008; Stanley & Brown, 2012). These statements describe activities that clients will do to address depressive and suicidal symptoms, rather than focusing narrowly on what the client will not do (that is, commit suicide). These plans also include ways for clients to access emergency support after hours, such as the national suicide prevention lifeline (800) 273-TALK or a similar emergency crisis number.

Stanley and Brown (2012) have developed a brief treatment for suicidal clients, called the Safety Planning Intervention (SPI). This intervention was developed from cognitive-therapy principles and can be used in hospital emergency rooms as well as inpatient and outpatient settings (G. Brown et al., 2005). The SPI includes six treatment components (Stanley & Brown, 2012, p. 257):

1. Recognizing warning signs of an impending suicidal crisis
2. Employing internal coping strategies
3. Utilizing social contacts as a means of distraction from suicidal thoughts
4. Contacting family members or friends who may help resolve the crisis
5. Contacting mental health professionals or agencies
6. Reducing the potential use of lethal means

Stanley and Brown (2012) noted that the sixth treatment component, reducing lethal means, isn't addressed until the other five safety-plan components have been completed. Component 6 also may require assistance from family members or a friend, depending on the situation. All six of

these components should be included in your documentation, including firearms management.

## Identifying Alternatives to Suicide

Engaging in a debate about the acceptability of suicide or whether clients with suicidal impulses “should” attempt suicide can backfire. Sometimes suicidal individuals feel so disempowered that they perceive the possibility of killing themselves as one of their few sources of control. Rather than argue, you need to focus on helping clients identify methods for coping with suicidal impulses and find more desirable life alternatives.

Suicidal clients may be unable to identify alternatives to suicide. As Shneidman (1980) suggested, clients need help to “widen” their view of life’s options.

Shneidman (1980) wrote of a situation in which a pregnant teenager came to see him in suicidal crisis. She had a gun in her purse. He agreed with her that suicide was an option, while pulling out paper and a pen to write down alternatives to suicide. Shneidman generated most of the options (e.g., “You could have the baby and give it up for adoption”), while she systematically rejected them (“I can’t do that”). He wrote them down anyway, noting that, together, they were only making a list of options. Eventually, he handed her the list of options and asked her to rank her preferences. To their surprise, she indicated that death by suicide was her third preferred option. Then they worked together to implement options one and two. Happily, she never needed to choose option three.

This is a straightforward intervention. You can practice it with your peers and implement it with suicidal clients. There’s always the possibility that clients will decide that death by suicide is their number-one choice (at which point you’ve obtained important assessment information). However, it’s surprising how often suicidal clients, once they’ve had help identifying concrete behavioral alternatives, will indicate they prefer one or more options that involve embracing life.

## Separating the Psychic Pain From the Self

Rosenberg (1999) wrote, “The therapist can help the client understand that what she or he really desires is to eradicate the feelings of intolerable pain rather than to eradicate the self” (p. 86). This technique can help suicidal clients because it provides empathy for their pain, while helping them see that their wish is for the pain, rather than the self, to stop existing.

Rosenberg (1999) also recommended helping clients reframe what’s usually meant by the phrase *feeling suicidal*. She noted that clients benefit

from seeing their suicidal thoughts and impulses as a communication about their depth of feeling, rather than as an “*actual intent to take action*” (p. 86, italics in original). Again, this approach can decrease clients’ need to act on suicidal impulses, partly because of the cognitive reframe and partly because of the therapist’s empathic connection.

### Becoming Directive and Responsible

When clients are a clear danger to themselves, it’s the therapist’s ethical and legal responsibility to intervene and provide protection. This mandate means taking a directive role. You may have to tell the client what to do, where to go, and whom to call. It also may involve prescriptive therapeutic interventions, such as urging clients to get involved in daily exercise, recreational activities, church activities, or whatever is preventive based on their unique needs.

Clients who are acutely suicidal may require hospitalization. Many professionals view hospitalization as less than optimal, but if you have a client with acute suicide ideation, hospitalization may be your best alternative. If so, be positive and direct. Clients may have negative views of life inside a psychiatric hospital. Statements similar to the following can aid in beginning the discussion:

- I wonder how you feel [or what you think] about staying in a hospital until you feel safer and more in control?
- I think being in the hospital may be just the right thing for you. It’s a safe place. You can work on coping skills and on any medication adjustments you may need or want.

Linehan (1993) discussed several directive approaches for reducing suicide behaviors through dialectical behavior therapy. She advocated the following:

- Emphatically instructing the client not to commit suicide
- Repeatedly informing the client that suicide isn’t a good solution and that a better one will be found
- Giving advice and telling the client what to do when/if he or she is frozen and unable to construct a positive action plan

These suggestions can give you a sense of how directive you may need to be when working with clients who are suicidal.

### Making Decisions About Hospitalization and Referral

Suicidality can be measured along a continuum from nonexistent to extreme. Clients with mild to moderate suicide potential can usually

manage their impulses on an outpatient basis. More frequent ideation, greater agitation, and clearer plans (assessed using SLAP) translate into the need for closer monitoring. We recommend developing a collaborative treatment plan, discussing suicide as one of many alternatives, separating the suicidal pain from the self, and the other aforementioned interventions.

Some clients with mild-to-moderate suicide ideation might be treated as though they're severely suicidal. For example, imagine a 55-year-old depressed male who presents with highly variable suicide ideation, a vague plan, and a sense of purposelessness. These symptoms might be classified as mild or moderate, but he may also have additional risk factors; if he's socially isolated, having panic attacks, and engaging in increased alcohol use, he probably needs to commit to a safety plan or be considered for hospitalization.

Clients who fall into the extremely suicidal category warrant swift and directive intervention. These clients shouldn't be left alone. You'll need to inform them in a caring but directive manner that it's your professional responsibility to ensure their safety. Actions may include contacting the police or a county/municipal mental health professional. Unless you have special training and it's the policy of your agency, *never* transport an extremely suicidal client on your own. Suicidal clients might jump from moving vehicles, attempt to drown themselves, and throw themselves into freeway traffic to avoid hospitalization.

Although hospitalization is probably the best option when clients are extremely suicidal, there are several reasons why it may not be the best option. For some, hospitalization is traumatic. It may cause deflated self-esteem, regression to lower functioning, or distancing from social support networks. Extremely suicidal clients who are employed, have adequate social support, and are implementing a safety plan may be better off without hospitalization. In such cases, you might increase client contact, perhaps even meeting for daily brief sessions and collaboratively and continually modifying the client's comprehensive safety plan. In all instances, you should consult with supervisors and colleagues regarding actions taken with clients who are suicidal, and document everything.

## Ethical and Professional Issues

VIDEO  
10.6

As noted in Chapter 2, the fact that you are required to break confidentiality in cases of suicidality should be included in your informed consent and part of your oral description of the limits of confidentiality. However, there are many additional professional issues linked to suicide assessment. Some of these issues are personal; others are professional or legal. It can be difficult to disentangle the personal from the professional-legal.

## Can You Work With Suicidal Clients?

Some therapists aren't well suited to working with suicidal clients. If you're prone to depression and suicide ideation, you may want to avoid regular work with suicidal clients. Working with suicidal clients can trigger depressive thoughts and add unnecessary burdens to your emotional well-being.

Depressed and suicidal clients are often angry and hostile toward professional service providers. This can be unpleasant and stressful. However, it remains your responsibility to maintain rapport and not become too irritated. Avoid taking the comments of irate or suicidal clients personally.

Strong values about suicide can be an important professional consideration. Some professionals strongly believe that clients shouldn't be prevented from committing suicide (Szasz, 1986):

All this points toward the desirability of according suicide the status of a basic human right (in its strict, political-philosophical sense). I do not mean that killing oneself is always good or praiseworthy; I mean only that the power of the state should not be legitimately invoked or deployed to prohibit or prevent persons from killing themselves.  
(p. 811)

If you have strong philosophical or religious beliefs either for or against suicide, those beliefs could impede your ability to be objective and helpful (Neimeyer, Fortner, & Melby, 2001). You may still be able to conduct suicide assessment interviews and do so professionally, but you may need additional collegial or supervisor support and guidance.

## Consultation

Consultation with peers and supervisors serves a dual purpose. First, it provides professional support; dealing with suicidal clients is difficult and stressful, and input from other professionals is helpful. For your health and sanity, you shouldn't do work with suicidal clients in isolation.

Second, consultation will provide you with feedback about appropriate practice standards. Should you ever need to defend your actions and choices during a postsuicide trial, you'll be able to show that you were meeting professional standards. Consultation is one way to regularly monitor, evaluate, and upgrade your professional competency.

## Documentation

Documentation is essential and includes a description of the rationale for your clinical decisions. For example, if you're working with a severely or

extremely suicidal client and decide against hospitalization, you should document exactly why you made that decision. You might be justified choosing not to hospitalize your client if a collaborative safety plan was established and your client had good social support (e.g., family or employment).

When you work with suicidal clients, keep documentation to show that you:

- Conducted a thorough suicide risk assessment
- Obtained adequate historical information
- Obtained records regarding previous treatment
- Asked directly about suicidal thoughts and impulses
- Consulted with one or more professionals
- Discussed limits of confidentiality
- Implemented suicide interventions
- Developed a collaborative safety plan
- Gave safety resources (e.g., telephone numbers) to the client
- Discussed restriction of access to firearms or other lethal means

The legal bottom line with regard to documentation is that if an event wasn't documented, it didn't happen (see Putting It in Practice 10.2).

## Dealing With Completed Suicides

In the unfortunate event that one of your clients dies by suicide, it's important to be aware of relevant personal and legal issues (McGlothlin, 2008). First, seek professional and personal support to deal with feelings of grief and guilt. Postsuicide discussion with supportive colleagues may be sufficient. Some professionals conduct "psychological autopsies" in an effort to identify factors that contributed to the suicide (Pouliot & De Leo, 2006). Psychological autopsies are especially helpful for professionals who regularly work with suicidal clients.

Second, you may want to consult an attorney immediately. It's helpful to know about your legal situation and how best to protect yourself (McGlothlin, 2008). Legal assistance may be available through your professional or state associations.

Unless your attorney, your supervisor, or your consultation group is adamantly against it, you should be responsive to your deceased client's family. They may want to meet with you in person or discuss their loss over the telephone. If you refuse to discuss the situation, you risk their disappointment and anger; obviously, angry families are more likely to prosecute

than families who see you as open and fair. Realize that anything you say to a deceased client's family can be used against you, but also realize that if you say nothing, you may be viewed as cold, distant, and unfeeling. Also, remember that the rules for confidentiality stay in place even after death. Unless you have a signed release, you cannot share with friends or family the specifics of what the client said in therapy.

Your attitude toward the family may be more important than what you disclose. Avoid saying, "My attorney recommended that I not answer that question." Make efforts to be open about your own sadness regarding the client's death, but avoid talking about guilt or regret. (For example, don't say, "Oh, I only wish I had decided to hospitalize him after our last session.") At the therapeutic level, talking with the family can be important for both them and you. In most cases, they'll regard you as someone who was trying to help their loved one get better. They'll appreciate your efforts and will expect that, to some degree, you share their grief and loss. Each case is different, but don't let legal fears overcome your humanity.

#### **PUTTING IT IN PRACTICE 10.2: A SUICIDE DOCUMENTATION CHECKLIST**

Check off the following items to ensure that your suicide assessment documentation is up to professional standards.

- 1.** The limits of confidentiality and informed consent were discussed.
- 2.** A thorough suicide assessment was conducted, including:
  - Risk factor assessment
  - Suicide assessment instruments or questionnaires
  - Assessment of suicidal thoughts, plan, client self-control (agitation), and intent
- 3.** Relevant historical information from the client regarding suicidal behavior (e.g., suicidal behaviors by family members, previous attempts, lethality of previous attempts) was obtained.
- 4.** Previous treatment records were requested/obtained.
- 5.** Consultation with one or more licensed mental health professionals was sought.
- 6.** A collaborative safety plan was established (including firearms safety).
- 7.** The patient was provided with information regarding emergency/crisis resources.

- 8.** In cases of high suicide risk, the appropriate authority figures (police officers) and/or family members were contacted.
- 9.** Suicide interventions were implemented.

## Summary

Working with clients who are suicidal is highly stressful. You may have emotional reactions to the content of this chapter, so seeking support is recommended. Suicide rates in the United States have been slightly rising in recent years, but are generally around 13 per 100,000 people. This makes suicide a rare and difficult-to-predict phenomenon.

Many different risk factors, protective factors, and warning signs are associated with suicidal behavior. Unfortunately, most of this statistical information pertaining to suicide risk isn't very helpful to individual practitioners. However, understanding the dynamics underlying the long list of potential risk and protective factors and warning signs can help practitioners understand suicidal clients on a deeper level.

Shneidman's theoretical approach to suicide emphasizes psychache, perturbability, and mental constriction. Joiner's interpersonal model articulates the key role of thwarted belongingness and perceived burdensomeness. Both Shneidman's and Joiner's models have empirical support and can be used to facilitate suicide assessment and intervention.

Conducting a suicide risk assessment involves six components: (a) risk and protective factors, (b) suicide ideation, (c) suicide planning, (d) client self-control and agitation, (e) suicide intent, and (f) safety planning. These components can be summarized with the acronym RIP SCIP. Most of these components are covered in a comprehensive suicide risk assessment interview. It can also be helpful to gather information from outside resources, such as collateral informants and assessment instruments.

When you're working with suicidal clients, it's important to establish rapport and a therapeutic relationship through effective listening. Supportive empathy is crucial. Suicidal clients may not have previously informed anyone of their suicidal thoughts and wishes. This chapter discussed several specific suicide intervention strategies, including safety planning, identifying alternatives to suicide, and separating the psychic pain from the self.

Decision making in suicide situations is difficult. Clients who are mildly or moderately suicidal can normally manage their symptoms in the context of an outpatient setting, but those with severe and extreme suicide ideation often require hospitalization.

There are several ethical and professional issues related to suicide assessment: (a) being sensitive to your own ability to work with suicidal clients, (b) consultation, (c) documentation, and (d) dealing with death by suicide.

## Suggested Readings and Resources

If this chapter piques your interest in suicide assessment and treatment, there are many additional resources you may be interested in exploring. The following readings and resources are only a small sampling of the many resources available on this important topic.

### Professional Books and Articles

Healy, D. (2000). Antidepressant induced suicidality. *Primary Care in Psychiatry*, 6, 23–28. This article describes ways in which serotonin-specific reuptake inhibitors may, in some cases, increase client suicidality.

Jobes, D. A. (2016). *Managing suicidal risk: A collaborative approach* (2nd ed.). New York, NY: Guilford Press. Jobes's text is an excellent resource for individuals who will be working with suicidal clients. As discussed in this chapter, it emphasizes empathic collaboration as the cornerstone of suicide assessment and intervention.

Joiner, T. (2005). *Why people die by suicide*. Cambridge, MA: Harvard University Press. This book describes Joiner's interpersonal theory of suicide.

Jordan, J. R., & McIntosh, J. L. (2011) *Grief after suicide: Understanding the consequences and caring for the survivors*. New York, NY: Routledge. A landmark publication in the suicide bereavement literature, this book contains information on supporting those bereaved by suicide as well as information on promising national and international programs for suicide bereavement.

Juhnke, G. A., Granello, D. H., & Granello, P. F. (2011). *Suicide, self-injury, and violence in the schools: Assessment, prevention, and intervention strategies*. Hoboken, NJ: Wiley. This well-organized resource covers content related to three challenging problems in the schools.

Shea, S. C. (2011). *The practical art of suicide assessment: A guide for mental health professionals and substance abuse counselors* (2nd ed.). Hoboken, NJ: Wiley. This entire book focuses primarily on interview methods for uncovering suicide ideation and intent in clients.

Shneidman, E. S. (1996). *The suicidal mind*. New York, NY: Oxford University Press. In this powerful book, the most renowned suicidologist in the world

reviews three cases that illustrate the psychological pain associated with suicidal impulses.

Stanley, B., & Brown, G. K (2012). Safety planning intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice*, 19(2), 256–264. This article describes a brief intervention for suicidal clients, the Safety Planning Intervention (SPI), which has been identified as a best practice by the Suicide Prevention Resource Center/American Foundation for Suicide Prevention Best Practices Registry for Suicide Prevention.

## Suicide Support Organizations and Websites

American Association of Suicidology, Alan L. Berman, PhD, executive director, 4201 Connecticut Avenue, NW, Suite 310, Washington, DC 20008. Phone: 202-237-2280. [www.suicidology.org](http://www.suicidology.org)

American Foundation for Suicide Prevention, 120 Wall Street, 22nd Floor, New York, NY 10005. Phone: 888-333-AFSP or 212-363-3500. [www.afsp.org](http://www.afsp.org)

Centers for Disease Control and Prevention: <http://www.cdc.gov/violenceprevention/suicide/>

National Organization for People of Color Against Suicide, P.O. Box 75571, Washington, DC 20013. Phone: 202-549-6039. Email: [info@nopcas.org](mailto:info@nopcas.org)

Suicide Assessment Five-Step Evaluation and Triage (SAFE-T): Pocket Card for Clinicians. Available for free at <http://store.samhsa.gov/product/Suicide-Assessment-Five-Step-Evaluation-and-Triage-SAFE-T-Pocket-Card-for-Clinicians/SMA09-4432>

Suicide Prevent Triangle: Lists support groups, suicide self-assessment procedures, software, and educational/resource information on suicide. <http://SuicidePreventTriangle.org>

Suicide Prevention Resource Center (SPRC), Education Development Center, Inc., 43 Foundry Avenue, Waltham, MA 02453. Phone: 877-GET-SPRC or 877-438-7772. [www.sprc.org](http://www.sprc.org)



## DIAGNOSIS AND TREATMENT PLANNING

### Chapter Orientation

Diagnosis and treatment planning are central to all mental health services. This seems like straightforward common sense. After all, shouldn't identifying client problems and developing a plan to address those problems always be clinical interviewing job-one? Unfortunately, diagnosis and treatment planning are less straightforward than you might expect, because humans have a way of not quite fitting perfectly into little boxes. This leads to debates over mental health diagnosis and fierce arguments about which therapy approaches work best for which problems. In this chapter, we begin with basic principles of mental disorder diagnosis and end with research-based principles to guide your diagnostic and treatment planning process.

#### VIDEO 11.1

### Modern Diagnostic Classification Systems

Even in the slighter forms of dementia praecox [schizophrenia], the . . . behavior of the patients keep up their incomprehensibility and their confusing tendency to jump from one thing to another.

—Emil Kraepelin, *Lectures on Clinical Psychiatry*,  
1913, p. 21

Emil Kraepelin (1856–1926) looms large as the greatest modern innovator in mental health diagnosis and treatment. Many of his essential categories of “mental disease” still give structure to contemporary diagnostic systems. Kraepelin developed a descriptive system based on direct observation of mental patients. His 1902 edition of

### LEARNING OBJECTIVES

After reading this chapter, you will be able to:

- Identify the two primary diagnostic classification systems (*ICD* and *DSM*) and describe their complex relationship
- Describe how mental disorders are defined in the *International Classification of Diseases-10-CM* and the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition, and common problems associated with assessment and diagnosis
- Define structured, semi-structured, comprehensive, and circumscribed diagnostic interviews
- Describe the reliability, validity, advantages, and disadvantages associated with structured and semi-structured diagnostic interviewing
- Identify components of a less structured approach to diagnostic interviewing
- List empirically supported matching variables that can be used to develop more effective treatment plans

(Continued)

## LEARNING OBJECTIVES (Continued)

- Describe how cognitive-behavioral therapists develop case formulations and treatment plans
- Identify cultural modifications and adaptations that are applied to diagnostic decision making and culturally sensitive diagnostic interviewing

*Clinical Psychiatry* included a small number of diagnostic categories and encompassed only 114 pages.

### The *ICD* and *DSM* Systems

There are several classification systems for categorizing mental disorders, including the *Psychodynamic Diagnostic Manual (PDM)*, the *International Classification of Diseases (ICD)*, the National Institute of Mental Health's Research Domain Criteria (RDoc), and the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. The two systems most relevant to clinical practitioners are the *ICD* and *DSM*.

Since Kraepelin's original work, psychiatric diagnosis has exploded into a multidimensional and practical behemoth. The first edition of the *DSM* (130 pages and 106 mental disorders) was published in 1952; the second, in 1968; the third, in 1980; a revision of the third edition, in 1987; the fourth edition in 1994; and in 2000, a text revision of *DSM-IV (DSM-IV-TR)*. The latest (fifth) edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* includes nearly three hundred mental disorders in its 947 pages (American Psychiatric Association, 2013). The 10th edition of the *International Classification of Diseases (ICD-10)* is also immense. Keeley and colleagues (2016) described the current status of the *DSM-5* and *ICD-10*:

It is overwhelmingly clear that there are major problems with the clinical utility of current classification systems—for example, excessive number of categories, overspecification, spurious comorbidity—that have grown worse over time. (p. 5)

Nothing about the diagnostic classification of mental disorders is simple. In fact, there are contentious arguments over just about everything.

The World Health Organization (WHO) approved the *ICD-10* in 1990, but the *ICD-10-CM* didn't become the required diagnostic nomenclature for health providers in the United States until October 1, 2015. Until then, both the *DSM* and *ICD* systems were used. The delay was mostly “due to pressure from health systems and health insurers, who were resistant to changing their information systems to accommodate a new classification of diseases” (Reed, 2010, p. 458). Now, instead of

using *DSM-5* criteria, mental disorders are diagnosed using *ICD-10-CM* criteria and codes. The *DSM-5* has shifted to *ICD-10-CM* codes, so using either manual is acceptable. For example, instead of using 295.3 for paranoid schizophrenia, the *DSM* also uses the *ICD-10-CM* code F20.0 (Reed, 2010).

The narrative and diagnostic criteria for mental disorders are similar across *ICD* and *DSM* systems. Both manuals include fascinating insights about mental health and psychopathology. Although the *ICD* is the required nomenclature, some practitioners continue to use and prefer the *DSM* because of the more extensive background, narratives, and ancillary materials (e.g., the Cultural Formulation Interview). Of course, there are problems with both systems, but there's also been progress, and hope for more progress. One hopeful bit of news for the future is that the *ICD-11* is due out in 2018, and the WHO is emphasizing clinical utility in its development (Keeley et al., 2016). For more information about the relationship between the *ICD* and *DSM* systems, see Putting It in Practice 11.1. You can download a free pdf of the *ICD-10-CM* (Search: WHO international classification of diseases mental and behavioural disorders filetype: pdf).

#### **PUTTING IT IN PRACTICE 11.1: UNDERSTANDING THE RELATIONSHIP BETWEEN ICD-10-CM AND DSM-5: Q & A WITH JARED KEELEY, PHD**

*What are your thoughts on whether to cover the distinctions between ICD-10-CM and the DSM-5 in a graduate psychopathology course?*

Personally, I think covering this issue is a very valuable educational experience for our students, because the bulk of our profession has been confused about the distinction for quite some time.

*What's the relationship between the ICD and DSM systems?*

The *ICD* is a product of the World Health Organization in an effort to standardize the reporting of health information. The WHO is an affiliate of the United Nations, and member countries have agreed to report health statistics using the *ICD*. Roughly, each edition of the *DSM* has corresponded to an edition of the *ICD*, going back to *DSM-I* and *ICD-6*. Contrary to some commentary, the authors of each were well aware of the other manual, and there were efforts to harmonize the manuals as much as possible. The *ICD-10* corresponds to *DSM-IV*, and while there are a number of intentional differences, many diagnostic concepts are similar.

*(Continued)*

*Why did the United States just recently adopt the ICD-10-CM in October 2015, instead of DSM-5?*

The USA is VERY behind in adopting *ICD-10*. Each member country may develop an adaptation of the *ICD* for use in their country: This is the *ICD-10-CM*. *ICD-10* was approved for use in 1992, and the *ICD-10-CM* was finalized in 1996. So *DSM-5* is actually harmonized with *ICD-11* (which will be released in 2018). Thus, trying to compare *DSM-5* to *ICD-10-CM* is a little like comparing apples to oranges; they were not intended to be equivalent, but both are definitely fruits.

*What's the point of studying both systems?*

As professionals and/or consumers of mental health services, recognizing the discrepancies and developing some cognitive flexibility for accommodating the reasons why each manual is different will help students in the long run. Depression is depression, whether defined in the *DSM* or *ICD*. The differences in the definition are an interesting empirical and epistemological question that our students should take the opportunity to examine. What effect do the differences have on diagnostic practices, prevalence, treatment, and policy? It's also worth examining how our diagnostic definitions have changed over time, evolving with (or without) fresh empirical evidence.

*Why do the ICD-10 symptom criteria seem different from disorder to disorder?*

The *ICD-10* descriptions are a bit different, and it's worth discussing why. There was not much standardization between the working groups that developed the *ICD-10* guidelines, so some diagnostic descriptions and criteria were far more detailed than others. That's why some are little prose paragraphs, and others look more like the bulleted menu diagnostic criteria of the *DSM*. For what it's worth, the *ICD-11* will have a standardized format that will include more information.

Dr. Keeley is an associate professor at Mississippi State University.

## VIDEO 11.2

### Defining Mental Disorders

The concept of mental disorder, like many other concepts in medicine and science, lacks a consistent operational definition that covers all situations. (American Psychiatric Association, 2000, p. xxx)

It's often difficult to draw a clear line between mental problems and physical illness. When you become physically ill, it's obvious that stress, lack of sleep, or mental state may be contributing factors. Other times, when experiencing psychological distress, your physical state can be making things worse (Witvliet et al., 2008).

## Why Mental Disorder and Not Mental Illness?

Many professionals, organizations, and media sources routinely use the term *mental illness* to describe diagnostic entities included in the *ICD* and *DSM* classification systems. This practice, although popular, is inconsistent with the *ICD* and *DSM*. Both manuals explicitly and intentionally use and plan to continue using the term *mental disorder*. From the *ICD-10*:

The term “disorder” is used throughout the classification, so as to avoid even greater problems inherent in the use of terms such as “disease” and “illness.” “Disorder” is not an exact term, but it is used here to imply the existence of a clinically recognizable set of symptoms or behaviour associated in most cases with distress and with interference with personal functions. (1992, p. 11)

The *ICD* and *DSM* systems are descriptive, atheoretical classification systems. They rely on the presence or absence of specific signs (observable indicators) and symptoms (subjective indicators) to establish diagnoses. Other than disorders in the F00–F09 *ICD-10* block (e.g., F00: Dementia in Alzheimer’s disease; F01: Vascular Dementia), there is no assumption of any physical, organic, or genetic etiology among *ICD* mental disorders.

Consistent with the *ICD* and *DSM*, we don’t use the term mental illness in this text. We also believe mental illness to be a more problematic term than mental disorder. In fact, often we step even further away from an illness perspective and use the phrase *mental health problems* instead. However, in the end, no matter what we call them, mental disorders are fairly robust, cross-cultural concepts that can be identified and often treated effectively.

## General Criteria for Mental Disorders

The *DSM-5* includes a general definition of mental disorder:

A mental disorder is a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. (American Psychiatric Association, 2013, p. 20)

This definition is consistent with *ICD-10-CM*. Nevertheless, significant vagueness remains. If you go back and read the *DSM-5* definition of mental

disorder several times, you'll find substantial lack of clarity. There's room for debate regarding what constitutes "a clinically significant disturbance." Further, how can it be determined whether human behavior "reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning" (p. 20)? Perhaps the clearest components of mental disorder comprise one of two relatively observable phenomena:

1. *Subjective distress*: Individuals themselves must feel distressed.
2. *Disability in social, occupational, or other important activities*: The cognitive, emotional regulation, or behavioral disturbance must cause impairment.

Over the years, the *DSM* system has received criticism for being socially and culturally oppressive (Eriksen & Kress, 2005; Horwitz & Wakefield, 2007). Beginning in the 1960s, Thomas Szasz claimed that mental illness was a myth perpetuated by the psychiatric establishment. He wrote:

Which kinds of social deviance are regarded as mental illnesses? The answer is, those that entail personal conduct not conforming to psychiatrically defined and enforced rules of mental health. If narcotics-avoidance is a rule of mental health, narcotics ingestion will be a sign of mental illness; if even-temperedness is a rule of mental health, depression and elation will be signs of mental illness; and so forth. (1970, p. xxvi)

Szasz's point is well taken. But what's most fascinating is that the *ICD* and *DSM* systems basically agree with Szasz. The *ICD* includes this statement: "Social deviance or conflict alone, without personal dysfunction, should not be included in mental disorder as defined here" (World Health Organization, 1992, p. 11). And the *DSM-5* authors wrote:

Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual. (American Psychiatric Association, 2013, p. 20)

The *ICD*'s and *DSM*'s general definitions of mental disorder and criteria for each individual mental disorder consist of carefully studied, meticulously outlined, and politically influenced subjective judgments. Science, logic, philosophy, and politics are involved. This is an important perspective to keep in mind as we continue down the road toward clinical interviewing as a method for diagnosis and treatment planning.

## Why Diagnose?

Like Szasz (1961, 1970), many of our students want to reject diagnosis. They're critical of and cynical about diagnostic systems and believe that applying diagnoses dehumanizes clients, ignoring their individual qualities. We empathize with our students' complaints, commiserate about problems associated with diagnosing unique individuals, and criticize inappropriate diagnostic proliferation (e.g., bipolar disorder in young people). But, in the end, we continue to value and teach diagnostic assessment strategies and procedures, justifying ourselves with both philosophical and practical arguments.

Following are some of the benefits of education and training in diagnosis:

- Clinicians are encouraged to closely observe and monitor specific client symptoms and diagnostic indicators.
- Accurate diagnosis improves prediction of client prognosis.
- Treatments can be developed for specific diagnoses.
- Communication with other professionals and third-party payers can be more efficient.
- Research on the detection, prevention, and treatment of mental disorders is facilitated.

Although we advise maintaining skepticism regarding diagnostic labels, knowledge about mental disorders is a professional requirement.

It seems ironic, but sometimes labels are a great relief for clients. When clients experience confusing and frightening symptoms, they often feel alone and uniquely troubled. It can be a big relief to be *diagnosed*, to have their problems named, categorized, and defined. It can be comforting to realize that others—many others—have reacted to trauma in similar ways, experienced depression in similar ways, or developed similar irrational thoughts or problematic compulsions. Diagnosis implies hope (Mulligan, MacCulloch, Good, & Nicholas, 2012).

## Specific Diagnostic Criteria

The *ICD-10-CM* and *DSM-5* provide specific, more or less measurable criteria for diagnosing mental disorders. Diagnoses typically comprise a description of essential features, followed by a symptom list for identifying the condition. For example, the essential features from the *ICD-10-CM* for generalized anxiety disorder (GAD, F41.1) include:

anxiety, which is generalized and persistent but not restricted to, or even strongly predominating in, any particular environmental

circumstances (i.e. it is “free-floating”). As in other anxiety disorders the dominant symptoms are highly variable, but complaints of continuous feelings of nervousness, trembling, muscular tension, sweating, lightheadedness, palpitations, dizziness, and epigastric discomfort are common. Fears that the sufferer or a relative will shortly become ill or have an accident are often expressed, together with a variety of other worries and forebodings. This disorder is more common in women, and often related to chronic environmental stress. Its course is variable but tends to be fluctuating and chronic. (World Health Organization, 1992, p. 115)

The essential features section (aka narrative section) orients you to the disorder, but to establish a GAD diagnosis, specific criteria are used. (See Table 11.1 for a comparison of *ICD-10-CM* and *DSM-5* diagnostic criteria for GAD.)

**Table 11.1** *DSM-5* vs. *ICD-10-CM* Diagnostic Criteria for Generalized Anxiety Disorder (F41.1)

	<b>DSM</b>	<b>ICD</b>
<b>General statements</b>	The <i>DSM</i> includes time period distinctions in its specific criteria (A-F)	The sufferer must have primary symptoms of anxiety most days for at least several weeks at a time, and usually for several months. These symptoms should usually involve elements of criteria A, B, and C.
<b>Criterion A</b>	The client has “excessive anxiety and worry” that occurs “more days than not for at least 6 months” and pertains to “a number of events or activities.”	Apprehension (worries about future misfortunes, feeling “on edge,” difficulty in concentrating, etc.)
<b>Criterion B</b>	The client has difficulty controlling the anxiety or worry.	Motor tension (restless fidgeting, tension headaches, trembling, inability to relax)
<b>Criterion C</b>	Three or more of the following specific symptoms are present and linked to the anxiety/worry: 1. feeling restlessness or “keyed up or on edge” 2. feelings of fatigue that come on easily 3. blank mind or problems with concentration 4. “irritability” 5. “muscle tension” 6. problems sleeping	Autonomic overactivity (lightheadedness, sweating, tachycardia, or tachypnoea, epigastric discomfort, dizziness, dry mouth, etc.).
<b>Criterion D</b>	The preceding symptoms (listed in criterion C) “cause clinically significant distress or impairment in social, occupational, or other important areas of functioning”	

	<b>DSM</b>	<b>ICD</b>
<b>Criterion E</b>	The symptoms aren't caused by a substance or a medical condition	
<b>Criterion F</b>	The symptoms aren't "better explained by another mental disorder"	
<b>Differential diagnosis guidance</b>		The transient appearance (for a few days at a time) of other symptoms, particularly depression, does not rule out generalized anxiety disorder as a main diagnosis, but the sufferer must not meet the full criteria for depressive episode (F32.-), phobic anxiety disorder (F40.-), panic disorder (F41.0), or obsessive-compulsive disorder (F42.-)

This table compares the primary *ICD-10-CM* and *DSM-5* diagnostic criteria for generalized anxiety disorder. Some of the language in both manuals has been slightly modified for clarity.

The diagnostic criteria for generalized anxiety disorder (in both the *ICD* and *DSM*) illustrate challenging tasks associated with accurate diagnosis. For analysis, we focus on *DSM* criteria A through F.

For a client to meet criterion A, the diagnostic interviewer must establish whether that client is experiencing “excessive” anxiety and worry, how frequently the anxiety is occurring, how long the anxiety has been occurring, and how many events or activities the individual is anxious or worried about. This information relies on the interviewer’s ability to gather symptom-related information *and* the client’s ability to articulately report symptom-related information. Obtaining information required by criterion A involves interviewer and client subjectivity (i.e., the determination of what constitutes “excessive”).

Under criterion B, interviewers must assess how difficult clients find it to control their worry. This information requires an evaluation of client coping skills and efforts (e.g., what clients have tried to do to quell their anxiety and how well these coping efforts have worked).

For criterion C (perhaps the most straightforward diagnostic task), interviewers must identify whether clients are experiencing specific anxiety-related symptoms (see Table 11.1). Even this task involves complications, especially in cases where clients are motivated to either over- or under-report symptoms. For example, clients seeking disability status for an anxiety disorder may exaggerate their symptoms; others may minimize symptoms. Thus, along with questioning about these specific anxiety symptoms, the interviewer must stay alert to the validity and reliability of the client’s self-reported symptoms (Gilboa & Verfaellie, 2010).

Criterion D includes the distress and impairment criteria. It requires interviewers to determine whether anxiety symptoms are causing “clinically

significant distress or impairment in social, occupational, or other important areas of functioning.” This criterion is subjective. Nowhere in *DSM-5* is a clinically significant impairment defined.

For criterion E, interviewers need to determine whether anxiety symptoms are caused by exposure to or intake of a substance, or by a general medical condition. Substances and medical conditions need to be ruled out as causal factors in virtually every *DSM-5* and *ICD-10-CM* diagnostic category.

Criterion F requires considerable knowledge of other diagnostic criteria. Eleven other diagnoses that may need to be ruled out are listed in *DSM-5*. This is no small task; it requires lengthy education, training, and supervision.

Overall, the GAD example illustrates a range of tasks and issues with which diagnostic interviewers must grapple. All mental disorders occur within the context of a unique individual. Indeed, if it were not for unique individuals and their variability in reporting personal experiences along with their confounding and confusing motivational and interpersonal dynamics, psychiatric diagnosis would be much simpler.

## Assessment and Diagnosis Problems

To establish whether a client meets the diagnostic criteria for GAD, interviewers must determine whether the client has three of six symptoms from criterion C (as shown in Table 11.1). Given this requirement, an interviewer might find it sufficient (and justifiable) to directly ask the client a series of questions about those six specific symptoms. (For example, “Over the past six months or more, have you felt restless, keyed up, or on edge for more days than not?”) Using this approach seems desirable and might produce an accurate diagnosis. However, the *DSM-5* emphasizes that diagnostic criteria shouldn’t be applied as though they were a checklist:

The case formulation for any given patient must involve a careful clinical history and concise summary of the social, psychological, and biological factors that may have contributed to developing a given mental disorder. Hence, it is not sufficient to simply check off the symptoms in the diagnostic criteria to make a mental disorder diagnosis. (American Psychiatric Association, 2013, p. 19)

Symptom checklists are inadequate and must be used with other information. Mental health professionals are imbued with the power to diagnose mental disorders. This power comes with great responsibility to care for

and protect clients, who may be vulnerable and uninformed. Part of meeting this responsibility involves understanding the problems associated with establishing accurate diagnostic labels for individual clients:

*Client deceit or misinformation.* Clients may not be straightforward or honest about their symptoms (Jaghab, Skodnek, & Padder, 2006). Even when being honest, clients have difficulty accurately describing their symptoms in ways that match *DSM* criteria. There's also no guarantee that information from collateral informants (e.g., teachers, parents, or romantic partners) will be valid. At the least, collateral informants are likely to rate clients differently than the clients themselves (Rothen et al., 2009).

*Interviewer countertransference.* It's possible for clinicians to lose objectivity and/or distort client information. This may occur partly because of countertransference (Aboraya, 2007). If clients trigger negative reactions in you, you may feel an impulse to "punish" them with a more severe diagnostic label. Alternatively, you may minimize psychopathology and associated diagnoses if you like your client.

*Diagnostic comorbidity.* Clients often qualify for more than one diagnosis. With regard to children, diagnostic comorbidity occurs more often than not (Watson, Swan, & Nathan, 2011). Comorbidity makes sorting out appropriate diagnostic labels even more difficult.

*Differential diagnosis.* Sometimes clients report confusing symptom clusters, requiring extensive questioning for diagnostic clarity. It's notoriously difficult to discriminate among some diagnoses (e.g., mood disorder with psychotic features versus schizoaffective disorder versus schizophrenia versus delusional disorder). Despite these difficulties, diagnostic specificity is important because of the treatment implications (i.e., medication type, treatment approach, hospitalization, prognosis).

*Confounding cultural or situational factors.* Culture and context influence diagnosis: "The boundaries between normality and pathology vary across cultures for specific types of behaviors" (*DSM-5*, p. 14). Consequently, your diagnostic task includes a consideration of your clients' individual social, cultural, and situational contexts.

Given these problems, many therapists and researchers advise using "multi-method, multi-rater, multi-setting assessment procedures" (J. Sommers-Flanagan & Sommers-Flanagan, 1998, p. 191). This means that, under ideal circumstances, diagnosticians gather a broad spectrum

of diagnostic-related information from (a) various assessment methods (e.g., clinical interview, behavior rating scales, projective assessments); (b) various raters (e.g., parents, teachers, clinicians, and/or romantic partners); and (c) various settings (e.g., school, home, clinician's office, work).

**VIDEO  
11.3**

## Diagnostic Interviewing

Many methods are available for gathering diagnostic information. These include diagnostic interviewing, gathering social/developmental history, questionnaires and rating scales, physical examinations, behavioral observations, projective techniques, and performance-based testing. Because this book is about interviewing-based approaches, our discussion focuses on diagnostic interviewing.

### Approaches to Diagnostic Interviewing

Diagnostic interviews are usually designated as semi-structured or structured.

- *Semi-structured interview:* a predetermined series of questions, followed by unplanned questioning or an exploration period.
- *Structured clinical interview:* a tight protocol wherein clinicians ask a series of predetermined questions, including predetermined follow-up questions. There's little or no opportunity for unplanned or spontaneous clinician questions or client responses.

Most diagnostic interviewing protocols in the United States are based on *DSM-III-R* or *DSM-IV* diagnostic criteria. They can be administered by counselors, social workers, psychologists, physicians, or technicians with specific training (Segal & Hersen, 2010). In some cases, the training required to administer a particular diagnostic interview is extensive.

The central focus of structured or semi-structured diagnostic interviewing is on gathering reliable and valid data to support accurate mental disorder diagnoses. Diagnostic interviews are also referred to as scales, schedules, or protocols. As data-gathering methods, they're judged by the same psychometric criteria (reliability and validity) as standardized assessment instruments.

Although clinicians read questions verbatim and the process is standardized, diagnostic interviews also rely on clinician judgment. For example, individual clinicians determine the meaning of the patient's response. At times, they also choose which question should be asked next or whether

to move to a different line of questioning (representing another branch of the diagnostic decision tree).

Beyond structured and semi-structured designations, there are two other main diagnostic interview subtypes: (a) broad or comprehensive interview protocols keyed to the *DSM* system and (b) narrow or circumscribed interview protocols for use with specific symptom clusters or mental disorders. The Structured Clinical Interview for DSM-IV Axis I Disorders—Clinician Version (SCID-CV; First, Spitzer, Gibbon, & Williams, 1996) is a comprehensive semi-structured diagnostic interview. It's used to evaluate for the presence of major *DSM* mental disorders (excluding personality disorders).

Narrower or circumscribed structured and semi-structured diagnostic interview protocols are symptom or disorder specific (rather than keyed to the *ICD* or *DSM*). They're briefer and more easily integrated into clinical practice. For example, the Hamilton Rating Scale for Depression (HAM-D) is a 17-item scale used to evaluate clinical depression within the context of a clinical interview. In a 49-year meta-analysis of 409 studies, an international research group concluded the HAM-D to be a reliable assessment procedure for clinical depression; the overall inter-rater reliability alpha coefficient was 0.937 (Trajković et al., 2011).

There are also numerous diagnostic interviewing schedules intended for use with children. These also can be classified as either broad spectrum (e.g., the Child Assessment Schedule; Hodges, 1985) or circumscribed (e.g., Anxiety Disorders Interview Schedule for Children; Silverman, 1987).

## The Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I) as Prototype

The SCID-I is a good example of a semi-structured diagnostic interview. Two forms exist: (a) the Clinician Version for DSM-IV Axis I Disorders (SCID-CV) and (b) the Research Version for DSM-IV Axis I Disorders (SCID-RV). There's also a SCID for DSM-IV Axis II Disorders (the SCID-II, used for personality disorder assessment).

The SCID is nearly completely structured. The only deviations from protocol during SCID administration are “parenthetical questions” to be asked as needed, and sections where clinicians are prompted to use the clients’ “own words” when constructing required or parenthetical questions. For example, if clients refer to their mood as gloomy, the interviewer can substitute the word *gloom* or *gloomy* for *depressed* when asking questions. Otherwise, questions are asked verbatim.

Originally, the SCID was designed for researchers and practitioners. However, researchers found the initial version too unstructured, while

practitioners found it too cumbersome. Subsequently, separate SCID versions (clinical and research) were developed. This illustrates the tension between clinical research and clinical practice needs. Even as a simplified protocol, the clinical version of the SCID (i.e., SCID-CV) isn't used much among practitioners, partly because it takes approximately 45–90 minutes to administer.

## The Science of Clinical Interviewing: Diagnostic Reliability and Validity

The clinical interview is the cornerstone of diagnostic assessment (J. Sommers-Flanagan, Zeleke, & Hood, 2015). No self-respecting (or ethical) mental health professional would consider diagnosing a client without conducting a clinical interview. But the scientific question remains: Do diagnostic interviews provide reliable and valid diagnostic data and more accurate conclusions?

*Reliability* refers to replicability and stability. If a procedure, such as a diagnostic interview, is reliable, it consistently produces the same result; two therapists interviewing the same client would come up with the same diagnosis. Statistically speaking, an instrument or procedure must be reliable (it must produce reproducible results) to be valid (producing a correct or truthful result). However, it's possible for an interview procedure to be highly reliable but invalid—when two or more interviewers consistently agree on diagnoses, but the diagnoses are incorrect.

In 1980, upon the publication of the *DSM-III*, many mental health professionals, especially psychiatrists, breathed a collective sigh of relief. Finally, after nearly 30 years of rampant diagnostic subjectivity, there was a comprehensive and atheoretical system for objectively diagnosing mental disorders. The *DSM-III* was showered with praise. The reliability problem (the problem articulated by the fact that two different psychiatrists, seeing the same patient in a brief period of time, often disagreed about the proper diagnosis) was finally addressed; in the minds of some mental health professionals, the reliability problem was solved.

However, other professionals believed that *DSM*'s diagnostic reliability problem was far from solved. In their critique of contemporary diagnosis, Kutchins and Kirk (1997) wrote:

Twenty years after the reliability problem became the central scientific focus of *DSM*, there is still not a single major study showing that *DSM* (any version) is routinely used with high reliability by regular mental health clinicians. Nor is there any credible evidence that any version

of the manual has greatly increased its reliability beyond the previous version. The *DSM* revolution in reliability has been a revolution in rhetoric, not in reality. (p. 53)

Although Kutchins and Kirk's (1997) position is extreme, mainstream researchers have also questioned the *DSM*'s reliability and validity (Craig, 2005; Hersen & Turner, 2003). For example, a study of how clinicians make judgments about mental disorders in youth showed that diagnostic decisions appropriately varied based on social context and race. However, clinician theoretical orientation, age, and occupation were also significantly associated with diagnostic decisions (Pottick, Kirk, Hsieh, & Tian, 2007).

Determining diagnostic validity is even more problematic, partly because there are no known physical or genetic mental disorder markers to serve as a gold standard in validity studies. This leaves researchers few options for determining validity, other than longitudinal studies that assess the predictive validity of diagnosis for future behaviors such as prognosis, treatment response, and long-term adjustment.

It would be possible to continue ad nauseam with critiques focusing on mental health diagnosis in general and the *DSM* or *ICD* in particular. But for now, the *DSM* and *ICD* systems are the best we have. Many respected researchers have concluded that the diagnostic reliability of *DSM*-based structured or semi-structured interviews for major mental disorders (e.g., depression and anxiety) are similar to the reliability coefficients that physicians obtain with medical disorders (alphas usually above 0.80; Lilienfeld, Smith, & Watts, 2013; Lobbestael, Leurgans, & Arntz, 2011). It's perfectly reasonable to prefer using unstructured or less structured interviewing formats for other purposes, but if your goal is to establish a reliable and valid diagnosis, there's no better way to do that than by using a published diagnostic interview protocol. With that in mind, let's look at the advantages and disadvantages of structured diagnostic interviewing.

## Advantages Associated With Structured Diagnostic Interviewing

Advantages associated with structured diagnostic interviewing include the following:

- Structured diagnostic interview schedules are standardized. Therapists systematically ask clients a menu of diagnostically relevant questions.
- Diagnostic interview schedules generally produce a diagnosis, consequently relieving clinicians of subjectively weighing many alternative diagnoses.

- Diagnostic interview schedules show better diagnostic reliability and validity than less structured methods.
- Diagnostic interviews are well suited for scientific research. Valid and reliable diagnoses support research on the nature, course, prognosis, and treatment responsiveness of particular disorders.

Structured and semi-structured diagnostic interviews are a part of the scientific foundation of psychology and counseling. Current systems are always in revision; realistically, progress (not a perfect system) is the goal. The diagnostic criteria from *DSM-III* and -IV and *ICD-9* and -10 were improvements on previous versions, and there's hope that the *DSM-5* and *ICD-11* will show further improvements in reliability, validity, and clinical utility (Keeley et al., 2016).

### **Disadvantages Associated With Structured Diagnostic Interviewing**

There are also disadvantages associated with structured diagnostic interviewing:

- Many diagnostic interviews require considerable time for administration. For example, the Schedule for Affective Disorders and Schizophrenia for School-Age Children (Puig-Antich, Chambers, & Tabrizi, 1983) may take one to four hours to administer, depending on whether both parent and child are interviewed.
- Diagnostic interviews don't allow experienced diagnosticians to take shortcuts. This is cumbersome because experts in psychiatric diagnosis might require less information to accurately diagnose clients than would beginning therapists.
- Some clinicians complain that diagnostic interviews are too structured and rigid, de-emphasizing rapport building and basic interpersonal communication between client and therapist. Extensive structure may not be acceptable for practitioners who prefer using intuition and who emphasize the therapeutic relationship.
- Although structured diagnostic interviews have demonstrated reliability, some clinicians question their validity. All diagnostic interviews are limited and leave out important information about clients' personal history, personality style, and other contextual variables. As noted earlier, two different therapists may administer the same interview schedule and consistently come up with the same incorrect diagnosis.

Given their time-intensive requirements in combination with the need of mental health providers for time-efficient evaluation, it's not surprising

that diagnostic interviewing procedures are underutilized and sometimes unutilized in clinical practice. Critics contend that even the diagnostic criteria themselves are more oriented toward researchers than clinicians (Phillips et al., 2012):

It is difficult to avoid the conclusion that the diagnostic criteria are mainly useful for researchers, who are obligated to insure [sic] a uniform research population. (p. 2)

Researchers and academics are far and away the primary users of contemporary structured diagnostic interviewing procedures.

## Less Structured Diagnostic Clinical Interviews

**VIDEO  
11.4**

If your goal is to conduct a state-of-the-science diagnostic clinical interview, then you'll use a structured or semi-structured format. But not all clinicians choose that approach. The features of a less structured approach consist of the following:

1. An introduction to the assessment process (aka role induction) characterized by culturally sensitive warmth and active listening. Depending on the situation and clinician preference, clinicians may employ culturally appropriate standardized questionnaires and intake/referral information (e.g., MMPI-2-RC; BDI-2; OQ-45).
2. An extensive review of client problems and associated goals, and a detailed analysis of the client's primary problem and goal. This could include questions about the client's symptoms using the *ICD-10-CM* or *DSM-5* as a guide, or a circumscribed, symptom-oriented diagnostic interview protocol (e.g., the HAM-D).
3. A brief discussion of experiences (personal history) relevant to the client's primary problem, including a history of the presenting problem if such a history hasn't already been conducted.
4. If appropriate, a brief mental status examination could be included, but more likely you'll review the client's current situation, including his or her social support network, coping skills, physical health, and personal strengths.

### Introduction and Role Induction

The goal of developing a diagnosis and treatment plan shouldn't change the therapist's interest in the client as a unique individual. After reviewing

confidentiality limits, you should introduce diagnostic interviews to clients using a statement similar to the following:

Today, we'll be working together to try to understand what has been troubling you. This means I want you to talk freely with me, but also, I'll be asking lots of questions to clarify as precisely as possible what you've been experiencing. If we can identify your main concerns, we'll be able to come up with a plan for resolving them. Does that sound okay to you?

This statement emphasizes collaboration and de-emphasizes pathology. The language “try to understand” and “main concerns” are client-friendly ways of talking about diagnostic issues. This statement is a role induction that educates clients about the interview process.

Beginning therapists often become too structured, excluding client spontaneity, or too unstructured, allowing clients to ramble. Remember to integrate active listening and diagnostic questioning throughout your diagnostic interview.

## Reviewing Client Problems

While reviewing client problems, consider the following.

### ***Respect Your Client's Perspective, but Don't Automatically Accept Your Client's Self-Diagnosis as Valid***

Diagnostic information is available to the general public. This leads many clients to offer their own diagnosis at the beginning of interviews:

- I'm so depressed. It's really getting to me.
- I think my child has ADHD.
- I took an online quiz and found out that I'm bipolar.
- I have a problem with compulsive behavior.
- My main problem is panic. Whenever I'm in public, I just freeze.

Some diagnostic terminology has been so popularized that its specificity has been lost. This is especially true with the term *depression*. Many people use the word depression to describe sadness. The astute diagnostician recognizes that depression is a syndrome and not a mood state. When clients report “being depressed,” further questioning about sleep dysfunction, appetite or weight changes, and concentration problems are necessary. Research has shown that using the single question “Are you depressed?”

isn't an adequate substitute for an appropriate diagnostic interview (Kawase et al., 2006; Vahter, Kreegipuu, Talvik, & Gross-Paju, 2007).

Similarly, the lay public overuses the terms *compulsive*, *panic*, *hyperactive*, and *bipolar*. In diagnostic circles, compulsive behavior generally alerts the clinician to symptoms associated with either obsessive-compulsive disorder or obsessive-compulsive personality disorder. In contrast, many individuals with eating disorders and substance abuse disorders refer to their behaviors as compulsive. Similarly, panic disorder is a specific syndrome in the *ICD-10-CM* and *DSM-5*. However, many individuals with social phobias, agoraphobia, or public speaking anxiety refer to panic. Therefore, when clients say they have panic, it should alert you to gather additional information about a range of different anxiety disorders. Finally, diagnostic rates of bipolar disorder in both youth and adults have skyrocketed (Blader & Carlson, 2007; Moreno et al., 2007). As a result, the lay public (and some mental health professionals) quickly attribute irritability and/or mood swings to bipolar disorder. Nevertheless, we recommend using established diagnostic criteria.

### ***Keep Diagnostic Checklists Available***

When questioning clients about problems, keep diagnostic criteria in mind, but don't expect to have perfectly memorized diagnostic criteria from the *ICD* or *DSM* systems. Using checklists to aid in recalling specific diagnostic criteria helps. But don't reduce your diagnostic musing to a simple checklist.

### ***Don't Expect to Accurately Diagnose Clients After a Single Interview***

It's good to have lofty goals, but in many cases, you won't be able to assign an accurate diagnosis to a client after a single interview. In fact, you may leave the first interview more confused than when you began. Fear not. The *ICD-10-CM* and *DSM-5* provide practitioners with procedures for handling diagnostic uncertainty. These consist of the following:

*V codes (DSM-5) and Z codes (ICD-10-CM):* V codes and Z codes are used to indicate that treatment is focusing on a problem that doesn't meet diagnostic criteria for a mental disorder.

*F99:* This code refers to *Unspecified Mental Disorder*. It's used when the clinician determines that symptoms are present, but full criteria for a specific mental disorder are not met. Also, the clinician doesn't need to specify why the criteria aren't met.

*Provisional diagnosis:* When a specific diagnosis is followed by the word *provisional* in parentheses, it communicates a degree of

uncertainty. A provisional diagnosis is a working diagnosis, indicating that additional information may modify the diagnosis. The *ICD-10-CM* also allows for using the word *tentative*, meaning there is uncertainty but that “more information is unlikely to become available” (p. 8).

Being uncertain about your client’s diagnosis after an intake interview should be an excellent stimulus for you to do some extra reading before meeting for a second appointment.

### **Client Personal History**

Even when time is limited, social-developmental history information helps ensure accurate diagnosis. For example, the *DSM-5* lists numerous disorders that have depressive symptoms as one of their primary features, including (a) persistent depressive disorder, (b) major depressive disorder, (c) various adjustment disorders, (d) bipolar I disorder, (e) bipolar II disorder, and (f) cyclothymic disorder. Many other disorders include depression symptoms or symptoms that are comorbid with one of the previously listed depressive disorders. Among others, these include (a) posttraumatic stress disorder, (b) generalized anxiety disorder, (c) anorexia nervosa, (d) bulimia nervosa, and (e) conduct disorder. The question is not whether depressive symptoms exist in a particular client but rather which depressive symptoms exist, in what context, and for how long. Without adequate historical information, you can’t discriminate between various depressive disorders and comorbid conditions.

In some cases, accurate diagnosis is directly linked to client history. For example, a panic disorder diagnosis requires information about previous panic attacks. Similarly, posttraumatic stress disorder, by definition, requires a trauma history; and for AD/HD (in *DSM-5*) and hyperkinetic disorders (in *ICD-10-CM*), the diagnosis can’t be given unless there is evidence that symptoms existed prior to age 12 (*DSM*) or age 6 (*ICD-10-CM*).

### **Current Situation**

Obtaining information about a client’s current functioning is a standard part of the intake interview. A few significant issues should be reviewed and emphasized.

A detailed review of your client’s current situation comprises an evaluation of his or her typical day, social support network, coping skills, physical health (if this area hasn’t been covered during a medical history), and personal strengths. Each of these areas can provide information crucial to the diagnostic process.

### ***The Usual or Typical Day***

Yalom (2002) has written that he believes an inquiry into the “patient’s daily schedule” is especially revealing. He wrote:

In recent initial interviews this inquiry allowed me to learn of activities I might not otherwise have known for months: two hours a day of computer solitaire; three hours a night in Internet sex chat rooms under a different identity; massive procrastination at work and ensuing shame; a daily schedule so demanding that I was exhausted listening to it; a middle-aged woman’s extended daily (sometimes hourly) phone calls with her father; a gay woman’s long daily phone conversations with an ex-lover whom she disliked but from whom she felt unable to separate. (pp. 208–209)

Asking about the client’s typical day can open up a cache of diagnostically rich data that moves you toward identifying appropriate treatment goals and an associated treatment plan.

### ***Client Social Support Network***

In some cases, it can be critical to obtain diagnostic information from people other than the client, especially when interviewing young clients. Parents are often interviewed as part of the diagnostic work-up (see Chapter 13). However, even when interviewing adults, you may need outside information:

Adults can also be unaware of their family histories or details about their own development. Patients with psychosis or personality disorder may not have enough perspective to judge accurately many of their own symptoms. In any of these situations, the history you obtain from people who know your patient well may strongly influence your diagnosis. (Morrison, 2007, p. 203)

Whether you need to interview a collateral informant to obtain diagnostic information should be determined on a case-by-case basis.

### ***Assessment of Client Coping Skills***

Client coping skills may be related to diagnosis and can facilitate treatment planning. For example, clients with anxiety disorders frequently use avoidance strategies to reduce anxiety. (For example, agoraphobics don’t leave their homes; individuals with claustrophobia stay away from enclosed spaces.) It’s important to examine whether clients are coping with their

problems and moving toward mastery or reacting to problems and exacerbating symptoms and/or restricting themselves from social or vocational activities.

Coping skills also may be assessed by using projective techniques or behavior observation. You might try having clients imagine an especially stressful scenario (sometimes referred to as a simulation) and describe how they would handle it. Behavioral observations may be collected either in your office or in an outside setting (e.g., school, home, workplace). Collateral informants also may provide information regarding how clients cope when outside your office.

### ***Physical Examination***

Often, a conclusive mental disorder diagnosis can't be achieved without a medical examination. When interviewing new clients, therapists should inquire about the most recent physical examination results. Some therapists ask for this information on their intake form and discuss it with clients.

Physical and mental states can have powerful and reciprocal influences on each other. For instance, a long-term illness or serious injury can contribute to anxiety and depression. Consider the following options when completing a diagnostic assessment:

- Gather information about physical examination results.
- Directly consult with the client's primary care physician.
- Refer clients for a physical examination.

Making sure that potential medical or physical causes or contributors to mental disorders are considered and noted is an ethical mandate.

### ***Client Strengths***

Clients who come for professional assistance may have lost sight of their personal strengths and positive qualities. Further, after experiencing an hourlong diagnostic interview, clients may feel even more sad or demoralized. As we've mentioned before, especially within the context of suicide assessment interviewing, it's important to ask clients to identify and elaborate on positive personal qualities throughout the interview, but especially toward the end of an assessment/diagnostic process. For example:

I appreciate your telling me about your problems and symptoms. But I'd also like to hear more about your positive qualities. Like how you've

managed to be a single parent and go to school and fight off those depressive feelings you've been talking about.

Exploring client strengths provides important diagnostic information. Clients who are more depressed and demoralized may not be able to identify their strengths. Nonetheless, be sure to provide support, reassurance, and positive feedback. In addition, as solution-oriented theorists emphasize, don't forget that diagnosis and assessment procedures can—and should—include a consistent orientation toward the positive. Bertolino and O'Hanlon (2002) stated:

Formal assessment procedures are often viewed solely as a means of uncovering and discovering deficiencies and deviancies with clients and their lives. However, as we've learned, they can assist with learning about clients' abilities, strength, and resources, and in searching for exceptions and differences. (p. 79)

Effective diagnostic interviewing isn't exclusively a fact-finding process. Throughout the interview, skilled diagnosticians express compassion and support for a fellow human being in distress. The purpose of diagnostic interviewing goes beyond establishing a diagnosis or "pigeonhole" for clients. Instead, it's an initial step in developing an individualized treatment plan.

## Treatment Planning

VIDEO  
11.5

Many different treatment planning models exist. A sampling of eclectic or atheoretical models include the BASIC ID (Lazarus, 2006), DO A CLIENT MAP (Seligman & Reichenberg, 2012), and the "treatment planners" (Jongsma, Peterson, & Bruce, 2006). A great many theoretically based conceptual systems are also available (Greenberg, 2002; Luborsky & Crits-Christoph, 1998; Shapiro, 2002).

Most contemporary approaches to mental health treatment planning is aligned with the biopsychosocial model (Engel, 1980, 1997). This model is integrative and embraces the possibility of biological, psychological, and social factors all contributing to and potentially alleviating client problems. One consistent problem with the biopsychosocial model, perhaps because it originated within the medical model, is that biomedical dimensions of mental disorders often dominate case formulation and treatment. This can lead to an overemphasis on medication treatments. (See J. Sommers-Flanagan &

Campbell, 2009, and Multicultural Highlight 11.1 for a different perspective on the biopsychosocial model.) Consistent with nonmedical professional disciplines (i.e., that of the ACA, APA, and NASW), this section focuses exclusively on psychosocial treatment planning.

### **MULTICULTURAL HIGHLIGHT 11.1: LISTENING TO THE DALAI LAMA: A SOCIAL-PSYCHO-BIO MODEL**

At a conference at Emory University, Charles Nemeroff, MD, presented a paper to His Holiness the Dalai Lama (Nemeroff, 2007). In his presentation, Nemeroff noted with authority that one-third of all depressive disorders are genetic and two-thirds are environmentally based. Nemeroff then discussed the trajectory of “depressive illness,” presenting findings from animal and human studies of trauma and depression. He concluded that trauma seems to initiate a biologically based depressive tendency in the brains of some individuals (and mice), but not others. At one point during the presentation, there was a flurry of interactions between the Dalai Lama, his interpreter, and Nemeroff. Finally, the interpreter posed a question to Nemeroff, saying something like: “His Holiness is wondering, if two-thirds of depression is caused by human experience and one-third is caused by genetics, but humans who are genetically predisposed to depression must have a trauma to trigger a depressive condition, then wouldn’t it be true to say that all depression is caused by human experience?” After a brief silence, Nemeroff conceded, “Yes. That would be true.”

Such admissions, as well as our own observations, have led us to believe that the ordering of the terms in the biopsychosocial model may be misleading. It may be more accurate to say *social-psycho-bio*, because early *social* interactions or relationships create *psychological* or *cognitive* patterns that eventually contribute to particular *biological* states.

## **From Symptoms to Diagnosis and Back Again**

It’s useful to take a step back and examine how mental health professionals connect diagnosis and treatment planning.

Usually, when clients come for an interview, they talk about symptoms and problems. As they talk, clinicians listen, question, observe, assess, and analyze client symptoms and problems in order to translate what the client is experiencing into a coherent set of symptoms (i.e., a syndrome). Then, as appropriate, this syndrome is aligned with a mental disorder diagnosis. Let’s take the example of moderate depressive episode (MDE; from *ICD-10-CM*).

The following symptoms are required to meet MDE diagnostic criteria:

**At least two of the following three**

1. Depressed mood
2. Loss of interest and enjoyment (aka anhedonia)
3. Increased fatigability

**AND at least three (preferably four) of the following seven symptoms**

1. Reduced concentration and attention
2. Reduced self-esteem and self-confidence
3. Ideas of guilt and unworthiness
4. Bleak and pessimistic views of the future
5. Ideas or acts of self-harm or suicide
6. Disturbed sleep
7. Diminished appetite

If you're familiar with the *DSM-5* diagnosis of major depressive disorder, you'll notice similarity between the two. Generally, these disorders are considered roughly equivalent.

Reading the narrative sections of the *ICD* and *DSM* systems as well as other information on psychopathology is strongly recommended (Ingersoll & Marquiss, 2014). However, for treatment planning purposes (and insurance reimbursement), after making a diagnosis, you'll need to transform it back to specific client-based symptoms, problems, and goals. For example, it's not appropriate to have "recover from MDE" as your exclusive treatment planning goal (although that might be your ultimate goal). Instead, you'll want to directly address measurable MDE-related symptoms or problems using concrete theoretically based or evidence-informed techniques. For example:

1. Elevate mood through (a) activity scheduling and (b) problem-solving strategies.
2. Increase interest and enjoyment (reduce anhedonia) via (a) generating a list of pleasant activities, (b) selecting one or more pleasant activities to engage in each day, and (c) using pleasure criteria instead of performance-based criteria for rating activities.
3. Reduce initial insomnia (time till falling asleep) through (a) mindfulness meditation and (b) sleep hygiene education and implementation.
4. Reduce suicidal thoughts and gestures through collaborative development and enactment of a safety plan.
5. Improve self-esteem and self-confidence ratings through (a) social role playing and (b) graduated application of effective social skills into real-life situations.

## Matching Treatment Plan to Client Characteristics, Preferences, and Problems

In 1969, Gordon Paul asked:

What treatment, by whom, is most effective for this individual with that specific problem, under which set of circumstances, and how does it come about? (p. 44)

This has come to be known as the Who-How-Whom question. In many situations, there's still not enough research available to answer Paul's question. However, recent and current research is quickly accumulating to help mental health practitioners match therapy, therapist, client, and client problems in ways that facilitate improved outcomes (Beutler, 2011; Norcross, 2011). We offer a brief review of the literature on matching variables clinicians can use to select effective treatments.

### ***Client Diagnosis and Empirically Supported Treatments (ESTs)***

In the broadest sense, clinicians can match client diagnosis with empirically supported treatments (ESTs). Although the history of ESTs is complex and contentious, there are now well over 50 ESTs available. An EST is defined as a psychosocial treatment that has been (a) manualized; and (b) found superior to placebo controls or another treatment, or shown equivalent to an established treatment in at least two "good" group design studies or in a series of single-case design experiments conducted by different investigators (Chambless & Hollon, 1998).

ESTs constitute one way in which diagnosis drives treatment selection. However, there are many cases where it's difficult to select an appropriate EST (Eells, 2009); for example:

- Your client's diagnosis is unclear.
- There are comorbid conditions that complicate treatment selection.
- Your client is opposed to using an EST.
- You're not trained in an EST connected to your client's diagnosis.
- Culture or ethnicity complicates the straightforward application of an EST.
- Your client has problems-in-living (V or Z codes) and doesn't meet diagnostic criteria for a mental disorder.

The concept of using ESTs to treat specific mental disorders derives from the medical model. But the ESTs that Division 12 of the American

Psychological Association and other organizations endorse are psychosocial (not biomedical) interventions. For the most part, ESTs are cognitive-behavioral, manualized, designed to treat specific mental disorders, and relatively time limited (Dickerson & Lehman, 2011).

There are a number of websites you can use to identify ESTs. To explore these therapies and the process by which they have achieved empirically supported status, see the website for Division 12 of the American Psychological Association (<http://www.apa.org/divisions/div12/cppi.html>).

### ***Client Preference***

Client preference matters in treatment planning and outcomes. Three dimensions of client preference have been identified (Swift, Callahan, & Vollmer, 2011):

1. *Role preferences.* This addresses behaviors that clients want to engage in during therapy, and behaviors they want or expect from their therapist. Examples include being allowed to talk freely most of the session, practicing effective communication, or receiving advice.
2. *Therapist preferences.* This involves the ideal characteristics clients want in their therapist. Examples include genuineness, an ethnic match, a particular sexual orientation, or experience level.
3. *Treatment-type preferences.* This refers to what sort of intervention is desired. Examples include theoretical orientation (e.g., psychoanalytic), medications, or the inclusion of a spiritual orientation or focus.

*Client preference* is defined as what clients hope for, not necessarily what they expect. This treatment planning factor is based on the philosophy that clients are experts in their own lives (Tompkins, Swift, & Callahan, 2013). According to a meta-analysis of 35 studies, accommodating client preference was significantly associated with improved outcomes and decreased dropout rates (Swift et al., 2011).

### ***Resistance/Reactance***

Some clients are more resistant to change than others. (See Chapter 12 for more detail on interviewing challenging clients.) Generally, research has affirmed that when clients are highly resistant to treatment, negative outcomes are more likely (Karno, Beutler, & Harwood, 2002; Piper, McCallum, Joyce, Azim, & Ogrodniczuk, 1999).

There's also substantial research evidence indicating that clients who are traditionally considered difficult or resistant (e.g., clients with substance-related diagnoses) respond well to motivational interviewing (MI;

W. Miller & Rollnick, 2013). Because MI is a nondirective approach, this evidence supports the idea that it may be more effective to employ nondirective approaches when working with resistant clients.

Beyond the MI literature, Beutler, Harwood, Michelson, Song, and Holman (2011) conducted a meta-analysis of 12 studies ( $n = 1,103$  clients). This meta-analysis examined the relationship between therapist directiveness, client resistance, and treatment outcomes. A large effect size was reported. The authors concluded that when working with cooperative clients, therapists may use directive techniques effectively. However, when working with resistant or reactant clients, therapists will find less directive approaches more effective. The researchers recommended the following (p. 140):

- De-emphasizing therapist authority and guidance
- Using tasks that “bolster patient control and self-direction”
- Not using “rigid homework assignments”
- Presenting homework assignments as experiments
- Listening more and talking less
- Providing fewer instructions
- Emphasizing “self-directed work and reading”

### *Religion/Spirituality*

Many clients who come for therapy have specific religious or spiritual beliefs and want to talk about these beliefs in the context of therapy. This has led clinicians to accommodate and embrace religion and spirituality within traditional treatments.

Worthington, Hook, Davis, and McDaniel (2011) conducted a meta-analysis of 46 studies and 3,290 clients. They reported that clients who received religious or spiritually oriented therapy showed more improvement than clients who received an alternative secular-only therapy. This improvement was obtained on both psychological and spiritual outcome measures.

Utilizing a complex array of analyses and results, the researchers' conclusions and recommendations included the following (Worthington et al., 2011, p. 212):

- Religious or spiritually oriented therapy is effective, at least in the short run, and there are possibly long-term positive effects.
- When religious or spiritual concepts are integrated in therapy with clients who desire religious or spiritual accommodation, spiritual well-being outcomes are enhanced.

- The decision to integrate spiritual or religious content into therapy should be made based on the “desires and needs of the client.”

Overall, client religious or spiritual orientation should be assessed in an initial clinical interview and, consistent with clients’ wishes, integrated into treatment planning.

### ***Coping Style***

It has long been suspected that clients with different coping styles might respond optimally to different therapy approaches. In particular, researchers and practitioners have described clients as having internalizing or externalizing styles.

*Internalizers* are described as sensitive. They tend to respond to environmental stressors with fear, social withdrawal, avoidance, and self-deprecation. As a group, they tend toward having problems that include depressive and anxiety symptoms.

*Externalizers* are described as outgoing, gregarious, and stimulation seeking. They’re much less sensitive to their internal experiences. As a group, externalizers tend toward having problems that include aggressive behavior, social insensitivity, and lack of empathy.

Beutler, Harwood, Kimpara, Verdirame, and Blau (2011) conducted a meta-analysis of 12 studies ( $n = 1,291$  clients) that focused on the efficacy of different therapy approaches for internalizing and externalizing clients. They reported a medium effect size. They found that internalizing clients who show tendencies toward avoidance and self-criticism benefited more from interpersonally focused therapy that was insight oriented. In contrast, externalizing clients showed more positive outcomes in response to skill-building therapies that focused on alleviating problematic symptoms.

### ***Positive Expectations***

For more than 50 years, client expectations or hope for therapy success has been viewed as important to achieving positive therapy outcomes (Frank, 1961). Constantino, Arnkoff, Glass, Ametrano, and Smith (2011) conducted a meta-analysis of 46 samples ( $n = 8,016$  clients) examining clients’ pre-therapy or early-therapy outcome expectations and treatment outcomes. They reported a small but significant effect size ( $d = 0.24$ ). In conclusion, they recommended the following:

- Assess clients’ outcome expectations at the beginning of therapy.
- Use gentle, empathic, but positive statements about likely outcomes. (For example, “Your problems are exactly the type for which this therapy can be of assistance” p. 190.)

- Notice and comment on previous or in-session client accomplishments.
- Normalize potential setbacks, noting that some setbacks are normal.

Attending to and addressing client outcome expectations can and should be integrated into treatment planning.

### ***Culture***

As noted throughout this text, culture and cultural contexts are of central importance to clinical interviewing. Many researchers, practitioners, and professional organizations emphasize that evidence-based treatment cannot be considered evidence based unless cultural issues are addressed in service delivery. A question remains, however: How can clinicians integrate cultural knowledge and expertise into treatment planning?

Smith, Rodríguez, and Bernal (2011) conducted a meta-analysis comparing traditional therapy approaches with therapy approaches specifically adapted for clients of color. They included 65 research studies and 8,620 participants. They reported a moderate effect size ( $d = .46$ ) and stated, “The most effective treatments tended to be those with greater numbers of cultural adaptations” (p. 166). Their recommendations:

- Align treatment with clients’ cultural background, especially with clients who are older and less acculturated (e.g., older Asian Americans).
- Conduct therapy in the client’s native or preferred language.
- Make efforts to align therapy with client culture along multiple dimensions; it may be that therapist efforts at cultural alignment are more important than which specific procedures are used.
- When possible, adapt therapy approaches to the specific client’s cultural background instead of general cultural characteristics; for example, describe goals that match the client’s goals and use metaphors and symbols in therapy that match the client’s worldview.

Overall, when you’re working with diverse clients, the more ways and the more specifically you can address culture in your treatment plan, the greater the likelihood that you’re creating an effective treatment plan.

### ***Evidence-Based Relationships***

As discussed in Chapter 7, relationship factors are significantly associated with positive treatment outcomes (Norcross, 2011). As a consequence, to develop an empirically informed treatment plan, you should incorporate relationship factors into treatment planning. Specific interactions such as collaborative goal setting and progress monitoring are relationship based

and also constitute technical strategies. Furthermore, attending to the development and maintenance of a working alliance is a legitimate treatment plan component. This is true despite the fact that the manner in which you develop and maintain a working alliance will vary from client to client.

### ***Therapist Skill or Expertise***

Therapist competence is an ethical and practical consideration in treatment planning (S. Anderson & Handelsman, 2013). You must have expertise in whatever approaches you're intending to include in the treatment plan. For example, if you have no training or experience in a particular treatment technique (e.g., hypnosis or eye-movement desensitization reprocessing), that technique shouldn't be employed—or if employed, you should use it only under close supervision.

### ***Client Resources***

Therapy is expensive. Some clients have coverage from third-party payers, but health care programs have specific benefits and limits for mental health care coverage. The client's health care coverage and the resources available after the coverage runs out are practical and ethical considerations in charting a treatment plan.

Ethically, therapists are required to choose among theoretically or empirically based treatments and to see the client through to some kind of responsible closure or offer reasonable alternatives, such as a transfer to another counselor or service (S. Anderson & Handelsman, 2010). Therefore, in agreeing to a course of treatment, you must assess your own resources as well, including availability, willingness to reduce fees, an adequate referral network, appropriate supervision, and access to collateral professionals (e.g., attorneys, medical personnel).

There are resources beyond finances and insurance benefits and beyond those of the professional, which also should be considered in treatment planning. These include client motivation, ego strength, and psychological mindedness. It's your duty to assess, formally or informally, your clients' ability to engage in treatment.

## **Case Formulation and Treatment Planning: A Cognitive-Behavioral Example**

**VIDEO  
11.6**

Case formulation is the bridge between clinical assessment and treatment planning. To give you an idea of how this process works, we'll use

a cognitive-behavioral (CBT) example from the literature. Persons (2008) identified four case formulation steps from the CBT perspective:

1. Create a problem list.
2. Identify possible mechanisms causing the problems.
3. Identify precipitants (triggers) that currently activate the problem.
4. Consider historical origins of the client's problem.

In the next sections, we detail a case from Ledley, Marx, and Heimberg (2010) to illustrate how to link CBT case formulation to a specific treatment plan.

### The Problem List

Michael, a 40-year-old White male, referred himself for therapy due to chronic social anxiety (Ledley et al., 2010). Based on an initial assessment, including reflections on his *DSM* diagnosis, the following problem list was collaboratively generated:

- Social anxiety
- Confusion about career choices
- Family conflict

The initial and primary problem focus was social anxiety.

### Underlying Mechanisms

Persons (2008) described three steps for determining mechanisms underlying specific problems: (a) select a symptom or symptoms on which to focus; (b) select a theory or theories to explain the symptom(s); and (c) use your theory to extrapolate to the individual case.

For Michael, the presenting problem of social anxiety had several component symptoms, comprising fear/anxiety, flushing/sweating, and avoidance behaviors. Beck's (2011) cognitive theory was used to help Michael understand his symptoms. The symptoms—and their cognitive explanations—comprised the following (adapted from Ledley et al., 2010, p. 70):

#### **Automatic thoughts occurring before and during social contact**

- I always look anxious.
- They will think I'm an idiot.
- They will think I'm incompetent.

### Intermediate (distorted) thoughts

- People who make mistakes are rejected.
- I make more mistakes than other people.
- It's terrible to make mistakes.
- I must "get it right" all the time.

### A core schemata or belief

- If I am not perfect, I will be rejected.

## Current Precipitants (Triggers)

During Michael's initial interview, two situational triggers for his social anxiety were identified. These consisted of (a) casual social encounters and (b) public speaking. Michael also reported specific automatic thoughts that occurred in anticipation of and during these social contacts.

## Problem Origins

CBT focuses primarily on the present. Nevertheless, CBT also includes an exploration of the origins of clients' problems. Ledley et al. (2010) explain the rationale for this:

Spending some time exploring early experiences during the process of assessment can reveal some valuable clues to the clinician as to how problem behaviors developed in the first place and why maladaptive thoughts and behaviors are maintained in the present. Furthermore, sharing his or her personal history makes a client feel more understood which can serve to strengthen the therapeutic relationship. (p. 71)

## Michael's Treatment Plan

Recall that case formulation is the bridge from the client's presenting problem to the treatment plan. Using Persons's (2008) model, there's a focus on cognitive mechanisms that create and sustain Michael's symptoms. Treatment will include specific components that directly address the cognitive mechanisms underlying Michael's symptoms. In this case, the treatment plan included an evidence-based treatment manual for social anxiety.

The following treatment plan is adapted from Ledley et al. (2010):

### Session 1

*Problem:* Michael's distorted, maladaptive beliefs.

*Intervention:* Provide educational material on social anxiety.

*Goals:* Normalize the phenomenon of social anxiety; introduce Michael to the CBT model.

### **Session 2**

*Problem:* Michael's distorted, maladaptive beliefs.

*Intervention:* Design a hierarchy of feared situations.

*Goals:* Identify feared social situations; plan for how to proceed with exposure.

### **Session 3**

*Problem:* Michael's distorted, maladaptive beliefs.

*Intervention:* Begin cognitive restructuring.

*Goals:* Teach Michael to identify, question, and reframe his maladaptive thoughts.

### **Session 4**

*Problem:* Michael's distorted, maladaptive beliefs.

*Intervention:* Continue cognitive restructuring; plan initial exposure experience.

*Goals:* Continued skill building for identifying, questioning, and reframing his maladaptive thoughts; teach Michael how to initiate behavioral exposure.

### **Session 5**

*Problem:* Michael's beliefs AND his physiological response to social contact AND his behavioral pattern of avoidance.

*Intervention:* First exposure session.

*Goals:* Demonstration and experiential learning about how exposure can challenge maladaptive beliefs.

### **Sessions 6–18**

*Problem:* Michael's beliefs AND his physiological response to social contact AND his behavioral pattern of avoidance AND his core beliefs about himself.

*Intervention:* Continued exposure; continued cognitive restructuring.

*Goals:* Minimize physiological responses to social contact; internalize new beliefs about social anxiety and avoidance, and modify core beliefs about the self.

## Sessions 19 and 20

*Problem:* Michael's beliefs AND his physiological response to social contact AND his behavioral pattern of avoidance AND his core beliefs about himself.

*Intervention:* Relapse prevention, goal setting, termination.

*Goals:* Prepare and plan for termination, including future expectations and goals.

The preceding evidence-based CBT treatment plan is, in many ways, the state-of-the-science in treatment planning. Following Persons's (2008) approach to case formulation allows clinicians to individualize treatment, thus expanding evidence-based treatment potential. However, it should be noted that this approach also has many limitations. For example, third-party payers may not commit to a 20-session treatment protocol. Further, although evidence suggests that this is an appropriate treatment for White clients from the dominant culture, there's no compelling evidence that this approach is either appropriate or effective for diverse or minority clients.

## Additional Cultural Modifications and Adaptations

Contemporary clinicians modify and adapt diagnosis and treatment planning procedures to accommodate diverse clients.

VIDEO  
11.7

### Diagnosis

As an international document, the *ICD-10* engaged the efforts of physicians, scientists, and psychological experts from many different cultures and nations. Consequently, close attention was paid to how diagnostic entities might translate across cultural and national boundaries. In its introduction, the *ICD-10-CM* includes the following statement about how specific disorders might manifest themselves differently, depending on cultural setting:

The need for a separate category for disorders such as latah, amok, koro, and a variety of other possibly culture-specific disorders has been expressed less often in recent years. . . Descriptions of these disorders currently available in the literature suggest that they may be regarded as local variants of anxiety, depression, somatoform disorder, or adjustment disorder; the nearest equivalent code should therefore be used if required, together with an additional note of which culture-specific disorder is involved. (p. 19)

The *ICD-10-CM* also notes that because of “locally accepted cultural beliefs and patterns,” syndromes such as the following should not be regarded as delusional:

- *Dhat syndrome*: excessive concern about debilitating effects linked to passing semen
- *Koro*: fear and anxiety that the penis is retracted or will retract into the body and cause death

## The Cultural Formulation Interview

To address the challenge of culture in diagnosis, *DSM-5* includes the Cultural Formulation Interview (CFI). The CFI is a semi-structured interviewing protocol to aid in diagnostic assessments.

The CFI is not a method for assigning clinical diagnoses. It's used as a supplementary interview that can enhance your understanding of possible cultural factors. It can also aid in the diagnostic decision-making process. The CFI includes an introduction and four sections (comprising a total of 16 questions). The four sections are as follows:

1. Cultural definition of the problem
2. Cultural perceptions of cause, context, and support
3. Cultural factors affecting self-coping and past help seeking
4. Cultural factors affecting current help seeking

Questions from each section are worded to help clinicians collaboratively explore the cultural dimensions of clients' problems. Question 2 is a good example: “Sometimes people have different ways of describing their problem to their family, friends, or others in their community. How would you describe your problem to them?” (American Psychiatric Association, 2013, p. 1).

Clinicians are encouraged to use the CFI in research and clinical settings (it's available free online). There's also a mechanism for users to provide the American Psychiatric Association with feedback on the CFI's usefulness. This collaborative process to collect data on the use of the CFI represents a positive step forward in increasing cultural sensitivity in diagnosis and treatment planning.

## Summary

The diagnosis of mental disorders is central to mental health work and treatment planning. The two most prominent diagnostic systems are the *ICD-10-CM* and the *DSM-5*. Although both systems are used, as of October

2015, all mental health providers in the United States have been required to use *ICD-10-CM* codes.

Controversies about psychiatric diagnosis abound, but there are important reasons for all mental health professionals to develop diagnostic skills. Diagnosis facilitates professional communication, stimulates research, and contributes to treatment planning. Some clients are relieved to have a diagnosis that assures them that others suffer from similar reactions, struggles, and complaints. The chapter included specific diagnostic criteria for generalized anxiety disorder. Despite substantial progress, problems with assessment and diagnosis remain.

Formal diagnostic interviews are either structured or semi-structured. They also can be broad spectrum or circumscribed to focus on specific disorders. In this chapter, the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I) was described as a semi-structured interviewing prototype. Despite limitations in diagnostic reliability and validity, structured interviews are the best method for providing an accurate diagnosis.

Many clinicians use less structured approaches to diagnostic interviewing. When doing so, therapists should include the following components: (a) a warm introduction to diagnostic assessment and role induction; (b) an extensive review of client problems and associated goals; (c) a brief review of client personal history, especially those historical experiences closely associated with the client's primary problem; and (d) a review of the client's current situation, including social supports, coping skills, physical health, personal strengths, and, if needed, a brief mental status examination. It's important to recognize the impossibility of memorizing all diagnostic criteria and that often a diagnosis cannot be established in one session.

Treatment planning flows directly from diagnosis or problem analysis. There are several evidence-based matching factors to consider when establishing a treatment plan. These are (a) client diagnosis and associated empirically supported treatments; (b) client preference; (c) client resistance/reactance; (d) client religion/spirituality; (e) client coping style; (f) positive expectations; (g) cultural factors; (h) evidence-based relationships; (i) therapist skill or expertise; and (j) client resources.

Case formulation is the bridge between client diagnosis/problem and treatment planning. The chapter included a sample case formulation and treatment plan from the cognitive-behavioral perspective.

Cultural adaptations to diagnosis and treatment planning are used to accommodate culturally diverse clients. The *ICD-10-CM* includes a discussion of various cultural issues in diagnosis. In addition, the *DSM-5* includes a semi-structured cultural formulation interview that can be downloaded for free to facilitate cultural sensitivity when interviewing diverse clients.

## Suggested Readings and Resources

Numerous publications focus on diagnosis and treatment planning in psychiatry, psychology, counseling, and social work. The following list is limited, but provides ideas for further reading and study.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author. This is the citation for the *DSM-5*. It includes the Cultural Formulation Interview (CFI), but the CFI is also available for free online.

Bryceland, C., & Stam, H. J. (2005). Empirical validation and professional codes of ethics: Description or prescription? *Journal of Constructivist Psychology*, 18(2), 131–155. This article discusses and critiques the trend in ethics codes mandating that therapists use empirically or theoretically supported treatments.

Ingersoll, R. E., & Marquis, A. (2014). *Understanding psychopathology: An integral exploration*. New York, NY: Pearson. This text has chapters that review a variety of different diagnostic classification systems (*DSM*, *ICD*, and others). There are also comprehensive literature reviews focusing on many different mental disorders.

Kutchins, H., & Kirk, S.A. (1997). *Making us crazy: DSM: The psychiatric bible and the creation of mental disorders*. New York, NY: Free Press. In this book, the authors provide a strong critique of the development and promotion of the *DSM* system as a method of categorizing mental disorders. In particular, the chapters on homosexuality and racism are enlightening reading.

Norcross, J. C., Beutler, L. E., & Levant, R. F. (Eds.). (2006). *Evidence-based practices in mental health: Debate and dialogue on the fundamental questions*. Washington, DC: American Psychological Association. This edited volume covers a wide range of pertinent questions related to evidence-based practice.

Schaffer, J., & Rodolfa, E. R. (2015). *A student's guide to assessment and diagnosis using the ICD-10-CM: Psychological and behavioral conditions*. Washington, DC: American Psychological Association. The *ICD-10-CM* is available free online, but it never hurts to have a companion text to help you better understand the manual and its clinical application.

Seligman, L., & Reichenberg, L. W. (2012). *Selecting effective treatments: A comprehensive, systematic guide to treating mental disorders* (4th ed.). Hoboken, NJ: Wiley. This is the fourth edition of Seligman's practical and accessible text on diagnosis and treatment planning.

**PART FOUR**

**SPECIAL POPULATIONS AND SITUATIONS**



# CHALLENGING CLIENTS AND DEMANDING SITUATIONS

## Chapter Orientation

Initially, most therapists prefer working with cooperative clients in comfortable, safe, and secure settings. It feels less stressful and more gratifying to work with clients who are motivated and eager to learn, and with whom rapport and a working alliance develop smoothly.

But eventually many mental health professionals learn to love working with clients who challenge them or in situations that offer more chaos than comfort.

One problem associated with these two interviewing scenarios is that we often don't know in advance when they will emerge. This chapter offers an introduction to interviewing challenging clients and conducting interviews in demanding situations.

### VIDEO 12.1

## Challenging Clients

Clients do not always follow therapists' suggestions . . . this is not viewed as resistance. When this happens, clients are simply educating therapists as to the most productive and fitting method of helping them change.

—William O'Hanlon and Michelle Weiner-Davis, *In Search of Solutions*, 1989,  
pp. 21–22

### LEARNING OBJECTIVES

After reading this chapter, you will be able to:

- Describe resistance as a naturally occurring phenomenon in therapy, along with general strategies for understanding and addressing resistance
- Identify and apply specific techniques from motivational interviewing and other theoretical perspectives for working effectively with different types of resistance and interviewing clients with substance issues
- Describe methods and guidelines for the assessment and prediction of violent behaviors
- Describe the psychological first aid (PFA) model for assisting with humanitarian and crisis situations, and identify specific ethical and professional issues associated with working with traumatized clients
- Discuss cultural competencies in disaster mental health, including cultural humility

Although some clients eagerly arrive for counseling with positive expectations, not all clients are equally cooperative. Here are a few opening lines we've heard over the years:

- Do I have to be here?
- No disrespect, but I hate counselors.
- I'll never talk to you about anything important.
- This is a shitty little office; you must be a shitty little therapist.
- How long will this take?
- You actually get paid for doing this?

In our work with adolescents and young adults, we've had the pleasure (or pain) of being in many interviews with people who want little to do with therapy and nothing to do with us. We've had clients refuse to be alone in the room with us, others who refused to speak, a few who insisted on standing, and many who told us with great disdain (and sometimes with exuberant profanity) that they *don't believe in counseling*.

The first part of this chapter is about interviewing clients who oppose the helping process. It's also about the deep satisfaction of working with clients who slowly or suddenly shift their attitudes. When these clients eventually enter the room, begin speaking, stop swearing, agree to sit, and begin believing in counseling (and counselors!), it can be a profoundly rewarding experience.

## Defining and Exploring Resistance

Freud viewed resistance as inevitable and ubiquitous. Following Freud's lead, psychotherapists for many years considered virtually anything clients did or said as potential signs of resistance, such as

- Talking too much
- Talking too little
- Arriving late
- Arriving early
- Being unprepared for psychotherapy
- Being overprepared for psychotherapy

### ***The Death (or Reframing) of Resistance***

Over the past several decades, some theorists and practitioners began questioning the nature and helpfulness of resistance as a concept. In 1984, writing from a solution-focused perspective, Steven de Shazer announced the

“death of resistance” and subsequently held a ceremony as he buried it in his backyard. Other theorists and researchers have followed his lead (Engle & Arkowitz, 2006; Hunter, Button, & Westra, 2014). They view resistance as an unhelpful linguistic creation that developed because sometimes clients don’t want to do what their “bossy-pants” therapist wants them to do. In other words, resistance isn’t a problem centered in the client; it’s a problem created by pushy therapists.

Around the time de Shazer was burying resistance in his backyard, William R. Miller was discovering that as he worked with substance-abusing clients, reflections, empathy, and encouragement outperformed confrontation and behavioral interventions (W. Miller, 1978, 1983). This discovery led to the development of motivational interviewing (W. Miller & Rollnick, 1991). Motivational interviewing (MI) is now widely acknowledged as an effective treatment for many different health, substance, and mental health problems (Magill et al., 2014; Romano & Peters, 2015). MI is defined as “a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence” (Rollnick & Miller, 1995, p. 326). Partly because Miller reframed client resistance as stemming from natural ambivalence, MI is especially well suited for clients in the precontemplation or contemplation stages of change in the transtheoretical model (see Prochaska & DiClemente, 2005, and Chapter 6).

### ***Resistance as Multidetermined***

Unlike what early analysts might have argued, resistance isn’t inevitable or ubiquitous, but it’s probably not dead either. Instead, resistance (or ambivalence or reluctance) can originate from three main sources:

1. *Resistance from the client.* It seems obvious that sometimes resistance is real and palpable and originates from clients’ beliefs, attitudes, ambivalence, or opposition to therapy. When resistance emanates from clients, they’re usually in the precontemplation (not interested in changing) or contemplation (occasional transient thoughts of changing) stages of change (Prochaska & DiClemente, 2005).
2. *Resistance that therapists stimulate.* Sometimes therapists behave in ways that create resistance rather than cooperation. For example, overuse of confrontation or interpretation, rather than focusing on clients’ positive potential for change, can stimulate client resistance (Romano & Peters, 2015). This is especially the case with teenage clients, reluctant clients, mandated clients, or clients from diverse cultures and backgrounds.

3. *Resistance as a function of the situation.* Resistance may not be the fault of clients or therapists. Instead it can be viewed as a product of a difficult and uncomfortable situation, a situation that naturally triggers reactance (i.e., negative expectations and defensiveness; Beutler, Harwood, Michelson, Song, & Holman, 2011). For most mandated clients and for many ambivalent clients, resistance to therapy should be framed as a natural, situationally triggered behavior (J. Sommers-Flanagan, Richardson, & Sommers-Flanagan, 2011).

We realize that framing resistance as multidetermined and natural (or burying it) doesn't automatically make it easy to handle (J. Sommers-Flanagan & Bequette, 2013). Resistance can still feel aggressive, provocative, oppositional, and threatening.

Overall, it's unrealistic to expect all clients—especially adolescents or mandated adults in the precontemplation or contemplation stages of change—to immediately speak openly and work productively with an unfamiliar adult authority figure. It's also unrealistic to expect clients to whom therapy is a new and uncomfortable experience to immediately begin sharing their innermost thoughts. If you choose to use the word resistance, it's helpful to add the word "natural" to the label. Doing so offers empathy for the client's entry into an uncomfortable situation and acknowledges the need for effective strategies and techniques for dealing with challenging client behaviors. The central question then becomes: What clinician behaviors can reduce natural client resistance and defensiveness?

## VIDEO 12.2

### Motivational Interviewing and Other Strategies for Working Through Resistance

In their groundbreaking text *Motivational Interviewing*, W. Miller and Rollnick (1991, 2002, 2013) described a practical approach to recognizing and working with client resistance. They emphasized that most humans are ambivalent about making changes because they have competing motivations. For example, a client may simultaneously have distinct and competing motivations about smoking cigarettes:

- I should quit because smoking is expensive and unhealthy.
- I should keep smoking because it's pleasurable and gives me a feeling of emotional control.

Imagine yourself in an interview situation. You recognize that your client is engaging in a self-destructive behavior (e.g., smoking, cutting, punching walls). In response, you educate your client and make a case for giving

up the self-destructive behavior. W. Miller and Rollnick (2002) described this scenario:

[The therapist] then proceeds to advise, teach, persuade, counsel or argue for this particular resolution to [the client's] ambivalence. One does not need a doctorate in psychology to anticipate what [the client's] response is likely to be in this situation. By virtue of ambivalence, [the client] is apt to argue the opposite, or at least point out problems and shortcomings of the proposed solution. It is natural for [the client] to do so, because [he or she] feels at least two ways about this or almost any prescribed solution. It is the very nature of ambivalence. (pp. 20–21)

In MI, resistance is framed as stemming from natural ambivalence about change. Consider this from a physical perspective. If you hold out an open hand and ask someone else to do the same and then push against his or her hand, the other person usually pushes back, matching your force. During a clinical interview, this process can happen verbally. The more you push for healthy change, the more clients push back with a rationale for staying less healthy (Apodaca et al., 2015; Magill et al., 2014).

This leads to the central MI hypothesis for resolving client ambivalence and activating motivation:

All of this points toward a fundamental dynamic in the resolution of ambivalence: *It is the client who should be voicing the arguments for change.* (W. Miller & Rollnick, 2002, p. 22, italics added)

But how can clinicians help clients make arguments for change?

Within the MI model, when clients voice their own arguments for change, it's referred to as *change talk*. When clients voice their arguments against change, it's referred to as *sustain talk* because clients are arguing to continue or sustain their unhealthy behaviors. The central hypothesis of MI is that the more clients engage in change talk, the more likely it is for positive change to occur.

MI has relational and technical components. The relational component involves embracing a spirit of collaboration, acceptance, and empathy. The technical components include intentional evocation and reinforcement of client change talk (W. Miller & Rose, 2009). In practice, it's difficult to separate the relational and technical components, and it's likely more efficacious when they're delivered together anyway. As you work with reluctant, ambivalent, or resistant clients, you'll need to make sure your Rogerian

person-centered hat is firmly in place, while simultaneously using good behavioral skills to evoke and reinforce change talk.

### Using Open Questions, Opening Questions, and Goal-Setting Strategies

Asking open questions is a fundamental MI skill. However, W. Miller and Rollnick (2013) cautioned asking too many questions, including open questions:

A simple rhythm in MI is to ask an open question and then to reflect what the person says, perhaps two reflections per question, like a waltz. Even with open questions, though, avoid asking several in a row, or you may set up the question-answer trap. (p. 63)

W. Miller and Rollnick recommend following their two-to-one waltz metaphor only loosely; the point is to remind you to do more reflecting than questioning. They offer a stronger warning against repeated closed questions, noting, “Chaining together a series of closed questions can be deadly for engagement” (p. 63).

When opening sessions with reluctant, ambivalent, resistant, or hostile clients, you have a better chance for a good meeting if you begin the interview in a positive, strength-focused, empathic, and nonblaming manner. Solution-focused and narrative therapists accomplish this with goal-oriented opening questions:

- What would make this a helpful visit?
- If we have a great meeting today, what will happen?
- What needs to happen in here for our time to be productive?

Consider the following example in an emergency room setting (M. Cheng, 2007, p. 163, parenthetical comments added):

**Clinician:** What would make today's . . . visit helpful? (*Clinician asks for goals.*)

**Patient:** I want to kill myself, just let me die. . . (*Patient states unhealthy goal/task.*)

**Clinician:** I'm sure you must have your reasons for feeling that way . . . What makes you want to hurt yourself? (*Clinician searches for underlying healthy goal.*)

**Patient:** I just can't stand the depression anymore and all the fighting at home. I just can't take it. (*The underlying healthy goal/task may be trying to cope with depression and fighting.*)

**Clinician:** . . . so we need to find a way to help you cope with the depression and the fighting. You told me yourself that there used to be less fighting at home. What would it be like if we found a way to reduce the fighting, have people getting along more?

**Patient:** A lot better, I guess. But it's probably not going to happen.

**Clinician:** Okay, I can see why you're frustrated and I do understand that probably the depression makes it hard to see hope. But I believe that there is a part of you that is stronger and more hopeful, because otherwise you wouldn't be here talking with me. (*Clinician externalizes unhealthy thoughts or behaviors as being part of the depression and tries to help the patient rally against the depression.*) That hopeful part of you said that your mood used to be happy. What would it be like if we could get your mood happy again?

**Patient:** A lot better I guess.

**Clinician:** Just to help me make sure I'm getting this right then, what would you like to see different with your mood? (*The clinician reinforces the client's goals by having the client articulate them.*)

**Patient:** I want to be happy again.

**Clinician:** And at home, what would you like to see with how people get along?

**Patient:** I want us to get along better.

**Clinician:** Let's agree then that we will work together on finding a way to help people get along, as well as help your mood get better. How does that sound? (*Clinician paraphrases patient's healthy goals.*)

**Patient:** Sounds good. . . (*Patient agrees with goals.*)

In this example, M. Cheng (2007) illustrated how to help patients articulate goals and acknowledge potential benefits of positive change. Although the physician initiated the interaction with a negatively worded question—"What makes you want to hurt yourself?"—he was listening for positive, health-oriented goals underlying the suicidal motivations. This is an important principle: Even when exploring the client's emotional pain, you can listen for and resonate with the unfulfilled positive goals contributing to that pain.

### Using Reflection, Amplified Reflection, and Undershooting

Throughout this text, we've emphasized nondirective interviewing skills: paraphrasing, reflection of feeling, and summarizing. Research on MI supports this emphasis, showing that these reflective techniques are powerful

tools for working with and eliminating resistance (Magill et al., 2014). W. Miller and Rollnick (2002, pp. 100–101) provided examples of simple reflections that can reduce resistance:

**Client 1:** I'm trying! If my probation officer would just get off my back, I could focus on getting my life in order.

**Therapist 1:** You're working hard on the changes you need to make.

or

**Therapist 1:** It's frustrating to have a probation officer looking over your shoulder.

**Client 2:** Who are you to be giving me advice? What do you know about drugs? You've probably never even smoked a joint!

**Therapist 2:** It's hard to imagine how I could possibly understand.

**Client 3:** I couldn't keep the weight off even if I lost it.

**Therapist 3:** You can't see any way that would work for you.

or

**Therapist 3:** You're rather discouraged about trying again.

When therapists accurately reflect their clients' efforts, frustration, hostility, and discouragement, the need for clients to defend their positions is reduced.

Reflections can also stimulate talk about the constructive side of the ambivalence. Recently, we supervised graduate students in counseling and psychology as they conducted hundreds of brief interviews with client-volunteers from introductory psychology classes. We noticed that when the student therapists made an inaccurate reflection, the volunteer-clients felt compelled to clarify their feelings and beliefs in ways that rebalanced their ambivalence. For example:

**Client:** I'm pissed at my roommate. She won't pick up her clothes or do the dishes or anything.

**Therapist:** You'd like to fire her as a roommate.

**Client:** No. Not that. There are lots of things I like about her, but her messiness really annoys me.

This exchange shows the interviewer inadvertently overstating the client's negative view of the roommate. In response, the client immediately pushes back, clarifying: "There are lots of things I like about her."

As it turns out, this interviewer accidentally used the MI technique amplified reflection (W. Miller & Rollnick, 2013). *Amplified reflection*

involves intentionally overstating of the client's main message. W. Miller and Rollnick wrote: "As a general principle, if you overstate the intensity of an expressed emotion, the person will tend to deny and minimize it, backing off from the original statement" (p. 59).

When used intentionally, amplified reflection can seem manipulative. This is why amplified reflection is used along with genuine empathy and never includes sarcasm. Instead of being a manipulative response, it's viewed as the therapist's effort to deeply empathize with the client's frustration, anger, and discouragement. The following are examples of amplified reflection:

**Client 1:** My child has a serious disability, so I have to be home for him.

**Therapist 1:** You need to be home 24/7 and need to turn off any needs you might have to get out and take a break.

**Client 1:** Actually, that's not totally true. Sometimes, I think I need to take some breaks so I can do a better job when I'm home.

**Client 2:** When my grandmother died last semester, I had to miss classes and it was a total hassle.

**Therapist 2:** You don't have much of an emotional response to your grandmother's death—other than it's really inconveniencing you.

**Client 2:** Well, it's not like I don't miss her, too.

Amplified reflection is an empathic effort to fully resonate with one side of the client's ambivalence; it naturally nudges clients the opposite direction.

It's also possible to use reflection to intentionally understate what clients are saying. W. Miller and Rollnick (2013) refer to this as *undershooting* and advocate using it to encourage clients to continue exploring their thoughts and feelings. You can use understating or undershoot-ing when focusing on client emotions, beliefs, values, and other salient issues:

**Client:** I can't stand it when my mom criticizes my friends right in front of me.

**Therapist:** You find that a little annoying.

**Client:** It's way more than annoying. It pisses me off.

**Therapist:** What is it that pisses you off when your mom criticizes your friends?

**Client:** It's because she doesn't trust me and my judgment.

In this example, the therapist uses an understatement and then an open question to continue exploring what hurts about the mother's criticism.

## Coming Alongside (Using Paradox)

Intentionally undershooting or using amplified reflections to move client talk in specific directions can feel manipulative. An extreme form of this is paradox. Paradox has traditionally involved prescribing the symptom (Frankl, 1967). For example, with a client who is using alcohol excessively, a traditional paradoxical intervention would involve something like “I think maybe you’re not drinking enough” or “It might be helpful if you could try to amp up your drinking a bit this next week.”

You can probably sense that paradox is a high-risk and blatantly manipulative intervention. We don’t advocate using paradox in this form. Interestingly, Viktor Frankl, who wrote about paradox in the early 1900s, viewed paradox as operating based on humor. It’s as if clients unconsciously or consciously understand the silliness of behaving in a destructive extreme and consequently pull back in the other direction. This formulation might be viewed as working with ambivalence in a manner similar to MI.

W. Miller and Rollnick (2013) discuss using paradox to address resistance, but refer to it as *coming alongside*. Similar to amplified reflection, coming alongside is used with empathy and respect. Here are two examples:

**Client 1:** I don’t think this is going to work for me, either. I feel pretty hopeless.

**Therapist 1:** It’s certainly possible that after giving it another try, you still won’t be any better off, so it might be better not to try at all. What’s your inclination?

**Client 2:** That’s about it, really. I probably drink too much sometimes, and I don’t like the hangovers, but I don’t think it’s that much of a concern, really.

**Therapist 2:** It may just be worth it to you to keep on drinking as you have, even though it causes some problems. It’s worth the cost.

Using coming alongside requires authentic empathy for the less healthy side of the ambivalence.

W. Miller and Rollnick (2002) commented on the difference between using coming alongside as compared to traditional paradoxical strategies:

We confess some serious discomfort with the ways in which therapeutic paradox has sometimes been described. There is often the sense of paradox being a clever way of duping people into doing things for their own good. In some writings on paradox, one senses almost a glee in finding innovative ways to trick people without their realizing what is happening. Such cleverness lacks the respectful and collaborative

tone that we understand to be fundamental to the dialectical process of motivational interviewing. (p. 107)

Paradoxical techniques should be integrated into the basic person-centered core attitudes of congruence, unconditional positive regard, and empathic understanding. They shouldn't be used as a clever means to outwit or trick clients.

### Using Emotional Validation, Radical Acceptance, Reframing, and Genuine Feedback

Clients sometimes begin interviews with expressions of hostility, anger, or resentment. If clinicians handle these provocations well, clients may eventually open up and cooperate. The key is to maintain an accepting attitude and restrain from lecturing, scolding, or retaliating when clients express hostility. Speaking from a psychiatric perspective, Knesper (2007) noted: "Chastising and blaming the difficult patient for misbehavior seems only to make matters worse" (p. 246).

Empathy, emotional validation, acceptance, and concession are more effective responses. We often coach graduate students to use concession when power struggles emerge, especially when working with adolescent clients (J. Sommers-Flanagan & Sommers-Flanagan, 2007b). For example, if a young client opens a session with "I'm not talking and you can't make me," conceding power and control can facilitate a more positive process: "You're absolutely right. I can't make you talk, and I definitely can't make you talk about anything you don't want to talk about." This statement validates the client's perspective and concedes an initial victory in what the client might view as a struggle for power. MI therapists refer to this as *affirming* the client.

Empathic, emotionally validating statements are also important. If clients express anger about meeting with you, a reflection of feeling and/or feeling validation response communicates that you hear their emotional message loud and clear. In some cases, you can go beyond empathy and emotional validation and join clients with a parallel emotional response:

- I don't blame you for feeling pissed about having to see me.
- I hear you saying you don't trust me, which is totally normal. After all, I'm a stranger, and you shouldn't trust me until you get to know me.
- It pretty much sucks to have a judge require you to meet with me.
- I know we're being forced to meet, but we're not being forced to have a bad time together.

*Radical acceptance* is a principle and technique based on dialectical behavior therapy and person-centered theory (Linehan, 1993). It involves consciously accepting and actively welcoming all client comments—even odd, disturbing, or blatantly provocative comments (J. Sommers-Flanagan & Sommers-Flanagan, 2007a). Here's a case where a client began a session with angry statements about counseling:

**Opening client volley:** I don't need no stupid-ass counseling. I'm only here because my wife is forcing me. This counseling shit is worthless. It's for pansy-ass wimps like you who need to sit around and talk rather than doing any real work.

**Radical acceptance return:** Wow. Thanks for being so honest about what you're thinking. Lots of people really hate counseling but just sit here and pretend to cooperate. So I really appreciate your telling me exactly where you're coming from.

Radical acceptance can be combined with reframing to communicate a deeper understanding about why clients have come for therapy. One version of this is the *love reframe* (J. Sommers-Flanagan & Barr, 2005).

**Client:** This is total bullshit. I don't need counseling. The judge required this. Otherwise, I can't see my daughter for unsupervised visitation. So let's just get this over with.

**Therapist:** You must really love your daughter to come to a meeting that you think is bullshit.

**Client:** (softening) Yeah. I do love my daughter.

The magic of the love reframe is that clients nearly always agree with the positive observation about loving someone. This frame can shift the interview to a more pleasant and cooperative focus.

Often, when working with angry or hostile clients, there's no better approach than reflecting and validating feelings . . . pausing . . . and then following with honest feedback and a solution-focused question.

I hear you saying you hate the idea of talking with me. I don't blame you for that. I'd hate to be forced to talk to a stranger about my personal life too. But can I be honest with you for a minute? [Client nods in assent.] You know, you're in legal trouble. I want to be helpful—even just a little. We're stuck meeting together. We can either sit and stare at each other and have a miserable hour, or we can talk about how you might dig yourself out of this legal hole. I can go either way. What do you think . . . if we had a good meeting today, what would we accomplish?

## Dealing With Resistant Clients Who May Be Lying or Delusional

Clients often tell stories that aren't exactly true. In particular, young clients will often minimize or exaggerate their problems or perspective (J. Sommers-Flanagan & Bequette, 2013).

Having a general policy of including family members or parents or caregivers for some or all of an initial interview can help you obtain a more balanced picture of client problems and potential solutions. If you have questions about your client's reliability, then contacting significant others is another reasonable option. These policies should be explained in your informed consent.

Sometimes clients who are prone to lying or are delusional will directly ask, "Do you believe me?" This question can be problematic because it puts you on the spot. If you say, "Yes, I believe you," you may have indicated to a client who's lying that you believe his lies (or you may be telling a delusional client that you believe she's being harassed by the FBI). But if you say you don't believe the client, the alliance can be damaged. To address this challenging situation, D. Robinson (2007, p. 241, parenthetical comment added) offered the following methods for stimulating further client disclosure:

**Client:** Do you believe me?

**Interviewer:** I'm keeping an open mind.

*or*

**Interviewer:** I can't decide without more information.

*or*

**Interviewer:** My job is to understand what your views are.

*or*

**Interviewer:** [Your] story is an unusual one, so I really want to hear more before making a decision; tell me [more] about . . . (*Refer patient back into an affectively charged detail from the story.*)

Our usual response in this situation is similar to Robinson's:

That's a good question. My job isn't to judge whether you're telling the truth. Only you know if what you say is true. I don't want to be an investigator or cop. My job is to listen to you, and my goal is to be helpful. And I can be more helpful if you're honest with me. But that's up to you.

There are many motivations for lying. These include (a) covering for shame or embarrassment, (b) self-protection, or (c) gaining some kind of

imagined or real advantage. As a general rule, people lie more if they feel the need to lie and lie less when they experience trust. Your goal is to build an alliance that includes enough trust to facilitate honesty. Confronting obvious or subtle lying behavior may be less productive than waiting for rapport and trust to build and for honest disclosure to flow naturally.

Remember that resistance emanates from the very center of a person and can give people stability and predictability in their interactions with others. Resistance exists because change and pain can be frightening and more difficult to face than retaining old, maladaptive ways of being. With culturally or developmentally different clients, therapists may actually cause resistance by refusing or failing to make culturally or developmentally sensitive modifications (J. Sommers-Flanagan & Sommers-Flanagan, 2007b). Table 12.1 includes strategies and techniques for working with client ambivalence or natural client resistance.

**Table 12.1** Checklist of Strategies and Techniques for Working with Natural Resistance

- |                          |   |
|--------------------------|---|
| <input type="checkbox"/> | 1. Adopt an attitude of acceptance and understanding because developing a therapeutic alliance is almost always a higher priority than confrontation.                     |
| <input type="checkbox"/> | 2. Recognize that clients will feel ambivalence about working toward and achieving positive change.   |
| <input type="checkbox"/> | 3. Resist your impulses to teach, preach, and persuade clients to make healthy decisions.   |
| <input type="checkbox"/> | 4. In the beginning and throughout, ask open-ended questions that link to potential positive goals.   |
| <input type="checkbox"/> | 5. Look for positive goals underlying your clients' emotional pain and discouragement—and then help clients be the ones who articulate those goals.                       |
| <input type="checkbox"/> | 6. Use simple reflections to reduce clients' needs to exhibit resistance.   |
| <input type="checkbox"/> | 7. Use concession or affirming: "You're right. I can't make you talk with me." This affirms to clients that they're in control of what they say.                          |
| <input type="checkbox"/> | 8. Use amplified reflection or understating to encourage clients to discuss the healthier side of their ambivalence.  |
| <input type="checkbox"/> | 9. Use emotional validation when clients are angry or hostile.  |
| <input type="checkbox"/> | 10. Use radical acceptance to compliment clients for their openness—even though the openness may be aggressive or disturbing.   |
| <input type="checkbox"/> | 11. Reframe client hostility and negativity into positive impulses whenever possible.   |
| <input type="checkbox"/> | 12. Provide genuine feedback about client behaviors that are of concern.  |
| <input type="checkbox"/> | 13. Use paradox carefully to respectfully come alongside clients' resistance.   |
| <input type="checkbox"/> | 14. If you're concerned about truthfulness, interview significant others to help you get an accurate story.   |
| <input type="checkbox"/> | 15. When clients ask "Do you believe me?" use a response that encourages more disclosure, such as "I'm not here to be a judge. I'm here to listen and try to be helpful." |
| <input type="checkbox"/> | 16. Remember (and be glad) that you're a mental health professional and not a judge.  |

## Interviewing Clients With Substance Issues or Problems

Interviewing clients with substance abuse or substance dependence problems requires specialized training and experience. This brief section provides basic information that might whet your appetite for further training in this area.

Some professionals who work with substance-using clients have a personal history of substance abuse or dependence. Researchers and clinicians have noted that having your own substance abuse history can be a benefit or a liability (Curtis & Eby, 2010; Gallagher, 2010). If you've experienced substance abuse problems, you probably know the big issues from the inside out; this can give you greater empathy for and knowledge about client dynamics. Alternatively, having your own substance abuse problems makes projecting your own issues and idiosyncratic solutions onto clients more likely (see Putting It in Practice 12.1).

### *Gathering Information*

Gathering valid information from substance-abusing clients can be difficult. To aid with the process, researchers and clinicians have developed numerous brief interviewing approaches. These approaches are especially important in settings where obtaining diagnostic information quickly and efficiently is a high priority.

#### **PUTTING IT IN PRACTICE 12.1: EXPLORING YOUR PERSONAL ATTITUDES TOWARD SUBSTANCES**

Reflecting on your attitudes toward alcohol and drug use is worthwhile. Whether you grew up in a family with strong prohibitions against drinking alcohol or a family with multiple addictions, your family experiences shaped how you think about people who use (or don't use) alcohol and other drugs. To become effective in working with substance-abusing clients, it helps to reflect on your personal alcohol and drug history, your current attitude toward substances, and your family's alcohol and drug history.

As you continue reading this chapter, keep reflecting on your attitudes toward alcohol and drugs. Also, as you study different approaches for assessing and working with substance-abusing clients, imagine yourself in both the therapist's and the client's shoes. Ask yourself the following questions:

- Do I have any assumptions about how therapists should act when interviewing substance-abusing clients?

(Continued)

- Is it necessary to be confrontational—to get clients to “fess up” about their substance use? Or will confrontational techniques increase client defensiveness and reduce honesty?
- If I don’t confront clients who are addicted to substances, will they just avoid admitting they have any problems?
- What do I think about the CAGE assessment questions [see text]? How about the NIAAA criteria [see text] for alcohol consumption? How would I answer the questions? Do I have, or have I ever had, a problem with alcohol or other drugs?

Regardless of your answers to these questions, be sure to talk with someone, privately or in a setting with people you trust, about your attitudes toward and experiences with alcohol and other drugs. Becoming aware of and working through your issues are part of your continuing development as a professional therapist.

Determining whether an individual is suffering from a substance use disorder is a specific diagnostic procedure. When faced with this task, some therapists simply pull out their latest edition of the *DSM* (or *ICD*) and ask clients questions based on the diagnostic criteria. In contrast, alcohol and drug researchers are likely to use a more detailed and lengthy diagnostic interview schedule as their gold standard for determining whether a substance-related disorder exists (Dawson, Smith, Saha, Rubinsky, & Grant, 2012).

The question of how much is “too much” substance use is often not answerable. Nevertheless, several methods exist. A commonly used brief interview for identifying alcohol problems is the CAGE questionnaire (Williams, 2014). CAGE is an acronym to help you remember four important questions to ask clients about their alcohol use:

- C** Have you ever felt that you should CUT DOWN on your drinking?
- A** Have people ANNOYED you by criticizing your drinking?
- G** Have you ever felt GUILTY about your drinking?
- E** Have you ever had an EARLY morning (eye opener) drink first thing in the morning to steady your nerves or to get rid of a hangover?

Although diagnosis of an alcohol disorder should never be based on a single, brief interview procedure such as the CAGE questionnaire, many therapists, as well as the National Institute on Alcoholism and Alcohol Abuse (NIAAA), consider a yes to any one of the CAGE questions to be possible evidence of an alcohol problem—although the criterion of two yes answers is a more valid cutoff (Williams, 2014).

The NIAAA has established use criteria: For men, in excess of 14 drinks a week or 4 drinks per occasion is considered a sign of alcohol abuse or alcoholism. For women, more than 7 drinks per week or 3 drinks per occasion is considered problematic (Welsh et al., 2014).

### ***Motivational Interviewing With Substance-Using Clients: Procedures and Techniques***

In the not-so-distant past, it was generally assumed that interviewing substance-abusing clients required using confrontational techniques. It was thought that because individuals who abuse alcohol and other drugs deny or minimize their substance problems, direct confrontation was needed to break through client defenses. A traditional interview with an alcoholic looked like this:

**Client:** Really, Doc, I'm just a social drinker; I don't have a problem.

**Interviewer:** You've got a choice. You can face your problem with booze or go on jeopardizing your health, your safety, and your family. If you do choose to face your problem, then you'll need to do as I say and follow our treatment program. If you don't, you'll probably end up in a gutter somewhere, drowning in your own vomit. Or maybe you'll end up in jail. The fact is you've got a problem, and you'll be better off admitting it right now.

In this approach, the therapist presents the argument for change. The therapist's presentation of rational evidence supposedly helps clients accept their problem and embrace treatment. However, as noted previously, MI reverses this approach. The clients should make the arguments for change.

Although MI procedures are largely nondirective, conducting a substance-related interview requires structuring the interview around several substance use and abuse questions and issues. At least 10 different content areas might be addressed (Rollnick & Bell, 1991).

1. *Bring up the subject of substance use and ask your client's permission to discuss it.* Asking permission is a technique that respects client autonomy. Following about 5 to 10 minutes of building rapport, consider using a summary statement (e.g., "It sounds like you've had some stress lately") and follow that with an indirect question and a swing question: "I wonder if we might talk a bit about your alcohol use. Would it be OK to discuss that for a few minutes?" (W. Miller, 2015, p. 255).

In most cases, clients respond affirmatively. This approach is tentative, gives clients control, and initiates a conversation about substance use.

2. *Ask about substance use or abuse in detail.* Questions like "What kind of a drinker are you?" or "Tell me about your use of marijuana; what

effect does it tend to have on you?" (Rollnick & Bell, 1991, p. 206) let clients talk about how they view their drinking or drug use (sustain talk) and can be followed with specific queries: "You said you like to have a few beers with your friends after work. What's a 'few beers' for you?"

3. *Ask about a typical day/session.* When clients are habitual users, they often use in consistent patterns. If you prompt clients with "Tell me about your drinking patterns on a typical day," you're likely to hear helpful assessment information. You can follow these general queries with specifics: "About how much does it take for you to get high?" or "When you're at your favorite bar, what's your favorite drink, who's your best buddy, and how many do you have?"

4. *Ask about lifestyle and stress.* From both conceptual and practical perspectives, it's important not to be preoccupied with asking about substances. By moving away from talking about substances toward talking about life stress and then back again, you help clients know you're interested in more than just gathering information about substance use. This can have the effect of opening up clients to talking more about the substances, rather than less. If clients talk about using substances for coping with stress, you can expand the discussion toward life stressors:

**Client:** I just like to kick back, have a few beers, and relax.

**Interviewer:** It sounds like kicking back and relaxing is important to you. What's happening in your life that you like to get away from?

5. *Ask about health, then substance use.* If your client has health issues related to substance use, it's helpful to focus first on the health issues and then gently explore the relationship between health and substance use. After discussing asthma symptoms, you might ask, "How does your marijuana use work with the asthma problems we've been talking about?"

6. *Ask about the good things and the less good things.* This strategy lets clients discuss what they like about substance use as well as what they like less about their substance use. Eventually, the goal is to get clients to expand on what's less good (change talk from their perspective). For example, a client may like getting high and identify it as a good thing, but also identify the "munchies," the expense, and negative feedback from his girlfriend as less good.

7. *Ask about substance use in the past and now.* Client substance use patterns usually shift over time. By asking, "How have your drinking patterns changed?" therapists can open up the discussion to issues like blackouts, tolerance, reverse tolerance, and eye openers.

8. *Provide information and ask, “What do you think?”* When you provide addiction education, do so in an open and collaborative manner. You might say, “I recently came across some interesting information on marijuana potency now, as compared to the 1970s. Would you mind if I shared some of this information with you?” After sharing information, you should follow up with “What do you think about all this?” and then revert to your reflective listening skills.

9. *Express your concerns directly and ask about their concerns directly.* At some point in a substance use interview, directly inquire about clients’ concerns about their use patterns. “I’d like to ask you a little more about your drinking. What you decide to do is up to you, of course, but I wonder if alcohol might be making your depression worse. Can you see how it might?” (W. R. Miller, 2015, p. 256). Another option is to ask directly, using an open question: “What concerns do you have about using alcohol?” Avoid closed questions. (For example, don’t ask: “Do you have any concerns about your alcohol use?”)

10. *Ask questions that evoke change talk.* After clients explore their substance use, you can use projective or hypothetical questions to broach what actions might be taken. “If you end up deciding to cut down on or quit alcohol, what would be your best first step?”

## Assessment and Prediction of Violence and Dangerousness

VIDEO  
12.3

Consider the following exchange with a 16-year-old client.

**John:** I hear you’ve been pretty mad at your shop teacher.

**Client:** I totally hate Mr. Smith. He’s a jerk. He puts us down just to make us feel bad. He deserves to be punished.

**John:** You sound a little pissed off at him.

**Client:** We get along fine some days.

**John:** What do you mean when you say he “deserves to be punished”?

**Client:** I believe in revenge. Really, I feel sorry for him. But if I kill him, I’ll be doing him a favor. It would end his miserable life and stop him from making other people feel like shit.

**John:** So you’ve thought about killing him?

**Client:** I’ve thought about walking up behind him and slitting his throat.

**John:** How often have you thought about that?

**Client:** Just about every day. Whenever he talks shit in class.

**John:** And exactly what images go through your mind?

**Client:** I just slip up behind him while he's talking with Cassie [fellow student] and then slit his throat with a welding rod. Then I see blood gushing out of his neck and Cassie starts screaming. But the world will be a better place without his sorry ass tormenting everybody.

**John:** Then what happens?

**Client:** Then I guess they'll just take me away, but things will be better.

**John:** Where will they take you?

**Client:** To jail. But I'll get sympathy because everyone knows what a dick he is.

During an initial interview or ongoing therapy, clients may describe aggressive thoughts and images. Some clients, as in the preceding example, will be concise about their thoughts, feelings, and images. Others will be less clear. Still others will be evasive and will avoid telling you anything about violent thoughts or intentions.

Assessing for violence potential is similar to assessing for suicide potential; it's a stressful responsibility, and predicting violence is extremely difficult. However, as with suicide assessment, clinicians still have a legal and ethical responsibility to conduct violence or dangerousness assessments that meet professional standards.

Over the years, there have been arguments about how to most accurately predict violence (Hilton, Harris, & Rice, 2006). There are three perspectives.

1. Some researchers contend that actuarial prediction based on specific, predetermined statistical risk factors is consistently the most accurate procedure (Quinsey, Harris, Rice, & Cormier, 2006).
2. Some clinicians believe that because actuarial variables are dimensional and interactive with individual and situational characteristics, prediction based on the clinician's experience and intuition is most accurate (Cooke, 2012).
3. Others take a moderate position, believing that combining actuarial and clinical approaches is best (Campbell, French, & Gendreau, 2009).

Overall, actuarial approaches to violence prediction are more accurate than clinical judgment (Monahan, 2013). However, actuarial violence prediction is not without flaws (Szmukler, 2012).

### Narrowing In on Particular Violent Behaviors

A single risk-factor formula to predict all forms of violent behavior doesn't exist. Instead, different violent behaviors are associated with

unique predictor variables. In the next sections, we provide three examples of violence predictors for three different specific violent behaviors or populations. The goal is to sensitize you to different violent behavior patterns.

### ***Fire Setting***

Fire setting is dangerous behavior that may or may not be associated with interpersonal violence. Nonetheless, depending on your work setting and the clinical population you serve, you may find yourself in a situation in which you need to decide whether to warn a family or potential victim about possible fire-setting behavior.

Mackay and colleagues (2006) identified the following variables—in decreasing order—as predictive of fire setting:

- Younger age at the time of the first fire-setting behavior.
- A higher total number of fire-setting offenses.
- Lower IQ.
- Additional criminal activities associated with the index (initial) fire.
- An offender acting alone in setting the initial fire.
- A lower aggression score. (Interestingly, offenders with higher aggression scores were more likely to be violent, but less likely to set fires.)

Fire-setting predictors illustrate a general violence-prediction principle. To predict future violence, it's necessary to focus on specifics. For example, future fire-setting potential is best predicted by past fire-setting behavior. Similarly, future physical aggression is best predicted by past physical aggression. But a history of physical aggression is not a good predictor of fire setting.

### ***Homicide Among Young Men***

Loeber and associates (2005) conducted a large-scale study of homicide among young men living in Pittsburgh. This study is notable because it was both prospective and comprehensive; the authors tracked 63 risk factor (predictor) variables in 1,517 inner-city youth. Obviously, even this large-scale study is limited in scope, and technically the results cannot be generalized beyond inner-city Pittsburgh youth near the time of the study. Nevertheless, the outcome data lend insight into risk factors that might contribute to homicidal violence in other populations.

Violent offenders scored significantly higher than nonviolent offenders on 49 of 63 risk factors across domains associated with child, family,

school, and demographic risk factors. The range and nature of these predictors were daunting. The authors reported:

Predictors included factors evident early in life, such as the mother's cigarette or alcohol use during pregnancy, onset of delinquency prior to 10 years of age, physical aggression, cruelty, and callous/unemotional behavior. In addition, cognitive factors, such as having low expectations of being caught, predicted violence. Poor and unstable child-rearing factors contributed to the prediction of violence, including two or more caretaker changes prior to 10 years of age, physical punishment, poor supervision, and poor communication. Undesirable or delinquent peer behavior, based either on parent report or self-report, predicted violence. Poor school performance and truancy were also among the predictors of violence. Finally, demographic factors indicative of family disadvantage (low family SES, welfare, teenage motherhood) and residence in a disadvantaged neighborhood also predicted violence. Among the proximal correlates associated with violence were weapon carrying, weapon use, gang membership, drug selling, and persistent drug use. (Loeber et al., 2005, p. 1084)

Homicidal violence was best predicted by a subset of general violence predictor variables. Specifically, homicide was predicted by "the presence or absence of nine significant risk factors" (Loeber et al., 2005, p. 1086):

- Screening risk score
- Positive attitude to substance use
- Conduct disorder
- Carrying a weapon
- Gang fight
- Selling hard drugs
- Peer delinquency
- Being held back in school
- Family on welfare

In particular, boys with at least four of these nine risk factors were 14 times more likely to have a future homicide conviction than violent offenders with a risk score less than four.

### ***Violence and Schizophrenia***

A diagnosis of schizophrenia doesn't confer increased violence risk. Instead, specific symptoms—when seen among individuals diagnosed

with schizophrenia—are associated with increased risk. These symptoms (Fresán, Apiquian, & Nicolini, 2006) include severe manifestations of

- Hallucinations
- Delusions
- Excitement
- Thinking disturbances

This research suggests that clinicians should be especially concerned about violence when clients diagnosed with schizophrenia have acute increases in the intensity and frequency of their psychotic symptoms, but not at other times.

## Research Versus Practice

You may conclude from this research review that therapists who hope to conduct accurate violence assessments should know and use actuarial violence-prediction risk factors. However, as is often the case, scientific research doesn't necessarily parallel real-life situations. Much of the actuarial violence research has been conducted on forensic or prison populations—with violent recidivism as the outcome measure. More typically, therapists face situations in schools, residential treatment centers, and private practice (Juhnke, Granello, & Granello, 2011). Although actuarial risk factors may be helpful, they don't generalize well to situations in which a counselor is making a judgment in a single clinical interview about whether there's a duty to protect (and, therefore, warn) a shop teacher about a boy (who has never been incarcerated) who reports vivid images of slitting his shop teacher's throat.

Given these limitations, it's more accurate to refer to clinical interview-based assessments in school and agency settings as *violence assessment*, rather than *violence prediction*. What most clinicians do in general practice settings, including public and private schools, falls far short of scientific violence prediction based on actuarial data.

## A Reasonable Approach to Violence Risk Assessment

Violence is a low base rate behavior, rendering accurate prediction a statistical improbability. Relevant variables shift, depending on many factors and situations. Despite these challenges, this section provides general guidelines for when you find yourself in a situation where violence assessment is necessary. In addition to this guide, you should pursue consultation and supervision when working with potentially violent clients.

Table 12.2 includes a general violence assessment guide. Please note that it doesn't include actuarial risk factors from two common instruments, the Violent Rate Appraisal Guide (VRAG; Harris, Rice, & Quinsey, 1993) or the Psychopathy Checklist-Revised (PCL-R; Hare et al., 1990). If you find yourself intrigued with violence risk assessment, you may want to learn more about the VRAG and PCL-R and explore a potential career in forensic psychology.

**Table 12.2** A General Guide to Violence Assessment

- 1. Ask direct and indirect questions about violent behavior history. Be especially alert to physical aggression and cruelty. If the threatened behavior is similar to a past violent behavior, risk is higher.
- 2. Because potentially violent individuals aren't always honest about their violence history, you may need to interview collateral informants (assuming you have a release of information signed or have an ethical-legal responsibility to protect someone from harm).
- 3. Listen for details to help identify potential victims. If the details aren't forthcoming, you may need to ask about those details. Identification of a specific victim increases violence risk (and provides you with information about whom to warn).
- 4. Listen for specifics about the plan and use curious and indirect questioning to further assess the specificity of the client's violence plan. More specific plans are associated with increased violence risk.
- 5. If clients don't tell you about access to weapons or means for committing a planned violent act, you should ask. Access to lethal means increases violence risk.
- 6. Historical information is doubly important. Generally speaking, the sooner violent behavior patterns began, the more likely they are to continue. Clients raised in chaotic and violent environments (including gang involvement) are at higher risk for violence.
- 7. Diagnostic information may be helpful. In the *DSM*, the best violence predictors include items from list A of the *DSM-5*'s antisocial personality diagnostic criteria (American Psychiatric Association, 2013, p. 659).
- 8. Evaluate violence-related cognitions. If clients have low expectations of being caught or of experiencing consequences, or view the consequences, even death, as a positive outcome, risk is higher.
- 9. Consider substance use. Positive attitudes toward substance use or substance use when carrying weapons confers greater risk.
- 10. Notice your intuition. Intuition isn't a great predictor of anything, but if risk factors are present and you have images of a particular client committing a violent act, consult your colleagues or supervisors, err on the conservative side, and begin warning potential victims.

*Note:* This checklist is a general guide to conducting violence assessment. It should not be used as a substitute for actuarial prediction.

## VIDEO 12.4

### Demanding Situations: Crisis and Trauma

This section provides guidance for demanding interviewing situations, such as may occur in emergency, disaster, or trauma settings. Therapists might

find themselves trying to cope with substantial cultural differences, limited resources, restricted settings, and psychological distress. Physical injury and loss of home, loved ones, or a sense of identity may further complicate these situations.

## Interviewing in Difficult Situations

Human-caused and natural disasters can deeply and irrevocably affect survivors. With the Internet providing instant information, and transportation readily available, the world continues to shrink. Traveling quickly to emergencies, disasters, and tragedies around the globe is possible. This easy accessibility belies the complexities of the skills and knowledge needed, should you choose to volunteer to be of assistance in such situations (North & Pfefferbaum, 2013). In addition to skills and knowledge, therapists need to attend to ethical considerations in crisis and humanitarian mental health interviewing (R. Sommers-Flanagan, 2007).

Many avenues are available to mental health professionals who wish to be involved in humanitarian or crisis intervention work. At the local, national, and international levels, there are nongovernmental organizations, churches, community groups, and government programs that help organize and place short-term volunteers. Longer-term paid or volunteer placements are also possible. At the local and state levels, sometimes agencies not primarily dedicated to disaster interventions respond to disasters or tragedies within communities. Most of these wide-ranging opportunities come with their own expectations, guidelines, and trainings or preparations. Some provide comprehensive training, including language immersion, cultural knowledge, and experiential components. Others are less able to provide volunteers with these foundational necessities.

In 1991, the Red Cross and American Psychological Association (APA) launched the Disaster Response Network, now called the Disaster Resource Network. The APA website includes a statement about the limited role of psychologists in disaster relief situations:

On disaster relief operations, these psychologists do not provide therapy. Instead, they use their training and professional judgment to help people employ their own coping skills and resources to deal with extremely stressful and often tragic circumstances. Psychologists help people to problem-solve, make referrals to community resources, advocate for workers' and survivors' needs, provide information and listen. (Retrieved February 3, 2013 from the American Psychological Association: <http://www.apa.org/practice/programs/drn/>)

Organizations related to the APA have also formed and are dedicated to responsible, culturally sensitive training and service provision. Similarly, the American Counseling Association (ACA) has developed emergency response opportunities, as has the National Association of Social Workers. These developments speak to the need for skilled and immediate psychological assistance across cultures in the event of natural or human-caused disasters.

It's beyond the scope of this text to prepare you for conducting skilled and ethical mental health interviews in crisis contexts. However, we provide basic guidelines to raise awareness that volunteering to conduct mental health interviews in disaster and crisis situations requires specialized training. Without adequate preparation, you may do more harm than good (B. G. Collins & Collins, 2005; H. B. Smith, 2006). Also, you may find yourself in demanding situations for which you are unprepared. Disaster can strike any community at any time, and although you may not be specifically prepared, you may be asked to provide assistance.

### **Disaster Intervention Guidelines: Psychological First Aid**

Psychological first aid (PFA) is the most commonly used model for disaster and trauma response and is described next. However, as you read this section, keep in mind the following comment from a 2013 review of mental health responses to community disasters:

Psychosocial interventions such as psychological first aid, psychological debriefing, crisis counseling, and psychoeducation for individuals with distress have not been sufficiently evaluated to establish their benefit or harm in disaster settings. (North & Pfefferbaum, 2013, p. 507)

The initial publication on PFA appeared in 1945. This article focused on preventing victim maladjustment and helping individuals deal with tensions and personal problems arising from specific incidents (Blain, Hoch, & Ryan, 1945). Subsequently, there was little discussion of PFA in the literature until the early 21st century.

Ruzek and colleagues (2007) described the purpose of modern PFA:

PFA is aimed at reducing initial post-trauma distress and supporting short- and long-term adaptive functioning. It is designed for delivery anywhere that trauma survivors can be found. Following a disaster, it can be offered in shelters, schools, hospitals, homes, staging areas, feeding locations, family assistance centers, and other community settings. The principles can also be applied immediately following

traumatization in many non-disaster settings, including hospital trauma centers, rape crisis centers, and warzones. PFA is designed for simple and practical administration in field settings. (p. 18)

In part, PFA was developed as an alternative to critical incident stress debriefing (CISD). Research on CISD had shown mixed results, and there was concern about possible adverse reactions with some clients (Campfield & Hills, 2001; Everly Jr. & Boyle, 1999). Although there's a logical rationale for replacing CISD with PFA, there's only minimal empirical evidence to support using PFA.

The following guidelines are organized around the eight core actions in the PFA model (Everly, Phillips, Kane, & Feldman, 2006; Ruzek et al., 2007):

1. Contact and engagement
2. Safety and comfort
3. Stabilization
4. Information gathering: current needs and concerns
5. Practical assistance
6. Connection with social supports
7. Information on coping support
8. Linkage with collaborative services

### ***Contact and Engagement***

All mental health service providers should enter disaster situations as part of “an authorized helping organization with a structured Incident Command System” (Ruzek et al., 2007, p. 24). There’s little tolerance for lone rangers in disaster settings.

Survivors often look to follow the lead of helping personnel. This is why mental health professionals are coached to approach disaster situations with calmness and self-control.

The goal of contact and engagement is to respond to affected individuals who approach you and to initiate helping contacts in a compassionate and nonintrusive manner. Providers should ask permission when initiating contact. In either case, service providers should offer brief and relevant information about themselves and their role in the situation.

### ***Safety and Comfort***

Many crisis situations are inherently chaotic. We have colleagues who have conducted interviews sitting on fallen trees, standing in the backyard of what was once a house, or searching through tornado ruins for a lost but

precious item with their stricken client. Counseling might happen in the back of a gym, on a neighbor's front porch, in a warehouse, or at a vacated business. No matter what, you're a visitor to the scene and may or may not have control over arranging your interviewing environment. Nonetheless, creating a sense of privacy and comfort is recommended:

Because disasters or terrorist incidents are often unexpected, shocking, and confusing, sense of safety and control can sometimes be strengthened by providing the survivor with accurate information, about what to do next, what is being done to assist them, what is currently known about the unfolding event, available services, and self and family care. But as with other elements of PFA, helpers should use judgment as to whether and when to present information. Does the individual appear able to comprehend what is being said, is he or she ready to hear the content of the messages, and are other things more important right now? (Ruzek et al., 2007, p. 27)

Moving to a place of safety and security, observing survivor functioning, and obtaining medical intervention as needed are crucial components prior to stabilization.

### ***Stabilization***

Strong emotions following crisis and trauma are normal. However, in some cases, individuals are so powerfully affected that they cannot comprehend the situation and respond to assistance. If this is the case, stabilization may be necessary. The following are potentially helpful interventions (adapted from Ruzek et al., 2007):

- Seeking aid from family members or friends
- Taking the affected person to a quiet place
- Talking quietly with the person with friends and family close by
- Addressing the individual's primary concern
- Providing a few minutes alone
- Using grounding procedures (e.g., asking survivors to report what they can see in the here and now)

Stabilization is crucial to moving to the next PFA step.

### ***Information Gathering: Current Needs and Concerns***

The goal of information gathering is to identify immediate survivor concerns and needs. This allows for tailoring of subsequent PFA interventions.

One challenge of information gathering is determining the extent to which survivors can respond to questioning. In many ways, information gathering takes a backseat to stabilization, but information gathering can also contribute to stabilization. Important information may include the following:

- The nature of any ongoing threat
- Location and safety of loved ones
- Physical health status and whether medications are needed
- Whether an immediate referral is needed
- The survivor's preexisting support network
- Previous, current, and future possible substance use and prior mental health treatment

PFA providers must use clinical judgment in determining how much to probe and how much to support when gathering information.

### ***Practical Assistance***

Practical assistance involves helping survivors address immediate concerns and needs. This stage of PFA will usually include gently gathering more specific and detailed information about the survivor's primary problem and what might help with that problem. In cases where survivors can articulate their needs, you should make efforts to respond actively. This might involve assisting with paperwork, setting up an appointment, and other concrete and practical ways of being helpful.

### ***Connection With Social Supports***

Reestablishing social support connections facilitates stabilization and recovery for most individuals during a crisis or disaster. These connections may involve family, friends, and community support personnel who have been helpful in the past. In this step, you might be the one to establish connection and communication with significant others in the survivor's life. This may be via telephone, email, Internet chat, Skype, or any form of communication available.

### ***Information on Coping Support***

The primary educational action during PFA is providing supportive information on coping strategies. This includes information that may help in the here and now and into the future.

Some survivors may be alarmed not only by the situation but also by their response to the situation. They may engage in negative self-talk,

referring to themselves as weak, defective, or inadequate. In such cases, you can provide information to normalize crisis and trauma responses. It's especially important to avoid diagnosing, pathologizing, or negatively labeling a survivor's symptoms. It's also important, depending on the survivor's receptivity, to discuss the differences between positive and negative coping responses.

### ***Linkage With Collaborative Services***

Some survivors will want supportive services in the future, whereas others are more reluctant (possibly due to beliefs that needing continued support is a sign of weakness). Again, linking survivors with helpful services requires sensitivity and clinical judgment. In many cases, however, walking survivors to services or connecting them with agencies via telephone is exactly the type of assistance needed. Having handouts with referral information may also be helpful. If you do hand out referral information, make sure the survivor has a place to keep such material.

### **Professional Responsibilities**

Beyond PFA, mental health personnel working in crisis or disaster situations may have additional professional responsibilities. These include the usual ethical standards associated with being a mental health professional. The following information may overlap with and need to be integrated into a PFA approach.

### ***Informed Consent and Record Keeping***

Depending on the nature of your contact with survivors, there may be more or less need for informed consent. If your contact involves PFA and is under the umbrella of a crisis services agency, the agency is likely to govern your ethical procedures. For example, if you're working as a psychologist through the APA's Disaster Resource Network, the Red Cross policy and procedures and APA *Ethical Principles for Psychologists and Code of Conduct* (2010a) will be your guide to informed consent and record keeping. Similarly, professional counselors can obtain free Red Cross disaster training at the annual ACA convention; this training offers preparation for potential deployment to disaster sites through the Red Cross and provides ethics guidance.

You may also serve as a referral source for crisis or disaster survivors. It's good to remember that individuals who have survived a disaster or experienced trauma may feel out of control. They need to gain control and, at the same time, may need more structure and direction than is typically provided in a clinical interview.

Within the context of your contact with survivors, an informed consent process probably won't involve the usual paperwork, insurance forms, and consents to release information. More likely it will be an interactive verbal process—and a brief one, at that. It should include the basic parameters of what you can offer, who you are, why you're there, how long you can talk with the client, how many times you can meet together, what limits there might be to keeping your conversation confidential, what the client can expect to gain from talking with you, and an explanation of any techniques you might use. If you have the option of making referrals, your client should be aware of this. If you'll be keeping case notes, your client should know why, where they'll be stored, and for how long. The point of all this is to provide survivors with basic, but not overwhelming, information about you and your role in a way that gives them a sense of control. Given the immediate swirl of chaos inherent in the situation, it's easy to forget about informed consent.

### ***Assessment Decisions***

Depending on your assigned duties, it may be necessary to engage in screening activities using formal or informal assessment strategies. You may be responsible for monitoring survivors for signs of shock, dissociation, and/or suicide ideation. Other relevant assessment areas might include medical/physical needs, availability of social support systems, and ability to communicate. Most likely, you'll be monitoring for current functioning (think mental status examination and orientation) and the ability to identify, access, and effectively utilize resources (Myer, 2001).

Human responses to trauma and crisis vary across at least three broad domains (Chiang, Lu, & Wear, 2005):

1. The nature of the crisis
2. Coping skills, ego strength, and resources available to individual survivors
3. Cultural beliefs and practices associated with trauma

Diagnostic labeling in trauma-related circumstances is necessarily tentative. H. B. Smith (2006) noted that a frequent error is to immediately pathologize victims based on normal reactions to abnormal, traumatic situations. Survivors of disaster don't need added stigma from diagnostic labels that insinuate personal weakness or mental disorders (Yehuda & Bierer, 2005). However, accurate diagnosis can contribute to understanding the magnitude of the impact and can play a role in treatment planning. Walking the line between accurate (and helpful) diagnosis and inappropriate (and unhelpful) labeling during a time of crisis is difficult.

### ***Confidentiality***

Confidentiality during crisis is often limited. You might be in a setting where people can see and hear as you work with a survivor. If clients are sharing deeply personal information, you may relocate if possible, or search for other ways to protect them from revealing more than they wish. Your client may not be able to make decisions about personal privacy. Assuring confidentiality becomes a greater responsibility for the therapist.

Unless you have specific permission to recount your interviewees' stories, you aren't free to do so. This is true even when you return to your home community or everyday practice. Recounting these stories will be tempting because of the compelling and dramatic nature of the circumstances and due to your own need to talk about vicarious trauma. Depending on many factors, you may be able to discuss the general parameters of your experience and generic aspects of what people experienced during the crisis and in the aftermath. Before doing so, however, it's wise to seek professional consultation. If you're feeling a strong internal pressure to talk about horrific traumas you witnessed or had described to you, your best option is to obtain your own therapy so that you can speak freely and confidentially with a professional.

### ***Techniques and Resistance***

Trauma survivors have often had their sense of invulnerability destroyed (Herman, 1992). Some of our friends who have been exposed to war describe trauma as a betrayal experience—an experience in which everything they knew about the world and depended on was ripped away. Knowing that trauma experiences are deeply interwoven with a sense of betrayal may help you better understand why some survivors become resistant to humanitarian interventions.

Many survivors might be ambivalent about trusting anything and anyone, including you. This can produce variability in the presentation of crisis survivors. Some may present as extremely upset, needy, and dependent, almost begging to be told what to do, how to feel better, and how to make sense of their terrifying experiences. Others may present as guarded, suspicious, and resistant to exploring emotions or cognitions related to their experiences. Still others may present with a perplexing combination of neediness and suspicion.

### ***Secondary or Vicarious Trauma***

Although we've long known that listening to trauma stories can be traumatic to helpers, it wasn't until 1990 that this phenomenon was labeled

*vicarious trauma* (McCann & Pearlman, 1990). If you work directly with clients who are wounded, bereaved, and/or psychologically devastated, you may begin to experience *flashbacks* or nightmares related to scenes and situations that you never directly experienced (Pearlman & Mac Ian, 1995). Vicarious trauma can include symptoms from any of the three posttraumatic stress symptom categories:

1. Reexperiencing (flashbacks or nightmares)
2. Negative cognitions or mood (e.g., self-blame)
3. Arousal (e.g., hypervigilance)

When you work with trauma survivors, attending to your basic personal needs is essential. If you don't, you're likely to suffer yourself and become less helpful to trauma victims. Actions that you can take to cope with vicarious trauma include (a) receiving supervision, (b) keeping your caseload within reason, (c) participating in ongoing education and training, and (d) engaging in professional and personal self-care (Trippany, Kress, & Wilcoxon, 2004). When managed well, vicarious trauma can stimulate personal growth and development (Cohen & Collens, 2012; Hernandez-Wolfe, Killian, Engstrom, & Gangsei, 2015). Many professionals who regularly work with trauma survivors have their own therapists available for ongoing support.

### ***Boundary Concerns***

Working in crisis situations can stimulate problems with professional boundaries. When you're affected emotionally by the same devastation that your client is struggling with, it's difficult to maintain a proper therapeutic distance. Your goal is be open and empathic, but not so emotionally immersed in the tragedy that you have nothing to offer but shared misery. When crisis survivors must console their therapists, appropriate boundaries and roles haven't been maintained.

Disaster circumstances are compelling. This may cause both clients and therapists to have stronger and wider emotional reactions than usual. These combined emotional intensities can activate strong transference and countertransference reactions (Weaver, 1995). For example, your kindness and empathy might ignite a positive romantic transference reaction in a bereft or traumatized client. This heightened attraction amid crisis is sometimes referred to as *trauma bonding* and can lead to unhelpful and unethical behaviors.

Another important boundary issue is self-referral. The APA Disaster Resource Network concurs with the American Red Cross's stance that no mental health professionals who work with clients in disaster contexts may

make self-referrals unless there's no other option in the region. Even then, the referral must be approved by the national office (American Psychological Association, 2013).

Although complicated and professionally challenging, volunteering in crisis or humanitarian situations can be rewarding and personally transforming. At the end of this chapter, we provide a short list of websites and contact information for organizations that offer training and support for mental health professionals who would like to engage in humanitarian volunteer work.

## Interviewing Trauma Survivors

When individuals are exposed to traumatic events, such as natural disasters, school or workplace shootings, sexual assault, or war-related violence, they often experience immediate and longer-term emotional and psychological symptoms. In this section, we briefly review issues associated with interviewing trauma survivors beyond trauma settings and within usual clinical practice.

### *Defining Trauma*

In 1980, when posttraumatic stress disorder was first included in *DSM-III*, *trauma* was defined as an event “outside the range of usual human experience” (American Psychiatric Association, 1980, p. 236). As Judith Herman (1992) wrote in *Trauma and Recovery*, “Sadly this definition has proved to be inaccurate” (p. 33). Many individuals, particularly women, experience sexual abuse, rape, and/or physical battering as a part of their “usual human experience.” In addition, soldiers, police officers, and emergency personnel experience trauma as a part of their occupational roles.

The recently updated trauma definition in *DSM-5* includes a general statement about trauma, followed by four specific ways that trauma exposure can occur. The individual must experience “exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways” (American Psychiatric Association, 2013, p. 271):

1. Direct experiencing of the trauma.
2. Witnessing of the event as it “occurred to others” (p. 271).
3. “Learning that the traumatic event(s) occurred to a close family member or close friend” (p. 271).
4. “Experiencing repeated or extreme exposure to aversive details of the traumatic event(s)” (p. 271). This specifically includes first responders and police officers and implies that other professionals who experience

repeated exposure may qualify for a posttraumatic stress disorder diagnosis.

Individuals who experience trauma bring unique issues with them to a clinical interview.

### ***Interviewing Clients Who Have Experienced Trauma: Issues and Challenges***

The benefits of talking about trauma are virtually indisputable (Cochran, Pruitt, Fukuda, Zoellner, & Feeny, 2008; Pennebaker, Zech, & Rimé, 2001). Nearly everyone who experiences trauma should talk about it—sometime, somehow, some way. However, despite the clear benefits of talking, traumatized people are often reluctant to talk. This can be because thinking about and talking about trauma brings up uncomfortable feelings. Trauma also often involves a betrayal or a violation of trust (e.g., sexual assault), making it difficult for trauma victims to trust anyone, including mental health providers. In addition, sometimes trauma survivors feel guilty about surviving or ashamed that the traumatic event happened to them (Foa & Riggs, 1994). These features are aptly described in the acute stress disorder section of the *DSM-5*:

Individuals with acute stress disorder commonly engage in catastrophic or extremely negative thoughts about their role in the traumatic event, their response to the traumatic experience, or the likelihood of future harm. [They] may feel excessively guilty about not having prevented the traumatic event or about not adapting to the experience more successfully. (American Psychiatric Association, 2013, p. 283)

Barriers to talking about trauma must be delicately managed (Steenkamp et al., 2011). Building rapport and trust is a central emphasis; otherwise, clients may be unwilling to share their stories or, if they do, may be retraumatized by your questioning.

Another challenge of working with trauma survivors is that traumatized clients often benefit from talking about their experiences within approximately 48 hours of the traumatic event (Campfield & Hills, 2001; G. Miller, 2012). Consequently, for therapists, there's a major conflict between trying to establish trust, which takes time, and encouraging clients to begin talking about traumatic experiences right away.

When clients disclose trauma, you have a professional responsibility to make sure the sharing of the trauma doesn't have an adverse effect. A calm and caring demeanor and a good sense of time boundaries are essential. It's irresponsible to allow someone to go too far into painful emotions

surrounding a trauma and conclude the session without adequate time for emotional regrouping. Moving gently away from talking about trauma to problem solving about therapeutic coping strategies can be helpful. In addition, asking questions about trauma symptoms—rather than requiring direct disclosure of the trauma itself—can be less activating.

It's not unusual for trauma survivors to use alcohol and avoidance strategies to cope with distress. This can make therapeutic interviewing more difficult because trauma survivors are relying on maladaptive strategies to deal with their symptoms (Collins & Collins, 2005). Because these coping efforts have felt protective, it's hard for the survivor to consider giving them up.

Interviewing people who have been traumatized requires skilled supervision and specialized training, regardless of whether the interview takes place directly in the aftermath of the trauma or later, in the context of general mental health practice. Given how common trauma has become, obtaining advanced training in one of the many evidence-based approaches to working with trauma is highly recommended.

## VIDEO 12.5

### Cultural Competencies in Disaster Mental Health

In crisis and disaster work there may be little time to prepare or to seek adequate cultural knowledge. There also may be less time to use empathic listening, collaborative goal setting, and other procedures to gain knowledge about your clients' cultural practices and beliefs. Therefore, if you wish to do effective humanitarian crisis work, you must add specific cultural knowledge to your training list—*before* you arrive on the scene. To facilitate this process, the US Department of Health and Human Services (USDHHS, 2003) provides a free online resource titled “Developing Cultural Competence in Disaster Mental Health Programs.”

### What Are the Cultural Competencies for Disaster Mental Health Work?

Developing and articulating mental health competencies is typically fraught with problems and controversy (Sommers-Flanagan, 2015). It's rare for competencies to satisfy everyone. Despite well-meaning efforts, professional competencies often become either too general or immensely detailed. The development of disaster mental health competencies is no exception to this process. One review and analysis of 39 articles presented the following conclusion:

Hundreds of competencies for disaster healthcare personnel have been developed and endorsed by governmental and professional

organizations and societies. Imprecise and inconsistent terminology and structure are evident throughout the reviewed competency sets. Universal acceptance and application of these competencies are lacking and none have been validated. (Daily, Padjen, & Birnbaum, 2010, p. 395)

Despite this critique, the USDHHS mental health cultural competencies for disaster relief settings are widely accepted. The cultural competence checklist for disaster crisis counseling programs consists of:

- Recognize the importance of culture and respect diversity.
- Maintain a current profile of the cultural composition of the community.
- Recruit disaster workers who are representative of the community or services area.
- Provide ongoing cultural competence training to disaster mental health staff.
- Ensure that services are accessible, appropriate, and equitable.
- Recognize the role of help-seeking behaviors, customs and traditions, and natural support networks.
- Involve community leaders and organizations representing diverse cultural groups as cultural brokers.
- Ensure that services and information are culturally and linguistically competent.
- Assess and evaluate the program's level of cultural competence.

The depth, breadth, and complexity inherent in this short list should give you a sense of why validating crisis and disaster competencies is so challenging. For a free copy of the USDHHS competencies, go to <http://store.samhsa.gov/product/Developing-Cultural-Competence-in-Disaster-Mental-Health-Programs/SMA03-3828>.

## Returning to Cultural Humility

A crisis worker who ventures into a different culture had better be aware that the residents of that culture are basing their ability to get through the crisis on their own set of cultural survival standards, and those don't necessarily square up with the worker's. (James & Gilliland, 2013, p. 29)

Individuals from dominant cultures—or any culture—often view their cultural perspective as right and good and sometimes as superior. This tendency implies that attaining multicultural competence isn't enough for

clinicians to be effective in their work with culturally diverse clients. Clinicians also need to let go of their own cultural perspective and value the different perspective of their clients (Hook, Davis, Owen, Worthington, & Utsey, 2013).

We described cultural humility in Chapter 1. It bears repeating that holding a culturally humble attitude will facilitate your ability to connect and work effectively with diverse clients. Cultural humility is probably especially important within the fragile circumstances surrounding crisis, disaster, and trauma. Remember to tread lightly into new cultural circumstances and remember the core principles and practices of cultural humility: Allow yourself to embrace an other-orientation, rather than focusing on your own values; hold high your respect for diverse cultural values and ways of being; and let go of any ideas you may have related to your own superiority.

## **Summary**

Although the prospect may initially be daunting, many mental health professionals eventually grow to enjoy working with challenging clients or in especially difficult situations.

Not all clients are equally cooperative, and some are labeled as difficult, challenging, or resistant. Historically, resistance was framed as an obstacle to effective interviewing and intervention. However, current theorists and clinicians regard it as a natural part of the human change process. Resistance is partly associated with the client, partly with the therapist, and partly with the situation.

Motivational interviewing is an evidence-based approach to working with clients who are resistant, ambivalent, or reluctant. In addition, solution-focused counseling, dialectical behavior therapy, and other theoretical models include technical strategies for working with and through resistance. Specific strategies comprise open questions, solution-focused openings, goal setting, reflection, amplified reflections, undershooting, coming alongside, emotional validation, radical acceptance, reframing, and offering genuine feedback. Motivational interviewing is the treatment of choice for working with the challenging problems of substance use, abuse, and dependence.

Assessing violence potential may become necessary in the course of a typical day for professional therapists. Although research suggests that actuarial systems produce more accurate violence predictions, most real-life interviewing situations don't closely parallel research-oriented violence-prediction scenarios. Consequently, clinicians are forced to use research-based knowledge in combination with clinical intuition and

sensitivity to make decisions about potentially violent or dangerous clients. This chapter includes a checklist to assist in that process.

Clinical interviewing in crisis or humanitarian disasters requires advanced skills and awareness of concerns related to this important but difficult professional activity. The current standard of care is called psychological first aid (PFA). The eight primary components of PFA are: (a) contact and engagement, (b) safety and comfort, (c) stabilization, (d) information gathering, (e) practical assistance, (f) connection with social supports, (g) information on coping support, and (h) linkage with collaborative services. Addressing the mental health needs of trauma survivors includes maintaining awareness of and sensitivity to unique ethical scenarios and potential trauma symptoms.

There are many different cultural competencies related to crisis and disaster counseling. Knowledge of these competencies is essential, even though their delineation is flawed, incomplete, and overwhelming. Revisiting the concept of cultural humility (discussed in Chapter 1) is recommended.

## Suggested Readings and Resources

There are many readings and resources for addressing resistance and working with crisis and trauma. This short list is a small taste of what's available.

### Readings

- de Shazer, S. (1984). The death of resistance. *Family Process*, 23, 79–93. This is de Shazer's original article in which he holds a funeral for resistance and symbolically buries it in his backyard.
- James, R. K., & Gilliland, B. E. (2012). *Crisis intervention strategies* (7th ed.). Pacific Grove, CA: Brooks/Cole. This is a good general resource for learning about crisis intervention strategies.
- Miller, G. (2012). *Fundamentals of crisis counseling*. Hoboken, NJ: Wiley. This book includes theory as well as hands-on techniques to assist clients in recovery from crisis.
- Sommers-Flanagan, J., & Sommers-Flanagan, R. (2004). *The challenge of counseling teens: Counselor behaviors that reduce resistance and facilitate connection*. Amherst, MA: Microtraining Associates. In this training video, we provide examples of how to work effectively with youth who display resistant behaviors. However, we must admit that the students we recruited to participate were far more cooperative than we expected.
- Webber, J., Bass, D., & Yep, R. (Eds.). (2005). *Terror, trauma, and tragedies: A counselor's guide to preparing and responding*. Alexandria, VA: American Counseling

Association. This edited volume provides a wide variety of stimulating material for counselors who want to work within humanitarian crisis settings.

## Websites

The web address for professionals wishing to connect with the Substance Abuse and Mental Health Services Administration is [http://www.samhsa.gov/Disaster/professional\\_disaster.aspx](http://www.samhsa.gov/Disaster/professional_disaster.aspx). The website is filled with connections and information related to volunteering in the context of a national disaster.

To access the USDHHS free resource on cultural competencies titled “Developing Cultural Competence in Disaster Mental Health Programs,” go to <http://store.samhsa.gov/product/Developing-Cultural-Competence-in-Disaster-Mental-Health-Programs/SMA03-3828>.

The web address for the Disaster Resource Network of the American Psychological Association is <http://www.apa.org/practice/programs/drn/>. This network provides placement, training, and support to members who wish to volunteer for disaster and crisis intervention work.

For school-related resources, go to [http://www.nasponline.org/resources/crisis\\_safety/](http://www.nasponline.org/resources/crisis_safety/), sponsored by the National Association of School Psychologists, and <http://www.schoolcounselor.org/content.asp?contentid=672>, sponsored by the American School Counseling Association, specifically offering guidance for the aftermath of school shootings.

## INTERVIEWING YOUNG CLIENTS

### Chapter Orientation

Interacting with children and teens can be far different from interacting with adults. In this chapter, we provide practical recommendations for interviewing and initiating therapy with young clients.

#### VIDEO 13.1

### Considerations in Working With Young Clients

Mr. Quimby wiped a plate and stacked it in the cupboard. “I’m taking an art course, because I want to teach art. And I’ll study child development—”

Ramona interrupted. “What’s child development?”

“How kids grow,” answered her father.

Why does anyone have to go to school to study a thing like that? wondered Ramona. All her life she had been told that the way to grow was to eat good food, usually food she didn’t like, and get plenty of sleep, usually when she had more interesting things to do than go to bed.

—Beverly Cleary, *Ramona Quimby, Age 8, 2009*, p. 13

Ramona thinks differently than most adults. You may find the developmentally different perspective of young clients to be intriguing, intimidating, or something else.

To this point, our primary focus has been on interviewing, assessment, and treatment planning with adult clients. This is a good start, but your “adult interviewing skills” won’t directly translate into child and adolescent interviewing skills (J. Sommers-Flanagan & Bequette,

### LEARNING OBJECTIVES

After reading this chapter, you will be able to:

- List major developmental and countertransference considerations that arise when working with children and adolescents
- Describe the preparation, planning, and first-contact issues that pertain to the introduction stage of a clinical interview with young clients
- Describe issues associated with the opening stage, which are first impressions, office décor, personal attire, confidentiality, informed consent, referral and background issues, goal-setting, caregiver assessment, and discussing assessment and treatment rationale
- Describe issues associated with the body stage, comprising whether to meet separately with parents, user-friendly assessment and information-gathering strategies, and limit-setting with young clients
- Describe issues associated with the closing and termination stages, such as reassuring and supporting youth, summarizing, clarifying, empowering young clients, tying up loose ends, and handling the intense responses young clients can have to ending sessions

(Continued)

## LEARNING OBJECTIVES (Continued)

- List six research- and common-sense-based principles for working effectively with culturally diverse young clients

2013). Young clients think, act, and interact much differently than adults.

### Countertransference Possibilities

Working with children, teenagers, and their parents might push your buttons and test your ability to stay balanced. Children and teenagers are *not* just like us, and because of the constantly changing world, they're also not just like us when we were younger. However, they're not unfathomable creatures either. Instead, children are rapidly developing human beings, sometimes coping with incredibly difficult lives. They deserve our respect, age-appropriate communication, information, and assistance.

Two common countertransference reactions with young clients are overidentification and withdrawal (Tishby & Vered, 2011). Therapists, teachers, and other adults who overidentify with children may project their own childhood conflicts onto children, fail to set appropriate boundaries, or be unable to appreciate unique aspects of the children with whom they work. Adults who emotionally withdraw from children may see children as aliens—puzzling creatures who need to be controlled or managed. Emotional withdrawal is likely to interfere with empathy.

In some ways, interviewing children is a form of cross-cultural counseling (Richardson, 2016; Vernon & Barry, 2013). To reach across the generational divide, you'll need specialized education and training (Mellin & Pertuit, 2009). Familiarity with developmental theory and direct experiences with children are minimal foundations. You need to be prepared for the unique and unexpected.

You might get poked in the eye, literally or figuratively. Sometimes you'll be tempted to judge each child as either good or bad. More often, you'll want to blame parents or caregivers for exposing their children to inappropriate stress, trauma, and bad parenting. If you get too imbalanced and judgmental in any direction, it can adversely affect your outcomes (J. Sommers-Flanagan & Sommers-Flanagan, 2011).

If you feel frightened, intimidated, or irritated about counseling children, adolescents, or parents, it's important to explore and work through these reactions. You may or may not be well suited to working with young clients. That's okay. Not everyone is able to work effectively with young people.

Even if you're excited to work with young people, there are pitfalls to consider. For instance, it's easy to have your rescue fantasies activated. You might think, "I want to take this child home and provide a better living environment." Besides being unethical, following through on rescue fantasies nearly always ends up in one form of disaster or another. If you want to rescue or adopt a young client, seek professional consultation and consider exploring this issue in personal counseling.

A healthy professional and psychological balance is especially necessary when working with children. Children constitute a vulnerable population. Most adult clients possess greater maturity and more education and life experience, and have a more fully developed sense of self. They're more able to advocate for themselves. They have more resources and are more autonomous. Most adults can extricate themselves from manipulative or unhelpful relationships with mental health providers, but most children cannot. One of your first tasks is to consider ways in which you can establish a healthy and balanced working alliance with young clients.

## The Introduction

VIDEO  
13.2

The introduction stage of the interview involves first contact and initiation of the helping or assessment relationship. It also includes planning—and when it comes to working with young clients, organization and planning are paramount.

## Preparation and Planning

Young people don't usually seek mental health services willingly (J. Sommers-Flanagan, Richardson, & Sommers-Flanagan, 2011). Children and adolescents are referred to professionals by parents, guardians, caregivers, or school personnel (Dugger & Carlson, 2007). In some cases, young clients may not believe they have any problems; they may not even know about their counseling appointment until they arrive! In other cases, they may be acutely aware of their distress or the distress others are experiencing.

With minors, the role of the caregiver (e.g., parent, grandparent, step-parent, foster parent, older sibling, group home manager) in the interview is central and requires deliberation. Some caregivers presume they'll be present for the interview; others follow the "I'm just dropping this child off for you to fix" philosophy. In most cases, your assessment of what's best will

determine caregiver involvement. Several factors, including the presenting problem, the child's age, and agency policies, will contribute to your decision making. Some therapists may spend time with the child and caregivers together first and move forward from there; others prefer meeting first with parents or caregivers to establish goals and begin treatment planning. There are pitfalls linked to both approaches:

- If you meet with parents alone, the child (especially teens) may wonder if you can be trusted.
- If you meet with the whole family, there may be a flurry of unpleasant conflict, which, unless you've got excellent conflict management skills, can damage everyone's perception of what therapy with you might be like; parents also may share information about themselves or the situation that's inappropriate for the child to hear. Meeting with angry, hostile, or stressed parents alone may be preferable to subjecting the child to a barrage of negativity.

Time management can be especially difficult. Scheduling an extended initial interview session so that the child has adequate time for self-expression and the caregivers also feel their concerns are sufficiently addressed is one method for dealing with time management issues.

## First Contact

First contact with young clients and caregivers can be stimulating and overwhelming. There are many management issues to address. A written informed consent is crucial and should be followed by an oral description of your informed consent and confidentiality policies. For example, if you meet with parents first but the child is your primary client, the child deserves to know at least generally what has been said about him or her. Letting caregivers know that you'll be summarizing and sharing information with the child will help set a meaningful semipermeable boundary (more on this in the informed consent section). If you don't have an up-front plan, you risk having a strong-willed family member control the initial interview (see Case Example 13.1).

### CASE EXAMPLE 13.1: WHO'S IN CONTROL?

Sandy Smith, a 12-year-old biracial child, was adopted by a mixed-race couple who later divorced. She was a gifted violinist and athlete, but had begun "hanging with the wrong crowd." Her father and stepmother insisted on counseling. Her mother and stepfather were less eager,

but felt something must be done about her increasing defiance. As planned in an initial telephone conversation, all four parent figures plus Sandy's four-year-old stepbrother arrived at the counseling office. Sandy's father was paying for the counseling and expected to talk with the counselor alone before anyone else was interviewed.

The counselor gave Sandy's father a smile, but oriented to Sandy in the waiting room, saying, "Hi. You must be Sandy. Looks like you've a pretty big fan club along with you today."

Sandy shrugged and mumbled, "Hi."

The counselor then said, "How about if everyone comes back for a few minutes so I can meet everyone together?"

Sandy's father asked pointedly, "Can I just see you first for a couple minutes?"

The counselor responded with warmth and limits: "To start, I'd like everyone to come in and hear about how I work with young people. [A significant smile is sent in Sandy's direction.] If we haven't gotten to your concerns, Mr. Smith, we may need some one-on-one time afterwards."

Mr. Smith nodded, and the whole group proceeded to the counselor's office.

Children's guardians have many legal rights, but if you're doing individual therapy with children, the children should know that your primary allegiance is to them (C. Stone, 2013). Achieving the right balance is difficult. You want to pay respectful attention to the caregivers' concerns, but not so much that the child feels overlooked. Early on, it's good to be clear about caregiver roles. A telephone conversation with a mother of a 15-year-old boy might proceed like this:

**Counselor:** Hello, my name is Kalinda Perry. I'm returning your call to the Riverside Counseling Center.

**Mom:** Yeah, I called yesterday because I want an appointment for my son. I'm a single parent, and I can't get through to him. He's angry and impossible to deal with. When can I get him in?

**Counselor:** I have open times next Monday at 1 p.m. and 3 p.m.

**Mom:** I'll take 3 p.m.

**Counselor:** Sounds good. (*Therapist explains fee arrangement, office forms to be completed, and directions to the counseling center.*) Also, at the beginning of the session, I'll meet with you and your son together. During that time, I'll talk with both of you about how I work with young people, and we'll establish goals for counseling.

**Mom:** You want to meet with me too? I thought I could just drop him off and run back to work.

**Counselor:** Yes, it's important for me to meet with both of you to start. That should take about 20 minutes. Then I'll meet with your son alone so I can get to know him and we can begin working together. While I meet with him, I'd like you to stick around\* and complete paperwork in the waiting room. Okay?

**Mom:** I'll have to make some arrangements for this at work.

**Counselor:** That would be great. I'll look forward to meeting with both of you on Monday.

\*Note: Experienced child therapists have noted that some parents want to run errands or leave the premises while the therapist meets with their child. This may or may not be acceptable, depending on the policies of your particular agency (C. Berger, personal communication, August 10, 2012).

Whether directly on the telephone (as in the preceding example) or at the outset of the interview (as in the first example), managing caregiver involvement is part of the process. Each situation is different, but articulating your policies and guidelines early clears up potential confusion and allows you to develop a working alliance with the child (and parent or caregiver).

#### **PUTTING IT IN PRACTICE 13.1: A CHECKLIST TO PREPARE FOR FIRST CONTACT**

- Consider the pros and cons of meeting with the whole family, parents only, or child only; be clear whom to include in the first interview and for how long.
- Develop an informed consent that describes your approach and how you'll handle confidentiality. This should include information on whether it's acceptable for parents to leave the premises while you're counseling their child.
- Consider scheduling a longer-than-typical initial session so that all parties (adults and children) can express themselves and feel heard.
- Manage caregivers, children, and potential conflicts. It's not unusual for you to have to do limit-setting during initial sessions.
- Keep reading about the different scenarios to expect when working with children and parents.

## The Opening

VIDEO  
13.3

The reason that all the children in our town like Mrs. Piggle-Wiggle is because Mrs. Piggle-Wiggle likes them. Mrs. Piggle-Wiggle likes children, she enjoys talking to them and best of all they don't irritate her. (MacDonald, 1947/1987, p. 1)

Child/adolescent interviews consist of two general goals:

1. To establish a warm and respectful relationship
2. To learn as much as possible about the client

Young clients are likely to be unfamiliar with interviewing and counseling procedures and may be shy, reluctant, or resistant (J. Sommers-Flanagan & Bequette, 2103). You can manage this challenge more easily if you follow Mrs. Piggle-Wiggle's lead.

Young people quickly perceive whether mental health professionals like them and enjoy spending time with them. They also readily notice if professionals are threatened or irritated by child/adolescent attitudes and behaviors. Perhaps another reason Mrs. Piggle-Wiggle did so well with children is that she joyfully accepted them as children and spoke to them in their developmental language, rather than prematurely trying to drag them into an adult world. If young clients don't believe they're liked or respected, there's much less chance that they'll listen, open up, or, if they have a choice in the matter, continue therapy (Oetzel & Scherer, 2003).

## First Impressions

Although it's tempting to chat with parents in the waiting room, doing so can make rapport building with young clients more difficult. It's helpful to try connecting with young clients first. A wave, a fist bump, or a handshake and a friendly "Hi, you must be Maggie" is a good start, followed by more quick exchanges, such as "It's very nice to meet you" or "Great biking weather out there, huh?" or "That's a great-looking Batman shirt." Many child counselors try to get down to the child's height level. Your goal is to send the message that you've been looking forward to meeting the young person and are eager to engage. Adult chatter is fine, as long as you don't forget to connect with the child.

Children are similar to involuntary clients. As with any involuntary client, it's wise to seek assent and introduce a few creative choices within the interview frame. For instance, you might say something like:

- Hi, Felix. Your mom and stepdad are going to fill out some boring paperwork while you and I talk together. I have some toys in this closet. You can pick two to bring with us to my office.

- Helen, I need to explain three important things to you. One is about how we will spend our time together today. One is about a word called *confidentiality*. And one is about why my office is so messy. Which one would you like me to talk about first?

Another way to empower and connect with young people is to offer food or drink. The options, depending on your values, budget, guardians' consent, and setting, might include milk, hot chocolate, juice, or sports drinks. Although you should watch out for food allergies, snacks might be pretzels, chips, granola bars, fresh fruit, crackers, candy, or yogurt. To feed or not to feed is a professional question we don't discuss at length in this book. Suffice it to say, feeding young people builds relationship (J. Sommers-Flanagan & Sommers-Flanagan, 2007b). Hungry people tend to think about being hungry. Even Freud fed clients when they were hungry (J. Sommers-Flanagan & Sommers-Flanagan, 2012). Food may be an especially important therapy tool when young children are meeting with you immediately after school. Although we try to avoid beverages with caffeine and highly sugary foods, other therapists we know use such items after obtaining parent or guardian permission.

## Office Management and Personal Attire

Professional offices aren't always youth-friendly. It can help to place a few items in clear view. Items such as popular sports cards, fantasy books, playing cards, drawing pads, clay, and hats may be appropriate. Trendy toys are the mark of a cool counselor, but you have to make a commitment to being up on the trends. Hardly any of John's young clients show much interest in playing with his Carl Rogers action figure. We would suggest items, but by the time you read this book, they might be uncool. We leave you to your own devices to discover what's cool, what's not, and what toys you can tolerate having in your office. It's also possible to try too hard. Striking a balance so that you're child-friendly but authentic should be your goal. More generically, soothing play-therapy objects, such as puppets and stuffed animals, can increase clients' comfort level. Sometimes, teenagers comment negatively about such items because they're associated with younger children, but the comments may be a cover for their comfort and dependency needs (J. Sommers-Flanagan & Bequette, 2013). Overall, the office should be interesting and welcoming to young people.

Although you may offer particular toys or objects for children to play with or hold, it's often better to let clients notice particular items on their own. Their natural exploratory behavior can help them become

comfortable in new settings. In addition, reactions to office items provide valuable assessment information. Some children will orient to the sports cards and begin estimating their resale value; others cuddle up with pillows and stuffed animals; still others ignore everything, appear overtly sullen, and roll their eyes. For you to maintain control, certain items may need to be placed in drawers or boxes if they become too distracting; other items, such as clay or a doodle pad, can give clients something to “mess around with” while talking. Having something to hold or squeeze or draw with can reduce client anxiety (Hanna, Hanna, & Keys, 1999).

Adolescents will sometimes take note of *your* clothing choices. This doesn’t mean you have to shop for cutting-edge brands or styles, but one of the most successful female therapists we’ve ever known attracted difficult adolescent girls, in part, because she dressed “way cool.” If you’re wondering how we know this, it’s because teens seen in therapy often talk with each other about their respective “shinks” and offer progress reports about their friends who are seeing other therapists. Listening to these assessments can be informative.

In contrast, some clothing choices may be off-putting. Traditional, conservative attire for males (suit jacket, shirt, and tie) may be viewed by adolescents with oppositional and misconduct behaviors as proof that you’re a rigid authority figure. Many adolescents have strong transference reactions to authority figures, and such reactions can impair or inhibit initial rapport (J. Sommers-Flanagan & Sommers-Flanagan, 2007b).

Generally, more casual attire is recommended when interviewing young clients. This doesn’t mean clients can’t overcome reactions to formal clothing choices. However, when working with youth, it’s useful to eliminate even superficial obstacles to rapport. Although you need to present yourself and work in ways that feel personally and professionally authentic, keeping an eye to youth-friendly accessories can be helpful.

You may decide to have youth-oriented interviews that move away from traditional seating or settings. This might involve being on the floor, going outside, or using child-size tables and chairs. If so, you’ll want clothing that comfortably allows for bending, squatting, or crawling.

## Discussing Confidentiality and Informed Consent

Confidentiality is traditionally discussed at the very beginning of the first session. It’s also advisable to review confidentiality with children and adolescents occasionally to ensure that the concept is fully understood. Teenagers sometimes fear that what they say in private will be reported back to caregivers or authority figures. Written parent informed consent forms

and child assent forms should be read and signed before client disclosure is expected (Welfel, 2016).

Confidentiality laws related to minors vary from state to state. This means you need to review regulations in your particular state. In addition, specific school counseling settings and agency settings may have idiosyncratic limits on confidentiality. For example, it's not unusual for schools to have a policy that requires all staff to report students in possession of drugs or weapons within a school. All limits to confidentiality should be fully explained to young clients both in writing and in person.

Explaining confidentiality to teenagers and parents is especially delicate. To do so well, you'll need to address several issues: (a) basic confidentiality limits, (b) how parents hold a legal right to access their teenager's records, (c) how you hope parents will give you and their teen freedom to talk openly without fearing their intrusion, and (d) whether and how much you'll disclose to parents when teen clients tell you about behaviors their parents wouldn't approve (see Case Example 13.2).

Teenagers need to hear more specifically about how their privacy will be maintained and protected. Most parents appreciate their children's need to talk privately with someone outside the family. In cases where diagnostic interviewing results are shared with a referral source or child study team, the child should be made aware in advance. If parents insist on being in the room continuously or constantly apprised of therapeutic details, a family systems interview or intervention is more appropriate. (For a nuanced sample adolescent informed consent form, go to the Center for Ethical Practice website at <http://www.centerforethicalpractice.org/Form-AdolescentConsent>.)

### CASE EXAMPLE 13.2: WALKING THE CONFIDENTIALITY TIGHTROPE WITH TEENAGE CLIENTS

This is an example of how to navigate confidentiality discussions with a parent and teenager (adapted from J. Sommers-Flanagan & Bequette, 2013, pp. 15–16).

**Therapist:** I really want to be clear about how important it is for your daughter [Eva] to be able to speak freely to me, so I'm asking you to respect her privacy even though you're the parent and you can demand the records at any time. Will you agree to that?

**Parent:** Yes. I really want Eva to be able to talk openly with you.

**Therapist:** That's great. I'm glad you recognize that therapy doesn't work very well unless we have a private space to talk openly.

**Parent:** I do recognize that.

**Therapist:** (*turning to Eva*) We need to talk about where the privacy boundaries end. For instance, if you're talking about suicide or about hurting someone or report child abuse to me, I'll need to tell your mom and maybe the police or family services. Does that make sense?

**Eva:** Yeah. I get that. That's fine.

**Therapist:** And because your mom is willing to respect your privacy, I also hope we can respect her right to know some of what we talk about. In most cases, I don't think she needs to know the details, but how about if once every month we invite her into a session to get an update on how therapy is going? Would that be okay with you?

**Eva:** Yeah. That's fine. She'd go crazy if we never tell her anything.

**Therapist:** Great. That's cool that you respect her right to be interested in what we talk about. But is that okay with you? (*turns to mom*)

**Parent:** Yes. That would be nice.

**Therapist:** Okay. One last detail. Eva, because you're still a minor—you're 15—I want to be able to tell your mom if you're doing anything that could be dangerous. So, even if you say you're not suicidal or anything like that, if you start telling me about drinking till you black out or using hard drugs or getting yourself in dangerous situations at parties, and I think it's in your best interests to have your mom come in so we can tell her what's going on, I want to be able to do that. Is that okay?

**Eva:** You mean if I'm partying you're gonna call my mom in and nark on me? That's not cool.

**Therapist:** You're right. That wouldn't be cool, and that's not what I mean. What I mean is that if you go over a safety line . . . like you tell me that you're driving drunk or you tell me that you're using a hard drug like meth . . . then I'll need to tell your mom. Here's an example: if you go to a party and have a couple drinks, I won't tell your mom. But if you go to a party and black out, I will tell her . . . partly because you could get raped and partly because that seems out of control and unsafe and way beyond just partying with your buddies.

**Eva:** Okay. I get that. That's all right.

**Therapist:** Mom, is that all right with you?

**Parent:** Yes. Those are definitely things I'd want to know about.

## Handling Referral and Background Information

Teachers, family members, or others concerned about children's behavior frequently refer youth for therapy or assessment. In most cases, therapists should tell young clients exactly why they were referred. We refer to this as

*acknowledging reality* and consider it an essential part of rapport building (J. Sommers-Flanagan & Sommers-Flanagan, 2007b).

Acknowledging reality doesn't mean you tell clients every detail of what you've heard, but you should be sure to say something about what you know. For example, a concerned teacher who observed a student throwing up in the bathroom after lunch may contact a school counselor. At the teacher's request, the counselor may invite the student for a meeting. We believe it would be a mistake to fail to mention the reason for concern. Of course, you must make these policies very clear to referral sources; if you don't, the referral sources may feel betrayed. The information source may or may not need to remain anonymous, but the information itself, in most situations, should be tactfully, compassionately, and honestly conveyed. Here's a possible scenario from our *Tough Kids, Cool Counseling* text (J. Sommers-Flanagan & Sommers-Flanagan, 2007b):

Immediately after introducing herself and offering a summary of the limits of confidentiality, [the therapist] states, "I'm sure you know I talked with your parents and your probation officer before this meeting. So, instead of keeping you in the dark about what they said about you, I'd like to just go ahead and tell you about what I've been told. This sheet of paper has a summary of all that (counselor holds up sheet of paper). Is it okay if I just share all this with you?"

After receiving the client's assent, the [therapist] moves her chair alongside the client, taking care to respect client boundaries while symbolically moving to a position where they can read the referral information together. She then reviews the information, which includes both positive information (the client is reportedly likeable, intelligent, and has many friends) and information about the legal and behavioral problems the adolescent has recently experienced. After sharing each bit of information, she checks in with the client by saying, "It says here that you've been caught shoplifting three times, is that correct?" or "Do you want to add anything to what your mom said about how you will all of a sudden get really, really angry?" When positive information is covered, the [therapist] says thing like, "So it looks like your teachers think you're very intelligent and say that you're well-liked at school . . . do you think that's true . . . are you intelligent and well-liked?" (p. 32)

If all the information you have is negative, screen and reframe the information so that it isn't overwhelming or off-putting to young clients. Also, when sharing negative information, it's important to show empathy and side with the client's feelings, while not endorsing the negative behaviors.

I can see you're really mad about your mom telling me this stuff about you. I don't blame you. It's hard to have people talking about you, even if they have good intentions.

Keeping secrets about why the youth was sent to therapy can harm the relationship. Referral and information sources are important, but they aren't your primary client.

After discussing confidentiality and informed consent, it's time to get an idea of the reasons the client has come for therapy. The following list isn't comprehensive, but provides a glimpse of common reasons for bringing preschool- to latency-age children (4- to 12-year-olds) for an interview:

- Moodiness, irritability, or aggressive behavior patterns
- Behaviors that caregivers believe to be abnormal or irritating
- Unusual fears or tendencies to avoid age-appropriate play activities
- Unusual sexual behaviors
- Exposure to trauma or difficult life circumstances, such as divorce, death, or abuse
- Hyperactivity or problems with inattentiveness
- Enuresis or encopresis
- Custody battles between parents
- School issues related to academics and/or bullying

The following are common reasons for adolescent therapy referrals:

- Depressive symptoms (usually recognized by a caregiver or teacher)
- Oppositional/defiant behaviors (usually experienced by authority figures)
- Anger management
- Eating disorders or weight problems
- Trauma (rape, sexual abuse, divorce, death in the family)
- Suicide ideation, gestures, or attempts
- A court order or juvenile probation mandate
- Substance abuse problems (usually identified by having been caught using)

Although it's important to have a general understanding of childhood psychopathology and typical complaints, each situation is unique and needs to be addressed with individualized concern. When children come to therapy, they should be asked about their understanding of the visit's

purpose. However, it's not unusual for young clients to give vague or surprising responses:

- My mom wants to talk with you because I've been bad.
- I don't know . . . I didn't even know we were coming here today.
- Because I hate my teacher and won't do my homework.
- Because my parents are stupid and they think I have a problem.

Some young clients will remain quiet when asked about reasons for counseling; it may be that they're (a) unable to understand the question, (b) unable to formulate or articulate a response, (c) unwilling or afraid to talk about their true thoughts and feelings with their parents in the room, (d) unwilling or afraid to talk openly with a stranger, or (e) unaware of, or strongly resistant to, admitting personal problems.

Resistant or nonresponsive children present therapists with a practical challenge. How can you obtain information and begin a working alliance if the client won't speak? A focus on wishes and goals, described next, can facilitate engagement and bypass resistance.

### **Wishes and Goals**

The following statement/question is designed for use with children over six years old when caregivers are present. For younger children, it's often best to meet with parents separately to focus on parenting strategies:

I'm interested in why you're all here, and so I want to ask about your goals for counseling. Usually, even though parents [look at parents] have goals for counseling, the youngest person in the room gets to go first. So, Rosie, you're youngest, so you get to go first. If you came to counseling a while ago and, for whatever reason, your life got better, what would change? What would you like to get better in your life?

Some children and adolescents understand this question and respond directly. However, several suboptimal responses may occur: The child may not understand the question; family dynamics may cause the child to be reluctant to respond to the question; the child may refocus the discussion onto the parents' problems; the parents may begin making encouraging comments to their child, some of which may even include tips on how to respond to the counselor's question; and finally, the parents may interrupt and unleash a barrage of criticisms.

Whatever the case, two rules follow: (a) Watch for and make mental notes regarding family dynamics and (b) if the child/adolescent doesn't answer the question satisfactorily, restate the question in terms of wishes.

## ***Introducing the Wish***

Using wishes to assess problem areas and obtain treatment goals is practical because it involves using a language most young people understand (J. Sommers-Flanagan & Sommers-Flanagan, 1995b). The following wish-based question is similar to the solution-focused miracle question (de Shazer & Dolan, 2007):

Let me put the question another way. If you had three wishes, or if you had a magic lamp, like in the movie *Aladdin*, and you could wish to change something about yourself, your parents, or your school, what would you wish for?

This question structures goal setting into three categories:

1. Self-change
2. Family change
3. School change

The youth has a chance to identify personal goals (and implied problems) in any or all of these categories. Depending on the child, and/or the parents' influence, there may still be resistance to identifying a wish in these areas. If there's resistance, the question can be amplified:

You don't have any wishes to make your life better? Wow! Maybe I should wish to change places with you. How about your parents? Isn't there one little thing you might change about them if you could? [Pause for answers.] How about yourself? Isn't there anything, even something small, that you might change about yourself? [Pause again.] Now, I know there must be something about your school or your teachers or your principal you'd like to have change . . . they can't all be perfect.

Nervous, shy, or shut-down children/adolescents may continue to resist this questioning process. If so, allow them to pass:

Would you like to pass on this question for now? I'll ask your parents next, but if you come up with wishes of your own, you can bring them up any time you want.

The purpose of wishes and goals is to get young clients to share their hopes for positive change. Diagnostic information also may emerge. Usually, clients with disruptive behavior disorders (e.g., attention-deficit/hyperactivity disorder, oppositional defiant disorder, or conduct disorder) report

that the school and parents have problems, but admit few, if any, personal problems. In contrast, clients with internalizing disorders (e.g., anxiety and depression) identify their personal shortcomings and goals (e.g., “I’d like to be happier”).

It’s not uncommon for children to jump into negative and accusatory statements about their parents. If this happens, stay calm and use the opportunity to model active listening skills, acceptance, and reframing. Experienced child and family therapists remind us that it may also be necessary to assist parents in responding in a healthy and receptive manner to their child (J. Pereira, personal communication, August 12, 2012).

### ***Obtaining Parental or Caregiver Goals***

After young clients identify at least one wish, or pass on the question, shift the focus to the parents. Direct interaction and attention to parent concerns is crucial to getting the full picture and to treatment compliance. If parents don’t think you’re addressing their concerns, they won’t support therapy.

During joint meetings with parents and children, actively work to limit the number of negative comments parents make about their children. Three problem statements are enough. Setting this limit protects young clients from feeling devastated or overwhelmed by their parents’ criticism. If parents have additional concerns, invite them to write down the concerns to review later. Another strategy is to ask parents to name a few of their child’s strengths. You can also reframe their concerns using positive language. If a parent says, “Annie is irresponsible and rude,” you might say, “You’d like Annie to be more responsible and kind.”

It can be useful to have a separate meeting with parents to directly address their concerns. However, when doing so, you should be sensitive to your relationship with the child. For example, you might explain your reasoning to the child: “Is it okay with you if I meet separately with your mom and dad to make a list of their concerns?” If an initial trusting relationship with the child has been established, resistance to gathering information in this way is usually minimal.

### ***Managing Tension***

During the wish-making procedure, tension may rise, especially if young clients make wishes about how their parents might change. Despite this tension, child/adolescent wishes about parents are a crucial part of the assessment process. It’s reassuring to most young clients to hear the therapist say things like, “I guess your parents aren’t perfect either.” Focusing on

less-than-ideal parent behaviors during an initial session provides a foundation for later working with parents on their problems. Finally, as suggested previously, parent-child interactions during this goal-setting procedure can reveal interesting family dynamics. We've observed children who seem afraid to comment on their parents' behavior (and their parents don't reassure them), and we've seen children who viciously criticize their parents. After help, encouragement, and humor, and after passing on their initial opportunity to wish for life change, if the young client is still unable or unwilling to identify a goal, prognosis may be limited.

## Observing Parents or Caregivers

Sometimes caregivers who bring children for an interview have more problems than the children. This can be a delicate situation for clinicians of all ages and experience levels.

If parents present with extreme psychological problems or display disturbing interactions with their children, you may be professionally obligated to take action. These actions can range from mild to extreme, depending on your perception of the severity of the parent-child problem. For example:

- You may be able to ignore the unhealthy patterns during the first session and wait until rapport has been established before providing feedback.
- You may need to provide gentle feedback immediately.
- You may need to gather further assessment information to determine if the child is in immediate danger.
- You may need to inform the parent of your obligation to report child abuse and proceed to do so.

If possible, it's best to wait for additional sessions and a stronger therapeutic relationship to give feedback and suggestions to parents, because parents are often naturally vulnerable and defensive (J. Sommers-Flanagan & Sommers-Flanagan, 2011). However, if unhealthy behaviors are mild and parents seem open, you may be able to provide feedback during an initial session. Also, you may be able to assign therapeutic homework to address the problem behavior.

Family status and the child's living situation are also important factors to evaluate and address. Many young clients have lived through or are currently living through divorce, remarriage, and stepfamily life. Other children reside in group homes, residential living centers, foster/kinship care, and other settings. These unique situations and settings present challenges to children in their day-to-day lives.

## Discussing Assessment and Therapy Procedures

Depending on the situation, you may ask parents to wait in the reception area with an assignment or questionnaire (e.g., a developmental history questionnaire or problem behavior checklist). If you need to interview the parents alone, young clients can be given drawing assignments or questionnaires to complete in the waiting room. With adolescent clients, it can be useful to have individual time and then have parents return for 5 to 10 minutes at the session's end to review therapy or follow-up procedures (e.g., appointment frequency, who will be attending, or a description of specific treatment approaches such as anger management or cognitive-behavioral treatment of depression).

It's crucial to explicitly discuss the rationale for assessment and therapy with parents and young clients. Direct explanations from therapists about assessment, treatment procedures, and rationale strengthen the working alliance, improve homework adherence, and are associated with positive outcomes (Jungbluth & Shirk, 2013; Shirk, Karver, & Brown, 2011).

### VIDEO 13.4

## The Body of the Interview

After obtaining child and parent perspectives on presenting problems and goals, it's time to shift to the body of the interview.

### Meeting Separately With Parents or Caregivers

Parenting in the 21st century is difficult and sometimes confusing. Parents have many sources of information and may be exceptionally sophisticated, misinformed, or uninformed about therapy. Consequently, although to this point we've emphasized meeting individually with children or jointly with parents and children, it may for many reasons be best for you to initially meet with parents separately to identify an appropriate treatment plan.

### *Using Radical Acceptance*

Interviewing parents can be even more difficult than interviewing children or adolescents. We strongly recommend using radical acceptance as a primary tool when working with parents (J. Sommers-Flanagan & Sommers-Flanagan, 2011).

Radical acceptance is derived from person-centered theory and Buddhist philosophy (Linehan, 1993; Rogers, 1980). It involves graciously and actively welcoming even absurd or offensive client statements. A generic response that embodies radical acceptance is "I'm glad you brought that up."

Radical acceptance is especially warranted when parents say something you personally or philosophically oppose (J. Sommers-Flanagan & Sommers-Flanagan, 2007a). These statements may be unusual, disagreeable, racist, sexist, or insensitive. Two examples of aversive parent statements and radical acceptance follow:

**Parent 1:** I believe in discipline. Parents need to be the authority in the home. And yes, that means giving my kids a swat or two if they get out of line.

**Clinician 1:** I'm glad you brought up the topic of spanking.

**Parent 2:** I can't accept homosexuality. My son has to resist it, and I won't endorse his behavior. He has to turn away from sin or leave my house.

**Clinician 2:** Many parents have views like yours but won't say them in here, and so I especially appreciate your sharing your beliefs so openly.

Radical acceptance involves actively welcoming any and all client comments (Theriault, 2012). To use this technique, you must move beyond feeling threatened, angry, or judgmental about what parents say and embrace whatever comes up while maintaining balance or objectivity.

Radical acceptance, as illustrated in the preceding examples, is more active, directive, and value laden than traditional person-centered therapy approaches. The goal is to communicate commitment to openness during the initial interview. If you don't value and welcome openness, parents may never speak of their underlying beliefs. Parents are unlikely to experience insight or be motivated to modify their beliefs or behaviors unless they are able to expose those beliefs to the light of personal and professional inspection.

Radical acceptance involves letting go of the need to immediately correct, counter, or teach parents new ways (J. Sommers-Flanagan & Sommers-Flanagan, 2011). Instead, you invest in a process that allows unhealthy beliefs to be accepted and to consequently shrink, melt, crumble, or deconstruct. For example, parents who use corporal punishment may want to articulate their position at the outset of therapy. After proclaiming their right to corporal punishment, they may be able to also admit they don't enjoy spanking, and to consider alternatives to punishment. Similarly, parents who won't accept their teenager's homosexuality may need to have painful feelings affirmed to move beyond those feelings and recover their original feelings of love and affection. Overall, when using radical acceptance, therapists are indirectly communicating the message: "I accept you as you are, and I am committed to helping you change for the better."

### ***Assessing Family Contingencies***

Many parents inadvertently pay excessive attention to their children's negative or undesirable behaviors and too little attention to positive or desirable behaviors. For example, caregivers might scold or yell at their children immediately following misbehavior and ignore positive behaviors. From a behavioral perspective, this pattern involves positive reinforcement of negative behaviors and extinction of positive behaviors (Kazdin, 2008). In our work with parents, we refer to this natural tendency as "backward behavior modification" (Sommers-Flanagan & Sommers-Flanagan, 2011, p. 68).

Regardless of theoretical orientation, all clinicians working with children and families should assess family contingency patterns. There are two straightforward ways to obtain this contingency-related assessment data. You can (a) observe for positive and/or dysfunctional reinforcement patterns during the caregiver-child session and/or (b) separate caregiver and child and then inquire directly about "what happens next" during family conflicts.

Some parents hold negative views about positive reinforcement; they equate it with bribery. If parents object to positive reinforcement (or perhaps before they object), you can explain that *bribery* is defined as "paying someone in advance to do something illegal" and that research shows positive reinforcement to be a more efficient behavior modifier than punishment (Kazdin, 2008). You can emphasize this by inquiring about positive reinforcements parents receive in their daily lives. Encouraging parents to spend time with their children (instead of relying on material items) can help parents use one of the most powerful positive reinforcements of all.

### **User-Friendly Assessment and Information-Gathering Strategies**

Therapists use formal assessment or evaluation procedures to obtain information that helps with diagnosis and treatment planning (Weisz & Kazdin, 2010). These include behavioral checklists, intellectual assessment, and personality inventories (e.g., the Child Behavior Checklist, Wechsler intelligence scales, Minnesota Multiphasic Personality Inventory). Although many mental health professionals use these traditional assessment procedures, many don't. Those who don't use traditional assessments may view them as invalid or unhelpful (Schneider & Krug, 2010).

Young clients often express criticism and/or sarcasm when asked to participate in traditional assessment (e.g., "This test totally sucks"). They may resist completing the instruments fully and thoughtfully. Fortunately, there are alternatives to formal assessment procedures for obtaining information.

The following procedures, sometimes referred to as qualitative or informal assessments, can help therapists gather information while at the same time capturing client interest and cooperation. These assessment procedures aren't a replacement for formal assessments; they're complementary or used in situations where formal assessment isn't necessary or has been rejected.

### ***What's Good About You?***

A relationship-building assessment procedure that provides a rich interpersonal interaction between young clients and counselors is the "What's good about you?" question-and-answer game (J. Sommers-Flanagan & Sommers-Flanagan, 2007b). The procedure provides useful information regarding child/adolescent self-esteem. Initially, it's introduced as a game with specific rules:

I want to play a game with you. Here's how it goes. I'm going to ask you the same question 10 times. The only rule is that you can't use the same answer twice. So, I'll ask you the same question 10 times, but you have to give me 10 different answers.

Clinicians then ask, "What's good about you?" and write down the response. Each client answer is greeted with "Thank you" and a smile. If the client responds with "I don't know," the response is simply written down the first time it's used; if "I don't know" (or any response) is used a second time, the therapist gently reminds the client that answers can be used only one time.

"What's good about you?" can provide insights into client self-perceptions and self-esteem. Some youth have difficulty stating a talent, skill, or positive attribute. They may identify possessions, such as "I have a new snowboard" or "I have friends" instead of taking personal ownership of an attribute: "I'm a good snowboarder" or "My friendly personality helps me make friends." They also may describe a role (e.g., "I'm a good son") rather than specific behaviors that make them good at the particular role (e.g., "I'm thoughtful with my parents, so I'm a good son"). The ability to articulate positive personal attributes implies healthy self-esteem.

Interpersonal assessment data also can be obtained through the "What's good about you?" procedure. We've had assertive or aggressive children request or insist that they be allowed to ask us the "What's good about you?" questions. We always comply with these requests, as it is a modeling opportunity and provides the clients with an empowerment experience. In addition, the manner in which young clients respond to this interpersonal request can be revealing. Some youth ridicule or mock the procedure; others cooperate and enjoy the process.

### ***Using Projective Drawings***

Projective assessment techniques, including the Draw-A-Person, Kinetic Family Drawing, House-Tree-Person, and other creative drawing techniques, can be excellent strategies for obtaining information and building rapport (Kim & Suh, 2013). Projective assessments are justifiably criticized as unreliable and as poor behavioral predictors (Wood, Nezworski, Lilienfeld, & Garbm, 2008); however, their utility in helping young clients open up and express themselves is high.

Projective drawings are fun, interesting, and prone to overinterpretation. For example, if a child introduces sexuality into a drawing, it's easy to quickly and sometimes inappropriately conclude that sexual abuse has occurred. Instead, projective drawings are best for stimulating conversation, generating hypotheses, and building rapport. Although drawings can be used to initiate conversations about sex and sexuality, they shouldn't be used to conclude that child sexual abuse has occurred.

Projective drawings also may prompt conversations about cultural issues. Children will often include objects with personal and cultural meaning in their drawings. This gives therapists an opening to discuss the young client's culture.

### **General Considerations for the Body of the Interview**

Limit-setting can be difficult for many clinicians—especially clinicians who naturally interact playfully with children. For one of us, getting poked in the eye during an initial interview with an active 10-year-old boy was inspiration to learn to gently, firmly, and empathically set limits. We encourage you to think about boundaries or limits you want in your work with children. The following guidelines may help:

- Plan ahead by thinking through what behaviors are acceptable and unacceptable in your office.
- Have simple ground rules you state in advance (e.g., “During our play time you can play with any of these toys, but my two rules are ‘No breaking toys’ and ‘No throwing toys’”). For every no, be sure to have something positive to offer.
- Remember, fewer rules encourage free expression, and vice versa.
- Be prepared for limit-testing; we’ve had young clients leave the room, climb out a window, grab items off a desk, call and text on their cell phone, spit, fall asleep, swear for 30 minutes, vomit, and light up a cigarette and blow smoke.

Rather than having a multitude of stated rules covering every possibility, it’s better to prepare to set firm limits as needed. Some theoretical

orientations prefer to leave all rules unstated; others recommend one or two basic rules (J. Sommers-Flanagan, Murray, & Yoshimura, 2015). For example:

Carlos, you're welcome to play with toys in my office [or things from the toy closet]. We don't have too many rules about playing here, but it's important that you know that it's not okay to break things or hurt yourself or anyone else with the toys or art supplies.

Cleaning up and putting things away also provide assessment data. An abrupt shift in attitude toward the toys or game may occur. Emotions directed toward you or the toys may signal how the child handles transitions or frustration. Does the child ignore you or refuse to cooperate? Is there frenetic overcompliance? Those few cleanup minutes at the session's end can be revealing. To give young clients the best chance to handle cleanup and the ending of the session, you should make your expectations clear and provide periodic "alerts" about when the session will be ending:

Hey Jameel, we've got 10 minutes left today. So in 5 minutes we'll start cleaning up together.

The following section describes supplies helpful in working with children; Putting It in Practice 13.2 lists these supplies and suggests a group art assignment.

### **PUTTING IT IN PRACTICE 13.2: ART ACTIVITIES—SUPPLIES AND PRACTICE**

Art therapy is a specialized profession in which practitioners obtain master's-level training. However, using art in working with young people doesn't require a degree in art therapy and can be rewarding for both you and your client. Most materials are simple and inexpensive. Before integrating advanced materials (e.g., acrylic paints) into your work, you should be familiar and comfortable with their use. If you're interested in using art to stimulate conversation and explore young clients' issues, consider the following items and see if you can convince your graduate faculty or fellow graduate students to pool resources and go shopping.

Drawing pencils (or charcoal pencils)

Colored pencils

Fat or skinny (and washable) markers and crayons

Colored plasticine clay

A big stack of nice white paper or colored construction paper

*(Continued)*

A roll of newsprint paper  
A big box of old magazines  
Aprons  
Colored chalk  
Oil pastels  
Watercolor paint sets  
A few basic color tubes of acrylic paint  
Some bottles of tempera paint  
Egg cartons for paint mixing  
Paintbrushes  
Paper towels or rags  
Chocolate (optional)

Right before finals is an excellent time for an experiential art party. Get a group together and engage in expressive art. Pair up and reflect on the process. Remember: Be open, nondirective, and nonjudgmental—with yourself and with your partners. Ask indirect or open questions like “Tell me about your work” or “How did it feel to do this?” or “What do you notice about your work?”

Treat each art piece respectfully. Notice the medium you chose. Finger-painting is the “loosest”; colored pencils are more controlled. In suggesting art as a modality to your client, you’ll be more effective, insightful, relaxed, and convincing if you’ve recently used art yourself.

### *Arts and Crafts*

**Drawing** is a favorite activity of many children and some adults (especially in the form of doodling through long, boring meetings). All that’s necessary are a few sharp pencils with good erasers, paper, and a nice flat surface. Crayons, washable markers, and pastels can bring out color. In contrast to the projective drawing procedures discussed previously, abstract and spontaneous assignments can be used: “Draw me a quick sketch of how you feel about math.”

You might wonder what to do while your client is drawing. Several options are possible:

- Doodle in a way that’s not distracting.
- Sit patiently, unobtrusively glancing at the child on occasion and commenting in ways consistent with your purpose (e.g., encouragement: “I

can see you're working hard at that drawing"; or exploration: "I wonder what you're drawing now?").

- Draw something yourself. You might make a sketch of the child drawing and then talk about what you observed.

Try to avoid hovering in ways that make the child feel shy or self-conscious. Although children and adolescents sometimes spontaneously explain their drawings, being naturally curious can help (e.g., "What's on the person's head?" or "Tell me about your picture").

**Play-Doh** is a familiar commodity in child therapist offices. It's a tactile, expressive modality and comfortable for most children. Having a cleanable surface is essential. If your office is carpeted, a plastic tablecloth can solve mess-management problems. Play-Doh accoutrements include molds and machines. Or you can use the projective process of letting children create things free-form.

**Clay** (plasticine) is similar to Play-Doh but dries out less quickly and requires more working before becoming malleable. Clays that require firing are more difficult to use in controlled, meaningful ways unless you're familiar with this medium.

**Painting** is a common expressive modality used in art therapy (Moon, 2010). Although messier and harder to control than drawing, paints can elicit more emotion. Given the opportunity to work with tempera or watercolor paints, some children shift from nonresponsive and unininvolved to happy, verbal, and engaged.

**Collage building** (using pictures or words) has become a favorite therapeutic use for old or unwanted magazines. Glue (or tape), scissors, magazines or picture calendars, and poster board are the essential ingredients. You can ask clients to select pictures or phrases that illustrate different issues and emotions, including life events, internal states, family troubles, and school worries. Clients can attach their selections any way they wish, sometimes creating an expression that would have been impossible to achieve with words (see Case Example 13.3).

#### CASE EXAMPLE 13.3: USING A COLLAGE TO STIMULATE EMOTIONAL DISCLOSURE

Cary was a 12-year-old intellectually gifted boy struggling with a father who believed deeply in control and a mother with depressive symptoms. Cary's mother was 55, and his father was 61. His elderly grandparents on his mother's side lived in the family home. Both grandparents

(Continued)

were frail and needed extra care, which Cary's mother provided. Cary was referred for therapy by his school counselor because his grades had slipped significantly, he refused to engage in his usual social activities, and he made self-destructive comments in class. The therapist invited Cary to build a collage about his family life. Until that point, Cary had, with his large, impressive vocabulary, indicated acceptance of his grandparents' needs, and pride in his mother for caring for them. However, the collage was filled with pictures of young parents with little children and peppered with happy, upbeat words from advertisements. As the therapist commented on the contents, Cary burst into tears and shared his longing for a "normal" family with young parents and happy, healthy grandparents. Although the therapist couldn't change Cary's family situation, the collage project provided assessment information that helped formulate a treatment plan to help Cary articulate his grief and move forward with his personal development.

Generally, wetter art modalities produce more emotionality and can stimulate a loss of self-control in some children. An art therapist colleague warned us that finger-painting may produce emotional looseness in young clients—a looseness that can result in an in-session loss of bowel or bladder control! (K. B. Campbell, personal communication, November 3, 2007).

Parent-child art psychotherapy (PCAP) is a new therapeutic model that has gained popularity in recent years (Regev & Snir, 2015). PCAP focuses on improving parent-child interactions and child well-being through joint artistic activity. This approach provides an intriguing alternative to traditional clinical interviewing and art therapy. Of course, it requires advanced training—in both art and in facilitating parent-child interaction (Buck, Dent-Brown, Parry, & Boote, 2014).

### ***Nondirective, Interactive, and Directive Play Options***

For children, play is the means through which they work out pain, achieve mastery, explore new terrain, and take risks. It's also a means through which they can distance themselves from things too difficult to deal with directly.

Therapists vary greatly in their use of play in working with children. Some model themselves after Virginia Axline, who advocated a nondirective, minimally interactive play therapy format, beautifully described in the book *Dibs: In Search of Self* (Axline, 1964). Others use play and storytelling to enhance the therapeutic relationship and explore children's issues (J. Sommers-Flanagan & Sommers-Flanagan, 2007b). Still others find more direct ways to use play and playful interactions, including computer games, to teach empathy and adaptive behaviors (Brezinka, 2014; Gotay, 2013).

Not all therapists have access to a full set of play items. Play therapy experts usually recommend toys that represent the following categories (Ray, 2011):

- Family/nurturing
- Scary
- Aggressive
- Expressive
- Real life
- Pretend/fantasy

The following toys and supplies can be used to facilitate playful child-therapist interactions.

**Action figures, dolls, and puppets** are fabulous instruments for encouraging expression. There are many media- and culturally based action figures and dolls. Ken and Barbie, Sesame Street characters, and generic puppets stimulate rich interactions. Superhero figures can lead to conversations about fears, strengths, and longed-for superpowers. Given the strong presence and influence of the military within American culture, regardless of your political leanings, it's useful to have a collection of a few "gray and green figures" to stimulate interactions and emotions that may be associated with war, conflict, or parental military involvement.

**Sand trays** come in all sizes and shapes. Working with sand trays is a specialized skill that can become a central treatment modality (Richards, Pillay, & Fritz, 2012). They can also be used simply for play or a tactile activity while talking. Sand is a tantalizingly movable medium that many children can't resist. A good, sturdy lid and adequate floor covering are essential. You can collect items to play with, such as tractors, trucks, action figures, and stones.

**Stuffed animals** offer a comforting presence. Sometimes, child-oriented mental health professionals collect stuffed animals for display or interaction. Children may create relationships among the animals. Having a stuffed animal family can stimulate the acting out of family dynamics.

**Dress-up clothes** are less common, but easy to obtain. A small suitcase of dress-up clothes can facilitate a breakthrough with an otherwise unresponsive child. Outfits that express themes, such as cowpoke, firefighter, artist, plumber, and ballerina, can be easily assembled. The suitcase itself can elicit play themes. Young children can be powerfully drawn toward dress-up activities.

**Construction sets** vary in size, number of parts, and age appropriateness. Lego blocks, Lincoln Logs, and Tinker Toys engage young clients in therapeutic activities. They shouldn't be used with small children, and you might want to

hide them if you're working with children who have impulse control problems or violence histories. They can easily be used as real or imagined weapons.

**Special props** can be especially useful with adolescent clients. For example, Magic 8 Balls, puzzles, stress balls, or anything they can manipulate while talking is fair game.

**Aggression items** should be carefully considered. Your own values, professional training, and agency policies will dictate your comfort level with toy guns, knives, swords, and other play weapons. They allow for aggressive expression. Some therapists worry that they're too provocative and promote violence; others worry that having them in an office endorses violence. These are issues for discussion in classes and with supervisors and colleagues as you determine which play items you're comfortable having in your office. The question is "How can these items be used therapeutically or for assessment?"

**Dollhouses** or other homelike environments are classic props for allowing children to reenact life dramas and traumas. Many toy companies produce schoolhouses, gas stations, playgrounds, city blocks, and other molded-plastic environments complete with figures, vehicles, pets, furnishings, and miniature toys. Children use these props and settings to build communities of friends, enemies, and families. Themes emerging in play can provide you with insights about challenges and situations your client is facing outside counseling.

**Anatomically correct dolls** are common and can be controversial. For a short time, child abuse investigators were urged to use anatomically accurate dolls with young children. If children had the dolls interact sexually, this was interpreted to indicate sexual exposure. Controversy quickly arose regarding the accuracy of such interpretations (Dickinson, Poole, & Bruck, 2005; Faller, 2005; Hungerford, 2005). Although anatomically accurate dolls still serve useful functions, clinicians should seek adequate training and supervision before using them (see Putting It in Practice 13.3).

A final comment about your toys: Be aware that you can inadvertently end up with a batch of toys that are culturally or socioeconomically narrow. A good general guideline is to collect toys and dolls that aren't overly expensive, have different racial features, and are sturdy and inviting.

#### **PUTTING IT IN PRACTICE 13.3: QUESTIONS AND INVESTIGATIVE INTERVIEWS WITH CHILDREN**

It should come as no surprise to find that children, even as young as three years old, can be reliable and valid reporters of their own personal experiences. However, there are a number of

challenges and strategies that should be considered when interviewing children about their personal—and sometimes traumatic—experiences.

Obtaining reliable and valid information from children via clinical investigative interviewing is a professional activity that requires advanced education, training, and supervision. Given that caveat, we provide the following information as a general guide to gathering information from children. The following points provide highlights of investigative interviewing practice and research.

- As a colleague of ours articulated, “The door to children’s feelings and memories locks from the inside. All we can do, as parents or professionals, is knock gently and respectfully, and hope children trust us enough to unlock their emotional doors and allow us access.”
- Children have developmental limitations regarding how they can respond to direct questioning. For example, they tend to respond very briefly to open-ended questions.
- Young children up to about age nine will comply with adults and provide a response to a query, even when they have no understanding of the question asked of them. Unless precautions are taken, interviewers can inadvertently coerce young clients into responding to questions they don’t understand.
- As Salmon (2006) noted, “Parents tend to underestimate their child’s distress about painful or traumatic experiences, particularly when they have participated in the episodes that caused the child’s distress” (p. 54). Parents may not be valid reporters about the intensity of their children’s distress.
- Toys and dolls may be especially helpful in putting children at ease in an investigative clinical interview. Toys and dolls also help children reenact traumatic events. However, whether toys and dolls are helpful or distracting in facilitating accurate disclosures depends on whether the individual interviewer uses these items in an evidence-based manner (Chang, Ritter, & Hays, 2005; Salmon, 2006; Vig, 2007).
- Open-ended prompts (“Tell me about . . .”) and cued invitations (“You said he hurt you; tell me about the hurting”) tend to be the most effective approaches to gathering accurate information from children. Further, Salmon (2006) noted: “Posing these kinds of questions in relation to neutral events (e.g., a school activity) at the beginning of the interview can facilitate rapport while providing the child with practice in retrieving and reporting her or his experiences and shaping accurate expectations of what is to come” (p. 55).

Reviewing this information about investigative interviews with children reminds us of how important it is to remain sensitive and knowledgeable about children’s developmental abilities and limitations. It also reminds us of how achieving competence in this specific area is impossible without advanced training.

### ***Fantasy and Games***

Fantasy and games can be used for assessment and therapeutic purposes in the body of an interview.

**Storytelling** has captivated and influenced children for centuries. Inviting clients to listen to stories, to make them up, or to share the process back and forth can be entertaining and revealing (R. Gardner, 1993). There are many ways to use stories and storytelling activities (BigFoot & Dunlap, 2006; Cook, Taylor, & Silverman, 2004). Very few materials are needed, but an active imagination helps. Having a few memorized favorite stories also may be useful (see Putting It in Practice 13.4).

**Acting or miming** is a highly projective activity. Often, children love to make up a play and assign the acting parts. This activity can uncover important themes in children's lives. Having the child write a script and act it out can be revealing to both therapist and child—especially when the child assumes roles of various characters in the play.

#### **PUTTING IT IN PRACTICE 13.4: STORYTELLING**

Some people believe that good storytellers are born, not made. We beg to differ. For this activity, you need one or more partners and access to the creative side of your personality.

Sit with one or more fellow students and start telling a story. You can tell any story you want. The only rules are that the story should have a beginning, middle, and ending. It also helps if the story includes characters (e.g., people, Martians, ants) that can have thoughts and feelings. The story can be about you, about animals, about spaceships, about anything. Simply start telling the story. Then stop telling it, while it's still incomplete, after about 30 to 60 seconds. At that point, another person takes over telling the same story, taking it in any direction desired. After about 30 to 60 seconds, switch storytellers again. The goals are to generate a story together with your partner or partners and further develop your storytelling skills and talents. At the end of the story, you may provide one another with gentle interpretive statements (e.g., "I noticed D'Angelo always brought conflict or tension back into the story, but Joyce seemed to get everything resolved so that the characters were feeling good again"). However, be sure to request permission before interpreting the meaning of anyone else's story line. This activity will help prepare you for creative storytelling activities with young clients. You may also want to look at various storytelling resources (e.g., Gardner's *Mutual Storytelling Technique* or Chapter 5 of our *Tough Kids, Cool Counseling* book; see Suggested Readings and Resources).

**Familiar children's games** such as Jenga, Connect Four, and Candy Land, or card games such as Crazy Eights and Uno, can help break the ice and establish relationships with children. For adolescents, games like checkers,

chess, and backgammon can be used therapeutically or for something to do together while talking. With all these games, assessment and therapy should be the focus (e.g., observing the young client's handling of setup, turn-taking, rule obedience, disappointing events, strategy, and winning or losing).

**Therapeutic games** are available through companies that serve mental health professionals' needs. They vary in format, themes covered, appeal, and sophistication. It's worth obtaining a catalogue and checking your options, depending on the type of work you intend to do.

\* \* \*

Creative ways to work effectively with children are abundant in the literature (Martinez & Lasser, 2013; Vernon & Barry, 2013). It's important to assess the needs, skills, and developmental level of your client; the identified problem areas; your setting and its limitations; and your own exposure and comfort level with the various tools and strategies listed in this section.

## Closing and Termination

VIDEO  
13.5

Children experience time differently than adults. In fact, even the linear, non-reversible quality of time isn't fully grasped by young children (Henderson & Thompson, 2011). Therefore, telling younger children that there are 10 minutes left during a session may be less helpful than saying something more concrete:

We just have a few more minutes left today. Probably enough time to read one more page [color one more picture, tell one more short story], and then I'll summarize what we've talked about and see if I remember everything. Then we'll make a plan for next week, okay?

As with adult interviews, you'll probably wish you could gather more information than you were able to get in 50 minutes. Unfortunately, you need to stop playing or gathering information and begin winding down to ensure a smooth, unhurried closing.

## Reassuring and Supporting Young Clients

Young people need support in their efforts to relate to you, so be sure to offer validation throughout the interview. Especially during the closing, provide reassuring, supportive feedback. Make comments such as these:

- You did some neat things with that Lego set.
- I know you told me this is your first time in counseling, but you know what? You're pretty good at it.

- I appreciate everything you told me about your family and your teachers and you.
- Thanks for talking with me.

Because most child clients don't come to therapy on their own, it's important to let them know you appreciate the risks they've taken. Some young clients, especially challenging adolescents, may have behaved rudely or defensively. You might experience countertransference impulses such as urges to withdraw, reprimand, or even punish the child (Willock, 1987). Expressing disappointment toward young clients who are resistant, defensive, or quiet is inappropriate; such reactions make it less likely they'll seek professional help again in the future. Instead, if your client is defensive, stay optimistic:

I know it wasn't your idea to come in and talk today. I don't blame you for being upset. We might be able to find ways to make this counseling stuff less of a pain. Maybe we can work together fast and get you done with counseling as soon as possible.

For more information on termination strategies with young clients, see "Termination as Motivation," in J. Sommers-Flanagan & Sommers-Flanagan (2007b).

### **Summarizing, Clarifying, and Engaging**

The most important closing tasks with young people are (a) summarizing your understanding of the problem areas, (b) making connections between the problems and possible counseling interventions, (c) reminding clients about ways caregivers will or will not be involved, and (d) as possible, engaging with clients. See Case Example 13.4 for two sample closings. The first is an example of a seven-year-old struggling with nightmares. The second is of an adolescent who was repeatedly caught stealing from classmates.

#### **CASE EXAMPLE 13.4: TWO SAMPLE CLOSINGS**

In these two case examples, the therapist makes a supportive and informative summary statement to help with the transition to ending the session.

##### **Closing 1**

Beth, our time is almost up. You've helped me understand what it's like trying to sleep at night. You get pretty frightened. Then everybody gets mad at you for not staying in bed.

There are some things we can work on together that will help. We'll need to talk more on our own and then with your parents. I'm going to set up a time for us to meet again next week. We'll draw some more pictures, and I have a story to share with you. Do you have any questions before you go?

### Closing 2

Tommy, we've got a few minutes left together. I know this hasn't been fun. People are pretty upset with you for taking stuff—and even though you say you're just borrowing stuff, it's getting you in more trouble than it might be worth. I appreciate your telling me about all this and answering my questions. I think we can work together to get things to chill out a little in your life. It wouldn't take too long because you're pretty smart, but at least a few more sessions. We'll need to check in with your mom a few minutes every session, but mostly it will be you and me working together. I know we can come up with ideas that will help. Do you think you can stand coming back and talking with me a few more times?

## Empowering Young Clients and Soliciting Feedback

Because young people don't have final authority over many aspects of their lives, they usually respond well to being given opportunities to ask questions. Therefore, although you should consistently check in with youth during an initial interview, at the end be sure to allow time for questions and for reflecting on having spent time together:

- I've asked lots of questions. Do you have any for me?
- Is there anything about this meeting we've had that's bothering you?
- Is there anything you want to say that I should have asked about?
- Do you have any advice for me on what I could have done differently or better with you today?

These queries help give young clients a sense of power and control, and, as with adult psychotherapy, asking for feedback is a collaborative and evidence-based strategy (Lambert & Shimokawa, 2011). Although it's important to maintain control toward the end of an interview, it's also important to carefully share a portion of that control with the child.

## Tying Up Loose Ends

Reconnecting with parents or guardians at the end of the session is an essential piece of closure. Children can't arrange details needed to get themselves back to another session, nor can they independently follow through on recommendations. You'll need to arrange these things with the parent.

Termination principles for ending interviews with adults are also mostly true for children and adolescents (see Chapter 3). Children can be more overt and extreme in their termination behaviors. Adults may *wish* to hug you but refrain, whereas children will jump into your arms. Adults may fantasize about telling you to “f—off” toward the end of the interview, but adolescents will just say it. Adults might feel sad; children will burst into tears. Adults may express disappointment; children will complain loudly that their time is up or rush out early. You need to stay in your role of observer, empathizer, and gentle limit-setter. Sometimes, children feel things, reflect things, and enact things acutely and dramatically. It’s part of the goodbye process.

**VIDEO  
13.6**

### Culture in Young Client Interviews

Research-based information to guide you in your work with culturally diverse youth is sparse. To make matters more complex, as noted at the beginning of this chapter, youth culture is already different from adult culture. In some ways, if you’re not matched on ethnicity with young clients, you’re likely to experience a double cultural divide. These complications led one writer to title an article “A Knot in the Gut” to describe the palpable transference and countertransference issues that can arise when working with issues of race, ethnicity, and social class in adolescents (Levy-Warren, 2014; see Multicultural Highlight 13.1).

In the face of this complexity, we’ve developed a simple research- and commonsense-based list to guide your work with culturally diverse youth (Bhola & Kapur, 2013; Norton, 2011; Shirk et al., 2011; Villalba, 2007):

- Use interpersonal skills (e.g., empathy, genuineness, respect) known to work well with adult minority group members.
- Find ways to show genuine interest in your young clients, while focusing on their assets and strengths.
- Treat the meeting, greeting, and first session with freshness and eagerness.
- Provide clear explanations of your procedure and rationale and then linger on those explanations as needed.
- Be patient with your clients; trust and alliance building take extra time and won’t necessarily develop during an initial session.
- Be patient with yourself; it may take time to feel empathy for young clients who engage in behaviors outside your comfort zone (e.g., cutting).

### MULTICULTURAL HIGHLIGHT 13.1: INDIVIDUALIZING INTRODUCTORY STATEMENTS WITH YOUNG CLIENTS

Whatever you say in the first few minutes of your session should fit your personality. If you're using a standard opening but it feels uncomfortable, children will sense there's something weird or phony going on. This activity involves formulating opening statements to use with young clients that fit with your personality. These statements focus on

1. Introducing yourself to the child and family.
2. Describing confidentiality and its limits to the child and family.
3. Describing other interviewing/counseling features (e.g., psychological assessment).

Think about the words you want to use when discussing these issues with children. Now shift your focus and imagine how you might change your introductory comments in situations with ethnically diverse clients. How would your first comments change if you were working with an American Indian, African American, Asian American, or Hispanic child and family? Would you alter your statements when working with populations from different economic classes or geographic regions? What issues would rise to the surface? If you have an ethnically diverse background, imagine the differences that might arise if you were working with a White child rather than someone from your own background. Discuss these issues with your class or classmates.

One in five children in the United States is a child of an immigrant (US Government Printing Office, 2012). The stresses and strains of fitting in are sometimes magnified by having parents or caregivers who speak a different language and have customs different from people at school and in the neighborhood. Clinicians shouldn't make assumptions about immigrant families or young people. It can be harmful to ignore intergenerational stress in immigrant families. It can also be harmful to assume that an immigrant family is suffering because of bicultural demands. The challenges make family life interesting, or they may be daunting and painful. You can observe and ask gentle, opening questions such as:

I notice your mom is wearing a traditional H'mong skirt, Tu. But you've got on jeans and a T-shirt. Do you dress traditional sometimes?

Or

Your parents have a cool accent. What languages do you speak at home?

Making observations that are slightly positive and following that with questions about the young person's cultural involvement communicate your interest in potential struggles and pride involved in being a family spanning two or more cultures.

## Summary

Interviewing children is different from interviewing adults. This chapter identifies basic differences between children and adults and discusses ways to professionally address these differences. It's possible for clinicians to over- or underidentify with young clients. Many immediate countertransference scenarios are possible.

During the introduction phase of the interview, you should plan and prepare for your first meetings with children and caregivers. You may or may not want to interview parents or caregivers separately before or after meeting with the child. This requires a clear and comprehensive written informed consent form.

During the opening phase, it's important to pay attention to both the child and caregivers in the waiting room. Most youth respond better to more casual attire and an office with youth-oriented items. There are special issues in confidentiality that must be addressed orally at the beginning of the first session. The child is a legal minor, and parents and guardians therefore have rights to therapy information. If young clients are unable or unwilling to identify personal goals for therapy, a procedure called *wishes and goals* is recommended to establish a positive tone, facilitate engagement, and give parents a sense of being heard. The first session is also an opportunity to formally or informally assess caregivers.

The body of an interview primarily involves a variety of nonverbal and verbal interaction strategies to facilitate assessment. These strategies may include arts and crafts, nondirective or directive play, and fantasy or games. Ideally, you'll gather assessment information in ways that simultaneously build the working alliance. Sometimes separate meetings with parents are necessary.

Closing and termination with children are similar to processes with adults, but can become more complicated for several reasons: There are more players to consider and more time demands to balance, and children may express their reactions to their interview experiences more overtly or bluntly than adults. Supportive, empowering reflections on the session can be helpful.

Research on initial interviews with diverse young clients is minimal. Using common sense and cultural sensitivity and relying on the scant research base are recommended.

## Suggested Readings and Resources

The following resources may be helpful to you as you strive to develop skills for working effectively with young clients and their parents.

- Castro-Blanco, D., & Karver, M. S. (2010). *Elusive alliance: Treatment engagement strategies with high-risk adolescents*. Washington, DC: American Psychological Association. This book includes many ideas for how to connect and work effectively with teenagers when they are behaving in ways that are difficult or challenging.
- Dugger, S. M., & Carlson, L. (Eds.). (2007). *Critical incidents in counseling children*. Alexandria, VA: American Counseling Association. This book offers clinical commentary on dozens of mental health and school-based child counseling scenarios.
- Hersen, M., & Thomas, J. C. (2007). *Handbook of clinical interviewing with children*. Thousand Oaks, CA: Sage. This thorough handbook discusses a wide range of topics associated with interviewing children, including such diverse topics as mental status examinations and fire setting.
- Kottman, T. (2011). *Play therapy: Basics and beyond*. Alexandria, VA: American Counseling Association. Kottman describes how counselors can use toys, art supplies, games, and other play media to communicate with children on their developmental level. She also focuses on the power of play to address issues from communication to catharsis.
- Murphy, J. (2015). *Solution-focused counseling with middle and high school students* (3rd ed.). Alexandria, VA: American Counseling Association. Of the many solution-focused books on counseling youth, this is our favorite. Murphy understands solution-focused counseling, but also conveys an empathic and youth-centered style.
- Richardson, B. (2016). *Working with challenging youth: Lessons learned along the way* (2nd ed.). New York, NY: Routledge. Richardson offers more than 50 lessons he has learned about providing counseling to difficult or challenging youth. Richardson is an excellent storyteller who “gets” youth and their family systems.
- Shapiro, J. P. (2015). *Child and adolescent therapy: Science and art* (2nd ed.). Hoboken, NJ: Wiley. This is an entry-level child and adolescent therapy book that includes theory-based chapters (e.g., behavior therapy) and problem-based chapters (e.g., stress and trauma).
- Sommers-Flanagan, J., & Sommers-Flanagan, R. (2007). *Tough kids, cool counseling: User-friendly approaches with challenging youth* (2nd ed.). Alexandria, VA: American Counseling Association. This book includes many techniques and strategies, all of which are seen as having the goal of establishing and deepening the therapy relationship.
- Sommers-Flanagan, J., & Sommers-Flanagan, R. (2011). *How to listen so parents will talk and talk so parents will listen*. Hoboken, NJ: Wiley. In this book, we focus on professional knowledge and skills needed to work effectively with parents. Because parents are a unique population, we recommend that you obtain ongoing education, supervision, and training on how to work with them effectively.



# INTERVIEWING COUPLES AND FAMILIES

## Chapter Orientation

When couples and families walk into your office, dynamics within the clinical interview grow complex. This can be exciting and intimidating. Adequate preparation is essential. Although reading this chapter won't establish you as competent for working with couples and families, it provides an important foundation.

### VIDEO 14.1

## Challenges and Ironies of Interviewing Couples and Families

For one human being to love another is perhaps the most difficult task of all, the epitome, the ultimate test. It is that striving for which all other striving is merely preparation.

—Rainer Maria Rilke, *Letters to a Young Poet*,  
1929/2000, p. 60

Clinical interviewing with one individual is challenging. Now imagine interviewing two or more individuals—at the same time!

Instead of assessing and addressing one client's problem areas, motivations, and expectations, when interviewing couples, you have two people *and* the problems, motivations, and expectations linked to their unique relationship in the room with you. Generally, as the number of clients increases, so does the complexity of your interviewing task.

Couples and families are powerful systems with explicit and hidden emotional coalitions and conflicts. As professionals, clinicians must respect these systems

## LEARNING OBJECTIVES

After reading this chapter, you will be able to:

- Identify unique challenges and ironies of working with couples and families
- Describe and manage issues related to the introduction stage of interviewing couples and families, such as preparation, first contact, meeting and greeting couples and families, couple and family education, and limit-setting
- Describe and manage issues related to the opening stage of interviewing couples and families, comprising alliance building, opening statements, initial observations and structuring, and maintaining balance
- Describe and manage issues related to the body stage of interviewing couples and families, comprising recognition of theoretical orientations, obtaining romantic histories, tracking clients' usual problem-solving patterns, expressing empathy, reframing partner motives, and providing psychoeducation

(Continued)

## LEARNING OBJECTIVES (Continued)

- Describe and manage issues related to the closing and termination stages of interviewing couples and families, such as time management, providing supportive summaries, and assigning homework
- Identify special considerations and relationship boundaries that may arise in couple and family counseling
- Identify diversity issues that can further complicate couple and family interviews

and their power. Sometimes, when we teach about couple and family therapy, we tell our students to *be afraid . . . be very afraid*. We say this not to scare them away from the gratifying profession of couple and family counseling but to highlight the depth and intensity of this work.

Counseling and psychotherapy with couples and families include several ironic truths.

### More Clients, Less Time

Although interviewing couples and families is more complicated and demanding than interviewing individuals, most therapists must work faster with couples and families than they do with individuals. This is because, on average, couples and families don't stay in counseling as long as individuals (Gurman, Lebow, & Snyder, 2015). There are several possible reasons for this:

- More than one person in the room means multiple motivation levels, expectations, and agendas. This variability may lead to premature termination.
- Insurance companies often don't directly reimburse for couple or family therapy. This makes it harder for families or couples to afford therapy.
- There may be cultural barriers to couple and family therapy. For example, LGBTQ couples and families will be reluctant to enter or stay in therapy unless they know that the professional is practicing from a LGBTQ-friendly perspective.
- The therapist must connect and develop therapeutic relationships with more than one person; if anyone has a negative reaction to the therapist, premature termination can occur (Friedlander, Escudero, Heatherington, & Diamond, 2011).
- Difficulty scheduling multiple individuals for the same appointment may reduce the time couples and families spend in counseling.

### Defining the Word *Couple*

Another irony about working with couples or families is that before you begin, you must define the terms you use to describe your clients. Some professionals advertise marriage or marital therapy; others use *couple counseling* or *couple therapy*.

Our position on using *couple* versus *marital* is based on inclusion. Throughout this chapter, we refer to interviewing and counseling techniques that include two people in a romantic relationship as *couple counseling*. Couple counseling may involve work with unmarried gay and lesbian couples; unmarried heterosexual couples (who never plan to marry); unmarried couples (who are pursuing premarital counseling); couples who have made a life commitment to cohabit; and legally married couples. It also includes couples who are divorced and reconciling. In contrast, *marital therapy* refers specifically to therapy with two people committed to each other through the bonds of matrimony, as defined by laws of the state.

Couple counseling also has been referred to as *relationship therapy* or *relationship enhancement*. However, unless you're using the specific relationship enhancement therapy approach (Guerney, 1977), we recommend avoiding this term because it doesn't distinguish among couple therapy, family therapy, or mediation. Also, two family members (e.g., mother and daughter, father and son) may pursue therapy together to improve their relationship. This is most aptly referred to as *family therapy* because it includes two members of one family who aren't romantically involved.

## Defining Families

The definition of family also can be politically loaded. Nevertheless, most mental health professionals use an inclusive definition and believe families come in all shapes and sizes. Family theorists and therapists differ with regard to whether they will treat subsets of family members when conducting family therapy (Goldenberg, Stanton, & Goldenberg, 2016). In our transient, mobile society, at any given time, the family may be defined and configured differently than it was a week ago or than it will be next week.

Children in coparenting situations often see themselves as having two or more families. Children raised in extended kinship systems, as reflected in many American Indian cultures, may live for periods with grandparents, aunts, uncles, or older siblings (Ho, Rasheed, & Rasheed, 2004). Families may include foster children, elderly relatives, and part-time members. As another example, African American lesbian couples and families may define family as blood relatives, extended kinship networks, lifelong friends who are experienced as siblings, LGBTQ youth, other LGBTQ minority persons, religious leaders, and community members (K. Johnson, personal communication, August 9, 2012). Also, sometimes, people who consider themselves family don't reside together, either by choice or by law;

it's not uncommon to do therapy with a family in which one member is living in a juvenile detention facility, group home, or rehabilitation setting.

Theoretical and practical approaches to interviewing families and conducting family therapy are wide ranging (Murray, Sommers-Flanagan, & Sommers-Flanagan, 2012). This theoretical and practical diversity, along with the complexities noted previously, requires that beginning clinicians have intensive supervision when working with families. Our preference is for family therapy training that includes cotherapy with a supervisor or with a *reflecting team* of colleagues/supervisors outside a one-way mirror (Mitchell, Rhodes, Wallis, & Wilson, 2014).

## Interviewing Stages and Tasks

It's helpful to consider clinical interviewing with couples and families through Shea's (1998) five stages.

### VIDEO 14.2

## The Introduction

The introduction stage consists of preparation and planning, first contact or scheduling, initial meeting and greeting, and client education.

## Preparation and Planning

In all clinical work, your personal beliefs and values will influence your therapeutic approach. This is especially true when working with families and couples. Although you may already appreciate how important it is to develop awareness of your own issues, family-related biases or unresolved issues can have a powerful way of surprising us (Fuenhausen & Cashwell, 2013). In particular, your frame of reference for how things worked in your family (for better or worse) will shape what you consider normal and abnormal in families and couples. This can make it difficult to understand and empathize with families who operate differently (different rules, roles, rituals, values, etc.). The interviewing process can be affected:

- You may not ask important questions because you assume you know the answer.
- You may get flustered when observing behaviors or getting verbal responses outside your expectations of "normal" family functioning.
- You may project your unresolved couple and family issues onto clients.

Before you begin working directly with couples and families, family counselor K. Fuenhausen (personal communication, September 12, 2012) encourages you to (a) cultivate awareness of your ideas about what normal

families look like; (b) question whether normal families and couples exist; and (c) thoroughly explore and reflect on your own family history, patterns, and experiences.

## First Contact I: Scheduling With Couples

When couples refer themselves for professional assistance, one partner is usually more eager than the other to engage in counseling. Ordinarily, but not always, the person who makes the initial telephone call is more motivated than the other party. On occasion, one party will call at the insistence of the other.

**Client:** Hello, my name is Bert Smith. I'm calling to schedule an appointment for marriage counseling.

**Clinician:** Okay; before we schedule the appointment, let me give you information about our services and ask a few questions. (*The clinician informs the client about the agency's fee structure, asks about insurance, asks about best appointment times, etc.*)

**Client:** Yeah, we can come in on Friday afternoons. You know, my wife told me to make this call or forget about our marriage. She thinks we need counseling. So I'd like to get this appointment scheduled right away.

Either way, whether it's the less motivated party or the more motivated party calling, you may hear a little something about the couple relationship dynamics:

I'm calling to make an appointment for marriage counseling. Our marriage is falling apart. I've been trying to get my husband to come to counseling for years. Now, I'm just making an appointment. Either he'll come with me or I'll come by myself.

It's not unusual for the person who makes the phone call to actively solicit sympathy from the clinician; this is an effort at coalition building. *Coalition building* is a common but less-than-optimal (and sometimes pathological) strategy for gaining power (Weeks, Odell, & Methven, 2005). We should note, however, that the desire to build coalitions and find someone who's sympathetic or supportive of your position outside the romantic relationship is perfectly natural.

Often, the clinician's gender or sexual orientation is an important variable; both partners may have strong beliefs that one gender or the other will understand their problems better. Sometimes an opposite-sex cotherapy team can work with couples and families. Although doing cotherapy adds therapist communication challenges to the already complicated mix,

it's usually seen as advantageous, especially in training clinics. Less experienced therapists gladly look to each other for support and direction when unclear about how to proceed. More advanced therapists may regard a cotherapist as a burden; they find that comments from a cotherapist detract from an efficient therapy process. However, if cotherapists are compatible and communicate well with each other, having two perspectives usually offers couples and families more comprehensive services.

Unfortunately for clients, clinicians rarely practice cotherapy in clinic or independent practice settings. There are exceptions, and some theoretical orientations consider two-therapist teams as fundamental (Young-Eisendrath, 1993). Generally, however, having two professionals work jointly with a couple or family is too costly. In some training clinics, the option for either a male or female therapist is presented when couple counseling has been requested:

**Clinician:** Sometimes, people coming for couple counseling prefer to see a male or a female therapist. Do you have a preference?

**Client:** Actually, she never said whether she wants to work with a lady or a man. I think she'd rather work with a lady counselor, but I'd rather talk to a man about this. You better schedule us with a man.

In this case, the husband is hoping for a gender-based coalition. He's thinking that a male clinician will see things from his perspective. As usual, we recommend that clinicians make mental notes of first impressions from the outset of their telephone contact, including whether the client who telephoned was trying hard to gain sympathy or support. It's not always possible to provide couples with their preferences, but it's always important to note them.

Gay or lesbian couples may also ask about the therapist's skills and/or attitudes. It's important to answer such questions honestly. You may or may not wish to share your own sexual orientation, but you should indicate your openness and experience in working with gay or lesbian couples.

## Meeting and Greeting Couples

Clinicians should be careful to greet couples with relatively equal warmth. Couples will watch for subtle signs that you favor one client over the other. Avoid even the appearance of a coalition; equal treatment is the order of the day.

Potential coalition building makes chit-chatting with couples in the waiting room a delicate task, requiring thought and observation. If you talk about the weather, one partner may take offense because it's a

problem behavior in the relationship. If you talk about how it was to locate the office, the couple may plunge into a conflict regarding who “took the wrong turn” when navigating to your office. When meeting and greeting couples in conflict, virtually anything you say can and will be used against you.

Despite prospective dangers, friendly waiting room small talk remains helpful. Stick with relatively neutral trivia, knowing that even trivia may trigger a reaction. If you shake hands, do so with both parties (if culturally acceptable), and avoid comments that might be interpreted as too personal or as evidence that you identify more with one client than the other.

## First Contact II: Scheduling With Families

Much of the previous advice can be applied to initial family therapy telephone contacts. The primary difference is that unless you work in a family therapy clinic, it's unusual for a family member to call and directly request family counseling.

Theoretical orientation, research evidence, and clinical judgment will help you determine whether family or individual therapy is the treatment of choice. Researchers have reported the following:

- Multisystemic family therapy for adolescent drug abuse and antisocial behavior is highly efficacious (Henderson, Dakof, Greenbaum, & Liddle, 2010; Tighe, Pistrang, Casdagli, Baruch, & Butler, 2012).
- Family therapies are helpful for improving schizophrenia treatment outcomes (Weisman de Mamani, Weintraub, Gurak, & Maura, 2014).
- Functional family therapy appears efficacious for behavioral problems and juvenile offending (Sexton & Turner, 2011).
- Family therapy is promising for reducing health care costs and for families with children who have health problems (Crane & Christenson, 2014).

When someone calls to request help with a situation that's a good fit for family therapy, it's advisable to arrange a time when all family members can attend an initial interview. All members may not attend all sessions, but meeting with everyone who lives in the family home is standard procedure when initiating family therapy (Goldenberg et al., 2016). Some family therapists welcome or encourage initial participation by extended family members.

### CASE EXAMPLE 14.1: SCHEDULING A FAMILY

**A sample telephone conversation follows:**

**Clinician:** Ms. Fallon-Tracy? This is Carrie Bolton. I'm a counseling intern at the University Counseling Center, returning your call.

**Ms. F-T:** Yes, I'd like to make an appointment to talk with someone about my husband and daughter. My husband said he might be willing to come, but I wasn't sure what would be best. Do you have openings? Dr. Gupta said your center would be good because we don't have insurance and you have a sliding fee.

**Clinician:** Yes, we have openings. I have several late-afternoon openings right now. It sounds like you want help with family relationships. Is that right?

**Ms. F-T:** Well, I don't know. My husband, Bill, is so upset with our daughter, Kim. She's 15, and she's got a mouth on her, if you know what I mean. And she's been pushing him. He's a quiet guy most of the time. Our son, Wally, is just lost. Maybe I should just bring Kim in, but she says it isn't her fault. She says she won't come if her dad doesn't come too.

**Clinician:** Kids growing up can be hard on everyone. One way I've been trained to help people is through family therapy. It's best if all of you could come in for at least the first few times. Do you have others living at home besides your husband, son, and daughter?

**Ms. F-T:** No. That's it.

**Clinician:** Do you think everyone could come in for an hour and a half next Thursday at four?

There are infinite variations on the themes in this phone call. Parents who call for counseling may not even be aware that family therapy is available.

### Meeting and Greeting Families

As is the case with couples, small talk with families requires consideration. Generally, it's better to find global comments that pertain to the whole family than to single out individuals. Orienting to the youngest family members first is one strategy. If physical surroundings are private, it's best to greet each family member by name before going to the counseling room.

### Couple and Family Education

Couples and families must be educated regarding counseling procedures and the interview plan. It's important to have a well-written informed consent form and to cover confidentiality very carefully, going over the legally mandated reasons you might break confidentiality. Because the potential

for needing to report child abuse is higher in couple or family work, you need to make a special point of carefully informing your clients about the laws and ethical practices in your state, your agency, and your profession. You'll also need to explain your policy with regard to (a) meeting separately with each member of the couple or family, (b) whether you'll take phone calls from one member of the couple or family that might involve discussing couple or family issues, and (c) whether you'll agree to keep secrets, temporarily or on an ongoing basis (see Putting It in Practice 14.1).

#### **PUTTING IT IN PRACTICE 14.1: TO KEEP SECRETS OR NOT TO KEEP SECRETS?**

Imagine a couple named Raphael and Trina. Trina calls for the appointment and tells you that Raphael has been depressed and lethargic. She says he has no sexual interest in her anymore. She thinks it's related to the biology of depression. She also mentions that Raphael's father committed suicide last year. Do you share that you know about all this during the initial session?

What if Trina also tells you she had an affair last year, but she ended it recently? She says she hasn't told Raphael about the affair, and she doesn't think she needs to. What do you tell her about your policy on keeping secrets in couple therapy?

Let's say Raphael calls instead and tells you he's lost sexual interest in Trina because she's gained 30 pounds over the past two years. He says he's developed a pornography addiction and is spending lots of time on the Internet, rather than interacting with his wife. When they attend their first session, do you share this information openly? What if Trina had called and described the same situation (that she had gained 30 pounds and suspected her husband was addicted to pornography)? Would you be more or less inclined to share the information during the first session?

Determining and maintaining confidentiality boundaries with couples is complex. Should you have a policy that you always repeat everything the caller tells you to the other party? (If so, you must make this policy clear *before* the caller starts telling you anything.) Alternatively, do you *selectively remember* what the first caller said . . . or do you bring it all up later . . . and if you don't bring it up, what message does that give the first caller about secret-keeping and a possible coalition?

Before you take couple therapy calls, get clear on your policy. We know therapists in our community who not only refuse to keep secrets but also directly ask the caller if there is an affair happening. If the caller indicates there's an affair, these therapists refuse to start therapy until the "love triangle" has been discussed and terminated.

Laura Brown, PhD, a psychologist in Seattle, includes the following statement in her informed consent:

*(Continued)*

The next is not a legal exception to your confidentiality. However, it is a policy you should be aware of if you are in *couples therapy* with me.

If you and your partner decide to have some individual sessions as part of the couples therapy, what you say in those individual sessions will be considered to be a part of the couples therapy, and can and probably will be discussed in our joint sessions. *Do not tell me anything you wish kept secret from your partner.* I will remind you of this policy before beginning such individual sessions. (Retrieved from <http://www.drlaurabrown.com/media/PsychotherapyConsentForm.pdf>)

Clarity about secrets is essential in couple and family therapy. According to the International Association for Marriage and Family Counseling ethics code, if you don't state otherwise, your client may assume that you *will* keep secrets:

Couple and family counselors should inform clients that they do not maintain family secrets, collude with some family members against others, or otherwise contribute to dysfunctional family system dynamics. (Hendricks, Bradley, Southern, Oliver, & Birdsall, 2011, p. 219)

### **Limit-Setting With Couples and Families**

Couples and families sometimes have impulsive and destructive styles and don't seem able to control themselves during therapy. In such cases, you may need to set therapeutic limits on couples and families. The rationale for this includes the following: (a) limits can prevent the couple or family from engaging in damaging behavior in session; (b) applying reasoned and thoughtful limits models how to stop destructive exchanges; (c) there's a chance that gentle and well-reasoned external limits can be internalized; and (d) heightened conflict can distract clients and keep them from focusing on underlying issues—limits help refocus the therapy.

Part of your preparation for working with couples and family involves being able to set and enforce limits when needed. (See Putting It in Practice 14.2 to explore this exciting interviewing dimension.) Another part of your preparation involves allowing couples or families to behave in less-than-optimal ways in your office. (We'll get to this in the discussion of the body of the interview.)

### PUTTING IT IN PRACTICE 14.2: TWO LIMIT-SETTING SCENARIOS

#### Imagine the following:

*Scenario 1:* Antonio and Lucy have been married four years. They arrive at the intake interview session with their eight-month-old baby girl in tow. Although she's quiet the first 10 minutes, she eventually begins wailing and screeching in a way that makes it impossible to continue talking. Discuss the following questions with your class, discussion group, or supervisor:

1. Should you politely end the session and reschedule another appointment?
2. Would you be able to gently ask the parents to leave their child with a babysitter next time?
3. How would you respond if, despite your gentle reminder, the parents showed up at the next appointment with their daughter, stating, "We tried to get a babysitter, but couldn't get one for today"?
4. Do you think working while the eight-month-old screams could have assessment and therapy value?

*Scenario 2:* The Johnsons were referred by youth court for family therapy. The family includes Margie Johnson, mother of twins Rick and Roy Johnson, and Calvin, Margie's live-in boyfriend. Margie is 37, and the twins are 15. Calvin has lived with Margie and the twins the past three years. His daughter, Mollie, lives with them on weekends. The boys' father is in prison for a violent offense and hasn't seen the boys since they were infants. During the initial visit, Margie, Roy, Rick, and Calvin are all present. The twins begin having a burping contest. Margie gets the giggles. Calvin sits, arms folded, looking hostile. The counselor waits until things settle down and then asks another question. Roy and Rick burp in response. Margie begins laughing again. No one responds to the question. Discuss the following.

1. What's your initial reaction to the scene? Do you wish you could call youth court and send back the referral? Do you imagine laughing along with Margie or sitting stone silent, like Calvin? Do you imagine feeling intimidated or disgusted or hopeless or something else?
2. Can you think of ways to get some cooperative interactions going?
3. What are your reactions to the idea of burping along with the boys?
4. For whom do you have the deepest empathy? How could you use this empathy therapeutically?

**VIDEO  
14.3**

## The Opening

The opening stage consists of alliance building, the clinician's opening statement, initial observations and structuring, and maintaining balance.

### Alliance Building

One important pantheoretical principle with couples and families is to engage in alliance building. Having more than one client makes this process complex, but skillful couple and family therapists are able to build alliances quickly and efficiently.

From the perspective of attachment theory, the alliance in couple counseling is formulated as the therapist's being a secure base toward which both partners feel trust and connection (S. Johnson, 2004). From a family systems perspective, alliance building is usually referred to as joining. *Joining* happens as therapists make efforts to fit in with the family, express empathy for individuals and the family system, and display affective resonance (Murray et al., 2012).

Alliance building also occurs as therapists maintain balance and obtain information from all parties about why they're seeking counseling. Although it's unrealistic to expect perfectly equal participation, systematically asking each partner or family member about treatment goals is standard practice and facilitates the therapist-couple or therapist-family alliance.

### The Clinician's Opening Statement in Couple Counseling

A generic interview opening includes at least two components:

1. Instructions on what to expect (your plan or goals)
2. A question or prompt to get the couple talking about why they've come to counseling and about their counseling goals

You might start like this:

I have several goals for today. First, I'll tell you a little bit about how I work with couples. Then I want to hear from each of you about what brings you to counseling. Either of you can start. After that, I'd like for you to take 10 minutes or so to discuss a current problem together with me listening. After that, I'll ask you questions to gather more background information. Then we'll talk more about what to focus on and how we'll work together.

Observing how couples respond to your opening statement is part of the assessment process. Who speaks next, how that's decided, and the verbal

and nonverbal interactions that take place provide excellent information. Some couple counselors also use questionnaires to collect data either before or after the session.

## Initial Observations and Structuring Sessions With Couples

As each member of the couple describes conflicts, troubles, and history, you may need to be more or less active and directive. If one partner is angry or agitated, more structure and limit-setting is necessary. If both partners are calm and polite, then you can let them talk more and structure the session less—at least in the beginning. Even when couples initially present with a calm demeanor, when conflict buttons get pushed, interpersonal fireworks can ensue.

Couples often begin discussing problems and conflicts directly with the clinician, sometimes as if the other person isn't even present in the room. Clinicians who use a communication-skills model encourage couples to discuss their problems directly with one another, at least intermittently, in front of the clinician. For example:

Sara and Linda, this may seem strange, but instead of directing comments and questions to me, when speaking about anything that has to do with the two of you, you should look at and talk with each other. Sometimes I'll interrupt and ask you to change your communication patterns, but I can do that best as I watch you communicate together.

Even after this instruction, couples will often keep turning to you, making such statements as:

I just don't know how to tell if she's interested in talking with me. I come home and she says hello, but she doesn't initiate conversation, and so I retreat to the garage.

In a communications model, your intervention would consist of gently directing:

Okay, Linda, turn to Sara and restate what you said, only this time, talk to her directly.

An underlying assumption of this model is that it's more important for Sara and Linda to learn to communicate effectively with each other than it is for them to learn to communicate effectively with you.

In contrast, when working with high-conflict couples who quickly launch into disrespectful and destructive communication, it may be advisable to instruct both partners to communicate through you.

For now, I'd like both of you to talk directly to me and not to each other. Later, as I get more information and we get comfortable, I'll ask you to begin speaking directly to each other to address your concerns.

One main question related to the opening stage is how soon and how much you should facilitate more effective communication interactions. This will usually wait until after you've gathered more assessment information. Your first steps in the opening involve managing interactions, making observations, and maintaining a positive focus (see Case Example 14.2).

### CASE EXAMPLE 14.2: KEEPING A FOCUS ON THE POSITIVE

Behaviorally oriented professionals systematically inquire about desirable and undesirable behaviors that occur in the couple context. They emphasize that when couples engage in frequent mutually rewarding activities or exchanges, they have higher relationship satisfaction (Datillio, 2010). During the opening stage with couples, it's equally important to avoid mutually punishing exchanges:

**Counselor:** I'd like each of you to tell the other what he or she could do to make the relationship more positive for you.

**Yoko:** I'd like him to work harder to hold down a job, stay home more often, and stop criticizing me.

**Brandon:** Are you kidding? This is the same stuff she tells me every day. I don't need to come to therapy to hear this!

This interaction carries the same mutually punishing quality that already exists in Yoko and Brandon's relationship (Christensen, McGinn, & Williams, 2009). Instead of asking each partner what the *other* person could do to make the relationship better, clinicians should ask both parties what they're willing to do *themselves* to make the relationship better:

**Counselor:** Brandon, would you begin by saying what you're willing to do to improve your relationship with Yoko? Just say what you're willing to do, and don't say anything you want or expect from Yoko.

**Brandon:** Okay. I'm willing to spend more time with her if she would just get off my case about my job.

**Counselor:** Oops. Remember, Brandon, just focus on what you're willing to do—completely on your own—regardless of whether Yoko gets on your case or not. We'll get to that later. For now, just focus *only* on what you're willing to do.

**Brandon:** Okay. I'm willing to go out with her more often and to plan a weekend away from the kids.

It's naturally difficult for couples to resist commenting on their partner's aversive behaviors. Of course, commenting on a partner's aversive behavior is just another form of aversive behavior. From a behavioral perspective, a major goal of the body stage is to help couples avoid mutually punishing exchanges.

## Maintaining Balance With Couples

Maintaining equilibrium is a universal aim when interviewing couples (Gurman et al., 2015). This begins in the opening stage and moves through the body and continues throughout couple therapy. In the end, no matter what theoretical orientation you embrace, you'll want both partners to conclude that you were balanced and fair in your interactions with them.

This brings up the question: What exactly should you be balancing during the opening and throughout the interview? At minimum, you should give each partner roughly equal attention and eye contact. You should engage verbally with each and make sure you are checking in with both as things move along. Especially during the opening, you should equalize your attention to clients as you engage in your primary assessment and intervention tasks (J. S. Gottman & Gottman, 2015; S. Johnson, 2004). Although these tasks vary depending on theoretical orientation, common assessment and intervention activities include the following:

1. Obtaining a romantic history
2. Tracking back and forth as clients describe positive and/or negative interaction patterns
3. Expressing empathy for both partners
4. Reframing partner motives, behavioral exchanges, or emotional bids in ways that speak to positive relationship or attachment needs—and not as criticisms of each other
5. Facilitating effective communication
6. Providing psychoeducation

Each of these targets for balancing your assessment and intervention with couples is described in more detail within the context of the body stage of the interview.

## The Family Clinician's Opening Statement

After getting everyone settled, you might consider a statement similar to this:

We'll be together today for 50 minutes. My first goals are to get to know you better and to get an idea of what's been going on and what brought you here. I hope you all feel comfortable talking. How about we start with Mario and then go around the room. Mario, what are a couple things you like best about your family?

Focusing first on family strengths is often recommended across theoretical perspectives because starting with problem descriptions can feel too intense too soon. If young children are included in a family intake, clinicians might begin with a drawing activity in which everyone draws a picture of their version of the family. To minimize adult resistance, you might introduce this activity as an initial method for getting everyone's perspective, to be followed by specific assessment questions.

Satir (1967) described a classic approach to opening a family interview:

In the first interview, the therapist starts out by asking questions to establish what the family wants and expects from treatment. He [or she] asks each person present, though not necessarily in these words:

“How did you happen to come here?”

“What do you expect will happen?”

“What do you hope to accomplish here?” (p. 109)

The main goal is to get everyone in the family to answer basic questions about family functioning, expectations, and hopes. As in interviews with children and parents, letting children go first so that they can engage in spontaneous disclosure instead of reacting to whatever their parents say is often recommended.

## Initial Observations and Structuring Sessions With Families

From opening to termination, your powers of observation must be on high alert. The family is your client. It's a complex organism, always communicating simultaneously with you and among its members. The potential number of “messages” at any given moment is staggering to consider and daunting to manage. However, observing and managing communication are at the heart of most family therapy approaches (see Case Example 14.3).

### CASE EXAMPLE 14.3: FATHER-DAUGHTER DYNAMICS

The mother of two daughters called to make a counseling appointment for her younger daughter, Alissa (age 14). Alissa had bizarre ideas that were making her husband and her wonder if Alissa was crazy. She reported that Alissa was afraid of crowds, heard voices as she fell asleep at night, was overly attached to her boyfriend, and was skipping school and underachieving, even though she was plenty smart. The older daughter no longer lived in the home. The counselor asked both parents to attend the initial interview with their daughter to determine whether family or individual therapy would be a better fit.

At the session, the parents talked openly about their professional lives, their religious convictions, and their pride in their daughters. Alissa was verbally active and displayed a quick sense of humor, which she interjected frequently. The parents weren't overly blaming and expressed concern for her well-being. The counselor was impressed with the family's sophisticated vocabulary and open communications and began wondering what could be troubling this nice, normal family. Then, out of the corner of her eye, she noticed that the daughter had slipped off her shoe and was stroking the top of her father's shoe, under his chair, with her bare foot. The father was ignoring this action, and the daughter did nothing to call attention to it either.

This isn't ordinary father-daughter behavior in an initial counseling session. It alerted the counselor that there was more going on here than was apparent on the surface. Although it would have been a mistake to draw attention to the foot stroking until a stronger alliance was established and she had more assessment information, her observations led her to investigate other boundary issues more thoroughly. She also determined that she needed to meet with members individually and perhaps in dyads to fully understand the family coalitions.

## Maintaining Balance With Families

A common situation in family work is the *identified patient* phenomenon (Goldenberg et al., 2016). The identified patient is the family member who is *the one who everyone thinks has the problem*. Instead of uncritically accepting that one family member is the problem, clinicians who use family systems approaches focus on how family dynamics might be creating problems in the identified patient and allowing everyone else off the hook for their own dysfunctional behaviors. In the opening minutes of an initial interview, one issue to address—if it arises—is the potential scapegoating or overfocus on one family member.

**James (father):** The reason we're here is because Rachel is completely out of control. (*Rachel rolls her eyes in response.*) She's breaking curfew. She's constantly disrespectful. She's skipping school. And I think she's smoking way too much pot.

**Therapist:** Thanks, James. That's good information. But since this is our first session, rather than focusing in on Rachel, I'd like to start with everyone sharing one thing that you think you're doing to contribute to your family in a positive way and one thing you each think you can do better to help your family in a positive way.

In this exchange, the therapist acknowledges the father's complaint, but immediately shifts to an assessment process designed to deflect the focus away from Rachel (the identified patient) and toward positive and problem behaviors of other family members.

**VIDEO  
14.4**

## The Body

The body flows from the opening and is where deeper and lengthier assessment and interventions occur. Your theoretical orientation will determine much of how you approach the body stage.

### Theoretical Orientations With Couples

There are many different approaches to working with couples. In the latest edition of the *Clinical Handbook of Couple Therapy* (Gurman et al., 2015), these approaches were organized into five broad categories:

1. *Behavioral*: including cognitive-behavioral couple therapy and integrative behavioral couple therapy
2. *Emotion centered*: including emotionally focused couple therapy (EFCT) and Gottman couple therapy
3. *Psychodynamic and multigenerational*: including the integrative problem-centered metaframeworks approach, functional analytic couple therapy, object relations couple therapy, and Bowen family systems couple coaching
4. *Social constructionist*: including narrative couple therapy and solution-focused couple therapy
5. *Systemic*: including brief strategic couple therapy and structural couple therapy

In addition to these five broad approaches, there are several other theory-based couple therapies (e.g., Adlerian and Jungian) and therapies specifically oriented toward improved sexual functioning and/or specific populations, such as religious groups (Mormons, Catholics, Muslims, etc.); the military; and gay, lesbian, and bisexual couples (Englar-Carlson & Carlson, 2012; O'Brien, 2012; Poelzl, 2011; Rutter, 2012).

The following content and process issues addressed in the body stage are derived from the most popular couple counseling approaches (i.e., behavioral, EFCT, and the Gottman approach).

## Obtaining a Romantic History

Couples often enter their first session ready to do battle. From a behavioral perspective, it's important to counter this expectation and instead facilitate exchanges that involve pleasant and positively reinforcing interactions. Obtaining the romantic history is one strategy that can produce positive memories and positive interactions.

The *romantic history* involves asking both partners how they met, what they found attractive about one another, positive dating experiences, and other factors associated with their decision to couple, cohabit, or marry. Common questions include:

When and how did you two first meet?

When did you notice first feeling attracted to \_\_\_\_\_?

What exactly did you find attractive about \_\_\_\_\_?

What did he/she do that you found attractive?

Tell me about a special date and time you had together where you felt especially close.

Although these questions usually stimulate positive responses, they can also trigger negative reactions. One partner might say, "I was attracted to her because she was extroverted and engaging. But now I hate that about her." Also, when couples reflect on good times, they may feel sadness for the loss of those good times. Regardless of these potential negative reactions, the romantic history can provide insights into what behaviors could help rekindle positive feelings in both partners.

## Tracking Clients as They Describe Positive and/or Negative Interaction Patterns

All couples engage in repeating interaction patterns. Some of these patterns are more positive, others more negative. From a solution-focused perspective, couple counselors should prompt couples to articulate, discuss, reproduce, and elaborate on their positive interaction patterns. This is good general advice, but most couples will also express a desire to talk about what's not going well.

Mental health professionals who work with couples or families range in their willingness to tolerate open conflict, profanity, and raised voices.

Some seasoned professionals believe it's useful (for assessment purposes) to observe couples and families acting out their conflict styles (J. S. Gottman & Gottman, 2015). Here's a rationale for watching and listening as couples engage in their usual conflict pattern.

Following some words of transition, I ask them if they would be willing to discuss a problem for 10 minutes. Any problem will do. I explain to them that I know it will be difficult to talk in front of me like they do at home, but to please try anyway. I won't be intervening, so I can see at this point how they do on their own. . . . Witnessing their discussion will help me to discern where they need help and what interventions might work best for them. (J. S. Gottman & Gottman, 2015, p. 43)

During an open problem discussion, one partner or both are likely to try to pull you into the conflict. Using the Gottmans' approach, you would sit back "like a fly on the wall and quietly watch" (p. 43). However, if you're working with high-conflict couples, it may be advisable to warn couples that you might step in to call time-out if the discussion gets too heated.

If either of you gets too far off track or upset, I'll ask for a time out. My reason for this is that research shows once your heart-rate gets too high, it's nearly impossible to manage conflict. Also, if one person dominates the session, then we don't get to hear both sides. It will be hard sometimes, but we're going to work together on positive and balanced ways to solve your conflicts . . . and that means I'll sometimes cut one or both of you off.

Whether you watch like a fly on the wall or apply more structure as couples discuss a conflict, tracking negative interaction patterns is crucial to assessment and treatment planning. Susan Johnson (2004, 2008), the primary developer of EFCT, uses attachment theory to understand the meaning underlying repetitive negative interaction patterns. Overall, negative patterns can be thought of as a repeating dance to old, maladaptive music. When the music starts, insecurity, ambivalence, withdrawal, and other relationship emotions and behaviors follow.

A common negative interaction pattern involves one partner attacking or criticizing and the other fleeing or withdrawing in response. Historically this pattern was attributed to gender-based differences in intimacy and autonomy needs (i.e., women, from Venus, seeking emotional intimacy and pursuing connection while their male partners, from Mars, withdraw

into their needs for autonomy). These broad gender-based descriptions are nearly always overgeneralizations. We recommend examining couples' repeated negative interactions from a more nuanced and individualized perspective, as in EFCT.

Clinicians who adhere to the EFCT model view couples as inadvertently pushing one another's underlying attachment insecurity buttons. The arguments or conflicts that happen represent only the surface: the tip of the proverbial iceberg. The ensuing angst, panic, insecurity, and distress are natural signals of threatened relationship bonds. Susan Johnson (2008) provides an apt description of how the content of the conflict is irrelevant:

Eventually the *what* of any fight won't matter at all. When couples reach this point, their entire relationship becomes marked by resentment, caution, and distance. They will see every difference, every disagreement, through a negative filter. They will listen to idle words and hear a threat. They will see an ambiguous action and assume the worst. They will be consumed by catastrophic fears and doubts, be constantly on guard and defensive. Even if they want to come close, they can't. (p. 33)

In EFCT, the therapist collaboratively and empathically tracks couples' negative interaction patterns and uses the clients' language to help them become more aware of the power of the cycle, instead of blaming each other (see Case Example 14.4).

## Expressing Empathy for Both Partners

In a published interview, Susan Johnson stated:

We try to help couples interact and get a handle on the negative interaction patterns that are constantly creating insecurity in both of them and keeping all of these negative emotions going. (Quoted in M. A. Young, 2008, p. 267)

Johnson's statement describes how couples often consistently trigger each other's insecure attachment issues, but it also fits as a rationale for why you should provide empathic comments equally toward both partners. This is because you need them to experience a secure attachment with you. If your empathic balance gets one-sided, the other partner may experience an insecure attachment toward you (see Case Example 14.4).

## Reframing Partner Motives, Behavioral Exchanges, or Emotional Bids

By the time couples reach you for an intake, it's likely they've become rather adept at the blame game. This is why relationship partners will show great insights into each other's maladaptive behaviors, but little awareness or responsibility for their own relational shortcomings. To address this problem, most clinicians specifically inform couples that they're not doing therapy on either individual, but instead are working on a third entity in the room: the relationship.

When tracking negative interaction patterns, you may feel a pull to blame one partner or the other. Instead, it's advisable to reframe the problem as emanating from positive relationship or attachment needs—and not because either partner is unlovable, unloving, or otherwise defective. Examples of how clinicians who work with couples conceptualize negative interaction patterns include the following:

- The problem is happening because underlying partner needs aren't being adequately articulated and therefore are not addressed.
- The problem is happening because underlying partner motives are being misunderstood.
- The problem is happening because negative behavior exchanges are elevating one or both of the partners' heart rates and consequently decreasing their ability to logically work on a problem together.

In an elegant conceptualization that couples easily understand, John Gottman articulated the importance of "emotional bids" to relationship satisfaction and stability (J. M. Gottman & DeClaire, 2001). He emphasized that loving partners offer up emotional bids to each other and, if the relationship is healthy, they receive and respond empathically to each other's emotional needs. For example, Betty might state:

I spent all day Saturday cleaning the garage while he was on the Internet. And then, when I came in and told Barney I was finished, instead of supporting me, he just said, "Boy, you sure took a long time cleaning our tiny garage."

In this situation, Betty offered a bid for emotional support and connection, and Barney missed it. Watching for missed emotional bids can help you see opportunities to facilitate emotional connection. A brief example of how a clinician provides empathic balance while assessing a negative interaction pattern and reframing client problems in a blame-free manner is in Case Example 14.4.

### CASE EXAMPLE 14.4: AN EMOTIONALLY FOCUSED COUPLE THERAPY (EFCT) OPENING

In this excerpt from Johnson et al. (2005, pp. 107–108), the therapist is tracking the clients' perceptions of their problem. Despite the clients' vastly different perspectives, you'll notice how the therapist (a) solicits information from each partner about his or her experience, (b) balances empathic listening, and (c) reframes the problems around relational needs for connection and space (aka intimacy and autonomy):

**Inez:** Look at this morning for example. We were getting ready to come here to see you. He's throwing things round the kitchen and yelling at the dog—he kicked her actually.

**Fernando:** And you come along and attack me!

**Inez:** I didn't. I just asked what's wrong. Maxie hadn't done anything wrong and you kicked her.

**Fernando:** I didn't kick her, I pushed her out of the way with my foot. I was worried we'd be late for our appointment.

**Therapist:** Sounds like you get a bit worried and tense. Is that it, Fernando?

*Reflecting the "worry" (tracking Fernando's emotional experience).*

**Fernando:** Yes, I get anxious inside, and then she's in my face, you know. She wants to know exactly what's going on.

**Therapist:** And what's that like for you?

*Goal here is to understand his experience and get a sense of the cycle.*

**Fernando:** I just want her to back off. Back off!

**Therapist:** You want her to give you some space?

*Reflecting; mild reframe.*

**Fernando:** Yes.

**Therapist:** So what happens then?

**Inez:** He snaps at me. (Inez looks sad; she looks down at her fingers)

**Therapist:** That's hard for you, eh Inez?

*Empathic reflection.*

**Inez:** (tightens her mouth) It's always been that way. I just do my thing. I should be used to it by now.

**Therapist:** So you kind of suck it up, is that right?

*Tracking cycle.*

For more on this and other EFCT cases, see *The Practice of Emotionally Focused Couple Therapy: Creating Connection* (S. Johnson, 2004).

## Providing Psychoeducation With Couples

Ineffective communication is a common characteristic among couples who seek therapy. Although you probably won't implement communication interventions during a first interview, you might start providing psychoeducation about communication. In particular, research from John Gottman's Love Lab at the University of Washington can be useful (J. M. Gottman, 2015).

J. S. Gottman and Gottman (2015) noted that effective couple counseling includes helping clients shift from old destructive conflict-escalation behaviors to constructive communication skills, linked with gentle and effective conflict management. The following information can help couples:

1. *Avoid criticism.* Criticism is one of what Gottman refers to as the four horsemen. The others are defensiveness, contempt, and stonewalling. When these behaviors occur in couples, there's a higher likelihood of divorce.
2. *When addressing conflict, use soft start-ups.* Hard start-ups emphasize criticism and blaming: "You always forget our anniversary." Soft start-ups emphasize behavior, emotions, and I-statements. "I feel hurt when you forget our anniversary. I'd like to feel more important."
3. *Express affection and the desire for closeness.* Just because there's a conflict happening doesn't mean there can't be simultaneous loving statements like "I'm saying this because I love you."
4. *When heart rate increases, reasoning and logic are impaired.* Taking a time-out when couples get emotionally or physically agitated is recommended. Couples shouldn't expect a productive discussion when heart rate is too high.

Psychoeducation for couples provides useful information to stimulate behavior change and can help couples shift from unrealistic to realistic expectations.

## Other Core Content Areas With Couples

There are many additional content areas that should be a focus of assessment in couple counseling, such as sex, money, in-laws, parenting, relationship commitment or security, and family-of-origin dynamics.

Each of these content areas can trigger strong emotions in couples (and clinicians too!). For example, it might be difficult, especially at first, for you to ask questions about sexual functioning. This is why it's important to practice talking about these topics in classes, with your classmates and colleagues, and with supervisors. This is one of our favorite homework

assignments for students who want to work with couples: “During the next week, spend several hours loudly discussing the details of your sex life with your partner [or friend] while out at a crowded local restaurant.”

After giving this assignment (and watching for the looks of horror on our students’ faces), we follow with: “Okay, if you don’t want to talk about sex loudly at a restaurant, how about talking quietly, in a private and confidential setting.” We’re convinced that students, mental health professionals, and couples benefit from becoming comfortable talking about sex and sexuality, as well as the other topics we mentioned (see Multicultural Highlight 14.1 to stretch your interviewing comfort zone).

#### **MULTICULTURAL HIGHLIGHT 14.1: WHAT’S NORMAL, WHAT’S NOT: EXPANDING YOUR COMFORT ZONE WITH DIVERSE SEXUAL VALUES AND BEHAVIORS**

This activity isn’t intended to change your sexual values or behaviors but rather to expand your comfort zone so that you can work effectively with clients whose sexual values and behaviors are different from yours. To engage in this activity, just read the following examples and reflect on your personal reactions and/or discuss your reactions with classmates. The following two examples are excerpts from professional journal articles.

This first example is a technical description of an issue that can and sometimes should be explored when interviewing gay males who are experiencing sexual dysfunction. This is an excerpt from the journal *Sexual and Relationship Therapy* (Rutter, 2012):

An important set of questions to include in clinical sexology intake interviews and assessments would be potential use of recreational or illicit psychoactive substances. [In a study] . . . of gay men who were seropositive [there was] a high comorbidity with erectile dysfunction, ejaculatory incompetence and potential desire decline. . . . The confusing element here is that MDMA use, in the moment, can actually cause sexual stimulation and feelings of attractiveness. It is the actual “mechanics” that suffer once physically engaged with a partner, i.e., erection may be partial or absent, ejaculate minimal or absent. (p. 37)

One question, among many, to think about in response to the preceding excerpt is, “How do you feel about asking gay males about the quality of their erections?”

This next excerpt is from the *Journal of Bisexuality*. It focuses on the use of sexual surrogates to explore and develop comfort with individual sexuality. The author of the article is an experienced sexual surrogate (Poelzl, 2011):

When Sally began working with me, she was desperate to clarify her sexual identity and find a way to meet and relate to women who would return her feelings fully. She had mixed feelings all the way around. She was attracted to men, but not her husband, and it was clear

(Continued)

that they needed to divorce. She knew she was attracted to women emotionally and sexually, and she often lubricated profusely when she spent time with Alice: There was often affectionate touch involved, primarily hugging and holding hands during their intimate emotional exchanges. She tended to prefer more feminine women ("soccer moms," she called them, who were often straight) and had avoided venturing into the lesbian community because she was terrified of butch, "manly" women. She also never thought about women's genitals as particularly sexually interesting. It was the face-to-face and eye contact that she craved. (p. 386)

What kinds of questions might you have if Sally were your client? Is bisexual behavior more confusing to consider than gay or lesbian sexuality?

Two final questions for reflection: What sexual scenarios have you experienced or heard about that might be outside your comfort zone as a therapist? How might you deal with these issues if they come up in a clinical interview?

## Theoretical Orientations With Families

There are also many different approaches to working with families. Distilling information from several family therapy texts (Capuzzi & Stauffer, 2015; Gehart, 2014; Goldenberg et al., 2016) yielded the following noncomprehensive list:

- Psychoanalytic and intergenerational family therapies
- Systemic and strategic therapies
- Structural family therapy
- Experiential humanistic family therapies
- Behavioral and cognitive-behavioral family therapies
- Solution-focused family therapies
- Collaborative and narrative family therapies
- Research-based approaches (e.g., multisystemic family therapy and functional family therapy)

Most family therapy theorists and therapists broadly employ a systems or ecological perspective (Bronfenbrenner, 2005; Murray et al., 2012). These perspectives emphasize that the family system, neighborhood, and other social systems drive human behavior and create wellness and dysfunction. Individual troubles are viewed as a signal about something amiss in the family environment.

As we've mentioned throughout this chapter, your theoretical model will influence how you approach family interviews. Although there are limits in describing a generic family interview approach, the following assessment approaches, domains, and interventions constitute the main activities likely to occur within the body of an initial family interview.

## Genograms

Couple and family clinicians often use genograms as tools for understanding multigenerational family dynamics. There are slight variations in the construction guidelines, but knowing how to do a basic genogram is essential (McGoldrick, Gerson, & Petry, 2008). The counselor may not actually do a genogram with the family present, but may accumulate the data necessary to complete one. Adlerian counselors refer to genograms as *family constellations* and use them to explore family history, legacies, birth order, and other family-of-origin dynamics that may influence the current couple or family relationship (Englar-Carlson & Carlson, 2012; Robey & Carlson, 2011).

## Gathering Family Therapy Goals

When gathering information, many family therapists maintain balance by systematically orienting toward each family member. For example, Lankton, Lankton, and Matthews (1991) stated: "We always ask each member what he or she would like to have changed in the family and how, and even if members contradict each other, each input becomes the basis of a goal" (p. 241). To avoid blame and scapegoating, it may be wise to remind everyone that it's easier to accomplish goals that focus on changing oneself or on changing a family situation. Although tempting, establishing goals that require someone else to change tends to be problematic (see Case Example 14.5).

### CASE EXAMPLE 14.5: YOUR GOAL SHOULD BE WITHIN YOUR CONTROL

During an initial session, Cassandra, a 15-year-old White female, is complaining about her parents' overcontrolling style. The clinician is trying, with limited success, to get Cassandra to focus on what she can control and not on changing her parents.

**Cassandra:** I want my parents to get off my case. They constantly criticize me. They hate my friends. They don't trust me. If they would just lay off, everything would be better.

**Therapist:** So you're saying you want your parents to lay off. That's like a goal for you.

**Cassandra:** That's right.

(Continued)

**Therapist:** Cassandra, it's good that you're clear about what you think will help. But it's difficult to make other people change. We could work really hard in here, but your parents still might not lay off, because we can't make them change. They're in charge of that. Let's shift the focus. Instead of saying what you want from your parents, tell me, what could you do that you think is trustworthy behavior?

**Cassandra:** Start acting like a kiss-ass all the time.

**Therapist:** That's one option. I think that's what you think they want. But what do you want, Cassandra? What would be a change that you would feel good about . . . and that might, at the same time, build back some trust? Because since we can't control whether or not your parents trust you, we need to ask, "What does Cassandra think is good and reasonable and trustworthy behavior?"

Even when goals have been established during the opening stage, family members may revisit them, and their wish to control the behavior of other family members may emerge more clearly. Over time, the family therapist will begin engaging all family members in a conversation about control and begin helping the family engage in healthy negotiations.

A key to gathering goals in family therapy is to emphasize inclusion and minimize constant references to the identified patient. In the case of Cassandra (Case Example 14.5), the focus needs to shift from back-and-forth blaming to a constructive dialogue about change. During that process, it's crucial to explore the strengths and weaknesses of all family members and use that information in the service of constructive family change (V. Thomas, 2005).

## Willingness to Make Changes

A close corollary to relationship commitment in couple interviewing is each person's willingness to do homework, try new things, experiment with change, and try out new perspectives. Besides asking directly, a good way to assess this area is to have each member try a new behavior or listening skill during the interview. This can be as simple as saying:

- Fred, I wonder if you could take Wilma's hand for a minute and just let her cry.
- Mom, it seems like you and Malia are sitting closer than anyone else. Let's have Malia sit by her brother while Dad moves over here and we talk further.
- Dad, would you please stand up and move behind Mom and stand behind her as a show of support?

When giving family (or couple) homework, it's useful to ask each person when, where, and how the homework will get completed. Without specifics, it's easier for everyone to ignore or forget about the homework.

### Kids, Parents, Neighbors, Friends

Often, couples and families are the core of a circle of wider relationships, all of which contribute to one another's well-being or struggles. Getting an idea of the interpersonal and role demands operating on the couple or family system is important. Grandparents, children and their friends, stepchildren, in-laws, close friends, and other associates can play influential roles in the happiness or unhappiness of couples and families and can contribute to, or deplete, many relationship resources. Considering the rich and interactive ways in which outside factors influence couples and families is a core concept of the ecological approach to therapy (Bronfenbrenner, 1976, 1986, 2005).

LGBTQ individuals and couples generally are exposed to higher cultural stressors than cisgender family members who fit more easily into the dominant culture. Herek (2007) used the term *sexual stigma* to describe how dominant cultural beliefs belittle, discredit, and invalidate LGBTQ identities as deviant from heterosexuality. This stigma can also be institutionalized; for example, some public, private, and governmental institutions directly and indirectly stigmatize and marginalize LGBTQ people. Consistent with Herek's ideas about the invalidating nature of LGBTQ sexual stigma, researchers have reported higher rates of mental disorders among LGBTQ individuals in states with laws that restrict LGBTQ legal benefits (Hatzenbuehler, Keyes, & Hasin, 2009; Heck, Flentje, & Cochran, 2013).

As a consequence, clinicians who work with sexual minority couples should be aware of how parents, neighbors, friends, and the dominant culture can increase or decrease their clients' distress and dysfunction. Moving sexual minority couples into settings that are affirming can decrease their stress and improve their functioning.

### Drugs, Alcohol, and Physical Violence

Gathering information about drugs, alcohol, and violence is essential. For some clients it may be easier to check a drug/alcohol/violence item on your intake form than it is to bring it up in a session; this is one reason why practitioners may use an intake form including these items. When you ask families questions about drugs, alcohol, and violence, it's not unusual to get an "Everything's fine" response, at least until trust has been established. However, asking about these issues, either in writing or verbally, communicates

to clients that you're interested in hearing about trouble in these and all areas.

When questionnaires or intake forms are used to inquire about sensitive issues, clinicians should review the forms thoroughly and discuss significant issues with the couple or family. It should be made clear to couples and families that any issues mentioned on questionnaires or intake forms are *not confidential* in the family or couple system and, therefore, may be discussed during the interview.

**VIDEO  
14.5**

## Closing and Termination

Time passes quickly when you have more than one client in the room. This adds to the usual challenge of keeping time boundaries. If new issues are raised toward the end, unless it's a crisis, it's appropriate to set limits and close the session:

Rosa, I'm glad you brought up changing your curfew. Unfortunately, we're out of time today. Next week if you'll bring up the curfew issue, we can discuss it sooner, when we have time to talk it through.

Couple and family interviews can involve intense emotional material. Allowing time to "put things back together" conveys respect for both your clients' emotional state and your time boundaries.

You can't be responsible for making each person feel better about the situation, nor is it ethical to minimize the problems so that everyone leaves feeling artificially hopeful. However, you can support and compliment everyone's efforts in coming for help. It's also in your power to provide structure that gives everyone a chance to regain composure, and to offer direction and hope to the family.

As with all closings, summarizing is important. S. Johnson (2004) described the positive focus of a summary from an EFCT perspective:

The summary at the end of the first sessions always includes a description of the struggles they have already engaged in and won, even if the only apparent one of this kind is that they have decided to come for help. By the end of the first session, the therapist is also creating an alliance where he or she is an accepted partner in the creation of a more loving relationship. (p. 129)

A sensitive and positive summary helps couples and families know they've been heard; it also helps clients make the transition to leaving your office. Here's an example:

We covered lots of ground today. You all deserve an award for dealing with Grandma's death directly and courageously. But even though you've faced her loss, it's still hard to move on, and grief is still affecting you. Some of the things that might be connected include Delvin's recent legal trouble, Ginny's decision to move in with her boyfriend next month, Dad being more angry than usual, and Mom feeling torn 50 different ways. I know I haven't covered everything we talked about, but it seems like our first steps are for you to reconnect and talk together in here. What are your reactions to the idea of working together as a family for the next five weeks, and then we can reevaluate how things are going?

Homework assignments are another closing tool. This might involve communication time, journaling, charting behaviors, going on dates, reading, listening to instructional tapes, sensate focus, or other couple and family activities.

When closing with multiple people, it can be helpful to acknowledge how their lives will continue in new and interesting ways after the session. You may develop a short statement, the essence of which communicates "Things will be different at home." Here's an example:

Being in counseling together, with me here to guide, ask questions, and even boss people around, is different from when you're together at home. We've talked about areas that are troubling. I'm sure you'll continue talking about them at home, but I hope you remember the guidelines we've used today. If you're talking at home and get stuck, remember, you can bring it in here next week. It's okay if everything doesn't get solved at once.

Having more than one client in the room makes everything take longer. If you don't have an office manager, you'll want extra time for scheduling the next appointment. It's awkward and unprofessional to run out of time and leave people unsure about the next meeting.

Parting comments should be brief, reassuring, and upbeat.

I'm glad you all came in. I respect you for participating. Counseling can be hard, but I think we can work together to make your family life more positive.

## Special Considerations

The following discussion focuses on situations and issues that are unique to interviewing and ongoing work with couples and families.

VIDEO  
14.6

## Identifying, Managing, and Modifying Conflict

Couples or families who come for help are frequently experiencing serious relationship conflicts and often lack conflict management skills. Clinicians must identify, manage, and sometimes modify how couples and families are addressing conflict. Some couples and families will be conflict avoidant and others will fight with each other with dizzying speed and intimidating intensity.

### ***Conflict Process and Content***

Top conflict areas among couples include money, sex, and in-laws. Of course, there are many other potential conflict areas, including division of labor, child rearing, violence, and recreational and religious pursuits and preferences (Sperry, Carlson, & Peluso, 2006). Families, too, arrive in counseling with a variety of conflicts. Shared duties, chores, children's independence, discipline, delinquency, and drug or alcohol use are common family issues in counseling.

For cultural minority couples and families, conflicts often involve child rearing, coparenting and parental rights, competition for attention between biological child and partner, relationship invisibility, religious beliefs, coming out, role identification, and how to handle stress and stigma (K. Johnson, personal communication, August 10, 2012). Although it's good to be aware of conflict-laden areas for specific cultural groups, it's also important to recognize that there will be similarities and unique differences in what each couple and family argues about.

*Conflict content* refers to *what* is argued about. *Conflict process* refers to *how* everyone argues. This is an important distinction; during the first session, clinicians help couples and families identify both *what* they're arguing about and *how* they're arguing with one another.

Many couples and families who come to therapy have significant skill deficits in communication and conflict management. They're having problems with the *how* of conflict. This is to be expected, as most humans haven't had opportunities to learn effective ways to communicate and handle conflict well.

### ***How Do You Feel About Conflict?***

Conflict content and process are always present during family or couple interviews. Both are important. Further, it's likely that you may have personal reactions to *what* families and couples argue about and *how* they argue.

Not everyone enjoys open conflict. Some people are conflict avoiders, and others are conflict seekers (Wilmot & Hocker, 2013). This is true about

counselors as well as clients. If you find yourself tending toward conflict avoidance, you may not be well suited to being a couple or family counselor. Generally, before you enter the couple and family counseling field, it's advisable to explore your reactions to interpersonal conflict and what conflict issues push your buttons (see Putting It in Practice 14.3).

#### **PUTTING IT IN PRACTICE 14.3: EXPLORING YOUR CONFLICT BUTTONS**

To explore how you might respond to couple and family conflict scenarios, reflect on the following questions:

1. Do you have specific conflict topics that push your emotional buttons? How about money, sex, and in-laws? How about interpersonal violence? Do you have strong feelings about corporal punishment or parents who are checked out and not providing discipline?
2. What biases do you have about how couples should behave in their marriage or partnership? What romantic relationship wounds have you suffered? Do you think the two might be connected?
3. Do you carry conflict home? Working with families and couples can be emotionally charged. The conflicts you witness and manage can be draining.
4. When you were growing up, what conflict issues and process styles characterized your family? Did your parents or caretakers avoid conflict? Did they engage in frightening conflicts? Did they handle conflict gracefully?

Exploring all these questions will help you understand your conflict buttons.

### **How Much Should You Let People Argue and Fight During Sessions?**

As you might guess, our answer to this question is: not much. Usually families and couples come to counseling partly because their joint conflict management skills are dysfunctional. If you allow them to engage in open conflict without intervening, they'll recapitulate their dysfunctional conflict patterns. It's your responsibility, among other things, to disrupt these patterns and help people establish new, different, and more adaptive conflict management patterns.

The only reasonable rationale for allowing couples or families to engage in their usual dysfunctional conflict patterns is to gather assessment information. J. S. Gottman and Gottman (2015) articulated how useful it is to see couples display their conflict management skills in session. However,

conflicts that emerge during an interview can quickly become destructive. If you plan to allow couples and families to engage in destructive conflict patterns, be ready to use limit-setting skills as needed.

Some theoretical orientations emphasize that unresolved family-of-origin issues drive couple conflict (Luquet, 2006). While managing conflict, it's also wise to note both content and process with this intergenerational view in mind.

Conflict can escalate quickly. Abusive or highly conflicted couples and families often have so much emotional energy and baggage that their conflicts erupt in powerful outbursts (Horwitz, Santiago, Pearson, & LaRussa-Trott, 2009). We've had clients refuse to speak for the remainder of a session, try to hit or kick each other in the counseling office, and abruptly leave sessions amid a flurry of profanity. The potential emotional explosiveness of couple and family interviews requires that clinicians maintain control throughout the session. With more disturbed couples or family systems, greater structure and control are needed.

### **Shifting From Individual to Couple or Family Therapy**

Throughout this chapter, we've emphasized that clinicians should treat all couple and family members equally and that relationship partners and family members may try to build coalitions with clinicians to attain greater power or control. For these reasons, it's recommended that you avoid the ubiquitous temptation to shift from seeing an individual to seeing the same individual within a couple or family system. We also advise against simultaneous individual and couple or family work with the same counselor. Our practice rules are as follows:

- Once an individual client, always an individual client. Generally, we won't do individual counseling with someone and then start couple or family work that involves that person. Instead, we offer a referral.
- After couple or family counseling has ended, on some occasions, we might consider working in individual therapy with one family member. However, when doing so, we make it clear: Once we start individual therapy, we won't return to couple or family therapy.

For a number of reasons, many therapists don't abide by these suggestions; consider the following scenarios:

- An individual client says to the therapist, "Because we've already been working together, I trust you. I don't want to start over and see someone different for marriage therapy. My husband says he doesn't mind."

- A teenage boy and his therapist mutually conclude that family therapy is needed. The boy states, “I refuse to go to therapy with anyone else but you! There’s no way I’m seeing a different shrink!”
- Clients may believe that a particular therapist is the best choice because he or she is already well versed in the couple’s or family’s therapy issues. It feels safe to stay with the same professional.

You may have noticed that we referred to the potential shift from individual to couple or family therapy as the “ubiquitous temptation.” From a therapist’s perspective, it’s nearly always tempting to continue counseling when there has been some success with a client, or when a client expresses a preference to continue counseling with you, or when there’s potential financial gain from continuing counseling. As you reflect on our views regarding this issue, keep in mind that we’re expressing our professional opinion and bias—some clinicians disagree with this cautious perspective (Hecker, 2010).

### ***Conflicts of Loyalty***

Perhaps the greatest reason to avoid shifting from individual to couple or family therapy is that conflicts of loyalty inevitably ensue. Unless you make great efforts to build trust and rapport with the original client’s romantic partner or family, the new parties are likely to believe that you hold a deeper loyalty to the original client—and their perception may be accurate. Alternatively, if you side with the new client, the original client may feel betrayed and abandoned. This could leave you stuck in a no-win therapy bind: both or all clients quickly suspect you’ve already “sided” with the original client or have switched allegiances. Such dynamics add unnecessarily to an already difficult task.

### ***You’re (Almost Always) Not the Only (Competent) Therapist in Town***

An excuse often offered for simultaneously doing individual, couple, and family work with the same people is that the people involved insist on it. Underlying their preference is their belief that you’ve done excellent work. This is flattering, but crossing relational boundaries can undo the good work you did in the first place. Avoiding dual or multiple roles, an ethical guideline present in all mental health professional ethics codes, includes avoiding being someone’s family therapist and individual therapist if being in both roles compromises your objectivity (R. Sommers-Flanagan, 2012).

Catering to the clients' idea that you're the best or only option isn't necessarily healthy. Helping clients attain more flexible functioning in the world and increasing their capacities for relationships are goals that undergird most therapies. Encouraging an individual to try a different therapist can be an important vote of confidence. It communicates that you believe the client can connect with another professional and use that therapeutic relationship to grow and change. It's rarely justified to allow or encourage client dependence on you. Obviously, in some rural settings, managing (or juggling) multiple therapy relationships in one family may be necessary. You may not be the only *competent* therapist in town; you may be the *only* therapist in town.

**VIDEO  
14.7**

## Diversity Issues

Working with gay and lesbian couples or with couples and families from different cultural backgrounds can present unique challenges (Bigner & Wetchler, 2012). When you and your clients have clear and unmistakable differences, clients may initially scrutinize you more closely than if there was cultural similarity. These circumstances call for sensitivity, tact, and a discussion of the obvious. Imagine the following:

You're a White, heterosexual, Christian male. You have a new appointment at 3 p.m. with Sandy Davis and Latisha Johnson for couple counseling. When you get to the waiting room, you see two African American females sitting together. You introduce yourself, and on the short walk back to your office, you mentally process the situation and come to several conclusions: (a) you're about to meet with an African American lesbian couple; (b) you've never done therapy with this particular cultural minority group; (c) you're aware of your uncertainty, and your concerns about your lack of knowledge make you uncomfortable, but you also recognize that you want the couple to be comfortable with you and realize they may be feeling similar discomfort about you; (d) you're clear that it's your ethical mandate to provide services to the best of your ability; and (e) although you don't feel competent to work with this couple, you realize they may have limited options. How do you proceed?

Here is a brief list of how a clinician might specifically handle this situation. Following this list, we provide a description of the underlying principles.

- Welcome the couple to your office with the warmth and engagement you offer all clients (e.g., "I'm glad you could come to the clinic today for your appointment and am happy to meet you").

- Explain confidentiality and the limits of confidentiality. Also review relevant agency policies that you routinely review with new clients.
- If you know the purpose of their visit (e.g., couple counseling) because of the registration form, explain how you usually work with couples.
- Let the couple know you'd like them to ask any questions of you they may have, but before they ask the questions, explain:

My usual approach with couples is primarily based on work with heterosexual couples. I don't have experience working with African American lesbian couples. I'd like to work with you as long as you're comfortable working with me and it seems like the work is helpful. I know there aren't lots of couple counseling options available. What I propose—if it's okay with the two of you—is that we start working together today. I'll ask you about your goals for counseling, but also about your interests, values, spirituality, and other things that will help me know you better as individuals and as a couple. Toward the end of our session, I'll ask you for feedback about how our session went, and I'll try to honor that feedback and make adjustments so we can work well together. If, for whatever reason, you want a different therapist, I'll try my best to offer you a good referral. What do you think of that plan?

The multicultural competencies include awareness (e.g., knowing your biases and limitations); knowledge (e.g., gathering information pertaining to specific cultural groups); skills (e.g., applying culturally specific interventions in a culturally sensitive manner); and advocacy (actively working to support the needs of minority clients). In addition to these competencies, the preceding case illustrates the need for clinicians to explicitly address cultural differences using the following strategies:

- Cultural universality (treating culturally different clients with the same respect you offer to culturally similar clients)
- Collaboration (working with the clients to understand the particulars of their culture and situation)
- Feedback and monitoring (soliciting ongoing feedback to monitor client perceptions of how the interview is proceeding and making adjustments based on that feedback)

No clinician can be expected to have awareness, knowledge, and skills for working with every possible diverse client. That being the case, if you also rely on cultural universality, collaboration, and feedback to help strengthen the therapeutic alliance, you'll increase the likelihood that therapy will proceed in an ethical manner.

## Identification, Projection, Joining, and Avoiding

Countertransference reactions with couples and families can involve over-identification with certain conflicts, projection of your own emotions or issues onto family members, and unconscious avoidance of material you don't want to think or talk about. It can also involve attraction to one client in a couple (or family) or aversion toward another. You can imagine how these dynamics might affect a clinical interview.

Adding to the complexity is the fact that effective assessment and therapy are enhanced by your life experiences. Even if it were possible to exclude your personal family and relationship issues from your work (including your unconscious processes and conflicts), it would be inadvisable. Common experiences form part of the foundation of any relationship and assist us in understanding other people's experiences.

Working with couples and families usually involves connecting in a way that's more intense than individual work. Your presence in the system alters the system, and your views are altered by having joined the system. Cultural differences compound the challenge of joining with couples and families. Keeping a professional perspective in the midst of all this isn't easy. Sometimes, counselors "overjoin" and lose perspective completely. Other times, they avoid joining at all, staying clinical and aloof. This is safer, but less informative and less therapeutic.

Joining with couples and families increases the likelihood of tripping on your own unresolved family, relationship, and cultural baggage. A big problem with unconscious unresolved issues that might affect your work is—they're unconscious! The following list may help you glimpse areas that may be active conflicts for you.

- Do you have any biases about clients from diverse cultural or ethnic backgrounds? For example, some counselors have difficulty accepting patriarchal or macho styles associated with some Hispanic, Middle Eastern, or religious couples.
- Does your cultural orientation inhibit your ability to work with some family dynamics? For example, Crow and Navajo cultures often teach that the son-in-law and mother-in-law shouldn't speak. Other cultures may be uncomfortable with men who directly express their sadness or grief through tears. Can you accept diverse cultural ways of being?
- Do you have biases against LGBTQ people and their intimate and sexual behaviors? If so, talk directly to a trustworthy supervisor about how to deal with these biases.

Feel free to add to this list. And, more important, feel free to grow and stretch your awareness, knowledge, and skills to the point where you feel

more comfortable and competent embracing the exciting world of couple and family counseling.

## Summary

Working with couples and families includes unique challenges. Generally, as the number of clients increases, so does the complexity of your interviewing task. Two interesting ironies add to the challenge: the need to work with more people with less time, and controversies in defining couples and families.

During the introduction and opening stages of interviewing couples and families, therapists must clarify confidentiality, identify who will attend sessions, and provide a detailed informed consent. Offering couple and family education about therapy and about healthy relationships is important. The therapist's opening statement helps further orient clients and establishes norms about the inclusion of everyone's voice. Maintaining balance is of particular importance during the opening stage.

Theoretical orientation strongly influences the content and process of the interview's body stage. Across theories, clinicians often obtain romantic histories and track clients as they engage in their usual approach to problem solving. Showing empathy for all parties, reframing partner motives, and providing additional psychoeducation are common. Creating genograms, setting family goals, and attending to many interactive variables within and outside the office are typical in family interviews.

During the closing and termination stages, a sensitive and positive summary helps couples and families know they've been heard. It also helps clients make the transition to leaving your office. Time boundaries are especially difficult to manage when there are more clients in your office. Maintaining balance, looking toward the future, and assigning homework are important tasks associated with these stages.

This chapter includes a discussion of several special considerations. Because conflict is common during couple and family sessions, clinicians should think about how conflict affects them and how they'd like to manage conflict. This may involve limit-setting. Although clinicians hold different perspectives on the issue, we discourage shifting from individual to couple or family therapy and back again.

Couples and families can have a powerful impact on therapists. This is especially true regarding diverse couples and families. It's possible to over-identify, excessively join or withdraw, and project your issues and values on clients. Because no clinician can be expected to have awareness, knowledge, and skills for working with every possible diverse client, relying on

principles of cultural universality, collaboration, and feedback is recommended to strengthen the therapeutic alliance.

## Suggested Readings and Resources

Couple and family interviews are challenging. The following resources can help you prepare to meet that challenge.

- American Association for Marriage and Family Therapy. (2012). *AAMFT code of ethics*. Washington, DC: Author. This is the code of ethics for members of the American Association of Marriage and Family Therapy. Go to [http://www.aamft.org/imis15/content/legal\\_ethics/code\\_of\\_ethics.aspx](http://www.aamft.org/imis15/content/legal_ethics/code_of_ethics.aspx).
- Bigner, J., & Wetchler, J. L. (Eds.). (2012). *Handbook of LGBT-affirmative couple and family therapy*. New York, NY: Routledge. This is an edited work that emphasizes the importance of using an affirmative stance when working with a vast array of sexual minority groups. This includes couples who change genders, transgender youth, LGBT parents, and more.
- Gottman, J. M., & DeClaire, J. (2001). *The relationship cure: A five-step guide for building better connections with family, friends, and lovers*. New York, NY: Crown. Gottman is the premier marriage researcher and writer in the United States. His books are based on his vast research and knowledge of marriage and family functioning.
- Gurman, A. S., Lebow, J. L., & Snyder, D. K. (2015). *Clinical handbook of couple therapy* (4th ed.). New York, NY: Guilford Press. This text offers broad coverage of many couple therapy interventions and theoretical perspectives. It also includes material on divorce, multicultural couple therapy, and how to work with couples who struggle with various medical or psychiatric problems.
- Hecker, L. (Ed.) (2010). *Ethical issues in couple and family therapy*. New York, NY: Routledge. This book offers an excellent overview of the many sticky ethical issues that can arise in couple and family therapy.
- Helm, K. M., & Carlson, J. (Eds.). (2013). *Love, intimacy, and the African American couple*. New York, NY: Routledge. This edited volume provides specific information about African American norms and values within couple relationships and is essential reading for practitioners who consistently work with African American couples.
- Ho, M. K., Rasheed, J. M., & Rasheed, M. N. (2004). *Family therapy with ethnic minorities* (2nd ed.). Thousand Oaks, CA: Sage. This text offers guidance for how to provide family therapy services to major ethnic minority groups, such as First Nations peoples, Latina(o)s, Asian Americans, and African Americans.
- Johnson, S. M. (2004). *The practice of emotionally focused couple therapy*. New York, NY: Brunner-Routledge. This book describes emotionally focused couple therapy, an empirically supported approach to working with couples. It

combines research evidence with practical advice on how to apply this approach to couples work.

Johnson, S. M. (2008). *Hold me tight: Seven conversations for a lifetime of love*. New York, NY: Little, Brown. In this very popular book about the emotionally focused model, Sue Johnson writes directly to couples to guide them through conversations that will help them maintain their loving relationships into the future.

Odell, M., & Campbell, C. E. (1998). *The practical practice of marriage and family therapy: Things my training supervisor never told me*. New York, NY: Haworth. In contrast to more theoretical and sterile approaches to writing about and teaching marriage and family therapy, this book has a strong practical and clinical focus. For example, chapters include "It Ain't Like the University Clinic" and "So What Do I Do After the Intake?" This practical approach is usually appreciated by beginning students who've had enough of reading and discussing theory.



## ELECTRONIC AND TELEPHONIC INTERVIEWING

### Chapter Orientation

Chances are that as a graduate student in this cyber-infused century, you've had significant opportunities to learn, teach, play, shop, and date online. The online community is active, vibrant, and immense. By the time you read this, approximately one billion people will be daily Facebook users, including over 50% of the North American population (<http://www.internetworkstats.com/facebook.htm>).

This chapter covers background, examples, and recommendations for clinical interviewing when the client isn't sitting in the room with you. These situations begin with asynchronous written correspondence (e.g., letter writing), but also include telephone interviews, videoconferencing, text-only synchronous messaging, and virtual environments designed to allow social and professional interactions using avatars. The permutations are overwhelming, so we limit our focus to two dimensions of online and non-FtF clinical interactions:

1. Clinical interviewing as an assessment procedure
2. Clinical interviewing as a procedure for developing a therapeutic alliance and initiating counseling or psychotherapy

### LEARNING OBJECTIVES

After reading this chapter, you will be able to:

- Describe how technology has become an extension of the self and ways in which face-to-face (FtF) is the same as or different from non-FtF clinical interviewing
- Identify distinct non-FtF communication modalities
- Discuss research findings on the therapy alliance and treatment outcomes in telephone and online therapy
- Identify ethical and practical problems and solutions related to non-FtF interviews
- Describe how to prepare for and apply basic clinical interviewing skills in non-FtF interviews
- Describe the challenge and importance of retaining multicultural sensitivity when working in non-FtF domains

**VIDEO  
15.1**

## Technology as an Extension of the Self

People meet and fall in love on the Internet. Why would a therapeutic relationship not also be possible?

—James R. Alleman, “Online Counseling,” in *Psychotherapy: Theory, Research, Practice, Training*, 2002, p. 20

The amount of time spent texting and talking on cell phones continues to increase every year. For many people in the electronic age, face-to-face (FtF) contact has been replaced by non-FtF communication. This shift to non-FtF contact is often not just a new norm but also a preference (Havas, de Nooijer, Crutzen, & Feron, 2011).

Non-FtF approaches aren’t new to counseling and psychotherapy, but the addition of modern technology has added an interesting twist (Harris & Robinson-Kurpius, 2014). Publications focusing on electronic and social media are growing as mental health professionals leap across the digital divide. In some cases, this leap is an ethical response to client needs; in other cases, the proliferation of online mental health treatments is less ethical and more entrepreneurial (Yuen, Goetter, Herbert, & Forman, 2012). The question of how to appropriately use or integrate this rapidly developing dimension of the human community into professional practice is on the minds of many helping professionals.

As online instruction expanded, teachers venturing into this realm had to learn new instructional skills to effectively deliver the educational content. Chalkboards were no longer adequate. As online and telephone-based clinical mental health work has become an alternative or adjunct to FtF work, professionals also have made adjustments (Epstein & Klinkenberg, 2001). Therapists have learned new technical skills, considered new ethical concerns, and adjusted their clinical approaches. It seems almost unnecessary to say this, but human communication cannot be separated from the constraints and benefits of the method or means of expression, connection, delivery, and reception. Words on a screen are experienced differently than words spoken on a cell phone or during video chat; and, of course, all are different from words shared in person. However, each of these communication methods adheres to many of the same human communication rules and dimensions as FtF interactions.

### What’s the Same and What’s Different?

At the heart of ethical and effective clinical interviewing is a professional relationship built on interpersonal communication. The various technological options now available for communicating are simply fancy tools to reach

and serve more people in more ways. It's still a professional human being on one end, and a person or set of people in need of services on the other.

The basic attending, listening, and action skills outlined and described in Chapters 4 through 6 are still the foundation for interviewer behavior—regardless of whether interviewer responses are delivered via voice or text. Another way of saying this is that a paraphrase is a paraphrase is a paraphrase. The purpose and function of a paraphrase, a feeling validation, or other interviewer responses remain consistent across various human communication delivery systems.

This is true even though the way in which a feeling validation is expressed may be different. For example, with text-based mediums, emoticons are a handy method for reflecting and validating feelings.

When I read your words on the screen, I could feel some of the sadness you feel at the loss of your romantic relationship ☺.

Of course, many responses to client feelings or emotions can be expressed without sound and without visual contact. This means that when addressing client emotions, a competent online clinical interviewer could use a range of different responses, such as:

- “U seem angry.” (nondirective reflection of feeling)
- “Your words have anger in them.” (nondirective reflection of feeling)
- “Tho I’m not totally sure, there seems to be anger or resentment under what ur saying.” (interpretive feeling reflection)
- “Ur words say one thing ☺, but I can’t help but think there’s something else going on for u too ☺.” (interpretive feeling reflection)
- “When I imagine myself in your shoes, I feel angry.” (feeling validation)
- An emoticon all by itself might have a feeling reflection purpose and function, but it also might convey a message of feeling validation
- “When I read ur words, I feel sad.” (This is a self-disclosure with an interpretive reflection of feeling quality designed to lead the client to get more in touch with sad feelings that haven’t yet been acknowledged.)

With the exceptions of telephonic and video-based communication, a major difference is that interviewers don’t have visual or auditory access to nonverbal feedback. This can be problematic on many levels. As discussed in Chapter 4, a large portion of human communication is nonverbal. The inability to use nonverbal communication to express empathy, for example, places a greater burden on interviewers to do so using text.

When it comes to basic attending and listening skills, the lack of nonverbal cues can affect both interviewer and client. As you recall, basic

attending skills include (a) eye contact, (b) body language, (c) vocal qualities, and (d) verbal tracking (Ivey & Ivey, 1999). Traditionally, demonstrating that you're listening has been viewed as essential in the counseling relationship; not demonstrating adequate or culturally appropriate listening skills can adversely affect counseling process and outcome. However, in the text-only interviewing and counseling domain, eye contact, body language, and vocal qualities have zero impact on the clinical encounter.

The elimination of nonverbal and visual contact between interviewer and client places far more emphasis on language. An interesting consequence of this is that recipients of online interviewing and counseling services often report increased relief, comfort, and control as a result of not having FtF visual and verbal contact. Just as the businessperson who stays at home and participates in a voice-only conference call can choose to remain in pajamas all day, clients engaging in online counseling can avoid in-person human contact and all the tedious social requirements associated with such contact. For some, having an alternative form of human contact feels good and alleviates significant interpersonal anxiety. However, it should also be noted that many online counselors make a point of dressing professionally for appointments as a means of shifting into a more professional persona (K. Goodrich, personal communication, September 15, 2012).

Therapeutic silence is another traditional interviewer response that's handled differently in the absence of visual contact. Without accompanying nonverbal cues, silence can more easily be misinterpreted. Anyone who has experienced dead sound during a telephone conversation can testify to the capacity for humans to project thoughts, feelings, and behaviors onto a blank screen. Similarly, when silence or a lapse in communication occurs online, it could be that the client has decided to take a bathroom break or is sipping coffee and thoughtfully reflecting on what to say next or has gotten angry and left the room. Because it's natural to wonder what might be going on when the other party goes quiet, if interviewers plan to wait for further input or not respond, it should be communicated explicitly. Typing a message like the following can be helpful:

I'm just waiting and looking forward to hearing what u have to say  
next. No pressure, tho.

This leads us to another difference between FtF and online communication. In FtF interviewing, time is set aside for the contact and measured in minutes. In the cyberworld, time is stretched and distorted. Many people multitask when talking on their phones or emailing. Text and Facebook messages can be posted anytime, and can be as short or as long as the

sender likes. It may be common for online counseling clients to expect to quickly hear back via text, instant messaging (IM), or email. This may be due to exposure to Internet social media platforms in which the news-feed process is continuous. If commentary isn't made within a few minutes of posting, the post moves into the past and is unlikely to garner much attention. Although this phenomenon might seem akin to a Gestalt therapy "Be here now" process, it also translates into an increased pressure for immediate responsiveness and a diminished likelihood of focusing on a slower, less immediately gratifying response process. One way we think of this is that although electronic messages and messaging may never die, they do quickly fall out of focus within the user's Gestalt figure/ground formation process (J. Sommers-Flanagan & Sommers-Flanagan, 2012).

To adapt to immediacy expectations and volume issues, online or text-only interviewers need to explicitly communicate their policy and typical response time to prospective clients. It may be important to frame interviewer responses as coming at a distinct pace and volume so that users can anticipate and perhaps add significance and meaning to interviewer or counselor communication. Professional online counselors can benefit from framing their communications to foster positive anticipation.

## Definition of Terms and Communication Modalities

VIDEO  
15.2

There are many non-FtF clinical interviewing strategies and venues. In this section, we define key terms that are crucial to our later discussion of how traditional clinical interviewing responses and strategies can be employed in non-FtF venues.

### Text-Only Asynchronous Communication

This communication modality involves written communication. A key factor in asynchronous communication is that participants send or post messages at different times; immediacy is lacking. Examples include letter writing, email, and listserv communications. Like all asynchronous communication, text-based communications may be either interactive or unidirectional (one person writes and the other reads).

Therapeutic letter writing has been an informal treatment modality since the development of written language. Most of us intuitively understand the therapeutic potential associated with receiving a handwritten letter. Words placed on paper and intentionally sent to another person carry substantial interpersonal significance and can create strong intellectual and emotional responses. Many people save letters for decades and even centuries.

In terms of modern psychotherapy and historical precedence, Sigmund Freud used letter writing as his main therapy strategy in the famous case of Little Hans (Freud, 1909). He used text-only asynchronous communication with Little Hans's father while delivering his case formulation and treatment. More recently, narrative therapists have advocated therapeutic letter writing. Specifically, White (1995) speculated that one letter may be the equivalent of four or five Ftf therapy sessions. We've used a trimmed-down version of this approach (note passing) in Ftf work with children and adolescents (J. Sommers-Flanagan & Sommers-Flanagan, 2007b).

### Voice-Only Asynchronous Communication

This communication modality involves vocal recordings passed back and forth from one party to the other. Again, this doesn't allow for spontaneous or immediate interaction. Examples include audio-recorded self-help tapes, CDs, and podcasts. These communications also may be either unidirectional (one person listens) or interactive.

Interviewers might choose to use a voice-only asynchronous communication to initiate an assessment or intervention. For example, instructions for completing an assessment or implementing a cognitive self-monitoring procedure can be delivered via an audio recording or podcast. Similarly, clinicians can offer audio recordings of a relaxation or meditation procedure as interventions. Typically, these assessment and intervention strategies have an educational or cognitive and behavioral theoretical foundation.

### Voice-Only Synchronous Distance Communication

Synchronous voice-only communication allows for spontaneous verbal interaction, but is of course limited to audio only. Many audio-only or telephonic clinical assessments and interventions are available (Bassilios, Harris, Middleton, Gunn, & Pirkis, 2014). Examples include telephone assessments, crisis counseling hotlines, and telephone-delivered psychotherapy (Brenes, Danhauer, Lyles, & Miller, 2014).

Kramer et al. (2009) described advantages and potential limits of using telephonic assessment procedures:

The telephone facilitates access to [clients] who prefer this option, live far from the research center, reside in unsafe environments, or are not available during workday hours. These logistic advantages, however, must be balanced against the possibility that information gathered by telephone may not be comparable to information collected in person.  
(p. 623)

Because telephone assessment and intervention provide increased anonymity and social distance, clients may be more open and honest. Alternatively, FtF contact also can facilitate deeper trust, which could translate into greater client honesty. These potential pros and cons have been discussed for at least seven decades (Wallin, 1949).

## Text-Only Synchronous Communication

In this communication modality, interviewer and client exclusively use text (no audio or visual contact), and although there may be an asynchronous delay, responses also can be immediate and continuous. Examples include IM, online chatting, and live or synchronous text messaging using smartphones.

Text messaging seems especially popular among young technology users (Gibson & Cartwright, 2014). In high school, college, and university settings, students often maintain more or less continuous text contact with friends, family, and others. Texting often goes on during class, during FtF counseling sessions, and (unfortunately) while driving. This form of communication has quickly become the norm in many social groups. Because texting feels natural to young clients, it holds significant potential as a method for reaching this age group for assessment and intervention purposes.

There are also opportunities for text-only communications to expand into the 3-D virtual world using avatars and created environments (e.g., Second Life). The choices of avatar, setting, and other variables move this modality slightly beyond the purely text based, but because the “contact” and visual input are not directly from the counselor or the client, 3-D communications might fit best, for now, in the text-based category.

## Video-Link Synchronous Distance Communication

This communication modality involves interactions using audio and visual representations of interviewer and client in real time. At present, these formats are the closest technological approximations to FtF assessment and intervention, but are still different from FtF. There are a number of important distinctions.

Full audio-video synchronous communication allows interviewers to send and receive nonverbal messages, including eye contact, body posture, vocal quality, and verbal tracking. However, even though interviewer and client can see and hear each other in more or less real time, there are still significant problems with client identity misrepresentation, confidentiality,

and emergency responsiveness (Rummell & Joyce, 2010). We will discuss these issues in greater detail later in this chapter.

\* \* \*

Each of the preceding non-FtF communication formats has a history and some quantity of medical, psychological, mental health, and counseling literature (Epstein & Klinkenberg, 2001; McCoyd & Kerson, 2006; Mitchell, Chen, & Medlin, 2010). Rummell and Joyce (2010) discussed the proliferation of terminology used to reference these different approaches:

There are many different terms that have been used in the literature to describe the specific type of computer-mediated communication that is used in online counseling, for example, e-mail therapy, telepsychiatry, Internet psychotherapy, cyberpsychology, cybertherapy, webcounseling, and computer-mediated psychotherapy. (p. 483)

The following are some additional terms:

- Online counseling (Mallen, Vogel, Rochlen, & Day, 2005)
- Internet-based therapy (Lampe, 2011)
- E-therapy (Rozbroj, Lyons, Pitts, Mitchell, & Christensen, 2014)
- Online therapy (Hanley, 2009)
- Videoconferencing or tele-assessment (Bernard et al., 2009)
- Internet-mediated telemental health (Yuen et al., 2012)

Many of these terms are very specific; others are general. Interestingly, in some cases the terms are more specific than their accompanying definitions. For example, Mallen et al. (2005) use *online counseling*, and, although that term implies use of the Internet, they defined it as

any delivery of mental and behavioral health services, including but not limited to therapy, consultation and psychoeducation, by a licensed practitioner to a client in a non-face-to-face setting through distance communication technologies such as the telephone, asynchronous e-mail, synchronous chat, and videoconferencing. (p. 764)

For our purposes, we lean toward terminology that fits each modality, such as non-FtF assessment and intervention, telephone assessment, and online counseling or Internet-based therapy. Perhaps leaders in the field will eventually come to a clearer consensus about a single preferred terminology. Until then, we're choosing some degree of specificity over generality.

## Non-FtF Assessment and Intervention Research

VIDEO  
15.3

I have connected deeply with you psychologically and emotionally on my computer, yet still remain isolated from you in every physical sense (no vision, no sound, no touch). It is very personal and not personal at all. (Lago, 1996, p. 288)

Non-FtF technology has changed the terrain of what constitutes intimacy. As Hanley (2009) wrote, “Critics challenge online practice because they believe relationships cannot reach sufficient levels of intimacy” (p. 5). However, it’s perfectly clear that for some individuals, Internet relationships are substantially gratifying and sometimes preferred. In the following sections, we explore research on non-FtF clinical assessments, intervention processes, and outcomes.

### The Therapeutic Alliance (Relationship)

The therapeutic alliance is generally considered the strongest predictor of positive counseling and psychotherapy outcomes over which interviewers or therapists can exert direct control (Safran & Kraus, 2014). The alliance is viewed as facilitating not only psychotherapeutic treatment but also the validity and reliability of interview-based assessments. Given the foundational role of the therapeutic alliance, it makes sense to examine what the research says about therapeutic alliances in non-FtF formats.

There is a small but growing research literature evaluating the therapeutic alliance in non-FtF assessment and therapy. In a summary article, Hanley and Reynolds (2009) wrote:

Each of the [five] studies [overall  $n = 161$ ] . . . supports the notion that good therapeutic alliances can be developed online. . . Clients perceived the alliance between them and the counsellor to be moderate or strong in nature. . . Within three out of the four studies that made comparisons to face-to-face equivalents, the online alliance proved higher than the comparison group. Such findings provide persuasive evidence supporting online therapy and challenge theoretical assumptions that relationships of sufficient quality to create therapeutic change cannot be developed online. (p. 8)

These researchers also noted that “a high percentage of the 161 total participants felt the quality of the relationship to be . . . sufficient . . . to create therapeutic change” (p. 9).

In an editorial focusing on Internet-based therapy with trauma patients, Jain (2011) summarized research by Knaevelsrud and Maercker (2006, 2007), stating:

Overall, they found evidence to suggest that a stable and positive online therapeutic relationship can be established via the Internet. Eighty-six percent of the sample described their Internet clinician experience as being personal and 60% reported that they did not miss face-to-face communication. However, this sample consisted largely of young, well-educated women with a range of PTSD symptoms, which limits the generalizability of these results. (p. 544)

More recent research continues to show that non-FtF formats can foster a therapeutic alliance. The following are some research highlights:

- *Telephone- vs. FtF-administered cognitive behavioral therapy for depression.* There were no between-treatment differences in alliance scores between 345 participants randomized into two groups (Stiles-Shields, Kwasny, Cai, & Mohr, 2014).
- *Telephone-based interventions for psychosis support.* In 21 cases, the therapeutic alliance was reported as operating in ways similar to FtF interventions (Mulligan et al., 2014).
- *A naturalistic study of text exchanges on therapy alliance.* The “impact” of text exchanges between 30 clients and 30 different online therapists “was similar to, but in some respects more positive than, previous evaluations of face-to-face therapy” (Reynolds, Stiles, Bailer, & Hughes, 2013, p. 370).
- *Telephonic treatment of hematopoietic stem cell transplant patients.* Therapeutic alliance scores predicted distress and depression outcomes among 46 patients in much the same way as alliance scores predict outcomes in FtF treatments (Applebaum et al., 2012).
- *Online versus in-clinic treatment of anxiety in 12- to 18-year-olds.* There were no differences in youth-rated therapeutic alliance between the 73 clients (total) who were randomly assigned to online versus in-clinic treatments. (*Note:* Their parents reported a stronger working alliance with in-clinic therapists; R. Anderson et al., 2012).

Researchers have also reported limits in the nature and quality of non-FtF therapeutic alliances (Leibert, Archer, Munson, & York, 2006). For example, Hufford, Glueckauf, and Webb (1999) reported that participants in videoconferencing intervention reported a weaker working alliance than an FtF control group. Overall, it appears that the working alliance or

therapeutic relationship in online or non-FtF formats is important to treatment outcomes. In many cases, online, text, and telephonic relationships appear to be as robust and influential as FtF relationships, although more research is needed to clarify this summary statement.

## Treatment Outcomes

Treatment-outcomes research for non-FtF assessment and intervention is limited but growing. Much of the research isn't well controlled, involves small sample sizes, and doesn't include random assignment to treatment and control conditions (Yuen et al., 2012). This is an area that will undoubtedly receive increased examination in the future.

### ***Telephone Assessment***

Historically the telephone has been the primary medium through which distance mental health assessment and treatment have been delivered. Telephone assessment procedures have been used for many years and have the most established research base. The fact that approximately 85% of US adults own a cell phone underlines the potential accessibility to clients that can be established through this communication modality (Zickuhr, 2011).

For the most part, researchers report that telephone assessment procedures are equivalent or nearly equivalent to FtF procedures. In particular, cognitive assessment of adults, especially older adults, via telephone is an accepted practice (Martin-Khan, Wootton, & Gray, 2010; Michel, Schimmelmann, Kupferschmid, Siegwart, & Schultze-Lutter, 2014; Wilson et al., 2010). These assessments include many approaches to evaluating cognitive functioning or mental status, such as self-report and performance-based testing. Wilson et al. concluded that administering cognitive test batteries by telephone is both valid and cost-effective for assessing cognitive functioning. As another example, Martin-Khan et al. showed that the 22-item Mini-Mental Status Examination (MMSE) was simple to administer by phone and correlated well with the FtF administration of the MMSE (see the Appendix for an extended MSE protocol that can be administered FtF, by phone, or online).

Telephonic diagnostic interviewing also has adequate reliability and validity (Senior et al., 2007). For example, in a study of in-person versus telephone diagnosis of social anxiety disorder (SAD), "very high" agreement between the two assessment modalities was reported: "in-person and telephone SAD diagnoses obtained with the SCID [Structured Clinical Interview for DSM–IV] are comparable" (Crippa et al., 2008, p. 244). This is a good example of the utility of non-FtF interviewing for clients whose

anxiety might make them unlikely to visit a professional interviewer in person.

### ***Telephone Interventions***

There is significant research focusing on the utility and effectiveness of telephone therapy for a variety of client problems and situations. The following list is a sampling of this research:

- Treatment of tobacco and nicotine dependence (Swartz, Cowan, Klayman, Welton, & Leonard, 2005)
- Therapy for obsessive-compulsive disorder and other anxiety disorders (Brenes et al., 2014; Turner, Heyman, Futh, & Lovell, 2009)
- Trauma treatment (Hirai & Clum, 2005)
- Therapy for clinical depression (Ransom et al., 2008; Sheldon et al., 2014)
- Interventions for insomnia (Bastien, Morin, Ouellet, Blais, & Bouchard, 2004)
- Interventions for obesity (Befort, Donnelly, Sullivan, Ellerbeck, & Perri, 2010)

In most cases, the effectiveness of these mental health and behavioral interventions via telephone is approximately equivalent to FtF therapy.

### ***Online Counseling and Psychotherapy Outcomes***

Barak, Hen, Boniel-Nissim, and Shapira (2008) published one of the earliest comprehensive reviews of Internet-based psychotherapy outcomes. They evaluated 92 studies that included 9,764 clients who received a wide range of Internet-based counseling and psychotherapy. Overall, based on Cohen's (1977) guidelines for effect size, they concluded that online work is moderately effective. They reported an overall mean-weighted effect size of  $d = 0.53$ . This effect size is slightly lower than those of FtF counseling and psychotherapy, but is within the same general range.

In a subsequent review and reanalysis of Barak et al.'s (2008) data, Hanley and Reynolds (2009) focused more specifically on text-only one-on-one online counseling and psychotherapy. They excluded research focusing on chat rooms and research including more sensory modalities (e.g., audio or video components). They concluded:

Excluding these findings leaves a total of 16 relevant studies for this review and cumulatively involve 614 clients. More specifically, they reflect effect sizes for text-based interventions using e-mail (Effect size = 0.51) and chat (Effect size = 0.53). (p. 7)

More recent research is consistent with previous reviews. For example, in a randomized controlled study comparing the efficacy of FtF versus Internet-based therapy in 75 clients diagnosed with social phobia, both groups reported significant gains in terms of symptom reduction and disability measures (Andrews, Davies, & Titov, 2011). Further, there were no significant differences in efficacy between FtF and Internet-delivered therapy. In another randomized control trial ( $n = 205$ ), it was reported that Internet-based interventions were efficacious for clients with alcohol use problems (Blankers, Koeter, & Schippers, 2011). Blankers et al. summarized their findings:

Results support the effectiveness of cognitive-behavioral therapy/motivational interviewing Internet-based therapy and Internet-based self-help for problematic alcohol users. At 6 months postrandomization, Internet-based therapy led to better results than Internet-based self-help. (p. 330)

The preceding results are just a small sampling of emerging research in the increasingly popular area of Internet-based psychological and behavioral interventions. New studies reporting positive results continue to be published (Herbst et al., 2014). Much more process-oriented research is needed to better understand how specific clinical interviewing strategies and techniques operate in non-FtF contexts.

Nevertheless, overall it's safe to say that whether conducted by telephone, via videoconference, or in text-only formats, non-FtF approaches to clinical assessment and intervention hold promise and potential. Researchers consistently report that a positive therapy alliance can be established and that these procedures are reasonably efficacious and effective. These findings have especially important implications for clients who, whether because of distance, disability, preference, or other factors, might not otherwise seek professional assessment or treatment.

## Ethical and Practical Issues: Problems and Solutions

Practitioners who deliver non-FtF services face many ethical and practical issues. In this section, we review common online or Internet interviewing challenges and offer ideas for potentially addressing or resolving these issues.

**VIDEO  
15.4**

### The Interviewer Doesn't Have Access to Nonverbal Cues

Most mental health professionals are well trained in behavioral observation skills and strategies. However, non-FtF interviewing and counseling

modalities eliminate nonverbal communication cues. Rummell and Joyce (2010) discussed this challenge:

Communicating purely in a text-based or even telephone domain lacks some ingredients that have always been considered important or possibly even essential for doing good psychotherapy. . . Without the visual cues required to identify nonverbal behaviors, the psychotherapist misses out on another dimension of important information about the client. . . In a text-based format . . . whatever the client does not provide in the conversation text, the psychotherapist does not know about. (p. 487)

Non-FtF interviewers must rely on alternative observational or assessment strategies. Even though you might find it tempting to lament the lack of direct auditory or visual observational data, longing for what's missing in this new format can get in the way of taking full advantage of the information and data at your disposal. We take comfort in the fact that history has shown that emotional attachments and meaningful relationships can be established and maintained through letter writing (Moules, 2003; White & Epston, 1990). Furthermore, experienced online clinical interviewers can read between the lines in text-only formats and make interpretive statements similar to those they would make while observing nonverbal behaviors. It's both reasonable and sometimes recommended that telephone or online interviewers directly ask clients to describe their nonverbal experiences:

- If I could see your face right now, what would it tell me?
- Describe what your body might say about what you're feeling about your work with me.

### **There Is Increased Potential for Client Identity Theft or Misrepresentation**

The ability to recognize clients and know who's on the other end of your clinical interview is difficult or impossible when contact is restricted to Internet chat, email, or text-only messaging. You may not know whether you're communicating with your client; with his or her spouse, parent, or child; or even with a stranger.

To address this issue, Rummell and Joyce (2010) suggested formulating a *challenge question* with clients during an initial session. This question (and answer) can be used at the beginning of subsequent sessions to verify client identity. They stated, "If the client does not give the decided-upon answer, the therapist can then be alerted to a possible confidentiality breach" (p. 492).

Of course, if the client chooses to share the answer, the interviewer could still be talking with someone other than the client. Motives for this deception could be specific to the client, the situation, the reasons for the interview, and the counselor-client relationship.

## Mental Health Provider Credentials May Be Absent

Just as it's difficult to ascertain the true identity of a client via the Internet, it can be equally challenging to determine whether an alleged mental health provider is, in fact, a credentialed professional. Unfortunately, many online counseling service providers don't appear to have a professional license or professional training. This is a disturbing reality. Although there's no national policy preventing nonlicensed providers from offering services, it's incumbent upon licensed providers to make verification of their license status available. Rummell and Joyce (2010) recommended providing a website link to enable prospective and ongoing clients to check on licensure status.

Practitioners also should be aware that crossing state lines to offer services to clients (even virtual state lines) can result in legal problems. (See Rummell & Joyce, 2010, for an excellent review on the ethics of online service provision, and Putting It in Practice 15.1 for a summary of our online search for Internet clinical services.)

### PUTTING IT IN PRACTICE 15.1: ONLINE COUNSELING: ETHICS AND REALITY

While reviewing information for this chapter, we perused Internet therapy options available to potential consumers. Previous publications suggested a possible excess of Internet counseling and psychotherapy providers with questionable professional credentials (Heinlen, Welfel, Richmond, & O'Donnell, 2003).

#### The Less Ethical Approach

Many providers offer online services but don't describe their specific credentials (e.g., a license). For example, practitioners with bachelor's degrees (and even some without) made statements similar to the following:

I am a counselor, yoga instructor, and spiritual guide with over 23 years of rich experience. I have studied the fields of education, counseling, psychology, personal growth, relationships, communications, business, computer programming and technology, languages, and spirituality!! In addition to my diverse training, my 18-year relationship with my partner has deepened my capacity to help others with relationship issues.

(Continued)

This sort of enthusiastic introduction was typically followed by equally enthusiastic statements about the breadth of services offered:

My online counseling services specialties include, but are not limited to: problems with guilt, trust issues, anxiety/panic, self-esteem, couples counseling, relationship advice, life and career coaching, emotional intelligence, personal growth, affairs, work and career, abuse/boundary problems, communication skills, conflict resolution and mediation, grief, emotional numbness, spiritual development, stress management, blame, court-ordered counseling, codependency, problem resolution, jealousy, attachment, anger problems, depression, food and body, and developing tranquility in life.

Curiously, we found that the broad range of claims on websites such as these did not move us toward developing any sense of professional tranquility in our lives.

### The More Ethical Approach

There were also websites that listed professional, licensed providers. One website listed and described eight *licensed* practitioners with backgrounds in professional counseling, social work, and psychology. These professionals offered therapy via webcam, text, email, and telephone.

Prices were clearly stated:

- Email therapy: \$25 per online counselor reply
- Unlimited email therapy: \$200 per month
- Chat therapy: \$45 per 50-minute session
- Telephone therapy: \$80 per 50-minute session
- Webcam therapy: \$80 per 50-minute session

Websites for ethical professional Internet services often included information related to theoretical orientation. For example, a “postmodern” approach was described as involving “staying positive . . . focused on the here and now . . . offering solutions that meet your needs . . . a collaborative and respectful environment . . . quick results”

### How to Choose an Internet Services Provider

The National Directory of Online Counselors (NDOC) exists to help consumers choose online providers. According to its website:

We have personally verified the credentials and the websites of each therapist listed in the National Directory of Online Counselors. Feel assured that the therapists listed are state board licensed, have a Master’s Degree or Doctoral Degree in a mental health discipline, and have online counseling experience.

The listed therapists and websites are set up and ready to handle secure communication, and offer various services such as eMail Sessions, Chat Sessions, and Telephone

Sessions. All work conducted by the professional licensed therapists meet[s] strict confidentiality standards overseen by their professional state board. (Retrieved March 6, 2012, from <http://www.etherapyweb.com/>)

Online therapy providers typically emphasize that help is only a click away.

## There Is Increased Potential for Immediate and Explicit Disclosure

Online communication sometimes diminishes inhibition. This is a polite way of saying that email or online exchanges can quickly become ugly. Suler (2004) used the term *toxic disinhibition* to describe online acting out (also sometimes called flaming). *Flaming* typically includes insults, profanity, and other behaviors that can be damaging to both the writer and the target (Lapidot-Lefler & Barak, 2012; Suler, 2004). Text-based flaming behaviors can involve direct and indirect threats to self and others, such as:

- Somebody should make sure that person dies a quick death.
- Maybe I should just kill myself and end my misery.

In nearly every case, these written messages can and should be quickly countered with clarification responses (see Chapter 4):

- When you say that person should die a quick death, it tells me you're angry, but it's also the kind of statement that I take very seriously. Are you planning to hurt this person?
- You wrote that maybe you should just kill yourself. And so now I really need to hear if you're seriously thinking about suicide. Are you saying that you want to or plan to kill yourself?

The preceding clarifications are a good first response because their seriousness and boundary-setting nature can help clients retract their disinhibited homicidal or suicidal statements. When this happens, a focus on the affect behind the threat is important:

Okay. I'm relieved to hear you're not homicidal [or suicidal]. But your statement tells me you're feeling lots of anger [or sadness/hopelessness, etc.] that we should explore together.

Although seeking clarification through direct questioning can pull clients back from their verbal edge, sometimes it doesn't—at which point

you're dealing with an emergency situation from a distance, and that introduces an additional online ethical and practical conundrum.

### **Emergency Response Procedures From a Distance Are Complex and Anxiety Provoking**

Working FtF with clients who are suicidal or homicidal is one of the most stressful situations a clinical interviewer can experience (Kleespies & Richmond, 2009). Part of this stress is related to not being able to exercise control over the client's suicidal or homicidal impulses. However, when you're facing this situation and working from a distance, you may feel greater stress and angst because you have even less direct control and influence. Rummell and Joyce (2010) offer sage advice for proactively dealing with this type of situation:

The client should be aware what behaviors will be construed by the clinician as an emergency (e.g., the client abruptly terminating the chat session, allusions to suicide, or direct threats) and what action will then be taken in the event that any of these behaviors occur. Similarly, clinicians should collect identifying client information, as well as the client's location and contact information, so that they are able to alert an emergency management team or Child Protective Services, if necessary, and direct them to the right place. One could make this a mandatory requirement for engaging in online psychotherapy. (p. 491)

Rummell and Joyce (2010) also recommend that online providers be aware of resources in the client's local community. This reminds us of the inherent two-way risks associated with client emergency situations. Although immediate client risk is always the number-one priority, there's a simultaneous legal and ethical risk to clinicians that further raises anxiety and doubt in these provocative situations. As noted in previous chapters on emergency situations, there's no substitute for having colleagues and supervisors available for both proactive and responsive consultation.

### **There Are Significant Limitations on Confidentiality**

Confidentiality is always limited in videoconferencing, telephone, or online assessment and intervention venues. When it comes to electronic or Internet confidentiality, most professionals immediately think about Internet security, records storage, passwords, firewalls, sockets, and other technological methods for ensuring some measure of data security. Although these are critical issues, there are also practical and imminent confidentiality threats to online or telephonic service provision.

Perhaps the biggest threat to client confidentiality is the potential presence of another person in the room or identity theft of a client by a close (and curious) family member or friend. Imagine the following scenario:

Margaret is getting online therapy for depression. As therapy progresses, it becomes clear that her depressive symptoms are related to a dissatisfying relationship with her romantic partner, Ruben. Not surprisingly, Ruben assumes that he's a common topic during Margaret's online therapy sessions. He can't resist the temptation and eventually contacts the therapist from Margaret's laptop, trying to initiate a discussion about what he (as Margaret) really thinks of Ruben. Perhaps even worse, if Ruben is a controlling sort, he might insist on being present in the room observing (and reading over Margaret's shoulder) the next time she logs on for her online counseling session.

This scenario illustrates the necessity of dealing with confidentiality or data security on two levels. The first level—whether the client is actually present and in an adequately private setting—can be dealt with using a pre-arranged challenge question (Rummell & Joyce, 2010), assuming the client has not been coerced to give it to someone else. If you plan to use this procedure, you should spell it out in your informed consent agreement and in your initial online session. You can also cope with this by always assuming that someone is looking over your client's shoulder as you type. With Skype, Face Time, or other video links, counselors can see the client's face and whatever else the client wishes to have in view. This visual access is limited; it doesn't guarantee privacy, but it does substantially reduce the chances of identity theft or intrusion.

The second level—data security—requires a technological rather than interpersonal solution. Unless you have terrific technology skills yourself, you should consider hiring a consultant to walk you and your computer or electronic hardware and software through a security detail. Establishing data encryption and using secure socket layer (SSL) encryption and/or firewalls require significant technological expertise. We know this partly because one of our experiences with encryption resulted in our not being able to access our own computer!

## **Parental Consent to Work Directly With Minor Clients Can Be Problematic**

Confidentiality and parental consent are challenging issues for clinical interviewers who work with minors. The nature of privilege and confidentiality for minors varies from state to state. In addition, some parents will

want complete access to their minor child's records, whereas others will show little or no interest in events that occur during the clinical hour. If you plan to work with minors online or from a distance, you should include descriptions of your specific privacy, confidentiality, and reporting policies. We recommend convening a telephone meeting or videoconference with parents to ensure that the major players are all on the same page.

### The General Solution: Use Informed Consent

Most of the complex and thorny issues associated with providing professional mental health services online can and should be dealt with using a clear, complete, and collaborative informed consent process (Rummell & Joyce, 2010). To help consumers understand this process, NDOC includes a statement on informed consent.

The therapist is obligated to provide information about treatment protocol, often called "informed consent" which is informative literature on the process of therapy, costs, confidentiality policies, security measures on the Internet, and termination policies. It includes information about what can and cannot be disclosed from the records created and kept by the therapist. It can also include treatment approaches used, and other important rules for the operation of the therapeutic alliance. (Retrieved March 6, 2012, from <http://www.etherapyweb.com/problems.html>)

One problem with using a detailed informed consent is that excess detail may adversely affect client views of online therapy. This conundrum makes it important for ethical online interviewers and counselors to strike a balance between an overwhelming and exhaustive informed consent and a cursory one. A potential solution is to provide some of the informed consent procedures up front with an informed consent form and then supply additional bits and pieces during an initial synchronous Internet contact.

The process can be collaborative as well. Clients can make choices based on their comfort with security and confidentiality. They also can provide the online counselor with important information, such as emergency services available in their community.

As you develop your online informed consent paperwork, use the topical guide provided in Chapter 2, but alter as necessary, depending on the type of services you are providing. Be aware that licensure and reimbursement requirements and practices vary widely from state to state and internationally. Be very clear about your fees, your billing methods, and related

matters. Your ability to collect third-party reimbursement for the types of online counseling currently available isn't as straightforward as traditional FtF counseling.

## Conducting Online or Non-FtF Interviews

VIDEO  
15.5

The five general counseling labs [in Second Life] each contained two couches, a coffee table, a side table, and an interactive box of Kleenex. Each counseling lab had different decorations for the walls and tables. One of the counseling labs emulated a school counselor's office. (Walker, 2009, p. 37)

Before entering into a non-FtF professional relationship, it's imperative that clinicians conduct a personal and professional competency check. Because explicit professional standards for online counseling don't yet exist, it's up to individual practitioners to self-monitor their preparation and competence in this area.

### Conducting a Professional Competency Check

Your competency check should be based partly on Internet therapy research, partly on existing ethical standards, and partly on common sense. The main competencies necessary for effective online or Internet clinical assessment or intervention include the following:

- Typing speed and accuracy (or an alternative voice-activated system that's both efficient and accurate)
- Computer literacy
- An understanding of data security and other methods for protecting confidentiality (which may require consultation with an expert in technology)
- Knowledge and skills in using common text-based expressions (e.g., abbreviations and emoticons)
- Confidence and experience communicating in whatever venue you're operating from (e.g., videoconferencing, telephonic assessment and intervention, and various text-only communication modalities)
- An informed consent process that is both accessible and thorough (as noted previously, this will likely involve presenting key informed consent topics in chunks so as not to overwhelm prospective online clients)
- Knowledge of discipline-specific ethical standards (e.g., ACA, APA, NASW)

- Sensitivity to specific needs of special or minority populations (e.g., clients with disabilities)

Traditionally, the three foundational pieces that support clinical practice within any domain are education, training, and supervision. For our purposes, this translates into a minimum competency level that comprises

- Reading professional journal articles and books about online service provision
- Attending professional workshops on non-FtF assessment and treatment
- Obtaining individual or group supervision and/or consultation in the practice of online counseling
- Obtaining technical instruction and support as needed

In recent years, there also has been growing emphasis on using client feedback systems to monitor clinical practice (Meier, 2015). Although it can be complicated, we encourage online practitioners to integrate both direct and anonymous feedback systems into their online counseling system.

## Determining the Purpose of the Online or Non-FtF Interview

As with FtF clinical contact, the interview's purpose drives non-FtF interview process and outcomes. If we boil down the purpose of clinical interviewing to its essentials, two components rise to the surface: assessment (or evaluation) and treatment (or intervention).

Similarly, although the nature of clinical interviewing can shift in many subtle ways, the specifics of what you offer to distance or online clients are primarily driven by both what the client wants and what you're competent to offer. Although this sounds simple, it's good to remember how easy it is to think we're more broadly competent than we are in reality. (See Putting It in Practice 15.1 for a warning about this tendency.)

## Preparing the Room

It may seem odd to talk about preparing the room for online clinical interviewing. In some ways, however, room preparation is even more important when interviewing from a distance, especially when working in web-based virtual worlds like Second Life, with avatars used for conducting therapy in virtual counseling rooms (Walker, 2009). However, even when you're conducting text-only online assessment and counseling, unless you have a designated clinical space, there can be a sudden loss of control over your

personal space or your client's personal space. Further, losing control of either your space or the client's can detract from the reliability and validity of an online assessment process or interfere with the efficacy of online therapy interventions.

The kinds of difficulties that might occur in physical counseling offices can occur in slightly altered ways in online counseling. Power outages can disrupt both situations, but because online work is at a distance, one or the other of the parties involved might lose service or power while the other does not. It's unlikely that your physical counseling office will be invaded by family members, pets, loud music, or other distractions while in session. But in online work, space designations may be different, serving multiple functions at once. These are a few obvious contingencies. There are many more, as this is still a new and developing practice domain. They should be managed, either through the informed consent process or along the way as necessary.

## Multicultural Issues: Culture and Online Culture

VIDEO  
15.6

Online communication opportunities may allow clients to express themselves in ways that don't necessarily fit with their cultural norms. This can be a liberating experience. For example, Slama (2010) described an online chatting phenomenon among Indonesian youth where "young unmarried women, who are otherwise expected to be shy and to retreat, [were able] to actually speak out and to articulate feelings" (p. 316).

The Internet offers unparalleled intercultural opportunity and contact. As a consequence, there's a danger of overwhelming individual cultural norms with online norms and values of free expression. This can lull online practitioners into assuming that cultural universality reigns supreme in the cyberworld. Nevertheless, all professional interviewers must still work toward deepening their self-awareness, gathering multicultural knowledge, developing specific culturally sensitive and appropriate assessment and intervention techniques, and considering whether cultural advocacy is warranted. Cultural humility is also necessary.

The following is a small sampling of multicultural communication standards and sensitivities to be integrated into non-FtF interviewing:

- *Charlar* (small talk) and *personalismo* (friendliness). Some cultural groups (and individuals) will want and need friendly chatter prior to more serious self-disclosures.
- *Familia* (focusing on family relations). Many Latina(o) and Asian individuals and families expect formal inquiry about the health and wellness of immediate family members.

- *Filial piety.* Honoring and caring for one's parents and ancestors may be a prominent dimension for Asian youth and adults.
- *Tribal identity.* It may be appropriate both to disclose your knowledge of particular Native American tribes and to inquire about your client's tribal affiliation.
- *Spirituality.* Spiritual and religious dimensions of life can be central for most clients, but especially for clients outside the dominant US culture.

Although it's true that all clients using computerized interviewing and counseling services are inserting themselves into modern online culture, this can't and shouldn't serve as an excuse to ignore diverse cultural perspectives (Wood & Smith, 2005). Continually embracing cultural humility and remembering and refocusing on cultural awareness, cultural knowledge, and specific skills for working with cultural issues form a central component of interviewer competence (D. W. Sue & Sue, 2016).

## Summary

In this chapter, beginning with the concept of technology as an extension of the self, we provided an overview of issues salient to offering non-FtF clinical services. To begin, it's important to recognize how 21st-century technology has affected the ways that counseling and psychotherapy services are delivered, and how this service delivery is both similar to and different from traditional therapy approaches. Although methods for offering specific interviewer responses shift due to missing nonverbal client data (e.g., silence), interviewers must still use the same range of skills necessary in FtF interviewing formats.

There are several distinct non-FtF communication modalities available to interviewers and counselors: (a) text-only asynchronous, (b) voice-only asynchronous, (c) voice-only synchronous, (d) text-only synchronous, (e) video-link synchronous, and (f) virtual counseling settings using avatars and set up through programs such as Second Life.

Although research on non-FtF and online counseling is limited, studies have focused on the development of therapeutic relationships, telephone assessment procedures, and online therapy treatment outcomes. For the most part, initial research is promising. It appears that therapeutic alliances can be established, that telephone assessments are roughly equivalent to in-person assessments, and that treatment outcomes are moderately positive for a range of different telephonic and online interventions.

Clinicians who conduct assessment and therapy interviews online or over the telephone face numerous ethical and practical challenges: (a) lack

of access to client nonverbal behavior, (b) increased potential for clients to misrepresent themselves or to have others act as if they are your client, (c) lack of credentials on the part of providers, (d) increased potential for disinhibited and disturbing disclosures, (e) complex and anxiety-provoking emergency procedures, (f) new and significant limits on confidentiality, and (g) challenges in obtaining parental consent.

Preparation for non-FtF interviews includes conducting a professional competency check, determining the purpose of the online or non-FtF interview, and preparing the room. Multicultural sensitivity, competence, and humility remain crucial even in the context of a universal online culture.

## Suggested Online Training Resources

In addition to the resources cited in this chapter, various organizations are working to offer credentialing and training experiences to providers interested in online counseling. The following is a short list, and we suspect that resources in this area will fluctuate considerably.

All CEUs (<http://www.allceus.com/>) offers e-therapy certification training.

The American Distance Counseling Association (<http://www.adca-online.org/about.htm>) offers membership and resources, and is working toward a credentialing system.

The Online Therapy Institute (<http://onlinetherapyinstitute.com/>) offers training, certification, and specialist certificates.

The American Counseling Association, American Psychological Association, and National Association of Social Workers have position statements on ethical practices for distance counseling and psychotherapy. They also occasionally post articles on their websites regarding online counseling and psychotherapy. Go to [www.counseling.org](http://www.counseling.org) or [www.apa.org](http://www.apa.org) or [www.socialworkers.org](http://www.socialworkers.org).



## APPENDIX

# EXTENDED MENTAL STATUS EXAMINATION INTERVIEW PROTOCOL

This appendix provides a structured protocol for conducting a face-to-face (FtF), telephone, or videoconference mental status examination (MSE) interview. Some of the material is modified from the Mini-Mental State Examination (MMSE; Folstein, Folstein, & McHugh, 1975). We encourage you to further modify the content or process in ways that work for your particular setting.

The protocol includes space for writing notes and scoring client responses. However, this procedure is not standardized and has no normative sample. Gathering information using this protocol will allow you to write a clear and concise MSE report. It also may support a more extensive psychological evaluation report. For standardized procedures with norms, an alternative approach should be used (e.g., see the Mini-Mental State Examination, second edition [MMSE-2]).

This protocol generates qualitative assessment data. Using your clinical judgment, you can organize the data-based outcomes into three broad evaluation categories:

1. No concerns
2. Mild concerns
3. Significant concerns

An MSE is based on interviewer observation. Although there are traditional methods for obtaining MSE data, MSE interviewing procedures vary, and MSEs are not necessarily highly structured. The process involves an interviewer interacting with a client in such a way as to glean data about client functioning that can be organized into the nine categories typically included in an

MSE report. Detailed information about MSE process and content is in Chapter 9 of this book. Reviewing Chapter 9 will help you conduct this interview more thoroughly and skillfully.

## **Preparation**

In some cases, the semi-structured nature of this interview assessment protocol (and all structured interviews) may facilitate relationship development and your credibility as an interviewer/counselor. In other cases, if the interview isn't well framed or used in a way that fits with your personal and professional style, it can adversely affect rapport and credibility. We recommend using the protocol flexibly while emphasizing the development and maintenance of a collaborative relationship.

## **Materials Needed**

Mental status examiners should have a private setting and materials available for note taking.

## **The Importance of Small Talk**

When using this or any semi-structured interview protocol, it's important to engage in friendly small talk before initiating the interview. After you have obtained informed consent, if you're interviewing from a distance, you might ask about the local weather, what room the client is in, and whether he or she is comfortable and ready to begin. To prepare for small talk, you can go online and skim through local newspapers to check on recent news events. For example, when you're interviewing clients from remote areas, it can enhance rapport if you can comment on and ask about popular local news items (e.g., a moose wandering into a small town, a performance of local sports teams).

## **Introducing the Assessment Protocol**

After engaging in small talk, you should transition to the formal assessment. As you gain confidence and experience, you'll find your own way to introduce this interview. In the meantime, you can use the following script as a guide.

In just a few minutes, I'll start a more formal method of getting to know you that involves asking you lots of questions. It will include easier and harder questions, some questions that might seem different or odd, and even a little mental math. This interview is just a standard

way for me to get to know you better and for me to understand a little more about how your brain works. As we go through this interview, you can ask me questions at any time, and I'll try my best to answer them. Do you have any questions before we start? [Answer directly and honestly whatever questions are asked; after the client's questions are answered, proceed with the formal assessment process.]

Are you ready? [You hope to get an affirmative answer here. If not, keep answering questions and chatting or conversing about the process and anything else that seems necessary.]

## MSE Categories

You can use the following outline to guide your MSE interview.

### Orientation and Consciousness

This is the technical opening of the MSE interview. Say something like “We’ll start with some easier things and then get to some harder things.”

Then ask: “What is your full name?”

Ask, “What is today’s date?”

Ask, “What day of the week is it today?”

Ask, “What season of the year is it?”

Ask, “What’s the name of the town or city where you’re living now?”

Say, “Now, this might be a hard one.” Then ask: “Who is the governor of your state?”

Evaluation of consciousness is conducted by observation. After the examination is over, you should identify and circle which of the following words is the best descriptor of your client’s level of consciousness:

Alert, Confused, Clouded, Stuporous, Unconscious/Comatose

### Immediate Memory

Ask, “Is it okay if I do a little test of your memory?”

Then say, “I’m going to say three items and then I’ll stop and have you say them back to me. Ready? Cup, newspaper, banana. Okay, now repeat those back to me.”

Write down the items your client immediately recalls.

If the client can’t recall all three items, go ahead and repeat them. Continue repeating them and having the client try again until the client is able

to recall the items. Up to six trials are recommended in the Mini-Mental State Examination, but depending on frustration level and persistence, you may need to stop sooner or later.

### **Attention and Calculation**

Depending on how your client did with the first memory task, you might say something like “Now I’ve got a harder one for you” or “How do you feel about numbers?” Then say, “I’d like you to start with the number 100 and then count backward by sevens. It’s like 100, minus 7, and so on.”

Many clients will work hard at this (and some won’t). Either way, you can stop after five subtractions (93, 86, 79, 72, 65). You can think about the client’s response categorically from no errors; to one, two, or three errors; to being unable to begin the task. You can also watch for the client’s self-talk and strategies for dealing with a cognitive challenge.

If the client has difficulty, be sure to express empathy or validation: “This is a hard one. Many college students struggle with subtracting sevens.”

The attention and calculation category is useful for observing the client’s level of consciousness, memory, mathematical ability (and mathematical confidence or self-efficacy), and ability to concentrate and calculate.

### **Intermediate or Remote Memory**

Ask the client: “Who is currently president of the United States?”

Follow that question with: “Who was president before him?”

Continue asking about presidents. The correct order going back in time is Obama, Bush, Clinton, Bush, Reagan, Carter, Ford, Nixon, Johnson, Kennedy. You can stop when clients get stuck or when they make it to Reagan. If the client is from a different cultural or an international setting, ask about recent and present political leaders there. Although this task technically involves memory assessment, it’s also a reasonable gauge of fund of knowledge or exposure to news and information.

### **Mood and Affect**

After making a transition statement like “Now I have some different questions for you,” ask the client: “How do you feel right now?”

(This question is a mood assessment; client self-report of prevailing emotional state.)

Ask, “Rate your mood right now, with 0 being the worst possible mood you could have—0 would mean you’re totally depressed and you’re

just going to kill yourself. A rating of 10 is the best possible mood. It would mean you're totally happy and maybe dancing and singing. What rating would you give your mood right now?"

Ask, "Now, what's the worst or lowest mood rating you've ever had?"

Ask, "What was going on then to make you feel so down?"

Ask, "Now, what would be a normal mood rating for you on a normal day?"

Ask, "Now tell me, what's the best mood rating you think you've ever had?"

Ask, "What was going on then to help you have such a high mood rating?"

Affect is the client's observable moment-to-moment emotional tone.

Affect is observed and measured in terms of the following:

Affect content (circle one): Angry, Anxious, Ashamed, Euphoric, Fearful, Guilty, Happy, Irritable, Joyful, Sad, Surprised, Other

Affect range (circle one): Blunted, Constricted, Expansive, Flat, Labile, Other

Affect appropriateness (circle one): Appropriate or Inappropriate

Observations:

Affect depth or intensity (circle one): Shallow, Normal, Intense

## Intermediate Memory Recall

Tell the client, "Now I've got a tricky question. Ready?"

Say, "Remember a while ago I asked you to remember three items. Can you remember those three items now?"

Circle the items recalled: cup, newspaper, banana

Record the total number recalled without prompts.

For this item, be sure to wait for the client to make a sincere effort. After 15 to 20 seconds, you can test to see (for each item) if the client can use a cue to recapture a trace memory. (The purpose of this is to see if a prompt can help with memory retrieval, which is of less concern than complete absence of recall.)

For cup, you can say: "It's something you might drink from."

For newspaper, you can say: "It's something you read."

For banana, you can say: "It's a type of fruit."

Record the total number recalled with prompts.

## Speech and Thought

Say, “Now I’m going to ask you a few questions about your thoughts and thinking. Are you ready?”

Ask, “Do you ever have thoughts that get stuck in your head that you think over and over?” (This focuses on obsessional thoughts.)

If the client says yes, ask: “What’s an example of a thought that might get stuck in your head?”

If warranted, ask: “How do you finally manage to get that thought back out of your head?” (If the client’s response suggests obsessive thinking, you should explore this with a few follow-up questions exploring frequency, intensity, duration, and associated affect.)

Ask, “Do you have any beliefs that some people consider unusual or odd? If so, what are they?” (Again, explore these beliefs as appropriate.)

Ask the client to repeat the phrase, “No ifs, ands, or buts.”

Observe the client’s speech throughout the MSE.

Note whether the client’s speech is: Loud, Normal, or Soft; Fast (pressured), Normal, or Slow (poverty of speech).

Also rate the speech as: Spontaneous, Labored, Blocked.

Note the presence of: Stuttering, Cluttering, Dysarthria, Dysprosody. (See Chapter 9 for more information on this.)

Be sure to track your client’s thinking process. Circle one or more of the following terms:

Circumstantiality, Clang associations, Flight of ideas, Mutism, Neologisms, Perseveration, Tangentiality, Word salad, Logical and coherent

## Perceptual Disturbances

Ask, “Do you ever see or hear things that other people don’t see or hear?”

If the answer is yes, gently explore the client’s experience with questions like the following:

“What do you see/hear that others don’t?”

“Can you give me an example?”

“How do you know others can’t also hear/see this?”

Ask, “Do you ever think the radio or television is speaking directly about you or directly to you?”

If yes, ask: "Can you think of an example of that?"

Ask, "Has anyone ever tried to steal your thoughts or read your mind?"

If yes, ask: "Can you think of an example of that?"

## Cognitive Skills (Intelligence), Abstract Thinking, and Social Judgment

Ask the following questions:

"Name six large US cities."

"What poisonous chemical is in automobile exhaust?"

"In what way are a pencil and computer alike?"

"What would you do if you found a gun hidden in the bushes near your home?"

"If you won a million dollars, what would you do?"

"What would you do if a person who was much smaller than you tried to pick a fight with you?"

"What would you do if a person who was much bigger than you tried to pick a fight with you?"

"What would you do if you had a close friend who obviously had a drug or alcohol problem?"

## Insight and Reliability

Insight and reliability are difficult to measure directly. You may be able to infer them from the preceding questions and activities. Reliability is especially difficult because it's hard to tell if someone is being honest or dishonest. Do your best to rate both insight and reliability.

Insight: Absent, Poor, Partial, Good

Reliability: Unreliable, Questionable, Reliable and honest

End the interview with thanks and by asking interviewees if they have any questions for you. Answer whatever questions the interviewee may have as directly, honestly, and gently as you can. For example, if a client had difficulty with a portion of the assessment and asks for feedback, you could say: "It seemed like there were parts of the interview that were harder for you. You had trouble with subtracting sevens and remembering presidents, but you did better with some of the other questions."

## **Appearance**

Client appearance cannot be evaluated unless you're conducting an assessment FtF or via video link. If you were able to observe your client's appearance, consider which of the following adjectives best describes his or her appearance:

Well-groomed, Disheveled

Note anything unusual about the appearance of your client's eyes, facial expression, posture, clothing, makeup, and other observables. Also note whether clients look older, younger, or about their actual age.

## **Behavior or Psychomotor Activity**

Client behavior or psychomotor activity cannot be evaluated unless you're conducting an assessment FtF or via video link. If you were able to observe your client's behavior, write down anything unusual or distinctive physical movements, gestures, repeated behaviors, etc.

## **Attitude Toward the Examiner (and Examination)**

Clients will have different responses to participating in an MSE. When determining a client's attitude toward the examiner, you're relying on observational data. No direct questions are asked about this. After completing the assessment, come back to this section and circle the words that best describe your observations of the client's attitude:

Cooperative, Resistant, Hostile, Indifferent, Ingratiating, Seductive,  
Suspicious, Impatient, Pleasant, Open, Curious

## **Evaluating and Communicating Results**

As noted previously, this protocol is not standardized and therefore can yield only qualitative information. When you initially begin using the protocol, you may feel awkward or unsure of how to use the data effectively. Keep in mind that experience helps, as does discussion and exploration of the specific items with classmates and with your instructor. It's an excellent idea to dissect the questions and tasks in small groups. For example, consider different possible responses to the "million dollars" question. Typical responses include ideas about saving money, spending money, and giving away money. Analyzing client responses can give you a sense of their values and judgment. Obviously there are no correct or incorrect answers, but the

client who tells you “Hell, I’d just book a trip to Hawaii, buy a bunch of pot, and smoke it all up” conveys something distinctly different from the client who says, “I’d invest half of it in something safe, buy a nice house, and then give 10% away to charity.”

The goal of an MSE is to evaluate client mental state as well as other client dimensions. This process is inherently judgmental. It’s important for you to be tentative in your conclusions and, whenever possible, to report your observations instead of making strong statements about your observations. For guidance in writing up MSE reports, review Chapter 9 of this book.



## REFERENCES

- Aboraya, A. (2007). Clinicians' opinions on the reliability of psychiatric diagnoses in clinical settings. *Psychiatry*, 4(11), 31–33.
- Achebe, C. (1994). *Things fall apart*. New York, NY: Doubleday.
- Ackerman, S. J., & Hilsenroth, M. J. (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical Psychology Review*, 23(1), 1–33.
- Adler, A. (1930). *Individual psychology*. Oxford, England: Clark University Press.
- Akhtar, S. (Ed.). (2007). *Listening to others: Developmental and clinical aspects of empathy and attunement*. Lanham, MD: Jason Aronson.
- Alleman, J. R. (2002). Online counseling: The Internet and mental health treatment. *Psychotherapy: Theory, Research, Practice, Training*, 39(2), 199–209.
- Amadio, D. M., & Pérez, R. M. (2008). *Affirmative counseling and psychotherapy with lesbian, gay, bisexual, and transgender clients*. Reno, NV: Bent Tree Press.
- American Counseling Association. (2014). *The American Counseling Association code of ethics*. Alexandria, VA: Author.
- American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.
- American Psychological Association. (2010a). *Ethical principles for psychologists and code of conduct*. Washington, DC: Author.
- American Psychological Association. (2010b). *Publication manual of the American Psychological Association* (6th ed.). Washington, DC: Author.
- American Psychological Association. (2013). Disaster Resource Network. Retrieved from <http://www.apa.org/practice/programs/drn/>
- Anderson, R.E.E., Spence, S. H., Donovan, C. L., March, S., Prosser, S., & Kenardy, J. (2012). Working alliance in online cognitive behavior therapy for anxiety disorders in youth: Comparison with clinic delivery and its role in predicting outcome. *Journal of Medical Internet Research*, 14(3), 86–101. doi:10.2196/jmir.1848
- Anderson, S. K., & Handelsman, M. M. (2010). *Ethics for psychotherapists and counselors: A proactive approach*. London, England: Wiley-Blackwell.

- Anderson, S. K., & Handelsman, M. M. (2013). A positive and proactive approach to the ethics of the first interview. *Journal of Contemporary Psychotherapy*, 43(1), 3–11.
- Andrews, G., Davies, M., & Titov, N. (2011). Effectiveness randomized controlled trial of face to face versus Internet cognitive behaviour therapy for social phobia. *Australian and New Zealand Journal of Psychiatry*, 45(4), 337–340. doi:10.3109/00048674.2010.538840
- APA Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist*, 61, 271–285.
- Apodaca, T. R., Jackson, K. M., Borsari, B., Magill, M., Longabaugh, R., Mastroleo, N. R., & Barnett, N. P. (2015). Which individual therapist behaviors elicit client change talk and sustain talk in motivational interviewing? *Journal of Substance Abuse Treatment*, doi:10.1016/j.jsat.2015.09.001
- Applebaum, A. J., DuHamel, K. N., Winkel, G., Rini, C., Greene, P. B., Mosher, C. E., & Redd, W. H. (2012). Therapeutic alliance in telephone-administered cognitive-behavioral therapy for hematopoietic stem cell transplant survivors. *Journal of Consulting and Clinical Psychology*, 80(5), 811–816. doi:10.1037/a0027956
- Asnaani, A., & Hofmann, S. G. (2012). Collaboration in multicultural therapy: Establishing a strong therapeutic alliance across cultural lines. *Journal of Clinical Psychology*, 68(2), 187–197.
- Axline, V. M. (1964). *Dibs in search of self*. New York, NY: Ballantine Books.
- Ayón, C., & Aisenberg, E. (2010). Negotiating cultural values and expectations within the public child welfare system: A look at familismo and personalismo. *Child & Family Social Work*, 15(3), 335–344. doi:10.1111/j.1365-2206.2010.00682.x
- Azorin, J., Kaladjian, A., Adida, M., Hantouche, E., Hameg, A., Lancrenon, S., & Akiskal, H. S. (2009). Risk factors associated with lifetime suicide attempts in bipolar I patients: Findings from a French national cohort. *Comprehensive Psychiatry*, 50(2), 115–120. doi:10.1016/j.comppsych.2008.07.004
- Baker, R. W., & Trzepacz, P. T. (2013). Conducting a mental status examination. In G. P. Koocher, J. C. Norcross, & B. A. Greene (Eds.), *Psychologists' desk reference* (3rd ed., pp. 17–22). New York, NY: Oxford University Press. doi:10.1093/med:psych/9780199845491.003.0002
- Baker, T. B., & McFall, R. M. (2014). The promise of science-based training and application in psychological clinical science. *Psychotherapy*, 51(4), 482–486. doi:10.1037/a0036563
- Baker-Henningham, H. (2011). Transporting evidence-based interventions across cultures: Using focus groups with teachers and parents of pre-school children to inform the implementation of the Incredible Years teacher training programme in Jamaica. *Child: Care, Health and Development*, 37(5), 649–661. doi:j.1365-2214.2011.01208.x
- Baldwin, S. A., Wampold, B. E., & Imel, Z. E. (2007). Untangling the alliance-outcome correlation: Exploring the relative importance of therapist and patient variability in the alliance. *Journal of Consulting and Clinical Psychology*, 75(6), 842–852. doi:10.1037/0022-006X.75.6.842

- Bandler, R. (2008). *Get the life you want: The secrets to quick and lasting life change with neuro-linguistic programming*. Deerfield Beach, FL: Health Communications.
- Bandler, R., & Grinder, J. (1975). *The structure of magic I: A book about language and therapy*. Palo Alto, CA: Science and Behavior Books.
- Barak, A., Hen, L., Boniel-Nissim, M., & Shapira, N. (2008). A comprehensive review and a meta-analysis of the effectiveness of Internet-based psychotherapeutic interventions. *Journal of Technology in Human Services*, 26(2–4), 109–160. doi:10.1080/15228830802094429
- Barnett, J. E. (2011). Psychotherapist self-disclosure: Ethical and clinical considerations. *Psychotherapy*, 48(4), 315–321. doi:10.1037/a0026056
- Bassiliou, B., Harris, M., Middleton, A., Gunn, J., & Pirkis, J. (2014). Characteristics of people who use telephone counseling: Findings from secondary analysis of a population-based study. *Administration and Policy in Mental Health and Mental Health Services Research*, doi:10.1007/s10488-014-0595-8
- Bastien, C. H., Morin, C. M., Ouellet, M., Blais, F. C., & Bouchard, S. (2004). Cognitive-behavioral therapy for insomnia: Comparison of individual therapy, group therapy, and telephone consultations. *Journal of Consulting and Clinical Psychology*, 72(4), 653–659. doi:10.1037/0022-006X.72.4.653
- Beck, A. T. (1976). *Cognitive therapy and the emotional disorders*. Oxford, England: International Universities Press.
- Beck, A. T., & Steer, R. A. (1988). *Manual for the Beck Hopelessness Scale*. San Antonio, TX: Psychological Corp.
- Beck, A. T., Steer, R. A., & Brown, G. (1996). *Beck depression inventory-II*. San Antonio, TX: Psychological Corporation.
- Beck, J. S. (2011). *Cognitive behavioral therapy: Basics and beyond* (2nd ed.). New York, NY: Guilford Press.
- Befort, C. A., Donnelly, J. E., Sullivan, D. K., Ellerbeck, E. F., & Perri, M. G. (2010). Group versus individual phone-based obesity treatment for rural women. *Eating Behaviors*, 11(1), 11–17. doi:10.1016/j.eatbeh.2009.08.002
- Beitman, B. D. (1983). Categories of countertransference. *Journal of Operational Psychiatry*, 14(2), 82–90.
- Bell, A. C., & D'Zurilla, T. J. (2009). Problem-solving therapy for depression: A meta-analysis. *Clinical Psychology Review*, 29(4), 348–353. doi:10.1016/j.cpr.2009.02.003
- Bell-Tolliver, L., & Wilkerson, P. (2011). The use of spirituality and kinship as contributors to successful therapy outcomes with African American families. *Journal of Religion & Spirituality in Social Work: Social Thought*, 30(1), 48–70.
- Benjamin, A. (1987). *The helping interview with case illustrations*. Boston, MA: Houghton Mifflin.
- Berg, I. K., & DeJong, P. (2005). Engagement through complimenting. *Journal of Family Psychotherapy*, 16(1–2), 51–56.
- Berg, I. K., & Dolan, Y. (2001). *Tales of solutions: A collection of hope-inspiring stories*. New York, NY: Norton.

- Berg, I. K., & Shafer, K. C. (2004). *Working with mandated substance abusers: The language of solutions*. New York, NY: Guilford Press.
- Berg, R. C., Landreth, G. L., & Fall, K. A. (2006). *Group counseling: Concepts and procedures* (4th ed.). New York, NY: Routledge/Taylor & Francis.
- Bernal, G., Jiménez-Chafey, M. I., & Rodríguez, M. M. (2009). Cultural adaptation of treatments: A resource for considering culture in evidence-based practice. *Professional Psychology: Research and Practice*, 40(4), 361–368.
- Bernard, M., Janson, F., Flora, P. K., Faulkner, G.E.J., Meunier-Norman, L., & Fruhwirth, M. (2009). Videoconference-based physiotherapy and tele-assessment for homebound older adults: A pilot study. *Activities, Adaptation & Aging*, 33(1), 39–48. doi:10.1080/01924780902718608
- Bernert, R. A., Turvey, C. L., Conwell, Y., & Joiner, T. E., Jr. (2014). Association of poor subjective sleep quality with risk for death by suicide during a 10-year period: A longitudinal, population-based study of late life. *JAMA Psychiatry*, 71(10), 1129–1137. doi:10.1001/jamapsychiatry.2014.1126
- Bertolino, B. (1999). *Therapy with troubled teenagers: Rewriting young lives in progress*. Hoboken, NJ: Wiley.
- Bertolino, B., & O'Hanlon, B. (2002). *Collaborative, competency-based counseling and psychotherapy*. Needham Heights, MA: Allyn & Bacon.
- Betan, E., Heim, A. K., Conklin, C. Z., & Westen, D. (2005). Countertransference phenomena and personality pathology in clinical practice: An empirical investigation. *American Journal of Psychiatry*, 162(5), 890–898. doi:10.1176/appi.ajp.162.5.890
- Beutler, L. E. (2011). Prescriptive matching and systematic treatment selection. In J. C. Norcross, G. R. VandenBos, & D. K. Freedheim (Eds.), *History of psychotherapy: Continuity and change* (2nd ed., pp. 402–407). Washington, DC: American Psychological Association. doi:10.1037/12353-019
- Beutler, L. E., Harwood, T. M., Kimpara, S., Verdirame, D., & Blau, K. (2011). Coping style. *Journal of Clinical Psychology*, 67(2), 176–183.
- Beutler, L. E., Harwood, T. M., Michelson, A., Song, X., & Holman, J. (2011). Resistance/reactance level. *Journal of Clinical Psychology*, 67(2), 133–142.
- Bhola, P., & Kapur, M. (2013). The development and role of the therapeutic alliance in supportive psychotherapy with adolescents. *Psychological Studies*, 58(3), 207–215. doi:10.1007/s12646-013-0191-0
- Bickford, J. O. (2004). Preferences of individuals with visual impairments for the use of person-first language. *RE:View*, 36(3), 120–126.
- BigFoot, D. S., & Dunlap, M. (2006). Storytelling as a healing tool for American Indians. In T. M. Witko (Ed.), *Mental health care for urban Indians: Clinical insights from native practitioners* (pp. 133–153). Washington, DC: American Psychological Association. doi:10.1037/11422-007
- Bigner, J. J., & Wetchler, J. L. (2012). *Handbook of LGBT-affirmative couple and family therapy*. New York, NY: Routledge.
- Birdwhistell, R. L. (1970). *Kinesics and context: Essays on body motion communication*. Philadelphia: University of Pennsylvania Press.

- Black, L., & Jackson, V. (2005). *Families of African origin: An overview*. New York, NY: Guilford Press.
- Blader, J. C., & Carlson, G. A. (2007). Increased rates of bipolar disorder diagnoses among U.S. child, adolescent, and adult inpatients, 1996–2004. *Biological Psychiatry*, 62(2), 107–114.
- Blain, D., Hoch, P., & Ryan, V. G. (1945). A course in psychological first aid and prevention. *American Journal of Psychiatry*, 101, 629–634.
- Blankers, M., Koeter, M.W.J., & Schippers, G. M. (2011). Internet therapy versus Internet self-help versus no treatment for problematic alcohol use: A randomized controlled trial. *Journal of Consulting and Clinical Psychology*, 79(3), 330–341. doi:10.1037/a0023498
- Bloomgarden, A., & Mennuti, R. B. (Eds.). (2009). *Psychotherapist revealed: Therapists speak about self-disclosure in psychotherapy*. New York, NY: Routledge.
- Bolton, J. M., Pagura, J., Enns, M. W., Grant, B., & Sareen, J. (2010). A population-based longitudinal study of risk factors for suicide attempts in major depressive disorder. *Journal of Psychiatric Research*, 44(13), 817–826. doi:10.1016/j.jpsychires.2010.01.003
- Bolton, J. M., Spiwak, R., & Sareen, J. (2012). Predicting suicide attempts with the SAD PERSONS scale: A longitudinal analysis. *Journal of Clinical Psychiatry*, 73(6), e735–e741. doi:10.4088/JCP.11m07362
- Bombay, A., Matheson, K., & Anisman, H. (2014). The intergenerational effects of Indian residential schools: Implications for the concept of historical trauma. *Transcultural Psychiatry*, 51(3), 320–338. doi:10.1177/1363461513503380
- Bond, K., & Anderson, I. M. (2015). Psychoeducation for relapse prevention in bipolar disorder: A systematic review of efficacy in randomized controlled trials. *Bipolar Disorders*, 17(4), 349–362. doi:10.1111/bdi.12287
- Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research, Practice, Training*, 16(3), 252–260. doi:10.1037/h0085885
- Bordin, E. S. (1994). Theory and research on the therapeutic working alliance: New directions. In A. O. Horvath & L. S. Greenberg (Eds.), *The working alliance: Theory, research, and practice* (pp. 13–37). Oxford, England: Wiley.
- Boyer, D. (Ed.). (1988). *In and out of street life: Readings on interventions with street youth*. Portland, OR: Tri-county Youth Consortium.
- Brammer, L. M. (1979). *The helping relationship*. Englewood Cliffs, NJ: Prentice-Hall.
- Brenes, G. A., Danhauer, S. C., Lyles, M. F., & Miller, M. E. (2014). Telephone-delivered psychotherapy for rural-dwelling older adults with generalized anxiety disorder: Study protocol of a randomized controlled trial. *BMC Psychiatry*, 14(34). doi:10.1186/1471-244X-14-34
- Brezinka, V. (2014). Computer games supporting cognitive behaviour therapy in children. *Clinical Child Psychology and Psychiatry*, 19(1), 100–110. doi:10.1177/1359104512468288

- Bronfenbrenner, U. (1976). The ecology of human development: History and perspectives. *Psychologia Wychowawcza*, 19(5), 537–549.
- Bronfenbrenner, U. (1986). Ecology of the family as a context for human development: Research perspectives. *Developmental Psychology*, 22(6), 723–742. doi:10.1037/0012-1649.22.6.723
- Bronfenbrenner, U. (Ed.). (2005). *Making human beings human: Bioecological perspectives on human development*. Thousand Oaks, CA: Sage.
- Brown, G. K., Beck, A. T., Steer, R. A., & Grisham, J. R. (2000). Risk factors for suicide in psychiatric outpatients: A 20-year prospective study. *Journal of Consulting and Clinical Psychology*, 68, 371–377.
- Brown, G. K., Have, T. T., Henriques, G. R., Xie, S. X., Hollander, J. E., & Beck, A. T. (2005). Cognitive therapy for the prevention of suicide attempts: A randomized controlled trial. *Journal of the American Medical Association*, 294(5), 563–570. doi:10.1001/jama.294.5.563
- Brown, D. H., Lawson, L. E., McDaniel, W. F., & Wildman, R. W., II. (2012). Relationships between the Nevada brief cognitive assessment instrument and the St. Louis University mental status examination in the assessment of disability applicants. *Psychological Reports*, 111(3), 939–951.
- Brown, L. S. (2010). *Feminist therapy*. Washington, DC: American Psychological Association.
- Bryant, C. M., Taylor, R. J., Lincoln, K. D., Chatters, L. M., & Jackson, J. S. (2008). Marital satisfaction among African Americans and Black Caribbeans: Findings from the national survey of American life. *Family Relations: An Interdisciplinary Journal of Applied Family Studies*, 57(2), 239–253. doi:10.1111/j.1741-3729.2008.00497.x
- Buck, E. T., Dent-Brown, K., Parry, G., & Boote, J. (2014). Dyadic art psychotherapy: Key principles, practices and competences. *The Arts in Psychotherapy*, 41(2), 163–173. doi:10.1016/j.aip.2014.01.004
- Busch, K. A., Fawcett, J., & Jacobs, D. G. (2003). Clinical correlates of inpatient suicide. *Journal of Clinical Psychiatry*, 64(1), 14–19.
- Buyukdura, J. S., McClintock, S. M., & Croarkin, P. E. (2011). Psychomotor retardation in depression: Biological underpinnings, measurement, and treatment. *Progress in Neuro-Psychopharmacology & Biological Psychiatry*, 35(2), 395–409. doi:10.1016/j.pnpbp.2010.10.019
- Byrne, S. L., Hooke, G. R., Newnham, E. A., & Page, A. C. (2012). The effects of progress monitoring on subsequent readmission to psychiatric care: A six-month follow-up. *Journal of Affective Disorders*, 137(1–3), 113–116. doi:10.1016/j.jad.2011.12.005
- Cabaniss, D. L., Cherry, S., Douglas, C. J., & Schwartz, A. R. (2011). *Psychodynamic psychotherapy: A clinical manual*. London, England: Wiley-Blackwell.
- Campbell, D. T., & Fiske, D. W. (1959). Convergent and discriminant validation by the multitrait-multimethod matrix. *Psychological Bulletin*, 56(2), 81–105. doi:10.1037/h0046016

- Campbell, M. A., French, S., & Gendreau, P. (2009). The prediction of violence in adult offenders: A meta-analytic comparison of instruments and methods of assessment. *Criminal Justice and Behavior, 36*(6), 567–590. doi:10.1177/0093854809333610
- Campfield, K. M., & Hills, A. M. (2001). Effect of timing of critical incident stress debriefing (CISD) on posttraumatic symptoms. *Journal of Traumatic Stress, 14*(2), 327–340. doi:10.1023/A:1011117018705
- Capra, F. (1975). *The tao of physics*. New York, NY: Random House.
- Capuzzi, D., & Stauffer, M. (2015). *Foundations of couples, marriage, and family counseling*. Hoboken, NJ: Wiley.
- Carkhuff, R. R. (1987). *The art of helping* (6th ed.). Amherst, MA: Human Resource Development Press.
- Carlson, J., Watts, R. E., & Maniaci, M. (2006). *Adlerian therapy: Theory and practice*. Washington, DC: American Psychological Association. doi:10.1037/11363-000
- Cassidy, F. (2011). Risk factors of attempted suicide in bipolar disorder. *Suicide and Life-Threatening Behavior, 41*(1), 6–11. doi:10.1111/j.1943-278X.2010.00007.x
- Castonguay, L. G., Boswell, J. F., Constantino, M. J., Goldfried, M. R., & Hill, C. E. (2010). Training implications of harmful effects of psychological treatments. *American Psychologist, 65*(1), 34–49. doi:10.1037/a0017330
- Center for Collegiate Mental Health. (2015, January). *2014 annual report* (Publication No. STA 15-30).
- Chambless, D. L., & Hollon, S. D. (1998). Defining empirically supported therapies. *Journal of Consulting & Clinical Psychology, 66*(1), 7–18.
- Chang, C. Y., & O'Hara, C. (2013). The initial interview with Asian American clients. *Journal of Contemporary Psychology, 43*(1), 33–42.
- Chang, C. Y., Ritter, K. B., & Hays, D. G. (2005). Multicultural trends and toys in play therapy. *International Journal of Play Therapy, 14*(2), 69–85.
- Chao, C. M. (1992). The inner heart: Therapy with Southeast Asian families. In L. A. Vargas & J. D. Koss-Chioino (Eds.), *Working with culture: Psychotherapeutic interventions with ethnic minority children and adolescents* (pp. 157–181). San Francisco, CA: Jossey-Bass.
- Cheng, A.T.A., Hawton, K., Chen, T.H.H., Yen, A.M.F., Chang, J., Chong, M., . . . Chen, L. (2007). The influence of media reporting of a celebrity suicide on suicidal behavior in patients with a history of depressive disorder. *Journal of Affective Disorders, 103*(1–3), 69–75. doi:10.1016/j.jad.2007.01.021
- Cheng, M.K.S. (2007). New approaches for creating the therapeutic alliance: Solution-focused interviewing, motivational interviewing, and the medication interest model. *Psychiatric Clinics of North America, 30*(2), 157–166. doi:10.1016/j.psc.2007.01.003
- Cheung, C., Kwan, A. Y., & Ng, S. H. (2006). Impacts of filial piety on preference for kinship versus public care. *Journal of Community Psychology, 34*(5), 617–634. doi:10.1002/jcop.20118

- Cheyne, J. A., & Girard, T. A. (2007). Paranoid delusions and threatening hallucinations: A prospective study of sleep paralysis experiences. *Consciousness and Cognition: An International Journal*, 16(4), 959–974. doi:10.1016/j.concog.2007.01.002
- Chiang, H., Lu, Z., & Wear, S. E. (2005). To have or to be: Ways of caregiving identified during recovery from the earthquake disaster in Taiwan. *Journal of Medical Ethics*, 31, 154–158.
- Christensen, A., McGinn, M., & Williams, K. J. (2009). *Behavioral couples therapy*. Arlington, VA: American Psychiatric Publishing.
- Christopher, J. C., Wendt, D. C., Marecek, J., & Goodman, D. M. (2014). Critical cultural awareness: Contributions to a globalizing psychology. *American Psychologist*, 69(7), 645–655. doi:10.1037/a0036851
- Chu, J., Floyd, R., Diep, H., Pardo, S., Goldblum, P., & Bongar, B. (2013). A tool for the culturally competent assessment of suicide: The cultural assessment of risk for suicide (CARS) measure. *Psychological Assessment*, 25(2), 424–434.
- Chung, T., Maisto, S. A., Mihalo, A., Martin, C. S., Cornelius, J. R., & Clark, D. B. (2011). Brief assessment of readiness to change tobacco use in treated youth. *Journal of Substance Abuse Treatment*, 41(2), 137–147. doi:10.1016/j.jsat.2011.02.010
- Clark, A. J. (2002). *Early recollections: Theory and practice in counseling and psychotherapy*. New York, NY: Brunner-Routledge.
- Clark, A. J. (2010). Empathy: An integral model in the counseling process. *Journal of Counseling & Development*, 88, 348–356.
- Clark, D. C. (1998). *The evaluation and management of the suicidal patient*. New York, NY: Guilford Press.
- Cleary, B. (2009). *Ramona Quimby, age 8*. New York, NY: HarperCollins.
- Cochran, B. N., Pruitt, L., Fukuda, S., Zoellner, L. A., & Feeny, N. C. (2008). Reasons underlying treatment preference: An exploratory study. *Journal of Interpersonal Violence*, 23(2), 276–291. doi:10.1177/0886260507309836
- Cohen, J. (1977). *Statistical power analysis for the behavioral sciences* (Rev. ed.). Hillsdale, NJ: Erlbaum.
- Cohen, K., & Collens, P. (2012). The impact of trauma work on trauma workers: A metasynthesis on vicarious trauma and vicarious posttraumatic growth. *Psychological Trauma: Theory, Research, Practice, and Policy*. doi:10.1037/a0030388
- Collins, B. G., & Collins, T. M. (2005). *Crisis and trauma: Developmental-ecological intervention*. Boston, MA: Lahaska Press.
- Collins, S., Arthur, N., & Wong-Wylie, G. (2010). Enhancing reflective practice in multicultural counseling through cultural auditing. *Journal of Counseling & Development*, 88(3), 340–347. doi:10.1002/j.1556-6678.2010.tb00031.x
- Comas-Díaz, L. (Director). (1994). *Ethnocultural psychotherapy* [Video/DVD]. Washington, DC: American Psychological Association.
- Constantino, M. J., Arnkoff, D. B., Glass, C. R., Ametrano, R. M., & Smith, J. Z. (2011). Expectations. *Journal of Clinical Psychology*, 67(2), 184–192.

- Constantino, M. J., Morrison, N. R., MacEwan, G., & Boswell, J. F. (2013). Therapeutic alliance researchers' perspectives on alliance-centered training practices. *Journal of Psychotherapy Integration*, 23(3), 284–289. doi:10.1037/a0032357
- Cook, J. W., Taylor, L. A., & Silverman, P. (2004). The application of therapeutic storytelling techniques with preadolescent children: A clinical description with illustrative case study. *Cognitive and Behavioral Practice*, 11(2), 243–248. doi:10.1016/S1077-7229(04)80035-X
- Cooke, D. J. (2012). Violence risk assessment: Things that I have learned so far. In M. Stemmler, T. Bliesener, & A. Beelmann (Eds.), *Antisocial behavior and crime: Contributions of developmental and evaluation research to prevention and intervention* (pp. 221–237). Cambridge, MA: Hogrefe.
- Corcoran, J. (2005). *Building strengths and skills: A collaborative approach to working with clients*. New York, NY: Oxford University Press.
- Cormier, L. S., Nurius, P. S., & Osborn, C. J. (2017). *Interviewing and change strategies for helpers: Fundamental skills and cognitive-behavioral interventions* (8th ed.). Boston, MA: Cengage.
- Craig, R. J. (Ed.). (2005). *Clinical and diagnostic interviewing* (2nd ed.). Lanham, MD: Jason Aronson.
- Crane, D. R., & Christenson, J. (2014). A summary report of cost-effectiveness: Recognizing the value of family therapy in health care. In J. Hodgson, A. Lamson, T. Mendenhall, & D. R. Crane (Eds.), *Medical family therapy: Advanced applications* (pp. 419–436). Cham, Switzerland: Springer. doi:10.1007/978-3-319-03482-9\_22
- Creswell, J. D., Pacilio, L. E., Lindsay, E. K., & Brown, K. W. (2014). Brief mindfulness meditation training alters psychological and neuroendocrine responses to social evaluative stress. *Psychoneuroendocrinology*, 44, 1–12. doi:10.1016/j.psyneuen.2014.02.007
- Crippa, J.A.S., de Lima Osório, F., Del-Ben, C. M., Filho, A. S., Da Silva Freitas, M. C., & Loureiro, S. R. (2008). Comparability between telephone and face-to-face structured clinical interview for *DSM-IV* in assessing social anxiety disorder. *Perspectives in Psychiatric Care*, 44(4), 241–247. doi:10.1111/j.1744-6163.2008.00183.x
- Cuéllar, I., & Paniagua, F. A. (Eds.). (2000). *Handbook of multicultural mental health: Assessment and treatment of diverse populations*. New York, NY: Academic Press.
- Curtis, S. L., & Eby, L. T. (2010). Recovery at work: The relationship between social identity and commitment among substance abuse counselors. *Journal of Substance Abuse Treatment*, 39(3), 248–254. doi:10.1016/j.jsat.2010.06.006
- Daily, E., Padjen, P., & Birnbaum, M. (2010). A review of competencies developed for disaster healthcare providers: Limitations of current processes and applicability. *Prehospital Disaster Medicine*, 25, 387–395.
- Dana, R. H. (1993). *Multicultural assessment perspectives for professional psychology*. Boston, MA: Allyn & Bacon.
- Daniel, M., & Gurczynski, J. (2010). Mental status examination. In D. L. Segal & M. Hersen (Eds.), *Diagnostic interviewing* (4th ed., pp. 61–88). New York, NY: Springer. doi:10.1007/978-1-4419-1320-3\_4

- Dattilio, F. M. (2010). *Cognitive-behavioral therapy with couples and families: A comprehensive guide for clinicians*. New York, NY: Guilford Press.
- D'augelli, A. R., Grossman, A. H., Salter, N. P., Vasey, J. J., Starks, M. T., & Sinclair, K. O. (2005). Predicting the suicide attempts of lesbian, gay, and bisexual youth. *Suicide and Life-Threatening Behavior*, 35(6), 646–660. doi:10.1521/suli.2005.35.6.646
- Dawson, D. A., Smith, S. M., Saha, T. D., Rubinsky, A. D., & Grant, B. F. (2012). Comparative performance of the AUDIT-C in screening for DSM-IV and DSM-5 alcohol use disorders. *Drug and Alcohol Dependence*, 126(3), 384–388. doi:10.1016/j.drugalcdep.2012.05.029
- De Jong, P., & Berg, I. K. (2008). *Interviewing for solutions* (2nd ed.). Belmont, CA: Thomson.
- de Shazer, S. (1984). The death of resistance. *Family Process*, 23, 79–93.
- de Shazer, S. (1985). *Keys to solution in brief therapy*. New York, NY: Norton.
- de Shazer, S. (1988). *Clues: Investigating solutions in brief therapy*. New York, NY: Norton.
- de Shazer, S., & Dolan, Y. (with Korman, H., McCollum, E., Trepper, T., & Berg, I. K.). (2007). *More than miracles: The state of the art of solution-focused brief therapy*. New York, NY: Haworth Press.
- De Vega, M. H., & Beyebach, M. (2004). Between-session change in solution-focused therapy: A replication. *Journal of Systemic Therapies*, 23(2), 18–26. doi:10.1521/jst.23.2.18.36644
- Dean, R. A. (2003). Native American humor: Implications for transcultural care. *Journal of Transcultural Nursing*, 14(1), 62–65. doi:10.1177/1043659602238352
- Dell Orto, A. E., & Power, P. W. (Eds.). (2007). *The psychological and social impact of illness and disability* (5th ed.) New York, NY: Springer.
- DeRicco, J. N., & Sciarra, D. T. (2005). The immersion experience in multicultural counselor training: Confronting covert racism. *Journal of Multicultural Counseling and Development*, 33(1), 2–16. doi:10.1002/j.2161-1912.2005.tb00001.x
- Diamant, A. (1997). *The red tent*. New York, NY: St. Martin's Press.
- Dickerson, F. B., & Lehman, A. F. (2011). Evidence-based psychotherapy for schizophrenia. *Journal of Nervous and Mental Disease*, 199(8), 520–526. doi:10.1097/NMD.0b013e318225ee78
- Dickinson, J. J., Poole, D. A., & Bruck, M. (2005). Back to the future: A comment on the use of anatomical dolls in forensic interviews. *Journal of Forensic Psychology Practice*, 5(1), 63–74. doi:10.1300/J158v05n01\_04
- Dimaggio, G. (2015). Awareness of maladaptive interpersonal schemas as a core element of change in psychotherapy for personality disorders. *Journal of Psychotherapy Integration*, 25(1), 39–44. doi:10.1037/a0038770
- Driessens, E., Cuijpers, P., de Maat, S.C.M., Abbass, A. A., de Jonghe, F., & Dekker, J.J.M. (2010). The efficacy of short-term psychodynamic psychotherapy for depression: A meta-analysis. *Clinical Psychology Review*, 30(1), 25–36. doi:10.1016/j.cpr.2009.08.010

- Drye, R. C., Goulding, R. L., & Goulding, M. E. (1973). No-suicide decisions: Patient monitoring of suicidal risk. *American Journal of Psychiatry*, 130(2), 171–174.
- Duan, C., Rose, T. B., & Kraatz, R. A. (2002). Empathy. In G. S. Tryon (Ed.), *Counseling based on process research: Applying what we know* (pp. 197–231). Boston, MA: Allyn & Bacon.
- Dugger, S. M., & Carlson, L. (Eds.). (2007). *Critical incidents in counseling children*. Alexandria, VA: American Counseling Association.
- Dunn, D. S., & Andrews, E. E. (2015). Person-first and identity-first language: Developing psychologists' cultural competence using disability language. *American Psychologist*, 70(3), 255–264. doi:10.1037/a0038636
- Dunner, D. L. (2005). Depression, dementia, or pseudodementia? *CNS Spectrums*, 10(11), 862.
- D'Zurilla, T. J., & Nezu, A. M. (2010). *Problem-solving therapy*. New York, NY: Guilford Press.
- Edlund, A., Lundström, M., Karlsson, S., Brännström, B., Bucht, G., & Gustafson, Y. (2006). Delirium in older patients admitted to general internal medicine. *Journal of Geriatric Psychiatry and Neurology*, 19(2), 83–90. doi:10.1177/0891988706286509
- Edwards, S. J., & Sachmann, M. D. (2010). No-suicide contracts, no-suicide agreements, and no-suicide assurances: A study of their nature, utilization, perceived effectiveness, and potential to cause harm. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, 31(6), 290–302. doi:10.1027/0227-5910/a000048
- Eells, T. D. (2009). Review of the case formulation approach to cognitive-behavior therapy. *Psychotherapy: Theory, Research, Practice, Training*, 46(3), 400–401. doi:10.1037/a0017014
- Egan, G. (2014). *The skilled helper: A problem-management and opportunity-development approach to helping* (10th ed.). Belmont, CA: Brooks/Cole.
- Ekman, P. (2001). *Telling lies: Clues to deceit in the marketplace, politics, and marriage*. New York, NY: Norton.
- El-Ghoroury, N., Galper, D. I., Sawaqdeh, A., & Bufka, L. F. (2012). Stress, coping, and barriers to wellness among psychology graduate students. *Training and Education in Professional Psychology: Research and Practice*, 6(2), 122–134. doi:10.1037/a0028768
- Elkind, D. (1964). Piaget's semi-clinical interview and the study of spontaneous religion. *Journal for the Scientific Study of Religion*, 4, 40–47.
- Elliott, R., Bohart, A. C., Watson, J. C., & Greenberg, L. S. (2011). Empathy. *Psychotherapy*, 48(1), 43–49. doi:10.1037/a0022187
- Engel, G. L. (1980). The clinical application of the biopsychosocial model. *American Journal of Psychiatry*, 137(5), 535–544.
- Engel, G. L. (1997). From biomedical to biopsychosocial: I. Being scientific in the human domain. *Psychotherapy and Psychosomatics*, 66(2), 57–62.
- Englar-Carlson, M., & Carlson, J. (2012). Adlerian couples therapy: The case of the boxer's daughter and the momma's boy. *Engaging men in couples therapy* (pp. 81–103). New York, NY: Routledge/Taylor & Francis.

- Engle, D. E., & Arkowitz, H. (2006). *Ambivalence in psychotherapy: Facilitating readiness to change*. New York, NY: Guilford Press.
- Epp, A. M., & Dobson, K. S. (2010). *The evidence base for cognitive-behavioral therapy*. New York, NY: Guilford Press.
- Epstein, J., & Klinkenberg, W. D. (2001). From Eliza to Internet: A brief history of computerized assessment. *Computers in Human Behavior*, 17(3), 295–314. doi:10.1016/S0747-5632(01)00004-8
- Eriksen, K., & Kress, V. E. (2005). *Beyond the DSM story: Ethical quandaries, challenges, and best practices*. Thousand Oaks, CA: Sage.
- Erickson, M. H., Rossi, E. L., & Rossi, S. (1976). *Hypnotic realities*. New York, NY: Irvington.
- Evans, K., Kincade, E. A., & Seem, S. R. (2011). *Introduction to feminist therapy: Strategies for social and individual change*. Thousand Oaks, CA: Sage.
- Everly, G. S., Jr., & Boyle, S. H. (1999). Critical incident stress debriefing (CISD): A meta-analysis. *International Journal of Emergency Mental Health*, 1(3), 165–168.
- Everly, G. S., Phillips, S. B., Kane, D., & Feldman, D. (2006). Introduction to and overview of group psychological first aid. *Brief Treatment and Crisis Intervention*, 6(2), 130–136. doi:10.1093/brief-treatment/mhj009
- Fairbairn, W.R.D. (1952). *Psychoanalytic studies of the personality*. London, England: Tavistock and Kegan Paul, Trench, & Trubner.
- Falkenström, F., Granström, F., & Holmqvist, R. (2013). Therapeutic alliance predicts symptomatic improvement session by session. *Journal of Counseling Psychology*, 60(3), 317–328. doi:10.1037/a0032258
- Faller, K. C. (2005). Anatomical dolls: Their use in assessment of children who may have been sexually abused. *Journal of Child Sexual Abuse*, 14(3), 1–21.
- Falvo, D. (2011). *Medical and psychosocial aspects of chronic illness and chronic disability* (4th ed.). Sudbury, MA: Jones and Bartlett Learning.
- Farabaugh, A., Nyer, M., Holt, D., Baer, L., Petrie, S., DiPierro, M., . . . Mischoulon, D. (2015). Screening for suicide risk in the college population. *Journal of Rational-Emotive & Cognitive-Behavior Therapy*, 33(1), 78–94.
- Farber, B. A. (2006). *Self-disclosure in psychotherapy*. New York, NY: Guilford Press.
- Farber, B. A., & Doolin, E. M. (2011). Positive regard and affirmation. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Evidence-based responsiveness* (2nd ed., pp. 168–186). New York, NY: Oxford University Press.
- Fatter, D. M., & Hayes, J. A. (2013). What facilitates countertransference management? The roles of therapist meditation, mindfulness, and self-differentiation. *Psychotherapy Research*, 23(5), 502–513. doi:10503307.2013.797124
- Fawcett, J., Clark, D. C., & Busch, K. A. (1993). Assessing and treating the patient at risk for suicide. *Psychiatric Annals*, 23(5), 244–255.
- Fenichel, O. (1945). *The psychoanalytic theory of neurosis*. New York, NY: Norton.
- Finn, S. E., Fischer, C. T., & Handler, L. (2012). Collaborative/therapeutic assessment: Basic concepts, history, and research. In *Collaborative/therapeutic assessment: A casebook and guide*. (pp. 1–24). Hoboken, NJ: Wiley.

- Finn, S. E., & Martin, H. (2013). Therapeutic assessment: Using psychological testing as brief therapy. In K. F. Geisinger, B. A. Bracken, J. F. Carlson, J.-I.C. Hansen, N. R. Kuncel, S. P. Reise, & M. C. Rodriguez (Eds.), *APA handbook of testing and assessment in psychology: Vol. 2. Testing and assessment in clinical and counseling psychology* (pp. 453–465). Washington, DC: American Psychological Association. doi:10.1037/14048-026
- Finn, S. E., & Tonsager, M. E. (2002). How therapeutic assessment became humanistic. *Humanistic Psychologist*, 30(1–2), 10–22. doi:10.1080/08873267.2002.9977019
- First, M. B., Spitzer, R. L., Gibbon, M., & Williams, J.B.W. (1996). *The Structured Clinical Interview for DSM-IV Axis I Disorders, Clinician Version (SCID-CV)*. Washington, DC: American Psychiatric Press.
- Fischer, C. (1994). *Individualizing psychological assessment: A collaborative and therapeutic approach*. Hillsdale, NJ: Lawrence Erlbaum.
- Flentje, A., Heck, N. C., & Cochran, B. N. (2014). Experiences of ex-ex-gay individuals in sexual reorientation therapy: Reasons for seeking treatment, perceived helpfulness and harmfulness of treatment, and post-treatment identification. *Journal of Homosexuality*, 61(9), 1242–1268. doi:10.1080/00918369.2014.926763
- Foa, E. B., & Riggs, D. S. (1994). *Posttraumatic stress disorder and rape*. Baltimore, MD: Sidran Press.
- Foley, R., & Sharf, B. F. (1981). The five interviewing techniques most frequently overlooked by primary care physicians. *Behavioral Medicine*, 8, 26–31.
- Folstein, M. F., Folstein, S. E., & McHugh, P. R. (1975). Mini-mental state: A practical method for grading the cognitive state of patients for the clinician. *Journal of Psychiatric Research*, 12(3), 189–198. doi:10.1016/0022-3956(75)90026-6
- Fontes, L. A. (2008). *Interviewing clients across cultures: A practitioner's guide*. New York, NY: Guilford Press.
- Forcano, L., Álvarez, E., Santamaría, J. J., Jimenez-Murcia, S., Granero, R., Penelo, E., . . . Fernández-Arand, F. (2011). Suicide attempts in anorexia nervosa subtypes. *Comprehensive Psychiatry*, 52(4), 352–358. doi:10.1016/j.comppsych.2010.09.003
- Fouad, N. A., & Arredondo, P. (2007). *Becoming culturally oriented: Practical advice for psychologists and educators*. Washington, DC: American Psychological Association. doi:10.1037/11483-000
- Fowler, J. C. (2012). Suicide risk assessment in clinical practice: Pragmatic guidelines for imperfect assessments. *Psychotherapy*, 49(1), 81–90. doi:10.1037/a0026148
- Fox, R. E. (1995). The rape of psychotherapy. *Professional Psychology: Research and Practice*, 26(2), 147–155. doi:10.1037/0735-7028.26.2.147
- Frances, A. J., & Widiger, T. (2012). Psychiatric diagnosis: Lessons from the DSM-IV past and cautions for the DSM-5 future. *Annual Review of Clinical Psychology*, 8, 109–130. doi:10.1146/annurev-clinpsy-032511-143102
- Frank, J. D. (1961). *Persuasion and healing*. Baltimore, MD: Johns Hopkins University Press.
- Frank, J. D., & Frank, J. B. (1991). *Persuasion and healing: A comparative study of psychotherapy* (3rd ed.). Baltimore, MD: Johns Hopkins University Press.

- Frankl, V. (1967). *Psychotherapy and existentialism: Selected papers on logotherapy*. New York, NY: Clarion.
- Franklin, A. J. (2004). *From brotherhood to manhood: How black men rescue their relationships and dreams from the invisibility syndrome*. Hoboken, NJ: Wiley.
- Franklin, A. J. (2007). *Gender, race, and invisibility in psychotherapy with African American men*. Washington, DC: American Psychological Association. doi:10.1037/11500-013
- Franklin, A. J., Boyd-Franklin, N., & Kelly, S. (2006). *Racism and invisibility: Race-related stress, emotional abuse and psychological trauma for people of color*. Binghamton, NY: Haworth Maltreatment and Trauma Press/Haworth Press.
- Fresán, A., Apiquian, R., & Nicolini, H. (2006). Psychotic symptoms and the prediction of violence in schizophrenic patients. In D. R. French (Ed.), *Schizophrenic psychology: New research* (pp. 239–254). Hauppauge, NY: Nova Science.
- Freud, S. (1909). Analysis of a phobia in a five-year-old boy. In J. Strachey (Ed.), *Standard edition of the complete psychological works of Sigmund Freud* (pp. 3–149). London, England: Hogarth Press.
- Freud, S. (1957). The future prospects of psycho-analytic therapy. In J. Strachey (Ed. & Trans.), *The standard edition of the complete works of Sigmund Freud* (pp. 139–151). London: Hogarth Press. (Original work published 1910)
- Freud, S. (1958). On the beginning of treatment: Further recommendations on the technique of psychoanalysis. In J. Strachey (Ed. & Trans.), *Standard edition of the complete psychological works of Sigmund Freud* (pp. 122–144). London, England: Hogarth Press. (Original work published 1912)
- Freud, S. (1949). *An outline of psychoanalysis*. (J. Strachey, Trans.). New York, NY: Norton.
- Friedlander, M. L., Escudero, V., Heatherington, L., & Diamond, G. M. (2011). Alliance in couple and family therapy. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Evidence-based responsiveness* (2nd ed., pp. 92–109). New York, NY: Oxford University Press.
- Fuenfhausen, K. K., & Cashwell, C. S. (2013). Attachment, stress, dyadic coping, and marital satisfaction of counseling graduate students. *The Family Journal*, 21(4), 364–370. doi:10.1177/1066480713488523
- Gallagher, J. R. (2010). Licensed chemical dependency counselors views of professional and ethical standards: A focus group analysis. *Alcoholism Treatment Quarterly*, 28(2), 184–197. doi:10.1080/07347321003648695
- Gallardo, M. E. (2013). Context and culture: The initial clinical interview with the Latina/o client. *Journal of Contemporary Psychotherapy*, 43(1), 43–52.
- Garcia-Preto, N. (1996). Latino families: An overview. In M. McGoldrick, J. Giordano, & J. K. Pearce (Eds.), *Ethnicity and family therapy* (2nd ed., pp. 141–154). New York, NY: Guilford Press.
- Gardner, H. (1999). *Intelligence reframed: Multiple intelligences for the 21st century*. New York, NY: Basic Books.

- Gardner, R. A. (1993). *Storytelling in psychotherapy with children*. Lanham, MD: Jason Aronson.
- Gawande, A. (2014). *Being mortal: Medicine and what matters in the end*. New York, NY: Metropolitan Books.
- Gazda, G. M., Asbury, F. S., Balzer, F. J., Childers, W. C., & Walters, R. P. (1984). *Human relations development: A manual for educators* (3rd ed.). Boston, MA: Allyn & Bacon.
- Gehart, D. (2014). *Mastering competencies in family therapy: A practical approach to theories and clinical case conceptualization* (2nd ed.). Belmont, CA: Brooks/Cole.
- Gelso, C. J., & Hayes, J. A. (1998). *The psychotherapy relationship: Theory, research, and practice*. New York, NY: Wiley.
- Gelso, C. J., & Hayes, J. A. (2007). *Countertransference and the inner world of the psychotherapist: Perils and possibilities*. Mahwah, NJ: Erlbaum.
- Gergen, K. J. (2009). *An invitation to social construction* (2nd ed.). Thousand Oaks, CA: Sage.
- Gershoff, E. T. (2013). Spanking and child development: We know enough now to stop hitting our children. *Child Development Perspectives*, 7(3), 133–137. doi:10.1111/cdep.12038
- Ghahramanlou-Holloway, M., Bhar, S. S., Brown, G. K., Olsen, C., & Beck, A. T. (2012). Changes in problem-solving appraisal after cognitive therapy for the prevention of suicide. *Psychological Medicine*, 42(6), 1185–1193. doi:10.1017/S0033291711002169
- Gibbs, M. A. (1984). The therapist as imposter. In C. M. Brody (Ed.), *Women therapists working with women: New theory and process of feminist therapy* (pp. 21–33). New York, NY: Springer.
- Gibbs, J. T., & Huang, L. N. (Eds.). (2003). *Children of color: Psychological interventions with culturally diverse youth*. San Francisco, CA: Jossey-Bass.
- Gibson, K., & Cartwright, C. (2014). Young people's experiences of mobile phone text counselling: Balancing connection and control. *Children and Youth Services Review*, 43, 96–104. doi:10.1016/j.childyouth.2014.05.010
- Gilboa, A., & Verfaellie, M. (2010). Telling it like it isn't: The cognitive neuroscience of confabulation. *Journal of the International Neuropsychological Society*, 16(6), 961–966. doi:10.1017/S135561771000113X
- Glass, G. V. (2001). Foreword. In B. E. Wampold, *The great psychotherapy debate: Models, methods, and findings* (pp. ix–x). Mahwah, NJ: Erlbaum.
- Glasser, W. (1998). *Choice theory: A new psychology of personal freedom*. New York, NY: HarperCollins.
- Glasser, W. (2000). *Reality therapy in action*. New York, NY: HarperCollins.
- Glasser, W. (2003). *Warning: Psychiatry can be hazardous to your health*. New York, NY: HarperCollins.
- Gluck, M., Mercado, E., & Myers, C. (2013). *Learning and memory: From brain to behavior* (2nd ed.). New York, NY: Worth.

- Goldenberg, I., Stanton, M., & Goldenberg, H. (2016). *Family therapy: An overview* (9th ed.). Pacific Grove, CA: Brooks/Cole.
- Goldfried, M. R., & Davison, G. C. (1976). *Clinical behavior therapy*. New York, NY: Holt, Rinehart & Winston.
- Gonçalves, M. M., Matos, M., & Santos, A. (2009). Narrative therapy and the nature of "innovative moments" in the construction of change. *Journal of Constructivist Psychology*, 22(1), 1–23. doi:10.1080/10720530802500748
- Gonzalez-Liencres, C., Shamay-Tsoory, S., & Brüne, M. (2013). Towards a neuroscience of empathy: Ontogeny, phylogeny, brain mechanisms, context and psychopathology. *Neuroscience and Biobehavioral Reviews*, 37(8), 1537–1548. doi:10.1016/j.neubiorev.2013.05.001
- Goodkind, J. R., Ross-Toledo, K., John, S., Hall, J. L., Ross, L., Freeland, L., . . . Lee, C. (2011). Rebuilding trust: A community, multiagency, state, and university partnership to improve behavioral health care for American Indian youth, their families, and communities. *Journal of Community Psychology*, 39(4), 452–477. doi:10.1002/jcop.20446
- Goodman, L. A., & Epstein, D. (2008). *Listening to battered women: A survivor-centered approach to advocacy, mental health, and justice*. Washington, DC: American Psychological Association.
- Gotay, S. (2013). Enhancing emotional awareness of at-risk youth through game play. *Journal of Creativity in Mental Health*, 8(2), 151–161. doi:10.1080/15401383.2013.792221
- Gottman, J. M. (2015). *Principia amoris: The new science of love*. New York, NY: Routledge/Taylor & Francis Group.
- Gottman, J. M., & DeClaire, J. (2001). *The relationship cure: A five-step guide for building better connections with family, friends, and lovers*. New York, NY: Crown.
- Gottman, J. S., & Gottman, J. M. (2015). *Ten principles for doing effective couples therapy*. New York, NY: Norton.
- Grafanaki, S. (2013). Experiencing congruence and incongruence. *Person-Centered and Experiential Psychotherapies*, 12(3), 183–186. doi:10.1080/14779757.2013.839361
- Greenberg, L. S. (2002). *Emotion-focused therapy: Coaching clients to work through their feelings*. Washington, DC: American Psychological Association.
- Greenberg, L. S., Watson, J. C., Elliot, R., & Bohart, A. C. (2001). Empathy. *Psychotherapy: Theory, Research, Practice, Training*, 38(4), 380–384.
- Greene, R. L. (2000). *The MMPI-2: An interpretive manual* (2nd ed.). Needham Heights, MA: Allyn & Bacon.
- Greenson, R. R. (1965). The working alliance and the transference neurosis. *Psychoanalytic Quarterly*, 34(2), 155–179.
- Greenson, R. R. (1967). *The technique and practice of psychoanalysis*. New York, NY: International University Press.

- Grinder, J., & Bandler, R. (1976). *The structure of magic II: A book about communication and change*. Oxford, England: Science & Behavior.
- Griner, D., & Smith, T. B. (2006). Culturally adapted mental health intervention: A meta-analytic review. *Psychotherapy: Theory, Research, Practice, Training*, 43(4), 531–548. doi:10.1037/0033-3204.43.4.531
- Grodberg, D., Weinger, P. M., Kolevzon, A., Soorya, L., & Buxbaum, J. D. (2012). The autism mental status examination: Development of a brief autism-focused exam. *Journal of Autism and Developmental Disorders*, 42(3), 455–459.
- Groth-Marnat, G. (2009). *Handbook of psychological assessment* (5th ed.). Hoboken, NJ: Wiley.
- Guilamo-Ramos, V., Dittus, P., Jaccard, J., Johansson, M., Bouris, A., & Acosta, N. (2007). Parenting practices among Dominican and Puerto Rican mothers. *Social Work*, 52(1), 17–30.
- Gunn, J. F., III, Lester, D., & McSwain, S. (2011). Testing the warning signs of suicidal behavior among suicide ideators using the 2009 national survey on drug abuse and health. *International Journal of Emergency Mental Health*, 13(3), 147–154.
- Gurman, A. S., Lebow, J. L., & Snyder, D. K. (2015). *Clinical handbook of couple therapy* (5th ed.). New York, NY: Guilford Press.
- Guterman, J. T. (2013). *Mastering the art of solution-focused counseling* (2nd ed.). Alexandria, VA: American Counseling Association.
- Haas, A. P., Eliason, M., Mays, V. M., Mathy, R. M., Cochran, S. D., D'Augelli, A. R., . . . Clayton, P. J. (2011). Suicide and suicide risk in lesbian, gay, bisexual, and transgender populations: Review and recommendations. *Journal of Homosexuality*, 58(1), 10–51. doi:10.1080/00918369.2011.534038
- Hagan, C. R., Podlogar, M. C., Chu, C., & Joiner, T. E. (2015). Testing the interpersonal theory of suicide: The moderating role of hopelessness. *International Journal of Cognitive Therapy*, 8(2), 99–113. doi:10.1521/ijct.2015.8.2.99
- Hahn, W. K., & Marks, I. L. (1996). Client receptiveness to the routine assessment of past suicide attempts. *Professional Psychology: Research and Practice*, 27, 592–594.
- Hall, E. T. (1966). *The hidden dimension*. New York, NY: Doubleday.
- Hall, R.C.W., Platt, D. E., & Hall, R.C.W. (1999). Suicide risk assessment: A review of risk factors for suicide in 100 patients who made severe suicide attempts: Evaluation of suicide risk in a time of managed care. *Psychosomatics: Journal of Consultation Liaison Psychiatry*, 40(1), 18–27.
- Hammer, A. L. (1983). Matching perceptual predicates: Effect on perceived empathy in a counseling analogue. *Journal of Counseling Psychology*, 30(2), 172–179. doi:10.1037/0022-0167.30.2.172
- Hanley, T. (2009). The working alliance in online therapy with young people: Preliminary findings. *British Journal of Guidance & Counselling*, 37(3), 257–269. doi:10.1080/03069880902956991
- Hanley, T., & Reynolds, D. J. (2009). Counselling psychology and the Internet: A review of the quantitative research into online outcomes and alliances within text-based therapy. *Counselling Psychology Review*, 24(2), 4–13.

- Hanna, F. J., Hanna, C. A., & Keys, S. G. (1999). Fifty strategies for counseling defiant, aggressive adolescents: Reaching, accepting, and relating. *Journal of Counseling & Development, 77*(4), 395–404.
- Hansen, J. T. (2013). *The future of humanism: Cultivating the humanities impulse in mental health culture*. Ross-on-Wye, England: PCCS Books.
- Hardin, E. E., Robitschek, C., Flores, L. Y., Navarro, R. L., & Ashton, M. W. (2014). The cultural lens approach to evaluating cultural validity of psychological theory. *American Psychologist, 69*(7), 656–668. doi:10.1037/a0036532
- Hardy, G., Cahill, J., & Barkham, M. (2007). *Active ingredients of the therapeutic relationship that promote client change: A research perspective*. New York, NY: Routledge/Taylor & Francis.
- Hardy, K. M. (2012). Perceptions of African American Christians' attitudes toward religious help-seeking: Results of an exploratory study. *Journal of Religion & Spirituality in Social Work: Social Thought, 31*(3), 209–225. doi:10.1080/15426432.2012.679838
- Hare, R. D., Harpur, T. J., Hakstian, A. R., Forth, A. E., Hart, S. D., & Newman, J. P. (1990). The revised psychopathy checklist: Reliability and factor structure. *Psychological Assessment: A Journal of Consulting and Clinical Psychology, 2*(3), 338–341. doi:10.1037/1040-3590.2.3.338
- Harris, G. T., Rice, M. E., & Quinsey, V. L. (1993). Violent recidivism of mentally disordered offenders: The development of a statistical prediction instrument. *Criminal Justice and Behavior, 20*(4), 315–335. doi:10.1177/0093854893020004001
- Harris, K. M., Syu, J., Lello, O. D., Chew, Y.L.E., Willcox, C. H., & Ho, R.H.M. (2015). The ABC's of suicide risk assessment: Applying a tripartite approach to individual evaluations. *PLoS ONE, 10*(6). doi:10.1371/journal.pone.0127442
- Harris, S. E., & Robinson-Kurpius, S. E. (2014). Social networking and professional ethics: Client searches, informed consent, and disclosure. *Professional Psychology: Research and Practice, 45*(1), 11–19. doi:10.1037/a0033478
- Hasley, J. P., Ghosh, B., Huggins, J., Bell, M. R., Adler, L. E., & Shroyer, A.L.W. (2008). A review of “suicidal intent” within the existing suicide literature. *Suicide and Life-Threatening Behavior, 38*(5), 576–591. doi:10.1521/suli.2008.38.5.576
- Hatzenbuehler, M. L., Keyes, K. M., & Hasin, D. S. (2009). State-level policies and psychiatric morbidity in lesbian, gay, and bisexual populations. *American Journal of Public Health, 99*(12), 2275–2281.
- Havas, J., de Nooijer, J., Crutzen, R., & Feron, F. (2011). Adolescents’ views about an Internet platform for adolescents with mental health problems. *Health Education, 111*(3), 164–176. doi:10.1108/09654281111123466
- Hayes, J. A., Gelso, C. J., & Hummel, A. M. (2011). Managing countertransference. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Evidence-based responsiveness* (2nd ed., pp. 239–258). New York, NY: Oxford University Press.
- Hayes, S. C. (2004). Acceptance and commitment therapy, relational frame theory, and the third wave of behavioral and cognitive therapies. *Behavior Therapy, 35*(4), 639–665. doi:10.1016/S0005-7894(04)80013-3

- Hayes-Skelton, S., Roemer, L., & Orsillo, S. M. (2013). A randomized clinical trial comparing an acceptance-based behavior therapy to applied relaxation for generalized anxiety disorder. *Journal of Consulting and Clinical Psychology*, 81(5), 761–773. doi:10.1037/a0032871
- Hays, P. A. (2008). *Addressing cultural complexities in practice: Assessment, diagnosis, and therapy* (2nd ed.). Washington, DC: American Psychological Association. doi:10.1037/11650-000
- Hays, P. A. (2013). *Connecting across cultures: The helper's toolkit*. Thousand Oaks, CA: Sage.
- Healy, D. (2009). Are selective serotonin reuptake inhibitors a risk factor for adolescent suicide? *Canadian Journal of Psychiatry/La Revue Canadienne de Psychiatrie*, 54(2), 69–71.
- Heck, N. C., Flentje, A., & Cochran, B. N. (2013). Intake interviewing with lesbian, gay, transgender, and bisexual clients: Starting from a place of affirmation. *Journal of Contemporary Psychotherapy*, 43(1), 23–32. doi:10.1007/s10879-012-9220-x
- Hecker, L. (Ed.). (2010). *Ethics and professional issues in couple and family therapy*. New York, NY: Routledge.
- Hegarty, E.L.H., Catalano, G., & Catalano, M. C. (2007). New onset delusions in the aftermath of the September 11th terrorist attacks. *Journal of Psychiatric Practice*, 13(6), 405–410.
- Heinlen, K. T., Welfel, E. R., Richmond, E. N., & O'Donnell, M. S. (2003). The nature, scope, and ethics of psychologists' e-therapy web sites: What consumers find when surfing the web. *Psychotherapy: Theory, Research, Practice, Training*, 40(1–2), 112–124. doi:10.1037/0033-3204.40.1-2.112
- Henderson, C. E., Dakof, G. A., Greenbaum, P. E., & Liddle, H. A. (2010). Effectiveness of multidimensional family therapy with higher severity substance-abusing adolescents: Report from two randomized controlled trials. *Journal of Consulting and Clinical Psychology*, 78(6), 885–897. doi:10.1037/a0020620
- Henderson, D. A., & Thompson, C. L. (2011). *Counseling children* (8th ed.). Belmont, CA: Brooks/Cole.
- Hendin, H., Maltsberger, J. T., & Szanto, K. (2007). The role of intense affective states in signaling a suicide crisis. *Journal of Nervous and Mental Disease*, 195(5), 363–368.
- Hendricks, B., Bradley, L. J., Southern, S., Oliver, M., & Birdsall, B. (2011). Ethical code for the International Association of Marriage and Family Counselors. *The Family Journal*, 19(2), 217–224.
- Herbst, N., Voderholzer, U., Thiel, N., Schaub, R., Knaevelsrud, C., Stracke, S., . . . Kulz, A. K. (2014). No talking, just writing! Efficacy of an Internet-based cognitive behavioral therapy with exposure and response prevention in obsessive compulsive disorder. *Psychotherapy and Psychosomatics*, 83(3), 165–175. doi:10.1159/000357570
- Herek, G. M. (2007). Confronting sexual stigma and prejudice: Theory and practice. *Journal of Social Issues*, 63(4), 905–925.

- Herlihy, B. J., Hermann, M. A., & Greden, L. R. (2014). Legal and ethical implications of using religious beliefs as the basis for refusing to counsel certain clients. *Journal of Counseling & Development, 92*(2), 148–153.
- Herman, J. L. (1992). *Trauma and recovery: The aftermath of violence—from domestic abuse to political terror*. New York, NY: Basic Books.
- Hermann, M. A., & Herlihy, B. R. (2006). Legal and ethical implications of refusing to counsel homosexual clients. *Journal of Counseling & Development, 84*(4), 414–418.
- Hernandez-Wolfe, P., Killian, K., Engstrom, D., & Gangsei, D. (2015). Vicarious resilience, vicarious trauma, and awareness of equity in trauma work. *Journal of Humanistic Psychology, 55*(2), 153–172. doi:10.1177/0022167814534322
- Hersen, M., & Turner, S. M. (2003). *Diagnostic interviewing* (3rd ed.). New York, NY: Kluwer Academic/Plenum.
- Hill, C. E. (2014). *Helping skills: Facilitating, exploration, insight, and action* (4th ed.). Washington, DC: American Psychological Association.
- Hilton, N. Z., Harris, G. T., & Rice, M. E. (2006). Sixty-six years of research on the clinical versus actuarial prediction of violence. *Counseling Psychologist, 34*(3), 400–409. doi:10.1177/0011000005285877
- Hipolito-Delgado, C. P., Cook, J. M., Avrus, E. M., & Bonham, E. J. (2011). Developing counseling students' multicultural competence through the multicultural action project. *Counselor Education and Supervision, 50*(6), 402–421. doi:10.1002/j.1556-6978.2011.tb01924.x
- Hirai, M., & Clum, G. A. (2005). An Internet-based self-change program for traumatic event related fear, distress, and maladaptive coping. *Journal of Traumatic Stress, 18*(6), 631–636. doi:10.1002/jts.20071
- Ho, M. K., Rasheed, J. M., & Rasheed, M. N. (2004). *Family therapy with ethnic minorities* (2nd ed.). Thousand Oaks, CA: Sage.
- Hodges, K. (1985). *Manual for the child assessment schedule*. Unpublished manuscript.
- Hölzel, B. K., Carmody, J., Vangel, M., Congleton, C., Yerramsetti, S. M., Gard, T., & Lazar, S. W. (2011). Mindfulness practice leads to increases in regional brain gray matter density. *Psychiatry Research: Neuroimaging, 191*(1), 36–43. doi:10.1016/j.pscychresns.2010.08.006
- Hook, J. N., Davis, D. E., Owen, J., Worthington, E. L., Jr., & Utsey, S. O. (2013). Cultural humility: Measuring openness to culturally diverse clients. *Journal of Counseling Psychology, 60*(3), 353–366. doi:10.1037/a0032595
- Hor, K., & Taylor, M. (2010). Suicide and schizophrenia: A systematic review of rates and risk factors. *Journal of Psychopharmacology, 24*(11, Suppl. 4), 81–90. doi:10.1177/1359786810385490
- Horesh, N., Levi, Y., & Apter, A. (2012). Medically serious versus non-serious suicide attempts: Relationships of lethality and intent to clinical and interpersonal characteristics. *Journal of Affective Disorders, 136*(3), 286–293. doi:10.1016/j.jad.2011.11.035

- Horvath, A. O., Re, A.C.D., Flückiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Evidence-based responsiveness* (2nd ed., pp. 25–69). New York, NY: Oxford University Press.
- Horwitz, A. V., & Wakefield, J. C. (2007). *The loss of sadness: How psychiatry transformed normal sorrow into depressive disorder*. New York, NY: Oxford University Press.
- Horwitz, S. H., Santiago, L., Pearson, J., & LaRussa-Trott, M. (2009). Relational tools for working with mild-to-moderate couple violence: Patterns of unresolved conflict and pathways to resolution. *Professional Psychology: Research and Practice*, 40(3), 249–256. doi:10.1037/a0012992
- Hoyt, M. F. (Ed.). (1996). *Constructive therapies* (Vol. 2). New York, NY: Guilford Press.
- Hoyt, T., & Duffy, V. (2015). Implementing firearms restriction for preventing U.S. army suicide. *Military Psychology*, doi:10.1037/mil0000093
- Hubble, M. A., & Gelso, C. J. (1978). Effect of counselor attire in an initial interview. *Journal of Counseling Psychology*, 25(6), 581–584. doi:10.1037/0022-0167.25.6.581
- Hufford, B. J., Glueckauf, R. L., & Webb, P. M. (1999). Home-based, interactive videoconferencing for adolescents with epilepsy and their families. *Rehabilitation Psychology*, 44(2), 176–193. doi:10.1037/0090-5550.44.2.176
- Hughes, C. W. (2011). Objective assessment of suicide risk: Significant improvements in assessment, classification, and prediction. *American Journal of Psychiatry*, 168(12), 1233–1234. doi:10.1176/appi.ajp.2011.11091362
- Human, L. J., & Biesanz, J. C. (2012). Accuracy and assumed similarity in first impressions of personality: Differing associations at different levels of analysis. *Journal of Research in Personality*, 46(1), 106–110. doi:10.1016/j.jrp.2011.10.002
- Hungerford, A. (2005). The use of anatomically detailed dolls in forensic investigations: Developmental considerations. *Journal of Forensic Psychology Practice*, 5(1), 75–87. doi:10.1300/J158v05n01\_05
- Hunter, J. A., Button, M. L., & Westra, H. A. (2014). Ambivalence and alliance ruptures in cognitive behavioral therapy for generalized anxiety. *Cognitive Behaviour Therapy*, 43(3), 201–208. doi:10.1080/16506073.2014.899617
- Ingersoll, R. E., & Marquis, A. (2014). *Understanding psychopathology: An integral exploration*. New York, NY: Pearson.
- Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century*. Washington, DC: National Academies Press.
- Ivanoff, A., Jang, S. J., Smyth, N. J., & Linehan, M. M. (1994). Fewer reasons for staying alive when you are thinking of killing yourself: The brief reasons for living inventory. *Journal of Psychopathology and Behavioral Assessment*, 16(1), 1–13.
- Ivey, A. E. (1971). *Microcounseling: Innovations in interviewing training*. Oxford, England: Charles C. Thomas.

- Ivey, A. E., & Ivey, M. B. (1999). Toward a developmental diagnostic and statistical manual: The vitality of a contextual framework. *Journal of Counseling & Development, 77*(4), 484–490.
- Ivey, A. E., Ivey, M. B., & Zalaquett, C. P. (2010). *Intentional interviewing and counseling: Facilitating client development in a multicultural society* (7th ed.). Belmont, CA: Brooks/Cole.
- Ivey, A. E., Ivey, M. B., Zalaquett, C. P., with Quirk, K. (2011). *Essentials of intentional interviewing: Counseling in a multicultural world* (2nd ed.). Pacific Grove, CA: Brooks/Cole.
- Ivey, A. E., Normington, C. J., Miller, C. D., Morrill, W. H., & Haase, R. F. (1968). Microcounseling and attending behavior: An approach to prepracticum counselor training. *Journal of Counseling Psychology, 15*(5, Pt.2), 1–12. doi:10.1037/h0026129
- Izard, C. E. (1982). *Measuring emotions in infants and children*. New York, NY: Cambridge University Press.
- Jaghab, K., Skodnek, K. B., & Padder, T. A. (2006). Munchausen's syndrome and other factitious disorders in children: Case series and literature review. *Psychiatry, 3*(3), 46–55.
- Jain, S. (2011). Treating posttraumatic stress disorder via the Internet: Does therapeutic alliance matter? *Journal of the American Medical Association, 306*(5), 543–544. doi:10.1001/jama.2011.1097
- James, R. K., & Gilliland, B. E. (2013). *Crisis intervention strategies* (7th ed.). Belmont, CA: Wadsworth/Cengage Learning.
- Jefferis, J. M., Mosimann, U. P., Taylor, J., & Clarke, M. P. (2011). "Do your eyes play tricks on you?" Asking older people about visual hallucinations in a general eye clinic. *International Psychogeriatrics, 23*(6), 1014–1015. doi:10.1017/S104161021100072X
- Jeltova, I., & Fish, M. C. (2005). Creating school environments responsive to gay, lesbian, bisexual, and transgender families: Traditional and systemic approaches for consultation. *Journal of Educational & Psychological Consultation, 16*(1–2), 17–33. doi:10.1207/s1532768xjepc161&2\_2
- Jenkins, W. M., Merzenich, M. M., Ochs, M. T., Allard, T., & Guk-Robles, E. (1990). Functional reorganization of primary somatosensory cortex in adult owl monkeys after behaviorally controlled tactile stimulation. *Journal of Neurophysiology, 63*(1), 82–104.
- Jensen, M. E., Pease, E. A., Lambert, K., Hickman, D. R., Robinson, O., McCoy, K. T., . . . King, J. K. (2013). Championing person-first language: A call to psychiatric mental health nurses. *Journal of the American Psychiatric Nurses Association, 19*(3), 146–151. doi:10.1177/1078390313489729
- Jia, C., Wang, L., Xu, A., Dai, A., & Qin, P. (2014). Physical illness and suicide risk in rural residents of contemporary China: A psychological autopsy case-control study. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 35*(5), 330–337. doi:10.1027/0227-5910/a000271

- Jing-ying, G. (2013). For the sake of whom: Conversation analysis of advice giving in offender counseling. *International Journal of Offender Therapy and Comparative Criminology*, 57(8), 1027–1045.
- Jobes, D. A. (2016). *Managing suicidal risk: A collaborative approach* (2nd ed.). New York, NY: Guilford Press.
- Jobes, D. A., Au, J., & Siegelman, A. (2015). Psychological approaches to suicide treatment and prevention. *Current Treatment Options in Psychiatry*, 2(4), 363–370.
- Jobes, D. A., Moore, M. M., & O'Connor, S. S. (2007). Working with suicidal clients using the collaborative assessment and management of suicidality (CAMS). *Journal of Mental Health Counseling*, 29(4), 283–300.
- Jobes, D. A., Nelson, K. N., Peterson, E. M., Pentiuc, D., Downing, V., Francini, K., & Kiernan, A. (2004). Describing suicidality: An investigation of qualitative SSF responses. *Suicide and Life-Threatening Behavior*, 34(2), 99–112.
- Jobes, D. A., & O'Connor, S. S. (2009). The duty to protect suicidal clients: Ethical, legal, and professional considerations. In J. L. Werth Jr., E. R. Welfel, & G.A.H. Benjamin (Eds.), *The duty to protect: Ethical, legal, and professional considerations for mental health professionals* (pp. 163–180). Washington, DC: American Psychological Association. doi:10.1037/11866-011
- Jobes, D. A., Rudd, M. D., Overholser, J. C., & Joiner, T. E. (2008). Ethical and competent care of suicidal patients: Contemporary challenges, new developments, and considerations for clinical practice. *Professional Psychology: Research and Practice*, 39(4), 405–413. doi:10.1037/a0012896
- Johnson, R. (2013). *Spirituality in counseling and psychotherapy: An integrative approach that empowers clients*. Hoboken, NJ: Wiley.
- Johnson, S. (2004). *The practice of emotionally focused couple therapy: Creating connection*. New York, NY: Brunner-Routledge.
- Johnson, S. (2008). *Hold me tight: Seven conversations for a lifetime of love*. New York, NY: Little, Brown.
- Johnson, S. S., Bradley, B., Furrow, J. L., Lee, A., Palmer, G., Tilley, D., & Woolley, S. (2005). *Becoming an emotionally focused couple therapist: The workbook*. New York, NY: Routledge.
- Johnson, S. S., Paiva, A. L., Cummins, C. O., Johnson, J. L., Dyment, S. J., Wright, J. A., . . . Sherman, K. (2008). Transtheoretical model-based multiple behavior intervention for weight management: Effectiveness on a population basis. *Preventive Medicine*, 46(3), 238–246. doi:10.1016/j.ypmed.2007.09.010
- Joiner, T. E. (2005). *Why people die by suicide*. Cambridge, MA: Harvard University Press.
- Joiner, T. E., & Silva, C. (2012). Why people die by suicide: Further development and tests of the interpersonal-psychological theory of suicidal behavior. In P. R. Shaver & M. Mikulincer (Eds.), *Meaning, mortality, and choice: The social psychology of existential concerns* (pp. 325–336). Washington, DC: American Psychological Association. doi:10.1037/13748-018

- Jones, K. D. (2010). The unstructured clinical interview. *Journal of Counseling & Development*, 88(2), 220–226. doi:10.1002/j.1556-6678.2010.tb00013.x
- Jones, M. C. (1975). A 1924 pioneer looks at behavior therapy. *Journal of Behavior Therapy and Experimental Psychiatry*, 6(3), 181–187.
- Jongsma, A. E., Peterson, L. M., & Bruce, T. J. (2006). *The complete adult psychotherapy treatment planner* (4th ed.). Hoboken, NJ: Wiley.
- Jordan, J. V. (2010). *Relational-cultural therapy*. Washington, DC: American Psychological Association.
- Juhnke, G. A., Granello, D. H., & Granello, P. F. (2011). *Suicide, self-injury, and violence in the schools: Assessment, prevention, and intervention strategies*. Hoboken, NJ: Wiley.
- Juhnke, G. A., Granello, P. F., & Lebrón-Striker, M. A. (2007). *IS PATH WARM? A suicide assessment mnemonic for counselors* (ACAPCD-03). Alexandria, VA: American Counseling Association.
- Jungbluth, N. J., & Shirk, S. R. (2013). Promoting homework adherence in cognitive-behavioral therapy for adolescent depression. *Journal of Clinical Child and Adolescent Psychology*, 42(4), 545–553. doi:10.1080/15374416.2012.743105
- Kanjee, R., Watter, S., Sévigny, A., & Humphreys, K. (2010). A case of foreign accent syndrome: Acoustic analyses and an empirical test of accent perception. *Journal of Neurolinguistics*, 23(6), 580–598. doi:10.1016/j.jneuroling.2010.05.003
- Karno, M. P., Beutler, L. E., & Harwood, M. (2002). Interactions between psychotherapy process and patient attributes that predict alcohol treatment effectiveness: A preliminary report. *Journal of Alcohol Studies*, 27, 779–797.
- Kawase, E., Karasawa, K., Shimotsu, S., Imasato, S., Ito, K., Matsuki, H., . . . Horikawa, N. (2006). Evaluation of a one-question interview for depression in a radiation oncology department in Japan. *General Hospital Psychiatry*, 28(4), 321–322. doi:10.1016/j.genhosppsych.2006.02.003
- Kazdin, A. E. (2008). *The Kazdin method for parenting the defiant child: With no pills, no therapy, no contest of wills*. Boston, MA: Houghton Mifflin Company.
- Keeley, J. W., Reed, G. M., Roberts, M. C., Evans, S. C., Medina-Mora, M., Robles, R., . . . Saxena, S. (2016). Developing a science of clinical utility in diagnostic classification systems field study strategies for ICD-11 mental and behavioral disorders. *American Psychologist*, 71(1), 3–16.
- Kelly, G. A. (1955). *The psychology of personal constructs*. New York, NY: Norton.
- Khanna, A., McDowell, T., Perumbilly, S., & Titus, G. (2009). Working with Asian Indian American families: A Delphi study. *Journal of Systemic Therapies*, 28(1), 52–71. doi:10.1521/jsyt.2009.28.1.52
- Kielbasa, A. M., Pomerantz, A. M., Krohn, E. J., & Sullivan, B. F. (2004). How does clients' method of payment influence psychologists' diagnostic decisions? *Ethics & Behavior*, 14(2), 187–195. doi:10.1207/s15327019eb1402\_6
- Kim, J. K., & Suh, J. H. (2013). Children's kinetic family drawings and their internalizing problem behaviors. *Arts in Psychotherapy*, 40(2), 206–215. doi:10.1016/j.aip.2012.12.009

- Kivlighan, D. M., Jr. (2002). Transference, interpretation, and insight: A research-practice model. In G. S. Tryon (Ed.), *Counseling based on process research: Applying what we know* (pp. 166–196). Boston, MA: Allyn & Bacon.
- Kivlighan, D. M., Jr., & Tibbits, B. M. (2012). Silence is mean and other misconceptions of group counseling trainees: Identifying errors of commission and omission in trainees' knowledge structures. *Group Dynamics: Theory, Research, and Practice*, 16(1), 14–34. doi:10.1037/a0026558
- Kleespies, P. M., & Richmond, J. S. (2009). Evaluating behavioral emergencies: The clinical interview. In P. M. Kleespies (Ed.), *Behavioral emergencies: An evidence-based resource for evaluating and managing risk of suicide, violence, and victimization* (pp. 33–55). Washington, DC: American Psychological Association. doi:10.1037/11865-002
- Knaevelsrud, C., & Maercker, A. (2006). Does the quality of the working alliance predict treatment outcome in online psychotherapy for traumatized patients? *Journal of Medical Internet Research*, 8(4). doi:10.2196/jmir.8.4.e31
- Knaevelsrud, C., & Maercker, A. (2007). Internet-based treatment for PTSD reduces distress and facilitates the development of a strong therapeutic alliance: A randomized controlled clinical trial. *BMC Psychiatry*, 7. doi:10.1186/1471-244X-7-13
- Knapp, M. L., Hall, J. A., & Horgan, T. G. (2013). *Nonverbal communication in human interaction* (8th ed.). Boston, MA: Wadsworth.
- Knesper, D. J. (2007). My favorite tips for engaging the difficult patient on consultation-liaison psychiatry services. *Psychiatric Clinics of North America*, 30(2), 245–252. doi:10.1016/j.psc.2007.01.009
- Knight, D. J. (2014). Toward a relational perspective on young black and Latino males: The contextual patterns of disclosure as coping. *Harvard Educational Review*, 84(4), 433–467.
- Kocet, M. M., & Herlihy, B. J. (2014). Addressing value-based conflicts within the counseling relationship: A decision-making model. *Journal of Counseling & Development*, 92(2), 180–186. doi:10.1002/j.1556-6676.2014.00146.x
- Kohn, N., Eickhoff, S. B., Scheller, M., Laird, A. R., Fox, P. T., & Habel, U. (2014). Neural network of cognitive emotion regulation—An ALE meta-analysis and MACM analysis. *NeuroImage*, 87, 345–355. doi:10.1016/j.neuroimage.2013.11.001
- Kohut, H. H. (1984). *How does analysis cure?* Chicago, IL: University of Chicago Press.
- Kolden, G. G., Klein, M. H., Wang, C., & Austin, S. B. (2011). Congruence/genuine ness. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Evidence-based responsiveness* (2nd ed., pp. 187–202). New York, NY: Oxford University Press.
- Kort, J. (2008). *Gay affirmative therapy for the straight clinician: The essential guide*. New York, NY: Norton.
- Kotbi, N., & Mahgoub, N. (2009). Somatic delusions and treatment challenges. *Psychiatric Annals*, 39(6), 320–320, 324. doi:10.3928/00485713-20090529-01
- Kraepelin, E. (1913). *Lectures on Clinical Psychiatry*. London, England: Bailliere.

- Kramer, J. R., Chan, G., Kuperman, S., Bucholz, K. K., Edenberg, H. J., Schuckit, M. A., . . . Bierut, L. J. (2009). A comparison of diagnoses obtained from in-person and telephone interviews, using the semi-structured assessment for the genetics of alcoholism (SSAGA). *Journal of Studies on Alcohol and Drugs*, 70(4), 623–627.
- Kurt, P., Yener, G., & Oguz, M. (2011). Impaired digit span can predict further cognitive decline in older people with subjective memory complaint: A preliminary result. *Aging & Mental Health*, 15(3), 364–369. doi:10.1080/13607863.2010.536133
- Kutchins, H., & Kirk, S. A. (1997). *Making us crazy*. New York, NY: Free Press.
- Lago, C. (1996). Computer therapeutics. *Journal of the British Association for Counselling*, 7(4), 287–289.
- Lake, A. M., & Gould, M. S. (2014). Suicide clusters and suicide contagion. *A concise guide to understanding suicide: Epidemiology, pathophysiology, and prevention* (pp. 52–61). New York, NY: Cambridge University Press.
- Lambert, M. J. (2007). Presidential address: What we have learned from a decade of research aimed at improving psychotherapy outcome in routine care. *Psychotherapy Research*, 17(1), 1–14. doi:10.1080/10503300601032506
- Lambert, M. J., & Shimokawa, K. (2011). Collecting client feedback. *Psychotherapy*, 48(1), 72–79. doi:10.1037/a0022238
- Lampe, L. A. (2011). Internet-based therapy: Too good to be true? *Australian and New Zealand Journal of Psychiatry*, 45(4), 342–343. doi:10.3109/00048674.2011.560138
- Lankton, S. R., Lankton, C. H., & Matthews, W. J. (1991). *Ericksonian family therapy*. Philadelphia, PA: Brunner/Mazel.
- Lapidot-Lefler, N., & Barak, A. (2012). Effects of anonymity, invisibility, and lack of eye-contact on toxic online disinhibition. *Computers in Human Behavior*, 28(2), 434–443. doi:10.1016/j.chb.2011.10.014
- Laska, K. M., Gurman, A. S., & Wampold, B. E. (2014). Expanding the lens of evidence-based practice in psychotherapy: A common factors perspective. *Psychotherapy*, 51, 467–481. doi:10.1037/a0034332
- Lau, M. A., Haigh, E.A.P., Christensen, B. K., Segal, Z. V., & Taube-Schiff, M. (2012). Evaluating the mood state dependence of automatic thoughts and dysfunctional attitudes in remitted versus never-depressed individuals. *Journal of Cognitive Psychotherapy*, 26(4), 381–389.
- Lau, M. A., Segal, Z. V., & Williams, J.M.G. (2004). Teasdale's differential activation hypothesis: Implications for mechanisms of depressive relapse and suicidal behaviour. *Behaviour Research and Therapy*, 42(9), 1001–1017. doi:10.1016/j.brat.2004.03.003
- Lazarus, A. A. (1994). How certain boundaries and ethics diminish therapeutic effectiveness. *Ethics & Behavior*, 4(3), 255–261.
- Lazarus, A. A. (1996). Some reflections after 40 years of trying to be an effective psychotherapist. *Psychotherapy: Theory, Research, Practice, Training*, 33(1), 142–145.
- Lazarus, A. A. (2006). *Brief but comprehensive psychotherapy: The multimodal way*. New York, NY: Springer.

- Lebowitz, M. S., Pyun, J. J., & Ahn, W. (2014). Biological explanations of generalized anxiety disorder: Effects on beliefs about prognosis and responsibility. *Psychiatric Services, 65*(4), 498–503. doi:10.1176/appi.ps.201300011
- Ledley, D. R., Marx, B. P., & Heimberg, R. G. (2010). *Making cognitive-behavioral therapy work: Clinical process for new practitioners* (2nd ed.). New York, NY: Guilford Press.
- Lee, S. J., Altschul, I., & Gershoff, E. T. (2015). Wait until your father gets home? Mothers' and fathers' spanking and development of child aggression. *Children and Youth Services Review, 52*, 158–166. doi:10.1016/j.childyouth.2014.11.006
- Leenaars, A. A. (1999). *Lives and deaths: Selections from the works of Edwin S. Shneidman*. New York, NY: Routledge.
- Leenaars, A. A. (2010). Edwin S. Shneidman on suicide. *Suicidology Online, 1*, 5–18.
- LeGuin, U. K. (1969). *The left hand of darkness*. New York, NY: Ace Books.
- Leibert, T., Archer, J., Jr., Munson, J., & York, G. (2006). An exploratory study of client perceptions of Internet counseling and the therapeutic alliance. *Journal of Mental Health Counseling, 28*(1), 69–83.
- Lester, D., McSwain, S., & Gunn, J. F., III. (2011). A test of the validity of the IS PATH WARM warning signs for suicide. *Psychological Reports, 108*(2), 402–404. doi:10.2466/09.12.13.PR0.108.2.402-404
- Levy-Warren, M. (2014). A knot in the gut: Transference/counter-transference and issues of race, ethnicity, and class in an adolescent treatment. *Journal of Infant, Child & Adolescent Psychotherapy, 13*(2), 133–141. doi:10.1080/15289168.2014.905340
- Lilienfeld, S. O., Smith, S. F., & Watts, A. L. (2013). Issues in diagnosis: Conceptual issues and controversies. In W. E. Craighead & D. J. Miklowitz (Eds.), *Psychopathology: History, diagnosis, and empirical foundations* (2nd ed., pp. 1–35). Hoboken, NJ: Wiley.
- Linderman, F. B. (2002). *Plenty-Coups, chief of the Crows* (Rev. ed.). Lincoln: University of Nebraska Press.
- Linehan, M. M. (1993). *Cognitive behavioral therapy of borderline personality disorder*. New York, NY: Guilford Press.
- Linehan, M. M., Goodstein, J. L., Nielsen, S. L., & Chiles, J. A. (1983). Reasons for staying alive when you are thinking of killing yourself: The reasons for living inventory. *Journal of Consulting and Clinical Psychology, 51*(2), 276–286. doi:10.1037/0022-006X.51.2.276
- Linehan, M. M., Korslund, K. E., Harned, M. S., Gallop, R. J., Lungu, A., Neacsu, A. D., . . . Murray-Gregory, A. (2015). Dialectical behavior therapy for high suicide risk in individuals with borderline personality disorder: A randomized clinical trial and component analysis. *JAMA Psychiatry, 72*(5), 475–482. doi:10.1001/jamapsychiatry.2014.3039
- Links, P., Nisenbaum, R., Ambreen, M., Balderson, K., Bergmans, Y., Eynan, R., . . . Cutcliffe, J. (2012). Prospective study of risk factors for increased suicide ideation and behavior following recent discharge. *General Hospital Psychiatry, 34*(1), 88–97. doi:10.1016/j.genhosppsych.2011.08.016

- Litman, R. E. (1995). Suicide prevention in a treatment setting. *Suicide and Life-Threatening Behavior*, 25(1), 134–142.
- Lobbestael, J., Leurgans, M., & Arntz, A. (2011). Inter-rater reliability of the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID I) and Axis II Disorders (SCID II). *Clinical Psychology & Psychotherapy*, 18(1), 75–79. doi:10.1002/cpp.693
- Loeber, R., Pardini, D., Homish, D. L., Wei, E. H., Crawford, A. M., Farrington, D. P., . . . Rosenfeld, R. (2005). The prediction of violence and homicide in young men. *Journal of Consulting and Clinical Psychology*, 73(6), 1074–1088. doi:10.1037/0022-006X.73.6.1074
- Lopes, R. T., Gonçalves, M. M., Fassnacht, D., Machado, P.P.P., & Sousa, I. (2015). Time to improve and recover from depressive symptoms and interpersonal problems in a clinical trial. *Clinical Psychology & Psychotherapy*, 22(2), 97–105. doi:10.1002/cpp.1873
- Luborsky, L. (1984). *Principles of psychoanalytic psychotherapy: A manual for supportive-expressive treatment*. New York, NY: Basic Books.
- Luborsky, L., & Barrett, M. S. (2006). The history and empirical status of key psychoanalytic concepts. *Annual Review of Clinical Psychology*, 2, 1–19. doi:10.1146/annurev.clinpsy.2.022305.095328
- Luborsky, L., & Crits-Christoph, P. (1998). *Understanding transference: The core conflictual relationship theme method* (2nd ed.). Washington, DC: American Psychological Association. doi:10.1037/10250-000
- Luquet, W. (2006). *Short-term couples therapy: The imago model in action* (2nd ed.). New York, NY: Brunner/Mazel.
- MacDonald, B. (1987). *Mrs. Piggle-Wiggle*. New York, NY: Scholastic. (Original work published 1947)
- MacKay, S., Henderson, J., Del Bove, G., Marton, P., Warling, D., & Root, C. (2006). Fire interest and antisociality as risk factors in the severity and persistence of juvenile firesetting. *Journal of the American Academy of Child & Adolescent Psychiatry*, 45(9), 1077–1084.
- Mackintosh, N. J. (2011). *History of theories and measurement of intelligence*. New York, NY: Cambridge University Press. doi:10.1017/CBO9780511977244.002
- Mackrill, T. (2010). Goal consensus and collaboration in psychotherapy: An existential rationale. *Journal of Humanistic Psychology*, 50(1), 96–107. doi:10.1177/0022167809341997
- Madigan, S. (2011). *Narrative therapy*. Washington, DC: American Psychological Association.
- Magill, M., Gaume, J., Apodaca, T. R., Walther, J., Mastroleo, N. R., Borsari, B., & Longabaugh, R. (2014). The technical hypothesis of motivational interviewing: A meta-analysis of MI's key causal model. *Journal of Consulting and Clinical Psychology*, 82(6), 973–983. doi:10.1037/a0036833
- Maj, M. (2008). Delusions in major depressive disorder: Recommendations for the DSM-V. *Psychopathology*, 41(1), 1–3. doi:10.1159/000109948

- Malin, A. J., & Pos, A. E. (2015). The impact of early empathy on alliance building, emotional processing, and outcome during experiential treatment of depression. *Psychotherapy Research, 25*(4), 445–459. doi:10.1080/10503307.2014.901572
- Mallen, M. J., Vogel, D. L., Rochlen, A. B., & Day, S. X. (2005). Online counseling: Reviewing the literature from a counseling psychology framework. *Counseling Psychologist, 33*(6), 819–871. doi:10.1177/0011000005278624
- Mandal, E., & Zalewska, K. (2012). Childhood violence, experience of loss and hurt in close relationships at adulthood and emotional rejection as risk factors of suicide attempts among women. *Archives of Psychiatry and Psychotherapy, 14*(3), 45–50.
- Manjunatha, N., Saddichha, S., Sinha, B.N.P., & Khess, C.R.J. (2008). Assessment of mood and affect by mental state examination in different cultural contexts. *Psychopathology, 41*(5), 336-337. doi:10.1159/000146072
- Marangell, L. B., Bauer, M. S., Dennehy, E. B., Wisniewski, S. R., Allen, M. H., & Miklowitz, D. J. (2006). Prospective predictors of suicide and suicide attempts in 1,556 patients with bipolar disorders followed for up to 2 years. *Bipolar Disorders, 8*(5, Pt. 2), 566–575.
- Marin, G., & Marin, B. V. (1991). *Research with Hispanic populations*. Thousand Oaks, CA: Sage.
- Markowitz, J. C., & Weissman, M. M. (2012). Interpersonal psychotherapy: Past, present and future. *Clinical Psychology & Psychotherapy, 19*(2), 99–105. doi:10.1002/cpp.1774
- Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 68*(3), 438–450. doi:10.1037/0022-006X.68.3.438
- Martinez, A., & Lasser, J. (2013). Thinking outside the box while playing the game: A creative school-based approach to working with children and adolescents. *Journal of Creativity in Mental Health, 8*(1), 81–91. doi:10.1080/15401383.2013.763688
- Martin-Khan, M., Wootton, R., & Gray, L. (2010). A systematic review of the reliability of screening for cognitive impairment in older adults by use of standardised assessment tools administered via the telephone. *Journal of Telemedicine and Telecare, 16*(8), 422–428. doi:10.1258/jtt.2010.100209
- Matsumoto, D. (2007). Culture, context, and behavior. *Journal of Personality, 75*(6), 1285–1320. doi:10.1111/j.1467-6494.2007.00476.x
- Matsumoto, D., & Yoo, S. H. (2005). *Culture and applied nonverbal communication*. Mahwah, NJ: Erlbaum.
- Mattis, J. S., & Grayman-Simpson, N. A. (2013). *Faith and the sacred in African American life*. Washington, DC: American Psychological Association. doi:10.1037/14045-030
- Maurer, R. E., & Tindall, J. H. (1983). Effect of postural congruence on client's perception of counselor empathy. *Journal of Counseling Psychology, 30*(2), 158–163. doi:10.1037/0022-0167.30.2.158

- Mayotte-Blum, J., Slavin-Mulford, J., Lehmann, M., Pesale, F., Becker-Matero, N., & Hilsenroth, M. (2012). Therapeutic immediacy across long-term psychodynamic psychotherapy: An evidence-based case study. *Journal of Counseling Psychology, 59*(1), 27–40. doi:10.1037/a0026087
- McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress, 3*(1), 131–149. doi:10.1007/BF00975140
- McCoyd, J.L.M., & Kerson, T. S. (2006). Conducting intensive interviews using email: A serendipitous comparative opportunity. *Qualitative Social Work: Research and Practice, 5*(3), 389–406. doi:10.1177/1473325006067367
- McGlothlin, J. M. (2008). *Developing clinical skills in suicide assessment, prevention, and treatment*. Alexandria, VA: American Counseling Association.
- McGoldrick, M., Gerson, R., & Petry, S. (2008). *Genograms: Assessment and intervention* (3rd ed.). New York, NY: Norton.
- McIntosh, P. (1998). White privilege: Unpacking the invisible knapsack. In M. McGoldrick (Ed.), *Re-visioning family therapy: Race, gender and culture in clinical practice* (pp. 147–152). New York, NY: Guilford Press.
- McKay, D., & Ojserkis, R. (2015). Exposure in experiential context: Imaginal and in vivo approaches. In N. C. Thoma & D. McKay (Eds.), *Working with emotion in cognitive-behavioral therapy: Techniques for clinical practice* (pp. 83-104). New York, NY: Guilford Press.
- Meador, B., & Rogers, C. R. (1984). Person-centered therapy. In R. Corsini (Ed.), *Current psychotherapy* (pp. 142–195). Itasca, IL: Peacock.
- Meier, S. T. (2015). *Incorporating progress monitoring and outcome assessment into counseling and psychotherapy: A primer*. New York, NY: Oxford University Press.
- Meier, S. T., & Davis, S. R. (2011). *The elements of counseling* (7th ed.). Belmont, CA: Thomson Brooks/Cole.
- Mellin, E. A., & Pertuit, T. L. (2009). Research priorities for mental health counseling with youth: Implications for counselor preparation, professional development, and research. *Counselor Education and Supervision, 49*(2), 137–155. doi:10.1002/j.1556-6978.2009.tb00093.x
- Messina, I., Palmieri, A., Sambin, M., Kleinbub, J. R., Voci, A., & Calvo, V. (2013). Somatic underpinnings of perceived empathy: The importance of psychotherapy training. *Psychotherapy Research, 23*(2), 169–177. doi:10.1080/10503307.2012.748940
- Metcalf, K., Langdon, R., & Coltheart, M. (2007). Models of confabulation: A critical review and a new framework. *Cognitive Neuropsychology, 24*(1), 23–47.
- Michel, C., Schimmelmann, B. G., Kupferschmid, S., Siegwart, M., & Schultze-Lutter, F. (2014). Reliability of telephone assessments of at-risk criteria of psychosis: A comparison to face-to-face interviews. *Schizophrenia Research, 153*(1–3), 251–253. doi:10.1016/j.schres.2014.01.025
- Miller, G. (2012). *Fundamentals of crisis counseling*. Hoboken, NJ: Wiley.

- Miller, M. (1985). *Information center: Training workshop manual*. San Diego, CA: Information Center.
- Miller, W. R. (1978). Behavioral treatment of problem drinkers: A comparative outcome study of three controlled drinking therapies. *Journal of Consulting & Clinical Psychology*, 46(1), 74–86.
- Miller, W. R. (1983). Motivational interviewing with problem drinkers. *Behavioural Psychotherapy*, 11(2), 147–172.
- Miller, W. R. (2015). Motivational interviewing in treating addictions. In H. Arkowitz, W. R. Miller, & S. Rollnick (Eds.), *Motivational interviewing in the treatment of psychological problems* (2nd ed., pp. 249–270). New York, NY: Guilford Press.
- Miller, W. R., & Rollnick, S. (1991). *Motivational interviewing: Preparing people to change addictive behavior*. New York, NY: Guilford Press.
- Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change* (2nd ed.). New York, NY: Guilford Press.
- Miller, W. R., & Rollnick, S. (2013). *Motivational interviewing: Preparing people for change* (3rd ed.). New York, NY: Guilford Press.
- Miller, W. R., & Rose, G. S. (2009). Toward a theory of motivational interviewing. *American Psychologist*, 64(6), 527–537. <http://doi.org/10.1037/a0016830>
- Minuchin, S., Rosman, B. L., & Baker, L. (1978). *Psychosomatic families: Anorexia nervosa in context*. Oxford, England: Harvard University Press.
- Mitchell, A., Chen, C., & Medlin, B. D. (2010). Teaching and learning with Skype. In C. Wankel (Ed.), *The 16th Americas conference on information systems* (pp. 36–56). Greenwich, CT: IAP Information Age.
- Mitchell, P., Rhodes, P., Wallis, A., & Wilson, V. (2014). A comparison of two systemic family therapy reflecting team interventions. *Journal of Family Therapy*, 36(3), 237–254. doi:10.1111/1467-6427.12018
- Molnar, B. E., Berkman, L. F., & Buka, S. L. (2001). Psychopathology, childhood sexual abuse and other childhood adversities: Relative links to subsequent suicidal behaviour in the US. *Psychological Medicine*, 31(6), 965–977. doi:0.1017/S0033291701004329
- Monahan, J. (2013). *Violence risk assessment*. Hoboken, NJ: Wiley.
- Moon, C. H. (Ed.). (2010). *Materials and media in art therapy*. New York, NY: Routledge.
- Moraga, A. V., & Rodriguez-Pascual, C. (2007). Accurate diagnosis of delirium in elderly patients. *Current Opinion in Psychiatry*, 20(3), 262–267.
- Morales, E., & Norcross, J. C. (2010). Evidence-based practices with ethnic minorities: Strange bedfellows. *Journal of Clinical Psychology*, 66(8), 821–829.
- Moreno, C., Laje, G., Blanco, C., Jiang, H., Schmidt, A. B., & Olfson, M. (2007). National trends in the outpatient diagnosis and treatment of bipolar disorder in youth. *Archives of General Psychiatry*, 64(9), 1032–1039.

- Moreno, C. L. (2007). The relationship between culture, gender, structural factors, abuse, trauma, and HIV/AIDS for Latinas. *Qualitative Health Research, 17*(3), 340–352. doi:10.1177/1049732306297387
- Morrison, J. (2007). *The first interview* (3rd ed.). New York, NY: Guilford Press.
- Morsette, A., van den Pol, R., Schuldberg, D., Swaney, G., & Stolle, D. (2012). Cognitive behavioral treatment for trauma symptoms in American Indian youth: Preliminary findings and issues in evidence-based practice and reservation culture. *Advances in School Mental Health Promotion, 5*(1), 51–62. doi:1754730X.2012.664865
- Mosak, H. H. (1989). Adlerian psychotherapy. In R. J. Corsini & D. Wedding (Eds.), *Current psychotherapies* (4th ed., pp. 65–116). Itasca, IL: F. E. Peacock.
- Moules, N. J. (2003). Therapy on paper: Therapeutic letters and the tone of relationship. *Journal of Systemic Therapies, 22*(1), 33–49. doi:10.1521/jsyt.22.1.33.24091
- Mueller, R. M., Lambert, M. J., & Burlingame, G. M. (1998). Construct validity of the outcome questionnaire: A confirmatory factor analysis. *Journal of Personality Assessment, 70*(2), 248–262.
- Muhtz, C., Daneshi, J., Braun, M., & Kellner, M. (2010). Carbon-dioxide-induced flashback in a healthy man with a history of near-drowning. *Psychotherapy and Psychosomatics, 80*(1), 55–56. doi:10.1159/000316798
- Mulligan, J., Haddock, G., Hartley, S., Davies, J., Sharp, T., Kelly, J., . . . Barrowclough, C. (2014). An exploration of the therapeutic alliance within a telephone-based cognitive behaviour therapy for individuals with experience of psychosis. *Psychology and Psychotherapy: Theory, Research, Practice, Training, 87*(4), 393–410. doi:10.1111/papt.12018
- Mulligan, J., MacCulloch, R., Good, B., & Nicholas, D. B. (2012). Transparency, hope, and empowerment: A model for partnering with parents of a child with autism spectrum disorder at diagnosis and beyond. *Social Work in Mental Health, 10*(4), 311–330. doi:10.1080/15332985.2012.664487
- Murphy, B. C., & Dillon, C. (2011). *Interviewing in action in a multicultural world* (2nd ed.). Belmont, CA: Thomson Brooks/Cole.
- Murphy, J. (2015). *Solution-focused counseling in schools* (3rd ed.). Alexandria, VA: American Counseling Association.
- Murray, K. W., & Sommers-Flanagan, J. (2014). Addressing sexual attraction in supervision. In M. Luca (Ed.), *Sexual attraction in therapy: Clinical perspectives on moving beyond the taboo—A guide for training and practice* (pp. 97–114). London, England: Wiley-Blackwell.
- Murray, K. W., Sommers-Flanagan, J., & Sommers-Flanagan, R. (2012). Family systems theory and therapy. In J. Sommers-Flanagan & R. Sommers-Flanagan (Eds.), *Counseling and psychotherapy theories in context and practice: Skills, strategies, and techniques* (2nd ed., pp. 405–438). Hoboken, NJ: Wiley.
- Mustanski, B., & Liu, R. T. (2013). A longitudinal study of predictors of suicide attempts among lesbian, gay, bisexual, and transgender youth. *Archives of Sexual Behavior, 42*(3), 437–448. doi:10.1007/s10508-012-0013-9

- Mutschler, I., Reinbold, C., Wankerl, J., Seifritz, E., & Ball, T. (2013). Structural basis of empathy and the domain general region in the anterior insular cortex. *Frontiers in Human Neuroscience*, 7, 177. doi:10.3389/fnhum.2013.00177
- Myer, R. A. (2001). *Assessment for crisis intervention: An assessment triage model*. Belmont, CA: Wadsworth.
- Nagaoka, C., Kuwabara, T., Yoshikawa, S., Watabe, M., Komori, M., Oyama, Y., & Hatanaka, C. (2013). Implication of silence in a Japanese psychotherapy context: A preliminary study using quantitative analysis of silence and utterance of a therapist and a client. *Asia Pacific Journal of Counselling and Psychotherapy*, 4(2), 147–152. doi:10.1080/21507686.2013.790831
- Nagata, D. K., Kim, J.H.J., & Nguyen, T. U. (2015). Processing cultural trauma: Intergenerational effects of the Japanese American incarceration. *Journal of Social Issues*, 71(2), 356–370. doi:10.1111/josi.12115
- National Association of Social Workers. (2008). Code of ethics of the National Association of Social Workers. Washington, DC: Author.
- Neff, K. D., & Harter, S. (2003). Relationship styles of self-focused autonomy, other-focused connectedness, and mutuality across multiple relationship contexts. *Journal of Social and Personal Relationships*, 20(1), 81–99. doi:10.1177/0265407503020001189
- Negy, C. (2004). *Cross-cultural psychotherapy: Toward a critical understanding of diverse clients*. Reno, NV: Bent Tree Press.
- Neimeyer, R. A., Fortner, B., & Melby, D. (2001). Personal and professional factors and suicide intervention skills. *Suicide and Life-Threatening Behavior*, 31(1), 71–82. doi:10.1521/suli.31.1.71.21307
- Nemeroff, C. B. (2007, October). *Early life factors in depression*. Paper presented at the conference Investigating the Mind: Mindfulness, Compassion, and the Treatment of Depression, Emory University Mind and Life Institute, Atlanta, GA.
- Newman, C. F. (2013). *Core competencies in cognitive-behavioral therapy: Becoming a highly effective and competent cognitive-behavioral therapist*. New York, NY: Routledge.
- Norcross, J. C. (2000). Psychotherapist self-care: Practitioner-tested, research-informed strategies. *Professional Psychology: Research and Practice*, 31(6), 710–713. doi:10.1037/0735-7028.31.6.710
- Norcross, J. C. (2011). Evidence-based therapy relationships. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Evidence-based responsiveness* (2nd ed.). New York, NY: Oxford University Press.
- Norcross, J. C., & Karpikak, C. P. (2012). Clinical psychologists in the 2010s: 50 years of the APA division of clinical psychology. *Clinical Psychology: Science and Practice*, 19(1), 1–12. doi:10.1111/j.1468-2850.2012.01269.x
- Norcross, J. C., & Lambert, M. J. (2011). Psychotherapy relationships that work II. *Psychotherapy*, 48(1), 4–8. doi:10.1037/a0022180
- North, C. S., & Pfefferbaum, B. (2013). Mental health response to community disasters: A systematic review. *Journal of the American Medical Association*, 310(5), 507–518. doi:10.1001/jama.2013.107799

- Norton, C. L. (2011). Developing empathy: A case study exploring transference and countertransference with adolescent females who self-injure. *Journal of Social Work Practice*, 25(1), 95–107. doi:10.1080/02650530903525991
- O'Brien, R. P. (2012). *Cognitive-behavioral therapy with military couples*. New York, NY: Routledge/Taylor & Francis Group.
- Oetzel, K. B., & Scherer, D. G. (2003). Therapeutic engagement with adolescents in psychotherapy. *Psychotherapy: Theory, Research, Practice, Training*, 40(3), 215–225.
- O'Hanlon, W. H. (1998). Possibility therapy: An inclusive, collaborative, solution-based model of psychotherapy. In M. F. Hoyt (Ed.), *The handbook of constructive therapies* (pp. 137–158). San Francisco, CA: Jossey-Bass.
- O'Hanlon, W. H., & Weiner-Davis, M. (1989). *In search of solutions*. New York, NY: Norton.
- Onedera, J. D. (Ed.). (2008). *The role of religion in marriage and family counseling*. New York, NY: Routledge/Taylor & Francis.
- Orbinski, J. (2008). *An imperfect offering: Humanitarian action for the 21st century*. New York, NY: Walker & Company.
- Ortiz, S. O., & Ochoa, S. H. (2005). *Advances in cognitive assessment of culturally and linguistically diverse individuals: A nondiscriminatory interpretive approach*. New York, NY: Guilford Press.
- O'Shea, G., Spence, S. H., & Donovan, C. L. (2014). Interpersonal factors associated with depression in adolescents: Are these consistent with theories underpinning interpersonal psychotherapy? *Clinical Psychology & Psychotherapy*, 21(6), 548–558.
- Ostrosky-Solís, F., & Lozano, A. (2006). Digit span: Effect of education and culture. *International Journal of Psychology*, 41(5), 333–341. doi:10.1080 /002027590500345724
- Othmer, E., & Othmer, S. C. (2002). *The clinical interview using DSM-IV-TR: Vol. 1. Fundamentals*. Washington, DC: American Psychiatric Publishing.
- Pabian, Y. L., Welfel, E., & Beebe, R. S. (2009). Psychologists' knowledge of their states' laws pertaining to Tarasoff-type situations. *Professional Psychology: Research and Practice*, 40(1), 8–14. doi:10.1037/a0014784
- Packman, W. L., Marlitt, R. E., Bongar, B., & Pennuto, T. O. (2004). A comprehensive and concise assessment of suicide risk. *Behavioral Sciences & the Law*, 22(5), 667–680. doi:10.1002/bls.610
- Paniagua, F. A. (2001). *Diagnosis in a multicultural context*. Thousand Oaks, CA: Sage.
- Paniagua, F. A. (2010). Assessment and diagnosis in a cultural context. In M. M. Leach & J. D. Aten (Eds.), *Culture and the therapeutic process* (pp. 65–98). New York, NY: Routledge/Taylor & Francis.
- Paprocki, C. M. (2014). When personal and professional values conflict: Trainee perspectives on tensions between religious beliefs and affirming treatment of LGBT clients. *Ethics & Behavior*, 24(4), 279–292. doi:10.1080/10508422.2013.860029

- Patrick, S., & Connolly, C. M. (2009). The token activity: Generating awareness of power in counseling relationships. *Journal of Multicultural Counseling and Development*, 37(2), 117–128. doi:10.1002/j.2161-1912.2009.tb00096.x
- Paul, G. L. (1969). Behavior modification research: Design and tactics. In C. M. Franks (Ed.), *Behavior therapy: Appraisal and status* (pp. 29–62). New York, NY: McGraw-Hill.
- Pearlman, L. A., & Mac Ian, P. S. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology: Research and Practice*, 26(6), 558–565. doi:10.1037/0735-7028.26.6.558
- Pease-Carter, C., & Minton, C.A.B. (2012). Counseling programs' informed consent practices: A survey of student preferences. *Counselor Education and Supervision*, 51(4), 308–319. doi:10.1002/j.1556-6978.2012.00023.x
- Pennebaker, J. W., & Ferrell, J. D. (2013). Can expressive writing change emotions? An oblique answer to the wrong question. *Changing emotions* (pp. 183–186). New York, NY: Psychology Press.
- Pennebaker, J. W., Zech, E., & Rimé, B. (2001). *Disclosing and sharing emotion: Psychological, social, and health consequences*. Washington, DC: American Psychological Association. doi:10.1037/10436-022
- Persons, J. B. (2008). *The case formulation approach to cognitive-behavior therapy*. New York, NY: Guilford Press.
- Peterson, J. F., Pun, B. T., Dittus, R. S., Thomason, J.W.W., Jackson, J. C., Shintani, A. K., & Ely, E. W. (2006). Delirium and its motoric subtypes: A study of 614 critically ill patients. *Journal of the American Geriatrics Society*, 54(3), 479–484. doi:10.1111/j.1532-5415.2005.00621.x
- Phillips, J., Frances, A., Cerullo, M. A., Chardavoyne, J., Decker, H. S., First, M. B., . . . Zachar, P. (2012). The six most essential questions in psychiatric diagnosis: A pluralogue part 3: Issues of utility and alternative approaches in psychiatric diagnosis. *Philosophy, Ethics, and Humanities in Medicine*, 7(9). doi:10.1186/1747-5341-7-9
- Piper, W. E., McCallum, M., Joyce, A. S., Azim, H. F., & Ograniczuk, J. S. (1999). Follow-up findings for interpretive and supportive forms of psychotherapy and patient personality variables. *Journal of Consulting and Clinical Psychology*, 67, 267–273.
- Pipes, R. B., & Davenport, D. S. (1999). *Introduction to psychotherapy: Common clinical wisdom*. Englewood Cliffs, NJ: Prentice Hall.
- Poelzl, L. (2011). Reflective paper: Bisexual issues in sex therapy: A bisexual surrogate partner relates her experiences from the field. *Journal of Bisexuality*, 11(4), 385–388. doi:10.1080/15299716.2011.620454
- Polanski, P. J., & Hinkle, J. S. (2000). The mental status examination: Its use by professional counselors. *Journal of Counseling & Development*, 78(3), 357–364.
- Pomerantz, A. M. (2011). *Clinical psychology: Science, practice, and culture* (2nd ed.). Thousand Oaks, CA: Sage.

- Ponton, R. F., & Sauerheber, J. D. (2014). Supervisee countertransference: A holistic supervision approach. *Counselor Education and Supervision*, 53(4), 254–266. doi:10.1002/j.1556-6978.2014.00061.x
- Pope, K. S. (1990). Therapist-patient sex as sex abuse: Six scientific, professional and practical dilemmas in addressing victimization and rehabilitation. *Professional Psychology: Research and Practice*, 21, 227–239.
- Pottick, K. J., Kirk, S. A., Hsieh, D. K., & Tian, X. (2007). Judging mental disorder in youths: Effects of client, clinician, and contextual differences. *Journal of Consulting and Clinical Psychology*, 75(1), 1–8. doi:10.1037/0022-006X.75.1.1
- Pouliot, L., & De Leo, D. (2006). Critical issues in psychological autopsy studies. *Suicide and Life-Threatening Behavior*, 36(5), 491–510. doi:10.1521/suli.2006.36.5.491
- Prochaska, J. O. (1979). *Systems of psychotherapy: A transtheoretical analysis*. Chicago, IL: Dorsey.
- Prochaska, J. O., & DiClemente, C. C. (2005). *The transtheoretical approach*. New York, NY: Oxford University Press.
- Prochaska, J. O., Norcross, J. C., & DiClemente, C. C. (1994). *Changing for good*. New York, NY: William Morrow.
- Puig-Antich, J., Chambers, W., & Tabrizi, M. A. (1983). The clinical assessment of current depressive episodes in children and adolescents: Interviews with parents and children. In D. Cantweel, & G. Carlson (Eds.), *Childhood depression* (pp. 157–179). New York, NY: Spectrum.
- Quiñones, V., Jurska, J., Fener, E., & Miranda, R. (2015). Active and passive problem solving: Moderating role in the relation between depressive symptoms and future suicidal ideation varies by suicide attempt history. *Journal of Clinical Psychology*, 71(4), 402–412. doi:10.1002/jclp.22155
- Quinsey, V. L., Harris, G. T., Rice, M. E., & Cormier, C. A. (2006). *Actuarial prediction of violence*. Washington, DC: American Psychological Association. doi:10.1037/11367-008
- Ransom, D., Heckman, T. G., Anderson, T., Garske, J., Holroyd, K., & Basta, T. (2008). Telephone-delivered, interpersonal psychotherapy for HIV-infected rural persons with depression: A pilot trial. *Psychiatric Services*, 59(8), 871–877. doi:10.1176/appi.ps.59.8.871
- Rassin, E., Cougle, J. R., & Muris, P. (2007). Content difference between normal and abnormal obsessions. *Behaviour Research and Therapy*, 45(11), 2800–2803. doi:10.1016/j.brat.2007.07.006
- Rassin, E., & Muris, P. (2007). Abnormal and normal obsessions: A reconsideration. *Behaviour Research and Therapy*, 45(5), 1065–1070. doi:10.1016/j.brat.2006.05.005
- Rastogi, M., & Wieling, E. (Eds.). (2004). *Voices of color: First person accounts of ethnic minority therapists*. New York, NY: Sage.
- Ratts, M. J., Singh, A. A., Nassar-McMillan, S., Butler, S. K., & McCullough, J. R. (2015). Multicultural and social justice counseling competencies. Alexandria,

- VA: American Counseling Association. Retrieved from <http://www.counseling.org/knowledge-center/competencies>
- Ray, D. C. (2011). *Advanced play therapy: Essential conditions, knowledge, and skills for child practice*. New York, NY: Routledge.
- Read, J., Agar, K., Barker-Collo, S., Davies, E., & Moskowitz, A. (2001). Assessing suicidality in adults: Integrating childhood trauma as a major risk factor. *Professional Psychology: Research and Practice*, 32(4), 367–372. doi:10.1037/0735-7028.32.4.367
- Reed, G. M. (2010). Toward ICD-11: Improving the clinical utility of WHO's international classification of mental disorders. *Professional Psychology: Research and Practice*, 41, 457–464. doi:10.1037/a0021701
- Reed, K. P., Nugent, W., & Cooper, R. L. (2015). Testing a path model of relationships between gender, age, and bullying victimization and violent behavior, substance abuse, depression, suicidal ideation, and suicide attempts in adolescents. *Children and Youth Services Review*, 55, 128–137. doi:10.1016/j.childyouth.2015.05.016
- Regev, D., & Snir, S. (2015). Objectives, interventions and challenges in parent-child art psychotherapy. *Arts in Psychotherapy*, 42, 50–56. doi:10.1016/j.aip.2014.12.007
- Rehfuss, M. C., Gambrell, C. E., & Meyer, D. (2012). Counselors' perceived person-environment fit and career satisfaction. *Career Development Quarterly*, 60(2), 145–151. doi:10.1002/j.2161-0045.2012.00012.x
- Reiter, M. D. (2010). Hope and expectancy in solution-focused brief therapy. *Journal of Family Psychotherapy*, 21(2), 132–148. doi:10.1080/08975353.2010.483653
- Reynolds, D. J., Jr., Stiles, W. B., Bailer, A. J., & Hughes, M. R. (2013). Impact of exchanges and client–therapist alliance in online-text psychotherapy. *Cyberpsychology, Behavior, and Social Networking*, 16(5), 370–377. doi:10.1089/cyber.2012.0195
- Ribeiro, J. D., Pease, J. L., Gutierrez, P. M., Silva, C., Bernert, R. A., Rudd, M. D., & Joiner, T. E. (2012). Sleep problems outperform depression and hopelessness as cross-sectional and longitudinal predictors of suicidal ideation and behavior in young adults in the military. *Journal of Affective Disorders*, 136(3), 743–750. doi:10.1016/j.jad.2011.09.049
- Ribeiro, J. D., Silva, C., & Joiner, T. E. (2014). Overarousal interacts with a sense of fearlessness about death to predict suicide risk in a sample of clinical outpatients. *Psychiatry Research*, 218(1–2), 106–112. doi:10.1016/j.psychres.2014.03.036
- Richards, S. D., Pillay, J., & Fritz, E. (2012). The use of sand tray techniques by school counsellors to assist children with emotional and behavioural problems. *Arts in Psychotherapy*, 39(5), 367–373. doi:10.1016/j.aip.2012.06.006
- Richardson, B. G. (2016). *Working with challenging youth: Lessons learned along the way* (2nd ed.). New York, NY: Routledge.
- Rilke, R. M. (2000). *Letters to a young poet* (J. Burnham, Trans.). Novato, CA: New World Library. (Original work published 1929)

- Robey, P. A., & Carlson, J. (2011). Adlerian therapy with couples. *Case studies in couples therapy: Theory-based approaches* (pp. 41–51). New York, NY: Routledge/Taylor & Francis.
- Robinson, D. J. (2007). My favorite tips for exploring difficult topics such as delusions and substance abuse. *Psychiatric Clinics of North America*, 30(2), 239–244. doi:10.1016/j.psc.2007.01.008
- Rodríguez Andrés, A., & Hempstead, K. (2011). Gun control and suicide: The impact of state firearm regulations in the United States, 1995–2004. *Health Policy*, 101(1), 95–103. doi:10.1016/j.healthpol.2010.10.005
- Rogers, C. R. (1942). *Counseling and psychotherapy*. Boston, MA: Houghton Mifflin.
- Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, 21, 95–103.
- Rogers, C. R. (1967). *The therapeutic relationship and its impact: A study of psychotherapy with schizophrenics*. Madison: University of Wisconsin Press.
- Rogers, C. R. (1961). *On becoming a person*. Boston, MA: Houghton Mifflin.
- Rogers, C. R. (1980). *A way of being*. Boston, MA: Houghton Mifflin.
- Rolling, E. S., & Brosi, M. W. (2010). A multi-leveled and integrated approach to assessment and intervention of intimate partner violence. *Journal of Family Violence*, 25(3), 229–236. doi:10.1007/s10896-009-9286-8
- Rollnick, S., & Bell, A. (1991). Brief motivational interviewing for use by the nonspecialist. *Motivational interviewing* (pp. 203–213). New York, NY: Guilford Press.
- Rollnick, S., & Miller, W. R. (1995). What is motivational interviewing? *Behavioural & Cognitive Psychotherapy*, 23(4), 325–334.
- Romano, M., & Peters, L. (2015). Evaluating the mechanisms of change in motivational interviewing in the treatment of mental health problems: A review and meta-analysis. *Clinical Psychology Review*, 38, 1–12. doi:10.1016/j.cpr.2015.02.008
- Roosevelt, E. (1992). *The autobiography of Eleanor Roosevelt*. New York, NY: Da Capo Press. (Original work published 1937)
- Rosenberg, J. I. (1999). Suicide prevention: An integrated training model using affective and action-based interventions. *Professional Psychology: Research and Practice*, 30(1), 83–87. doi:10.1037/0735-7028.30.1.83
- Rothen, S., Vandeleur, C. L., Lustenberger, Y., Jeanprêtre, N., Ayer, E., Gamma, F., . . . Preisig, M. (2009). Parent-child agreement and prevalence estimates of diagnoses in childhood: Direct interview versus family history method. *International Journal of Methods in Psychiatric Research*, 18(2), 96–109. doi:10.1002/mpr.281
- Rozbroj, T., Lyons, A., Pitts, M., Mitchell, A., & Christensen, H. (2014). Assessing the applicability of e-therapies for depression, anxiety, and other mood disorders among lesbians and gay men: Analysis of 24 web- and mobile phone-based self-help interventions. *Journal of Medical Internet Research*, 16(7), 144–154. doi:10.2196/jmir.3529

- Rudd, M. D. (1989). The prevalence of suicidal ideation among college students. *Suicide and Life-Threatening Behavior, 19*(2), 173–183.
- Rudd, M. D., Mandrusiak, M., & Joiner, T. E. (2006). The case against no-suicide contracts: The commitment to treatment statement as a practice alternative. *Journal of Clinical Psychology, 62*(2), 243–251. doi:10.1002/jclp.20227
- Rummell, C. M., & Joyce, N. R. (2010). “So wat do u want to wrk on 2day?”: The ethical implications of online counseling. *Ethics & Behavior, 20*(6), 482–496. doi:10.1080/10508422.2010.521450
- Runyan, C. W., Brown, T. L., & Brooks-Russell, A. (2015). Preventing the invisible plague of firearm suicide. *American Journal of Orthopsychiatry, 85*(3), 221–224.
- Rutter, P. A. (2012). Sex therapy with gay male couples using affirmative therapy. *Sexual and Relationship Therapy, 27*(1), 35–45. doi:10.1080/14681994.2011.633078
- Ruzek, J. I., Brymer, M. J., Jacobs, A. K., Layne, C. M., Vernberg, E. M., & Watson, P. J. (2007). Psychological first aid. *Journal of Mental Health Counseling, 29*(1), 17–49.
- Sáez-Fonseca, L. L., & Walker, Z. (2007). Long-term outcome of depressive pseudodementia in the elderly. *Journal of Affective Disorders, 101*(1–3), 123–129. doi:10.1016/j.jad.2006.11.004
- Safran, J. D., & Kraus, J. (2014). Alliance ruptures, impasses, and enactments: A relational perspective. *Psychotherapy, 51*(3), 381–387. doi:10.1037/a0036815
- Safran, J. D., Muran, J. C., & Eubanks-Carter, C. (2011). Repairing alliance ruptures. *Psychotherapy, 48*(1), 80–87. doi:10.1037/a0022140
- Safran, J. D., Muran, J. C., & Rothman, M. (2006). *The therapeutic alliance: Cultivating and negotiating the therapeutic relationship*. Amsterdam, Netherlands: Elsevier.
- Saint-Exupéry, A. de. (1971). *The little prince*. New York, NY: Harcourt Brace Jovanovich. (Original work published 1943)
- Salmela, S., Poskiparta, M., Kasila, K., Vähäsarja, K., & Vanhala, M. (2009). Transtheoretical model-based dietary interventions in primary care: A review of the evidence in diabetes. *Health Education Research, 24*(2), 237–252. doi:10.1093/her/cyn015
- Salmon, K. (2006). Toys in clinical interviews with children: Review and implications for practice. *Clinical Psychologist, 10*(2), 54–59. doi:10.1080/13284200600681601
- Satir, V. M. (1967). *Conjoint family therapy* (Rev. ed.). Palo Alto, CA: Science and Behavior Books.
- Schneider, K. J., & Krug, O. T. (2010). *Existential-humanistic therapy*. Washington, DC: American Psychological Association.
- Schoenholtz, J. C. (2012). *The managed healthcare industry: A market failure* (2nd ed.). North Charleston, SC: CreateSpace.
- Searles, H. F. (1955). The informational value of the supervisor's emotional experiences. *Psychiatry: Journal for the Study of Interpersonal Processes, 18*, 135–146.
- Segal, D. L., & Hersen, M. (Eds.). (2010). *Diagnostic interviewing* (4th ed.). New York, NY: Springer.

- Seligman, L., & Reichenberg, L. W. (2012). *Selecting effective treatments: A comprehensive, systematic guide to treating mental disorders* (4th ed.). Hoboken, NJ: Wiley.
- Senior, A. C., Kunik, M. E., Rhoades, H. M., Novy, D. M., Wilson, N. L., & Stanley, M. A. (2007). Utility of telephone assessments in an older adult population. *Psychology and Aging, 22*(2), 392–397. doi:10.1037/0882-7974.22.2.392
- Serby, M. (2003). Psychiatric resident conceptualizations of mood and affect within the mental status examination. *American Journal of Psychiatry, 160*(8), 1527–1529. doi:10.1176/appi.ajp.160.8.1527
- Sexton, T., & Turner, C. W. (2011). The effectiveness of functional family therapy for youth with behavioral problems in a community practice setting. *Couple and Family Psychology: Research and Practice, 1*, 3–15. doi:10.1037/2160-4096.1.S.3
- Shapiro, F. (2002). *EMDR as an integrative psychotherapy approach: Experts of diverse orientations explore the paradigm prism*. Washington, DC: American Psychological Association.
- Sharpley, C. F. (1984). Predicate matching in NLP: A review of research on the preferred representational system. *Journal of Counseling Psychology, 31*(2), 238–248. doi:10.1037/0022-0167.31.2.238
- Shaw, S. L., Lombardero, A., Babins-Wagner, R., & Sommers-Flanagan, J. (2016). *Psychotherapy with Canadian Aboriginal peoples: Therapeutic alliance, psychotherapist training, and outcome*. Unpublished manuscript.
- Shea, S. C. (1998). *Psychiatric interviewing: The art of understanding* (2nd ed.). Philadelphia, PA: Saunders.
- Shea, S. C. (2004). Suicidal ideation: Clear understanding and use of an interviewing strategy such as the chronological assessment of suicide events (CASE approach) can help clarify intent and immediate danger to the patient. *Psychiatric Annals, 34*(5), 385–400.
- Shea, S. C., & Barney, C. (2015). Teaching clinical interviewing skills using role-playing: Conveying empathy to performing a suicide assessment: A primer for individual role-playing and scripted group role-playing. *Psychiatric Clinics of North America, 38*(1), 147–183. doi:10.1016/j.psc.2014.10.001
- Shedler, J. (2010). The efficacy of psychodynamic psychotherapy. *American Psychologist, 65*(2), 98–109. doi:10.1037/a0018378
- Sheldon, C., Waxmonsky, J. A., Meir, R., Morris, C., Finkelstein, L., Sosa, M., & Brody, D. (2014). Telephone assessment, support, and counseling for depression in primary care medical clinics. *Cognitive and Behavioral Practice, 21*(3), 282–295. doi:10.1016/j.cbpra.2014.04.005
- Shelton, K., & Delgado-Romero, E. A. (2013). Sexual orientation microaggressions: The experiences of lesbian, gay, bisexual, and queer clients in psychotherapy. *Psychology of Sexual Orientation and Gender Diversity, 1*, 59–70.
- Sher, L. (2006). Alcoholism and suicidal behavior: A clinical overview. *Acta Psychiatrica Scandinavica, 113*(1), 13–22.

- Shimoyama, T. (2012). *Barefoot psychotherapy* [in Japanese]. Tokyo, Japan: Misuzu. (Original work published 1989) (Quotation in Nagaoka et al., 2013, is translated by the authors under supervision of a native English speaker.)
- Shirk, S. R., Karver, M. S., & Brown, R. (2011). The alliance in child and adolescent psychotherapy. *Psychotherapy, 48*(1), 17–24. doi:10.1037/a0022181
- Shneidman, E. S. (1980). Psychotherapy with suicidal patients. In T. B. Karasu & A. S. Bellack (Eds.), *Specialized techniques in individual psychotherapy*. (pp. 306–328). New York, NY: Brunner/Mazel.
- Shneidman, E. S. (1984). Aphorisms of suicide and some implications for psychotherapy. *American Journal of Psychotherapy, 38*(3), 319–328.
- Shneidman, E. S. (1996). *The suicidal mind*. New York, NY: Oxford University Press.
- Silverman, M. M., & Berman, A. L. (2014). Suicide risk assessment and risk formulation part I: A focus on suicide ideation in assessing suicide risk. *Suicide and Life-Threatening Behavior, 44*(4), 420–431.
- Silverman, W. (1987). *Anxiety disorders interview schedule for children (ADIS)*. Albany, NY: Graywind.
- Skinner, B. F. (1977). Why I am not a cognitive psychologist. *Behaviorism, 5*, 1–10.
- Skovholt, T. M., & Trotter-Mathison, M. (2011). *The resilient practitioner: Burnout prevention and self-care strategies for counselors, therapists, teachers, and health professionals* (2nd ed.). New York, NY: Routledge/Taylor & Francis.
- Slama, M. (2010). The agency of the heart: Internet chatting as youth culture in Indonesia. *Social Anthropology/Anthropologie Sociale, 18*(3), 316–330. doi:10.1111/j.1469-8676.2010.00110.x
- Smith, H. B. (2006). Providing mental health services to clients in crisis or disaster situations. In G. R. Walz, J. Bleuer, & R. K. Yep (Eds.), *VISTAS: Compelling perspectives on counseling, 2006* (pp. 13–15). Alexandria, VA: American Counseling.
- Smith, H.F.I. (2011). *The mental status examination and brief social history in clinical psychology*. lulu.com: Author.
- Smith, T. B., Rodríguez, M. D., & Bernal, G. (2011). Culture. *Journal of Clinical Psychology, 67*(2), 166–175.
- Smith-Hanen, S. S. (1977). Effects of nonverbal behaviors on judged levels of counselor warmth and empathy. *Journal of Counseling Psychology, 24*(2), 87–91. doi:10.1037/0022-0167.24.2.87
- Sommers-Flanagan, J. (2015). Evidence-based relationship practice: Enhancing counselor competence. *Journal of Mental Health Counseling, 37*, 95–108.
- Sommers-Flanagan, J. (2016). Clinical interview. In J. C. Norcross, G. R. Vandenberg-Bos, & D. K. Freedheim (Eds.), *APA handbook of clinical psychology* (pp. 1–16). Washington, D.C.: American Psychological Association.
- Sommers-Flanagan, J., & Barr, L. (2005). Three constructive interventions for divorced, divorcing, or never-married parents. *The Family Journal, 13*(4), 482–486. doi:10.1177/1066480705278725

- Sommers-Flanagan, J., & Bequette, T. (2013). The initial psychotherapy interview with adolescent clients. *Journal of Contemporary Psychotherapy*, 43(1), 13–22.
- Sommers-Flanagan, J., & Campbell, D. (2009). Psychotherapy and (or) medications for depression in youth? An evidence-based review with recommendations for treatment. *Journal of Contemporary Psychotherapy*, 39(2), 111–120.
- Sommers-Flanagan, J., & Means, J. R. (1987). Thou shalt not ask questions: An approach to teaching interviewing skills. *Teaching of Psychology*, 14(3), 164–166.
- Sommers-Flanagan, J., Murray, K. W., & Yoshimura, C. (2015). Filial play therapy and other strategies for working with parents. In D. Capuzzi and M. Stauffer (Eds.), *Foundations of couples, marriage, and family counseling* (pp. 361–388). Hoboken, NJ: Wiley.
- Sommers-Flanagan, J., Richardson, B. G., & Sommers-Flanagan, R. (2011). A multi-theoretical, evidence-based approach for understanding and managing adolescent resistance to psychotherapy. *Journal of Contemporary Psychotherapy*, 41(2), 69–80. doi:10.1007/s10879-010-9164-y
- Sommers-Flanagan, J., & Sommers-Flanagan, R. (1989). A categorization of pitfalls common to beginning interviewers. *Journal of Training & Practice in Professional Psychology: Research and Practice*, 3(1), 58–71.
- Sommers-Flanagan, J., & Sommers-Flanagan, R. (1995a). Intake interviewing with suicidal patients: A systematic approach. *Professional Psychology: Research and Practice*, 26(1), 41–47.
- Sommers-Flanagan, J., & Sommers-Flanagan, R. (1995b). Psychotherapeutic techniques with treatment-resistant adolescents. *Psychotherapy: Theory, Research, Practice, Training*, 32(1), 131–140. doi:10.1037/0033-3204.32.1.131
- Sommers-Flanagan, J., & Sommers-Flanagan, R. (1998). Assessment and diagnosis of conduct disorder. *Journal of Counseling & Development*, 76(2), 189–197.
- Sommers-Flanagan, J. & Sommers-Flanagan, R. (Directors). (2004). *The challenge of counseling teens: Counselor behaviors that reduce resistance and facilitate connection* [Video/DVD]. North Amherst, MA: Microtraining Associates.
- Sommers-Flanagan, J., & Sommers-Flanagan, R. (2007a). Our favorite tips for interviewing couples and families. *Psychiatric Clinics of North America*, 30(2), 275–281. doi:10.1016/j.psc.2007.02.003
- Sommers-Flanagan, J., & Sommers-Flanagan, R. (2007b). *Tough kids, cool counseling: User-friendly approaches with challenging youth* (2nd ed.). Alexandria, VA: American Counseling Association.
- Sommers-Flanagan, J., & Sommers-Flanagan, R. (2011). *How to listen so parents will talk and talk so parents will listen*. Hoboken, NJ: Wiley.
- Sommers-Flanagan, J., & Sommers-Flanagan, R. (2012). *Counseling and psychotherapy theories in context and practice: Skills, strategies, and techniques* (2nd ed.). Hoboken, NJ: Wiley.
- Sommers-Flanagan, J., Zeleke, W., & Hood, M. E. (2015). The clinical interview. In R. Cautin and S. Lilienfeld (Eds.), *The encyclopedia of clinical psychology* (pp. 1–9). London, England: Wiley-Blackwell.

- Sommers-Flanagan, R. (2007). Ethical considerations in crisis and humanitarian interventions. *Ethics & Behavior, 17*(2), 187–202.
- Sommers-Flanagan, R. (2012). *Boundaries, multiple roles, and the professional relationship*. Washington, DC: American Psychological Association. doi:10.1037/13271-009
- Sommers-Flanagan, R., Elliott, D., & Sommers-Flanagan, J. (1998). Exploring the edges: Boundaries and breaks. *Ethics & Behavior, 8*(1), 37–48. doi:10.1207/s15327019eb0801\_3
- Sommers-Flanagan, R., & Sommers-Flanagan, J. (2007). *Becoming an ethical helping professional: Cultural and philosophical foundations*. Hoboken, NJ: Wiley.
- Spencer, R. J., Wendell, C. R., Giggey, P. P., Katzel, L. I., Lefkowitz, D. M., Siegel, E. L., & Waldstein, S. R. (2013). Psychometric limitations of the mini-mental state examination among nondemented older adults: An evaluation of neurocognitive and magnetic resonance imaging correlates. *Experimental Aging Research, 39*(4), 382–397. doi:10.1080/0361073X.2013.808109
- Sperry, L., Carlson, J., & Peluso, P. R. (2006). *Couples therapy: Integrating theory and technique* (2nd ed.). Denver, CO: Love Publishing.
- Spiegler, M. D., & Guevremont, D. C. (2016). *Contemporary behavior therapy* (6th ed.). Belmont, CA: Wadsworth/Cengage Learning.
- Stanley, B., & Brown, G. K. (2012). Safety planning intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice, 19*(2), 256–264. doi:10.1016/j.cbpra.2011.01.001
- Steenkamp, M. M., Litz, B. T., Gray, M. J., Lebowitz, L., Nash, W., Conoscenti, L., . . . Lang, A. (2011). A brief exposure-based intervention for service members with PTSD. *Cognitive and Behavioral Practice, 18*(1), 98–107. doi:10.1016/j.cbpra.2009.08.006
- Stefansson, J., Nordström, P., & Jokinen, J. (2012). Suicide intent scale in the prediction of suicide. *Journal of Affective Disorders, 136*(1–2), 167–171. doi:10.1016/j.jad.2010.11.016
- Stern, E. M. (1985). *Psychotherapy and the religiously committed patient*. New York, NY: Haworth Press.
- Sternberg, R. J. (2005). *The triarchic theory of successful intelligence*. New York, NY: Guilford Press.
- Stiles-Shields, C., Kwasny, M. J., Cai, X., & Mohr, D. C. (2014). Therapeutic alliance in face-to-face and telephone-administered cognitive behavioral therapy. *Journal of Consulting and Clinical Psychology, 82*(2), 349–354. doi:10.1037/a0035554
- Stocks, E. L., Lishner, D. A., Waits, B. L., & Downum, E. M. (2011). I'm embarrassed for you: The effect of valuing and perspective taking on empathic embarrassment and empathic concern. *Journal of Applied Social Psychology, 41*(1), 1–26. doi:10.1111/j.1559-1816.2010.00699.x
- Stolle, D., Hutz, A., & Sommers-Flanagan, J. (2005). The impracticalities of R. B. Stuart's practical multicultural competencies. *Professional Psychology: Research and Practice, 36*(5), 574–576. doi:10.1037/0735-7028.36.5.574

- Stolzenberg, S., & Pezdek, K. (2013). Interviewing child witnesses: The effect of forced confabulation on event memory. *Journal of Experimental Child Psychology*, 114(1), 77–88. doi:10.1016/j.jecp.2012.09.006
- Stone, C. B. (2013). *School counseling principles: Ethics and law* (2nd ed.). Alexandria, VA: American School Counselor Association.
- Stone, J., Smyth, R., Carson, A., Warlow, C., & Sharpe, M. (2006). La belle indifférence in conversion symptoms and hysteria: Systematic review. *British Journal of Psychiatry*, 188(3), 204–209. doi:10.1192/bjp.188.3.204
- Strassle, C. G., Borckardt, J. J., Handler, L., & Nash, M. (2011). Videotape role induction for psychotherapy: Moving forward. *Psychotherapy*, 48(2), 170–178. doi:10.1037/a0022702
- Strub, R. L., & Black, F. W. (1977). *The mental status exam in neurology*. Philadelphia, PA: Davis.
- Strupp, H. H. (1983). Psychoanalytic psychotherapy. In M. Hersen, A. E. Kazdin, & A.S. Bellack (Eds.), *The clinical psychology handbook* (pp. 471–488). New York, NY: Pergamon Press.
- Sue, D. W. (2010). *Microaggressions in everyday life: Race, gender, and sexual orientation*. Hoboken, NJ: Wiley.
- Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling & Development*, 70(4), 477–486.
- Sue, D. W., & Sue, D. (2016). *Counseling the culturally diverse: Theory and practice* (7th ed.). Hoboken, NJ: Wiley.
- Sue, S. (1977). Community mental health services to minority groups: Some optimism, some pessimism. *American Psychologist*, 32, 616–624.
- Sue, S. (1998). In search of cultural competence in psychotherapy and counseling. *American Psychologist*, 53, 440–448.
- Sue, S. (2006). Cultural competency: From philosophy to research and practice. *Journal of Community Psychology*, 34(2), 237–245. doi:10.1002/jcop.20095
- Sue, S., & Zane, N. (2009). The role of culture and cultural techniques in psychotherapy: A critique and reformulation. *Asian American Journal of Psychology*, 5(1), 3–14.
- Suler, J. (2004). The online disinhibition effect. *CyberPsychology & Behavior*, 7(3), 321–326. doi:10.1089/1094931041291295
- Sutton, C. T., & Broken Nose, M. A. (2005). *American Indian families: An overview*. New York, NY: Guilford Press.
- Swartz, S. H., Cowan, T. M., Klayman, J. E., Welton, M. T., & Leonard, B. A. (2005). Use and effectiveness of tobacco telephone counseling and nicotine therapy in Maine. *American Journal of Preventive Medicine*, 29(4), 288–294. doi:10.1016/j.amepre.2005.06.015
- Sweeney, T. J. (2009). *Adlerian counseling and psychotherapy: A practitioner's approach* (5th ed.). New York, NY: Routledge/Taylor & Francis.
- Swift, J. K., Callahan, J. L., & Vollmer, B. M. (2011). Preferences. *Journal of Clinical Psychology*, 67(2), 155–165.

- Szasz, T. S. (1961). *The myth of mental illness: Foundations of a theory of personal conduct*. New York, NY: Hoeber-Harper.
- Szasz, T. S. (1970). *The manufacture of madness*. New York, NY: McGraw-Hill.
- Szasz, T. (1986). The case against suicide prevention. *American Psychologist*, 41(7), 806–812.
- Szmukler, G. (2012). Risk assessment for suicide and violence is of extremely limited value in general psychiatric practice. *Australian and New Zealand Journal of Psychiatry*, 46(2), 173–174. doi:10.1177/0004867411432214
- Tao, K. W., Owen, J., Pace, B. T., & Imel, Z. E. (2015). A meta-analysis of multicultural competencies and psychotherapy process and outcome. *Journal of Counseling Psychology*, 62(3), 337–350. doi:10.1037/cou0000086
- Teasdale, J. D., & Dent, J. (1987). Cognitive vulnerability to depression: An investigation of two hypotheses. *British Journal of Clinical Psychology*, 26(2), 113–126.
- Teyber, E., & McClure, F. (2011). *Interpersonal process in therapy: An integrative model* (6th ed.). Belmont, CA: Brooks/Cole.
- Theriault, B. (2012). Radical acceptance: A nondual psychology approach to grief and loss. *International Journal of Mental Health and Addiction*, 10(3), 354–367. doi:10.1007/s11469-011-9359-9
- Thomas, A., Kirchmann, H., Suess, H., Bräutigam, S., & Strauss, B. (2012). Motivational determinants of interpersonal distress: How interpersonal goals are related to interpersonal problems. *Psychotherapy Research*, 22(5), 489–501. doi:10.1080/10503307.2012.676531
- Thomas, V. (2005). *Initial interview with a family*. Ashland, OH: Hogrefe & Huber.
- Thoresen, C. E., & Mahoney, M. J. (1974). *Behavioral self-control*. New York, NY: Holt, Rinehart & Winston.
- Tighe, A., Pistrang, N., Casdagli, L., Baruch, G., & Butler, S. (2012). Multisystemic therapy for young offenders: Families' experiences of therapeutic processes and outcomes. *Journal of Family Psychology*, 26(2), 187–197. doi:10.1037/a0027120
- Tishby, O. & Vered, M. (2011). Counter transference in the treatment of adolescents and its manifestation in the therapist-patient relationship. *Psychotherapy Research*, 21(6), 621–630.
- Tohn, S. L., & Oshlag, J. A. (1996). Solution-focused therapy with mandated clients: Cooperating with the uncooperative. In M. F. Hoyt (Ed.), *Handbook of solution-focused brief therapy* (pp. 152–183). San Francisco, CA: Jossey-Bass.
- Tombini, M., Pellegrino, G., Zappasodi, F., Quattrocchi, C. C., Assenza, G., Melgari, J. M., . . . Rossini, P. M. (2012). Complex visual hallucinations after occipital extrastriate ischemic stroke. *Cortex: A Journal Devoted to the Study of the Nervous System and Behavior*, 48(6), 774–777. doi:10.1016/j.cortex.2011.04.027
- Tompkins, K. A., Swift, J. K., & Callahan, J. L. (2013). Working with clients by incorporating their preferences. *Psychotherapy*, 50(3), 279–283.
- Trajković, G., Starčević, V., Latas, M., Leštarević, M., Ille, T., Bukumirić, Z., & Marinković, J. (2011). Reliability of the Hamilton Rating Scale for Depression: A meta-analysis over a period of 49 years. *Psychiatry Research*, 189(1), 1–9.

- Trimble, J. E. (2010). Bear spends time in our dreams now: Magical thinking and cultural empathy in multicultural counselling theory and practice. *Counselling Psychology Quarterly*, 23(3), 241–253. doi:10.1080/09515070.2010.505735
- Trippany, R. L., Kress, V.E.W., & Wilcoxon, S. A. (2004). Preventing vicarious trauma: What counselors should know when working with trauma survivors. *Journal of Counseling & Development*, 82(1), 31–37.
- Tryon, G. S., & Winograd, G. (2011). Goal consensus and collaboration. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Evidence-based responsiveness* (2nd ed., pp. 153–167). New York, NY: Oxford University Press.
- Tseng, W. (2006). From peculiar psychiatric disorders through culture-bound syndromes to culture-related specific syndromes. *Transcultural Psychiatry*, 43(4), 554–576. doi:10.1177/1363461506070781
- Tucker, R. P., Crowley, K. J., Davidson, C. L., & Gutierrez, P. M. (2015). Risk factors, warning signs, and drivers of suicide: What are they, how do they differ, and why does it matter? *Suicide and Life-Threatening Behavior*, 45(6), 679–689. doi:10.1111/sltb.12161
- Turner, C., Heyman, I., Futh, A., & Lovell, K. (2009). A pilot study of telephone cognitive-behavioural therapy for obsessive-compulsive disorder in young people. *Behavioural and Cognitive Psychotherapy*, 37(4), 469–474. doi:10.1017/S1352465809990178
- Turner, E. H., Matthews, A. M., Linardatos, E., Tell, R. A., & Rosenthal, R. (2008). Selective publication of antidepressant trials and its influence on apparent efficacy. *New England Journal of Medicine*, 358(3), 252–260. doi:10.1056/NEJMsa065779
- US Department of Health and Human Services. (2003). Developing cultural competence in disaster mental health programs. Retrieved from <http://store.samhsa.gov/product/Developing-Cultural-Competence-in-Disaster-Mental-Health-Programs/SMA03-3828>
- US Food and Drug Administration. (2007). *FDA proposes new warnings about suicidal thinking, behavior in young adults who take antidepressant medications*. Retrieved from <http://www.fda.gov/bbs/topics/NEWS/2007/NEW01624.html>
- US Government Printing Office. (2012). *America's children in brief: Key national indicators of well-being*. Washington, DC: Federal Interagency Forum on Child and Family Statistics.
- Vahter, L., Kreigipuu, M., Talvik, T., & Gross-Paju, K. (2007). One question as a screening instrument for depression in people with multiple sclerosis. *Clinical Rehabilitation*, 21(5), 460–464. doi:10.1177/0269215507074056
- Van Orden, K. A., Witte, T. K., Cukrowicz, K. C., Braithwaite, S. R., Selby, E. A., & Joiner, T. E. (2010). The interpersonal theory of suicide. *Psychological Review*, 117(2), 575–600. doi:10.1037/a0018697
- Vander Stoep, A., Adrian, M., McCauley, E., Crowell, S. E., Stone, A., & Flynn, C. (2011). Risk for suicidal ideation and suicide attempts associated with co-occurring depression and conduct problems in early adolescence. *Suicide and Life-Threatening Behavior*, 41(3), 316–329. doi:10.1111/j.1943-278X.2011.00031.x

- Vargas, L. (2004). Reflections of a process-oriented contextualist. In J. Sommers-Flanagan & R. Sommers-Flanagan (Eds.), *Counseling and psychotherapy theories in context and practice* (p. 20). Hoboken, NJ: Wiley.
- Vazquez, C. I., & Clauss-Ehlers, C. S. (2005). Group psychotherapy with Latinas: A cross-cultural and interactional approach. *NYS Psychologist*, 17(3), 10–13.
- Vernon, A., & Barry, K. L. (2013). *Counseling outside the lines: Creative arts interventions for children and adolescents—Individual, small group, and classroom applications*. Champaign, IL: Research Press.
- Vig, S. (2007). Young children's object play: A window on development category. *Journal of Developmental and Physical Disabilities*, 19(3), 201–215. doi:10.1007/s10882-007-9048-6
- Villalba, J. A., Jr. (2007). Culture-specific assets to consider when counseling Latina/o children and adolescents. *Journal of Multicultural Counseling and Development*, 35(1), 15–25. doi:10.1002/j.2161-1912.2007.tb00046.x
- Wagner, L., Davis, S., & Handelsman, M. M. (1998). In search of the abominable consent form: The impact of readability and personalization. *Journal of Clinical Psychology*, 54(1), 115–120. doi:10.1002/(SICI)1097-4679(199801)54:1<115::AID-JCLP13>3.0.CO;2-N
- Walitzer, K. S., Dermen, K. H., & Conners, G. J. (1999). Strategies for preparing clients for treatment: A review. *Behavior Modification*, 23(1), 129–151. doi:10.1177/0145445599231006
- Walker, V. L. (2009). Using three-dimensional virtual environments in counselor education for mental health interviewing and diagnosis: Student perceived learning benefits. *Dissertation Abstracts International: Section A. Humanities and Social Sciences*. (MSTAR\_622196210; 2010-99031-352).
- Wallin, P. (1949). An appraisal of some methodological aspects of the Kinsey report. *American Sociological Review*, 14(2), 197–210.
- Walsh, M. (2015, June). A “view” from the courtroom: A marriage celebration. Retrieved from <http://www.scotusblog.com/2015/06/a-view-from-the-courtroom-a-marriage-celebration/>
- Walters, R. P. (1980). *Amity: Friendship in action. Part I: Basic friendship skills*. Boulder, CO: Christian Helpers.
- Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings*. Mahwah, NJ: Erlbaum.
- Wampold, B. E., & Imel, Z. E. (2015). *The great psychotherapy debate: The evidence for what makes psychotherapy work* (2nd ed.). New York, NY: Routledge/Taylor & Francis Group.
- Warden, S., Spiwak, R., Sareen, J., & Bolton, J. M. (2014). The SAD PERSONS scale for suicide risk assessment. A systematic review. *Archives of Suicide Research*, 18(4), 313–326. doi:10.1080/13811118.2013.824829
- Waterhouse, L. (2006). Inadequate evidence for multiple intelligences, Mozart effect, and emotional intelligence theories. *Educational Psychologist*, 41(4), 247–255.
- Watson, H. J., Swan, A., & Nathan, P. R. (2011). Psychiatric diagnosis and quality of life: The additional burden of psychiatric comorbidity. *Comprehensive Psychiatry*, 52(3), 265–272. doi:10.1016/j.comppsych.2010.07.006

- Weaver, J. (1995). *Disasters: Mental health interventions*. Sarasota, FL: Professional Resource Press.
- Wechsler, D. (1958). *The measurement and appraisal of adult intelligence* (4th ed.). Baltimore, MD: Williams & Wilkins.
- Weeks, G. R., Odell, M., & Methven, S. (2005). *If only I had known: Avoiding common mistakes in couples therapy*. New York, NY: Norton.
- Weiner, I. B. (1998). *Principles of psychotherapy* (2nd ed.). Hoboken, NJ: Wiley.
- Weiner-Davis, M. (1993). Pro-constructed realities. In S. G. Gilligan & R. Price (Eds.), *Therapeutic conversations* (pp. 149–157). New York, NY: Norton.
- Weisman de Mamani, A., Weintraub, M. J., Gurak, K., & Maura, J. (2014). A randomized clinical trial to test the efficacy of a family-focused, culturally informed therapy for schizophrenia. *Journal of Family Psychology*, 28(6), 800–810. doi:10.1037/fam0000021
- Weisz, J. R., & Kazdin, A. E. (2010). *Evidence-based psychotherapies for children and adolescents* (2nd ed.). New York, NY: Guilford Press.
- Welfel, E. R. (2016). *Ethics in counseling and psychotherapy: Standards, research, and emerging issues* (6th ed.). Boston, MA: Cengage.
- Welsh, C., Earley, K., Delahanty, J., Wright, K. S., Berens, T., Williams, A. A., . . . DiClemente, C. C. (2014). Residents' knowledge of standard drink equivalents: Implications for screening and brief intervention for at-risk alcohol use. *American Journal on Addictions*, 23(2), 194–196. doi:10.1111/j.1521-0391.2013.12080.x
- White, M. (1988, Winter). The process of questioning: A therapy of literary merit. *Dulwich Centre Newsletter*, 8–14.
- White, M. (1995). *Re-authoring lives: Interviews and essays*. Adelaide, South Australia: Dulwich Centre Publications.
- White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York, NY: Norton.
- Wiarda, N. R., McMinn, M. R., Peterson, M. A., & Gregor, J. A. (2014). Use of technology for note taking and therapeutic alliance. *Psychotherapy*, 51(3), 443–446. doi:10.1037/a0035075
- Wilcox, H. C., & Fawcett, J. (2012). Stress, trauma, and risk for attempted and completed suicide. *Psychiatric Annals*, 42(3), 85–87. doi:10.3928/00485713-20120217-04
- Williams, N. (2014). The CAGE questionnaire. *Occupational Medicine*, 64(6), 473–474. doi:10.1093/occmed/kqu058
- Willock, B. (1987). The devalued (unloved, repugnant) self: A second facet of narcissistic vulnerability in the aggressive, conduct-disordered child. *Psychoanalytic Psychology*, 4, 219–240.
- Wilmot, W. W., & Hocker, J. L. (2013). *Interpersonal conflict* (9th ed.). New York, NY: McGraw-Hill.
- Wilson, R. S., Leurgans, S. E., Foroud, T. M., Sweet, R. A., Graff-Radford, N., Mayeux, R., & Bennett, D. A. (2010). Telephone assessment of cognitive function in the late-onset Alzheimer's disease family study. *Archives of Neurology*, 67(7), 855–861. doi:10.1001/archneurol.2010.129

- Winslade, J. M., & Monk, G. D. (2007). *Narrative counseling in schools: Powerful & brief* (2nd ed.). Thousand Oaks, CA: Corwin Press.
- Wise, E. H., Hersh, M. A., & Gibson, C. M. (2012). Ethics, self-care and well-being for psychologists: Reenvisioning the stress-distress continuum. *Professional Psychology: Research and Practice*, 43(5), 487–494. doi:10.1037/a0029446
- Witvliet, C.V.O., Worthington, E. L., Root, L. M., Sato, A. F., Ludwig, T. E., & Exline, J. J. (2008). Retributive justice, restorative justice, and forgiveness: An experimental psychophysiology analysis. *Journal of Experimental Social Psychology*, 44(1), 10–25. doi:10.1016/j.jesp.2007.01.009
- Wolberg, L. R. (1995). *The technique of psychotherapy* (4th rev. ed.). New York, NY: Grune & Stratton.
- Wollburg, E., & Braukhaus, C. (2010). Goal setting in psychotherapy: The relevance of approach and avoidance goals for treatment outcome. *Psychotherapy Research*, 20(4), 488–494. doi:10.1080/10503301003796839
- Wollersheim, J. P. (1974). The assessment of suicide potential via interview methods. *Psychotherapy: Theory, Research, Practice, Training*, 11(3), 222–225.
- Wood, A. F., & Smith, M. J. (2005). *Online communication: Linking technology, identity, and culture* (2nd ed.). Mahwah, NJ: Erlbaum.
- Wood, J. M., Nezworski, M. T., Lilienfeld, S. O., & Garbm, H. N. (2008). *The Rorschach inkblot test, fortune tellers, and cold reading*. Amherst, NY: Prometheus Books.
- Woods, D. L., Kishiyama, M. M., Yund, E. W., Herron, T. J., Edwards, B., Poliva, O., . . . Reed, B. (2011). Improving digit span assessment of short-term verbal memory. *Journal of Clinical and Experimental Neuropsychology*, 33(1), 101–111. doi:10.1080/13803395.2010.493149
- Worell, J., & Remer, P. (2003). *Feminist perspectives in therapy: Empowering diverse women* (2nd ed.). Hoboken, NJ: Wiley.
- World Health Organization. (1992). *International statistical classification of diseases and related health problems* (10th revision). Geneva: Author.
- Worthington, E. L., Jr., Hook, J. N., Davis, D. E., & McDaniel, M. A. (2011). Religion and spirituality. *Journal of Clinical Psychology*, 67(2), 204–214.
- Wright, B. A. (1983). *Physical disability: A psychosocial approach*. New York, NY: Harper & Row. doi:10.1037/10589-000.
- Wright, J. H., & Davis, D. (1994). The therapeutic relationship in cognitive-behavioral therapy: Patient perceptions and therapist responses. *Cognitive and Behavioral Practice*, 1(1), 25–45. doi:10.1016/S1077-7229(05)80085-9
- Wright-McDougal, J., & Toriello, P. J. (2013). Ethical implications of confirmation bias in the rehabilitation counseling relationship. *Journal of Applied Rehabilitation Counseling*, 44(2), 3–10.
- Wubbolding, R. E. (2011). *Reality therapy*. Washington, DC: American Psychological Association.
- Wubbolding, R. E., Brickell, J., Imhof, L., Kim, R. I., Lojk, L., & Al-Rashidi, B. (2004). Reality therapy: A global perspective. *International Journal for the Advancement of Counselling*, 26(3), 219–228. doi:10.1023/B:ADCO.0000035526.02422.0d

- Yalom, I. D. (2002). *The gift of therapy*. New York, NY: HarperCollins.
- Yalom, I. D., & Leszcz, M. (2005). *The theory and practice of group psychotherapy* (5th ed.). New York, NY: Basic Books.
- Yehuda, R., & Bierer, L. M. (2005). Re-evaluating the link between disasters and psychopathology. In J. J. Lopez-Ibor, G. Christodoulou, M. Maj, N. Sartorius, & A. Okasha (Eds.), *Disasters and mental health* (pp. 65–80). Hoboken, NJ: Wiley.
- Yellow Bird, M. (2001). Critical values and First Nations peoples. In R. Fong & S. M. Fulero (Eds.), *Culturally competent practice: Skills, interventions, and evaluations* (pp. 61–74). Needham Heights, MA: Allyn & Bacon.
- Young, J. E., Klosko, J. S., & Weishaar, M. E. (2003). *Schema therapy: A practitioner's guide*. New York, NY: Guilford Press.
- Young, M. A. (2008). Attachment theory's focus in EFT: An interview with Susan Johnson. *The Family Journal*, 16(3), 264–270.
- Young, M. E. (2013). *Learning the art of helping: Building blocks and techniques* (5th ed.). New York, NY: Pearson Education.
- Young-Eisendrath, P. (1993). *You're not what I expected: Breaking the "he said-she said" cycle*. New York, NY: Touchstone.
- Yuen, E. K., Goetter, E. M., Herbert, J. D., & Forman, E. M. (2012). Challenges and opportunities in Internet-mediated telemental health. *Professional Psychology: Research and Practice*, 43(1), 1–8. doi:10.1037/a0025524
- Zahl, D. L., & Hawton, K. (2004). Repetition of deliberate self-harm and subsequent suicide risk: Long-term follow-up study of 11,583 patients. *British Journal of Psychiatry*, 185(1), 70–75. doi:10.1192/bjp.185.1.70
- Zetzel, E. R. (1956). Current concepts of transference. *International Journal of Psychoanalysis*, 37, 369–376.
- Zickuhr, K. (2011). Generations and their gadgets. Pew Internet & American Life Project. Retrieved from <http://pewinternet.org/Reports/2011/Generations-and-gadgets.aspx>
- Zilcha-Mano, S., McCarthy, K. S., Dinger, U., & Barber, J. P. (2014). To what extent is alliance affected by transference? An empirical exploration. *Psychotherapy*, 51(3), 424–433. doi:10.1037/a0036566
- Zimmer, A. T., Chovan, M. J., & Chovan, W. L. (2010). Some observations about two versions of mental status examinations: Implications for screening dementia patients in nursing homes. *Perceptual and Motor Skills*, 110(2), 348–352.
- Ziv-Beiman, S. (2013). Therapist self-disclosure as an integrative intervention. *Journal of Psychotherapy Integration*, 23(1), 59–74. doi:10.1037/a0031783
- Zuckerman, E. L. (2010). *The clinician's thesaurus: The guide to conducting interviews and writing psychological reports* (7th ed.). New York, NY: Guilford Press.
- Zur, O. (2007). *Boundaries in psychotherapy: Ethical and clinical explorations*. Washington, DC: American Psychological Association.

## AUTHOR INDEX

- Aboraya, A., 403  
Achebe, C., 306  
Ackerman, S. J., 240  
Adler, A., 99, 185, 194, 215, 270, 275  
Agar, K., 349  
Ahn, W., 192  
Aisenberg, E., 80  
Akhtar, S., 230  
Allard, T., 115  
Alleman, J. R., 554  
Altschul, I., 198  
Amadio, D. M., 63  
American Academy of Pediatrics, 198  
American Counseling Association, 207–208, 209  
American Psychiatric Association, 94, 394, 396, 397, 398, 402, 428, 466  
American Psychological Association, 198, 206–207, 209, 287, 457, 466  
Ametrano, R. M., 421  
Anderson, I. M., 192  
Anderson, R. N., 562  
Anderson, S. K., 423  
Andrews, E. E., 288  
Andrews, G., 565  
Anisman, H., 56  
Apiquian, R., 455  
Apodaca, T. R., 437  
Applebaum, A. J., 562  
Apter, A., 372  
Archer, J., Jr., 562  
Arkowitz, H., 435  
Arnkoff, D. B., 421  
Arntz, A., 407  
Arredondo, P., 20, 62  
Arthur, N., 222  
Asbury, F. S., 42  
Ashton, M. W., 92  
Asnaani, A., 240  
Au, J., 348  
Austin, S. B., 219  
Avrus, E. M., 55  
Axline, V. M., 498  
Ayón, C., 80  
Azim, H. F., 419  
Azorin, J., 350  
Babins-Wagner, R., 252  
Bailer, A. J., 562  
Baker, L., 94  
Baker, R. W., 308  
Baker, T. B., 218  
Baker-Henningham, H., 251  
Baldwin, S. A., 240  
Ball, T., 115  
Balzer, F. J., 42  
Bandler, R., 131  
Bandura, A., 247  
Barak, A., 564, 569  
Barber, J. P., 234  
Barker-Collo, S., 349  
Barkham, M., 240  
Barnett, J. E., 214  
Barney, C., 16, 363  
Barr, L., 444  
Barry, K. L., 474, 503  
Baruch, G., 517  
Bassilios, B., 558  
Bastien, C. H., 564  
Beck, A. T., 263, 295, 357, 367, 377  
Beck, J. S., 11, 188, 242, 424  
Beebe, R. S., 346

- Befort, C. A., 564  
Beitman, B. D., 237  
Bell, A., 177, 449, 450  
Bell-Tolliver, L., 59  
Benjamin, A., 34, 168, 175, 199, 204  
Bequette, T., 243, 436, 445, 480, 482  
Berg, I. K., 10, 134, 135, 186, 190, 195  
Berg, R. C., 162  
Berger, C., 20, 62, 478  
Berkman, L. F., 350  
Berman, A. L., 348  
Bernal, G., 18, 87, 251, 422  
Bernard, M., 560  
Bernert, R. A., 348  
Bertolino, B., 190, 415  
Betan, E., 236  
Beutler, L. E., 182, 418, 419, 420, 421, 436  
Beyebach, M., 186  
Bhar, S. S., 357  
Bhola, P., 506  
Bickford, J. O., 288  
Bierer, L. M., 463  
Biesanz, J. C., 39  
BigFoot, D. S., 502  
Bigner, J., 546  
Birdsall, B., 520  
Birdwhistell, M. L., 119  
Birnbaum, M., 469  
Black, F. W., 303  
Black, L., 58  
Blader, J. C., 411  
Blain, D., 458  
Blais, F. C., 564  
Blankers, M., 565  
Blau, K., 421  
Bloomgarden, A., 176  
Bohart, A. C., 226  
Bolton, J. M., 348, 349, 356  
Bombay, A., 56  
Bond, K., 192  
Bongar, B., 372  
Bonham, E. J., 55  
Boniel-Nissim, M., 564  
Boote, J., 498  
Borckardt, J. J., 81  
Bordin, E. S., 16, 239, 240, 241  
Boswell, J. F., 12, 240  
Bouchard, S., 564  
Boyd-Franklin, N., 59, 215  
Boyle, S. H., 459  
Bradley, L. J., 520  
Brammer, L. M., 136  
Braukhaus, C., 259  
Braun, M., 325  
Bräutigam, S., 259  
Brenes, G. A., 558, 564  
Brezinka, V., 498  
Broken Nose, M. A., 57, 58  
Bronfenbrenner, U., 536, 539  
Brooks-Russell, A., 353  
Brosi, M. W., 202  
Brown, D. H., 304  
Brown, G., 263, 377, 382  
Brown, G. K., 357  
Brown, K. W., 67  
Brown, L. S., 18, 249  
Brown, R., 490  
Brown, T. L., 353  
Bruce, T. J., 415  
Bruck, M., 500  
Brüne, M., 227  
Bryant, C. M., 58  
Buck, E. T., 498  
Bufka, L. F., 65  
Buka, S. L., 350  
Burlingame, G. M., 263  
Busch, K. A., 349, 359  
Butler, S., 517  
Butler, S. K., 24  
Button, M. L., 435  
Buxbaum, J. D., 304  
Buyukdura, J. S., 310  
Byrne, S. L., 102  
Cabaniss, D. L., 86  
Cahill, J., 240  
Cai, X., 562  
Callahan, J. L., 419  
Campbell, D. T., 275, 415–416  
Campbell, K. B., 498

- Campbell, M. A., 452  
Campfield, K. M., 459, 467  
Capra, F., 303, 306  
Capuzzi, D., 536  
Carkhuff, R. R., 138, 228, 230  
Carlson, G. A., 411  
Carlson, J., 184, 275, 528, 537, 542  
Carlson, L., 475  
Carson, A., 314  
Cartwright, C., 559  
Casdagli, L., 517  
Cashwell, C. S., 65, 514  
Cassidy, F., 350  
Castonguay, L. G., 12  
Catalano, G., 321  
Catalano, M. C., 321  
Chambers, W., 408  
Chambless, D. L., 419  
Chang, C. Y., 22, 61, 62, 142, 501  
Chao, C. M., 62  
Chatters, L. M., 58  
Chen, C., 560  
Cheng, A. T. A., 353  
Cheng, M. K. S., 439  
Cherry, S., 86  
Cheung, C., 62  
Cheyne, C., 324  
Chiang, H., 463  
Childers, W. C., 42  
Chiles, J. A., 377  
Chovan, M. J., 304  
Chovan, W. L., 304  
Christensen, A., 524  
Christensen, B. K., 359  
Christensen, H., 560  
Christenson, J., 517  
Christopher, J. C., 20  
Chu, C., 352, 378, 379–380  
Chung, T., 184  
Clark, A. J., 227, 230, 270  
Clark, D. C., 349, 372  
Clarke, M. P., 327  
Clauss-Ehlers, C. S., 61  
Cleary, B., 473  
Clum, G. A., 564  
Cochran, B. N., 21, 62, 63, 211, 467  
Cohen, J., 219, 564  
Cohen, K., 465  
Collens, P., 465  
Collins, B. G., 458, 468  
Collins, S., 222  
Collins, T. M., 458, 468  
Coltheart, M., 330  
Comas-Díaz, L., 61  
Conklin, C. Z., 236  
Conners, J., 81  
Connolly, C. M., 8  
Constantino, M. J., 12, 240, 421  
Conwell, Y., 348  
Cook, J. M., 55  
Cook, J. W., 502  
Cooke, D. J., 452  
Cooper, R. L., 353  
Corcoran, J., 191  
Cormier, C. A., 164, 452  
Cormier, L. S., 119, 123  
Cougle, J. R., 322  
Cowan, T. M., 564  
Craig, R. J., 407  
Crane, C., 517  
Creswell, J. D., 67  
Crippa, S. L., 564  
Crits-Christoph, P., 415  
Croarkin, P. E., 310  
Crowley, K. J., 348  
Crutzen, R., 554  
Cuéllar, I., 60  
Curtis, S. L., 447  
Dai, A., 352  
Daily, E., 469  
Dakof, G. A., 517  
Dana, R. H., 60  
Daneshi, J., 325  
Danhauer, S. C., 558  
Daniel, S. S., 309  
Dattilio, F. M., 524  
D'augelli, A. R., 353  
Davenport, D. S., 35, 44  
Davidson, C. L., 348

- Davies, E., 349  
Davies, M., 565  
Davis, D., 119  
Davis, D. E., 25, 420, 470  
Davis, M. K., 240  
Davis, S., 52  
Davis, S. R., 15, 121, 127, 145, 165, 199  
Davison, G. C., 237  
Dawson, D. A., 448  
Day, S. X., 560  
De Leo, D., 387  
de Nooijer, J., 554  
de Shazer, S., 158, 185, 186, 187, 195, 203, 434,  
    435, 487  
De Vega, M. H., 186  
Dean, R. A., 56  
DeClaire, J., 532  
DeJong, P., 134, 186, 190  
del Rio, C., 368  
Delgado-Romero, E. A., 18  
Dell Orto, A. E., 64  
Dent, J., 359  
Dent-Brown, K., 498  
Dermen, K. H., 81  
Diamant, A., 118  
Diamond, G. M., 512  
Dickerson, F. B., 419  
Dickinson, J. J., 500  
DiClemente, C. C., 10, 182, 435  
Dillon, C., 6  
Dimaggio, G., 281  
Dinger, U., 234  
Dobson, K. S., 141  
Dolan, Y., 186, 187, 190, 195, 203, 487  
Donnelly, J. E., 564  
Donovan, C. L., 275  
Doolin, E. M., 223, 224, 251  
Douglas, C. J., 86  
Downum, E. M., 228  
Driessen, E., 234  
Drye, R. C., 360  
Duan, C., 227  
Duffy, V., 353  
Dugger, S. M., 475  
Dunlap, M., 502  
Dunn, D. S., 288  
Dunner, D. L., 332  
D'Zurilla, T. J., 158, 177  
Eby, L. T., 447  
Edlund, A., 328  
Edwards, S. J., 360  
Eells, T. D., 418  
Egan, G., 153  
Ekman, P., 121  
El-Ghoroury, N., 65  
Elkind, D., 5  
Ellerbeck, E. F., 564  
Elliott, R., 226, 227, 230  
Engel, G. L., 415  
Englar-Carlson, M., 528, 537  
Engle, D. E., 435  
Engstrom, D., 465  
Enns, M. W., 349  
Epp, A. M., 141  
Epstein, D., 269  
Epstein, J., 554, 560  
Epston, D., 566  
Erickson, M. H., 193, 195  
Eriksen, K., 398  
Escudero, V., 512  
Eubanks-Carter, C., 235  
Evans, K., 249  
Everly, G. S., Jr., 459  
Falkenström, F., 240  
Fall, K. A., 162  
Faller, K. C., 500  
Falvo, D., 64  
Farabaugh, A., 358  
Farber, B. A., 141, 221, 223, 224, 251  
Fassnacht, D., 258  
Fatter, D. M., 236  
Fawcett, J., 349, 350, 359  
Feeny, N. C., 467  
Feldman, D., 459  
Fener, E., 357  
Fenichel, O., 153, 155, 156, 158  
Feron, F., 554  
Ferrell, J. D., 313

- Finn, S. E., 7, 13, 263, 264, 265  
First, M. B., 405  
Fischer, C. T., 7, 13, 263, 265  
Fish, M. C., 63  
Fiske, D. W., 275  
Flentje, A., 11, 21, 62, 63  
Flores, L. Y., 92  
Flückiger, C., 240  
Foa, E. B., 467  
Foley, R., 72  
Folstein, M. F., 332  
Folstein, S. E., 332  
Fontes, L. A., 19, 46  
Forcano, L., 351  
Forman, E. M., 554  
Fortner, B., 386  
Fouad, N. A., 62  
Fowler, J. C., 345, 352, 373  
Fox, R. E., 218  
Frances, A. J., 92  
Frank, J. B., 10, 103  
Frank, J. D., 10, 103, 421  
Frankl, V., 158, 442  
Franklin, A. J., 59, 214, 215  
French, S., 452  
Fresán, A., 455  
Freud, S., 153, 233, 236, 239, 434, 558  
Friedlander, M. L., 512  
Fritz, E., 499  
Fuenhausen, K., 65, 514  
Fukuda, S., 467  
Futh, A., 564
- Gallagher, J. R., 447  
Gallardo, M. E., 60, 176, 251, 252  
Galper, D. I., 65  
Gambrell, C. E., 4  
Gangsei, D., 465  
Garbm, H. N., 494  
Garcia-Preto, N., 60  
Gardner, H., 334  
Gardner, R. A., 502  
Garske, J. P., 240  
Gawande, A., 3  
Gazda, G. M., 42
- Gehart, D., 536  
Gelso, C. J., 39, 233, 236, 237  
Gendreau, P., 452  
Gergen, K. J., 358  
Gershoff, E. T., 198  
Gerson, R., 537  
Gahramanlou-Holloway, M., 357  
Gibbon, M., 405  
Gibbs, J. T., 61  
Gibbs, M. A., 146  
Gibson, C. M., 65  
Gibson, K., 559  
Gilboa, A., 330, 401  
Gilliland, B. E., 469  
Girard, T. A., 324  
Glass, C. R., 421  
Glass, G. V., 217  
Glasser, W., 94, 185, 271  
Gluck, M., 334  
Glueckauf, R. L., 562  
Goetter, E. M., 554  
Goldenberg, H., 513  
Goldenberg, I., 513, 517, 527, 536  
Goldfried, M. R., 12, 237  
Gonçalves, M. M., 258, 262  
Gonzalez-Liencres, C., 227, 228  
Good, B., 399  
Goodkind, J. R., 57  
Goodman, L. A., 269  
Goodrich, K., 556  
Goodstein, J. L., 377  
Gotay, S., 498  
Gottman, J. M., 525, 530, 532, 534, 543  
Gottman, J. S., 525, 530, 534, 543  
Gould, M. S., 353  
Goulding, M. E., 360  
Goulding, R. L., 360  
Grafanaki, S., 220  
Granello, D. H., 355, 455  
Granello, P. F., 455  
Granström, F., 240  
Grant, B., 349  
Grant, B. F., 448  
Gray, L., 563  
Grayman-Simpson, N. A., 59

- Greden, L. R., 12, 197  
Greenbaum, P. E., 517  
Greenberg, L. S., 226, 232, 415  
Greene, R. L., 263  
Greenson, R. R., 158, 233, 239  
Gregor, J. A., 36  
Grinder, J., 131  
Griner, D., 18  
Grisham, J. R., 377  
Grodberg, D., 304  
Gross-Paju, K., 411  
Groth-Marnat, G., 75  
Guevremont, D. C., 247  
Guilamo-Ramos, V., 60  
Guk-Robles, E., 115  
Gunn, J., 558  
Gunn, J. F., 348, 356  
Gurak, K., 517  
Gurczynski, J., 309  
Gurman, A. S., 218, 512, 513, 525, 528  
Guterman, J. T., 191  
Gutierrez, P. M., 348
- Haas, A. P., 353  
Haase, R. F., 119  
Hagan, C. R., 352  
Hahn, W. K., 362  
Haigh, E. A. P., 359  
Hall, E. T., 119  
Hall, J. A., 121  
Hall, R. C. W., 352  
Hammer, A. L., 132  
Handelsman, M. M., 52, 423  
Handler, L., 13, 81, 263  
Hanley, T., 560, 561, 564  
Hanna, C. A., 481  
Hanna, F. J., 481  
Hansen, J. T., 17  
Hardin, E. E., 92  
Hardy, G., 240  
Hardy, K. M., 59  
Harris, G. T., 452, 456  
Harris, M., 558  
Harris, S. E., 554  
Harwood, M., 419
- Harwood, T. M., 420, 421, 436  
Hasin, D. S., 539  
Hasley, J. P., 372  
Hatzenbuehler, M. L., 539  
Havas, J., 554  
Hawton, K., 352  
Hayes, J. A., 233, 236, 237, 238  
Hayes, S. C., 278  
Hayes-Skelton, S., 202  
Hays, D. G., 501  
Hays, P. A., 17, 18, 76, 80, 87, 104, 267, 314  
Healy, D., 352  
Heatherington, L., 512  
Heck, N. C., 21, 62, 63, 211  
Hecker, L. L., 545  
Hegarty, E. L. H., 321  
Heim, A. K., 236  
Heimberg, R. G., 99, 424  
Heinlen, K. T., 567  
Hempstead, K., 353  
Henderson, C. E., 517  
Henderson, D. A., 503  
Hendin, H., 378  
Hendricks, B., 520  
Herbert, J. D., 554  
Herbst, N., 565  
Herek, G. M., 539  
Herlihy, B. J., 12, 197, 203, 206, 209, 211, 212  
Herlihy, B. R., 206  
Herman, J. L., 464, 466  
Hermann, M. A., 12, 197, 206  
Hernandez-Wolfe, P., 465  
Hersen, M., 404, 406  
Hersh, M. A., 65  
Heyman, I., 564  
Hill, C. E., 12, 113, 126, 162, 199, 201  
Hills, A. M., 459  
Hilsenroth, M. J., 240  
Hilton, N. Z., 452  
Hinkle, J. S., 307, 309  
Hipolito-Delgado, C. P., 55  
Hirai, M., 564  
Ho, M. K., 60, 513  
Hoch, P., 458  
Hocker, J. L., 41, 542

- Hofmann, S. G., 240  
Hollon, S. D., 418  
Holman, J., 420, 436  
Holmqvist, R., 240  
Hölzel, B. K., 115  
Hood, M. E., 5, 6, 7, 406  
Hook, J. N., 25, 26, 420, 470  
Hooke, G. R., 102  
Hope, K., 313  
Hor, K., 350  
Horesh, N., 372  
Horgan, T. G., 121  
Horvath, A. O., 240, 241  
Horwitz, A. V., 94, 359, 399  
Horwitz, S. H., 544  
Hoyt, M. F. E., 280  
Hsieh, D. K., 407  
Huang, L. N., 61  
Hubble, M. A., 39  
Hufford, B. J., 562  
Hughes, C. W., 376  
Hughes, M. R., 562  
Human, L. J., 39  
Hummel, A. M., 237  
Humphreys, K., 318  
Hungerford, A., 500  
Hunter, J. A., 435  
Hutz, A., 25  
  
Imel, Z. E., 222, 240, 241  
Ingersoll, R. E., 417  
Ivanoff, A., 377  
Ivey, A. E., 113, 119, 168, 556  
Ivey, M. B., 119  
  
Jackson, J. S., 58  
Jackson, V., 58  
Jacobs, M., 359  
Jaghab, K., 403  
Jain, S., 562  
James, R. K., 469  
Jang, S. J., 377  
Jefferis, J. M., 327  
Jeltova, I., 63  
Jenkins, W. M., 115  
  
Jensen, M. E., 288  
Jia, C., 352  
Jiménez-Chafey, M. I., 251  
Jing-ying, G., 199  
Jobes, D. A., 346, 348, 360, 363, 370, 381, 382  
Johnson, K., 120, 542  
Johnson, R., 21, 64  
Johnson, S., 184, 522, 525, 530, 531, 533  
Johnson, S. S., 533  
Joiner, T. E., 348, 352, 357, 360, 365, 382  
Jokinen, J., 372  
Jones, K. D., 4, 72  
Jones, M. C., 247, 257  
Jongsma, A. E., 415  
Jordan, J. V., 253  
Joyce, A. S., 419  
Joyce, N. R., 560, 566, 567, 570, 571, 572  
Juhnke, G. A., 355, 455  
Jungbluth, N. J., 490  
  
Kane, D., 459  
Kanjee, R., 318  
Kapur, M., 506  
Karno, M. P., 419  
Karpik, C. P., 4  
Karver, M. S., 490  
Kasila, K., 184  
Kazdin, A. E., 492  
Keeley, J. W., 394, 408  
Kellner, M., 325  
Kelly, G. A., 184  
Kelly, S., 59, 215  
Kennedy, A., 124  
Kerson, T. S., 560  
Keyes, K. M., 359  
Keys, S. G., 481  
Khanna, A., 62  
Khess, C. R. J., 341  
Kielbasa, A. M., 8  
Killian, K., 465  
Kim, J. H. J., 56  
Kim, J. K., 494  
Kimpala, S., 421  
Kincade, E. A., 249  
Kirchmann, H., 259

- Kirk, S. A., 406–407  
Kivlighan, D. M., 126, 234  
Klayman, J. E., 564  
Klein, M. H., 219  
Klinkenberg, W. D., 554, 560  
Klosko, J. S., 275  
Knaevelsrud, C., 562  
Knapp, M. L., 121  
Knesper, D. J., 443  
Knight, J. R., 144  
Kocet, M. M., 206, 211, 212  
Koeter, M. W. J., 565  
Kohn, N., 116  
Kohut, H. H., 243  
Kolden, G. G., 219, 220, 221, 222  
Kolevzon, A., 304  
Kort, J., 63, 117  
Kotbi, N., 321  
Kraatz, R. A., 227  
Kraepelin, E., 393, 394–395  
Kramer, J. R., 558  
Kraus, J., 244, 561  
Kreegipuu, M., 411  
Kress, V. E., 398  
Kress, V. E. W., 465  
Krohn, E. J., 8  
Krug, O. T., 492  
Kupferschmid, S., 563  
Kurt, P., 332  
Kutchins, H., 406–407  
Kwan, A. Y., 62  
Kwasny, M. J., 562
- Lago, C., 561  
Lake, A. M., 353  
Lambert, M. J., 16, 96, 218, 241, 258, 263, 505  
Lampe, L. A., 560  
Landreth, G. L., 162  
Langdon, R., 330  
Lankton, C. H., 537  
Lankton, S. R., 537  
Lapidot-Lefler, N., 569  
LaRussa-Trott, M., 544  
Laska, K. M., 218  
Lasser, J., 504
- Lau, M. A., 359, 381  
Lawson, L. E., 304  
Lazarus, A. A., 75, 176, 415  
Lebow, J. L., 512  
Lebowitz, M. S., 192  
Lebrón-Striker, M. A., 355  
Ledley, D. R., 99, 424, 425  
Lee, S. J., 198  
Leenaars, A. A., 346–347  
LeGuin, U., 71  
Lehman, A. F., 419  
Leibert, T., 562  
Leonard, B. A., 564  
Lester, D., 348, 356  
Leszcz, M., 152, 196  
Leurgans, M., 407  
Levi, Y., 372  
Levy-Warren, M., 506  
Liddle, H. A., 517  
Lilienfeld, S. O., 407, 494  
Linardatos, E., 234  
Lincoln, K. D., 58  
Linderman, F. B., 215  
Lindsay, E. K., 67  
Linehan, M. M., 225, 243, 351, 377, 384,  
    444, 490  
Links, P., 351  
Lishner, D. A., 228  
Litman, R. E., 347–348  
Liu, R. T., 353  
Lobbestael, J., 407  
Loeber, R., 453, 454  
Lombardero, A., 252  
Lopes, R. T., 258  
Lovell, K., 564  
Lozano, A., 334  
Lu, Z., 463  
Luborsky, L., 145, 275, 415  
Luke, C., 15, 95, 169  
Luquet, W., 544  
Lyles, M. F., 558  
Lyons, A., 560
- MacCulloch, R., 399  
MacDonald, B., 479

- MacEwan, G., 240  
Machado, P. P. P., 258  
MacKay, S., 453  
Mackintosh, N. J., 334  
Mackrill, T., 11  
Madigan, S., 186  
Maercker, A., 562  
Magill, M., 435, 437, 440  
Mahgoub, N., 321  
Mahoney, M. J., 266  
Malin, A. J., 114  
Mallen, M. J., 560  
Maltsberger, J. T., 378  
Mandal, E., 352  
Mandrusiak, M., 360  
Maniaci, M., 184, 275  
Manjunatha, N., 341  
Marangell, L. B., 349  
Marin, B. V., 60  
Marin, G., 60  
Markowitz, J. C., 275  
Marks, L. I., 362  
Marlitt, R. E., 372  
Marquis, A., 417  
Martin, D. J., 240  
Martin, H., 264  
Martinez, A., 503  
Martin-Khan, M., 563  
Marx, B. P., 99, 424  
Matheson, K., 56  
Matos, M., 262  
Matsumoto, D., 18, 62  
Matthews, A. M., 234  
Matthews, W. J., 537  
Mattis, J. S., 59  
Maura, J., 517  
Maurer, R. E., 122  
Mayotte-Blum, J., 162  
McCallum, M., 419  
McCann, I. L., 465  
McCarthy, K. S., 234  
McClintock, S. M., 310  
McClure, F. H., 81, 86, 275  
McCoyd, J. L. M., 560  
McCullough, J. R., 24  
McDaniel, M. A., 420  
McDaniel, W. F., 304  
McDavis, R. J., 20  
McDowell, T., 62  
McFall, R. M., 218  
McGinn, M., 524  
McGlothlin, J. M., 387  
McGoldrick, M., 537  
McHugh, P. R., 332  
McIntosh, P., 19  
McKay, D., 32  
McMinn, M. R., 36  
McSwain, S., 348, 356  
Meador, B., 129, 135  
Means, J. R., 163  
Medlin, B. D., 560  
Meier, S. T., 13, 15, 17, 102, 103, 121, 127, 165,  
    199, 574  
Melby, D., 386  
Mellin, E. A., 474  
Mennuti, R. B., 176  
Mercado, E., 334  
Merzenich, M. M., 115  
Messina, I., 228  
Metcalf, K., 330  
Methven, S., 515  
Meyer, D., 4  
Michel, C., 563  
Michelson, A., 420, 436  
Middleton, A., 558  
Miller, C. D., 119  
Miller, G., 467  
Miller, M., 369  
Miller, M. E., 558  
Miller, W. R., 10, 15, 130, 137, 153, 160, 161,  
    172, 182, 360, 420, 435, 436–437, 440–441,  
    442, 449, 450  
Minton, C. A. B., 8  
Miranda, R., 357  
Mitchell, A., 560  
Mitchell, P., 514  
Mohr, D. C., 562  
Molnar, B. E., 350  
Monahan, J., 452  
Monk, G. D., 188, 189, 191

- Moore, M. M., 360  
Moore, T., 58, 59, 120  
Moraga, A. V., 328  
Morales, E., 250  
Moreno, C., 411  
Moreno, C. L., 61  
Morin, C. M., 564  
Morrill, W. H., 119  
Morrison, J., 167, 240, 296, 413  
Morsette, A., 251  
Mosak, H. H., 270  
Mosimann, U. P., 327  
Moskowitz, A., 349  
Moules, N. J., 566  
Mueller, R. M., 263  
Muhtz, C., 325  
Mulligan, J., 399, 562  
Munson, J., 562  
Muran, J. C., 235, 240, 243  
Muris, P., 322  
Murphy, B. C., 6  
Murphy, J. J., 10, 169  
Murray, K. W., 495, 514, 522, 536  
Mustanski, B., 353  
Mutschler, I., 115  
Myers, C., 260, 334
- Nagaoka, C., 127  
Nagata, D. K., 56  
Nash, M., 81  
Nassar-McMillan, S., 24  
Nathan, P. R., 403  
National Association of Social Workers, 50  
Navarro, R. L., 92  
Negy, C., 62  
Neimeyer, R. A., 382  
Nemerooff, C. B., 416  
Newman, J. C., 242, 243  
Newnham, E. A., 102  
Nezu, A. M., 158  
Nezworski, M. T., 494  
Ng, S. H., 62  
Nguyen, T. U., 56  
Nicholas, D. B., 399  
Nicolini, H., 455
- Nielsen, S. L., 377  
Norcross, J. C., 4, 16, 17, 114, 182, 218, 250,  
253, 418, 422  
Nordström, P., 372  
Normington, C. J., 119  
North, C. S., 457, 458  
Norton, C. L., 506  
Nugent, W., 353  
Nurius, P., 119, 164
- O'Brien, R. P., 528  
Ochoa, S. H., 335  
Ochs, M. T., 115  
O'Connor, S. S., 346, 360  
Odell, M., 515  
O'Donnell, M. S., 567  
Oetzel, K. B., 479  
Ogrodniczuk, J. S., 419  
Oguz, M., 332  
O'Hanlon, B., 415  
O'Hanlon, W. H., 134, 433  
O'Hara, C., 22, 61, 62, 142  
Ojserkis, R., 32  
Oliver, M., 520  
Olsen, C., 357  
Onedera, J. D., 64  
Orbinski, J., 150  
Orsillo, S. M., 202  
Ortiz, S. O., 335  
Osborn, C. J., 119, 164  
O'Shea, G., 275  
Ostrosky-Solís, F., 334  
Othmer, E., 309, 316, 332  
Othmer, S. C., 309, 316, 332  
Ouellet, M., 564  
Overholser, J., 382  
Owen, J., 25, 222, 470
- Pabian, Y. L., 346  
Pace, B. T., 222  
Pacilio, L. E., 67  
Packman, W. L., 372  
Padder, T. A., 403  
Padjen, P., 469  
Page, A. C., 102

- Pagura, J., 349  
Paniagua, F. A., 60, 310, 320, 332  
Paprocki, C. M., 207  
Parry, G., 498  
Patrick, S., 8, 39, 41  
Paul, G., 418  
Pearlman, L. A., 465  
Pearson, J., 544  
Pease-Carter, C., 8  
Peluso, P. R., 542  
Pennebaker, J. W., 313  
Pennuto, T. O., 372  
Pérez, R. M., 63  
Perls, F., 154  
Perri, M. G., 564  
Persons, J. B., 99, 424, 425, 426, 427  
Pertuit, T. L., 474  
Perumbilly, S., 62  
Peters, L., 435  
Peterson, J. F., 328  
Peterson, L. M., 415  
Peterson, M. A., 36  
Petry, S., 537  
Pezdek, K., 331  
Pfefferbaum, B., 457, 458  
Phillips, J., 409  
Phillips, S. B., 459  
Piaget, J., 5, 28  
Pillay, J., 499  
Piper, W. E., 419  
Pipes, W. H., 35, 44  
Pirkis, J., 558  
Pistrang, N., 517  
Pitts, M., 560  
Platt, D. E., 352  
Plenty Coup (chief), 215  
Podlogar, M. C., 352  
Poelzl, L., 528, 535  
Polanski, P. J., 307, 309  
Pomerantz, A. M., 8, 132  
Ponton, R. F., 252  
Poole, D. A., 500  
Pos, A. E., 114  
Poskiparta, M., 184  
Pottick, K. J., 407  
Pouliot, L., 387  
Power, P. W., 64  
Prochaska, J. O., 10, 182, 183, 215, 435  
Pruitt, L., 467  
Puig-Antich, J., 408  
Pyun, J. J., 192  
Qin, P., 352  
Quiñones, V., 357  
Quinsey, V. L., 452, 456  
Ransom, D., 564  
Rasheed, J. M., 60, 513  
Rasheed, M. N., 60, 513  
Rassin, E., 322  
Rastoqi, M., 64  
Ratts, M. J., 24  
Ray, D. C., 499  
Read, J., 349  
Reed, G. M., 395  
Reed, K. P., 353  
Regev, D., 498  
Rehfuss, M. C., 4  
Reichenberg, L. W., 415  
Reinbold, C., 115  
Remer, P., 249  
Reynolds, D. J., 561, 562, 564  
Rhodes, P., 514  
Ribeiro, J. D., 351, 357  
Rice, M. E., 452, 456  
Richards, S. D., 499  
Richardson, B. G., 103, 436, 474  
Richmond, J. S., 567  
Riggs, D. S., 467  
Rilke, R. M., 511  
Ritter, K. B., 501  
Robbins, M., 41  
Roberts, J., 124  
Robey, P. A., 537  
Robinson, D. J., 320, 325, 445  
Robinson-Kurpius, S. E., 554  
Robitschek, C., 92  
Rochlen, A. B., 560  
Rodríguez, M. D., 18, 87, 422  
Rodríguez, M. M., 251

- Rodríguez Andrés, A., 353  
Rodríguez-Pascual, C., 328  
Roemer, L., 202  
Rogers, C. R., 15, 16, 78, 113, 114, 115, 116, 117, 129, 134, 135, 137, 146, 153, 162, 199, 217–218, 219, 220, 221, 222, 223, 225, 226, 227, 230, 249, 251, 253, 480, 490  
Rolling, E. S., 202  
Rollnick, S., 10, 15, 130, 137, 153, 160, 161, 172, 182, 360, 420, 435, 436–437, 440–441, 442, 449, 450  
Romano, M., 435  
Roosevelt, E., 31  
Rose, G. S., 437  
Rose, T. B., 227  
Rosenberg, J. I., 383–384  
Rosenthal, R., 234  
Rosman, B. L., 94  
Rossi, E. L., 193  
Rossi, S., 193  
Rothen, S., 403  
Rothman, M., 240  
Rozbroj, T., 560  
Rubinsky, A. D., 448  
Rudd, M. D., 360, 378, 382  
Rummell, C. M., 560, 566, 567, 570, 571, 572  
Runyan, C. W., 353  
Rutter, P. A., 528, 535  
Ruzek, J. I., 458, 459, 460  
Ryan, V. G., 458
- Sachmann, M. D., 360  
Saddichha, S., 341  
Sáez-Fonseca, L. L., 332  
Safran, J. D., 235, 240, 243, 244, 246, 248, 561  
Saha, T. D., 448  
de Saint-Exupéry, A. D., 164  
Salmela, S., 184  
Salmon, K., 501  
Santiago, L., 544  
Santos, A., 262  
Sareen, J., 349  
Satir, V. M., 131, 526  
Sauerheber, J. D., 252  
Sawaqdeh, A., 65
- Scherer, D. G., 53, 479  
Schimmelmann, B. G., 563  
Schippers, G. M., 565  
Schneider, K. J., 492  
Schuldberg, D., 251  
Schultze-Lutter, F., 563  
Schwartz, A. R., 86  
Searles, H. F., 225  
Seem, S. R., 249  
Segal, D. L., 404  
Segal, Z. V., 359, 381  
Seifritz, E., 115  
Seligman, L., 415  
Senior, A. C., 563  
Serby, M., 313, 316  
Sévigny, A., 318  
Sexton, T., 417  
Shamay-Tsoory, S., 227  
Shapira, N., 564  
Shapiro, F., 415  
Sharf, B. F., 72  
Sharma, M., 65  
Sharpe, M., 314  
Sharpley, C. F., 132  
Shaw, S. L., 252  
Shea, S. C., 16, 35, 36, 66, 72, 73, 84, 96, 98, 168, 309, 363, 514  
Shedler, J., 234  
Sheldon, C., 564  
Shelton, K., 18  
Sher, L., 350  
Shimokawa, K., 96, 241, 505  
Shimoyama, T., 127  
Shirk, S. R., 490, 506  
Shneidman, E. S., 345, 346–347, 356, 358, 360, 380, 383, 389  
Siegelman, A., 348  
Siegwart, M., 563  
Silva, C., 357  
Silverman, M., 348  
Silverman, P., 502  
Silverman, W., 405  
Singh, A. A., 24  
Sinha, B. N. P., 341  
Skinner, B. F., 181

- Skodnek, K. B., 403  
Skovholt, T. M., 67  
Slama, M., 575  
Smith, H. B., 458, 463  
Smith, H. F. I., 307, 308, 311  
Smith, J. Z., 421  
Smith, M. J., 576  
Smith, S. F., 407  
Smith, S. M., 448  
Smith, T. B., 18, 87, 422  
Smith-Hanen, S. S., 123  
Smyth, N. J., 377  
Smyth, R., 314  
Snir, S., 498  
Snyder, D. K., 512  
Sommers-Flanagan, J., 4, 5, 6, 7, 18, 25, 52, 58, 74, 81, 99, 103, 114, 134, 135, 159, 163, 168, 169, 176, 184, 188, 190, 191, 194, 218, 230, 243, 247, 252, 266, 346, 358, 403, 406, 415–416, 436, 443, 444, 445, 446, 468, 474, 475, 480, 481, 482, 484, 487, 489, 490, 491, 492, 493, 495, 498, 504, 514, 557, 558  
Sommers-Flanagan, R., 18, 52, 58, 81, 99, 103, 134, 135, 159, 168, 169, 176, 184, 188, 190, 191, 194, 223, 230, 247, 266, 346, 358, 403, 436, 443, 444, 446, 457, 474, 475, 480, 481, 484, 487, 489, 490, 491, 492, 493, 498, 504, 514, 545, 557, 558  
Song, X., 420, 436  
Soorya, L., 304  
Sousa, I., 258  
Southern, S., 520  
Spence, S. H., 275  
Spencer, R. J., 332  
Sperry, L., 542  
Spiegler, M. D., 247  
Spitzer, R. L., 405  
Spiwak, R., 348, 349  
Stanley, B., 382  
Stanton, M., 513  
Stauffer, M., 536  
Steenkamp, M. M., 467  
Steer, R. A., 263, 377  
Stefansson, J., 372  
Stern, E. M., 64  
Sternberg, R. J., 334  
Stiles, W. B., 562  
Stiles-Shields, C., 562  
Stocks, E. L., 228  
Stolle, D., 25, 251  
Stolzenberg, S., 331  
Stone, C. B., 477  
Stone, J., 314  
Strassle, C. G., 81  
Strauss, B., 259  
Strub, R. L., 303  
Strupp, H. H., 249  
Sue, D., 18, 175, 223, 576  
Sue, D. W., 18, 20, 21, 23, 59, 175, 223, 576  
Sue, S., 18, 22, 23, 26, 120, 308  
Suess, H., 259  
Suh, J. H., 494  
Suler, J., 569  
Sullivan, B. F., 8  
Sullivan, D. K., 564  
Sutton, C. T., 57, 58  
Swan, A., 403  
Swaney, G., 251  
Swank, J., 312  
Swartz, S. H., 564  
Sweeney, T. J., 270  
Swift, J. K., 419  
Symonds, D., 240  
Syrus, Publius, 199  
Szanto, K., 378  
Szasz, T. S., 17, 92, 94, 386, 398, 399  
Szmukler, G., 452  
Tabrizi, M. A., 408  
Talvik, T., 411  
Tao, K. W., 222  
Taube-Schiff, M., 359  
Taylor, J., 327  
Taylor, L. A., 502  
Taylor, M., 350  
Taylor, R. J., 58  
Teasdale, J. D., 359  
Tell, R. A., 234  
Teyber, E., 81, 86, 275  
Theriault, B., 491

- Thomas, A., 259  
Thomas, V., 538  
Thompson, C. L., 503  
Thoresen, C. E., 266  
Tian, X., 407  
Tibbits, B. M., 126  
Tighe, A., 517  
Tindall, J. H., 122  
Tishby, O., 474  
Titov, N., 565  
Titus, G., 62  
Tombini, M., 324  
Tompkins, K. A., 419  
Tonsager, M. E., 264  
Toriello, P. J., 17  
Trajković, G., 405  
Trimble, J. E., 46  
Trippany, R. L., 465  
Trotter-Mathison, M., 67  
Tryon, G. S., 99, 240  
Trzepacz, P. T., 308  
Tucker, R. P., 348  
Turner, C., 564  
Turner, C. W., 517  
Turner, E. H., 234  
Turner, S. M., 407  
Turvey, C. L., 348  
  
Utsey, S. O., 25, 470  
  
Vähäsarja, K., 184  
Vahter, L., 411  
van den Pol, R., 251  
Van Orden, K. A., 352, 367  
Vander Stoep, A., 351  
Vanhala, M., 184  
Vargas, L., 25  
Vazquez, C. I., 61  
Verdirame, D., 421  
Vered, M., 474  
Verfaellie, M., 330, 401  
Vernon, A., 474, 503  
Villalba, J. A., Jr., 506  
Vogel, D. L., 560  
Vollmer, B. M., 419  
  
Wagner, L., 52  
Waits, B. L., 228  
Wakefield, J. C., 94, 359, 398  
Walitzer, K. S., 81  
Walker, V. L., 573, 574  
Walker, Z., 332  
Wallin, P., 559  
Wallis, A., 514  
Walsh, M., 124  
Walters, R. P., 42, 121  
Wampold, B. E., 218, 240, 242  
Wang, C., 219  
Wang, L., 352  
Wankerl, J., 115  
Warlow, C., 314  
Waterhouse, L., 334  
Watson, H. J., 403  
Watson, J. C., 226  
Watter, S., 318  
Watts, A. L., 407  
Watts, R. E., 184, 275  
Wear, S. E., 463  
Weaver, J., 465  
Webb, P. M., 562  
Webber, W. B., 225  
Wechsler, D., 334  
Weeks, G. R., 515  
Weiner, I. B., 80, 158  
Weiner-Davis, M., 135, 433  
Weinger, P. M., 304  
Weintraub, M. J., 517  
Weishaar, M. E., 275  
Weisman de Mamani, A., 517  
Weissman, M. M., 275  
Welfel, E. R., 8, 42, 47, 346, 482, 567  
Welsh, C., 449  
Welton, M. T., 564  
Westen, D., 236  
Westra, H. A., 435  
Wetchler, J. L., 546  
White, M., 188, 558, 566  
Wiarda, N. R., 36  
Widiger, T. A., 92  
Wieling, E., 64  
Wilcox, H. C., 350

- Wilcoxon, S. A., 465  
Wildman, R. W., II, 304  
Wilkerson, P., 59  
Williams, J. B. W., 405  
Williams, J. M. G., 381  
Williams, K. J., 524  
Williams, N., 353, 448  
Wilmot, W. W., 542  
Wilson, R. S., 563  
Wilson, V., 514  
Winograd, G., 11, 99, 240  
Winona, J., 327  
Winslade, J. M., 188, 189, 191  
Wise, E. H., 65  
Witvliet, C. V. O., 396  
Wolberg, L. R., 173, 174, 259  
Wollersheim, J. P., 363, 369  
Wong-Wylie, G., 222  
Wood, A. F., 576  
Wood, J. M., 494  
Woods, D. L., 333  
Wootton, R., 563  
World Health Organization, 398, 400  
Worrell, J., 249  
Worthington, E. L., Jr., 25, 420, 470  
Wright, J. H., 119, 288  
Wright-McDougal, J., 17  
Wubbolding, R. E., 185  
Xu, A., 352  
Yalom, I. D., 152, 196, 413  
Yehuda, R., 463  
Yellow Bird, M., 56  
Yener, G., 332  
Yoo, S. H., 62  
York, G., 562  
Yoshimura, C., 41, 495  
Young, J. E., 275  
Young, K. M., 113  
Young, M. A., 531  
Young-Eisendrath, P., 516  
Yuen, E. K., 554, 560, 563  
Zahl, D. L., 352  
Zalaquett, C. P., 119, 139, 168  
Zalewska, K., 352  
Zane, N., 120  
Zeleke, W., 5, 6, 7, 406  
Zetzel, E. R., 239  
Zickuhr, K., 563  
Zilcha-Mano, S., 234  
Zimmer, A. T., 304  
Ziv-Beiman, S., 221  
Zoellner, L. A., 467  
Zuckerman, E. L., 259, 303, 309  
Zur, O., 141



## SUBJECT INDEX

- AAS. *See American Association of Suicidology*
- Abuse, 353; empathy for, 231–232. *See also* Substance abuse or dependence; Trauma
- ACA. *See American Counseling Association*
- Accurate empathy, 147, 217, 229, 253
- Acknowledging reality, 484
- Active listening. *See Attending behavior; Listening*
- Adolescents. *See Child interview*
- Advanced empathy, 153–155
- Advice: cross-cultural giving of, 213–214; giving of, 198–201; listening without giving, 14–15
- Affect, 312–313; appropriateness, 314; content of, 313; depth or intensity, 314–316; in MSE, 312–316; range and duration, 313–314
- African Americans. *See Black or African American culture*
- Agreement-disagreement, 196–197
- Alcohol. *See Substance abuse or dependence*
- Alliance building. *See Working alliance*
- American Association of Suicidology (AAS), 355
- American Counseling Association (ACA), 458; on counselor values, 207–208
- American Psychological Association (APA), 53–55, 457; on psychologist values, 206–207
- Amplified reflection, 439–441
- Anorexia nervosa, 350–351
- Antecedent questions, 261
- APA. *See American Psychological Association*
- Appearance, 309–310; child interview and, 480–481
- Approval-disapproval, 202–204
- Art activities, child interview, 495–498
- Asian American culture, 142, 422, 507; authority orientation, 62; family roles, 61–62; spiritual and religious matters, 62–63
- Assessment, 91–92, 265, 295, 413–414, 561–563; child interview and, 490, 492; cultural sensitivity and, 379–380; current functioning, 276–278; diagnosis problems and, 402–404; skills, 17; theory-based, 72, 184, 275, 300. *See also Suicide assessment*
- Attending behavior: body language, 121–122; negative, 122–123; verbal tracking, 121; visual/eye contact, 119–120; vocal qualities, 120–121
- Attitude: MSE and, 311–312; nonjudgmental, 16
- Audio recording, 37–38
- Awareness-knowledge-skill-advocacy, 55–56
- Background information, 267–268, 280; child interview, 483–484. *See also Specific histories*
- Behavior, 89, 126–128, 532; attending, 119, 119–121; of directive listening, 150; interpersonal evaluation, 271, 274–276, 280–281; MSE and, 310–311; negative attending, 122–123; socially deviant, 398; of violence, 453–455. *See also Self-presentation and social behavior*
- Behavioral ABCs, 266–267
- Bipolar disorder, 350
- Black Lives Matter, 23
- Black or African American culture, 58; assumptions, 59; couple and gender roles, 59; family roles, 59; religion and spirituality, 59
- Body (stage of interview), 90; assessment, 91–92; checklist for, 95; child interview, 490–503; couple and family interview, 528–540; interventions, 94–95; mental disorder and, 92–93

- Body language, 121–122  
Borderline personality disorder, 351  
Boundaries: defining appropriate, 9; with trauma, 465–466  
Bullying, 353
- CAMS. *See* Collaborative assessment and management of suicide  
Case formulation, 99–100; treatment planning and, 296–297, 423–427  
Centers for Disease Control and Prevention (CDC), 347  
Change: readiness for, 181–182; stages of, 182–184; talk, 437  
Charlar, 60, 176, 575  
Chief complaint, 259  
Child abuse. *See* Trauma  
Child interview, 508; art activities, 495–498; assessment and therapy procedure discussion and, 490; background and referral information, 483–484; body stage of, 490–503; closing stage of, 503–506; confidentiality and, 481–483; considerations with, 473–474; control of, 476–477; CT possibilities and, 474–475; cultural sensitivity and, 506–507; empowerment and feedback from, 505; family contingencies assessment, 492; fantasy and games, 502; first contact of, 476–478; first impressions, 479–480; information-gathering strategies for, 492–503; informed consent and, 481–482; introduction stage of, 475–478; multicultural competencies, 507; office management and personal attire, 480–481; opening stage of, 479–486; parental or caregiver observation with, 489–490; preparation and planning for, 475–476; questions used in, 500–501; radical acceptance, 490–491; reassurance and support from, 503–504; wishes and goals of, 486–489  
Clarification, 135–137  
Classification systems, 92, 393–396  
Cleavage and crotches, straight talk about, 39–41  
Client, 171, 289, 413–419; behavior of, during opening interview stage, 89; challenging, 433–434; collaboration, 359–360; confidentiality introduction for, 48–49; deceit or misinformation, 403; delusional or lying, 445–446; diagnostic interviewing, 410–412; directing of, 176–178; directive listening participation by, 176–178; expectation evaluation for, 81–83; as expert, 12–13; fear and doubts of, 77–78; guiding and empowerment of, 101–102; insight, 339; nonjudgmental attitude toward, 16; opening response by, 86–87; perceptual disturbances asked by, 325–327; records of, 374–376; resources of, 423; self-expression struggles by, 87–88; society's contribution to problems of, 94; therapy choice by, 10–11; touching of, 42–43  
Client identity theft, 566–567  
Client motivation, professional relationship and, 10–11  
Client reflection stimulation questions, 262–263  
Client registration forms, for intake interview, 279  
Client talk, nondirective listening behavior encouraging, 126–128  
Client welfare, 212–213  
*Clinical Handbook of Couple Therapy* (Gurman et al.), 528  
Clinical interview, 3, 28–29; counseling and psychotherapy *versus*, 7–9; definition of, 5–7; diagnostic reliability and validity, 406–407; key dimensions of, 8; learning model for, 13–14; in mental health training, 4–5; multicultural perspective, 19–28; non-FtF, 573–575; semi-structured, 5, 404; structured, 404  
*Clinical Psychiatry* (Kraepelin), 394–395  
Closed questions, 165–167  
Closing (stage of interview), 95; case formulation, 99–100; checklist for, 104; child interview, 503–506; client guidance and empowerment, 101–102; couples and family interview, 540–541; instilling hope, 103; loose ends tied during, 103; progress monitoring, 102–103; reassurance and support in, 96–97; role induction, 97–98; summarization in, 98

- Coalition building, 515
- Collaborative assessment and management of suicide (CAMS), 360
- Collaborative goal-setting, 11, 77–78
- Collateral information: intake report and, 285–287; suicide assessment, 378–379
- Coming alongside, MI and, 442–443
- Communication: styles of, 58; text-only asynchronous, 557–558; text-only synchronous, 559; two-way, 118–119; of unconditional positive regard, 223–224; video-link synchronous, 559–560; voice-only asynchronous, 558; voice-only synchronous distance, 558–559
- Competency check, 573–574
- Complainants, 10
- Completed suicides, 387–389
- Conduct disorder, 351
- Confabulation, 330
- Confidentiality: child interview and, 481–483; client's introduction to, 48–49; consultation and, 50–51; ethical codes related to, 49–50; limits to, 47–48; non-FtF and, 570–571; trauma and, 464
- Conflict: clinician's feelings on, 542–543; identification, management and modification for, 542–546; of loyalty, 545; process and content of, 542; during sessions, 543–544; values solutions for, 211–212
- Conflict management, between couples, 534
- Confrontation, 159–162
- Congruence, 251; across cultures, 222; evidence base for, 219–220; guidelines for use of, 220–221
- Consciousness, 373
- Consultation: confidentiality and, 50–51; as stress management, 67–68; suicides and, 386
- Contextual factors, suicide and, 352–353
- Coping questions, 262
- Coping skills assessment, 413–414
- Counseling, clinical interviewing *versus*, 7–9
- Countertransference (CT), 252; child interview and, 474–475; clinician contributions to, 239; couples and family interviews and, 548–549; evidence base for, 236–239; examples of, 237–238; management of, 238
- Couples, 59, 531; conflict management between, 534; defining of, 512–514; individual therapy shift to, 544–545; initial observations and structuring sessions with, 523–524; positive focus on, 524–525; theoretical orientations with, 528
- Couples interview, 539, 550; balance maintained in, 525; behavioral exchanges and, 532; body stage of, 528–540; challenges of, 511–512; clinician's opening statement in, 522–523; closing stage of, 540–541; conflict during, 543–544; core content areas for, 534–535; CT and, 548–549; diversity issues and, 546–547; education in, 518–519; emotional bids and, 532; empathy expressed in, 531; first contact with, 515–516; genogram, 537; interaction patterns and, 529–531; introduction stage of, 514–519; limit-setting with, 520–521; meeting and greeting, 516–517; motive reframing and, 532; preparation and planning for, 514–515; romantic history and, 529–530; scheduling of, 515–516; willingness to make changes, 538–539. *See also* Family interview
- Credential presentation, 43–44
- Crisis. *See* Trauma
- CT. *See* Countertransference
- Cultural competencies, disaster mental health and, 468–469
- Cultural formulation interview, 428
- Cultural knowledge, 21
- Cultural self-awareness, 19–20
- Cultural sensitivity, 25; child interviews and, 506–507; couples and family interviews and, 541; diagnosis and, 427–428; non-FtF and, 565–566, 575–576; suicide risk assessment and, 379–380; treatment planning and, 427–428
- Culture, 222; of Asian Americans, 61–63; of Black or African American, 58–59; connections with, 80; of First Nation Peoples, 56–58; of Hispanic/Latina(o) Americans, 60–61; humility returning to, 469–470; influences of, 100–101; nondirective listening and, 143–145; time and, 46–47; treatment planning and, 422

- Culture-sensitive advocacy, 23–24  
Culture-specific expertise, 21–22
- Delirium, 328  
Demographic factors, suicide and, 352–354  
Depression, 349, 365–368  
Diagnosis, 296; assessment and problems with, 402–404; classification systems, 393–394; cultural sensitivity and, 427–428; ESTs and, 418–419; reason for, 399; skills for, 17; specific criteria for, 399–402; treatment planning and, 416–417; validity and reliability of, 406–407
- Diagnostic and Statistical Manual of Mental Disorders (DSM)*, 92, 94, 394–396
- Diagnostic comorbidity, 403  
Diagnostic interviewing: advantages associated with, 407–408; approaches to, 404–405; checklist available during, 411; client personal history, 412; client perspective respect during, 410–411; client problem review and, 410–411; current situation, 412–415; disadvantages associated with, 408–409; expectation of, 411; introduction and role induction, 409–410; less structure of, 409
- Dibs: In Search of Self* (Axline), 498  
Differential diagnosis, 403  
Digit span, 333  
Directing, ethics of not, 142–143  
Directive approach, 181; advice giving, 198–201; agreement-disagreement, 196–197; approval-disapproval, 202–204; client welfare and, 212–213; cross-cultural, 213–214; ethical and multicultural considerations for, 204–205; ethics, diversity, and self-disclosure, 214–215; psychoeducation, 192–193; self-disclosure, 201–202; suggestion, 193–195; techniques and effects of, 205; urging, 202; values and, 205–212
- Directive historical leads, 269–271  
Directive listening, 149; behaviors of, 150; client's participation in, 176–178; confrontation as, 159–162; effects of, 174; ethical and multicultural considerations for, 175–176; immediacy as, 162–163; interpretation as, 155–159; interpretive reflection of feeling as, 153–155; questions and, 163–174; validation as, 150–152
- Disabilities, persons with, 64  
Disagreement, resisting, 196–197  
Disaster mental health, cultural competencies in, 468–469
- Disaster Response Network, 457  
Disorientation, 327  
Diversity, 214–215, 298–299; issues of, with couple and family interviews, 546–547
- Documentation procedures, 52; record-keeping guidelines, 53–55; SOAP note, 53; for suicides, 387–388
- Doorknob statements, 105  
Double question, 135  
Draw-A-Person, 494  
Drugs, 539–540  
*DSM*. *See Diagnostic and Statistical Manual of Mental Disorders*
- Dynamic sizing, 22–23
- EFCT. *See Emotionally focused couple therapy*
- Electronic interviewing, 553  
Emergency responses, non-FtF and, 570  
Emotion: nondirective listening and, 143–145; safe words for, 145  
Emotional bids, 532  
Emotional validation, 443–444  
Emotionally focused couple therapy (EFCT), 528, 533  
Empathy, 233, 251; accurate, 147, 217, 229, 253; advanced, 153–155; core subprocesses of, 227–230; evidence base for, 226–227; expressed in couples therapy, 531; listening with, 114–117; misguided attempts at, 230–231; mutual, 249–250; suicide intervention and, 381; for trauma and abuse, 231–232
- Empirically supported treatments (ESTs), 418–419  
Empowerment, 101–102, 505  
Ending of session: time, 46, 104–105. *See also Termination (stage of interview)*
- Episodic memory, 334  
ESTs. *See Empirically supported treatments*

- Ethical and multicultural considerations: for directive approach, 204–205; for directive listening, 175–176; for nondirective listening, 142–143
- Ethical issues. *See* Professional and ethical issues
- Ethical obligation, homosexual clients and, 117–118
- Ethical Principles for Psychologists and Code of Conduct* (APA), 462
- Ethics: confidentiality and, 49–50; of directive approach, 214–215; of intake report, 285–289; of not directing, 142–143; of online counseling, 567–568; of questions, 175–176. *See also* Professional and ethical issues
- Evidence-based relationships, 219–220, 226–227, 253–254; CT, 236–239; modeling, 247–249; multicultural, 250–252; mutuality and mutual empathy, 249–250; psychotherapy debate on, 217–218; repairing ruptures within, 243–247; transference, 233–236; treatment planning and, 423; working alliance, 239–243. *See also* Psychotherapy
- Exception questions, 191–192
- Externalizing questions, 190–191
- Eye contact. *See* Visual/eye contact
- Face-to-face contact (FtF), non-FtF compared to, 554–557
- Familia, 575
- Family: defining of, 513–514; roles, 57, 59–62
- Family contingencies, 492
- Family interview, 550; body stage of, 528–540; challenges of, 511–512; clinician's opening statement in, 522–523, 526; closing stage of, 540–541; conflict during, 543–544; CT and, 548–549; diversity issues and, 546–547; drugs, alcohol, and physical violence and, 539–540; education in, 518–519; first contact with, 517–518; genogram and, 537; initial observations and structuring session with, 526–527; introduction stage of, 514–519; limit-setting with, 520–521; meeting and greeting during, 518; more clients, less time and, 512; preparation and planning for, 514–515; scheduling of, 517–518; theoretical orientations, 536–537
- Family roles, 57
- Family therapy, 513, 539; balance maintained with, 527–528; goals for, 537–538; individual therapy shift to, 544–545
- Fantasy and games, child interview and, 502
- Father-daughter dynamics, 527
- Feedback, genuine, 443–444
- Feeling validation. *See* Validation
- Feeling vocabulary, 138
- Filial piety, 22–23, 576
- Fire setting, 453
- Firearms, availability of, 353
- First contact: of child interview, 476–478; with couples interview, 515–516; with family interview, 517–518; and introduction stage, 73–74
- First Nation Peoples cultures, 56, 576; communication styles, 58; family roles, 57; humor, 57; sharing and material goods, 57–58; spirituality, 57; time, 58; tribal identity, 57
- Flaming, 569
- Flashbacks, 325–326
- Four big reality therapy questions, 185
- FtF. *See* Face-to-face contact
- Functioning assessment, current, 276–278
- Gender: nondirective listening and, 143–145; roles of, 59, 61
- Genogram, 537
- Giving advice, 14–15, 198–201, 213–214
- Goals: collaboration for, 11, 77–78; for family therapy, 537–538; intake interview, 259–263; MI and, 438–439; review of, during intake interview, 278–279. *See also* Wishes and goals
- Grooming and attire, 38–39
- Hallucinations, 323–324
- Hamilton Rating Scale for Depression (HAM-D), 405
- Hispanic/Latina(o) American cultures, 507, 548; family roles, 60–61; gender roles, 61; personalismo, respeto, and charlar, 60; religion and belief systems, 60
- Historical information, 267–268

Homicide, among young men, 453–454  
Homosexuality, ethical obligation and, 117–118  
Hope, instilling of, 103  
House-Tree-Person, 494  
Humility, multicultural, 25–26  
Humor, 57

*ICD.* See *International Classification of Diseases*

Illusions, 324–325  
Immediacy, 162–163  
Immediate memory, 330  
Implied questions, 168–169  
Indirect questions, 168–169  
Informants, intake report and, 285–287  
Informed consent, 8, 51–52, 462–463; child interview and, 481–482; non-FtF and, 572–573  
Insight, 339  
Insomnia, 351  
Institutional setting, for intake interview, 279  
Intake interview, 257, 300–301; background and historical information, 267–268; brief, 280; checklist for, 281; client registration forms and, 279; current functioning assessment, 276–278; directive historical leads, 269–271; diverse client do's and don'ts for, 298–299; factors affecting procedures of, 279–280; goal analyzation, 261–263; goal prioritization and selection, 260–261; goal review and change monitoring, 278–279; identifying, evaluating, and exploring client problems and goals from, 259–260; institutional setting and, 279; interpersonal behavior evaluation, 271, 274–276, 280–281; nondirective historical leads, 268–269; objectives for, 258–259; professional background influencing, 280; psychosocial history, 267–268, 272–274, 280–281; theoretical orientation, 279–280  
Intake report: audience for, 282; client sharing of, 289; collateral information and informants, 285–287; concise and clear writing, 298; ethics of, 285–289; multicultural, 288–289; nondiscriminatory language for, 287–288; outline for, 283–285

Intake report structure: behavioral observations, 290; case formulation and treatment plan, 296–297; current problem history, 291; current situation and functioning, 294; developmental history, 293; diagnostic impressions, 296; formal assessment data, 295; MSE and, 290; past treatment and family treatment history, 291–292; referral reason and information identification, 290; relevant medical history, 292; social and family history, 293  
Intelligence. See Memory and intelligence  
Intentionally directive paraphrase, 133–134  
International Association for Marriage and Family Counseling, 520  
*International Classification of Diseases (ICD)*, 92, 394–396  
Interpersonal behavior evaluation, 271, 274–276, 280–281  
Interpretation: psychoanalytic, 155–158; reframing or postmodern, 158–159; trial, 157  
Interpretive reflections of feeling, 153–155  
Interventions, 94–95  
Interview. See *Specific interviews*  
Interviewer countertransference, 403  
Introduction (stage of interview): checklist for, 84; child interview, 475–478; client fear and doubt sensitivity, 77–78; client's ease with, 79; conversation and small talk, 79–80; couples and family interview, 514–519; cultural connection, 80; diagnostic interview and, 409–410; first contact, 73–74; initial face-to-face meeting, 75–76; rapport establishment, 76; role induction and client expectation evaluation, 81–83; self-disclosure, 80–81  
Invisibility syndrome, 59  
IS PATH WARM (suicide warning signs), 355–356  
Joiner's interpersonal theory, on suicide, 357  
Joining, 522  
Kinetic Family Drawing, 494  
Knowledge, cultural, 21

- Learning model, for clinical interview, 13–14
- Legal issues, with suicides, 387
- Lesbian, gay, bisexual, transgender, and queer (LGBTQ), 63
- Listening: with empathy, 114–117; without giving advice, 14–15; skills for, 113–114. *See also* Directive listening; Nondirective listening
- Listening continuum, 125–126
- Loneliness, 352
- Loyalty, conflicts of, 545
- Marital therapy, 513
- Material goods and sharing, 57–58
- Memory and intelligence, 330–335
- Mental constriction, 356–357
- Mental disorders, 428–429; defining of, 92, 396; explanations for, 94; general criteria for, 92–93, 397–398; mental illness compared to, 397; suicide and, 349–352
- Mental health training, clinical interview in, 4–5
- Mental illness, 397
- Mental status examination (MSE), 303–304; affect and mood, 312–316; appearance, 309–310; checklist, 340; cultural differences in, 340–341; individual and cultural considerations for, 305–308; intake report and, 290; memory and intelligence, 330–335; orientation and consciousness, 327–329; perceptual disturbances, 323–327; reliability, judgment, and insight, 335–339; single-symptom generalization and, 307–308; speech and thought, 317–323; when to use, 340–342
- MI. *See* Motivational interviewing
- Microaggressions, 23–24
- Military personnel, 352
- Mini-Mental Status Examination (MMSE), 563
- Minority group professionals, 65–66
- Miracle question, 189–190
- Mirroring, 122
- Mistake making, 66
- MMSE. *See* Mini-Mental Status Examination
- Modeling, 247–249, 252
- Mood, 312–313, 316–317
- Mood ratings, with suicide floor, 363–364, 366
- Motivational interviewing (MI), 470–471; coming alongside and, 442–443; emotional validation and, 443–444; genuine feedback and, 443–444; goal-setting strategies and, 438–439; open questions for, 438–439; radical acceptance and, 443–444; reflection and, 439–441; reframing and, 443–444; for resistance, 436–438; substance abuse and, 447–451; violence assessment and, 451–452
- Motive reframing, 532
- MSE. *See* Mental status examination
- Multicultural competencies, 17, 26–28; child interview, 507; couples interview and, 535–536; four principles of, 19–25
- Multicultural humility, 25–26
- Multicultural preparation: Asian Americans, 61–63; awareness-knowledge-skill-advocacy for, 55–56; Black or African American, 58–59; First Nation Peoples, 56–58; Hispanic/Latina(o) Americans, 60–61; LGBTQ, 63; other minority groups, 63–65; persons with disabilities, 64; religiously committed, 64
- Multicultural sensitivity, 25
- Mutual empathy, 249–250, 253
- Mutuality, 249–250
- Narrative therapeutic questions, 186
- National Institute on Alcoholism and Alcohol Abuse (NIAAA), 448
- Negative attending behaviors, 122–123
- Neurogenesis, 114–117
- Neurolinguistic programming (NLP), 131
- NIAAA. *See* National Institute on Alcoholism and Alcohol Abuse
- NLP. *See* Neurolinguistic programming
- Nondirective historical leads, 268–269
- Nondirective listening, 147–148; clarification as, 135–137; as directive, 123–125; effects of, 127; ethical and multicultural considerations for, 142–143; gender, culture, and emotion and, 143–145; not knowing what to say and, 145–146; paraphrase as, 130–135; questions and, 172; reassurance

- and, 141–142; therapeutic listening as, 126–130; as unethical, 142–143
- Non-face-to-face contact (non-FtF), 577; assessment and intervention research on, 561–563; client identity theft or misrepresentation and, 566–567; clinical interviews by, 573–575; confidentiality limitations and, 570–571; cultural sensitivity and, 565–566, 575–576; emergency responses and, 570; ethical and professional issues with, 565–566; FtF compared to, 554–557; immediate and explicit disclosure increased potential with, 569–570; informed consent and, 572–573; mental health provider credentials missing with, 567; nonverbal cues unavailable with, 565–566; parental consent for work with minor clients and, 571–572; purpose of, 574; room preparation and, 574–575; therapeutic relationship and, 561–562; treatment outcomes and, 563–565
- Nonjudgmental attitude, 16
- Non-suicidal self-injury (NSSI), 352
- No-suicide contracts, 360
- Note taking, 35–37
- NSSI. *See* Non-suicidal self-injury
- Objectivity, 305–307
- Office clutter and decor, 35
- Online counseling: ethics and reality of, 567–568; psychotherapy outcomes and, 564–565
- Open questions, 164–165; MI and, 438–439
- Opening (stage of interview), 84–90; checklist for, 90; child interview, 479–486; client behavior during, 89; of couples and family interview, 521–528
- Opening statement, 84–88
- Orientation and consciousness, MSE and, 327–329
- Paralinguistic, 120
- Paraphrase, 135; intentionally directive, 133–134; sensory-based, 131–132; simple, 130–131; summarization as, 139–141
- Parent-child art psychotherapy (PCAP), 498
- PDM. *See* *Psychodynamic Diagnostic Manual*
- Perceptual disturbance: clients asking about, 325–327; MSE and, 323–327
- Personal factors, suicide and, 352–353
- Personal loss, 352
- Personalismo, 80, 575
- Perturbability, 356–357
- PFA. *See* Psychological first aid
- Physical illness, 352
- Physical setting, of interview, 31–38
- Physical violence, 539–540
- Play therapy, 498–499
- Positive therapy relationships, 16–17
- Post-hospital discharge, 351
- Postmodern interpretations, 158–159
- Posttraumatic stress disorder, 349–350
- Preparation, for interview, 31–70, 171, 475–476, 514–515; confidentiality, 47–51; documentation procedures, 52–55; informed consent, 51–52; minority group professionals considerations, 65; mistake making, 66; multicultural, 55–65; physical setting, 31–38; professional and ethical issues, 38–47; self-presentation and social behavior, 38–44; stress management and self-care, 65–66
- Presuppositional questions, 169–170, 189
- Pretreatment change question, 186–187
- Previous attempts, suicide, 352, 374–375
- Problem experience focus questions, 261–262
- Professional and ethical issues, 8–9, 38–47; non-FtF and, 565–566; suicide and, 386–388
- Professional background, intake interview influenced by, 280
- Progress monitoring, 102–103
- Projective questions, 169–170
- Protective drawings, 494
- Protective factors, for suicide, 353–355; outside information for, 374–380
- Pseudodementia, 332
- Psychache, 356–357
- Psychiatric treatment, suicide and, 349–352
- Psychoanalytic interpretations, 155–158
- Psychodynamic Diagnostic Manual (PDM)*, 394
- Psychoeducation, 192–193; couples interview and, 534–535

- Psychological first aid (PFA), 458–466; collaborative service linkage, 462; contact and engagement, 459; coping support information, 461–462; information gathering, 460–461; practical assistance, 461; safety and comfort, 459–460; social support connection, 461; stabilization, 460
- Psychologist values, 205
- Psychomotor activity, 310–311
- Psychosocial history, 267–268, 272–274, 280–281
- Psychotherapy: clinical interviewing *versus*, 7–9; congruence and, 219–222, 251; core conditions needed for, 218–221; empathy and, 226–233; great debate on, 217–218; online counseling and outcomes of, 564–565; unconditional positive regard and, 222–225, 251
- Questionnaires, 263–264
- Questions, 163; antecedent and triggering, 261; benefits and liabilities of, 170–171; in child interview, 500–501; client preparation for, 171; client reflection stimulating, 262–263; closed, 165–167; for concrete behavioral examples, 173; coping, 262; curiosity, culture, and professional ethics, 175–176; directive listening, 163–174; exception, 191–192; externalizing, 190–191; four big reality therapy, 185; general guidelines for, 171–172; implied or indirect, 168–169; miracle, 189–190; narrative and solution-focused, 186; nondirective listening and, 172; open, 164–165; presuppositional, 189; pretreatment change, 186–187; problem experience focusing, 261–262; projective or presuppositional, 169–170; relevancy of, 172–173; scaling, 187–188; on sensitive areas, 174–175; swing, 168–169; therapeutic, 184–192; unique outcomes or redescription, 188–189
- Radical acceptance, 443–444, 490–491
- Rapport, building, 16–17, 76
- Rating scales, 263–264
- RDoc. *See* Research Domain Criteria
- Reassurance, 96–97, 141–142, 503–504
- Recent memory, 330
- Record-keeping guidelines, 53–54, 462–463
- Red Cross, 457
- Redescription questions, 188–189
- Reflecting team, 514
- Reflection: amplified, 439–441; of feeling, 137–138; MI and, 439–441. *See also* Empathy
- Reframing interpretations, 158–159, 443–444
- Relationship boundaries, 9
- Relationship enhancement, 513
- Relationship therapy, 513
- Reliability, of clinical interview, 406–407
- Religion. *See* Spirituality
- Religiously committed persons, 64
- Remote memory, 330
- Report writing. *See* Intake report
- Representational systems, 131
- Research Domain Criteria (RDoc), 394
- Resistance, 196–197, 419–420; delusional or lying clients and, 445–446; exploring and defining of, 434–436; functional, 436; MI for, 436–438; as multidetermined, 435–436; reframing of, 434–435; therapist stimulation of, 435; trauma techniques and, 464
- Respecto, 60
- RIP SCIP (suicide assessment acronym), 361
- Role induction, 81–83, 97–98; diagnostic interviewing and, 409–410
- Romantic history, 529–530
- Room setting, 31–33, 480–481, 574–575
- Rupture repair: evidence base for, 243–247; examples of, 244–245; guidelines and strategies for, 245–247
- Safety planning, 382–383
- Scaling questions, 187–188
- Schizophrenia, 350; violence and, 454–455
- SCID-I. *See* Structured Clinical Interview for DSM-IV Axis I Disorders
- Scientific mindedness, 21–22
- Seating arrangements, 33–34
- Secondary trauma, 464–466
- Secrets, 519–520
- Self-awareness, cultural, 19–20

- Self-care, 65; approaches to, 66–67; mistake making, 66
- Self-disclosure, 80–81, 201–202, 214–215. *See also* Immediacy
- Self-expression struggles, 87–88
- Self-presentation and social behavior, 398; cleavage and crotches, 39–41; client touch and, 42–43; credential presentation, 43–44; grooming and attire, 38–39; monitoring of, 42
- Semantic memory, 334
- Semi-clinical interview, 5, 404
- Sensory-based paraphrase, 131–132
- Serial sevens, 332
- Serotonin specific reuptake inhibitors (SSRIs), 351–352
- Sexual and Relationship Therapy* (Rutter), 535
- Sexual orientation, 353
- Shneidman's theory, on suicide, 356–357
- Simple paraphrase, 130–131
- Single-symptom generalization, 307–308
- Skill memory, 334
- Small talk and conversation, 79–80
- SOAP note. *See* Subjective, objective, assessment, and plan
- Social behavior. *See* Self-presentation and social behavior
- Social factors, suicide and, 352–353
- Social isolation, 352
- Socially deviant behavior, 398
- Solution-focused questions, 186
- Speech and thought, 317–323; content of, 320–321; obsessions, 322–323; process descriptors, 319–320
- Spirituality, 57, 59–60, 62–63, 576; treatment planning and, 420–421
- SSRIs. *See* Serotonin specific reuptake inhibitors
- Stages of clinical interview, 71–72, 107–108. *See also* Body (stage of interview); Closing (stage of interview); Introduction (stage of interview); Opening (stage of interview); Termination (stage of interview)
- Standardized introduction, 75–76
- Stereotyping, 26–28
- Storytelling, 502
- Stress management, 65; approaches to, 66–67; consultation as, 67–68; mistake making, 66
- Structured clinical interview, 5
- Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-1), 405–406
- Subjective, objective, assessment, and plan (SOAP note), 53
- Subjective distress, 398
- Subjective memory complaints, 332
- Substance abuse or dependence, 350, 539–540; interview content addressing, 449–451; MI and, 447–451
- Suggestion, 193–195
- Suicide, 390; completed, 387–389; consultation and, 386; contagion, 353; demographics and, 353, 354; documentation procedures for, 387–389; facing situation of, 344–346; intent, 372; Joiner's interpersonal theory for, 356; legal issues and, 387; mental disorders and, 349–352; personal reactions to, 346–347; previous attempt exploration, 373–374; professional and ethical issues for, 386–388; protective factors for, 353–355; psychiatric treatment and, 349–352; psychosis, mental constriction, and perturbability, 356–367; Shneidman's theory on, 356–357; statistics of, 347–348; theoretical and research-based foundation for, 356–357; warning signs for, 355–356
- Suicide assessment: client records for, 374–376; collateral information for, 378–379; cultural sensitivity and, 379–380; instruments for, 376–378; interview for, 8, 360–361; outside information for, 374–380; RIP SCIP, 361
- Suicide ideation, 361–364; asking directly about, 362–364; cognitive symptoms explored with, 367–368; depressive symptoms explored with, 365–368; mood ratings with suicide floor, 363–364, 366; mood-related symptoms explored with, 365–367; normalizing frame for, 362–363; physical or neurovegetative symptoms explored with, 367; research on, 358–359; responding to, 364–365; social/interpersonal symptoms explored with, 368

- Suicide interventions, 380–385; alternative identification, 383; becoming directive and responsible, 384; empathy, 381; hospitalization and referral decisions, 384–385; non-FtF contact and, 570; psychic pain separation from self and, 383–384; safety planning, 382–383; therapeutic relationship establishment, 381–382
- Suicide plan assessment, 368–370; arousal/agitation observance, 371; availability, 370; client self-control and, 370–371; directly asking about, 370–371; lethality, 369; proximity, 370; specificity, 369
- Suicide research: client collaboration, 359–360; of ideation, 358–359; medical model for, 357–358; new empirical and conceptual approaches to, 357–358; risk factor overemphasis, 359–360
- Suicide risk: abuse and bullying, 353; anorexia nervosa, 350–351; bipolar disorder, 350; borderline personality disorder, 351; conduct disorder, 351; demographics, 353; depression, 349; factors, 348–353; firearms availability, 353; insomnia, 351; military personnel and veteran status, 352; NSSI, 352; outside information for, 374–380; personal loss, 352; physical illness, 352; post-hospital discharge, 351; posttraumatic stress disorder, 349–350; previous attempts, 352; schizophrenia, 350; sexual orientation and sexuality, 353; social, personal, contextual, and demographic factors, 352–353; social isolation/loneliness, 352; SSRIs, 351–352; substance abuse or dependence, 350; suicide contagion, 353; unemployment, 352
- Summarization, guidelines for, 139–141
- Sustain talk, 437
- Swing questions, 168–169
- Telephone assessment, 563
- Telephone interventions, 564
- Termination (stage of interview), 104–107; checklist for, 107; doorknob statements, 105; guidance and control for, 105–106; personal issues during, 106–107
- Text-only asynchronous communication, 557–558
- Text-only synchronous communication, 559
- Theoretical orientation, for intake interview, 279–280
- Theory-based assessment, 72, 184, 275, 300
- Therapeutic action, skills for encouraging, 184–186
- Therapeutic assessment, 265
- Therapeutic attitude, adoption of, 114
- Therapeutic listening, 126–130
- Therapeutic orientation: with couples, 528; for family interview, 536–537
- Therapeutic questions. *See Questions*
- Therapeutic relationships: non-FtF and, 561–562, 576; positive, 16–17; suicide intervention and, 381–382. *See also Working alliance*
- Therapeutic silence, 126–127; examples of, 128–129; explanation of, 128; guidelines for, 129–130
- Therapist, as expert, 12, 13, 545–546; treatment planning and, 423
- Therapy, client choice for, 10–11
- Time, 58, 512; culture and, 46–47; ending session, 46; starting session, 44–45; termination of clinical interview, 104–105
- Tough Kids, Cool Counseling* (Sommers-Flanagan and Sommers-Flanagan), 484
- Toxic disinhibition, 569
- Transference, 233–236, 252
- Trauma, 456; assessment decisions with, 463; boundary concerns with, 465–466; confidentiality and, 464; defining of, 466–467; empathy for, 231–232; interviewing of survivors of, 457–458, 466–468; issues and challenges with, 467–468; PFA and, 458–466; professional responsibilities with, 462–465; resistance and techniques for, 464; secondary or vicarious, 464–466
- Trauma and Recovery* (Herman), 466
- Treatment planning, 415, 429; case formulation and, 296–297, 423–427; client characteristics, preferences, and problems matched with, 418–419; coping style

- influencing, 421; culture and, 422, 427–428; diagnosis and, 416–417; evidence-based relationships and, 423; positive expectations for, 421–422; religion/spirituality and, 420–421; resistance/reactance to, 419–420
- Trial interpretation, 157
- Tribal identity, 57, 576
- Triggering questions, 261
- Two-way communication, 118–119
- Unconditional positive regard, 222, 251; communication of, 223–224; evidence base for, 223; parallel process and, 225
- Undershooting, 439–441
- Unemployment, 352
- Unique outcomes questions, 188–189
- Unstructured clinical interview, 5
- Urging, 202
- Validation, 150–152; emotional, 443–444
- Validity, of clinical interview, 406–407
- Values, 205; ACA on, 207–208; APA on, 206–207; conflict solutions for, 211–212; laws regarding, 208–209; student and clinician implications of, 209–210; training programs and professor implications of, 210–211
- Verbal tracking, 121
- Veteran status, 352
- Vicarious trauma, 464–466
- Video recording, 37–38
- Video-link synchronous communication, 559–560
- Violence: assessment and prediction of, 451–452, 455–456; behaviors of, 453–455; fire setting, 453; homicide among young men, 453–454; physical, 539–540; schizophrenia and, 454–455
- Visitors to treatment, 10
- Visual/eye contact, 119–120; perspectives on, 120
- Vocal qualities, 120–121
- Voice-only asynchronous communication, 558
- Voice-only synchronous distance communication, 558–559
- Voices of Color: First Person Accounts of Ethnic Minority Therapists* (Sharma), 65
- Web Based Injury Statistics Query and Reporting System (WISQARS), 347
- What's good about you (relationship-building assessment), 493
- WHO. *See* World Health Organization
- Wishes and goals: child interview and, 486–489; introduction of, 487–488; of parents or caregivers, 488; tension management for, 488–489
- WISQARS. *See* Web Based Injury Statistics Query and Reporting System
- Working alliance, 252, 522; clinical interviewing for, 6, 90, 553; evidence base for, 239–243; non-FtF, 576; note-taking, 36; recommendations for, 241–243
- Working memory, 334
- World Health Organization (WHO), 395
- Young clients. *See* Child interview











