

Instructor's Manual

for

CLINICAL INTERVIEWING: INTAKE, ASSESSMENT, AND THERAPEUTIC ALLIANCE

with

**JOHN SOMMERS-FLANAGAN
AND RITA SOMMERS-FLANAGAN**

Manual by

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psychotherapy.net

The *Clinical Interviewing: Intake, Assessment, and Therapeutic Alliance with John Sommers-Flanagan and Rita Sommers-Flanagan* (Institutional/Instructor's Version). Video available at www.psychotherapy.net.

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Clinical Interviewing: Intake, Assessment, and Therapeutic Alliance with John Sommers-Flanagan and Rita Sommers-Flanagan

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Tips for Making the Best Use of the Video

1. USE THE TRANSCRIPTS

Make notes in the video **Transcript** for future reference; the next time you show the video you will have them available. Highlight or notate key moments in the video to better facilitate discussion during and after the video.

2. FACILITATE DISCUSSION

Pause the video at different points to elicit viewers' observations and reactions to the concepts presented. The **Discussion Questions** sections provide ideas about key points that can stimulate rich discussions and learning.

3. ENCOURAGE SHARING OF OPINIONS

Encourage viewers to voice their opinions. What are viewers' impressions of what is presented in the interviews?

4. CONDUCT A ROLE-PLAY

The **Role-Play** sections guide you through exercises you can assign to your students in the classroom or training session.

5. SUGGEST READINGS TO ENRICH VIDEO MATERIAL

Assign readings from **Related Websites, Videos and Further Reading** prior to or after viewing.

6. ASSIGN A REACTION PAPER

See suggestions in the **Reaction Paper** section.

PERSPECTIVE ON VIDEOS AND THE PERSONALITY OF THE CLINICIAN

Psychotherapy portrayed in videos is less off-the-cuff than therapy in practice. Clinicians may feel put on the spot to offer a good demonstration, and clients can be self-conscious in front of a camera. Clinicians often move more quickly than they would in everyday practice to demonstrate a particular technique. Despite these factors, counselors and clients on video can engage in a realistic session that conveys a wealth of information not contained in books or therapy transcripts: body language, tone of voice, facial expression, rhythm of the interaction, quality of the alliance—all aspects of the therapeutic relationship that are unique to an interpersonal encounter.

Psychotherapy is an intensely private matter. Unlike the training in other professions, students and practitioners rarely have an opportunity to see their mentors at work. But watching therapy on video is the next best thing.

One more note: The personal style of counselors is often as important as their techniques and theories. Counselors are usually drawn to approaches that mesh well with their own personality. Thus, while we can certainly pick up ideas from master clinicians, students and trainees must make the best use of relevant theory, technique and research that fits their own personal style and the needs of their clients.

PRIVACY AND CONFIDENTIALITY

Because this video contains actual counseling sessions, please take care to protect the privacy and confidentiality of the clients who have courageously shared their personal lives with us.

The Sommers-Flanagans' Approach to Clinical Interviewing*

The clinical interview has been referred to as the foundation of all mental health treatment and as arguably the most valuable skill among psychologists and other mental health practitioners. Professionals from several different disciplines (i.e., psychologists, psychiatrists, counselors, and social workers) utilize clinical interviewing procedures. Although defined differently by different authors, the clinical interview includes an informed consent process and has as its primary goals (a) initiation of a therapeutic alliance; (b) assessment or diagnostic data collection; (c) case formulation; and/or (d) implementation of a psychological intervention.

All clinical interviews implicitly address the first two primary goals (i.e., relationship development and assessment or evaluation), while some also include a case formulation or psychological intervention. Using the Sommers-Flanagan approach, it is possible to simultaneously address all of these goals in a single clinical interview. For example, in a crisis situation, a mental health professional might conduct a clinical interview designed to quickly establish rapport or an alliance, gather assessment data, formulate and discuss an initial treatment plan, and implement an intervention or make a referral.

Overall, the quality and quantity of information gathered and the intervention applied depends almost entirely on the interview's purpose and the clinician's theoretical orientation. For example, if the interview's purpose is to establish a working psychiatric diagnosis, the clinician will be asking specific questions about patient symptoms. In contrast, if the purpose of the interview is to establish rapport and initiate a working alliance, then the interviewer is likely to use more nondirective listening skills designed to show empathic understanding of the patient's situation, concerns, and emotions.

In this video, John and Rita Sommers-Flanagan guide clinicians through more basic listening skills onward to more advanced, complex interviewing activities such as intake interviewing, mental status examinations, and suicide assessment. For beginning clinicians or those with more substantial experience, this video presents a systematic

outline of the skills needed for conducting competent and professional clinical interviews.

*Adapted from

Sommers-Flanagan, J., Zeleke, W., & Hood, M. E. (2014, in press). The clinical interview. In R. Cautin and S. Lilienfeld (Eds). The encyclopedia of clinical psychology (page numbers unknown). London: Wiley-Blackwell.

Sommers-Flanagan, J. and Sommers-Flanagan, R. (2014). *Clinical Interviewing*, Fifth Ed.

Basic Listening Skills

SUMMARY

Basic listening skills, according to the Sommers-Flanagans, are part of a wider continuum of clinical interviewing behaviors (or “listening responses”) that serve to establish a therapeutic alliance, glean diagnostic information, set the basis for a treatment plan, and act as a relational background for therapeutic interventions. This continuum ranges from less directive, or nondirective, listening behaviors to more active-directive, complex ones that aim to guide the client toward a specific therapeutic goal.

Nondirective listening responses include:

- Attending behaviors (drawn from clinician Alan Ivey):
 - eye contact
 - body posture
 - voice tone
 - verbal tracking
- Other behaviors presented by the Sommers-Flanagans:
 - silence
 - clarifications (verbal prompt)
 - paraphrasing
 - reflection of feeling
 - summarization

It is important to note that these behaviors do not represent a static, linear set of interventions, but rather can be modified and tailored to your client, in your own voice. John Sommers-Flanagan emphasizes the role of therapist authenticity in a client’s feeling heard; indeed the very act of listening, he says, is a gift that clients will resonate with if offered from a place of awareness.

It is also imperative for therapists to understand the various factors—cultural, personality-based, etc.—that may be either implicitly or explicitly impacting a client’s experience. Some clients, for instance, may balk at “too much” eye contact or questioning, while others may feel less

trusting of a therapist who asks fewer questions. The power differential between therapist and client, furthermore, may mean that a clinician may be perceived as directive even when he or she isn't intending to be. The Sommers-Flanagans stress the need for therapists to find a balance between their natural tone and one that takes into account the particular qualities of each client.

That said, they also maintain that basic listening is a skill set that can be learned and will improve with time and practice. As you watch this section of the video, observe which basic listening behaviors most (and least) resonate with your personal style, and consider which responses might be most (or least) impactful to you as a client.

Discussion Questions

Professors, training directors and facilitators may use some or all of these discussion questions, depending on what aspects of the video are most relevant to the audience.

1. **The nondirective approach:** What thoughts and feelings arise for you around the concept of nondirective listening behaviors? Do they seem like “enough” to move the interview forward? Do you prefer a more directive approach? Why or why not?
2. **Cross techniques:** Do you agree or disagree with Sommers-Flanagan’s statement that the therapeutic relationship is inherently uneven? Have you experienced the sense of a power differential in your work with clients? In your work with your own therapist? How have you dealt with this? Have you addressed this issue outright with your clients and, if so, what was the result?
3. **Cultural sensitivity:** Have you noticed or been made aware of cultural differences in your work with clients? If so, how did you handle it? Which of the basic skills from this section, if any, triggered this awareness? Can you think of cultural contexts in which each skill might be considered off-putting to a client?
4. **Silence:** John Sommers-Flanagan says that beginning therapists often find silence challenging as an intervention. Is this true for you? What does silence bring up in you as you’re sitting with someone, client or otherwise? If silence is no longer a challenge for you, how did you overcome your discomfort with it?

Role Plays

After watching the video and reviewing “Basic Listening Skills” in this manual, break participants into groups of two and have them role-play a brief interview between a therapist and client in which the therapist only uses the nondirective listening responses presented in this section.

One person will start out as the therapist and the other person will be the client, and then invite participants to switch roles. Therapists can focus on just one type of response (for instance, silence, clarification, paraphrasing, reflection of feeling, or summarization), or they can alternate among the various types—but they are not allowed to ask questions or use interventions from elsewhere in the video. Clients may play themselves, or role-play Jessie from the video, a client or friend of their own, or they can completely make it up. The primary emphasis here is on giving the therapist an opportunity to practice interviewing clients using a variety of basic listening skills, and on giving the client an opportunity to see what it feels like to participate in this type of intervention.

After the role-plays, have the groups come together to discuss their experiences. What did participants learn about the Sommers-Flanagans’ approach to basic listening? Invite the clients to talk about what it was like to role-play someone being interviewed and how they felt about the approach. How did they feel in relation to the therapist? What worked and didn’t work for them during the session? Did they feel any defensiveness or other resistance arise? Then, invite the therapists to talk about their experiences: How did it feel to facilitate the session? Did they have difficulty sticking to this type of intervention? Which type of response did they gravitate toward? Which did they tend to avoid? What would they do differently if they did it again? Finally, open up a general discussion of what participants learned about clinical interviewing using basic listening responses.

An alternative is to do this role-play in front of the whole group with one therapist and one client; the rest of the group can observe, acting as the advising team to the therapist. The therapist can use the role-play to focus on one type of skill, or may switch between types. At

any point during the session the therapist can timeout to get feedback from the observation team, and bring it back into the session with the client. Other observers might jump in if the therapist gets stuck. Follow up with a discussion on what participants learned about using the nondirective listening skills presented by the Sommers-Flanagans.

Directive Listening Responses

SUMMARY

Moving further along the clinical interviewing skills continuum, directive listening responses bring progressively more active components to the therapeutic dyad. Unlike the basic skills of attending behavior and nondirective listening responses, directive responses bring the interviewer's perspective into the room.

Directive listening responses include:

- feeling validation
- interpretive reflection of feeling (“advanced empathy”)
- interpretation (can be especially prone to resistance)
- reframe
- confrontation (pointing out discrepancies between what clients say they want and what they're actually doing)

Because these more complex responses go beyond the client's words, they can lead to greater degrees of client resistance. John Sommers-Flanagan points out that a “gentle” approach to these methods—such as asking permission to give an interpretation, for example, or asking a client what he or she thinks of your view—can lead to greater engagement and collaboration.

If directive listening is more related to taking a client where the therapist wants to go, how do you know when it resonates? According to the Sommers-Flanagans, an interpretation of feeling can be seen as accurate when it leads a client into deeper material. Even when the interviewer is incorrect, the client's response can be worked with empathically. These more advanced skills offer opportunities to deepen the therapeutic alliance.

Finally, it is important to remember that directive listening skills also take practice, and they build on the more basic skills presented previously. Rita Sommers-Flanagan argues that directive responses are tempting for the beginning interviewer, because they're more typical of our cultural discourse; listening well is as crucial as these more active skills. As you watch this section of the video, observe which directive listening behaviors are being demonstrated, and reflect on what goals John is attempting to achieve with TJ.

Discussion Questions

1. **The value of listening:** How does your own life experience impact your view of listening and/or your capacity to listen? Did your family and/or culture value nonjudgmental listening as part of a strong relationship? What examples come to mind as you consider this? How might the skills in this section help or hinder you in your work with clients?
2. **The directive style:** Rita Sommers-Flanagan says that listening well can be as challenging as the more “advanced” directive responses. Do you agree or disagree? Which type of response do you prefer? Why? What comes up for you as you consider working in the style that resonates the least?

Role Plays

After watching the video and reviewing “Directive Listening Skills” in this manual, break participants into groups of two and have them role-play a brief interview between a therapist and client in which the therapist only uses directive listening responses, using the behaviors presented in this section.

One person will start out as the therapist and the other person will be the client, and then invite participants to switch roles.

Therapists can focus on up to two types of responses (for instance, validation, interpretive feeling reflection, interpretation, reframing, or confrontation)—but they are not allowed to ask questions or use interventions from elsewhere in the video. Clients may play themselves, or role-play Trudi from the video, a client or friend of their own, or they can completely make it up. The primary emphasis here is on giving the therapist an opportunity to practice interviewing clients using a variety of directive listening skills, and on giving the client an opportunity to see what it feels like to participate in this type of intervention.

After the role-plays, have the groups come together to discuss their experiences. What did participants learn about the Sommers-Flanagans’ approach to directive listening? Invite the clients to talk about what it was like to role-play someone being interviewed and how they felt about the approach. How did they feel in relation to the therapist? What worked and didn’t work for them during the session? Did they feel any defensiveness or other resistance arise? Then, invite the therapists to talk about their experiences: How did it feel to facilitate the session? Did they have difficulty sticking to this type of intervention? Which type of response did they gravitate toward? Which did they tend to avoid? What would they do differently if they did it again? Finally, open up a general discussion of what participants learned about clinical interviewing using directive listening responses.

An alternative is to do this role-play in front of the whole group with one therapist and one client; the rest of the group can observe, acting as the advising team to the therapist. The therapist can use the role-play to focus on one type of skill, or may switch between types. At any point during the session the therapist can time-out to get feedback

from the observation team, and bring it back into the session with the client. Other observers might jump in if the therapist gets stuck. Follow up with a discussion on what participants learned about using the directive listening skills presented by the Sommers-Flanagans.

Directives & Action Responses

SUMMARY

Moving further still along the clinical interviewing skills continuum, directives and action responses move clients toward acting, feeling, or thinking in particular ways. Rita Sommers-Flanagan notes that the interviewing skills continuum isn't linear; lots of nondirective interventions can be experienced as directive, and vice versa.

Directives and action responses include:

- psychoeducation
- suggestion
- agreement-disagreement
- advice
- self-disclosure
- urging

Rita Sommers-Flanagan points out that clinicians with a more reserved personality may find directives challenging to make. On the other hand, because it can be exciting to encounter clients who appear ready to engage and work hard toward change, it can also be tempting to frame directives in inappropriate ways. John Sommers-Flanagan demonstrates the importance of integrating nondirective listening skills into this type of inquiry, showing that interventions can be delivered in authoritarian or value-laden ways that increase client resistance and undermine a clinician's credibility. Directives must be collaborative and the client must always be the final authority.

As you watch this section of the video, observe which directives and action responses are being demonstrated, and reflect on how you might structure your interventions differently from John in his session with Lisa.

Discussion Questions

1. **Ready to engage:** How can you tell when a client is ready to engage in the work of therapy? Have you ever thought this was the case, only to discover that it wasn't? How might you check this out with a client?
2. **“Bossy” vs. “passive”:** Do you consider yourself to be more forward or reserved when it comes to the idea of using directives with clients? Do you find any of the various responses from this section especially engaging? Why? How might you work with this in a session where such a response might be called for?
3. **Bad reframes:** In the demo with Lisa, John Sommers-Flanagan makes a series of authoritative and value-laden reframes. Have you ever made any of these types of reframes with clients? What led you to make these interventions? How did your client respond? How did you work through it?
4. **Self-disclosure:** What are your personal and professional views on appropriate self-disclosure? When do you think self-disclosure is inappropriate? Do you use self-disclosure with your clients? For what purpose? In your own therapy, has your therapist disclosed information to you? How did you respond?

Role Plays

After watching the video and reviewing “Directive & Action Responses” in this manual, break participants into groups of two and have them role-play a brief interview between a therapist and client in which the therapist only uses directives and action responses, using the techniques presented in this section.

One person will start out as the therapist and the other person will be the client, and then invite participants to switch roles. Therapists can focus on just one or two types of response (for instance, psychoeducation, suggestion, agreement-disagreement, advice, or urging)—but they are not allowed to ask questions or use interventions from elsewhere in the video. Clients may play themselves, or role-play Lisa from the video, a client or friend of their own, or they can completely make it up. The primary emphasis here is on giving the therapist an opportunity to practice interviewing clients using a variety of directives and action responses, and on giving the client an opportunity to see what it feels like to participate in this type of intervention.

After the role-plays, have the groups come together to discuss their experiences. What did participants learn about the Sommers-Flanagans’ approach to directives and action responses? Invite the clients to talk about what it was like to role-play someone being interviewed and how they felt about the approach. How did they feel in relation to the therapist? What worked and didn’t work for them during the session? Did they feel any defensiveness or other resistance arise? Then, invite the therapists to talk about their experiences: How did it feel to facilitate the session? Did they have difficulty sticking to this type of intervention? Which type of response did they gravitate toward? Which did they tend to avoid? What would they do differently if they did it again? Finally, open up a general discussion of what participants learned about clinical interviewing using directives and action responses.

An alternative is to do this role-play in front of the whole group with one therapist and one client; the rest of the group can observe, acting as the advising team to the therapist. The therapist can use the role-

play to focus on one type of intervention, or may switch between types. At any point during the session the therapist can timeout to get feedback from the observation team, and bring it back into the session with the client. Other observers might jump in if the therapist gets stuck. Follow up with a discussion on what participants learned about using the directives and action responses presented by the Sommers-Flanagans.

Questions & Therapeutic Questions

SUMMARY

Questions pose unique challenges for the interviewer, because they can easily stoke defensiveness in clients. According to the Sommers-Flanagans, questions are considered advanced listening responses due to their powerful, intimidating, and controlling nature—indeed, they are all directive, used to guide what clients say—and therefore have the potential for misuse.

In the video, the Sommers-Flanagans cite several types of questions:

- open
- closed
- indirect
- swing
- projective/presuppositional
- therapeutic (as opposed to assessment-based)
- exception

They also highlight several “reality therapy” questions—direct, solution-focused queries that are less therapeutic and more geared toward problem-solving:

- What do you want?
- What are you doing?
- Is it working?
- Should you make a new plan?

As an assessment or therapeutic tool, questions have both benefits and liabilities. Benefits include greater therapist control, potential deep 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.

Questions are a diverse and flexible interviewing tool; they can be used to stimulate or restrict client talk, facilitate rapport, show interest in clients, gather information, and focus on solutions, among other objectives. John Sommers-Flanagan notes that while it’s important to tailor the question to the client, almost all types of questions are

designed to help move a client toward a more positive future.

As you watch the demonstrations in this section of the video, take note of the different types of questions and therapeutic questions used by interviewers Chris and John, and listen for the client responses they elicit. Which types of questions most resonate with your personality? With your therapeutic orientation?

*Adapted from

Sommers-Flanagan, J., and R. Sommers-Flanagan. 2014. *Clinical Interviewing*, Fifth Ed.

Discussion Questions

1. **Therapeutic questions:** The Sommers-Flanagans distinguish between questions and therapeutic questions in this section. Does this distinction make sense to you? Does your own theoretical orientation provide a different set of questions, with different objectives? How might the various questions here bring fresh perspective to your work?
2. **Client defensiveness:** Do you agree with John Sommers-Flanagan that questions can potentially stoke defensiveness in clients? Why or why not? Have you observed this in your own work, either as a therapist or as a client? If you were the therapist, how did you handle it? Which types of the questions listed in this section might be more likely to elicit to a defensive response?
3. **Personal style:** Which of the types of questions listed in this section most resonate with your personal style? Which least resonate? Why? Can you think of ways to modify each type to express the same intention with a client?
4. **Benefits and liabilities:** What do you think are the benefits and liabilities of each of the types of questions from this section? When might a particular type of question be inappropriate? How do you distinguish between a question that is therapeutically appropriate and one designed to satisfy your personal curiosity?

Role Plays

After watching the video and reviewing “Questions and Therapeutic Questions” in this manual, break participants into groups of two and have them role-play a brief interview between a therapist and client in which the therapist only asks questions, using the question types presented in this section.

One person will start out as the therapist and the other person will be the client, and then invite participants to switch roles. Therapists can focus on just one type of question (for instance, only projective, indirect, or swing questions), or they can alternate among the various types—but they are not allowed to paraphrase, reflect, or use interventions from elsewhere in the video. Clients may play themselves, or role-play Umut from the video, a client or friend of their own, or they can completely make it up. The primary emphasis here is on giving the therapist an opportunity to practice interviewing clients using a variety of questions and therapeutic questions, and on giving the client an opportunity to see what it feels like to participate in this type of intervention.

After the role-plays, have the groups come together to discuss their experiences. What did participants learn about the Sommers-Flanagans’ approach to asking questions? Invite the clients to talk about what it was like to role-play someone being questioned and how they felt about the approach. How did they feel in relation to the therapist? What worked and didn’t work for them during the session? Did they feel any defensiveness or other resistance arise? Then, invite the therapists to talk about their experiences: How did it feel to facilitate the session? Did they have difficulty sticking to this type of intervention? Which type of question did they gravitate toward? Which did they tend to avoid? What would they do differently if they did it again? Finally, open up a general discussion of what participants learned about clinical interviewing using questions and therapeutic questions.

An alternative is to do this role-play in front of the whole group with one therapist and one client; the rest of the group can observe, acting as the advising team to the therapist. The therapist can use the role-

play to focus on one type of question, or may switch between types. At any point during the session the therapist can timeout to get feedback from the observation team, and bring it back into the session with the client. Other observers might jump in if the therapist gets stuck. Follow up with a discussion on what participants learned about using the questions presented by the Sommers-Flanagans.

Intake Interview

SUMMARY*

The Sommers-Flanagans present the intake interview as the first of a set of “complex interviewing skills” that also includes the mental status examination and suicide assessment (see later summaries). The intake interview is primarily an assessment tool, although the task of establishing a therapeutic alliance is an integral element. Many factors can shape this, such as the client’s temperament or feelings regarding the intake or interviewer, the intake’s setting, or the interviewer’s own feelings, among others.

Intake components include the following (each can be expanded upon or minimized):

- identify and explore “chief complaint”
- take personal history and info
- review current functioning

A successful intake helps guide clients through a potentially new process (and new relationship), supports the establishment of safety, and provides clients with opportunities to reflect. The skills necessary for conducting a successful intake integrate the basic listening responses described in previous summaries; while the focus is on assessment, for instance, therapists can also use empathic statements such as paraphrases, feeling validation, and nondirective reflection of feeling. Therefore, intakes require that therapists be flexible enough to follow the client and establish rapport alongside their commitment to protocol.

In addition to taking stock of symptoms and building an alliance, the intake interview helps the therapist begin to create a case formulation and treatment plan. Therapists can engage their clients in this process, too, thereby furthering rapport, instilling hope, and increasing commitment to treatment.

As you watch this chapter of the video, observe how Rita Sommers-Flanagan addresses issues such as family history, physiological and cognitive symptoms, past vs. present experience, and goal-setting in her intake interview with Michelle. Notice what resonates with you about this process. Also consider how your own curiosity about Michelle

might lead you to ask different questions or make different observations.

*Adapted from

Sommers-Flanagan, J., and R. Sommers-Flanagan. 2014. *Clinical Interviewing*, Fifth Ed.

Discussion Questions

- 1. Meeting clients:** Have you conducted intake interviews? If so, what do they tend to be like for you? Do you notice any anxiety or resistance, either inside you or from your clients? How have you worked with this? What are some of the challenges you encounter during intakes? What are some things you enjoy about them?
- 2. Time constraints:** Do you think you have enough time during intakes to gather all of the information you need to begin treatment? Do you conduct intakes over the phone, in person, or in a combination of ways? If in person, do you take just one session for intakes, or more? What factors influence how much time you spend?
- 3. Intake components:** What do you consider to be the objectives of a successful intake? Do your intakes comprise the three components listed in the video, or do you gather different information from clients? Is there additional information you prefer to get from or give to clients during this process?
- 4. Acknowledging strengths:** Rita Sommers-Flanagan asks about Michelle's coping skills and acknowledges her strengths during the demonstration. How do you think Michelle responded to this? Do you notice or name your client's coping skills, either during an intake or throughout treatment? How might you use your client's strengths to develop your treatment plan?

Role Plays

After watching the video and reviewing “Intake Interview” in this manual, break participants into groups of two and have them role-play an intake interview between a therapist and client, using the components presented in this section and building on the listening skills from earlier in the video.

One person will start out as the therapist and the other person will be the client, and then invite participants to switch roles. Clients may play themselves, or role-play Michelle from the video, a client or friend of their own, or they can completely make it up. The primary emphasis here is on giving the therapist an opportunity to practice an intake interview with clients, and on giving the client an opportunity to see what it feels like to participate in an intake interview using the Sommers-Flanagans’ approach.

Identify and explore chief complaint

The therapist should begin by finding out about the client’s primary reason for coming to therapy, with an emphasis on understanding symptoms. The therapist can inquire about physiological, cognitive, and emotional symptoms, their triggers, the order in which symptoms arise, and the like.

Take personal history and information

While maintaining a flow between past and present, the therapist should get a sense of the client’s history, including family dynamics, family history with similar complaints, legal problems, substance abuse, and anything else that might be impacting the client’s presenting issue.

Review current functioning

Finally, review the client’s current level of functioning, including any strengths, coping skills, or adaptive self-care the client exhibits. If you have extra time, consider exploring the client’s goals, with an emphasis on case formulation and instilling hope. Find out what the client wants in their life—what are they missing out on because of the problem? What would they like to be able to do differently? Would any intermediate goals or homework assignments help the client?

If there isn't sufficient time to do this entire exercise, the instructor can choose to limit the role-play to just one of the intake components, as described above.

After the role-plays, have the groups come together to discuss their experiences. What did participants learn about the Sommers-Flanagans' approach to intakes? Invite the clients to talk about what it was like to role-play someone being interviewed for the first time and how they felt about the approach. How did they feel in relation to the therapist? What worked and didn't work for them during the session? Did they feel any defensiveness or other resistance arise? Then, invite the therapists to talk about their experiences: How did it feel to facilitate the session? Did they have difficulty getting the information they needed? Which type of questions did they gravitate toward? Which did they tend to avoid? What would they do differently if they did it again? Finally, open up a general discussion of what participants learned about intake interviews.

An alternative is to do this role-play in front of the whole group with one therapist and one client; the rest of the group can observe, acting as the advising team to the therapist. The therapist can use the role-play to focus on one intake component, or may do a more comprehensive interview. At any point during the session the therapist can timeout to get feedback from the observation team, and bring it back into the session with the client. Other observers might jump in if the therapist gets stuck. Follow up with a discussion on what participants learned about using the intake model presented by the Sommers-Flanagans.

Mental Status Examination

SUMMARY

The purpose of the mental status examination (MSE), another assessment tool, is to gather data or observations on the client that you can then organize into what the Sommers-Flanagans refer to as the nine different mental status examination domains (see below). For some clinicians, the MSE serves as a fairly standard tool for evaluating cognitive processes, using a format generally understood among professionals. John Sommers-Flanagan underscores the need to conduct this interview in an empathic and collaborative way, particularly in light of a common concern among new clinicians that such a structured interview might adversely affect the therapeutic relationship.

The nine domains of the mental status examination are:

- Appearance
- Behavioral/psychomotor activity
- Attitude toward interviewer
- Affect & mood
- Speech & thought
- Perceptual disturbances
- Orientation & consciousness
- Memory & intelligence
- Reliability, judgment, & insight

According to the Sommers-Flanagans, the first three domains (appearance, behavior/psychomotor activity, and attitude toward interviewer) are always inferred by the interviewer, in his or her observation of the client. The last six domains are assessed more directly, through questioning.

Again, interview questions can be framed in a way that engages rather than alienates clients, and it's important to incorporate empathic listening responses into this advanced interview. Moreover, as John Sommers-Flanagan notes of his video demonstrations with Carl, a client's personality traits—in Carl's case, his humor and tangential references—are data that can inform the structured questions and deepen rapport.

This section of the video features John Sommers-Flanagan conducting an MSE with Carl, with additional focus on assessing intermediate memory. As you watch, consider your reactions to the structure of the interview, your internal reactions to Carl, and ways you might tailor such questions based on your own theoretical orientation.

Discussion Questions

Professors, training directors and facilitators may use some or all of these discussion questions, depending on what aspects of the video are most relevant to the audience.

- 1. Prior Experience:** Have you conducted mental status examinations with any of your clients? What was your experience like? How did your clients respond, and how did the results inform your treatment plan?
- 2. The nine domains:** Based on the demo, how would you assess Carl's mental status, both overall and within each of the nine domains? Are some domains less clear to you than others? How would you decide when to make inferences as to a client's presentation or when to assess more directly? Would this change based on your particular client?
- 3. Structured vs. free-form:** How do you feel about giving such a structured type of assessment? Do you prefer more or less structured interviews? As John Sommers-Flanagan notes, do you wonder if a mental status interview might adversely affect the therapeutic relationship? How might you work with a client resistant to this type of inquiry?
- 4. Personal reactions:** What are your internal reactions to Carl as you watch the demonstrations? What are your feelings regarding his humor, physical tics, discussion of bestiality, and general presentation? How would it be for you to receive this type of information? Would his responses impact your attempts to build rapport? Have you worked with clients who've offered surprising information? How did you handle it?

Role Plays*

After watching the video and reviewing “Mental Status Examination” in this manual, break participants into groups of two and have them role-play a brief mental status examination between a therapist and client. One person will start out as the therapist and the other person will be the client, and then invite participants to switch roles. Therapists will focus on just one of the directly assessed domains: affect and mood. Clients may play themselves, or role-play Carl from the video, a client or friend of their own, or they can completely make it up.

During the assessment, therapists may incorporate the clinical interviewing skills previously presented in the video to build rapport. Note that the intention of this role-play is not to make conclusive statements about mental status, but rather to give the therapist an opportunity to practice conducting a mental status examination with a client, and on giving the client an opportunity to see what it feels like to participate in this type of interview.

Client affect

The therapist should begin by finding out about the client’s chief complaint, while noting affect. Affect is the visible moment-to-moment emotional tone observed by the interviewer (i.e., sadness, euphoria, irritability, anxiety, fear, anger, happiness, etc.), typically based on nonverbal behavior. While the client is speaking, observe the client and identify his or her affective state, informed by the nonverbal behavior you see. In addition, observe the range and duration of affect: Is it extremely variable within the session? Finally, is the client’s affect appropriate (does it match the content of the client’s story)?

Client mood

In contrast to affect, mood is the client’s internal, subjective, verbal self-reported state. Ask the client about his or her mood directly with an open-ended question such as, “How have you been feeling lately?” or “Would you describe your mood for me?” rather than a closed and leading question that suggests an answer (such as “Are you depressed?”). Next, using a scale of 0-10, ask the client to rate his

or her (a) current mood, (b) normal mood, (c) lowest mood in the past two weeks, and (d) highest mood in the past two weeks. After obtaining mood ratings, additional follow-up questions may be asked, such as, “What’s going on right now that makes you rate your mood as a 4?” As time allows, take the time to respond empathically.

Finally, write down a brief summary of your findings (one or two sentences each for affect and mood will suffice).

After the role-plays, have the groups come together to discuss their experiences. What did participants learn about the Sommers-Flanagans’ approach to mental status examinations, particularly affect and mood? Invite the clients to talk about what it was like to role-play someone being interviewed and how they felt about the approach. How did they feel in relation to the therapist? Did they understand the intention of each question? What worked and didn’t work for them during the session? Did they feel any defensiveness or other resistance arise? Then, invite the therapists to talk about their experiences: How did it feel to facilitate the interview? Did they have difficulty sticking to this type of assessment? What would they do differently if they did it again? Finally, open up a general discussion of what participants learned about affect, mood, and mental status examinations.

An alternative is to do this role-play in front of the whole group with one therapist and one client; the rest of the group can observe, acting as the advising team to the therapist. At any point during the interview the therapist can timeout to get feedback from the observation team, and bring it back into the session with the client. Other observers might jump in if the therapist gets stuck. Follow up with a discussion on what participants learned about mental status examinations as presented by the Sommers-Flanagans.

*Adapted from
Sommers-Flanagan, J., and R. Sommers-Flanagan. 2014. *Clinical Interviewing*, Fifth Ed.

Suicide Assessment Interview

SUMMARY

Talking about suicide and suicide ideation isn't easy for anyone; for beginning clinicians, it can be difficult to discern which types of questions and listening responses will be most helpful to clients, and when these interventions can best be leveraged. In this section of the video, John and Rita Sommers-Flanagan discuss the steps involved in conducting a thorough, empathic suicide assessment interview, and they offer a demonstration of John sitting with Tommi, a “moody” client with intermittent suicidal ideation.

The Sommers-Flanagans name several main components of a suicide assessment interview:

- suicide risk factors (not always direct questions)
- depression assessment (symptoms)
- exploration of suicidal ideation (direct questions framed in way the client can answer truthfully)
- exploration of suicide plan
- determination of suicide intent & reasons for living (getting reasons can be way of assessing intent)
- inference of client self-control; one way to do that is by forming a collaborative development of a safety plan

John Sommers-Flanagan stresses the importance of asking about suicide directly. He also demonstrates asking whether the client has a plan; note that the more basic listening responses can be of great use here, particularly in paraphrasing the underlying message of the client's plan (or past attempts, if applicable). In addition to the above points, a suicide assessment interview can also include asking about exceptions (“What's going on when you're free from suicidal ideation?”), asking about positive emotions along with the negative, exploring the meaning a client might create around being alive; and, more diagnostically, exploring the client's frequency, duration, and intensity of his or her ideation.

Working with suicidal clients can be especially challenging because every person is unique—and so there is no exact formula for making an assessment. However, the points above constitute an integral outline for

such an inquiry, and because decision-making is so stressful in this area, it's important to take clear notes and get consultation, both to protect against liability and ensure a thorough assessment.

As you watch the demonstrations in this section of the video, observe which interventions John uses with Tommi, and consider what you might do differently. Also note your internal reaction toward suicidal clients in general and Tommi in particular, and consider how your feelings might impact the interview if you were her therapist.

Discussion Questions

1. **Working with suicidality:** Have you ever worked with a client who had attempted suicide in the past, or with someone contemplating suicide? How did you respond internally? How did you handle it with your client? Were your interventions similar to or different from the ones proposed in the video? If you haven't worked with a suicidal client, what feelings arise for you as you consider this type of assessment?
2. **Cultural inquiry:** What did you think of the way John addressed culture with Tommi? How do you think she felt about this? How do you know? How might your assessment be affected by an understanding of your client's cultural background?
3. **Following intuition:** What feelings or thoughts arise in you as you consider the many ways to inquire into suicidality? How would you know which lines of questioning to follow? Would you discuss your choices with your client directly? Why or why not?
4. **Positive vs. negative:** John Sommers-Flanagan says that he tends to focus more on the more positive aspects of a client's experience during suicide assessments. How is his style similar to or different from yours in this regard? How might your focus be influenced by what your client says?

Role Plays*

After watching the video and reviewing “Suicide Assessment Interview” in this manual, break participants into groups of two and have them role-play a suicide assessment between a therapist and client, using the components presented in this section and building on the interviewing skills from earlier in the video.

One person will start out as the therapist and the other person will be the client, and then invite participants to switch roles. Clients may play themselves, or role-play Tommi from the video, a client or friend of their own, or they can completely make it up. The primary emphasis here is on giving the therapist an opportunity to practice a suicide assessment with a client, and on giving the client an opportunity to see what it feels like to participate in a suicide assessment using the Sommers-Flanagans’ approach.

Therapists can focus on just one area of assessment, or they can explore multiple areas as time allows. The interview can include an assessment of suicide risk factors; symptoms of related mood disorders; suicidal ideation (framed directly, in a way the client can answer truthfully); the presence of a suicide plan; suicide intent and reasons for living (getting reasons can be way of assessing intent); client self-control. Consider leaving time for the collaborative development of a safety plan. As the role-play winds down, therapists can write down a summary of their findings and any questions regarding next steps.

After the role-plays, have the groups come together to discuss their experiences. What did participants learn about the Sommers-Flanagans’ approach to suicide assessments? Invite the clients to talk about what it was like to role-play someone being interviewed and how they felt about the approach. How did they feel in relation to the therapist? What worked and didn’t work for them during the session? Did they feel any defensiveness or other resistance arise? Then, invite the therapists to talk about their experiences: How did it feel to facilitate the interview? Did they have difficulty getting the information they needed? Which type of questions did they gravitate toward? Which did they tend to avoid? What would they do differently

if they did it again? Finally, open up a general discussion of what participants learned about suicide assessments.

An alternative is to do this role-play in front of the whole group with one therapist and one client; the rest of the group can observe, acting as the advising team to the therapist. The therapist can use the role-play to focus on one suicide assessment component, or may do a more comprehensive interview. At any point during the session the therapist can timeout to get feedback from the observation team, and bring it back into the session with the client. Other observers might jump in if the therapist gets stuck. Follow up with a discussion on what participants learned about suicide assessments as presented by the Sommers-Flanagans.

Reaction Paper for Classes and Training

Video: Clinical Interviewing: Intake, Assessment, and Therapeutic Alliance with John Sommers-Flanagan and Rita Sommers-Flanagan

- **Assignment:** Complete this reaction paper and return it by the date noted by the facilitator.
- **Suggestions for Viewers:** Take notes on these questions while viewing the video and complete the reaction paper afterwards. Respond to each question below.
- **Length and Style:** 2-4 pages double-spaced. Be brief and concise. Do NOT provide a full synopsis of the video. This is meant to be a brief reaction paper that you write soon after watching the video—we want your ideas and reactions.

What to Write: Respond to the following questions in your reaction paper::

1. **Key points:** What important points did you learn about the Sommers-Flanagans' approach to clinical interviewing? What stands out to you about the topics covered?
2. **What I found most helpful:** As a therapist, what was most beneficial to you about the techniques presented? What tools or perspectives did you find helpful and might you use in your own work? What challenged you to think about something in a new way?
3. **What does not make sense:** What principles/techniques/interventions did not make sense to you? Did anything push your buttons or bring about a sense of resistance in you, or just not fit with your own style of working?
4. **How I would do it differently:** What might you do differently from the Sommers-Flanagans when starting work with clients? Be specific about what different approaches, interventions and techniques you would apply.
5. **Other questions/reactions:** What questions or reactions did you have as you viewed the therapy sessions with the clinicians in the video? Other comments, thoughts or feelings?

Related Websites, Videos and Further Reading

WEB RESOURCES

John Sommers-Flanagan's Official Website

<http://johnsommersflanagan.com>

Training Institute for Suicide Assessment and Clinical Interviewing (TISA)

www.suicideassessment.com

American Counseling Association

www.counseling.org

RELATED VIDEOS AVAILABLE AT WWW.PSYCHOTHERAPY.NET

Motivational Interviewing Step by Step: 4-Video Series with Cathy Cole

Becoming a Therapist: Inside the Learning Curve with Erik Sween

Suicide & Self-Harm: Helping People at Risk with Linda Gask

The Therapeutic Relationship, Individualized Treatment and Other Keys to Successful Psychotherapy with John C. Norcross

RECOMMENDED READINGS

Norcross, J.C. ed. 2011. *Psychotherapy relationships that work: Evidence-based responsiveness*, 2nd ed. New York: Oxford University Press.

Othmer, E., and S. Othmer. 2002. *The clinical interview using DSM-IV-TR: Vol 1: Fundamentals*. Washington, D.C.: American Psychiatric Publishing.

Shea, S.C. ed. 2007. "Clinical interviewing: Practical tips from master clinicians." *Psychiatric Clinics of North America*, 30: 145-321.

Sommers-Flanagan, J., and R. Sommers-Flanagan. 2006. *Becoming an Ethical Helping Professional*. Hoboken, NJ: John Wiley & Sons.

Sommers-Flanagan, J., and R. Sommers-Flanagan. 2012. *Counseling and Psychotherapy Theories: In Context and Practice*, 2nd ed. Hoboken, NJ: John Wiley & Sons.

Complete Transcript

JOHN SOMMERS-FLANAGAN: Welcome to our clinical interviewing DVD. In this video, we describe and demonstrate a wide range of different clinical interviewing responses. Our goal is to help you further develop your clinical interviewing repertoire. The material in this DVD is based on our textbook, cleverly titled clinical interviewing.

RITA SOMMERS-FLANAGAN: In our life as professors, we really have come to believe in that old kindergarten activity called show and tell. So in this video, we're obviously going to be telling you about clinical interviewing skills, but we also will be showing you video clips that illustrate these. And we really hope that together they'll combine to help you become excellent clinical interviewers.

JOHN: And we begin with a focus on very basic interviewing and listening skills, skills that everyone needs to do a really good clinical interview. These skills include attending behavior, non-directive listening, directive listening, and action responses, as well as the skill the use of questions. Later, we move to demonstrating more complex assessment interviews, including intake, mental status, and suicide assessment interviewing.

RITA: You know, our overall goal in this DVD is to help you become aware of how to do the skills and when to do the skills. Awareness isn't under-girding. That's very important in conducting professional clinical interviews and in being a mental health professional.

JOHN: You know, just a few years ago, Rita, although I might be underestimating that, we had a clinical supervisor who used to always say, don't fly by the seat of your pants. You need to know what you're doing and why you're doing it. You need to know where you're going, basically. And I think what he also was saying is that as clinical interviewers, we need to become more intentional. And so that's another goal that we have for this video. And that is we hope that it can move you in that direction so you become a little bit more intentional in your clinical interviewing activities. In the next four parts of this interviewing DVD, we focus on what we call the

continuum of listening responses, beginning with the less directive, almost non-directive listening approaches and extending to the more complex and directive interviewing or even action skills.

RITA: I think it's important before we actually talk about the techniques that we take a minute to think about a couple of things that are across techniques in interviewing. One is that because there's a power differential in the relationship, and we can never not communicate, the interviewer can be seen as directive even when they're not doing anything. It's just associated with the authority.

JOHN: Yeah. Rita, that reminds me. And it goes without saying, but you know me, I'm going to say it anyway, that culture and the individual characteristics of the client are very important in the clinical interviewing process. For example, if you don't consider race, sex, ethnicity, and many other background factors, it may be that you'll be tuned out and insensitive to things that you're doing that might be off putting to the client. For example, if you're listening closely, and leaning forward, and nodding vigorously, making great eye contact, but your client is sort of leaning backwards, and looking awkward, and uncomfortable, it's your problem. It is definitely not the client's problem. And you need to make some changes in your approach. I also find that there's a little subjectivity in how I respond personally to interviews. And for example, when you said, I understand, I just really kind of don't like that at all. Because I think technically you can't really understand the deep experience of another person, especially if the person's from another race or another culture.

RITA: Yeah, yeah, you're right. It's very subjective. And there are, I think, some bad or ineffective ways of listening that aren't just ineffective. I think they are harmful. I think looking at your watch, glancing around, yawning—

JOHN: Or maybe interrupting, interrupting could be one of those negative behaviors.

RITA: Yeah, I agree. I think that across cultures, people have some kind of awareness or radar that tells them when they're not being listened to and they're not being respected, yeah.

JOHN: So I guess the bottom line is listen well, listen authentically for you, but also try to calibrate or adjust the way you're listening for the specific individual who you're with in the room.

RITA: Yeah, I think too I want to underline something I tell my students over and over again. Listening is a gift. Listening in our culture, being listened to very, very well, is really a rare and a helpful gift.

Let's talk about some of these listening techniques, the least directive set of interviewing skills, non-directive listening responses.

JOHN: Right.

RITA: So the first one is Allen Ivey's attending behaviors. And these include eye contact, body posture, voice tone, and verbal tracking.

JOHN: And Ivey wrote about those as basic micro skills that are always present in the interviewing interaction. In addition to those, there are also some non-directive listening responses. These include silence, clarifications, paraphrasing—and there's several different kinds of paraphrases people can use—reflection of feeling, and summarization.

RITA: Silence can be a very compassionate response. Just sitting quietly after somebody has shared their pain or their story can be difficult but very powerful. The important thing is, John, you've got to have your body, and your mind, and your face all really connected to the client, really saying, I hear you. I'm right here in the room with you. I can handle this.

JOHN: You know, I think that's a great point. Almost every student I've ever worked with has wished that they had exactly the right thing to say at the right time.

RITA: Right.

JOHN: And sometimes silence is exactly the right thing to say. Although, I think especially for beginning interviewers, five or 10 seconds of silence can seem like an eternity. And so they can feel like they need to say something. And even myself, at times, I noticed I should put my hand over my mouth and try to stop myself from

talking too much.

RITA: Verbal output, yeah, so silence certainly is a skilled tool and an important one. But of course, we also need some other non-directive techniques that we can use.

JOHN: Tell me more about that.

RITA: Well, that was one, and verbal prompt. And also we can use paraphrasing, which means just reflecting back the content that you've heard. Although, I have to say something about that. When paraphrasing is done in a clumsy way, I think it can seem like you're mimicking the client. It can seem kind of robotic.

JOHN: So what you're saying is that although you think paraphrasing is very important, you really don't like it when it's done in kind of a mimicky or robotic way.

RITA: Thank you, John Carl Rogers John. I hate when you do that. So what you're saying is you really don't like it when I talk like Carl Rogers.

RITA: Well, I like Carl Rogers, but so let's move on. How about this. How about you say something, and I'll demonstrate a clarification.

JOHN: Sounds good. You know, one of the things that is I think true for me is that sometimes in my students, I have observed them having naturally good listening skills. It's like they seem to be born to listen, while other students, it's more of a challenge for them.

And they need to work at it a little harder. But what I found is that the virtually everyone is able to increase or improve their listening skills. And so that kind of gives me hope for everyone.

RITA: So what I think I hear you saying is that listening skills and abilities can be something someone naturally has, more or less of. But in the years you've worked in this area, you've realized that everyone can learn to be a better listener. Did I get that right?

JOHN: Absolutely right, and it feels good to be heard. And so now let's watch the magic of listening skills in action. Now this video clip begins a couple of minutes into a session where the client, Jessie, is talking about a roommate problem. The therapist, Megan, has a very

gentle and accepting style, which allows Jessie to explore her concerns in depth.

Early on, you should especially watch for Megan's paraphrase about Jesse having no time for herself. Because there's not even a hint of a robot in the room.

JESSIE: I just, I can't. I feel like she uses me as like a sounding board, and I get nothing in return.

RITA: You said several times while talking that she doesn't listen to you or doesn't even give you the opportunity to talk. It seems like she just talks, talks, talks.

JESSIE: Yeah.

MEGAN: And then you're listening, and that's exhausting. Or you're kind of getting angry and irritated by it.

JESSIE: Yeah, yeah, I do. It's just frustrating when somebody comes and they talk to you for like half an hour about all of their problems. And then it's like once they're done, they're like, OK. I don't care about how you are, what you're doing.

So she'll go off and do whatever, or watch TV, or something. And whenever I do try to talk to her, she's like either playing a video game or on her phone. Or she'll just start in with oh, did that happen to you? That happened to me. And it's just like, oh my gosh.

MEGAN: Then she'll go on into it.

JESSIE: Yeah, and then she'll just go off about her own story. I care about our friendship, because it's been like a five or six or something year-long friendship. And so I would like to continue that. And so I think we could still be friends, if we didn't live together. But the whole not living together part has to be crucial. Yeah.

MEGAN: Yeah, it seems like you've talked a lot about the different things that you're dealing with within this relationship with her, in terms of not being heard and not enjoying, just not enjoying, being around her anymore and not wanting to go home.

JESSIE: That's the worst part.

MEGAN: And feeling frustrated by it, but also just it almost seems like you're not sure what to do about it.

JESSIE: Yeah. I guess I'm just not sure how to bring up not living together anymore. I'll be gone for the summer, so part of me thinks that would be a way. Because like she has to find a new place or continue to pay rent where we are. And I don't want to have to do that. And so part of me wants to be like, well, I'm just not going to be here. So we can't live together because of that. Because you need to get into a place and start paying before I'll even be here. And so I kind of want to just approach it that way. But that's definitely not confronting the real reason of why I don't want to live with her.

MEGAN: What's hard about that, about confronting her?

JESSIE: Because I like confrontations. And I don't like making people feel upset. And I'm pretty sure that she would cry, and get defensive, and angry.

And we couldn't continue a friendship. It would be like I'm a horrible person for this, and she wouldn't want to be my friend. I would just imagine her getting defensive and blame me or something.

MEGAN: So when you think about confronting her, you think that it would end the relationship. Am I getting that right? Or that it would kind of lead to that?

JESSIE: Yeah, that's what I'm afraid of. Because honestly, I want to say I can't stand your dogs, and I can't stand your attitude. And I am so exhausted with you. And I can't continue to live with her. That's how I feel.

RITA: That was really nice. You know, we showed that video, we didn't really talk about summarizing or summarization. Summarizing can really be a great technique to use, partly because it forces you to listen so well. Because you're going to list the main points that you've just heard.

JOHN: Yeah, and I think Megan did a great job of that. Especially because for myself, and I think many people I know, it's so easy for the points that you're listening to kind of evaporate in your mind as you're trying to formulate the summary. And she did a great job. She

identified that the client was feeling very unhappy in the roommate situation, that she was not wanting to come home, that she didn't feel heard, that but she really didn't even like her roommate anymore.

RITA: Yeah, that was a great summary. One warning is probably not to number the items that you're going to say. Because you can get to number two and suddenly have no idea what number three was. So John there's one last skill that I think maybe we should talk about before ending this segment. And that is called the reflection of feeling.

JOHN: Absolutely, and I'm really glad that you remembered that. I find myself just as we go through this production process, it's sort of nerve wrecking. I feel nervous. I feel anxious. I try to keep an external composure. But on the inside, I feel pressure. I'm worried that we'll make mistakes, and that maybe it's going to be not hopeful, or even worthless, or even the worst possible scenario that I would just terribly embarrass myself.

RITA: Yeah, so lots of feelings there—you feel anxious. You want this to go well. You have kind of this calm veneer, but underneath there's anxiety. There's a kind of worry that this won't go well. And it just spirals down to the point where we might be wasting people's time and really might just be embarrassed.

JOHN: That is very nice. You did a great and accurate job of identifying a range of different emotions that I'm feeling. And I have to say I really appreciate the fact that stayed with the basic non-directive reflection of feeling. You didn't interpret anything. You didn't try to go for my deep-seated neuroses.

RITA: Right, well no, it was tempting. And in the next sections, we'll have opportunities for that. But our time's up for this section. And we'll move on to more directive listening and action responses.

JOHN: Previously on this video, we focused on listening skills and techniques that help the interviewer stay less directive. And our therapist on the proceeding video clip, Megan Hopkins, she is a member of the Sioux Assiniboine tribe. And that particular tribe has strong values and deep beliefs about the importance of listening to one another respectfully. And the extent to which you as a professional

clinical interviewer value listening may also depend on your cultural background and even on your personal experiences.

RITA: That's true. You know, being able to stay non-directive and nonjudgmental is an important part of interviewing. But we also have to learn how to use more directive interventions and actions in a way that maintains the therapy relationship.

JOHN: Absolutely. In this next section, we begin moving further along the continuum toward more complex and more directive listening responses. These responses are referred to as directive listening responses, because they still primarily focus on listening. But they also include components that are progressively more directive.

And so they involve lots of listening, and a little bit of directing, or pushing clients to see or think about things a bit differently. Directive listening responses are more judgmental. And they include guidance or validation from the interviewer. For example, you might use a feeling validation like, I can sure see why you would feel angry about that. And that's sort of a validating response. It's no longer non-directive.

RITA: Right, and you might do an interpretive reflection of feeling, which takes it a little past the feeling that has been stated. And you might take a guess at a feeling that might actually be implied or just underneath what the client is saying.

JOHN: Some people, Rita, refer to that as advanced empathy, because it goes beyond the client's words. And speaking of going beyond the client's words, from the psychoanalytic perspective, an even more directive listening response is interpretation. Interpretations are designed to put two different observations together and along with an attentive statement about how they might be related or what they might mean. These meanings that the interviewer picks up on might relate to earlier life experiences of the client or perhaps to some kind of unconscious processes.

RITA: Right, and of course that is sort of theoretically laden. And some people are little resistant to that kind of interpretation. But another way of thinking about it is when you take information the

client is giving you and you link that to a different reality or different way of seeing reality, and we call that a re-frame. It's also quite directive.

JOHN: Yeah, and you might even do a gentle confrontation. At least I prefer gentle confrontations. Because confrontations simply involve pointing out inconsistencies or discrepancies between what clients are saying they want and what they're actually doing.

RITA: In this next set, we're going to see John working with Trudy, who's struggling in her marriage with her husband named Jamie. And it's also important to notice that they have a son named Ross who has a disability. And Ross is still living with them. It may be subtle, but notice the difference in tone and style when the interviewer's being slightly more directive than the previous segment with Megan.

TRUDY: And I keep telling him, he doesn't have to do it all today. But then I think he thinks that I'm trying to sabotage his good health. I don't know. It's just like everything that I do that I think is going to be a good thing, a positive thing, doesn't turn out that way.

JOHN: Yeah, you mentioned before you feel a little bit scared at the idea of really being out there kind of on your own. But also I hear maybe some sadness and some frustration in the relationship now and that you're not even sure where to start.

TRUDY: You know, I don't. I sit and think about how our relationship has been in the past. And I realized that it wasn't just since Jamie's first heart attack that things have been different. I just remember a time when this friend of mine that I was telling you about that is concerned about me, she called me for lunch one day. And so we made arrangements go to lunch. And you know what? I took Ross with me. And I remember her looking at me like, I invited you to lunch. And Ross was 17 years old. And so consequently, we never talked about girl things that we might have talked about or anything like that. It was just about kind of about Ross and trying to keep him in the conversation, which isn't always easy because he has some autism problems. And I don't know why I did that.

JOHN: Is it OK with you, Trudy, if I just share with you a thought that

I have about one of the dynamics that I think might be going on.

TRUDY: Sure.

JOHN: I hear you saying that sometimes Jamie says or wonders if you're trying to sabotage some of his exercise.

TRUDY: Yeah.

JOHN: But I also hear you maybe sometimes actively sabotaging the possibility of intimacy with him. And I just wonder what your reaction is when I say that.

TRUDY: It's very possible. And you know, this is one thing, John. This just really upsets me about myself when I think about it. I don't think I even know how to be intimate anymore. It would seem so foreign to me to spend time with just Jamie and to talk about our feelings.

JOHN: Yeah.

RITA: So in that last section, we saw two interesting things. We saw an interpretation of feeling, and we saw confrontation. The first, the interpretation of feeling, led Trudy to go into deeper material. And that's often an indicator that the interpretation was accurate. And then we saw the confrontation, which of course was very gentle. We asked the client's permission, then offered the interpretation, and then asked her what she thought about it. And again, we saw Trudy just go for it. And that's an indication that the confrontation was OK with her.

JOHN: One of the reasons I think I like to ask client's permission to do a confrontation is because I'm kind of naturally averse to confronting people. So it's a hard thing for me. And I also think it helps to engage them in a more collaborative way. The other thing I noticed about that clip was that although Trudy was talking about sabotaging a lunch with a friend, I brought it back with the confrontation to her presenting complaint, which was intimacy with her husband.

RITA: Yeah, so in this next little clip, we're going to watch John work with TJ. TJ is a 22-year-old young man with issues around anger, aggression, and social skills. This clip that you're about to see focuses on TJ's anger and aggression. And you'll see a paraphrase,

then an attempt, and an interpretive reflection of feeling, which TJ corrects, and then a reflection of feeling, and a clarification. You'll see John creating a context for interpretation and then offering the interpretation.

TJ:—fights with family that don't fully escalate physically, but kind of break you down.

JOHN: So you've had some fights with your family that have been emotionally pretty painful, maybe lasting emotional effects, not so much physical. OK. And when I hear you say that, it sounds like one of the costs of that is you feel some regret. Have I got that right? Or is it something else?

TJ: Not completely, more like sympathy.

JOHN: Tell me about that.

TJ: Well, I think emotions are a weakness. And if I have emotions that make me vulnerable, when people feel sympathetic of it, it doesn't help me at all.

JOHN: OK. So it is painful to you emotionally to be seen as having a weakness. And so when your family or people have some sympathy for you, that actually is something you don't like?

TJ: No.

JOHN: No.

TJ: No, because it's like they feel like they have to do something to make you feel better to get you out of it.

JOHN: OK. I've heard you use the word weakness at least three times.

TJ: Yup.

JOHN: And sometimes when we talk about anger and anger management stuff, one of the things we do is we talk about what are the triggers or the buttons they get pushed that bring that anger up. And it makes you wonder if maybe one of the buttons or the triggers for you is a sense of feeling weak. Would you say at that might make you pretty pissed sometimes?

TJ: Yeah.

RITA: So John, you were really working with TJ with his emotions and the triggers that are associated with his aggression. And you did have that attempt to do an interpretation of feeling, and he was able to say, not quite right. Yeah. He also, I think, after you corrected, was starting to get some awareness that even the slightest whiff of weakness was going to be a trigger for him.

JOHN: Yeah, I do think it's good to follow the client's lead on interpretive material in particular. And so when he clarified or told me that it wasn't quite right, I wanted to go with his direction rather than mine. And you know, I think that's really important, partly because interpretations when they go well are collaborative. And Otto Fenichel said this over 60 years ago, and that is, that we have to prepare clients for interpretations and that interpretations are really a way of us working on the edge of our client's consciousness or awareness.

RITA: Yeah, there's nothing mysterious or woo-woo about interpretations. They're not like mind reading. They really involve a lot of listening and a lot of work. So directive listening responses obviously depend more on the view of the interviewer, and the direction is this a little bit more related to where the interviewer wants to go than the client.

JOHN: Yeah, directive listening responses are more advanced responses by clinical interviewers.

RITA: Well, I agree with you in one sense. But I also think that actually listening really, really well is as hard as some of the more directive responses.

JOHN: Well, you know, actually I totally agree with you. You've convinced me. And really what I was trying to say is I was trying to make the point that interviewing in a directive way is sometimes very tempting. And it's very natural. It's similar to the way we behave socially in social environments. And so I do think that to do it well, it really requires awareness of your goal. It requires sensitivity to the client, and it requires practice and probably some wisdom as well.

RITA: So in this section, we're going to be talking about directives and action responses, which actually move us a little further along the

continuum of directive listening skills.

JOHN: Directives are really sort of like prescriptions in that they push or move clients a little bit toward acting, feeling, or thinking in certain particular ways. And so it's really important when using these kinds of approaches that we weave back and forth or we integrate into the approach some less directive or non-directive listening skills—so a non-directive listening skill like a paraphrase, and then a directive action response, and then a check in or paraphrase to follow it.

RITA: And you know we're talking a lot about the continuum as if it's a linear sort of process. But actually, it's sort of dimensional. Because something that seems very non-directive can be done in a way that was experienced as pretty directive. Raised eyebrow, a tone of voice, choice of words, posture those kinds of things can be experienced as a pretty directive or not attractive.

JOHN: I know, I've seen some people raise one eyebrow. And I've never been able to do that.

RITA: Can you raise one nose nostril?

JOHN: I don't want to try, especially not on video.

RITA: OK, fine. So in general, I think the truth is that non-directive things can be directive and directed things can come off as non-directive, really depending on how you use them.

JOHN: Yeah, when interviewers start sharing information, or making suggestions, or expressing agreement, or disagreement, or approval or disapproval—

RITA: Or giving advice—

JOHN: Self-disclosing—

RITA: Yeah, self-disclosing, urging—

JOHN: When those kinds of things are happening, it's obvious that the interviewer is moving toward action. And we're trying to change in those situations the client's way of thinking, or way of being, or behaving. We are in the realm of the directive, which may be one reason why directives are most effective with clients who are in Prochaska and DiClemente's action stage in the transtheoretical

model. These are people who are ready to engage and work hard toward change.

RITA: Right, right, well, being directive is not a bad thing. It's just that it comes very natural to some bossy firstborn people. And they might need, like you've been talking about, to tone it down, to be aware of when to use it. On the other hand, there are people who are very passive and the idea of offering something directive can be sort of terrifying.

So in this next clip, we see John using agreement, suggestion, and he provides psychoeducational material effectively and appropriately. Watch how he engages his client Lisa with the information and the ideas he offers.

LISA: Well, I don't want to take drugs. I've tried a couple of glasses of wine at night, doesn't seem to help.

JOHN: That doesn't help either.

LISA: No. I've tried a good book, and that's fine until I turn off the light. And then my mind starts racing again. I just feel overwhelmed and behind. All my life there have been times like that, but I've been able to see the big picture and know that it's just a bump in the road. Now I'm swallowed up.

JOHN: Yeah, that does sound really intense. Now let's focus on the sleep just for a little while. There are three kinds of insomnia, mainly. One is difficulty falling asleep. And that's when you lay there, oftentimes with racing thoughts, but you can't get to sleep often for hours.

The second type is early morning awakening. And that's when you go to sleep, and you sleep most of the night. But maybe 2:00 or 3:00 in the morning, depending on when you went to bed, but way earlier than you want to wake up, you wake up and then you can't get back to sleep. And so that's early morning awakening. And the first one is difficulty falling asleep. And the third one is a thing called choppy sleep or intermittent insomnia. And that's when maybe you have some difficulty falling asleep. You go to sleep. You wake up. You go to sleep. You wake up. And you kind of wake up intermittently through

the night. Which do you think is the best description of the troubles you're having?

LISA: The first one.

JOHN: OK. Are you interested if I might suggest to you a few ideas about how to approach the sleep issue?

LISA: Sure.

JOHN: I know that there are other things that we could and will talk about. But it seems like if we focus on the sleep for a little while that that might be useful. Is that OK?

LISA: Yes. I think it's all magnified by the fact that I have such a sleep deficit. And if I can sleep better, I'll handle things better.

JOHN: Yeah, I think that might be true for everybody. The lack of a good night's sleep can make all of us a little less able to cope with things. And anything else you've tried to maybe push the thoughts aside or to speed the onset of sleep for you?

LISA: No.

JOHN: OK. Have you ever heard of mindfulness meditation or have you ever tried meditating?

LISA: No, I never have.

JOHN: No? OK. I'm just going to describe one approach to that. And actually I'll probably describe several approaches. And what I'm going to do is I just want you to think about them and try them on as I'm talking. OK?

LISA: OK.

JOHN: So there's a guy who did some research long ago. And he identified four things that people need to experience a relaxed state of mind. They need a comfortable position.

I'm guessing in your bed it's comfortable. They need a quiet place. Is it more or less quiet?

LISA: More or less.

JOHN: OK. Then they need a mental device. And what that means is

a thought. It could be an image to focus on. It could be a word. You've tried counting sheep. That's an example of a mental device. And we'll talk more about that in a moment. And then the fourth thing you need is passive attitude. And a passive attitude, do you know what I mean by that?

LISA: Well, go back to the one before.

JOHN: Mental device.

LISA: Yes, at some point I hope you'll explain that one to me. And no, I'm not sure exactly what you mean by a passive attitude.

JOHN: OK, well, let me try to explain both. Mental device, the sort of Zen people who are into meditation would say that your mind is like a barking dog—bark, bark, bark, bark, bark. And it barks when you stop reading, and you lay down.

And they sometimes say yapping, you know? But a barking or a yapping dog, and then in order to get that mind to stop barking at you, you need to give it a bone. You need to give it something to chew on.

And that is what we refer to as a mental device, mental device being sometimes a mantra. People who do sort of Buddhist stuff might say the word ohm over and over. People who are religious, I know a guy who is religious, and he likes to say something they feels sort of spiritually right to him.

And his mantra is to say, I am here. Here I am. So with his in breath he says, I am here.

With his out breath, he says, here I am. And that sort of got some spiritual meaning for him. And so he finds that very soothing, and he can stick with it.

RITA: So Lisa is obviously happy to get some information and help with her insomnia. She's eager to try those ideas.

JOHN: Yeah, I have to say it's exciting, maybe little ego boosting, to have a client who's really ready for action. And so I can provide her with a little scientifically based psychoeducation. She responds in a very positive way and is ready to get to work.

RITA: Yeah, it's so nice in fact that it can be a little bit seductive, and

the interviewer who's providing all that information and guidance can get a little too full of himself. And things can take a nasty turn.

JOHN: Your son and your son's family have moved into your home?

LISA: Yes, and I do love them, and I love my grandbaby. But I've had many years of living alone, thinking I've paid my dues. I raised my children.

I love having them come back for visits. But this, there's always somebody under foot. And except for midnight and on, it's hard to find quiet in the house.

JOHN: Yeah, yeah. What great family time, though. It's one of those things in life if you get the lemons, that sometimes you make lemonade. And it sounds to me like you're probably getting lots of great time with your family that you maybe would've gotten before.

LISA: Well, I thought that six months ago when they had to move in because of the unemployment situation. And they asked. And I said they could. I have room. I'd do anything to help them.

But it's been six months. And I don't even like lemonade anymore.

JOHN: But think of the six months, I mean, you wouldn't have that wonderful family time if all this hadn't happened.

LISA: Now I've worked real hard at adjusting my attitude to accept what has happened in my life. I'm here to talk to you. I'm looking for help because I haven't been doing so well over the last few months. How would you feel? How would you feel if suddenly you had three people who are noisy and move into your house, and your space, and impact your work?

JOHN: I'm really glad you asked. I mean, I've actually been kind of lonely lately. And so it would actually feel nice to me to have a house full of children and people there. And so I guess what I'm trying to say to you is it's really a matter of attitude. And I wonder if maybe you could consider shifting your attitude toward one that welcomes the company as opposed to fighting against it. You're kind of fighting against it.

LISA: I don't think you're remembering exactly what I told you last

week. It was all rosy the first three weeks. I didn't imagine it would go on this long. And I still don't know how long it's going to go on.

And it is wearying. I can't keep up my responsibilities with my job, without sleeping, with all this. I've talked to them. They're very nice people, but the house isn't that big.

JOHN: Well it sounds to me like you would just like to get rid of them, maybe just get them completely out of the house—

LISA: Well, I—

JOHN: —as soon as possible.

RITA: Phew. Thank goodness that's over with. That sort of deteriorated into a disagreement on how Lisa should view her own life. That was kind of like bad TV therapy.

JOHN: Now as much as I would like to be a bad TV therapist, I want to emphasize I did that on purpose.

RITA: OK.

JOHN: Although I like the term you used before the clip of it's seductive. It really is. When clients act so interested in what you have to offer, it's seductive and that you start to think that they really want to know everything about you.

RITA: Yeah.

JOHN: And then you can go overboard with self-disclosure. And you can go overboard with I think I know what's right for you. And in the clip where it ended, I could have even gone on and been even more of authoritarian or authoritative.

RITA: I'm not sure you wouldn't won though.

JOHN: No, she was clearly showing a little push back. But I guess the main point is that even though we might have a really good point to make, or we might have a really interesting life story to tell, that's really not the fault—

RITA: It's kind of like not the point.

JOHN: That's not the point we should be making.

RITA: Right. So directive and action responses need to be developed collaboratively, and the client is always the final authority.

JOHN: In this final section associated with listening continuum, we explore questions in general and therapeutic questions in particular. And we focus on these because questions can be so common, commonly used. They can also be very effective. But then I think oftentimes interviewers can misuse questions.

RITA: Why do you feel that way, John?

JOHN: Well, it's because I—

RITA: I mean, are you feeling kind of insecure about this section?

JOHN: I think right now I am.

RITA: Yeah, I don't understand it. I wonder why you want this section right here anyway.

JOHN: And right now I'm feeling very insecure about the whole thing. And I guess that's the point. I mean I get the fact the questions can be very powerful. And they can be intimidating. They can be used in ways that make clients respond in a defensive way—questions like, when did you stop lying to your employer? What are you really thinking about your mother? And those kinds of things can insinuate things. They can be used to wound people, definitely used to control the interview or the conversation.

RITA: And, of course, our clients are not as skilled as your average politician at sliding away from a question. And so they're stuck. They either have to answer the question or be seen as resistant. So questions can become kind of a no win situation for clients.

JOHN: Yeah. That's one of the reasons that in teaching I like to assign the students a pretty long interview where they can't ask any questions or they just have to use active listening skills to gather information. And I think that can be a real learning experience for clients for students, maybe even up to 30 minutes of non-directive listening without questions.

RITA: Yeah.

JOHN: There are many different types of questions.

RITA: There are open, closed, indirect, swing, projective, and of course a group of questions that we just call therapeutic.

JOHN: Now at this point, we've moved a little bit away from the listening continuum in that questions vary in their level of directiveness. They're all directed, because questions come from the interviewer and are used to guide, or manage, or control what clients say. But some questions are much more leading. And others are much more gentle and less directive.

RITA: In this next clip, our colleague from the University of Montana, Cris Fiore, demonstrates the use of questions as she works with Umit, who's a graduate exchange student from Turkey. And you'll see the skilled use of questions woven together with some other non-directive and directive listening responses. And you know, John, of course this is how a real clinical interview goes. You weave things together.

You use more and less directive things. And you'll notice that even sometimes Cris will do a paraphrase, but they'll be a rise in her voice. They'll be a little inflection change that works the same way as a question.

FIORE: Hi, how can I help you today?

UMIT: I don't know, it's kind of a long winter in Missoula And I'm not used to it. It's my third year in Missoula. I'm not used to it. But it was the longest winter for me, I think.

FIORE: So it's not just the weather, because you've been here three years. It just feels long for you?

UMIT: Yeah, maybe, because I didn't see sunshine a long time. And I feel weak sometimes. I cannot get up. It makes me thing Missoula or what I'm doing.

FIORE: Oh, so you feel bad enough that you can't get up. Can you tell me more about that?

UMIT: Where I'm from is more than 300 days of sunshine. And just you know, people are walking around a lot. And just it's kind of crowded. People don't go to bed early. I feel like I just miss sometimes them.

RITA: So you're missing home a lot and a big change from Missoula is we don't have 300 days of sunshine.

UMIT: Yeah, absolutely. You have in August and September, and I'm not here in August or September.

FIORE: OK, so this is a big adjustment for you. But you've been here three years.

UMIT: Yeah.

FIORE: What's it like for you during the winter? You mentioned a little bit that sometimes you don't feel like getting up.

UMIT: Yeah, six or seven hours of sleeping was enough for me. But now it feels like I'm sleeping more than 10 hours.

FIORE: OK.

UMIT: In my culture, we usually hang out a lot of times like three hours just chatting, four hours. But here, everybody's busy, or at work. That's fine. Even if I am free, how can I hang out with people?

FIORE: OK, OK. So you and your friends have a different life here.

UMIT: Yeah.

FIORE: So in the best case scenario, how would you want your day to look like? What would it look like in the best case scenario?

UMIT: Firstly, I want to finish my homework as early as possible. And in Turkey, usually my mom cooked for me. That's why it's that way.

FIORE: It's very different. It's all very different here. Do you keep in contact with your family?

UMIT: Yeah.

FIORE: How often?

UMIT: I call my mom almost every day. Yeah, because if I don't call, she really misses me. I am the best for her.

And I call her every day. And I call the other family members. I have six siblings, including me. And three of them have got married. I just call the others once or twice a week. My expectations are from friendship, relationship, is different than there.

FIORE: Right.

UMIT: That's why it doesn't work sometimes.

FIORE: OK, OK. It sounds like you're adjusting to a lot of different things.

UMIT: Oh yeah.

FIORE: Food, light, time, how you're spending your time, and also this difference in how friends are, and even your communication—

UMIT: Yes.

FIORE: —and that's a lot to adjust to in the time you're here. So what would be helpful for you at this point? What do you think you could do with the time that we have talking? How could I be helpful?

UMIT: I don't know. Maybe I have to learn more. I have to accept I am here in Missoula. And actually, I said all these bad things about living here.

But there are some good things also. That's why I'm staying here. I have a chance to go back. But in my culture, it's so complicated.

People just judge everything and just gossip. In here, nobody cares anything. That's why I love here. You just do your business and go home. It's the best part of living here.

FIORE: OK.

UMIT: And you can walk around just by yourself. It's not crowded. There are advantages about living here also.

If there's a party at 8:00 PM, you can go 9:00 PM. And you can leave 9:40. Nobody said anything. But in Turkey, if you go at 9:00 PM. You might have trouble, because you are late. If you leave early, you will have trouble. Here is—

FIORE: Different expectations, different expectations.

RITA: You know, John, I'm struck by how graceful and skilled Cris is. In that tape, she's simultaneously expressing interest, even her facial expressions and her mixing of directive, indirective, and questions. It was really very nice.

JOHN: Yeah, her attending skills are fabulous. She's very smooth. But I wonder if you can say which of the types of questions did she not use during her interview with Umit?

RITA: And I can say that. It was the indirect question. Partly I noticed that because I don't think that's really a question. Grammatically, it's not a question.

JOHN: And I think you're absolutely right. It's not, although we use that language just because it sort of is an implied question. It kind of draws information out of clients. Another thing I wanted to comment on in Cris's interview is that she uses a question about the best scenario that is possible for Umit.

And I think that question is an example of a projected question, which is a therapeutic question, which in the solution-focused theoretical place, it would be referred to as a presuppositional question. Because it really asks Umit to project himself into a future place with a better or best scenario.

RITA: You know, I want to say a little more about that. But first I also want to note that questions are another one of those techniques that have cultural meaning and valence. So cultures handle amounts of questions differently. The appropriateness of questions varies. People can feel very lost if they're from a culture where they expect the person in authority to ask questions and you don't, or pummeled if they're not used to a lot of questions.

JOHN: Exactly.

RITA: And as you said, there's a big theoretical link to some kinds of questions. There's the big four in the reality therapy questions. Of course, that's what do you want?

JOHN: And what are you doing? Is it working? And should you make a new plan?

RITA: Very good.

JOHN: And those are very direct questions that help clients focus on problem solving as well. But really I think when it comes to therapeutic questions, those kinds of questions most squarely fall

in the domain of solution focus theory in therapy. They're really questions.

And there are many different kinds. And they can be used well, and they can be overdone. But basically what they do is they have clients focus on positive scenarios, often the future, constructive things that are already working in their lives.

RITA: Right, right. So I think there is a good example of that in a clip with TJ. So let's watch just a couple more minutes of John with TJ.

JOHN: I want to go back a little bit. I've got kind of a hard question for you. You have had times, 30 times or so, that you've gotten in fights.

I'll bet there have been some times when you almost got in a fight but then you chose not to, somehow, one way or another. Has that ever happened? And if so, how did you manage to choose not to fight?

TJ: When it wasn't worth.

JOHN: OK, evaluate.

TJ: Fighting for nothing is stupid.

JOHN: Yeah. What do you think, in our last three minutes, what do you think as you look at the future for you? What do you think some of the most important things are that you're going to learn about yourself, and about staying out of fights?

TJ: I'm going to learn about myself. I'm definitely going to think about a lot of things I have done before, the bad things that happened and what's led up to that.

JOHN: OK.

TJ: See the signs of where it's going, stop it before it happens.

RITA: So John, that was great. I really like how you used the exception question and framed it as saying, this is kind of a hard question. Because that hooks a kid like TJ to maybe pay attention and see if he can get it right.

JOHN: Yeah, thank you. I think it's a good example of how it's important to gear the therapeutic question to the individual client. And questions, therapeutic questions, solution-focused questions can

be asked in many different ways. And yet they almost always focus on moving the client toward the future and toward a more positive future.

RITA: So John, if you woke up tomorrow morning—

JOHN: And a miracle occurred—

RITA: And you suddenly had more spare time, what would that look like?

JOHN: Well, I think my wife and I would be spending a lot of time in a video production.

RITA: Yeah, well, I guess we can see where this is going. Obviously you can see the importance of using those solution-focused questions.

JOHN: And the power of questions, I think, should not be underestimated.

RITA: That's right.

JOHN: In this section, Rita is demonstrating an intake interview. And of course, intake interviews are shaped by the client, by the interviewer, by the setting, and by just about every factor that you can imagine. In this particular intake example, the client, Michelle, comes in and has filled out a form. But it only identified in a general in a way that she was struggling with anxiety in her life. And so you should watch at the very beginning of this video clip at how quickly Michelle jumps into her specific problem, describes her symptoms. And then Rita does a nice job both exploring and sticking with the chief complaint but also staying with the format or structure of an intake interview. Keep in mind that some clients will not jump so quickly into their presenting complaint. I remember back in the day, well maybe just a few years ago when we were younger, that we might take three or four sessions just to deeply identify a presenting complaint and develop a problem formulation.

RITA: OK, so let's watch the beginning of this work with Michelle.

RITA: So Michelle, it's nice to meet you.

MICHELLE: It's nice meeting you too.

RITA: And I would like to start today by just checking in with you on what brought you in today for the counseling.

MICHELLE: OK. This feels a little bit weird. I've never gone to see a counselor before. So I'm not exactly sure how to start.

But I had a couple of, I guess what they called panic attacks. I went to the hospital for one, because I didn't know what was wrong. And I was kind of freaking out. So I went there.

I thought there's something wrong with me. And they said that there wasn't anything physically wrong with me. But I was having some anxiety issues. So they said to come here to the clinic. And so I did.

RITA: Wow.

MICHELLE: So I really don't know other than that.

RITA: Wow. So you had a couple of those happen?

MICHELLE: Yeah, well the first one was the one that I went—well, I had a couple littler ones before that. But the first big one was the one I went to the hospital for. Because I just felt like my chest was hurting. I couldn't breathe. And I thought maybe, I don't know. I didn't know what to think.

So I went there, and they ran a battery of tests, and blood pressure, and all that kind of stuff. And so then they said that I was OK. But I should probably check in with a mental health person. And that kind of made me feel weird, because I've never had anything like this happen before.

RITA: Yeah, so it kind of like uh-oh. They're telling me something's in my head. And you felt weird about it. But here you are, decided to go after it. So is it OK if I ask you a little bit about what led up to those experiences?

MICHELLE: Sure. Well, a couple of them seemed like that came out of the blue. But I've been having some stress at school. I'm a second year at the university up here.

RITA: Yeah, so you had a couple of those classroom-based sort of uhh.

MICHELLE: Well, the other one I was at a concert, like at a bar. And

there was lots of people there. And I was kind of right in the middle of the crowd. So it wasn't at school, but it kind of seemed like when there was a lot of people it made me—

RITA: Just that crowded feeling, and then—

MICHELLE: Like I can't get out, and I need to get out. And I can't get out.

RITA: OK, what's the first physical symptom or thought? Which comes first?

MICHELLE: Usually it's the chest heaviness.

RITA: So right here?

MICHELLE: I can't breathe. And then just kind of then it feels like I can't get out. And I need to. Then I freak myself out I think at that point.

RITA: What starts to go on in your head?

MICHELLE: I think that I can't get out. I'm not going to be able to get out. I need to be able to get out. What happens if I can't get out? And then it just sort of feeds on itself from there. And I start breathing heavy. My chest starts hurting more. Then it just kind of gets worse, and worse, and worse.

RITA: I'm guessing about that point you thought, OK, fine. I'll go see somebody.

MICHELLE: I know, I kind of tried to play it off like, if the bad one doesn't happen again, then I can probably deal with the other one. Like I said, I've never talked to a counselor. So I wasn't really sure I wanted to or not. But at this point, I was like, well, if it works, great. If not, then I guess I'm not any worse off than I was before.

RITA: All right. OK. So I think what I'd like to do, if it's all right with you, is kind of go backwards for a few minutes. But I do want to note that we're pretty clear on what our goal would be in working together.

MICHELLE: Yeah.

RITA: And that would be—

MICHELLE: No more panicking, which would be delightful.

RITA: Yeah, yeah. And we may not be able to go right to no more panic, but maybe an intermediate goal would be how to handle when that heaviness comes, when those thoughts start, how to handle that. And maybe in some way we gradually get control of it as sort of steps toward the ultimate goal of no more panic attacks. Does that seem OK?

MICHELLE: Anything's better than what's going on now, I think.

RITA: Yeah, yeah.

MICHELLE: So I'm pretty much game for whatever.

RITA: You know, I do want to notice a couple things, though, and that is you've coped with some things that are pretty scary. And you had a lot of common sense, sort of got yourself out of the situation. You breathed. You walked. You gave yourself permission not to go back to class. And so I'm just noticing that you've got a lot of skills already—

MICHELLE: Cool.

RITA: —that we'll probably notice again.

RITA: So, John, it's a little bit startling when the client arrives and has already got a diagnosis and is ready to begin fixing the problem.

JOHN: Absolutely, you can feel, I think, like you have a lot of pressure on you to jump immediately into fixing the problem. But I'm glad that instead that you kept exploring the presenting complaint or the chief complaint, and then you went a little bit into other areas and really were building and gathering information that helped with establishing the beginning of a treatment plan. In particular, I liked the fact that you identified for the client, for Michelle, what was heaviness in your chest. And that seemed to be a trigger for her panic attacks.

RITA: Right, right. I did intentionally transition to history. But before I went there, I really had noticed some strengths in Michelle and wanted to reflect those before we went into history taking.

JOHN: At the risk of complimenting you too much, I really did like the way that you focused on her strengths. And I liked the way you developed with her some intermediate goals rather than sort of feeding into the idea that the goal is to eliminate all panic attacks. In

fact, it can be very discouraging for clients if that's their only goal. And you helped her see that there might be some intermediate goals along the way.

RITA: Yeah, I did explicitly foreshadow that shift. Then we did do some history taking. And that was important, I think, to signal that we were going to make that shift, especially in an intake interview. Because clients don't know where things are going.

JOHN: And you know, gathering at least a little information about personal history is important. I think it's important from the client's perspective. And there are many different ways of doing it. But clients often have a sense of continuing from the past to the present to the future. Now let's watch as Rita's intake interview with Michelle continues.

RITA: So let's do a little bit of background. You can't go see a shrink without a little background.

MICHELLE: Do I have to lay down on the couch?

RITA: Yeah, yeah, if you would, please.

MICHELLE: All right, that'd be awesome.

RITA: Yeah.

MICHELLE: My dad was around until I was about four, and then they divorced. And I didn't really have a lot of contact with my dad after that. My mom was a single mom and took care of me.

She was a nurse. And so she was working a lot, but she had somebody to watch me during the night, so she was there during the day a lot. But sometimes she had to sleep, but a lot of times she was there, especially after I went to school. Then she'd sleep while I was at school and be up when I was up. And then after she put me to bed, she'd go to work late night.

RITA: Oh my gosh, she sounds like a pretty hardworking mom.

MICHELLE: Yeah, she was very hardworking and very supportive.

RITA: Is she still alive?

MICHELLE: She is, yeah.

RITA: How's your relationship these days?

MICHELLE: It's good. She's, like I said, very supportive and has always been there for me.

RITA: Brothers, sisters?

MICHELLE: I have two older brothers. One's in the Navy, and he's on deployment. So that's kind of nerve wracking. And then the other one is at school at a university in California.

So they're both gone. And I'm kind of close with my mom and go over and visit her all the times, and stuff like that. They still keep in touch and things like that, but they're obviously not around as much.

RITA: So do you know if either of them have had anything like what you're coping with?

MICHELLE: I think that not the brother that's in the Navy, because they wouldn't allow him in with anything like that. But I think the one in California mentioned that he had been diagnosed with something like generalized something like with anxiety. Like he just was worried about a lot of stuff all the time.

We talk sometimes, but not super often. But I think I remember him saying something like that. And then he's on medication for it.

RITA: OK. I should have asked this before, but did they give you any medication at the hospital?

MICHELLE: No.

RITA: OK.

MICHELLE: Nope.

RITA: So how about mom and anxiety?

MICHELLE: I mean, she's always seemed like a real worrier. But she's never seen anybody for it or anything. She's one of those kind of catastrophic thinkers that's always like, what happens if this happens? And then you lose your car. Then you won't have a job. And then you'll be a bum. It's kind of like that all the time with her, just a constant run it into the ground. I learned at an early age not to tell are things that I thought might be at all dangerous seeming. Because she

wouldn't let me do them.

RITA: Just gets up in arms and yeah.

MICHELLE: So I'd just do them and not tell her.

RITA: Yeah, yeah, interesting. So you protect her a little bit from things that would make her anxious. So do you mind if I ask you about your drug and alcohol history a little?

MICHELLE: Sure. I really used to like smoking pot a lot. I quit probably six months, eight months ago.

The first year of pharmacy I was able to do it without really studying or being that concerned about getting buckled down. But now it's getting harder, so I really felt like I needed to stop. But I've been smoking pot pretty much since I was 11 or 12. I started with one of my older brothers. I really liked it, because it mellowed me out. I was laid back.

RITA: How long ago? What's the last time?

MICHELLE: About six, seven months ago, I would say.

RITA: So you just kind of stopped cold turkey?

MICHELLE: Yeah, I was just like this is not helpful for me right now. I don't need to do this anymore. But my boyfriend kept something. And that, like I said, is part of—

RITA: Problems, yeah, yeah.

MICHELLE: And I mean, me being in the area that I'm going into, I really can't have somebody with pot sitting in my house smoking. If he got busted, then my career is basically down the toilet. So, I don't know if that's something I want to be connected to for the rest of my life. And at this point, we've been together off and on for four years. I feel like either I need to be done or we need to do something.

RITA: It's kind of a point of stress right now or a point of concern? Yeah. OK, so I'm wondering about other drugs or caffeine, those kinds of substances in your life—

MICHELLE: Right now?

RITA: Right now, yeah.

MICHELLE: I drink quite a bit of caffeine, probably, well it depends on what's going on. Because if it's like a time when an exam's coming up, I end up drinking a crap load of it. I'll drink a couple pots to cram for a test and stay up most of the night. On normal basis, I'll probably have three, four cups of coffee in the morning and then maybe a soda in the afternoon.

RITA: OK. Are you drinking that kind of heavily caffeinated sodas? Or energy drinks?

MICHELLE: No, I don't really go for those. They make me kind of crazy feeling. But mostly like definitely caffeinated, though, like Mountain Dew, I like Mountain Dew quite a bit, or Pepsi, Coke, those kinds of things.

RITA: All right. Any problems with the law in your history?

MICHELLE: I did get a couple of minor possessions for alcohol when I was younger. And then I got a possession of marijuana also and paraphernalia when I was younger.

RITA: OK. All right. One thing I like to ask people too is what are you doing to take care of yourself?

MICHELLE: Well, it's kind of hard when you work all the time and also are a student and kind of crazy relationship. But I've tried to start working out lately. I've been swimming some at the university pool. I've really gotten to like that. I never really had done that before. So that's something that I've kind of liked. Just in the last couple months I've started doing that, kind of since this started. I was like, I need to maybe try to do something that's going to slow this roll a little bit.

RITA: So you are doing a little swimming and other things?

MICHELLE: I pretty much just hang out with friends. Although now I kind of worry if we go somewhere that's got a lot of people. Like that concert was out with friends.

RITA: Right

MICHELLE: So I've kind of curtailed some of my social engagements just because I'm worried about freaking out. And then what are my friends going to think? And then I don't want to be weird.

RITA: So it's starting to kind of affect your friendships and social life, your work and school a little bit.

MICHELLE: Yeah.

RITA: So it's kind of bleeding out into some places that make it difficult.

MICHELLE: Yeah.

RITA: Yeah.

MICHELLE: Absolutely. Which is, like I said, part of the reason that I—

RITA: Here you are.

MICHELLE: —bucked up and came to counseling.

RITA: Yeah.

JOHN: Rita, you did a nice job of exploring Michelle's personal history. One of the things that I might say is that there are many different ways to explore personal history. And one of things I found really useful is to do an early memory, or sometimes in my work with young adults and adolescents, I will kind of jointly draw a family tree with them, sort of like an Adlerian family constellation or just a basic genogram. And doing that collaboratively to explore history seems to be a pretty effective way to go back into the past and identify some issues or themes that the client has faced.

RITA: I do think working with the client to understand the family in some way, whether it's a family tree or genogram. It helps a lot. I was trying to help Michelle take a look at the possibility of other family members having problems coping with anxiety or panic. And of course, I also wanted to convey to her that I saw her as coping with anxiety rather than being victimized by it or struggling with it.

JOHN: And you really made a nice flow from the past back to the present, which is a key part of the intake interview. Every intake interview is unique and selective, and that you focus a little bit on slightly different content here and there, and emphasize different things. But most intakes include the coverage of the least these three main general areas, the first of which is the identification and

exploration of the client's chief complaint. That's kind of the first general area.

RITA: Right, and then of course, personal history and information related to that.

JOHN: Right, and many ways to get that information and sometimes many areas within the personal history. And finally, there's a transition back to or review of the client's current functioning. How is the client doing now?

RITA: Right.

JOHN: Each of these areas can be expanded upon or minimized. For example, depending on your setting and your client's presenting problem, it might be important to gather specific information about the client's family history, or maybe military history, or maybe drug and alcohol history.

RITA: Yeah, the purpose of the intake, the goals, the theoretical orientation, the resources, the length of time that you have, these are all can influence what the interviewer focuses and what amount of time you have to deal with it.

JOHN: Right, Rita, you focused on the relevant historical and current coping issues that Michelle had. And I think you did a really nice job of that. I specially was glad that you focused on her caffeine use, which can trigger panic and also focusing on self-care and some of the medical issues, just really important and relevant pieces of the interview with Michelle.

RITA: Right, right. You know, it was interesting. There was a part of the tape we didn't show. But Michelle starts making any connection between her stopping the use of pot, which she had used since she was 11 or 12 and the onset of those panic symptoms. So the client herself was starting to make connections that might end up being very important.

JOHN: Which is something that can happen in a good intake interview, because it provides the client with opportunities to reflect.

RITA: Right. So in this next section, we'll watch as the interview

shifts toward case formulation, homework, and instilling the hope for change, making sure we take full advantage of that placebo effect.

RITA: Well, let me do a little summary of what I've heard. And then maybe we can talk about some plans for our next sessions together. And if you don't mind, I might even give you a little bit of homework.

MICHELLE: OK. Do you think this is something that people get better from?

RITA: Yeah.

MICHELLE: OK, because I'm kind of worried about it.

RITA: Yeah. And the good news is that actually the problem that you brought in today is one of those that shows really good results.

MICHELLE: Oh good, because I don't like it at all. And it really scares me quite a bit.

RITA: Yeah, yeah. So that's kind of the good news. The bad news, of course, is that anything like this requires some work, and some time, and understanding. And it doesn't go away magically. You already tried that.

MICHELLE: Yeah, ignoring, ignoring it didn't work.

RITA: Denying, yeah. Yeah, but I think there's a really good chance that we can make a big difference in this. And it's certainly worth a try.

MICHELLE: Can't be any worse than I was before. The way that I am avoiding things already now, like going out with friends, like even when I have to go to big classes, I'm kind of like, ahh. I sit on the edges of the things or in the back. And sometimes I can't hear as well.

So I think that I'm worried like I've seen those shows of the shut-in people that stay in their house and never leave. And that scares me. I'm not by any means at that point, but I just worry if it's getting worse and worse that things could get worse. And then I could end up with a grocery delivery and that's the only people that talk to me.

RITA: Yeah, or you're sitting in the car at Walmart like a homeless person.

MICHELLE: Yeah, exactly.

RITA: Right, right. So does this remind you of anybody that we've talked about today?

MICHELLE: Not really.

RITA: That's a trick question. You told me your mom catastrophizes.

MICHELLE: Wow, I'm surprised I didn't make that connection.

RITA: It's funny how we mirror our mothers sometimes.

MICHELLE: I know, well it's lalala and just like totally space it out after a while. But she does leave the house. So that I guess was the part. But yeah, I don't want to end up like my mom either. That'd be terrible. I mean, she's very nice.

RITA: Oh, yeah, but that tendency to do to be able to take one difficult life event and go uh-oh. This is going to leave to this.

MICHELLE: It's going to blow up—

RITA: This is going to lead to this. And then I'll be homeless and shut-in. And then I won't get a suntan anymore.

MICHELLE: Yeah, I guess that's where I was going with that. That sounds exactly like her. I've become my mother.

RITA: No, you haven't, no, no, no. We learn a lot from our parents and their coping styles. And one coping style is to face right into it a tough potential reality and say, if I don't do something about this, it could go there.

So it's not a bad or good thing. It's just one of the ways you've learn to deal with things. And the good outcome of that is it brought you here. Because you kind of looked down that road and said, hmm. I think I don't want to go there. So, here you are.

JOHN: Rita, I really liked the way you made the connection between Michelle's tendency to do a catastrophizing in her thinking with what she had identified herself before as her mom's tendency to do the same thing. You also wove in something that was very smooth, and that is suggesting to Michelle that maybe the path of the catastrophizing was not very much pathology. And so I think by doing that, you kind of

give her an opportunity to choose to work on it or not.

RITA: Right, yeah, I think it kind of led to a little bit of an insight, which I think sometimes motivates people. When you have an insight into the way you are and a way you might want to change, you actually might have a little motivation to do things like homework. So we did have a homework assignment, as you saw. And then we had summary, enclosure, and we had a plan to get back together, including permission for her to call the clinic earlier. Because when you are dealing with panic attacks, sometimes you need that reassurance that you can make contact earlier. So in this section, we're going to watch a mental status examination with a young man named Carl. This is a general check in. He was referred because of some odd ideation and bizarre behaviors. So his vocational instructors and educators were a little bit concerned.

JOHN: A traditional mental status examination includes about nine domains. And the first three—appearance, behavior or psychomotor activity, and attitudes toward the interviewer or examiner—are always just inferred. In other words, you just observe the clients and then you make some inferences about those three categories. The remaining six categories are usually assessed in a little bit more of a direct way. And these other six categories include affect and mood together, speech and thought together, perceptual disturbances, orientation and consciousness, memory and intelligence, as well as reliability, judgment, and insight.

RITA: As I look at that list, it seems to me that the client's speech is something more inferred or observed.

JOHN: I think you're right. It's usually inferred or observed more indirectly also. Although in the upcoming interview, I accidentally forgot to ask one of the speech assessment items, which is to ask Carl to repeat after me—no ifs, ands, or buts.

RITA: So, well, no ifs, ands, or buts, let's watch a little section of Carl. Carl is a 19-year-old young man who is a student at Trapper Creek Job Corps. He has a lot of adjustment struggles and eccentricities. And you'll notice that he also has some tick-like mannerisms. We both met with Carl in earlier sessions. And we've talked about those

mannerisms. So in this tape you won't hear us inquiring about those.

JOHN: As you get ready to watch this mental status examination interview with Carl, it might be a good idea to pull out a piece of paper and jot down a few notes in each of the nine domains as you observe the interview.

JOHN: Well, Carl, thank you for coming in. And what I would like to do with you today is just a very standard interview that is sort of a way for me to get to know how your brain is working. And so what I'm going to do is I'm going to ask you some questions.

But first I just want to start off by sort of asking some very easy questions. And then some of the questions will get harder as we go. And so, does that sound OK to you?

CARL: Yeah, that sounds OK.

JOHN: First one is state your full name.

CARL: I've actually had quite a few different names growing up. You want my current name?

JOHN: Whatever you would like.

CARL: Carl Dunn.

JOHN: OK. You said you've had quite a few different names growing up.

CARL: Yes, actually, my mother changed her name. I don't know whether or not she legally changed them or anything. But she always changed our last name depending on what guy or girl she was dating at the time.

And I was CJ once. I tried to be Todd the second time, but the name just kind of sounded ridiculous. I've got Warren, Jr., Raccoon because of the rings around my eyes.

JOHN: What's your favorite name for yourself?

CARL: Just Carl Dunn.

JOHN: Carl Dunn, OK.

CARL: I don't really have a favorite name for myself, I just pick

whichever one sticks better.

JOHN: OK. Well, I'll just stick with Carl if that's OK.

CARL: OK.

JOHN: And what is today's date, Carl?

CARL: 3-29-2012, I believe.

JOHN: OK. All right. What day of the week is it?

CARL: No, it's 3-20, and I don't remember what day it is. OK, what?

JOHN: What day of the week is it?

CARL: OK, it's Thursday.

JOHN: Thursday, OK. And can you tell me what season of the year it is?

CARL: It seems to be spring, going from winter into spring. But judged by the weather, it's still kind of wintery. There's a lot of snow.

JOHN: So we're going from winter into spring.

CARL: Yeah.

JOHN: Yeah. Which one do you think we're in?

CARL: Here spring, but back at Job Corps, winter.

JOHN: OK. And what is the name of the town or city where you are living now?

CARL: Darby.

JOHN: Darby. OK. OK. Now this is a hard question. Do you know who the governor of Montana is?

CARL: No.

JOHN: No, OK. So my next question is going to be a test of your memory. Is that OK if we do that?

CARL: Yeah.

JOHN: So I'm going to say three things. And all you need to do is when I'm finished saying them, you repeat them back.

CARL: OK.

JOHN: OK. So the three things are cup, newspaper, banana.

CARL: OK.

JOHN: What are the three things?

CARL: Cup, newspaper, banana.

JOHN: OK. All right, good work. Now this one is a little bit harder. You ready for something a little bit more of a mental challenge? I'd like you to begin with the number 100 and then count backwards by sevens. So it's like 100—

CARL: Oh yeah. 100, 93, 86, 79, 72, 65, 58, 51, 44.

JOHN: You can stop, good work. That seemed pretty easy for you.

CARL: It was pretty easy. I used to be able to multiply double digit numbers.

JOHN: Yeah, so you're pretty good with math. You're pretty good with numbers.

CARL: Yeah, I used to be a lot better reading. In the second grade, I knew words that none of the college teachers I used to visit knew. And I was able to read beyond a college level and in a couple other languages. And then I forgot all that. But that's another story.

JOHN: Sure. So try this one. Spell the word "world" backwards.

CARL: D-L-R-O-W.

JOHN: OK. Now who is currently the president of the United States?

CARL: I believe it's still Obama.

JOHN: OK. Do you know who was president before Obama?

CARL: Bush, I believe.

JOHN: OK, do you know who was president before Bush?

CARL: No, I don't remember who it was before Bush. I mean, I know who it is. I just don't remember the name.

JOHN: OK. Can you describe the person?

CARL: A Christian white guy.

JOHN: OK.

CARL: I'll know him when I see him.

JOHN: OK.

CARL: Then before that was Bush.

JOHN: OK, so before the Christian white guy there was Bush. And then—

CARL: Another Christian white guy. OK, I'll remember the faces. If I see a face of the president, I'll be able to recognize it.

JOHN: You can recognize—

CARL: I don't really know that much about the presidents.

JOHN: Do who was before the first Bush?

CARL: His father.

JOHN: OK.

CARL: Before Bush, it was his father Bush. Before him was the other Christian white guy.

JOHN: OK.

CARL: Why is it that all the presidents up until Obama were Christian white males?

JOHN: I don't know.

CARL: You don't know.

JOHN: Why do you think?

CARL: Because people are naturally judgmental, and there are a lot of racist people out there. Everything's always going to be fair. It's always going to have something to do with looks, religion, and ethnic national background, stuff like that. Christianity and stuff like that just happens to be one of the more powerful religions. So coming from that aspect, lots of people are compelled by their religious beliefs to do a lot of things. It would all make sense that the government in general would look for white Christian males.

JOHN: OK. Sounds good. Now I'm going to ask you some questions

that are a little different, questions about feelings. OK.

CARL: Feelings, feelings, yes.

JOHN: And my first question about that is how are you feeling right now?

CARL: Calm, that's about it.

JOHN: OK. So you're feeling calm. If you were to rate your mood, zero is the worst possible mood. It's like you're so down and depressed that you're just going to kill yourself. It's over. And 10 is the happiest you could possibly feel. You're so happy maybe—I don't know what you do when you're really happy—but maybe you're dancing, and singing, and you're just super happy. On that scale of zero to 10, how would you rate your mood right now?

CARL: Right down the middle.

JOHN: You're about a five, you think? Down the middle?

CARL: Well, I had a pretty good day. But yesterday was pretty crappy. And I've got some stressful things on my mind. So it's about a five.

JOHN: So you're about a five.

CARL: Yeah, it's right there in the middle.

JOHN: OK. Now if you were to say the worst mood you've had for the last three months.

JOHN: You know, Rita, many professionals I think are a little reluctant to do something as structured and evaluative as a mental status examination for fear that it might adversely affect the report or the therapeutic relationship. One thing that I found, and maybe it's just because I'm a little bit weird, is that I actually find that using that kind of structure and the assessment parts of the mental status examination can be framed in a way that engages the clients and I think at least doesn't adversely affect the relationship. And I think I try to frame questions as they might be difficult. And I try to respond empathically when clients have trouble or struggle with the questions.

RITA: I think you do put people at least. I like how you kind of ask permission. You tell them it's going to be a hard question.

But even with all of that reassurance, you can feel the anxiety that comes up in Carl when he can't get something right. And then he says, he was able to multiply double digit numbers in second grade. But really, there is always that urge to ask about the past, to explore. And mental status exams are about the functioning of the client in the present.

JOHN: So even Carl's defensiveness that we saw, and maybe his exaggeration, and his use of humor, that's all data that the mental status examiner or the clinical interviewer can use to make statements within those nine different domains. In particular, I think at the very least, we know Carl is a creative young man.

RITA: Yes, we do. And one thing that has always been a little confusing for me in mental status exams is affect and mood. So the strategies for assessing those are important.

Remember that affect is something that you infer, that you observe. And mood is something that you actually ask about. And you ask about the mood now with some rating form. And then you can also ask about mood the past three months, the highest, the lowest, do an average with that.

JOHN: And you get a chance to compare where the client is now with previous highs and lows. In this next section—

RITA: Yeah, let's watch another one.

JOHN: OK, in this next section, I start off by doing an assessment of Carl's intermediate memory. And one thing I think that we'll discover is he has an excellent intermediate memory. He also shows that he has a pretty darn good sense of humor.

RITA: All right.

JOHN: Now I've got kind of a tricky question for you. You ready?

CARL: Does this question do back flips? Then it's not very tricky, is it?

JOHN: All right, I guess not.

CARL: OK.

JOHN: Remember a few minutes ago I asked you to remember three

things that I said? Can you remember what those three things are?

CARL: Cup, banana, and newspaper.

JOHN: OK. You've got them.

CARL: Well, it was cup, newspaper, banana, in that order. But still.

JOHN: You got all three anyway. You even remember the order they came in.

CARL: Of course, of course, I'm smarter than your average Job Corps kid, which is about average.

JOHN: OK. All right, now I have some questions. Those were questions about your feelings and emotions. And now have some questions that are more about your thinking, OK?

And then we might come back to feeling a little bit too. But tell me, let's see. Do you ever get any thoughts stuck in your head, they just kind of go over, and over, and over?

CARL: I've got millions of those. Which one do you want?

JOHN: What would be a typical that gets stuck in your head?

CARL: Well, I sometimes whenever something happens, I picture another event happening as a result of it that gets stuck in my head. Songs get stuck in my head. Voices get stuck in my head.

JOHN: Yeah.

CARL: They don't really [UNINTELLIGIBLE], but they just kind of sit there. And they used to tell me to do things, but now I get into arguments with them on occasion.

JOHN: OK, so you have some songs that get stuck in your head and then some voices that get stuck in your head.

CARL: Well, yeah, I like to make up the voices, because it helps drown out the music. I mean, the voice thing is intentional. Because it helps get the songs, and the thoughts, and memories out of my head. So that's kind of like a self-help right there.

JOHN: So one of the ways you get something that's stuck in your head out of your head is maybe you sort of creative these voices in your

head? And they kind—

CARL: It's kind of like an invisible imaginary friend.

JOHN: OK. Do you have a consistent, invisible imaginary friend?

CARL: No, not really, because they're not technically imaginary friends. They're just little bodily voices that I made up in my head. They're like a little thoughts that I created, like I find a way create a thought that overpowers all the other noises and stuff that I hear in my head. They kind of just [UNINTELLIGIBLE] these other voices that—it's pretty much I'm using my imagination.

JOHN: Sure. This is just a different kind of question. Do you have any beliefs that other people think are strange or odd? Unusual beliefs?

CARL: Quite a few, actually.

JOHN: Well, give me an example. What would be an unusual belief?

RITA: Well, I really don't care if anybody's into bestiality. I mean, for starters, there are guys out there that are raping little kids, people out there getting violated 24-7. There are necrophiliacs. There are all this other stuff. I mean, unless it's like the most powerful out of the seven sins out there.

And animals, for instance, for that example, they're pretty much born to mate. I mean, I really don't care. The only reason why it's considered a bad thing is because people just didn't understand it back then, which is nothing really to understand. The only risk is that they find a new kind of STD.

JOHN: So one of your unusual beliefs might be that you don't—

CARL: I really don't care about bestiality. I don't think—

JOHN: One way or another, It doesn't matter to you much. Yeah.

CARL: Yeah.

JOHN: I have some more questions for you. Are you ready? Do you ever see or hear things that other people don't see or hear?

CARL: Sometimes I see ghosts. But other people see them too.

JOHN: OK. And do you ever think that the radio or the television is

speaking directly to you?

CARL: Right. I don't think that the radio or the television's speaking directly to me.

JOHN: That would be a no.

CARL: No.

JOHN: Definitely not, OK.

CARL: I mean, unless the TV turned on and the guy said—and I just happen to be sitting in my room, by myself, in my house. Let's say I have a house, in my house and watching TV. And the TV magically comes on and I'm single at the time, and the guy goes, are you lonely? A little. Even a little lonely? Oh, yeah, yeah. Are you sitting underneath the covers with—I'm not going to get into that. I'm just saying, I'm probably not going to believe it unless some really weird stuff goes on.

JOHN: OK. So for the most part, you're saying probably absolutely not.

CARL: I'm trying to watch my language here.

JOHN: Yeah. Has anyone ever tried to steal your thoughts or read your mind? I know that's kind of an unusual question. It's OK. Some people think that. And that's just mostly why I'm asking.

CARL: People try to steal other thoughts or read their mind. So that's original. Well, how do I answer this one?

JOHN: Yes or no.

CARL: I never thought that anybody was trying to steal or read my mind. But I used to have friends and family and stuff that were Wiccan. And I've met quite a few people—

JOHN: Speaking of knowledge, I've got a few more questions for you.

CARL: Yes, yes.

JOHN: And these are a little more knowledge based. So in what way is a pencil and a computer alike?

CARL: You write with them. You can transfer knowledge from one spot to another with it. Pretty much the only difference between a

pencil and a computer is that the computer's electrical and the pencil, you can't store small bits of data on, except for the pencil's entire system and [UNINTELLIGIBLE] the computer or across multiple components. So yeah, there's a lot of differences in them two. But they're pretty much the same thing.

JOHN: There are a lot of differences, but they can use some of the same purpose.

CARL: Yes, the same purpose, they even have the same function.

JOHN: Yeah.

CARL: Don't they? Just one's one-handed. The other's two-handed. There's a lot of differences.

JOHN: What if in the future some time—

CARL: It's pretty much the person doing the exact same thing.

JOHN: OK. What if in the future some time you found a gun hidden in the bushes near your home. What would you do?

CARL: If I found a gun in the bushes around my home, I would probably—because I always have a friend like this that's either in the police division or has worked for the government or something. I'd just get them to check the gun, see if there's any signs that may have been used to harm somebody, if not, register the gun and keep it for myself.

JOHN: So you'd get somebody to check the gun out?

CARL: Yes. Then I'd see if I could get the gun registered so I could keep it.

JOHN: And see if you could keep it.

CARL: Because it's a free gun.

JOHN: Yeah, and the last question, and then if you have questions for me I'll try to answer them. But what would you do if a close friend of yours obviously had a drug or an alcohol problem?

CARL: Well, as far as the getting drunk part goes, I actually do care if they get drunk. So I would do what I can to take care of it. Well, if somebody, though, did do drugs but it didn't affect them in a negative

way, per se, like if it was like marijuana or hemp, I really wouldn't care as long as they—

JOHN: But let's say they had a serious problem.

CARL: Oh, an actual problem, then I'd try to help them with it. I'd try to get them off of it.

JOHN: You'd try to be helpful?

CARL: I'd try to tell them to [UNINTELLIGIBLE] down the doses, come up with strategies. But I wouldn't really try to make anybody quit just cold turkey. I wouldn't.

JOHN: Try to help them cut down.

CARL: Yeah.

JOHN: OK.

CARL: Because I really don't care. I mean, marijuana could help the world. But the lumber company got pissed. And then marijuana is illegalized because of all of its uses.

JOHN: Well now, questions for me.

JOHN: The purpose of the mental status examination is to gather data or observations on the client that you can then organize into the nine different mental status examination domains. But as you probably noticed, my preference is to try to do that in a way that is empathic and collaborative.

RITA: Which I think is great, I really think that it's a great relationship building thing. And you actually get more information that way. But of course, that accounts for some of the wide ranging and sometimes tangential content that you saw with Carl. But it is important information.

JOHN: Although it would make the interview shorter if I stayed a little more structured. Now if you watched the mental status examination interview with Carl and you jotted down a few notes in those nine different areas, now would be a really good time for you to look back at those notes and the nine areas and to try to make a few statements that are a little more conclusive about what you saw in Carl during

that interview. And even better, it would be a really good idea to compare those notes and those conclusions with your classmates so that you can get a little bit more objective in how you are evaluating the mental status examination data.

RITA: In this section, we're going to demonstrate a suicide assessment interview. We're going to see John working with a young woman named Tommi, who's been referred by staff at Trapper Creek Job Corps, where John has seen Tommi one another time in a group setting. So he doesn't know her very well.

The staff is worried about her because she's moody. And she's had intermittent suicidal ideation. So they want a mental status sort of check in on that.

You will see as the tape begins that we're a little ways into this session. John started an assessment of mood and depression. Because Tommi's indicated she's a little bit down. And also she's talked a small amount about her family troubles and some other areas of concern, like personal insecurities, that are affecting her mood. So we'll go ahead and watch some of this tape.

JOHN: I know from our conversation before also that you're Native Alaskan.

TOMMI: Yes.

JOHN: And you're from a tribe in Alaska. That's your main tribal connection.

TOMMI: Yeah, yup.

JOHN: And that's the—

TOMMI: Yupik.

JOHN: Yupik.

TOMMI: The Y-U-P-I-K.

JOHN: Y-U-P-I-K. And as we're talking today, if there's anything that maybe from your cultural background or from your tribal perspective that I maybe am not getting, I hope that you would feel free to say, hey, John. From my perspective or from my cultural perspective, this is the

way we think about or this is the way we do it. And so would that be OK if you let me know if I'm going the wrong direction?

TOMMI: That'd be fine.

JOHN: OK. A All right. And sometimes when people are down, it affects them in a lot of different areas. And one of the places that it can affect you is the way you think. OK, it can affect some thoughts you have about yourself.

CARL: Yeah.

JOHN: Or about the world, or about the future. So I'm wondering if in particular you're having any negative thoughts about yourself, or the world, or the future outlook of things.

TOMMI: Sometimes I feel really hopeless. I don't know, like things seem to get worse all the time. So I don't really think about the future.

JOHN: Sometimes people when they're feeling down, they have some physical symptoms too. Like sometimes people have trouble sleeping. Sometimes they have trouble eating. Or then sometimes they sleep too much and sometimes they eat too much. Have you had anything like that going on?

TOMMI: Yeah. I haven't been sleeping. You can't really sleep when you're too busy thinking.

JOHN: So your mind is kind of buzzing along at night, and so it's hard to lay down and really get yourself to go to sleep?

TOMMI: But once I do sleep, I don't want to wake up. I'd rather stay asleep and dream and actually have to wake up and deal with reality.

JOHN: Yeah.

TOMMI: So.

JOHN: Sometimes people have their social relationships sort of affected by when you're down too. And I'm wondering how your social life is going. Is it going OK? You have some contacts and connections?

TOMMI: I have friends, but it seems like everyone's having fun. And I'm there just to be there. Like, they call me a zombie.

JOHN: I'm going to just ask this question directly. Tell me because

sometimes when people feel down, it's really not unusual for people to also think about suicide or about death. And I'm wondering if you've had any thoughts about suicide, or about death, and stuff like that?

TOMMI: There's been some.

JOHN: OK. So you had some thoughts.

TOMMI: Yeah, more than some probably, daily basis.

JOHN: Think about that most of the day, part of the day.

TOMMI: Whenever, sometimes it's never. But maybe sometimes it's like throughout the day.

JOHN: OK. What are some times when you're not thinking about death or suicide? What's usually going on when you're free from those thoughts?

TOMMI: When I'm not thinking about suicide?

JOHN: Yeah.

TOMMI: Probably singing.

JOHN: OK, when you're singing? OK. So kind of engaged in making music in some ways, and that sort of takes you away from those more negative and sad—

TOMMI: Yeah, I write poetry too.

JOHN: OK. And that's helpful?

TOMMI: Yeah.

JOHN: OK. Sometimes when people think about suicide, they think about it in a very active way, like, oh here's how I think I would kill myself. And sometimes people think about it in a less active way. It's like, oh, I just kind of wish I was dead. But I don't really have a plan or any specific ideas about how I might end my life.

Which is more true for you? Do you have some specific ideas about a plan or a way that you would end your life? Or do you just sort of think, ah, I wish I—

TOMMI: Well, I have a couple plans. But there's days where it's inactive.

JOHN: Inactive in it's not—

TOMMI: It's like I wish I was dead.

JOHN: OK.

TOMMI: Or the world would be better with me or something like that.

JOHN: OK.

TOMMI: So I could hurt the people in my family, and they would feel bad for it. But I was either going to shoot myself. But that was out of the plan, because there was no guns in the house. So I was going to hang myself in my room and write on the walls everything that ever hurt me to my parents. So whenever they decided, wow, she's been in her room too long, they could go in there and tah-dah. Yeah.

JOHN: So one parts for you is to send a message to your parents about how you feel.

TOMMI: Yeah.

JOHN: About how you've been treated.

RITA: Well, it's certainly clear that not all of these interactions are scripted or planned ahead of time. They're very real. And so they're not perfect. We'll talk about some things that happened that went well and some things that maybe you wish you'd included.

JOHN: Right.

RITA: So one thing I noticed right away was a kind of interesting where she spelled the name of her tribe. And at that moment in the interview, her move lifted. She smiled. That's kind of interesting.

JOHN: Yeah, I notice that also. I thought it was interesting. I'm not sure what to make of it. It's one of those things I kind of put in the back of my head. It might be worth exploring somewhat later. Maybe there's something meaningful and affectively uplifting about her connection with her tribe.

RITA: Yeah, there was something there. I also noticed that she was speaking and processing pretty slowly. She wasn't at all agitated or hostile. But her tone was actually almost kind of flat.

JOHN: Yeah, and that's not very unusual for people who have sort of a unipolar depression that doesn't have much agitation in it. And I noticed that when I was trying to do was to assess her cognitive, her physical, and her social depressive symptoms. I noticed she had some symptoms in each of those areas. And then I asked directly about suicide. And I was glad of that. But I felt a little bad that I never explored the frequency, duration, and intensity of her suicide ideation very completely.

RITA: Right, frequency, duration—

JOHN: Intensity.

RITA: But you did ask directly about suicide and about wanting to die or kill herself, which is very hard to do. And you did it in a way that I thought was acceptable. She went with it. She answered you. The other thing I liked is you asked about times that she's free of any suicidal ideation.

JOHN: Which I think is really important to sort of flow into some positive emotions or positive situations as much as possible during a suicide assessment interview. And you know, when someone admits to suicidal thoughts, it's also important to check on suicidal plan. And the plan can be something that's sort of underneath the surface that you need to ask directly about as well.

TOMMI: I tried two times and I realized that I was being selfish. So I guess, I don't know, mostly selfish.

JOHN: So you tried a couple of times. And it sounds like after those, your conclusion, what you came to in your mind, was that feels selfish. And that you're not really wanting to do that?

TOMMI: Well, I tried two times to kill myself, two different occasions. So I just thought, well, two times of trying to kill yourself and you didn't die. Why didn't I die? Maybe I'm supposed to be here. So I don't know. I've been trying to think positive, but I don't know.

JOHN: Maybe surviving means something.

TOMMI: Yeah.

JOHN: It's maybe that's a message from the universe or from—

TOMMI: Something.

RITA: Wow, that was an interesting exchange. You know, I had the feeling that she really wanted to ask her more about those two suicide attempts.

JOHN: Yeah, I think you're probably right. And it was a hard choice. I ended up deciding to go with exploring the meaning of her staying alive, which seemed also important to her. That's one of the challenges in the suicide assessment interview is do you go more for deeper assessment of suicide, or suicidal plans, or thoughts, or even previous attempts, or do you focus a little more strategically on the positive and more hopeful parts of the interview?

RITA: Yeah, OK, well, let's watch a little bit more.

TOMMI: Well, I guess there's no good reason to commit suicide. But you know, I don't know what I'm trying to say. My friend committed suicide because he got caught with a can of chew. He got kicked off the wrestling team.

JOHN: OK.

TOMMI: Yep, he shot himself in the head.

JOHN: And as you say that to me, I think that it sounds like you feel both sad and a little bit angry that he killed himself.

TOMMI: Well, I'm sad. Don't get me wrong. He was a good kid. It makes me angry because you hurt a lot of people when you take your life. Like who are you to take your own life? Like you're hurting your family, your friends. I don't know.

JOHN: Yeah. Yeah. So I hear you saying reasons to live, one is suicide you kind of hurt people, maybe even people you don't intend to hurt. Another reason is you've got a brother who you think the world of you want to help him in his life.

TOMMI: Yeah, I guess I don't want him to end up like me.

JOHN: I just want to check in with you on maybe a little plan you to stay safe. Because I know you've had some thoughts about suicide. It sounds like for the most part, and let me know if I've got this right, that for the most part you're pretty clear that you want to live and

move forward toward your dream and be a positive influence with your brother.

Have I got that right? That's the main thing. Now if you were in a situation and you were feeling suicidal, what would help you feel better?

TOMMI: That's a really hard question, because when something really gets me down, I don't really think about what makes me happy. I'm kind of pessimistic in some way.

JOHN: But the good thing is right now, you're at a three or four. So you're not all the way down there at a zero or one.

TOMMI: Yeah.

JOHN: So right now when you're feeling a little better, what do you think, what could you remind yourself, oh, here's what I think I should do when or if I start to feel more suicidal? What would be a healthy thing you could do.

TOMMI: Well, I'd say eat, but that's not too healthy.

JOHN: Well, it depends on what you eat, I guess.

TOMMI: Well, I binge eat sometimes.

JOHN: So maybe having a small, nutritious meal.

TOMMI: No, working out or singing karaoke or something.

JOHN: Working out, singing, OK, those would help. Would it help to call somebody, talk with a friend?

TOMMI: I don't really like to talk to people about things they never went through.

JOHN: OK.

TOMMI: They don't understand. They can sit there and be like yeah.

JOHN: Anybody on your list of friends who might understand?

TOMMI: Nope.

JOHN: Nope. Not even the person who was on the phone with you for three hours?

TOMMI: They'd be able to understand, but I'd rather call my sister. Because we grew up together. We know what we went through.

JOHN: OK. So the possible things you might do is you might work out. You might sing. You might call your sister. Anything else that would help a tiny bit? Write some good poetry?

TOMMI: Yeah.

JOHN: Yeah?

TOMMI: Write some poetry.

JOHN: You know, one of the things I just want to say, and then we'll probably stop here in just a minute, is that it's hard to know when people are going to feel down, right? And so it's good to have a plan ahead of time for what you're going to do. Because when you're feeling down, then sometimes you're not very creative. And you can think of all the good options. So what I'm wondering is if you and I can agree that if you have a really down time that you will try working out, singing, calling your sister, writing poetry, and maybe even add that to, if you really were terribly suicidal, maybe even call 911, try to get some help?

TOMMI: Yeah.

RITA: So you know, this section is really tough. And this whole enterprise of suicide assessment is tough. People are unique. And there is no exact formula for assessing suicidality. I really appreciate the way you worked to make the assessment a positive therapeutic experience. But it's also a scary endeavor.

JOHN: You know, it was stressful and challenging. Tommi, I think, is a very interesting and complicated young woman. It's hard. I think at times she was very cooperative with me. And there are times when she was much more challenging. She's a bright young woman. There are a lot of factors mixed in there.

I think I probably, if I erred on one side, it was toward being more positive and focusing on maybe more therapeutic questions and what's going well for her and maybe ignored a little bit of negative side. One interesting thing that I didn't bring up earlier is that when she talked

about her suicidal plan, which had been in the past, and that was a good thing, she also was talking about an underlying motive. And that's often the case with a suicide plan.

And for hers, it was a little bit of a revenge motive, a little bit of a send a message to my parents motive. And so I think that's a place where you can take the opportunity to turn a discussion about a plan into something that's more therapeutic and help her focus on how could she give that message to her parents without having it involve anything to do with suicide.

RITA: So even though every suicide assessment is unique, there are some factors that should be considered in each interview.

JOHN: That's absolutely true. And now if you look at the slide, you can see that the first part of a comprehensive suicide assessment interview involves evaluating suicide risk factors. And oftentimes, you don't do all that directly. But you find out about the different suicidal factors that may be operating. Typically, you do a depression assessment. Because almost always there are some depression symptoms. You do an exploration of the suicide ideation. You ask directly. You want to frame that in a way the client can answer truthfully. Also you explore the suicide plan and move on to trying to determine whether or not the client has a high level of suicide intent. And one of the ways of doing that is to check in to their reasons for living. And then the last categories are two try to infer the client's level of self-control. And one way of doing that is to try to develop a collaborative and cooperative safety plan between you and your client.

RITA: So if we were going to do a little summary, Tommi has tried suicide twice by her own account. She has a good friend who killed himself. Her family background includes some substance abuse, and probably some physical abuse, and a very serious addiction problem that Tommi herself has.

So certainly, she's in a high risk population. But on the other hand, she's future-oriented. And she's in a setting that's structured and is providing her with the opportunity to work on vocational skills and on her sobriety.

JOHN: What you're saying reminds me of the fact that we need to talk about decision making. And that could be one of the most stressful and tormenting things I think for a mental health professional is deciding, well, how do I act in this particular situation? I think because of the things you said, including the fact that she has a pretty high mood rating and she collaborated on a safety plan, that in fact, I probably wouldn't go toward hospitalization.

RITA: Right, yeah.

JOHN: But it's really important to integrate or to weave in some documentation of what you're doing and some consultation with other professionals in order to protect yourself from liability and to make sure you're doing a thorough comprehensive suicide assessment.

RITA: Right, yeah. And you know that not only brings us to the end of this section but to the end of the DVD.

JOHN: You know one thing I'm struck at the end of this whole production is just how much there always is to learn, and how complicated individuals are, and how many different ways you can look at the clients with whom you're working, and how many different ways there are to approach the clinical interview.

RITA: Right. You know, if I was going to offer a summarization of that, I'd pretty much say, you think that it's a lifelong learning process.

JOHN: And you'd be pretty much right about that.

RITA: And we both hope that this has been helpful to you in your journey toward becoming a really excellent clinical interviewer. Thanks.

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