DIAGNOSIS AND TREATMENT OF MENTAL DISORDERS ACROSS THE LIFESPAN

Stephanie M. Woo, PhD
Carolyn Keatinge, PhD

John Wiley & Sons, Inc.

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To my parents, Larry and Delia Woo, for always believing in me; my husband Kenneth, for your constant support and love; and my children Daniel and Tatiyana, for the joy you bring me each and every day.
—SMW

To John, as promised, thank you for being you. Love and thoughts always, Mum. To Dr. Lois Mendelson and the staff of the JCC therapeutic nursery, who everyday bring hope to children with autism and their families. Thank you for the hope.
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Preface

Understanding the origins of psychological distress and how to ameliorate its symptoms has been both a source of fascination and a challenge since time immemorial. Today, mental health professionals are able to benefit from a rapidly growing understanding of the features, etiology, course, and treatment of mental disorders that has been informed by modern research methodologies utilizing cutting-edge, state-of-the art science and improved assessment measures and diagnostic systems. Our knowledge of how to best work with people struggling with the often devastating effects of mental illness has also been aided by the wealth of information gleaned from the decades of experience of astute clinicians treating clients on the front lines. For the mental health clinician, whether a student just starting out on his or her professional journey or an experienced therapist, the task of grasping and integrating these diverse sources of information can be daunting. Our purpose in writing this text was influenced by our experiences teaching graduate courses in introductory psychopathology and the need for a clinical diagnostic training text for beginning mental health clinicians that could also serve as an essential reference for experienced therapists. By integrating the key information necessary for clinical practice for a wide range of disorders across the continuum of development we also hoped to focus on clinical populations that are sometimes overlooked and often underserved. Our intent is to present the information in a practical, applied, and accessible manner that also incorporates current advances in the field.

OUTLINE OF THIS VOLUME

This book is divided into two parts, which are intended to facilitate the learning experience. The first four chapters of the book focus on essential clinical skills that lay the foundation for the evaluation and treatment of mental disorders. Included are chapters on "Intake and Interviewing," "Crisis Issues," "Essentials of Diagnosis," and "Fundamentals of Treatment Planning." These chapters draw from clinical and research literature and contain practical strategies and tips for dealing with a wide range of clients. The format of these chapters is designed to orient and guide the novice clinician through the skills needed for clinical practice and to serve as useful reminders to experienced clinicians. Basic and advanced information is organized in an easily accessible format to enhance clinical utility and recall. Information regarding the role that cultural factors play in the evaluation, diagnosis, and treatment process is woven throughout the text.

The second part of the book addresses clinical disorders and illustrates the application of the clinical principles reviewed in Part I to specific forms of psychopathology. Importantly, the chapters in Part II provide a comprehensive overview of the disorders most commonly encountered in clinical practice (e.g., disruptive behavior, mood and anxiety disorders). Information is provided on the clinical presentation, associated features, course,

epidemiology, etiology, diversity considerations, assessment, treatment of a wide range of disorders, and the therapeutic challenges encountered by clinicians. Important aspects of the developmental presentation of psychopathology (i.e., in children and adolescents as well as older adults) are also summarized throughout the chapters. Clinical diagnosis and the clinical disorders are discussed in terms of the *Diagnostic and Statistical Manual of Mental Disorders,* fourth edition, text revision (*DSM-IV-TR*) system, the classification system that is the current standard in the field, and the limitations and strengths of this system are reviewed. Discussion of treatment issues in the clinical disorders chapters are informed by evidence-based approaches (e.g., cognitive-behavioral treatment for mood disorders, exposure-based treatments for anxiety disorders, multidisciplinary treatment for Schizophrenia, autism, and dementia due to Alzheimer's disease), but also integrates the real-world approaches taken by today's clinicians. Both psychosocial and pharmacologic interventions are discussed, and each disorder is considered from a multidisciplinary framework that teaches the novice clinician ways to interface and benefit from contact with a variety of health professionals and services, including psychologists, physicians, social workers, and local agencies. Each clinical disorders chapter ends with an advanced topic, which presents information on a specialized issue related to assessment, diagnosis, or treatment. Collectively, these topics cover a wide range of subjects, from early intervention and multisystemic treatment for disruptive behavior disorders, to the epidemic of methamphetamine abuse and dependence, to postpartum mood disorders, which we hope will be of interest to today's mental health professional. Finally, an appendix provides an overview of psychopharmacology. Our hope is to provide a book that will introduce new clinicians to the field and serve as their resource book as they challenge themselves to work with different populations and add their contribution to our clinical knowledge.

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PART I

FUNDAMENTAL CLINICAL SKILLS

Chapter 1

INTAKE AND INTERVIEWING

A good clinician is like a detective trying to solve a mystery. Clues must be gathered, facts ascertained, leads followed up, a time line of events created, and pieces of a puzzle eventually put together to tell a story that hopefully answers some important questions. But whereas a detective strives to answer the question "*Who* dunnit?" the clinician must answer questions such as "*What* is this person's diagnosis?" "*When* did these problems begin?" "*Why* is this person seeking help now?" and "*How* can I best help?" Like the detective, the clinician needs a specific set of skills and tools to answer these questions. The four chapters in Part I review the essentials necessary to diagnose and treat a wide array of clients. This chapter reviews one of the most fundamental of these skills: the ability to conduct a comprehensive intake interview. A well-done intake interview provides clients an opportunity to tell their own stories, including information about self-concept, values, self-expectations, and the meaning of the symptoms and experiences (S. B. Miller, 1987). The information collected creates nothing less than the road map that ultimately guides the clinician and client toward an appropriate diagnosis and treatment plan. When an interview is poorly conducted and treatment decisions subsequently made are based on incomplete or inaccurate information, a client's well-being is directly threatened (S. M. Turner, Hersen, & Heiser, 2003).

This chapter addresses the fundamentals of a good intake interview. The chapter begins with factors to consider prior to the interview itself. A separate section is devoted to legal and ethical considerations in interviewing and addresses such important issues as client confidentiality, communication between treatment providers, and records release. This is followed by a discussion of process issues involved in interviewing, including the establishment of rapport and listening and questioning skills. Next, content areas that should be addressed in a standard intake interview are reviewed, as well as details of conducting a mental status exam. Consideration of the benefits and drawbacks of conducting structured versus unstructured interviews follows, and the chapter ends with a discussion of how the interviewing skills and content areas discussed should be adapted when working with individuals at either end of the life span spectrum: children and older adults.

Before delving into this information, a general piece of advice is offered. If you want to become a skilled interviewer, the key is repeated practice. As will become evident in reading this chapter, interviewers must possess a variety of skills and be able to accomplish multiple tasks at once. Skill in dealing with one client does not necessarily generalize across clients. Differences in presenting problems, verbal skills, insight, and cultural factors can all influence a client's manner of relating as well as the specific skill set

required to conduct an effective interview. Thus, during one's training it is wise to take advantage of as many opportunities as possible to conduct supervised interviews in order to develop and maintain skills in this most important of clinical areas.

PREPARING FOR THE FIRST INTERVIEW

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

Depending on the setting in which you work, you may have very little or quite a bit of information about a new client prior to the first meeting. Clients seen through outpatient clinics have often been through a telephone screening with a staff person, and information on the presenting problem, past treatment, current medication, and much more may be available. In contrast, a private practice clinician may opt to do relatively little screening over the telephone and will have only the most basic idea of the client's presenting complaint prior to the first meeting. In either case, it is helpful before the first session to begin building a profile of what is known about your client and what you need to find out (Lukas, 1993). For example, if phone intake notes indicate that the client has recently been hospitalized, during the intake interview you will want to be certain to find out the reason(s) for the hospitalization (including any thoughts and behavior indicating an intent to harm self or others), the length of stay, whether the hospitalization was voluntary, diagnoses rendered, medications the client was treated with, and if this was the client's first inpatient stay.

Although the client's diagnosis and full range of presenting problems may not be known before the first meeting, you will likely have some idea of the general type of problems or symptoms the client is experiencing. It is therefore useful to refamiliarize yourself with diagnostic criteria for disorders that are likely to be under consideration. For example, if you know that the client has a history of depression and multiple sclerosis, familiarity with the symptoms, prognoses, and typical treatments for both, as well as ways the conditions can affect each other is helpful. Reviewing past treatment records (obtained with the client's permission) is a good way to do this advance preparatory work. However, one should not overly rely on such records in forming an impression of the client since the utility of the information contained in them is highly dependent on the competence and insight of those who reported it (Lukas, 1993). Also, some clients may be reluctant to release records to a clinician they have not met in person and are not certain they will continue seeing.

With this said, it is important to be flexible and remain open to attending to and following up on information that may contradict any preconceived ideas about the client's problems or diagnosis. Effective interviewers take care to avoid the *confirmatory bias effect,* or asking only questions that will confirm diagnostic preconceptions, as well as the *halo effect,* in which an initial impression of the client guides subsequent questioning and diagnostic decision making (e.g., deciding that a client who presents as irritable and difficult to interview must have personality pathology). The power that mistaken initial impressions can have on subsequent conceptualizations of clients is aptly illustrated by a study that found a group of psychoanalytically oriented therapists were more likely to rate a male interviewee seen in a videotape as disturbed when he was labeled as a "patient"

compared to when he was labeled as a "job applicant" (Langer & Abelson, 1974). This finding does not mean that members of one theoretical orientation are more likely than others to draw biased conclusions about individuals they see, but merely illustrates the need to be vigilant to the tendency to jump to conclusions based on limited information.

Consider How the Setting Will Guide the Interview

Later in this chapter key areas typically addressed during a first interview will be reviewed. The areas that are emphasized and the time spent on them may vary considerably depending on the interview setting. Therefore, you should spend time deciding on the type of interview structure and style that will most likely achieve the goals dictated by your work setting. Table 1.1 compares presenting client issues in three different treatment settings and suggests interview formats for each.

Consider Issues That Could Impact Interview Effectiveness

Our past experiences (e.g., events, relationships), current needs, motivations, physical state, cultural assumptions, biases, and blind spots can all affect the quality of the relationship that is established with the client, which in turn can affect the quality of information obtained in the initial interview (J. Sommers-Flanagan & Sommers-Flanagan, 1993). These problems may come to the clinician's awareness only during or after the initial interview. However, it is sometimes possible to anticipate such issues ahead of time, make a concerted effort to remain aware of them during the interview, and therefore reduce the likelihood that they will adversely impact the initial working relationship with the client. For example, suppose a 28-year-old male clinician is scheduled to meet a 56-year-old male client for an intake interview. Prior to the session the therapist reflects on how he typically interacts with older male clients or older men in general, and recognizes that he often feels insecure, is often overly deferential, and tends to be hyperattuned to any verbal or nonverbal signs that they are disappointed or irritated with him. Awareness of these reactions may lead the clinician to take such steps as role-playing before the interview how he might ask questions, making a list of specific questions he thinks he might (un)-consciously be reluctant to ask, exerting a special effort to catch himself and question his motives when he decides not to ask the client a particular question, and practicing cognitive reframing of possible client reactions ("If the client frowns during the interview that doesn't necessarily mean I've asked the wrong question; he may just be remembering something upsetting").

The astute clinician is mindful throughout treatment (not just in preparation for or during the first interview) of the ways personal reactions to clients can affect clinical impressions, diagnostic decisions, and treatment interventions. *Countertransference* is a psychoanalytic concept that refers to the development of feelings in a therapist about a client that are similar to those the therapist has had toward someone from his or her past. One does not have to be working from a psychodynamic framework to experience such feelings, and countertransference will be experienced with all clients to some degree (Leon, 1982). However, when left unchecked, countertransference reactions can obscure clinical judgment and lead to inappropriate diagnosis and/or treatment (Wiger & Huntly, 2002). An extreme example would be a therapist who mistakenly diagnoses a client as

Table 1.1 A comparison of three interview settings

Emergency Diagnostic Centers/Crisis Settings	Outpatient (Clinics/ Private Practice)	Medical Settings
Goal:	***Goal:***	***Goal:***
Address crisis issues (e.g., suicidality). Gain enough information for diagnosis and immediate disposition.	Learn as much as possible about client's emotional functioning to determine reasons for seeking consultation.	Gain enough information for diagnosis and immediate disposition.
Additional considerations:	***Additional considerations:***	***Additional considerations:***
Clients may be frightened by their symptoms and agitated; intimidated by the interview setting. Adopt a calm, structured, reassuring manner to put client at ease. Client ability to clearly provide history may be diminished. Decrease emphasis on obtaining a detailed psychosocial history. A mental status examination is important. Clinician will likely need to supplement information from client with other sources (e.g., family, police).	Client problems are likely to be less acute/ severe than seen in crisis settings. Devote ample time to establishment of rapport and a strong therapeutic relationship. More time is available for detailed questioning. Client is likely to request information on clinician's diagnostic impressions, treatment recommendations, prognosis.	Clients often not self-referred (referred by treating physician). Clients may have questions or doubts about the need for psychological treatment and consequently may be reluctant to be interviewed. Format and length of questioning may be affected by client pain, fatigue, physical discomfort. Interviewing process may be protracted. Clinician may need to slowly approach idea of psychological (versus solely medical) factors contributing to client functioning. Client may try to get clinician to side with him or her against treating physician.

From "The Interviewing Process" (pp. 3–20), by S.M. Turner and M. Hersen in *Diagnostic Interviewing,* third edition, M. Hersen and S. M. Turner (Eds.), 2003, New York: Kluwer Academic Publishers. Adapted with kind permission of Springer Science and Business Media.

having Borderline Personality Disorder primarily based on countertransference feelings of anger or hatred (Reiser & Levenson, 1984). Research suggests that therapists rated as having good self-awareness and reduced countertransference potential are more likely to be viewed as excellent therapists (Van Wagoner, Gelso, Hayes, & Diemer, 1991). Thus, when strong reactions are aroused by a client, consultation with a colleague or supervisor may lend insight into why these feelings are being aroused and how they might be

affecting the treatment process. Among therapist factors identified as being helpful in the management of countertransference feelings are self-insight, empathy, self-integration (i.e., healthy character structure), anxiety management (i.e., ability to experience, control, and understand one's anxiety), and conceptualizing ability (i.e., ability to theoretically understand what is happening in the therapeutic relationship; Gelso & Hayes, 2001). In cases when a clinician has continued difficulty working through countertransference issues, personal psychotherapy may be the best avenue through which to address and hopefully resolve these feelings. In some cases, the clinician may ultimately need to refer the client to another treatment provider if countertransference issues continue to adversely affect the client's treatment (R. Sommers-Flanagan & Sommers-Flanagan, 1999). Although it may seem that countertransference is always an obstacle to therapy (this was actually Freud's view), many contemporary psychoanalytic theorists point to the valuable information that can be gleaned from scrutiny of these feelings. For example, countertransference reactions can clue the clinician into understanding the client's impact and effect on others, which can be particularly helpful in assessing problematic aspects of the client's personality (McWilliams, 1994).

Good interviewers recognize that not only can their behavior be affected by characteristics of the client, but interviewer variables such as gender, ethnicity, age, and other demographics can differentially influence the behavior, comfort level, and openness of clients. Although findings from the literature are mixed, there is evidence that treatment length is improved for African American, Mexican American, and Asian American adult and adolescent clients when there is a match with their therapist in terms of ethnicity or language (Flaskerud & Liu, 1991; Fujino, Okazaki, & Young, 1994; Gamst, Dana, Der-Karabetian, & Kramer, 2000; Rosenheck, Fontana, & Cottrol, 1995; Sue, Fujino, Hsu, Takeuchi, & Zane, 1991; Yeh, Eastman, & Cheung, 1994). This does not imply that therapists should treat only individuals from the same ethnic or linguistic background as themselves, nor does research suggest that ethnicity and language factors are the top criteria ethnic minority clients cite when asked about therapist characteristics that are important to them (attitudes, educational level, personality, and maturity have been found to rank higher; H. Coleman, Wampold, & Casali, 1995). However, these research findings call attention to the need to be sensitive to *potential* impediments to the therapy process when treating a client whose ethnic or linguistic background is different from one's own and the necessity to educate oneself (through reading, workshops, supervision, etc.) about a client's cultural background.

Consider Physical Presentation and Surroundings

When interacting with clients it is important to be well groomed and professionally dressed. The therapy room is not the place to make a fashion statement, and care must be taken to consider how a variety of clients might interpret your dress. For example, novice therapists who look very young and are planning to work with adult clients may wish to avoid dressing in clothes or wearing a hair style that accentuates their youth. As a safety consideration, avoid wearing anything that could be used to inflict harm (i.e., long necklaces, pins).

Equally important as one's physical presentation is the impression that the physical environment of the therapy room makes. Ideally the therapy room should be a

comfortable refuge that helps put the client at ease and encourages open dialogue. An uncomfortable, dirty, or inappropriately furnished room reflects poorly on one's professionalism, is likely to distract the client and discourage disclosure, and decreases the likelihood that the client will return for treatment. While personal taste and desires in terms of decor need not be sacrificed, the clinician should reflect on whether any furnishings, pictures, or photographs would be likely to offend, disturb, or overly distract clients. For example, although a clinician may cherish a photograph of herself hugging her 5-year-old daughter, placing this picture in clear view of a client may invite trouble, including unwanted personal questions about her family life or client reluctance to divulge troubling feelings about parenting issues for fear of therapist disapproval or disappointment.

Furniture in the therapy office should be clean, comfortable, and arranged in such a way that the client and clinician do not have to sit too close together (e.g., feet almost touching) nor too far apart. Allowing clients a personal space of about 3 feet around their body should be sufficient (Twemlow, 2001). Tissue should be available in the event a client cries during the session. Keep paperwork and client files you are working on so that they cannot be seen when the client enters the office or is seated. If child clients are seen, age-appropriate toys, books, and furniture (e.g., low table and small chairs) should be available. Lighting should be moderate; strong overhead fluorescent lights that can impart an institutional feeling should be avoided whenever possible. Conversely, a darkened therapy room with minimal light or use of lit candles as accessories can evoke an inappropriately intimate atmosphere. The therapy office should afford privacy and protection from interruptions, and to these ends care should be taken to ensure that there is adequate soundproofing, that the telephone ringer is turned off, and that others are instructed not enter the office (Phares, 1992).

Attend to Safety Issues

All clinicians, regardless of the setting in which they work, should take steps to keep themselves safe from potentially aggressive or violent clients. Unfortunately, assaults (verbal and physical) by clients are not entirely rare and are probably underreported (Owen, Tarantello, Jones, & Tennant, 1998). Surveys of psychiatric residents suggest that between one third and one half have been assaulted during their training (K. J. Black, Compton, Wetzel, Minchin, & Farber, 1994; Chaimowitz & Moscovitch, 1991; Coverdale, Gale, Weeks, & Turbott, 2001; D. Fink, Shoyer, & Dubin, 1991; T. L. Schwartz & Park, 1999). A study of patient assaults experienced by marriage and family therapists found that 44% reported being assaulted at least once (this included property damage, pushing, grabbing, holding, and being knocked down, kicked, slapped, scratched); 35% of these assaults occurred in the therapists' offices, and another 14% occurred in the reception areas and/or hallways. Despite these sobering statistics, many mental health professionals receive no or inadequate training on dealing with verbally or physically aggressive clients (Coverdale et al., 2001). Chapter 2, "Crisis Issues," provides a detailed review of steps for dealing with potentially homicidal clients, but some general principles for dealing with aggressive clients during the intake and interview phase of treatment will now be reviewed.

If a clinician suspects that a client may pose a danger, intake or waiting room staff should be questioned prior to the interview about behavioral manifestations of agitation

(e.g., pacing, verbally threatening behavior) and whether the client appears intoxicated, psychotic, or in possession of a weapon or other potentially dangerous object. The clinician and intake staff should also continually stay alert for changes in the client's demeanor and signs of escalation and increased agitation. When working with impulsive clients, an awareness of physical surroundings, including knowledge of emergency alert procedures and access to the door, panic buttons, and distress codes, is essential. If the clinician has concerns about the client's level of agitation, arrangements should be made for the interview to be conducted in the vicinity of other staff members. A quiet corner of the waiting room, where the client's confidentiality may be maintained and visibility with other staff members ensured, may be appropriate. New clients should always be scheduled at times when staff are present and support is available.

In the therapy room, the clinician should avoid sitting so that access to the door is blocked and should consider removing any items that could be used to inflict injury (e.g., letter openers, paperweights, decorative items such as vases; Twemlow, 2001). The clinician's hands should be visible, and he or she should make no abrupt gestures. A physically safe distance from the client is often considered "two quick steps" from the client, since this allows one to easily avoid or intervene should the client's behavior escalate. A sideways stance also avoids the potential for a direct body assault (Eichleman, 1996). Finally, rather than sitting directly opposite the client, which may be perceived as confrontational, the clinician may favor sitting at a lesser angle, suggesting a supportive nonverbal tone.

When interacting with an agitated client, the tendency to match the client's level of heightened emotionality and to rush through the interview should be avoided. Instead, a relaxed, natural, nondefensive manner should be displayed that imparts a sense that the clinician is knowledgeable and in control, and the client should be firmly told that violence is not acceptable. Maintaining a verbal and emotional tone that is below the client's in intensity also serves to model appropriate affect, and most clients who are feeling out of control will find a clinician who is calm and in control reassuring (Hipple, 1983). Genuine interest and concern in the client's story can further help reassure the client that the interview is a safe environment and discourage the use of inappropriate ways of communicating distress. Twemlow (2001) suggests that "rational maneuvering" or pointing out the consequences of a client's violent actions in a nonthreatening manner can also help with de-escalation. Emotionally charged material should be approached cautiously and only after rapport has been established and the client calmed down in order to minimize the likelihood of escalation. One guideline for working with agitated clients is that the therapist be active for 10 seconds of every minute (Eichleman, 1996). Agitated clients with cognitive limitations may require frequent restating, paraphrasing, and reaffirming of what has been said. If the client appears psychotic, the interviewer can provide reassurance about the purpose of the interview in a straightforward manner, thus assisting the client's reality testing. The clinician should assess the client's ability to respond to verbal limitations and interventions (e.g., Is the client calmed or further agitated when the clinician attempts to change topics or asks the client to breathe deeply and collect his or her thoughts?). If escalation occurs, the clinician may need to change topics or end the interview altogether. The interview may also need to be stopped if the client is intoxicated or extremely psychotic (e.g., highly disorganized or paranoid; McNeil, 1998).

Table 1.2 Basic safety strategies

Know the agency's emergency and security procedures.
Review prior records and intake information.
Be sensitive to scheduling and availability of others.
Be aware of physical surroundings, door access, and furnishings.
Conduct interview in a safe environment.
Use appropriate interviewing techniques.
Observe a safe distance when approaching client.
Do not make abrupt moves; approach in a calm, nonthreatening manner.
Attend to verbal and nonverbal cues.
Do not make provocative or threatening comments.
Calm and reassure the client, and assist the client's reality testing.
Address threats directly; explore veiled or indirect threats.
Be alert for escalating emotions or loss of control.
Leave physical restraint to those trained in the procedures.

In summary, clinicians should trust their gut instinct regarding danger, and if at all concerned have another person present or move the interview to a more secure setting. Obtaining training in basic self-defense strategies is a good idea for clinicians, particularly those who work in settings where agitated or potentially violent clients are frequently seen. Several safety guidelines to minimize the risk to therapist safety are summarized in Table 1.2.

Gather Relevant Paperwork

Basic paperwork, such as the consent to treatment form, Health Insurance Portability and Accountability Act (HIPAA) forms, release of information forms, clinician's business card and emergency contact information, and information regarding clinic policies and procedures, should be readied for the client prior to the initial interview. Because a great deal of information is typically gathered in the first session, an interview form on which notes can be written and organized is highly recommended. While it is helpful to jot down key phrases or descriptions that the client uses or any instances of unusual language use (see section on the mental status exam, later in this chapter), avoid trying to write down verbatim everything that the client says, as this will make it difficult for you to adequately listen to the client, observe his or her behavior, and make appropriate eye contact (Phares, 1992). Clients usually will not mind if notes are taken during the interview. In fact, some clients may resent the clinician who writes nothing down during the interview and may interpret this to mean that the clinician does not take their comments seriously (H. I. Kaplan & Saddock, 1998). Packets of necessary paperwork can be made in advance so that one can be assured of always having all necessary forms before going into the first interview. It is also helpful to have an up-to-date referral notebook available that contains the business cards or names and phone numbers of fellow treatment providers who may be able to provide adjunctive services (e.g., psychiatrists who can conduct medication evaluations) or to whom referral of the client might ultimately need to be made.

LEGAL AND ETHICAL ISSUES IN INTERVIEWING

Informed Consent

Just as the decision to enter psychotherapy is not made lightly by most individuals, clinicians too must take seriously their obligation to provide prospective clients with sufficient information that will allow them to make an informed decision about pursuing treatment. According to Welfel (2002), disclosure and free consent are two key aspects of informed consent; that is, clients should be provided with full information about issues that could affect their decision to engage in treatment, and their decision to enter treatment should not be the result of coercion or undue pressure (e.g., warning clients that they will not get better unless they enter treatment with you). Major mental health professional organizations, including the American Psychological Association (APA), American Counseling Association (ACA), American Association of Marriage and Family Therapists (AAMFT), and the National Association of Social Workers (NASW), contain within their ethics codes guidelines regarding informed consent. The language used in these codes varies somewhat, but important principles emphasized in them include (a) obtaining informed consent during treatment, (b) providing adequate information to the client in developmentally and culturally appropriate language, (c) ensuring that the client has the capacity to consent, (d) avoiding coercion of the client and communicating the right of the client to refuse or withdraw from services, and (e) documenting client consent (AAMFT, 2001; ACA, 2005; APA, 2002; NASW, 2000).

What constitutes adequate information in the context of informed consent? Clients should be informed, for example, of your credentials and training, information relating to the process of treatment (e.g., goals, therapy techniques), confidentiality, and practical issues such as your fee, cancellation policy (e.g., how far in advance appointments must be canceled to avoid being charged), and how to contact you in an emergency or after hours. Table 1.3 lists elements that are recommended for inclusion in an informed consent process. The use of the term *process* here stresses that informed consent is not solely

Table 1.3 Elements to include in an informed consent process

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

addressed at the start of treatment or through the signing of an informed consent form, but should be considered an ongoing dialogue as issues, goals, risks, and benefits of treatment change over time (Handelsman, 2001). However, it is important to initially address the issue of informed consent as early as possible in the treatment relationship so that the client is made aware of information that could affect his or her willingness to pursue treatment with you. Although state laws vary regarding the requirement to document informed consent in writing, it is good practice to provide clients with a written informed consent form that they sign and receive a copy of, rather than solely relying on an oral consent procedure. Sole reliance on an oral consent procedure is problematic for several reasons, including the difficulty most clients would have in remembering everything that should be covered in an informed consent procedure and the possibility that a client who chooses to sue a clinician may deny having ever given oral consent (Sales, Miller, & Hall, 2005).

In addition to documenting informed consent through the use of a signed form, any discussions that pertain to issues of informed consent that occur throughout treatment should be clearly documented in the client's case notes. Indeed, clinicians are likely to find that certain issues that are relevant to informed consent (e.g., psychotherapy duration, goals, and activities) are not easily addressed at the start of treatment and are likely to be meaningfully discussed only as the treatment progresses and the client's background and presenting problems are more fully understood (Pomerantz, 2005).

It is important to ensure that an individual has the capacity to consent. If an individual is deemed unable to meaningfully provide consent because of psychiatric, developmental, or cognitive limitations, consent must be obtained by a legally authorized individual. Children, for example, are not recognized as being legally capable of providing informed consent because of limitations in judgment and experience. As such, consent must be provided by the child's legal parent or guardian. If parents share custody of a child, obtaining the consent of both parents is advisable (Welfel, 2002). Sales et al. (2005) note the importance of determining the custodial status of any parent seeking to place a child in treatment as some states will allow only a parent with legal custody to consent to treatment and/or will allow a noncustodial parent to consent to treatment only in certain emergency situations. Under certain circumstances a child (i.e., person under the age of 18) may be able to consent to mental health services. For example, certain states recognize the rights of emancipated minors to consent to mental health treatment services. Some states also allow unemancipated minors to consent to certain forms of treatment such as contraceptive services, testing and treatment for HIV and other sexually transmitted diseases, prenatal care and delivery services, and treatment for alcohol and drug abuse. Clinicians who treat minors should become familiar with state laws concerning these issues.

Even when an individual cannot legally provide informed consent, it is advisable to obtain his or her *assent* to treatment. This means that the client agrees to services even though the agreement is not legally recognized (Handelsman, 2001). The information imparted to an individual in such a situation must obviously be tailored to his or her psychological capacities (APA, 2002). For example, although very young children may not be able to meaningfully understand what agreeing to treatment means, Morrison and Anders (1999) suggest that beginning around age 7 children are able to reasonably participate in discussions of issues such as confidentiality. As Welfel (2002) notes, in the case of older adolescents the information imparted in an assent procedure will increasingly approximate what is included in a typical informed consent process with an adult client.

Confidentiality

Most clients enter psychotherapy with an expectation that what they disclose will be kept strictly confidential (D. J. Miller & Thelen, 1986). Although this expectation is reasonable for the most part, clinicians have legal and ethical responsibilities both to maintain confidentiality and also to breach it under certain circumstances. For example, all 50 states require mental health professionals to report cases of suspected child abuse or neglect, and most states have similar mandated reporting laws for cases of suspected elder or dependent abuse (although the precise wording of such laws varies by state). Similarly, when a client discloses a threat to harm a specific individual, laws specify the steps clinicians must take to protect these potential victims, which may include breaching confidentiality. Confidentiality may also be breached if an individual is at risk of self-harm (e.g., a clinician can discuss the client's case with other treatment professionals in arranging for an involuntary hospitalization). If a client initiates legal action against a therapist, client confidentiality is waived to allow the clinician to defend himself or herself by discussing details of the treatment in court. Also, if a client is involved in litigation in which he or she is claiming psychological harm (and citing treatment with you in building his or her case), confidentiality is not protected (Welfel, 2002). Clinicians can also be compelled by a court order to produce treatment records or give testimony about a client. In certain states, if a client discloses the intent to commit a crime in the future and the client is being investigated by law enforcement officials, the clinician may be compelled to report this to the officials (Glosoff, Herlihy, & Spence, 2000). In certain states, confidentiality of an individual's positive HIV status cannot be guaranteed. For example, some states require new HIV-positive test results (including the names of affected individuals) to be reported to governmental agencies, and some states require disclosure of HIV-positive status to an individual's sexual partner (Sales et al., 2005).

The preceding discussion is not an exhaustive list of situations in which confidentiality may be breached, and it is beyond the scope of this text to provide such a review (for further information, see Sales et al., 2005; Welfel, 2002). It is probably safe to say that most clients will not be aware of the many circumstances in which confidentiality cannot be assured, and as such these exceptions should be discussed with the client and clearly documented in a written informed consent to treatment form that the client reads and signs at the start of treatment. The preceding discussion also emphasizes the importance of clinicians taking responsibility for becoming familiar with the laws governing confidentiality in the state in which they practice and keeping abreast of statutes and case law relating to this issue. The latter is probably most efficiently and easily achieved by participating in continuing education workshops and through updates provided by one's professional organization (Glosoff, Herlihy, Herlihy, & Spence, 1997). Clinicians should also be familiar with their professional organization's ethics code as it relates to issues of confidentiality (AAMFT, 2001; ACA, 2005; APA, 2002; NASW, 2000).

As previously noted, a child is rarely able to consent to treatment. This raises interesting questions about the confidentiality of the child's disclosures in treatment. From a legal perspective, if a parent consented to treatment on behalf of the child, the parent will have the right to access the child's treatment records. However, parents and guardians consenting to treatment may also have an expectation that beyond this, you will discuss with them everything the child says in sessions with you. Parents and guardians need to understand that if

such an agreement is made, it is very likely the child will not be forthcoming with you and that this could adversely affect the course of treatment. Of course, parents and guardians have a right to know if a child discloses anything in a session that indicates the child's health or well-being is in jeopardy (e.g., if the child expresses suicidal ideation, if the child reports abuse, if the child is taking drugs; Morrison & Anders, 1999). This should be explained to the parents and guardian and the child client, along with the fact that certain disclosures required by law (e.g., child abuse) necessitate that third parties be informed.

In cases where confidentiality must be breached, it is important to fully document the rationale and the steps taken in reaching this decision in the client's case notes. Such documentation can show that a clinician thoughtfully considered issues pertaining to the client's confidentiality and are valuable should questions later arise as to the appropriateness of a clinician's actions (Reamer, 2005).

Health Insurance Portability and Accountability Act

In 1996, the U.S. Congress enacted the Health Insurance Portability and Accountability Act, Public Law 104–191, in an effort to improve the efficiency and effectiveness of the health care system. More specifically, HIPAA was designed to facilitate the transfer of health care benefits from one employer to another (hence the name "portability"), to give individuals greater access to their own medical records and increased control over how personally identifiable health information is used, and to reduce administrative paperwork and decrease fraud within the health care system (Brendal & Bryan, 2004). Although HIPAA is intended to improve aspects of the health care system related to the storage and transmission of patient health information, it has been criticized for being convoluted, difficult to comply with, and misleading with regard to how well the privacy of health information is actually protected (Kuczynski & Gibbs-Wahlberg, 2005). Nevertheless, HIPAA is now the law of the land, and individuals or organizations considered to be "covered entities" must comply with its provisions. A covered entity is any health plan, health care clearinghouse, or health care provider who conducts certain transactions (e.g., claims, inquiries regarding eligibility and benefits, enrollment information, referral and authorization requests, payments) electronically (e.g., through the use of computers and computer networks).

An important part of HIPAA is the Privacy Rule, which took effect in April 2003. This rule outlines for covered entities who can and cannot receive an individual's protected health information, requires that reasonable administrative, technical, and physical safeguards be put in place to protect the privacy of such information, and mandates that clients be notified of their health care provider's privacy policies. With regard to the last item, HIPAA requires that a good faith effort be made to obtain clients' written acknowledgment of receipt of such notice. The notice of privacy policies informs clients of how their personally identifiable health information may be used and disclosed and specifies those situations in which written authorization from the client is required for disclosure and when disclosures of information can be made without the client's authorization (Sales et al., 2005). Thus, if you determine that you or the organization for which you work is a covered entity, you will need to provide your client with notice of your privacy policies and document the client's receipt of it.

Clinicians who are considered covered entities or who work in a setting that is considered a covered entity by HIPAA should familiarize themselves with all applicable HIPAA provisions. Detailed information about HIPAA is available through the U.S. Department

of Health and Human Services' website (www.hhs.gov/ocr/hipaa/). In addition, one's professional organization can be consulted for HIPAA-relevant information.

Release of Information

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

The HIPAA regulations discussed previously outline the elements that should be included in a valid written authorization to release information. These include the name of the client, the name and address of the facility or person from whom information will be obtained and to whom information will be released, the purpose of the disclosure, limitations of the disclosure (e.g., regarding the type of information to be released), a statement that the client can revoke the authorization, and the length of time for which the authorization will be valid (e.g., 1 year). If a clinician is not subject to the HIPAA provisions (i.e., is not a covered entity), the elements of a release of information specified under the HIPAA provisions provide a reasonable standard to follow, and we recommend including these in any written release of information form. The release form should be signed and dated by the client or his or her legal guardian (e.g., in the case of a child client or a client under conservatorship). When requesting information from a third party, always send a copy of the release of information to the individual or agency from whom information is being requested and keep the original in the client's file.

Sometimes clients are hesitant to have others contacted as part of the intake process. There may be reluctance to reveal being in treatment to others, or, if there were conflicts with previous treatment providers, there may be concern about how these individuals will portray the client. Such concerns should not be summarily dismissed by simply insisting that additional information from collateral sources is necessary. While such information may be very important for understanding the client's current situation, the client's concerns must first be addressed. For example, you can explain exactly what kinds of information you are hoping to obtain from collateral sources and the limits of information that will be provided to these sources (e.g., obtaining only historical information from the client's sister but disclosing nothing to her about the reasons the client is seeking treatment).

INTERVIEWING THE CLIENT

Establishing Rapport

The new client, however motivated for treatment, faces a daunting task in the first session: He or she must be prepared to reveal to a virtual stranger highly personal thoughts, feelings, and experiences, many of which may be distressing or embarrassing. For clients to

lower their defenses enough to provide meaningful information to assist in diagnosis and treatment planning, they must feel sufficiently safe with the clinician (Wiehe, 1996). The establishment of rapport and a good working relationship with the client is a necessary component of this process. Rapport can be defined as the feeling of harmony and confidence that exists between client and clinician (Morrison, 1995b). Rapport helps put a client at ease, contributes to feeling that one's worldview and suffering are understood, and instills hope that the clinician has the insight and expertise to help (Ivey & Matthews, 1984; Othmer & Othmer, 1989). As Phares (1992, p. 166) aptly notes, "Rapport . . . is not a state wherein the clinician is always liked or always regarded as a great person. It is, rather, a relationship founded upon respect, mutual confidence, trust, and a certain degree of permissiveness. It is neither a prize bestowed by an awed client nor a popularity contest to be won by the clinician." Rapport and a strong therapeutic alliance are not only critical for eliciting information during the initial interview, but also consistently predict more positive overall outcomes in psychotherapy (Constantino, Castonguay, & Schut, 2002; Horvath, 1994; D. N. Klein et al., 2003; P. Solomon, Drain, & Delany, 1995; Sue, 1988). Thus, the establishment of rapport is not just a goal to be sought during the initial interview, but an ongoing process that operates throughout treatment (C. Rogers, 1992; Utay & Utay, 1999).

Skills such as listening, reflecting and summarizing, asking pertinent and correctly timed questions, and displaying appropriate nonverbal behavior contribute to the process of establishing rapport. Not surprisingly, such interpersonal process skills have been found to highly correlate with client satisfaction (Bögels, van der Vleuten, Kreutzkamp, Melles, & Schmidt, 1995). However, clinicians often do not closely monitor and evaluate these skills, because many (e.g., nonverbal behavior) occur with little conscious awareness and greater attention is usually allocated to *what* areas will be addressed in the interview rather than *how* they will be approached (i.e., content versus process skills). Thus, it is helpful to review fundamental skills of good interviewing before addressing specific content areas that should be covered in the initial interview.

Setting the Tone

The verbal style adopted in the interview does much to facilitate or hamper the establishment of rapport. For example, an overly casual style ("Hi, Mary" versus "Hello, Mrs. Martinez") may be viewed as nonprofessional by some clients. When in doubt about how to address a client, the least offensive alternative should be adopted, which usually means using the most formal and/or conservative option (R. Sommers-Flanagan & Sommers-Flanagan, 1999). However, recognize that some clients (e.g., adolescents) may feel the clinician is out of touch with their experiences if more casual terminology or vernacular with which a client is comfortable is not used. The wording a clinician uses throughout the interview (in asking questions, making comments, providing information) should be appropriate to the client's cognitive and developmental level, and care should be taken to avoid the use of technical words that the client may misunderstand or not know (Morrison, 1995b).

Introducing the Interview

Information on the purpose and format of the interview should be presented before delving into questions about why a client is seeking treatment or about his or her background.