Clinical *Interviewing*

Fifth Edition

John Sommers-Flanagan

Rita Sommers-Flanagan

WILEY

FIFTH EDITION

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To Chelsea: in honor of your excellent interviewing skills and perpetual pursuit of knowledge.
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Preface

Clinical interviewing is the cornerstone for virtually all mental health work. It involves integrating varying degrees of psychological or psychiatric assessment and treatment. The origins of clinical interviewing long precede the first edition of this text (published in 1993).

The term *interview* dates back to the 1500s, originally referring to a face-to-face meeting or formal conference. The term *clinical* originated around 1780; it was used to describe a dispassionate, supposedly objective bedside manner in the treatment of hospital patients. Although difficult to determine precisely when clinical and interview were joined in modern use, it appears that Jean Piaget used a variant of the term *clinical interview* in 1920 to describe his approach to exploring the nature and richness of children's thinking. Piaget referred to his procedure as a semi-clinical interview (see Sommers-Flanagan, Zeleke, & Hood, in press).

Our initial exposure to clinical interviewing was in the early 1980s in a graduate course at the University of Montana. Our professor was highly observant and intuitive. We would huddle together around an old cassette player and listen to fresh new recordings of graduate students interviewing perfect strangers. Typically, after listening to about two sentences our professor would hit the pause button and prompt us: "Tell me about this person."

We didn't know anything, but would offer limited descriptions like "She sounds perky" or "He says he's from West Virginia." He would then regale us with predictions. "Listen to her voice," he would say, "she's had rough times." "She's depressed, she's been traumatized, and she's come to Montana to escape."

The eerie thing about this process was that our professor was often correct in what seemed like wild predictions. These sessions taught us to respect the role of astute observations, experience, and intuition in clinical interviewing.

Good intuition is grounded on theoretical and practical knowledge, close observation, clinical experience, and scientific mindedness. Bad intuition involves personalized conclusions that typically end up being a disservice to clients. Upon reflection, perhaps one reason we ended up writing and revising this book is to provide a foundation for intuition. In fact, it's interesting that we rarely mention intuition in this text. Although one of us likes to make wild predictions of the future (including predictions of the weather on a particular day in Missoula, Montana, about three months in advance), we still recognize our limitations and encourage you to learn the science of clinical interviewing before you start practicing the art.

LANGUAGE CHOICES

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

Patient or Client or Visitor

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

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

Sex and Gender

Consistent with Alfred Adler, Betty Freidan, contemporary feminist theorists, and American Psychological Association (APA) style, we like to think of ourselves as promoting an egalitarian world. As a consequence, we've dealt with gender in one of two ways: (1) when appropriate, we use the plural *clients* and *their* when referring to case examples; and (2) when necessary, we alternate our use between *she* and *he*.

Interviewer, Psychotherapist, Counselor, or Therapist

While working at a psychiatric hospital in 1980, John once noticed that if you break down the word *therapist* it could be transformed into the-rapist. Shocked by his linguistic discovery, he pointed it out to the hospital social worker, who quipped back, "That's why I always call myself a counselor!"

This is a confusing issue and difficult choice. For the preceding four editions of this text we used the word *interviewer* because it fit so perfectly with the text's title, *Clinical Interviewing*. However, we've started getting negative feedback about the term. One reviewer noted that he "hated it." Others complained "It's too formal" and "It's just a weird term to use in a text that's really about counseling and psychotherapy."

Given the preceding story, you might think that we'd choose the term *counselor*, but instead we've decided that exclusively choosing *counselor* or *psychotherapist* might inadvertently align us with one professional discipline over another. The conclusion: Mostly we use *therapist* and occasionally we leave in the term *interviewer* and also allow ourselves the freedom to occasionally use *counselor*, *psychotherapist*, and *clinician*.

WHAT'S NEW IN THE FIFTH EDITION?

As the world changes, our understanding of the world needs to change as well. In this fifth edition, we've worked to make the content accessible, culturally tuned-in,

accurate, and sometimes provocative. We've made our examples more current and relevant to the technological and diagnostic changes witnessed in recent years.

Although there are too many minor changes to list, here are the 19 biggest changes:

1. All chapters have been revised and updated using feedback from over 50 graduate students and professors from various disciplines throughout the United States.
2. Chapters 1, 2, 3, 4, 7, 8, and 9 now include Video Resource Center (VRC) call-outs. These call-outs provide instructors with suggestions about where material from the new accompanying Clinical Interviewing VRC might be included.
3. Chapter 1 includes a new section on developing a multicultural orientation and the three principles of multicultural competency.
4. Consistent with an evidence-based approach, there's a greater emphasis on collaborative goal setting and the client as expert beginning in Chapter 2 and throughout the text.
5. Within the context of professional attire, Chapter 2 also includes a new section on cleavage.
6. Chapter 3 includes a new multicultural highlight focusing on eye contact and including contrasting views on the subject between two professional Black or African American females, as well as new material on summarization and a new section on immediacy.
7. In response to reviewer feedback, Chapter 4 has been reorganized into two sections. Section One is Using General and Therapeutic Questions, and Section Two is Directive Interviewing Techniques. Additional content has been added on Adler's "The Question" as well as the four main questions of reality therapy. There's also a new Putting It in Practice feature titled A General Guide to Using Stages of Change Principles in Clinical Interviewing.
8. Chapter 5 has been substantially reorganized to shift its emphasis from theory-based relationship factors to research-supported evidence-based relationships.
9. In Chapter 6 we've added a section on personalismo and making cultural connections. A new Putting It in Practice on developing an informed consent form is included. There's also a new Multicultural Highlight focusing on a universal exclusion criterion for mental disorders and new content on developing case formulations.
10. Chapter 7 includes a new section on Reviewing Goals with Clients.
11. Chapter 8 includes a new section on the Dangers of Single Symptom Generalizations. There's also new content on flashbacks, memory, and on writing the mental status examination report.
12. A new Putting It in Practice on the latest acronym for suicide risk (IS PATH WARM) is featured in Chapter 9. The chapter is substantially updated with a greater emphasis on the interpersonal theory of suicide. A new Putting It in Practice designed to help beginning clinicians become more comfortable talking about suicide with clients is also included.
13. Chapter 10 has been reorganized and rewritten to correspond with *DSM-5* and now also emphasizes case formulation and treatment matching variables in addition to treatment planning.

14. The last several chapters were reordered, with Chapter 11 now becoming the Multicultural Interviewing chapter. Chapter 11 now includes a new section on professional issues.
15. Chapter 12 includes a new Table: A General Guide to Violence Assessment. It also has undergone a major rewrite to more completely clarify the nature and process of working in crisis situations, including a description of psychological first aid.
16. Chapter 13 has a new emphasis on preparation for working with youth, including a section on limit setting in the session.
17. Chapter 14 has a new Multicultural Highlight, focusing on helping new clinicians expand their comfort zone when working with sexuality issues.
18. Chapter 15 is a new chapter focusing on online and non-face-to-face interviewing formats.
19. All chapters have been updated to include the most recent research and practice as it pertains to clinical interviewing.

Using the Video Resource Center (VRC) That Comes With This Text

This fifth edition of *Clinical Interviewing* has an accompanying videos hosted online at the VRC designed to bring interviewing skills described in this text to life. If you decide to use the videos to supplement your learning, you should be aware of two things:

First, the videos are not scripted. Instead of writing out a script to make sure we covered every possible skill in exactly the right order, we decided it would be a better learning tool for you to see us and our colleagues engaging in live and unscripted interviewing interactions. This was a judgment call, and some readers may wish for a more mechanical teaching and learning resource. However, after watching a number of other videos designed to help teach interviewing, counseling, and psychotherapy skills, we decided reality was more engaging than play acting. In the end, although volunteer clients and therapists were provided with guidelines and outlines about what to cover, the recorded interactions are spontaneous. The result: Sometimes specific techniques are illustrated out of sequence. For example, in the Basic Listening Skills demonstration featuring Maegan Hopkins as the counselor, Maegan demonstrates the use of an open question . . . even though basic listening skills are the focus in Chapter 3 and questions aren't covered until Chapter 4.

Second, the VRC is organized in a way that allows you to access specific content as needed.

The videos are divided into eight sections. Each section shows us discussing a topic and introducing the upcoming counseling demonstration vignette. However, if you prefer to skip our *exciting* discussions and introductory comments, you can watch the 15 different specific counseling demonstrations.

To help you identify places in the text that are linked to particular video content, we have two different forms of call-outs. The first type of call-out indicates where it might be beneficial to watch a specific video section in which we discuss a skill and introduce a counseling demonstration. The second type of call-out links particular text sections with specific counseling demonstrations. Access to the Clinical Interviewing DVD can also be purchased separately at

www.wiley.com/go/videoresourcecenter. However you use it, we hope you find the VRC helpful to the teaching and learning process.

Using the Online Instructor's Manual and Ancillary Materials

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

- An online Instructor's Manual, coauthored with Lindsey Nichols, Ph.D., that has supplementary lecture material, discussion questions, and classroom demonstrations and activities.
- A test bank, coauthored with Emily Sidor, M.A., that has over 40 test items for each chapter.
- A downloadable set of generic PowerPoint slides geared to the textbook chapters.

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Like raising children, producing a textbook requires a small village. We have many people to thank.

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Photo courtesy of Todd Johnson, University of Montana.

John Sommers-Flanagan, PhD, is a clinical psychologist and professor of counselor education at the University of Montana. He has been a columnist for the *Missoulian* newspaper, a local public radio show co-host of "What Is It with Men?," and is coauthor of over 50 professional publications. John is a long-time member of both the American Counseling Association and the American Psychological Association and regularly presents professional workshops at the annual conferences of both these organizations.

Rita Sommers-Flanagan, PhD, has been a professor of counselor education at the University of Montana for the past 21 years. Her favorite teaching and research areas are ethics and women's issues, and she served as the director of Women's Studies at the University of Montana, as well as the acting director of the Practical Ethics Center. She is the author or co-author of over 40 articles and book chapters, and most recently authored a chapter entitled "Boundaries, Multiple Roles, and Professional Relationships" in the new *APA Handbook on Ethics in Psychology*. She is also a clinical psychologist, and has worked with youth, families, and women for many years.

John and Rita work together as the mental health consultants for Trapper Creek Job Corps. They also enjoy providing seminars and professional presentations nationally and internationally.

Together, John and Rita have coauthored nine books, including books aimed at helping mental health professionals work more effectively with their clients. These include:

- *How to Listen so Parents Will Talk and Talk so Parents Will Listen* (Wiley)
- *Tough Kids, Cool Counseling* (American Counseling Association)
- *Problem Child or Quirky Kid* (Free Spirit Press)
- *The Last Best Divorce Book* (Families First)
- *Don't Divorce Us!* (American Counseling Association; also available in Turkish, co-authored with Senel Poyralzi)

John and Rita have also written two other textbooks with John Wiley & Sons. They are:

1. *Counseling and Psychotherapy Theories: In Context and Practice, Second Edition*
2. *Becoming an Ethical Helping Professional*

John and Rita have two daughters, one son in-law, twin grandbabies, and can hardly believe their good fortune. They are deeply rooted in Montana, and in the summers, alternate writing with irrigating and haying on the family ranch. Both John and Rita enjoy professional speaking, exercising, gardening, exploring alternative energy technologies, and restoring old log cabins, old sheds, and any other old thing that crosses their path—which, given the passage of time, is now starting to include each other.

PART ONE

Becoming a Mental Health Professional

CHAPTER

1

Introduction: Philosophy and Organization

CHAPTER OBJECTIVES

This chapter welcomes you to the professional field of clinical interviewing and orients you to the philosophy and organization of this book. After reading this chapter, you will understand:

- The philosophy and organization of this book.
- How becoming a mental health professional can be both challenging and gratifying.
- The authors' teaching philosophy.
- An effective learning sequence for acquiring clinical interviewing skills.
- How clinicians from different theoretical orientations approach the interviewing task.
- Why and how a multicultural orientation to interviewing can be useful.
- Advantages and disadvantages of being nondirective in your interviewing approach.
- Your potential cultural biases when interviewing.
- The goals and objectives of this book.

Imagine sitting face-to-face with your first client. You carefully chose your clothing. You intentionally arranged the seating, set up the video camera, and completed the introductory paperwork. You're doing your best to communicate warmth and helpfulness through your body posture and facial expressions. Now, imagine that your client:

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

Any and all of these responses are possible in an initial clinical interview. If one of these scenarios plays out, how will you respond? What will you say? What will you do?

From the first client forward, every client you meet will be different. Your challenge or mission (if you choose to accept it) is to make human contact with each client, to establish rapport, to build a working alliance, to gather information, to instill hope, and, if appropriate, to provide clear and helpful professional interventions. To top it off, you must gracefully end the interview on time and sometimes you'll need to do all this with clients who don't trust you or don't want to work with you.

These are no small tasks—which is why it's so important for you to remember to be patient with yourself. This is only the beginning of your developmental journey toward becoming a mental health professional.

As a prospective psychologist, professional counselor, psychiatric nurse, social worker, or psychiatrist, you face a challenging and rewarding future. Becoming a mental health professional requires persistence and an interest in developing your intellect, interpersonal maturity, a balanced emotional life, counseling/psychotherapy skills, compassion, authenticity, and courage. Many classes, supervision, workshops, and other training experiences will pepper your life in the coming years. In fact, due to the ever-evolving nature of this business, you will need to become a lifelong learner to stay current and skilled in mental health work. But rest assured, this is an exciting and fulfilling professional path (Norcross & Guy, 2007). As Norcross (2000) stated:

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

The clinical interview may be the most fundamental component of mental health training (Jones, 2010). It is the basic unit of connection between the helper and the person seeking help. It is the beginning of a counseling or psychotherapy relationship. It is the cornerstone of psychological assessment. And it is the focus of this book.

WELCOME TO THE JOURNEY

This book is designed to teach you basic and advanced clinical interviewing skills. The chapters guide you through elementary listening skills onward to more advanced, complex professional activities such as intake interviewing, mental status examinations, and suicide assessment. We enthusiastically welcome you as new colleagues and fellow learners.

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

In his 1939 classic, *The Wisdom of the Body*, Walter Cannon (1939) wrote:

> When we consider the extreme instability of our bodily structure, its readiness for disturbance by the slightest application of external forces . . . its persistence through so many decades seems almost miraculous. The wonder increases when we realize that the system is open, engaging in free exchange with the outer world, and that the structure itself is not permanent, but is being continuously broken down by the wear and tear of action, and as continuously built up again by processes of repair. (p. 20)

This observation seems equally applicable to the psyche. The psyche is also impermanent, permeable, and constantly interacting with the outside world. As most of us would readily agree, life brings many challenging experiences. Some of these experiences psychologically break us down and others build us up. The clinical interview is the entry point for most people who have experienced psychological or emotional difficulties and who seek a therapeutic experience to repair and build themselves up again.

Teaching Philosophy

Like all authors, we have underlying philosophies and beliefs that shape what we say and how we say it. Throughout this text, we try to identify our particular biases and perspectives, explain them, and allow you to weigh them for yourself.

We have several biases about clinical interviewing. First, we consider clinical interviewing to be both art and science. We encourage academic challenges for your intellect and fine tuning of the most important instrument you have to exercise this art: yourself. Second, we believe that the clinical interview should *always* be designed to facilitate positive client development. Reasons for interviews vary. Experience levels vary. But as Hippocrates implied to healers many centuries ago, we should work very hard to *do no harm*.

We also have strong beliefs and feelings about *how* clinical interviewing skills are best learned and developed. These beliefs are based on our experiences as students and instructors and on the state of scientific knowledge pertaining to clinical interviewing (J. Sommers-Flanagan & Heck, 2012; Stahl & Hill, 2008; Woodside, Oberman, Cole, & Carruth, 2007). The remainder of this chapter includes greater detail about our teaching approach, theoretical and multicultural orientation, and the book's goals and objectives.

Learning Sequence

We believe interviewing skills are acquired most efficiently when you learn, in sequence, the following skills and procedures:

1. How to quiet yourself and focus on what your client is communicating (instead of focusing on what *you* are thinking or feeling).
2. How to establish rapport and develop positive working relationships with a wide range of clients—including clients of different ages, abilities and disabilities, racial/cultural backgrounds, sexual orientation, social class, and intellectual functioning.

3. How to efficiently obtain valid and reliable diagnostic or assessment information about clients and their problems.
4. How to appropriately apply individualized counseling or psychotherapy interventions.
5. How to evaluate client responses to your counseling or psychotherapeutic methods and techniques (outcomes assessment).

This text is limited in focus to the first three skills listed. Extensive information on implementing and evaluating counseling or psychotherapy methods and techniques (items 4 and 5) is not the main focus of this text. However, we intermittently touch on these issues as we cover situations that clinicians may face.

Quieting Yourself and Listening to Clients

To be effective therapists, mental health professionals need to learn to quiet themselves; they need to rein in natural urges to help, personal needs, and anxieties. This is difficult for both beginning and experienced therapists. We still need to consistently remind ourselves to hold off on giving advice or establishing a diagnosis. Instead, the focus should be on listening to the client and on turning down the volume of our own internal chatter and biases.

Quieting yourself requires that you be fully present to your client and not distracted by your own thoughts or worries. Some students and clinicians find that it helps to arrive early enough to sit for a few minutes, clearing the mind and focusing on breathing and being in the moment.

In most interviewing situations, listening nondirectively is your first priority, especially during beginning stages of an interview. For example, as Shea (1998) noted, "... in the opening phase, the clinician speaks very little ... there exists a strong emphasis on open-ended questions or open-ended statements in an effort to get the patient talking" (p. 66).

Quieting yourself and listening nondirectively will help you empower your clients to find their voices and tell their stories. Unfortunately, staying quiet and listening well is difficult because, when cast in a professional role, many therapists find it hard to manage their mental activity. It's common to feel pressured because you want to prove your competence by helping clients resolve their problems immediately. However, this can cause you to unintentionally become too directive or authoritative with new clients, and may result in them shutting down rather than opening up.

When students (and experienced practitioners) become prematurely active and directive, they run the risk of being insensitive and nontherapeutic. This viewpoint echoes the advice that Strupp and Binder (1984) gave to mental health professionals three decades ago: "... the therapist should resist the compulsion to do something, especially at those times when he or she feels under pressure from the patient (and himself or herself) to intervene, perform, reassure, and so on" (p. 41).

In a majority of professional interview situations the best start involves allowing clients to explore their own thoughts, feelings, and behaviors. When possible, therapists should help clients follow their own leads and make their own discoveries (Meier & Davis, 2011). We consider it the therapist's professional responsibility to *encourage* client self-expression. On the other hand, given time constraints commonly imposed on therapy, therapists also are responsible for *limiting* client