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The Clinical Interview

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THERE ARE VARYING TYPES of trauma and various ways in which patients experience and cope with trauma. Trauma can be a single occurrence, such as a natural or man-made disaster, or it can be experienced in a repeated fashion over many months or years before coming to the attention of a mental health professional. Patients who experience trauma may present for the initial interview in a variety of settings, including the emergency department, a pediatrician's office, or an outpatient mental health clinic, or they may even present to a school counselor or other school authority. When a child or teenager is the patient, he or she may have been referred or brought in for a treatment by an adult rather than of his or her own accord. In fact, sometimes the patient will not understand why he or she has been brought in for an evaluation, the purpose of the session, or the role of the clinician. In this chapter, I explore the clinical interview in detail, reviewing the key components of the interview, providing clinical examples, and addressing ways to prepare for and deal with common obstacles.

Building Rapport

The most important initial step of the first encounter is to establish rapport with the patient. The strength of the therapeutic alliance is vital in gathering critical and sensitive information and also sets the tone for progress in the therapy that follows the initial interview. The clinician will establish rapport in different ways, depending on the age of the patient and the type of therapy, and these will be elaborated in further detail later in this chapter and in the book. The clinician should give an introduction of his or her role and prepare the patient for what will happen during the course of the initial session (King et al. 1997; Stubbe 2007). Many mental health professionals will forgo their traditional title followed by last name and use only their first name to help put younger patients at ease. Other providers feel that using their title, such as "doctor," actually allows the patient to feel more secure, knowing they are talking to a person whom they can trust and who is designated to help.

Choosing a setting for the session that helps the patient to feel calm and safe is ideal although not always possible. The intention is to reassure the patient that he or she will be accepted so that the patient can share any of his or her thoughts and feelings without fear of judgment, criticism, shame, or stigmatization. Projecting a feeling of warmth, empathy, and sensitivity is essential and is done with both verbal and nonverbal communication (Manley 2000). The patient should be informed of the benefits and bounds of confidentiality so that he or she may speak freely. The clinician should allow the patient to initiate the exchange, following his or her lead, and encouraging further elaboration with open-ended questions (Carlat 2012). Younger patients may need the clinician to initiate the discussion or begin with a game, activity, or free play. Sometimes, a clinician will conduct the interview independently, but in other settings a multidisciplinary team, including a psychologist, social worker, marriage and family therapist, and/or psychiatrist will conduct the interview together. Obviously, the number of clinicians in the room at a given time can have an impact on rapport, and this should be taken into consideration.

Gathering a Thorough History

Obtaining a Patient's History

During the initial clinical interview, it is important to obtain a detailed history of the patient's background, both biological and psychosocial. When

working with children and teenagers, information from parents, guardians, or other adults involved in their lives (e.g., teachers, pediatrician) will be vital. The purpose of meeting with the parent or guardian is not only to obtain details about the patient's current functioning and history but also to better assess the functioning of the parents and family as a whole (King et al. 1997). For younger children, gathering history from the parent(s) or guardian should be completed first. For teenagers, the decision of whom to meet with first will vary on the basis of the patient's comfort and maturity level. Patients should always be given time to meet with the clinician individually because there may be information that the patient does not feel comfortable disclosing in front of the parent or guardian. Discrepancies between the parent and child perspectives should be noted and explored further.

Items of history that should be covered in the initial intake are detailed in the following subsection, and clinical examples will be provided later in the chapter. It is worth noting that this information need not be covered in exactly this order nor in a single session, but obtaining basic information early in the course of treatment will help in clarifying the diagnosis and determining the best initial plan for ongoing care. Additionally, the clinician need not cover every symptom in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association 2013) but rather should begin with basic screening questions and use his or her judgment to further pursue areas that seem most relevant (King et al. 1997). In addition to the clinical interview, the clinician may also choose to administer other screening or assessment tools as part of the initial assessment.

Key Elements of the Patient's History

- *History of the present illness:* The clinician should obtain further details about the patient's primary complaint or reason for seeking treatment.
- *Previous psychiatric history:* The clinician should gather information about previous courses of psychotherapy, any previous psychiatric hospitalizations or suicide attempts, and any previous trials of psychotropic medication (including details about efficacy of medication and any adverse reactions).
- *Past medical history:* Often elicited by a psychiatrist or other medical doctor, the past medical history includes information about any acute, chronic, or severe physical illnesses; surgical procedures; or head injuries. In addition, information about over-the-counter medicines or

supplements, non-psychotropic medications, and allergies is also reviewed.

- *Family history:* The presence of mental health disorders or symptoms, including a history of trauma, in any family members is also important to obtain because both environmental and genetic factors can influence the patient's symptoms and response to treatment.
- *Birth and development:* Information about the health and care of the mother of the patient during pregnancy, as well as any complications or concerns that occurred during delivery, should be recorded. Notable pieces of the patient's early development such as temperament as a baby, feeding (including whether or not the patient was breastfed and the duration), motor and speech development, and challenges with separation from primary caregiver(s) are important as well. This information may not be available depending on the age of the patient and whether or not the biological parents are still involved in the patient's care.
- *Social history:* The social history includes information about where and with whom the patient resides, including any changes in residence or caregivers. Identification of key social supports (both family and community) and quality of friendships and peer relationships is useful. For children and adolescents, the clinician should obtain an educational history, including where the patient attends school, his or her current grade, and current academic standing. For adult patients or parents of younger patients, information about occupation and financial stability are relevant. Information about any extracurricular activities, hobbies, and cultural or religious affiliations also provides a picture of who the patient is and how he or she relates to the surrounding social environment. If the patient or family has any legal history or current involvement with the legal system, this would also be important to document.
- *Trauma history:* Although some patients come to the clinic specifically seeking support related to a traumatic experience and reveal this at the outset, it is not uncommon for patients to refrain from revealing any history of traumatic events until later in the course of treatment. Given the sensitivity of the topic, it is often necessary to establish trust between the patient and therapist before the patient feels comfortable disclosing a trauma history. Regardless, the clinician should inquire about a history of trauma during the initial clinical session. The clinician must find a balance between directness and softness when asking about trauma so as not to stigmatize patients while also helping them feel reassured that therapy will be a safe place to talk about anything.

- *Substance use:* Use of illicit substances (alcohol, street drugs) or misuse of prescription drugs can co-occur with other mental health symptoms. It is necessary to know which substances the patient uses currently or has tried in the past and the frequency and duration with which each substance is or was used.

Assessing the Patient's Mental State

The Mental Status Examination

In addition to a thorough history, observations about the patient's mental state should be recorded. As a complement to the history, the mental status examination gives the practitioner a picture of who the patient is and how he or she interacts with the surrounding world. The key elements of the examination, as detailed by Manley (2000), are listed in the following subsection. The clinician can use the examination to determine whether or not the patient is behaving in a developmentally appropriate way. Abnormalities in the mental status examination may be suggestive of a trauma history, even if the history is not obviously concerning, and warrants further clinical assessment. The mental status examination is of particular importance in patients who, because of age (or other reasons), are unable to thoroughly articulate a trauma history in words. Clinical examples of mental status examinations will be provided later in the chapter.

Key Elements of the Mental Status Examination

- *Appearance:* Important information about the patient can be obtained by simply taking note of his or her attire, grooming, and hygiene. The patient's general weight and stature, as well as whether or not his or her appearance matches the stated biological age, should also be noted.
- *Speech:* The clinician should observe the tone, rate, volume, and amount of the patient's speech as well as whether the patient's speech is spontaneous or whether he or she only gives brief responses to questions without elaboration or detail. The patient's speech may be pressured, making it difficult for the clinician to speak or interrupt, or there may be a delay in responses for a variety of reasons. The prosody,

or patterns of intonation, is also important. The patient's vocabulary is worth noting because, again, it can provide clues about the patient's developmental age and whether or not it appropriately matches the biological age.

- *Behavior:* The patient's movements, facial expression, and eye contact are key components of behavior that need to be documented. If the patient is fidgeting or unable to sit still or if he or she moves slowly or minimally, with a downcast gaze and no eye contact throughout the session, these items would be important to note as well as whether these behaviors occur throughout the session or only when discussing particular topics.
- *Affect:* Noting affect requires the clinician to infer the internal emotion of the patient on the basis of the patient's demeanor, facial expression, and other objective observations.
- *Mood:* The clinician should note the patient's subjectively stated emotions.
- *Thought:* The clinician needs to note both the patient's thought process, whether linear and logical or aberrant (e.g., following tangents with or without returning to the topic of discussion, moving quickly from one idea to another, jumping from one topic to another without any clear association), and the content of the thought, including suicidal or homicidal thoughts, bizarre or paranoid delusions, or any obsessions.
- *Perception:* The clinician should note how the patient perceives the world around him or her. This includes instances in which the patient perceives things that are not real as if they were real, as with auditory and visual hallucinations, illusions, and perceptions that others are not who they say they are or are reading or controlling the patient's mind.
- *Cognition:* Components of the patient's cognition include orientation (to his or her own person, current location, and current time), memory (immediate, recent, and remote), concentration (ability to attend to the session and engage in the interview without distraction), abstract reasoning (ability to apply general concepts to specific situations), and fund of knowledge (which will vary with age).
- *Insight:* The clinician should be able to assess the patient's ability to "recognize and understand his or her own symptoms" via direct questioning and/or observation over the course of the clinical interview (Manley 2000).
- *Judgment:* Through both questions and observation, the clinician should try to determine the patient's level of judgment. This is the pa-

tient's ability to make and follow through on appropriate and safe choices about a particular course of action, using whatever information is available to him or her. Like affect, assessment of a patient's judgment is generally inferred rather than directly measured.

Family Evaluation

In addition to meeting with the patient and caregivers individually, the clinician should meet with the entire family together, which also provides useful information. It is important to observe the interaction between each caregiver and the child and between caregivers in the child's presence. Things to pay close attention to include how attuned the caregivers are to the child, whether or not they are able to show empathy for and curiosity about their child, and whether they allow space for the child to express himself or herself without intrusion or censorship. The interviewer can observe the child's attachment to the caregiver, which is expected to be different at various developmental stages. For example, a preschool-age child would be expected to explore the surrounding environment while intermittently looking to the caregiver for his or her involvement and feedback, whereas an adolescent may be more withdrawn and less talkative when a caregiver is present. It is important to note how the caregiver responds to high expressed emotion in the child and if the caregiver is able to manage his or her own emotions in that context. If there are concerns during the evaluation of the family, this can inform decisions about future treatment, including the need for individual or couples therapy for caregivers, dyadic therapy with the caregiver and child, or family therapy.

Assessing the family as a whole also aids in screening other members of the family for symptoms of posttraumatic stress disorder (PTSD), particularly if they were exposed to the same trauma as the patient (Box 1–1). If PTSD in the caregivers is missed, it can impact the progress of treatment for the patient because healthy caregivers and a stable home environment are essential to the child's mental health. If there are siblings or other extended family members living in the home who are involved in the patient's life, their participation in the assessment process may also be valuable, although this can happen at a later stage in the treatment. With young adults, the patient's autonomy and independence must be recognized and prioritized, but it may be appropriate to involve family members in the evaluation of these patients as well, particularly if the young adult is still living at home with his or her nuclear family.

Diagnostic Criteria

Although the initial interview should be comprehensive, for the purpose of this book it is worth reviewing the DSM-5 criteria for posttraumatic stress disorder (Box 1–1).

Box 1–1. DSM-5 Diagnostic Criteria for Posttraumatic Stress Disorder

Posttraumatic Stress Disorder

Note: The following criteria apply to adults, adolescents, and children older than 6 years. For children 6 years and younger, see corresponding criteria below.

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

   1. Directly experiencing the traumatic event(s).
   2. Witnessing, in person, the event(s) as it occurred to others.
   3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
   4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse).

      Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

   1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).

      Note: In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.

   2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).

      Note: In children, there may be frightening dreams without recognizable content.

   3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)

      Note: In children, trauma-specific reenactment may occur in play.

4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:

1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).
2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined").
3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
5. Markedly diminished interest or participation in significant activities.
6. Feelings of detachment or estrangement from others.
7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
2. Reckless or self-destructive behavior.
3. Hypervigilance.
4. Exaggerated startle response.
5. Problems with concentration.