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Before the Initial Interview

Mrs. Escutia's voice quivers nervously over the phone line at a community counseling clinic, "I must speak to a counselor . . . please!" she exclaims. "My grandson is in trouble, he needs help. I don't know what to do any more. I'm afraid he could. . . ." The clinic intake worker jots down a few notes and quickly calls up one of the clinic's family therapy interns. "I've got a woman on the phone whose grandson just killed a hamster with a shovel," the intake worker says. "Can you take her?" For a brief moment, the new client and the new intern share a silent space filled with questions and anxieties. The first contact is about to take place, and it can easily make or break a future collaboration where healing work can be done.

DEALING WITH FAMILIES' EXPECTATIONS AND ANXIETIES ABOUT THERAPY

Were it possible to stop action, as we have done in the preceding case material, we would capture a glimpse of one of the most critical periods of the therapeutic experience—before therapy ever begins. It is during this fragile period that prospective clients decide if they want to risk going to therapy. While clients with previous positive therapy experiences may reinstate treatment with a hopeful attitude, others have ambivalent hopes, expectations, and fears about beginning therapy.

Consider Mrs. Escutia. In her family, problems have traditionally been handled by husbands and wives, aunts and uncles, grandpa long-time friends, and others who are close to the family hearth. Her anxiety

about calling in "professional" help is matched only by her concern for her grandson, whose violent temper has pushed the entire family past its limits. With no previous experience in therapy, she wonders what a stranger in this clinic could possibly do to help—after all, everything has been tried! Will this counselor believe her? How should she present this terrible dilemma? Will anyone out there really care? Does seeking help mean she has failed?

It is not uncommon for families to be at their wit's end when they finally decide to seek treatment or are otherwise referred and call for an appointment. Chances are they're worn out, fed up, and feeling hopeless. Further, individual family members may differ remarkably in their attitudes, expectations, and motivations regarding a try at therapy. They may have both overt and covert reasons for coming to therapy, and rarely are the family members' reasons the same. Uncovering much of this information may not occur until the first interview or even beyond, but it is a good idea to keep the following questions in mind right from the first contact:

"What are the clients' expectations about therapy?"

"What are their anxieties about coming to therapy?"

"What motivates them to come to therapy, and who is the referral source?"

"Why do they want to come to therapy now?"

If the therapist isn't aware of the often hidden issues related to clients' motivation, expectations, and anxieties, he or she may inadvertently respond in a manner that causes clients to decide that therapy is not worth the risk, or, conversely, that leads to accepting clients who might be better served elsewhere. For example, beginning therapists may find themselves drawn into legal cases that involve divorce, custody, adoption, or numerous other types of litigation. Family therapists are seldom trained in the specifics of mediation or custody evaluation, and, for most of us, it is best to decline doing therapy in such situations.

Even in cases where therapy is clearly indicated and doesn't involve potential legal tangles, family members' reasons for starting treatment and levels of motivation are important to assess. In individual work, these issues may be less salient because rarely do individuals come to therapy without wanting to be there. Conjoint treatment presents a different picture. For example, in couple therapy there is often one person who is more motivated to come to therapy or at least views therapy as an effective method for dealing with relationship problems. The partner may be resistant to treatment, have other preferred solutions for addressing marital issues, or be willing to come to therapy only if it is framed as a way to "help my partner" or "save the marriage."

With families, reasons and motivations for therapy vary further. Perhaps one powerful family member is coercing others to attend. Perhaps the safety of a "neutral" therapist and a scheduled weekly hour is necessary for a family to talk together about personal and significant issues. In addition, referral sources and previous treatment are absolutely crucial to consider when gauging family members' diverse responses to seeing a therapist. Court-ordered treatment may indicate a potentially resistant or reluctant client, though this is by no means the rule. Referrals by school counselors, ministers, physicians, or family friends will likely influence how families first approach treatment. For example, family members may not agree with a school counselor's view of "the problem" and as a result have little investment in seeking therapy. On the other hand, such a referral from a perceived "professional" may be just the validation the family needs to actively seek help. Similarly, the nature of previous contacts with other agencies or individuals may predispose a family to have enormous expectations for therapy, or none at all. Since these rarely articulated expectations and anxieties will alter how a therapist approaches treatment with a new family, it is essential to get a "feel" for them from the outset.

Clients like Mrs. Escutia will have as many questions swirling about as the therapist does when the first contact is made. Topping the list may be concerns about the therapist's ability to truly understand and care, and questions about whether he or she can actually help. Clients may find answers to these questions in how quickly their phone calls are returned or in their sense that the listener understands a brief explanation of the problem. The therapist's (or agency's) flexibility in responding to individual needs communicates answers to these questions. The degree of focus on charges and payments versus listening to the client may communicate that the client is not a priority—money is. If the client decides, via these early perceptions, that the therapist doesn't care or can't help, the initial session may never happen. On the other hand, an initial call that relays empathy and confidence can begin to create the foundation upon which a successful therapy can be built.

SUGGESTIONS FOR INITIAL CONTACT WITH THE CLIENT

Keeping in mind the myriad expectations, anxieties, and questions of potential clients, therapists can be guided through the first-time telephone conversation by using a number of pragmatic suggestions for handling initial contacts:

1. *Listen and reflect to the client what you hear.* Simply by listening and briefly reflecting what is said, you can help the prospective client feel

he has been heard. Effective listening can be done in 5 minutes and the client can hang up with a new sense of hope about resolving the problem.

2. *Assess if this is a crisis situation.* The initial phone call may indicate a need for immediate crisis intervention, hospitalization, removal of family members from the home, and/or involvement of other agencies such as police or child protective services. Therapists should be knowledgeable about the clinic's or agency's protocol for handling crises, and of community or state laws that may apply (e.g., child abuse reporting laws).

3. *Consider scope-of-practice issues.* Do you have the knowledge and experience to diagnose and treat the presenting problem? Some agencies carefully screen the clients that beginning therapists treat. For example, a problem that is primarily biomedical, one that involves suicide risk or serious drug and alcohol use, or a purely individualized problem (such as a phobia) may not be within the scope of practice for a marriage and family therapist. You can begin clarifying your strengths and limits immediately.

4. *Respond as promptly as possible.* Return phone calls, set up the initial session, and complete an assessment as quickly as you can. These behaviors indicate that you take the client's concerns seriously and are competent to respond to his or her needs. You create a sense of credibility and ensure the client that you can help early on.

5. *Consider why this particular family member made the initial contact and keep in mind that a sense of rapport with each individual in the family is important.* Therapists often make several mistakes around this issue. It is easy to be drawn to the most "psychologically minded" or powerful client and inadvertently ignore those who are likely part of the problem as well as part of the solution. Before the first session, the family member who made the phone call is in essence the family spokesperson. However, the therapist may want contact with other family members before the first session. The goal of additional phone contacts is to make sure every family member feels welcome and knows that their feelings and ideas matter to the therapist.

6. *Address the "business" of therapy as quickly and efficiently as possible while not detracting from the client's need to be heard.* Basic explanations about fees and payment, how to make appointments, and policies about keeping and canceling appointments are important. Transportation issues are relevant for many families, too. Do the clients have a car, or someone who can drive them to appointments? Must they navigate and pay for public transportation? Do they have directions to the clinic? What about family work and school schedules? Do they have childcare, if this is needed? Addressing such concerns up front can assist the therapist and family in avoiding no-shows and cancellations due to logistic problems that were never worked out. Issues such as informed consent and confidentiality may be dealt with on the telephone, or more

frequently through mailed information or forms provided at the clinic just before the first session. (Chapter 3 addresses these issues in detail.) Regardless of how this information is communicated, it is important to ensure that clients are clearly informed about what is expected of them and what they can expect from therapy.

7. *Limit the first contact by sticking to basic, relevant information and issues.* This is not the time to offer interventions, advice, or suggestions. Be prepared to direct the telephone interview. Prospective clients may be interested in lengthy venting of problems, in getting detailed information about your qualifications, methods, and philosophy, in obtaining an immediate diagnosis, or in any other manner of fact and opinion that, while valid, is best saved for a first meeting.

WHAT INFORMATION SHOULD BE OBTAINED?

Most agencies and therapists have an “intake” form that gathers basic information about the client during the initial contact. This information may be obtained by an “intake receptionist” or a therapist over the phone. Other possibilities include mailing the form to the client before the first session or having the client complete the form in the waiting room before the first session. Even when initial telephone contacts are time-limited and may not be as comprehensive as formal intake questionnaires, the call can still begin the processes of evaluation and joining by focusing on the following questions:

1. What is the problem and how does the client present it? Is this a crisis, a severe or moderate problem, a discrete situation, a chronic difficulty?
2. How has the family responded to the situation? How have they managed so far?
3. Has there been previous therapy?
4. Why is the family seeking treatment now?
5. What additional factors are influencing the situation (e.g., nature and frequency of various stressors—whether they are vocational, personal, physical, or otherwise)?

Figure 2.1 provides a sample intake form that reflects the information deemed most important by marriage and family therapists. The emphasis on specific information varies, depending on the training of the mental health professional. For example, most psychiatric intake forms focus on individual symptoms instead of relationships, whereas a child psychologist may include questions about a child’s prenatal history and