Interviewing Skills for Chemical Dependency Counseling

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Course Summary

This course will provide mental health professionals with an understanding of a clinical interview. It will discuss the advantages of the interview along with the major types of clinical interviews that exist. Some of the therapist behaviors that affect the interview will also be explored. Characteristics of good interviewing skills and components of good listening skills will be identified. Assessing acute alcohol or drug intoxication will also be addressed.

Course Objectives

Upon completing this course students will:

1. Be able to define what a clinical interview is
2. Understand the difference between a conversation and an interview
3. Have knowledge surrounding the different types of clinical interviews that exist
4. Understand the interview stages
5. Be able to identify characteristics of good interviewing skills and components of good listening
6. Understand the features of a Diagnostic Interview and Crisis Interview
7. Learn how to assess acute alcohol and other drug intoxication

Brief Bio:

Jamie Berman, LCSW-R, CASAC is the Admissions Director at a leading enhanced substance abuse treatment agency in Manhattan. She is a licensed social worker in the states of New York and New Jersey and a licensed psychotherapist in New York. Jamie received her Master of Social Work from Adelphi University and SIFI Certification from New York University. She is an adjunct professor of graduate studies at Touro College and a mentor to Social Work graduate students. Jamie has conducted trainings on topics such as Signs and Symptoms of Withdrawal – Detoxification Process, Interview Skill for Chemical Dependency Counseling and Assessing Client Risk for Self Harm. Jamie is a member of the National Association of Social Workers and an active member of a planning committee to provide annual state conferences for criminal justice system and treatment providers.
**Introduction**

A clinical interview is a, “Conversation with a purpose.”

http://homepage.psy.utexas.edu/homepage/ page 1, 2000. It is designed to gather information about the clients past. It is a forum to demonstrate empathic understanding. It gives the client an opportunity to develop a relationship with the therapist. A conversation has no central theme. The clients’ roles are not clearly defined and it starts and ends at will. Unlike a conversation, interviews content should achieve a specific purpose. There are defined roles between clients. A clinical interview occurs at a definitive time and place.

**The Clinical Interview**

A clinical interview is not a cross-examination but rather a process in which the interviewer must be aware of the client’s voice intonations, rate of speech, as well as non-verbal messages such as facial expression, posture, and gestures. Although, it is sometimes used as the sole method of assessment, it is more often used along with several other methods. The clinical interview serves as the basic context for almost all other psychological assessments. It is the most widely used assessment method. The advantages of the clinical interview is that it is inexpensive, taps both verbal and non-verbal behaviors, flexible, and it facilitates the building of the therapeutic relationship. When conducting an interview, it is to convey to the interviewee that you understand their feelings and attitudes. Use open-ended rather than close-ended questions to extract more information. Use language that is understandable and not offensive. It is important to avoid excessive talking about personal experiences during the interview. Allow the interviewee to use silence for reflection.
Types of Clinical Interviews

Intake Interview

The purpose of the intake interview is to uncover the immediate reasons why the client is seeking help; when did the presenting complaint become a problem and who defined it as such; and what does the client know about the services you provide and how it relates to their expectations for treatment. During this interview the client’s distortions or biases about the problem need to be examined. As the mental health provider, you must be aware of any physical/medical problems that is present. If there are any, you must consider a consulting physician for further information. As the clinician you should understand where the client’s beliefs about the origin of his/her symptoms stem from. This interview should also include any attempts the client has made to solve the problem, any strengths the client possesses that might be helpful in the process, and whether or not you as the therapist possesses the necessary competencies to help this client.

Diagnostic Interview

The purpose of a Diagnostic Interview is to arrive at a clinical diagnosis. This particular interview uses a specific diagnostic criterion. Standard structure questions are used to determine if the diagnostic criteria are met. Branching is used throughout the interview. Examples are the SCID and the ADIS.


Crisis Interview

The purpose of a crisis interview is to assist the client/family with an immediate crisis. The focus is on identifying the immediate problem and assesses lethality.
It is the job of the therapist to assist the client/patient in problem-solving ways to cope with the problem. The therapist should also assist the client/family with a referral when necessary.

**Interview Structure**

“The structure is the degree to which the interviewer determines the content and course of the conversation.” [http://web.jjay.cuny.edu](http://web.jjay.cuny.edu). Page 1. There are three different structures to speak of: Nondirective, Semi-structured, and Structured. In an non-directive interview the clinician does as little as possible to interfere with the natural flow of the client’s flow of topics. A semi-structured interview has an organized set of topics that is explored in a way that gives the interviewer flexibility in wording questions, interpreting answers, and guiding decisions about what to address next. In a structured interview the interviewer asks a series of specific questions phrased in a standard manner and presented in a uniform order; rules are consistent and are provided for scoring client’s answers; it does not however prohibit interviewers from formulating their own questions in order to clarify ambiguous responses; It does however provide specific rules about what the interviewer is permitted to do in certain situations.

**Interview Stages**

**Beginning**

The goal of the beginning stage of an interview is to develop or resume rapport with a client. The client should be made to feel as comfortable as possible. A warm, comfortable atmosphere that encourages the client to speak freely and honestly about relevant topics should be created. The therapist should appear
warm and approachable but also show the client their importance by getting down to the matter at hand in an appropriate time frame.

**Middle**

During the middle stage of an interview, the therapist should make use of non-directive as well as some directive techniques. Open ended questions should be used when appropriate. Active listening skills should be demonstrated by the therapist. When done appropriately the therapist should be able to indicate understanding and encourage further elaboration of details from the client. During this phase, the therapist should also make use of the technique known as paraphrasing. This is when the therapist restates what the client says in order to show that he/she was listening closely. This also gives the client a chance to correct any misinterpretations. This technique allows the therapist to focus in on the emotion that the client is feeling. Direct questions should be asked in a form that gets specific information but that also leaves the client free to choose their own words. Assumptions should never be made. Clients should be asked to explain how they are/were feeling. The client should also be asked what certain things mean to them. Questions that suggest answers or that assume should be avoided.

**End**

The end of an interview allows for the therapist to provide an overview of what was stated by the client along with a chance for the client to correct any misinformation or to ask any questions. It is a signal that the interview is coming to an end. It is the time when feelings are reflected to the client. Allow time for questions or clarifications or for the client to make comments. Always watch for what happens
at the end as this time often includes clinically significant behavior or information.

As much importance should be attached to this stage as to the stages that precede it.

**Communication in the Interview**

**Verbal**

Educational, social, ethnic, cultural, economic, and religious factors can impair communication. Clients may be reluctant to correct misperceptions or to ask questions if a safe environment is not created. Jargon should also be avoided. Questions should be asked in a straightforward manner. The therapist’s verbal behavior should convey patience, concern and acceptance.

**Nonverbal**

Both members of an interview send and receive non-verbal messages. The therapist should always be sensitive to incoming as well as outgoing signals. Looks for inconsistencies between verbal and nonverbal channels of communication. Be aware of your own verbal and non-verbal communications so as not to convey ambiguous messages to the client. Friendly eye-contact is encouraged. Head nodding; occasional smiling; and attentive posture should also be demonstrated. Always be genuine. If you are not comfortable then learn how to be comfortable.

**Attending Skills**

Attending skills require you to mentally step back from an interview in order to listen and observe even as you remain engaged. Attending skills and techniques include using silence; waiting and listening; Observing how someone speaks; Noting what subjects the client emphasizes/minimizes/avoids; Observing how a person sits and what gestures they use. A therapist should remain aware of self by noting the
verbal responses the client elicits from you; Noting any feeling the interview process may create in you. A therapist must be sure not to over-identify with the client. It is important to stay grounded by differentiating what you know about yourself and what you know about the client.

**Assessing acute AOD (alcohol and other drugs) intoxication**

Common signs and symptoms to look for: slurred speech, rapid speech, partially closed eyes, diminished inhibition, mood swings, loud or inappropriate behavior, shaking, nodding, problem with gait and balance, odor, red eyes, and red nose.

Many commonly abused substances can cause: delirium, delusions, hallucinations, moods disorders, anxiety disorder, persistent memory problems, sleep disturbances, and sexual dysfunction. The goal of an AOD assessment is to understand the circumstances which lead up to the client seeking/being brought into the therapist for the assessment. This may be called the presenting problem. The severity of the problem should become clear during this time and a clearer picture of the user’s background should also be identified during this time. Additional goals are for the therapist to understand the relationship between problems in other life areas and the AOD use: for example; problems caused/exacerbated by AOD use; AOD use as coping mechanism for problems. The therapist should also develop a diagnostic impression of the client’s strengths, weaknesses, problems, and needs. At this time it is also important for the therapist to determine what level of care is likely to work for the client; assess motivation for treatment; and recommend types of interventions and state why they may prove helpful.

**Chemical Dependence Assessment Points include**
• Age of onset

• Duration/frequency of use

• Administration, patterns

• Precipitators (e.g., peer pressure, depression, life crisis, increased tolerance)

• Consequence of use

• Influences and effects associated with chemical dependence

• Patient’s own perception of chemical dependence

• Self-help involvement

• Prior treatment history (e.g., detoxification, rehabilitation, outpatient treatment, etc.)

When making an evaluation focus on the nature and severity of the drug/alcohol problem by describing how it is related to other life areas. These other life areas include daily living skills, legal involvement, education/vocation, employment, family, leisure, HIV/communicable disease risk assessment, medical/health, mental health, housing, spirituality, domestic violence, other areas of importance not mentioned.

**Daily Living Skills**

Assessment point includes:

• Personal hygiene and appearance

• Money and time management

• Managing medication

• General responsibilities, i.e., paying bills, keeping home clean, keeping
Assessment methods of daily living skills must also include direct observation. This life area cannot be assessed based solely on an interview.

**Legal Involvement**

Assessment points include:

- Conviction history with DWIs
- Current/pending legal issues with scheduled court appearances
- Parole/probation status
- Precipitators
- When legal involvement will end

**Education/Vocation**

Assessment points include:

- Assessment of literacy skills
- Highest grade completed
- GED status
- Degrees obtained
- Strong and weak subjects
- Adjustment problems in school
- Learning disabilities
- Skills learned in trade school, the military or while incarcerated

**Employment**

Assessment points include:
• Work history with lengths of employment and dates
• Reasons why left employment or changed jobs
• Client’s aspirations, strengths, weakness
• Other skills which might have been obtained
• Effects of chemical dependence on job performance
• Current and past welfare/WEP/TANF involvement
• Identification as a member of the workforce

**Family**

Assessment points include:

• Indicate relationship with family members, peers and significant others
• Include impact of patient’s use of alcohol and substances on family
• Include history and impact of the use of alcohol and substances by family members, significant others and by peer group
• Family mental health history
• Family trauma issues
• Significant others in treatment
• Birth order
• Number of children
• Current and past ACS involvement
• Children in foster care
• Cultural and ethnic background
• Loss/abandonment issues

**Leisure**
Assessment points include:

- All leisure activities (past and present)
- Hobbies and interests (past and present)
- Individuals with whom the client associates
- Address activities which are isolating and do not encourage socialization

**HIV/Communicable Disease Risk Assessment**

- Knowledge of harm reduction techniques and safer sex practices
- History of tuberculosis, HIV, hepatitis, or other STDs or infectious disease
- HIV status
- Date of HIV test
- Patient’s most recent risk for exposure to HIV and STD’s
- Patient’s most recent risk for exposure to TB

All information should be corroborated via MD or hospital records.

**Medical/Health**

Assessment points include:

- Date of last physical examination
- Medical History
- Current medical problems/chronic medical conditions
- Current medications
- Smoking history
- Nutritional information including regular daily diet
• Dental history

**Mental Health**

Assessment points include:

• Patient lethality i.e. if patient is a danger to him/herself or others

• Emotional state at time of interview

• Psychiatric emergency room visits including reason/circumstances

• History of psychiatric hospitalizations including lengths of stay

• Suicide attempts

• Current treatment

• Psychiatric treatment including psychoactive medication regimen, name of prescribing physician

• Indicate current status and diagnosis of known

**Housing**

Assessment points include:

• History of homelessness

• Present living arrangements (outpatient)

• Persons living with client and whether they are active abusers or not

• Conditions of living quarters

**Spirituality**

Assessment points include:
• Past religious experiences

• Current beliefs

• Present attitudes

• What makes life meaningful to the client

**Domestic Violence**

Assessment points include:

• Past or current domestic violence issues, i.e., physical/sexual/mental/emotional abuse history

• Age abuse began

• Current emotional state

• Prior/current relationship with perpetrator

• Counseling received

• Charges filed, order of protection

• Whether perpetrated others

• Reluctance to address

**Other**

• Other relevant factors which may aid in treatment plan development

• Military history

• Veteran’s status

• Other entitlements

**Conclusion**

A clinical interview for chemical dependency should be broad in its detection of individuals who have a potential AOD abuse problem, regardless of the specific
drug or drugs being abused. Certain cognitive and behavioral signs and symptoms are associated with AOD abuse. Although many of these signs and symptoms can be the result of various medical, psychiatric, and social problems, individuals with an AOD abuse disorder generally exhibits several of them.

A person’s consumption pattern – frequency, length, and amount of use of AODs is an important marker for evaluating whether he or she has an AOD abuse problem. Patterns of AOD consumption can vary widely among individuals or even for the same individual. Although substance use disorders often consist of frequent, long-term use of AOD, addiction problems may also be characterized by periodic binges over shorter periods. (SAMSHA Tip 11)

The symptoms of preoccupation and loss of control are common in persons with substance abuse disorders. Preoccupation refers to an individual spending inordinate amount of time concerned with matters pertaining to AOD use. Loss of control over AOD use is defined by the consumption of more of the substance(s) of abuse originally intended.

Addiction invariably involves consequences in numerous areas of an individual’s life, including physical, psychological, and social domains. Examples of adverse physical consequences include experiencing black outs, injury and trauma, withdrawal symptoms or contracting infectious diseases. Adverse psychological consequences include depression, mood changes, anxiety, delusions, paranoia, and psychosis. Negative social consequences involve loss of employment, intimate relationships, friends, and legal problems. As an individual’s use continues over
time and addiction continues, adverse consequences tend to worsen. (SAMSHA Tip11)

The clinical interview for chemical dependency is only the first step in the process for clients with AOD abuse problems. When an individual with a potential AOD problem is identified through a clinical interview, the interviewer has the further responsibility of linking the individual to resources for further assessment and treatment.
References


Murphy, William Francis (1955). The Clinical Interview, 7.

Othmer, Ekkehard (1994). The Clinical Interview Using the DSM – IV

http://homepage.psy.utexas.edu/homepage/class/Psy364/Telch/Lectures/OnScreenPresentations/Interviewing/


Tip 11 -SAMHSA