

# 10

## BEHAVIORAL MEDICINE

### A Holistic Look at Health and Illness

In recent years, the mortality rate among the mental health population has skyrocketed, beyond that of the general population, as a result of primary medical conditions that go unmitigated (Brown, Bennett, Li, & Bellack, 2011; Felker, Yazel, & Short, 1996; Harris & Barraclough, 1998). In fact, Barnett et al. (2012) and Kessler et al. (2005) hypothesized that nearly 50% of clients with mental illness have at least one comorbid chronic medical disease (e.g., diabetes, hypertension, high cholesterol, stroke, asthma, cardiovascular and pulmonary disease). In response to this health care crisis, clinical mental health settings have begun to integrate primary health care services into their existing paradigm of service delivery. This shift in treatment delivery has profound implications for clinical mental health counselors in the 21st century, requiring them to have specialized knowledge, training, and skills (Council for Accreditation of Counseling and Related Educational Programs [CACREP], 2016). Thus, counselors employed in these integrated settings work well using a team-based approach, are effective communicators and coordinators of services, and have knowledge that spans across the helping disciplines (e.g., counseling, medicine, psychology, psychiatry, sociology).

We begin by shedding light on what behavioral medicine is. Next, we explore a practical application of the behavioral medicine approach in managing mental and behavioral issues in medical clients. Then we transition into how counselors can effectively communicate with both clients and providers in an integrated system of care, as well as transfer those skills when conducting client interviews. Finally, we conclude with how to motivate medical clients to engage in and sustain behavioral change across the life span.

## LEARNING OBJECTIVES

After reading this chapter, you will be able to do the following:

- Describe the major tenets of the behavioral medicine approach for medical clients with comorbid behavioral and mental health disorders (CACREP 5C-1-b)
- Identify and describe the three mechanisms of the biopsychosocial model, along with their interactions, to the contribution of disease formation and illness prevention (CACREP 5C-2-g)
- Demonstrate appropriate strategies for effectively communicating with clients and providers in an integrated system of care (CACREP 5C-3-d)
- Identify and apply a systematic approach to conducting interviews with clients diagnosed with comorbid disorders (CACREP 5C-3-a)
- Contrast the differing roles and responsibilities clinical mental health counselors experience in an integrated system of care (CACREP 5C-2-a)
- Describe the significance of self-regulation and its impact on motivating behavioral change among medical clients with comorbid behavioral and mental health disorders

## BEHAVIORAL MEDICINE APPROACH

Understanding how behaviors directly impact a person's overall health is at the foundation of the behavioral medicine approach. The word *behavioral* in behavioral medicine can be misleading and is best understood from a broader context of the whole person and the impact on the entire health system, and less in terms of the manifestation of a specific behavior. Counselors applying this approach develop interventions designed to target a specific behavior or set of behaviors in hopes of managing the debilitating effects of an illness, preventing a new illness, and improving a person's overall health and quality of life (Society of Behavioral Medicine, 2016). To help visualize the behavioral medicine approach in practice, let us examine the case of Sarah described in Case Illustration 10.1.

### CASE ILLUSTRATION 10.1

Sarah is a 55-year-old Caucasian female who identifies herself as lower-middle class. She was recently widowed, has no children, and lives

alone. She reports her major problem as feeling depressed all the time. During the third counseling session, she reports that her husband died a

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few years ago in a tragic car accident. Over the years, Sarah has gained a significant amount of weight that results in her using a wheelchair, although not all the time. She was clinically diagnosed as obese and has other health-related illness (e.g., body pains and aches, headaches, low energy, loss of interest in activities) not present prior to the death of her husband. During the initial patient interview, Sarah disclosed that she has a family history of diabetes, obesity, and other heart-related issues. Sarah and her counselor Bennett collaboratively established goals of managing her weight, increasing her physical activity, and improving her mood. Bennett worked with Sarah for 1 year on a variety of personal issues, including developing a diet and exercise regimen and managing her depression, concurrently. Sarah also met with the agency's psychiatrist and primary care physician to manage her symptoms of depression and address her medical concerns. Sarah is very sensitive about her weight; thus, the suggestion that she exercise and better manage her diet was met with resistance. Knowing this, Bennett had to approach her in a unique way. He started simple. He began with education on how healthy eating does not necessarily mean "tasteless eating."

He went grocery shopping with Sarah, taking note of how she shopped and what she bought. He observed how Sarah "doctored up" her coffee before their sessions. He noted times when she walked instead of using the wheelchair. Through learning more about Sarah's habits, Bennett offered simple suggestions such as using milk versus heavy cream and a sugar substitute instead of sugar in her coffee. On their shopping trips, Bennett suggested that Sarah buy fresh fruits and vegetables instead of frozen, knowing that it would force her to be more active in the cooking process versus her simply heating the food in a microwave. Bennett often encouraged Sarah to walk with him around the office building prior to their sessions. Individually, these suggestions of behavioral change seemed small, but in the long run, they had profound effects. At the end of Sarah and Bennett's counseling relationship, Sarah was down 15 pounds, cooked most of her meals using fresh ingredients, relied less on her wheelchair, and reported feeling significantly less depressed over the 1-year period. Sarah still has a long road ahead of her; however, it was these small changes in behavior that not only impacted her physical health but also improved her mental well-being.

Counselors adhering to the behavioral medicine approach recognize most chronic diseases as having a behavioral component that can be targeted to improve overall health, which is the focus of this chapter. To fully appreciate the behavioral medicine approach, we must first understand its development.

### Origin and History of Behavioral Medicine

Behavioral medicine, as we understand it today, first emerged in the 1970s in response to the biomedical model, the dominantly held ideology at the time. Research laboratories established at the University of Pennsylvania and Stanford University provided both medical and mental health researchers and practitioners the opportunity to develop the field of behavioral medicine. Additionally, publications like Leo Birk's 1973 book *Biofeedback: Behavioral Medicine* and journals such as the *Journal of Behavioral Medicine* and *Annals of Behavioral Medicine* shed light on the growing field of behavioral medicine and provided outlets for new research to be disseminated.

Aided by the growing body of research supporting behavioral medicine, the 1990s saw the formation of professional societies and federal agencies focused primarily on

the field of behavioral medicine. In 1990, the International Society of Behavioral Medicine (ISBM) was created to serve the needs of vested disciplines interested in behavioral medicine issues; and in 1995, the National Institute of Health (NIH) created the Office of Behavioral and Social Science Research (OBSSR) to focus solely on behavioral and social constructs specific to mental and physical health and foster collaboration and cooperation among researchers and practitioners across various disciplines of study. More recent influences that have contributed to the continual development of behavioral medicine include the evidence-based practice movement beginning in the early 2000s, advances in technology promoting behavior change, developments in epidemiology in identifying risk factors, and growing concerns in health care cost efficiency (Keefe, 2011).

### So What Exactly Is Behavioral Medicine?

The first definition of behavioral medicine was established by behavioral and biomedical experts at the Yale Conference on Behavioral Medicine (Schwartz & Weiss, 1977, p. 379):

Behavioral Medicine is the field concerned with the development of behavioral-science knowledge and techniques relevant to the understanding of physical health and illness and the application of this knowledge and these techniques to diagnosis, prevention, treatment and rehabilitation. Psychosis, neurosis and substance abuse are included only insofar as they contribute to physical disorders as an end point.

As a result of Schwartz and Weiss's experience at this very same conference, they expanded on the original definition:

Behavioral Medicine is the interdisciplinary field concerned with the development and integration of behavioral and biomedical science knowledge and techniques relevant to health and illness and the application of this knowledge and these techniques to prevention, diagnosis, treatment, and rehabilitation. (Schwartz & Weiss, 1978, p. 249)

In 1979, Pomerleau and Brady, recognizing the contributions of behavior in health and illness, offered the following definition:

Behavioral medicine can be defined as (a) the clinical use of techniques derived from the experimental analysis of behavior—behavior therapy and behavior modification—for the evaluation, prevention, management, or treatment of disease or physiological dysfunction; and (b) the conduct of research contributing to the functional analysis and understanding of behavior associated with medical disorders and problems in health care. (p. xii)

A more contemporary definition provided by the ISBM (n.d.) described behavioral medicine as “the interdisciplinary field concerned with the development and integration of

psychosocial, behavioral and biomedical knowledge relevant to health and illness and the application of this knowledge to prevention, etiology, diagnosis, treatment and rehabilitation” (para. 1).

As you can see from the rapid evolution of the field of behavioral medicine, certain tenets have persisted. For the purposes of our discussion, **behavioral medicine** is defined as a multidisciplinary science that integrates knowledge from various fields related to health and illness and applies that knowledge to the treatment and prevention of illness through the use of behavioral interventions. From this perspective, chronic illnesses such as obesity, substance use, depression, and hypertension are understood to occur from the interaction between genetic factors, social and cultural influences, and state of psychological well-being that lead to particular lifestyle choices. It is these amendable risk factors (behaviors) such as smoking, poor dietary habits, limited physical activity, and high levels of stress that can potentially exacerbate current illnesses and further compromise overall health that most concern practitioners. As you saw from Sarah’s experience described earlier in this chapter, many factors contributed to her state of health and well-being. As such, clinical mental health counselors practicing from the behavioral medicine approach must have a firm theoretical understanding of how biological, psychological, and social factors contribute to illness formation and health persistence. This is best explained by the biopsychosocial model.

### Biopsychosocial Model

The biopsychosocial model was first introduced by George Engel in 1977 as an alternative to the biomedical model, which has dominated the field of medicine since the mid-20th century. The application of the **biomedical model** is the manner in which health professionals diagnosis and treat disease, focusing primarily on biology while disregarding psychological and social factors that contribute to disease and illness (Engel, 1977). In other words, disease and illness are the result of viruses, gene expression, and physical abnormalities, in absence of other contributing factors such as living conditions, substance use, dietary habits, and so forth. Despite the dominance of the biomedical model and its support observed in both medicine and psychiatry, proponents (Borrell-Carrió, Suchman, & Epstein, 2004; Engel, 1977, 1980; Epstein & Borrell-Carrió, 2005) of the biopsychosocial model often criticized the biomedical model for many reasons. The most notable reasons summarized by Engel included the dualistic separation of person and illness; the reductionistic viewpoint, that is, if something could not be reduced or explained in its simplest form it was ignored; and finally, the objective observer who remained distant and separated from the client (Borrell-Carrió et al., 2004).

The **biopsychosocial model** is best thought of as a philosophy of client care and an approach to clinical practice in treating disease and illness. From this perspective, causes of disease and illness are the result of interactions among biological (e.g., genetic, sex), psychological (e.g., personality, self-esteem), and social factors (e.g., culture, peers). In its simplest form, the biopsychosocial model signifies the mind-body connection. To better understanding this model and interacting factors and their impact on health and illness, please refer to Figure 10.1.

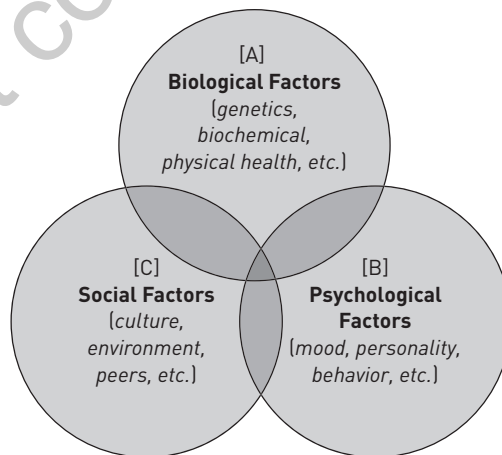
As you can see in Figure 10.1, the biopsychosocial model is made up of three factors: (A) biological, (B) psychological, and (C) social. No single (A, B, or C) factor is more

important than the other; however, understanding that each factor interacts with the other, regardless of whether the outcome is positive or negative, is critical to understanding illness formation and health persistence. Notice the overlapping area, represented by a darker shade of gray, among the three factors. The shared areas between A and B, B and C, and A and C can be thought of as characteristics, traits, or dynamics representative of the interaction between two factors that do not explain the cause of disease or illness but contribute to its existence. For example, being overweight (Biological [A]) and having a low socioeconomic status (Social [C]) may contribute to a low rate of glucose metabolism (gray shaded area between A and C). Likewise, low socioeconomic status (Social [C]) and poor coping skills (Psychological [B]) may contribute to the experience of trauma (gray shaded area between C and B). Being overweight (Biological [A]) and poor coping skills (Psychological [B]) may contribute to an introverted personality type (gray shaded area between A and B).

In each of these examples, a possible outcome for the interaction between two factors is described, but according to the biopsychosocial model, it is the interaction among *all* factors that best explains health determination and illness formation. Therefore, let us reexamine the previous examples from a holistic view, as intended by the biopsychosocial model, to include the respective third missing factor and the interaction among factors.

Considering all factors together, being overweight (A), low socioeconomic status (C), poor coping skills (B), low metabolism (A and C), adverse experience to trauma (C and B), and an introverted personality type (A and B) may collectively explain obesity, diabetes, hypertension, depression, and post-traumatic stress disorder (A and B and C).

**FIGURE 10.1** ■ The biopsychosocial model is composed of three interacting factors: biological, psychological, and social, providing a theoretical framework to understanding illness formation and health persistence.



As clinical mental health counselors, it is important to understand that the interaction among factors (center of Figure 10.1) collectively describes the cause of illness. Further, altering one or more factors may contribute to a different prognosis, and a similar factor composition between two persons may result in a different disease or illness diagnosis. Although our conversation regarding the biopsychosocial model has so far consisted of describing the causes of illness, the same model can be used to inform health promotion and disease prevention. If disease and illness are the product of interactions among biological, psychological, and social factors, then it makes sense that interventions must align with this ideology. In the next section, we begin to see the practical application of the behavioral medicine approach in managing mental and behavioral issues in medical clients in a service delivery approach known as integrated care.

## MANAGING MENTAL AND BEHAVIORAL ISSUES IN MEDICAL CLIENTS

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Managing mental and behavioral issues in medical clients poses its own set of challenges. As counselors, should we focus on mental and behavioral issues only and ignore medical concerns? Is it necessary to address medical issues before attending to mental and behavioral problems? Are mental and behavioral disorders best explained by medical conditions? These are some of the concerns clinical mental health counselors face when working with medical clients who have comorbid mental and behavioral health disorders.

Of the many challenges faced by medical clients with comorbid mental and behavioral issues, access to and navigating the array of necessary services (Barnett et al., 2012; Brekke et al., 2013) is one of the more prevalent, especially for novice counselors. Rarely does a single entity or organization offer every service possible to persons with chronic illnesses. Instead, clients often must navigate through what is known as a continuum of care. A **continuum of care** (CoC) is “a system that guides and tracks clients over time through a comprehensive array of health services spanning all levels and intensity of care” (Healthcare Information and Management Systems Society, 2014, para. 1). Although not a formal system of care delivery, CoC can be thought of as a collection of service providers in varying levels of communication with one another. And with advances in secure technologies and electronic health records (EHRs), mutual sharing of information is becoming more and more of a reality between health care providers.

Nonetheless, challenges such as funding, compatibility among EHRs systems, and agreement between providers on what type of information should be shared persists. To address these challenges, most, if not all, health care organizations have designated workers (e.g., CoC coordinators or specialists) who specialize in tracking clients from one entity to the next and ensure a continuum of care through maintaining appropriate relationships, management and sharing of vital health information, and advocating for client services when necessary (Haggerty et al., 2003; Reid & Wagner, 2008). Despite the advances in CoC practices, clients unfortunately do fall through the cracks as a result of errors made by health care providers and clients not fully committing to the treatment process. One solution to circumvent these gaps in care is the resurgence of integrated care treatment in the 21st century, especially in clinical mental health settings.



## Integrated Care Treatment

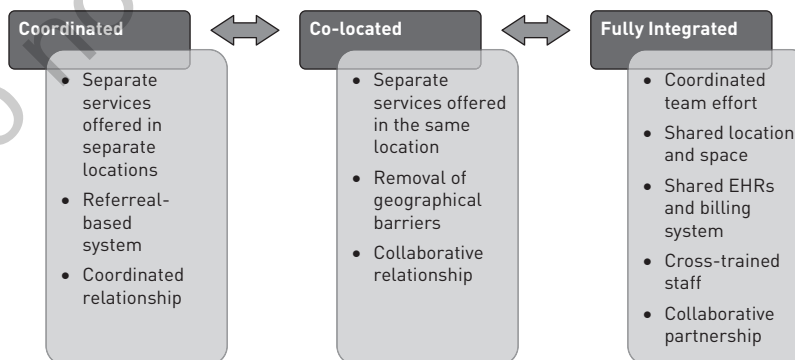
Integrated care treatment is grounded in the behavioral medicine approach, focusing on the holistic self to improve health and treat illness. **Integrated care treatment** is “the systematic coordination of general and behavioral healthcare” (Substance Abuse and Mental Health Services Administration-Health Resource and Service Administration, Center for Integrated Health Solutions [SAMHSA-HRSA, CIHS], n.d., para. 3). From this perspective, treatments are designed to address complex health care issues such as mental illness, physical illness, and substance use, concurrently, in recognition of the parallel effects between the mind and body. Since the early 1980s, researchers (e.g., Caton, 1981; Regier et al., 1990) have found higher prevalence of substance use among persons with mental illness, a trend continuing into the 21st century (Chow, 2013). A more recent concern for health care professionals is a higher mortality rate among persons with mental health illness. These persons are dying 15 to 20 years sooner than persons from the general population with similar primary health conditions (Thornicroft, 2011). Many factors contribute to early death in this population, such as a sedentary lifestyle, poor diet, smoking and consumption of illicit substances, disparities in accessing primary health care services, difficulties in navigating the health care system, and stigma associated with mental illness.

To combat this phenomenon, SAMHSA, in 2009, awarded funding to 100 behavioral health agencies across the United States for the purpose of integrating primary health care services into clinical mental health settings (Scharf et al., 2013). Many primary health care settings have integrated mental health services within their paradigm of treatment. Regardless of the direction of integration (behavioral and mental health into primary care or primary care into behavioral and mental health), the care that results from these multidisciplinary teams made up of behavioral and mental health and primary health care practitioners is the strength behind integrated care treatment. Interdisciplinary teams’ level of interaction and method of communication varies depending on where they fall on the continuum of service integration.

## Continuum of Service Integration

Blount (2003) described service integration between behavioral health and primary health care entities along a continuum (see Figure 10.2). At one end of the continuum,

**FIGURE 10.2** ■ Continuum of Service Integration





services are identified as *coordinated*. Coordinated services are those rendered in two or more locations by two or more different health care professionals. However, each professional and entity are connected through a referral-based system (Westheimer, Steinley-Bumgarner, & Brownson, 2008). For example, a client discharging from an inpatient psychiatric hospital might receive referrals to a community mental health agency, a primary care physician, and a marriage counselor. In most instances, the referring hospital has some degree of relationship with the outside entities that is best characterized as coordinated. The referral-based system depends on the resources available in the community or nearby communities and poses a significant challenge for rural and underserved geographical settings. Directly in the middle of the continuum is service coordinating identified as co-located. Co-located services are highlighted by providers that are distinctly separate (i.e., specialized in mental health or primary health but not both); however, the providers of those services exist in the same location. In most instances, providers of care share the same building space. On one side of the building is behavioral and mental health services and on the other side is primary health. Having different providers in the same location benefits client care and allows for more opportunities to collaborate and coordinate among health care professionals. A medical professional only needs to walk across the building to consult with a behavioral health professional concerning a client's compliance with treatment and coordinate future services.

On the other side of the continuum, opposite from coordinated, is *fully integrated*. Service provision identified as fully integrated is based on a coordinated partnership. In other words, differing health care professionals work together in teams. They share the same location and in most instances the same office space. It is not uncommon for a fully integrated entity to have the same support staff interacting with every client (e.g., greeting them, assisting with paperwork, managing behavioral and medical appointments). Furthermore, a fully integrated system of care shares the same EHRs, billing department, and treatment plan and meets regularly as a treatment team (Blount, 2003; Westheimer et al., 2008). Despite the specific characterizations of each—coordinated, co-located, and fully integrated—most organizations and entities that offer integrated services occur along the continuum of service delivery. This is true for many reasons: (a) budgetary constraints, (b) limited physical space, (c) lack of available health professionals, (d) geographical isolation, and (e) health care needs. What is important to understand is that service integration (i.e., coordinated, co-located, fully integrated) offers a stringent approach to managing behavioral and mental illness in medical clients by mitigating many of the barriers experienced by clients navigating the continuum of care.

## GUIDED PRACTICE EXERCISE 10.1

In class, in groups of three, each student will take ownership of an integrated model along the service continuum (coordinated, co-located, or fully integrated). Describe to your partners the strengths and limitations of your selected model

regarding client care, coordination of services, and communication among providers. How do you foresee your selected model of service integration circumventing many of the perceived and actual barriers that clients experience?

## Interventions Implemented in Integrated Care Treatment

Integrated care treatment encompasses a vast array of services individualized to the person and his or her needs. Although degrees of consistency exist among mental and primary health disease (e.g., symptomology), the behavioral medicine approach recognizes that no two persons are the same. Thus, no two treatment approaches are the same. Treatment is highly specialized to the individual; treatment goals are created collaboratively and have the following characteristics: specific, measurable, realistic, and meaningful to the person. In an integrated system of care, interventions include psychiatric services, medical services, medication management, individual and group counseling, case management, social support services, and psychoeducation. Although a team approach is used and roles and responsibilities tend to blend between health care professionals, clinical mental health counselors' primary roles and responsibilities are to provide individual and group counseling; facilitate psychoeducational sessions; design, develop, and implement individualized behavioral interventions; conduct diagnostic assessments; and assist in providing crisis services. Regardless of roles and responsibilities, health care professionals in an integrated care treatment recognize that behaviors and lifestyle choices are at the center of disease and illness formation. Fisher et al. (2011) supported this ideology, stating that behavior is fundamental to “prevention, treatment, and management of the preventable manifestations of diseases and health conditions” (p. e15). In other words, interventions are designed to target specific behaviors contributing to disease and illness formation. To better understand this ideology, let us explore two common primary health diseases (i.e., obesity, diabetes) found in the mental health population, as well as common behavioral interventions clinical mental health counselors can implement in community mental health settings.

Obesity is a primary medical disease characterized by an excessive accumulation of body fat, often a contributing factor to other health disorders (Mayo Clinic, 1998-2016). Since the early 1980s, obesity has been on the rise in both the general and mental health population and strongly associated with the rise in diabetes (Brown et al., 2011). Obesity and diabetes both have a behavioral-health linkage (Fisher et al., 2011), and amendable risk factors such as poor diet, sedentary lifestyle, excessive alcohol consumption and substance use, cigarette smoking, and unaddressed behavioral and primary health disorders contribute to the development and progression of these diseases (Sharma, 2007). To combat these diseases, counselors and other health care professionals focus their efforts on designing, implementing, evaluating, and then redesigning interventions that target overall health by focusing on behaviors such as diet, nutrition, and weight loss; physical activity and weight loss; tobacco use; alcohol and substance use; and mental illness, concurrently.

Table 10.1 provides an example of various interventions designed collaboratively by both the counselor and client to synchronously manage comorbid illnesses. However, successful client outcomes rest on more than just a concurrent delivery of services. They also require providers to effectively communicate with their clients and among each other.

**TABLE 10.1 ■ Concurrent Interventions Used in an Integrated Treatment Approach**

Diet, Nutrition, and Weight Loss	Physical Activity and Weight Loss	Tobacco Use	Alcohol and Substance Use	Mental Illness
Preplanning meals weekly or monthly	Low-impact exercises such as Chair Zumba and swimming	Clinician-assisted tobacco cessation program	Cognitive-behavioral therapy to help clients recognize, avoid, and cope with stressors associated with using alcohol and other substances	Medication management
Creating grocery list prior to shopping; Clinician-assisted grocery shopping	Weight-training exercises; using a trainer	Nicotine replacement therapy	Medication management	Individual and group counseling
Healthy cooking classes	Daily group walking exercise	Support group	Individual and group counseling	Case management
Use of a food tracker app	Use of an exercise monitoring app	Use of a cessation app	Support group	Life skills group
Food pyramid education	Benefits of physical activity education	Harmful effects of tobacco usage education	Education on the cycle of addiction and stages of change	Education on mental illness

*Note:* Table 10.1 describes possible interventions implemented for clients with comorbid behavioral and mental illnesses and primary health disorders. Interventions are provided concurrently and tailored to the individual client.

## COMMUNICATING WITH CLIENTS AND PROVIDERS

Navigating the continuum of care for the novice clinical mental health counselor can be challenging and at times seem overwhelming. Providers of care are, although not intentional, not as forthcoming with information as one would hope (Durbin et al., 2012). This can occur for many reasons, but the most notable are related to concerns with confidentiality and the Health Insurance Portability and Accountability Act (HIPAA) of 1996, differences in professional language, geographical barriers, and imperfect relationships between providers (Clochesy, Dolansky, Hickman Jr., & Gittner, 2015; Erickson & Millar, 2005; Forster et al., 2004). Likewise, clients often under- or overreport health information, making it challenging to ascertain an accurate and complete picture of what is really going on.

It is not uncommon for clients to present for service with certain symptoms and underreport others—which can occur for many reasons. A few of those reasons

identified in the literature include the stigma associated with mental and physical illness, negative experiences with previous health care providers, cultural differences between client and provider, and cause-and-effect of symptoms associated with their mental illness and compromised physical health (Bradford, Coleman, & Cunningham, 2007; Cohen & Krauss, 2003; Dickey, Normand, Weiss, Drake & Azeni, 2002). Therefore, it may not be until the initial screening or intake process that clients are made aware of these “unknowns” and/or additional issues. Client issues are expansive and can range from emotional distress to severe and persistent mental health disorders to personality disorders, which are often confounded with primary medical illnesses and/or substance use problems. Thus, the 21st-century clinical mental health counselor is effective in communicating with other health care providers and their clients in identifying and treating complex health care issues. This begins with developing and nurturing the therapeutic alliance.

### Therapeutic Alliance

The concept of the therapeutic alliance can be traced back to Freud’s (1913) work and the development of the concept of transference. However, many researchers (e.g., Bordin, 1979; Bowlby, 1988; Greenson, 1965; Horwitz, 1974; Rogers, 1951; Zetzel, 1956) have conceptualized the therapeutic alliance differently than Freud. In fact, most noted that the therapeutic alliance was something that is present focused. Rogers (1951) identified three components of the therapeutic alliance: congruence, empathy, and unconditional positive regard, which are artifacts of the counselor and essential in developing and fostering a relationship. Likewise, Luborsky (1976) conceptualized the alliance into two components along the therapy continuum. In early therapy, the therapeutic alliance was understood as the client’s perception of the counselor as being supportive; in later therapy, the alliance was characterized as the collaborative partnership between client and counselor. Bordin (1979) operationalized the therapeutic alliance by outlining specific qualifiers, to include agreement on goals, agreement on tasks, and an establishment of a bond between client and counselor. Despite differences in how therapeutic alliance is conceptualized from one author to the next, certain commonalities exist.

First, the therapeutic alliance is attended to in the present. Effective counselors are constantly monitoring and evaluating the quality of the client-counselor relationship. They note times when the relationship is strong and times when it is not so strong to facilitate the counseling process and assist clients in reaching their desired goals. Second, the therapeutic alliance is constantly in flux. Just because the last session was productive does not mean the next one will be. Clients’ perceptions of the counselor are ever changing, and a positive perception can be easily thwarted from one moment to the next, especially with persons with complex health care issues. Therefore, it is not uncommon for the therapeutic alliance to ebb and flow throughout the counseling process, especially at the onset of the counseling relationship. Finally, the therapeutic alliance describes the relationship dynamics between client and counselor, one that significantly contributes to successful client outcomes (Lambert & Barley, 2001).

Up to this point, we have discussed the therapeutic alliance in terms of client and counselor; however, rarely does a person have just a single provider. As we have seen in

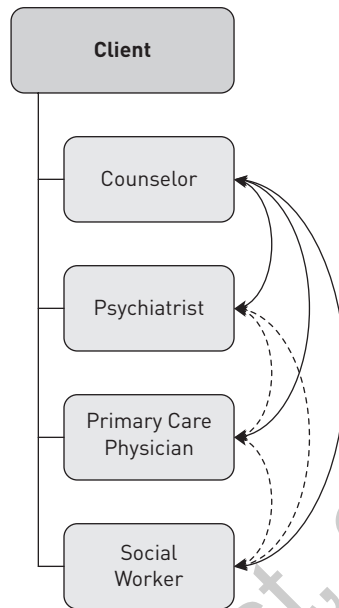
the previous section, clients often traverse the continuum of care, meeting with many different health care providers. Therefore, in contemporary clinical mental health settings offering integrated services, the therapeutic alliance extends beyond the counselor and client and includes the relationship between the client and all providers in the continuum of care, as well as the relationships between all practitioners who provide care to the client.

To help visualize this proposed relationship dynamic, let's take a look at Figure 10.3. In this figure the client is positioned at the top of the diagram with an array of health care providers in the client's continuum of care listed below. The client is served by a counselor, psychiatrist, primary care physician, and social worker. Note that the left side of the diagram represents the relationship between the client and the various providers in the continuum of care whereas the right side of the diagram denotes the relationships between the client's providers of care. No single dyad is considered more important than the other; rather, it is the synergistic effect of all relationships that contributes to the greatest client outcomes. Let us examine the case of David, a client seeking services for the first time (see Case Illustration 10.2).

## CASE ILLUSTRATION 10.2

David is a 24-year-old male who self-identifies as multiracial. He is married with two children and works as a financial planner. He is a very positive person with a good attitude about life. Over the past 6 months, David reports that he has experienced some weird sensations—it was difficult to explain—and he was hearing and seeing strange things not previously experienced. David called three private counselors to seek out help and received little reassurance that they could assist him. David was hesitant to contact the local community mental health agency because of how others portrayed it, yet this was his only option. David eventually called because he needed to seek out help and gain some answers as to what was going on. David spoke with a counselor on the phone who conducted a screening assessment. The counselor on the phone was very direct and to the point, but David had so many questions and was concerned about what was going on. He did not feel like he was being helped at that moment, but the counselor was able to get him an intake appointment. David's interaction with the intake counselor was no more successful than with the counselor he spoke to on the phone.

After completing the intake assessment, David was scheduled to meet with the agency's psychiatrist and primary care physician later in the week to address additional concerns indicated by David and the intake counselor. However, David is unsure if this is the right approach for him. His initial experiences during the screening and intake made him more anxious and unsure about following through with the next two appointments. He is starting to think he made a huge mistake. Within a continuum of care, and especially when using an integrated care treatment approach, clients like David need to feel safe and supported by the counselors they work with. David's feelings surrounding his interactions with the first counselor carried over to the intake counselor. It was unfortunate that he had a similar experience during the intake assessment, and now he is considering discontinuing services altogether. Practitioners working in a coordinated system of care (e.g., integrated care treatment approach) need to be cognizant of how the therapeutic alliance extends to all practitioners in that system. Imagine what would have happened if David had the opposite experience.

**FIGURE 10.3 ■ The Therapeutic Alliance in an Integrated System of Care**

One model that emulates the importance of these relationships dynamics necessary for effective communication in an integrated system of care is the client-centered care paradigm.

### Client-Centered Care

Client-centered care, although not a novel approach, has been consistently misunderstood by health care providers due to the lack of agreement of what it actually entails (Hughes, 2011; Robinson, Callister, Berry, & Dearing, 2008). In 2001, the Committee on Quality of Health Care in America and Institute of Medicine defined **client-centered care** as “providing care that is respectful of and responsive to individual client preferences, needs, and values and ensuring that client values guide all clinical decisions” (p. 40). Over the years, numerous models and frameworks have been constructed to depict what client-centered care should look like (Shaller, 2007). In fact, Cronin (2004) was commissioned by the National Health Council to systematically review nine differing models of client-centered care and synthesize elements of consensus and divergence. Her work yielded 45 concepts embedded in descriptors of what client-centered care entails. Six elements consistently appeared in three or more definitions: “(a) education and shared knowledge, (b) involvement of family and friends, (c) collaboration and team management, (d) sensitivity to nonmedical and spiritual dimensions of care, (e) respect for client needs and preferences, and (f) free flow and accessibility of information” (Shaller, 2007, pp. 4–5).

## Provider-to-Provider Communication in an Integrated System of Care

In an integrated care treatment approach, effective communication among providers is critical when using a team-based approach (Lardieri, Lasky, & Raney, 2014). Thus, a culture shift is often required for any clinical mental health settings that integrate new areas of health care (i.e., behavioral or medical), as well as for the providers of those new areas of health care. The previously held ideology of a single specialty of care (i.e., behavioral health only or medical health only) is no longer feasible in an integrated system of care. The infusion of medical and behavioral health professionals, each with their own specific skill set and areas of expertise, can pose certain provider-to-provider challenges such as boundary crossing, diffusion of roles and responsibilities, and professional language differences. Despite these challenges, health care professionals in an integrated system of care must collaborate and coexist to deliver comprehensive and effective services. Because provider-to-provider communication primarily involves the exchange of information, it must be effective and efficient across various services and settings (Gulmans, Vollenbroek-Hutten, Van Gemert-Pijnen, & Harten, 2007). Here are four simple considerations to facilitate effective communication between providers: (a) respect, (b) integrative use of language, (c) clarification of roles and responsibilities, and (d) cross-training.

### Respect

Respect for other professionals within an integrated system of care can translate into higher quality of care for clients. For instance, respect can create avenues of easier access to vital information, facilitate a smoother exchange of information, and improve relationships between providers. Further, respect communicates a level of professionalism that increases the likelihood other providers will be willing to interact with you in the future.

### Integrative Use of Language

Language is our primary method of communicating from one provider to the next. It can occur in written form such as clinical case notes, consultation reports, and medical charts, or it can be spoken between two or more professionals. Communication difficulties occur when professionals have a specific language they use in their discipline of practice and are unable to use or comprehend the vernacular or jargon used by other disciplines. For instance, doctors and nurses write in shorthand, using medical symbols or abbreviations. Counselors speak in terms of prevention, personal strengths, and wellness and highlight the counseling relationship to facilitate change. Psychologists may reference scores obtained from a battery of assessments in their consultation report. Each individual believes he or she is contributing valuable information to be used in treating the client. However, the differences in professional language create an unnecessary barrier, keeping those on the inside informed and everyone else on the outside looking in. Therefore, health care providers in an integrated system of care should become familiar with the common verbiage used and incorporate that when writing and speaking to professionals in disciplines other than their own.



## GUIDED PRACTICE EXERCISE 10.2

In class, with a partner, identify the potential shared roles and responsibilities practitioners (e.g., doctors, nurses, counselors, social workers, psychologists) may undertake in an integrated care treatment approach. Also consider the unique role of each practitioner. For example, a psychiatrist's unique function is to treat mental illness by

prescribing psychotropic medications. Counselors do not prescribe medications but instead implement counseling interventions to treat symptoms of mental illness. However, both the psychiatrist and the counselor may offer clients' medication and symptom management and share the responsibility of ensuring clients' health and well-being.

### Clarification of Roles and Responsibilities

In an integrated system of care, it is extremely important to clarify each person's role and responsibility (Lardieri et al., 2014). Confusion over who does what can easily get convoluted in a team-based approach. Each provider in an integrated system of care serves a unique purpose in the pathway to care; however, each member also serves to bridge the gaps in care through shared roles and responsibilities. Therefore, it is critical to identify, at the onset, each provider's unique role and responsibilities as well as the shared roles and responsibilities. For instance, a counselor's role might be to implement behavioral interventions that promote weight loss and increased physical activity, and a doctor's role might be to prescribe medications to manage diseases of diabetes and hypertension. Despite the different role of each professional, they share the responsibilities of ensuring client compliance with treatment interventions, providing referrals when necessary, and sharing vital health information.

### Cross-Training

The idea of cross-training might seem unnecessary to some and overwhelming to others, but understanding what others do in an integrated system of care is critical in a team-based approach. Cross-training gets professionals to interact, create opportunities to talk using a shared language, model how they practice, and facilitate the formation of working relationships (Lardieri et al., 2014). Cross-training can take the form of counselors demonstrating how they deescalate crisis situations, medical doctors providing education on common primary medical diseases occurring in mental health clients, or psychiatrists describing their assessment process when meeting with a client for the first time. The goal of cross-training is to get everyone on the same page to create an efficient and effective system of care.

### Provider-to-Client Communication in an Integrated System of Care

Interpersonal communication between provider and client is critical to client satisfaction, compliance with treatment, and successful client outcomes (de Negri, Brown, Hernandez, Rosenbaum, & Roter, n.d.; Flickinger et al., 2016). Within an integrated system of care are numerous contact points for clients, beginning with checking in with

support staff to meeting with a counselor for screening or intake to the first visit with a psychiatrist and/or medical doctors. Although each interaction may occur independently, depending on the model of integration implemented, the effects of each interaction reverberate from one contact to the next. Therefore, as a future provider of care it is paramount to engage in effective communication practices. Four simple considerations to facilitate effective communication between provider and client are: (a) respect, (b) creating a caring environment, (c) engaging in conversation, and (d) effectively using verbal and nonverbal communication.

### **Respect**

Just like the respect described in provider-to-provider communication, counselors and other providers need to respect their clients, and clients need to perceive that they are respected. This occurs through establishing a therapeutic alliance. Respect for clients can translate into fewer no-show appointments, compliance with medications, a willingness to try new interventions, and better client outcomes.

### **Creating a Caring Environment**

Empathy, compassion, and respect can go a long way in creating an environment that helps clients feel safe and secure. This begins the minute they are greeted and continues until the appointment is finished. Be thoughtful in how you communicate messages and remain present the entire time. Also, do not be afraid to incorporate a visually pleasing décor. Think about it for a moment. How many times have you been to a bland doctor's office or met with a colleague in their unflattering office? Did you feel welcomed or uncomfortable? Remember, a little can go a long way in creating a sense of security for clients who may have reservations about being there in the first place.

### **Engaging in Conversation**

Effective communication is a two-way process. In its simplest form, information is communicated in a clear and understandable manner. Next, that information is received, comprehended, and acknowledged. In an integrated system of care, both the client and provider have the opportunity to speak, ask questions, express similar or disagreeing opinions, and come to a mutual understanding of what was discussed (de Negri et al., n.d.).

### **Effectively Using Verbal and Nonverbal Communication**

Both spoken words and body language send messages that can be perceived positively or negatively by clients. Usually, clients do not seek out services under the most ideal conditions. A pleasant vocal tone and a positive attitude can go a long way with persons seeking health care services. Also, language in itself can be complex and difficult for persons from different cultural backgrounds to speak and understand. It behooves practitioners to use simplistic and common words and phrases and avoid professional jargon when communicating with clients. Procedures should be explained in easy-to-follow language, and opportunities to ask questions should be extended to the client.

## CONDUCTING CLIENT INTERVIEWS

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As one of the most critical phases in the treatment process, client interviewing takes center stage. Think of it as the point of origination or the phase of possible termination, depending on the client's experience. In early medicine and psychiatry, the perspective held by the majority of practitioners was the biomedical approach (Engel, 1977). The primary clinical focus was on disease, better understood as a biological deviation from what was considered normal. Information obtained under this paradigm consisted of symptomatology, medical history, and findings from diagnostic assessments (Lyles, Dwamena, Lein, & Smith, 2001). In other words, any biological information that could be reduced to its simplest measurable form was obtained. Despite this dominantly held ideology, George Engel (1977) insisted that to truly understand the problems or issues of the human condition, practitioners must consider the holistic self, to include not only biomedical characteristics but also the inherent psychological and social aspects. Therefore, client interviewing not only focuses on what type of data to obtain but also considers the method by which data are obtained. In other words, the “how” of obtaining the “what” are not mutually exclusive. As a result, clinical mental health counselors need to have basic competencies to be effective in the interviewing process. This section focuses on the skills and processes required for the client interview. We begin by exploring the basic interviewing skills counselors must possess. Next, we explore the general stages and processes of the client interview. Finally, we discuss unforeseen incidents that may arise during the interview process.

### Basic Interviewing Skills

Basic interviewing skills facilitate communication of vital information between practitioner and client. Within the client-centered care model, the therapeutic alliance rests on the practitioner's ability to initiate and foster a relationship, and this begins in the initial interview. A negative experience during the initial interview could result in the client generalizing that experience to all providers within the integrated system of care, creating additional unnecessary barriers to health and wellness. Therefore, clinical mental health counselors are proficient in the skills of active listening, expressing empathy, appropriate use of open and closed questions, and awareness and monitoring of nonverbal body language.

### Active Listening

A method of both intentional listening and responding, **active listening** better facilitates mutual understanding between two persons. Active listening is not passive listening—simply hearing what has been said. Rather, active listening is a process constantly occurring throughout the interviewing process. Bodie (2011) and Drollinger, Comer, and Warrington (2006) characterized active listening as a process that involves three stages: sensing, processing, and responding.

The stage of *sensing* relates to listening behaviors that demonstrate attention to information and signal to the other individual that they are present-focused (Vickery, Keaton, & Bodie, 2015). Sensing behaviors include appropriate eye contact, a nonjudgment

facial expression, engagement in silence, and well-placed minimal encouragers (e.g., head nodding, one or two word utterances such as *um-hm*, *hmm*, *I see*, *yes*). *Processing* relates to listening behaviors that allow for remembering, synthesization, and reconstruction of information (Vickery et al., 2015). Processing behaviors include engaging in silence and reflecting on content said before responding. The last stage, *responding*, is characterized by listening behaviors that ensure continuity of information exchange (Vickery et al., 2015). Responding is not reacting to information. Rather, it is the appropriate exchange of information facilitated by open- and closed-ended questions and nonverbal body language to encourage additional information and to clarify misunderstood information. However, a skilled clinician would respond not only by using open- and closed-ended questions but also by reflecting content and feeling.

**Reflection of content** is the process of stating back to the client the essence of what was said in a nonjudgmental or leading manner. It is not parroting word for word what the client said but rather uses different words to communicate back the meaning of what was said. Reflection of content takes two forms: paraphrasing and summarizing. Paraphrasing is a succinct restatement of what was said, thereby keeping the original meaning but using different words. For example, suppose a client states, “I am constantly tired, even when I wake up from 8 or 10 hours of uninterrupted sleep.” The counselor may state, “You’re tired no matter how much sleep you get.” Summarizing is similar to paraphrasing, however, it involves more information verbalized by the client. Summarizing is often used at the end of an interview, when finishing a specific topic, or when changing a topic.

**Reflection of feeling** is similar to reflection of content; however, there is an explicit identification of feelings, and feeling words are included in the statement. For example, a client may state, “I thought earning my bachelor’s degree was going to help me get a job. Instead, I have been to five interviews and no one has called me back. My rent is due in a few weeks and I am almost out of savings. I am not sure what I am going to do.” The counselor may state, “You are under a lot of pressure to find a job, and it is causing you to feel stressed.” Open- and closed-ended questions, appropriate nonverbal body language, and reflection of content and feeling are all appropriate methods of responding in the skill of active listening. They communicate to clients that you hear and understand what is being said, express empathy, and facilitate development of the therapeutic alliance.

## Empathy

Carl Rogers (1959) defined **empathy** as “the ability to perceive the internal frame of reference of another with accuracy, and with the emotional components and meanings . . . as if one were the other person” (p. 210). In other words, empathy is the counselors’ ability to put themselves in the other person’s shoes, without losing their own cognitive and emotional self, and the ability to engage in dialogue that reflects this. For clients presenting with both mental health and medical-related issues, there might be a great deal of anxiety or trepidation. Here, empathy plays an important role in strengthening the counselor-client relationship.

## Open-Ended Questions

These questions are structured in a manner that continues a conversation and are not sufficiently answered with a simple yes or no response. Usually **open-ended questions**

begin with “what” and “how” and avoiding using “why” to encourage clients to speak without reservation throughout the interview process. Open questions also encourage elaboration and provide additional information that may prove to be invaluable in later phases of the interview. Some examples of open-ended questions are “How are you feeling today?” or “What brings you into my office today?” The word *describe* can be powerful in the interview process. For instance, “Describe your reaction to the medication for me.”

### Closed-Ended Questions

These questions limit a client’s response to usually a one-word yes or no response. **Closed-ended questions** are designed to tailor a conversation to a specific point or event. For example, “Are you taking your medications as prescribed?” or “Is this the first time you have sought out counseling services?” Notice that both questions can be answered with either a yes or no response and direct the interview to a specific event. Closed-ended questions are not incorrect or “bad.” Rather, they by design lend little additional information to the counselor.

### Nonverbal Body Language

**Nonverbal body language** is everything other than words that communicates messages to the client. This includes facial expressions, body posture, vocal tone, gestures, eye movements, and attitude. Although most counselors’ intent with nonverbal body language is harmless, clients often interpret these messages and decipher their own meaning throughout the interview. Additionally, be aware of how cultural differences and background may inform how clients perceive nonverbal body language. What may have been intended to communicate one message may be interpreted to mean something completely different. In situations like this, counselors should regularly check in with their clients to make sure their messages are being received as intended.

## GUIDED PRACTICE EXERCISE 10.3

The basic counseling skills of active listening that include reflection of content and reflection of feeling, open- and closed-ended questions, and management of nonverbal body language are critical to successful client interviews. In groups of three, role-play the interview process. One student will play the role of the client, the second student will play the role of the interviewer, and the third student will be the process observer. The goal of this role-play is to practice basic interviewing skills. Each student in the triad should have the opportunity to play every role.

Use the following guidelines in setting up your role-play: (a) this is the client’s first time seeking out integrated care treatment, (b) the client has both behavioral and medical health care concerns, and (c) the client is unsure of whether seeking help is the right step. Attempt to use as many of the basic counseling skills as possible. The process observer’s job is to provide an outside perspective on the skills used by the counselor. Remember that this is practice; do not be afraid to attempt any of the basic counseling skills, and finally, have some fun with this activity.

## Stages and Processes of the Client Interview

Using a behavioral medicine approach, the client interview can span many facets of a person's life. Areas covered generally consist of the presenting problem and other additional problems, history of the presenting problem and other additional problems, medical and mental health history, assessment of basic needs, family history, alcohol and illicit substance use, criminal history, mental status exam, social history, medication history, physical examination, assessment of suicidality, history of hospitalizations, and identification of personal strengths. This list is not exhaustive of the type of information that can be collected during the interview, and it often depends on the setting and scope of the agency of where the client seeks services. Regardless of the type of information collected, a good interview is a systematic process that occurs in stages and relies on the basic interview skills.

Generally speaking, client interviews occur across the following six stages:

Stage 1: Do your homework

Stage 2: Establish the environment

Stage 3: Identify major problem(s) and any additional pressing problem(s)

Stage 4: Develop a mutual understanding of the problem(s)

Stage 5: Collaboratively plan and identify next steps

Stage 6: Termination

### Stage 1: Do Your Homework

Bickley (2013) stressed the importance of preparing for the interview session. Accessing and reviewing available information (e.g., medical charts, clinician case notes, referral forms) prior to the interview can assist the interviewer during the interview. Knowing prior diagnoses, medication history, and treatment history is always useful. When possible, consult with the client's previous providers of care (with proper consent of course). In a fully integrated system of care, a client's consent is applicable to all providers of treatment within that system, allowing for easier sharing of vital health care information.

### Stage 2: Establish the Environment

Do you remember how you felt when meeting with your doctor or dentist for the first time? Was it pleasant? What made it pleasing? If not, what could have been done differently that would have made it more pleasurable for you? Remember that not all clients are excited to seek health care services, and this is never more apparent than during the initial interview. Therefore, take the time to establish the working environment and build the therapeutic alliance. Introduce yourself and explain your role as the interviewer, identify the purpose of the interview, be inviting and pleasant, attend to your nonverbal body language, remain open to casual conversation, and address any initial concerns the client may have. Try limiting your questions during this stage, for it may make the client feel interrogated in later stages of the interview. The goal of this stage is to create an environment highlighted by feelings of trust and safety. Using the basic skills of active listening and reflection of content is helpful in building rapport early in the interview.



### **Stage 3: Identity Major Problem(s) and Any Additional Pressing Problem(s)**

This is the information-gathering phase. Both Bickley (2013) and Smith (2003) recommend establishing the agenda early on in this stage for two reasons. First, it helps to ensure that both the client and the interviewer achieve their goals for the interview. Second, it assists with time management. Interviews can be time-consuming and exhausting for both the client and the interviewer. Setting the agenda assists with time constraints and errors of omission. In identifying problems, clients often use a story format. Usually it is loaded with important information that needs to be distilled through further conversation and appropriate use of closed-ended questions. At other times, the interviewer needs to ask open-ended questions to draw out and clarify what was said. Skilled interviewers integrate both questions and reflection of content and feeling to facilitate a deeper level of understanding. Similarly, it is not uncommon for clients to become emotional during this stage. As you and the client collaboratively explore their problems, sudden feelings of anger, sadness, frustration, and so forth are embedded within the context of what is said. It is important, as the interviewer, to acknowledge those feelings by reflecting feeling. This demonstrates effective listening on your behalf and validates what the client is currently feeling.

### **Stage 4: Develop a Mutual Understanding of the Problem(s)**

Once the problem or problems have been identified, it is important that you and the client agree as to what they actually are and share a common understanding of how they developed. This can be challenging, especially if you and the client disagree as to what the problems are and how they originated. Remember that being correct is not more important than being collaborative. Therefore, a careful review of what has been discussed is warranted. During this stage, it is important for the interviewer to engage in paraphrasing and summarization skills. It is recommended that after paraphrasing or summarizing critical information, the interviewer conduct a check-in with the client. Examples of check-ins are “Does that sound right to you?,” “Have I summed up everything correctly?,” or “Are we on the same page?” Getting the client to agree or disagree helps to ensure accuracy of information and provides opportunities for clarifying any misunderstandings.

### **Stage 5: Collaboratively Plan and Identify Next Steps**

Now that the major problems have been identified and agreed on, it is time to establish a plan to approach those problems. This usually means referral to services within or outside the system of care and additional in-depth assessments (e.g., health, medical, substance use, basic needs, suicidality). Planning occurs collaboratively; however, the client takes the lead in identifying which problem or set of problems they wish to address first. Even with a collaborative approach to planning, some clients may feel hesitant or overwhelmed with deciding on what problem to address first, or they may feel they have to take on every problem right away. Both situations have their pitfalls and could result in clients experiencing minimal success or maximum failure. The skills of paraphrasing and open- and closed-ended questions are helpful in navigating these types of outcomes. Once the plan is established and mutually agreed on, it is important that the interviewer



be transparent in what will happen next, outlining clients' responsibilities and ensuring they have access to the necessary information to be successful in carrying out their plan (e.g., referrals in hand, dates and times of their next appointment, linked with appropriate health care providers).

### Stage 6: Termination

The final stage of the interview process is termination. Unexperienced interviewers may find it challenging to end an interview session, especially with clients who are talkative and continuously asking questions. Likewise, clients may have a hard time with feeling abandoned or experience a sense of remorse for sharing so much about their lives in such a short period. It is important to address clients' concerns of remorse and feeling abandoned. The basic skills of reflecting feelings and content, expressing empathy, and relying on the established rapport can be effective with clients who seem ambivalent about termination. Interviewers who find it difficult to terminate should always prepare themselves and their clients for termination. Indirectly remind clients that interviews are time limited. For instance, inform them that there is only 10 minutes left in the interview and that the two of you need to begin the process of termination. Because the process of termination is more than just saying goodbye, take the time to provide a brief review of the plan, answer any final questions the client may have, and ensure the client has the necessary information in hand before leaving the interview.

### Unanticipated Incidents During the Interview

A primary task of clinical mental health counselors is to conduct client interviews. Even though a systematic process ensues, which spans from the beginning to middle to end, unexpected events or situations may occur that can challenge the most skilled counselor and ultimately end the interview process. These unforeseen incidents are broken down into three categories based on severity, each requiring a differing level of action on behalf of the interviewer. The first category is *minor incidents* and includes situations or behaviors such as a client refusing to answer questions, getting up and leaving the interview, or being disruptive. The second category is *intermediate incidents* and includes situations or behaviors such as a client who is actively psychotic, engaged in deception, or has a physical or cognitive disability. The last category is *major incidents* and includes situations or behaviors such as a client expressing suicidality or being under the influence of drugs or alcohol.

#### Minor Incidents

Minor incidents of a client refusing to answer questions, getting up to leave, or being disruptive can certainly challenge the interview process. Not all clients are receptive to health care services and may even be against the idea of some stranger asking them questions about their personal life. Interviews are designed to identify sensitive information, which may cause an unexpected reaction of someone refusing to answer your questions or even go as far as someone suddenly leaving the interview. Do not fret. There are a few things you can do to avoid these unexpected reactions. First, prepare clients ahead of time and inform them that you will be asking

questions regarding personal and sensitive information. It is also helpful to remind them they are the architect of the interview and you are just the facilitator. In other words, empower them and help them realize that they are in control. Also, remind them of confidentiality (as well as limits to confidentiality) and how information will remain private.

Even with planning, it may be impossible to avoid disruption in the interviewing environment. Often clients bring family members, their children, and others to the interview. Or the client's cell phone rings, or the interviewer is paged across the loudspeaker. Remaining open and flexible is key in addressing these minor disruptions. Politely ask that children wait in the play area (most clinical settings now have a supervised play area). Remind clients that the interview can be a lengthy process and distractions could result in the interview taking longer than necessary. Ask clients to set their phone to silent prior to starting the interview and silence your own phone, which avoids the potential distraction all together; inform support staff to hold all your phone calls until you have finished the interview. Regardless of the type of minor incidents that could occur, careful planning, remaining flexible and open, and being polite can have a profound impact on the interview process.

### Intermediate Incidents

Intermediate incidents pose a greater challenge to the interview process. Depending on the type of incident that occurs, a client or the interviewer could decide one of two things: adapt and continue or end the interview. Situations or behavior such as a client being actively psychotic, engaging in deception, or having a physical disability all warrant a differing level of response. For clients that are actively psychotic, the interviewer needs to evaluate the safety of the individuals, the accuracy of information obtained, and the overall effectiveness of the interview process. If the client's baseline (normal functioning) is identified as psychotic and the client is safe to self and others and willing to participate, then the interview can continue. However, if those parameters are not in place, the interview should probably be discontinued and the person's needs attended to.

Likewise, a person being deceptive or unwilling to participate makes for one difficult interview. This could result in the interviewer determining the information to be inaccurate or the process to be ineffective and may result in termination of the interview. However, if the client is committed to seek help, perhaps more time and attention are needed to build rapport. If you perceive your client to be deceptive or providing incongruent statements, consider the following: Often clients live with severe and persistent conditions that they become desensitized to, resulting in a failure to report a problem as a problem, even though it may be obvious to you; clients with an extensive history of mental illness and/or physical health disorders, especially when untreated, may be poor historians of their own life events. The key is to not react by jumping to conclusions but rather respond using the basic interviewing skills learned previously, which can assist in identifying if a client is truly being deceptive.

A final intermediate incident relates to disabilities and the challenges they may pose to the interview process. It is not uncommon for clients seeking mental and/or primary health care services to have a physical or cognitive disability. Generally speaking,

disabilities include intellectual and cognitive disorders; visual, vocal, and auditory impairments; and mobility constraints. The impairment from any one disability varies from person to person and therefore should be addressed early in the interview process and approached with sensitivity and respect for the person.

Even though it may be impossible to plan for a person with disabilities, there are some general action steps you can take. First, when clients call to schedule an interview appointment, ask them if they have any physical or cognitive impairments. It is better to be prepared versus being ill-equipped to handle what comes your way. Second, for clients with visual, vocal, and auditory disabilities, be sure to provide images and text in a large font size. Be flexible in how you deliver and receive information; not everything has to be spoken. Use visual aids and other formats when presenting information. On a similar note, language barriers can pose additional challenges to both the interviewer and interviewee. Language differences can lead to misunderstanding, recording false information, and a negative interview experience. Most, if not all, clinical mental health settings are contracted with a language interpretive service (e.g., Language Line) that is free to the client. However, these interpretative services require some preplanning on behalf of the interviewer.

### Major Incidents

Major incidents pose an even greater challenge to the interviewing process. Incidents such as clients stating they are suicidal or who appear to be intoxicated or under the influence of illicit substances warrant your immediate attention. This usually requires counselors to stop the interview to address the client's current needs, often involving crisis services (e.g., crisis assessment and intervention, coordinating acute hospitalization or detoxification services). Having a client verbalize suicidality can be anxiety provoking. But to ignore these expressions for help is even more disconcerting. Likewise, interviewing a client who is intoxicated or under the influence of drugs can lead to uncooperative behaviors and become a safety issue for both the client and interviewer. Due to the limited cooperation and potential safety issues that arise from being under the influence of substances, it may be best practice to terminate the interview and reschedule it (Kabale, Nkombua, Matthews, & Offiong, 2013). Remember, your first priority is to ensure your clients' safety and your own; regardless of the incident that arises, nothing beats being prepared.

## GUIDED PRACTICE EXERCISE 10.4

On your own, consider additional unanticipated incidents not previously mentioned that you think would impact the interview process. Once identified, answer the following questions:

1. How would I classify the incident (i.e., minor, intermediate, or major)?
2. What evidence indicates that it is a minor, intermediate, or major incident?
3. How would you address the incident, if termination of the interview was not necessary?
4. What basic interviewing skills would be helpful for each incident identified?

## MOTIVATING BEHAVIOR CHANGE IN MEDICAL CLIENTS

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Change can be difficult for anyone, especially if what needs changing has become habitual and highly rewarding (Bouton, 2014). It is not uncommon to cringe at the thought of change and even feel anxious or trepidatious when considering it. Imagine if you could no longer have your morning cup of coffee or drink carbonated beverages with your afternoon meal. What if you were told you had to quit smoking cigarettes or drinking alcohol because of health reasons? For some of you reading this, you might be thinking, *that doesn't sound too difficult* or *I could easily give up drinking sodas* or *that's a no-brainer for me*. Others may have a deeper insight into how difficult halting a behavior such as drinking caffeine or smoking cigarettes can actually seem. It might be like crossing the Sahara with only a single bottle of water—nearly impossible. Persons who hold this perspective regarding behavior change would rather have others or the environment adapt to them. This type of mentality is what makes sustaining behavioral changes across the life span so difficult. That is because behavioral change is a continuous lifestyle choice (Westenhoefer, 2001). So, how do clinical mental health counselors motivate behavioral change in medical clients? To answer this question, we begin by briefly exploring the stages of change. Next, we examine two sources of motivation for change that counselors can impact through their therapeutic work with clients presenting with comorbid behavioral and mental health disorders.

### Transtheoretical Model of Behavioral Change

Behavioral change is as much a process of cognitive fortitude as it is behavioral action (Lenio, n.d.). When a client decides to eat healthier and commit to exercise to improve health, rarely does this occur as a single event but rather as a series of events. It requires awareness, decision-making, and a commitment to change. Prochaska and DiClemente (1983) originally described behavioral change as occurring across five stages: precontemplation, contemplation, preparation, action, and maintenance. These stages contain 10 processes that persons experience as they enter into change: consciousness raising, dramatic relief, self-reevaluation, environmental reevaluation, self-liberation, social liberation, counterconditioning, stimulus control, contingency management, and helping relationship. In 1997, Prochaska and Velicer introduced a sixth stage, termination. The termination stage is best theorized as maintaining total self-efficacy and having no temptation to revert to an original behavior (Prochaska & Velicer, 1997). For clients with comorbid disorders, helping them understand the process of change and identifying where they are in the process can be a powerful first step. For future clinical mental health counselors such as yourselves, having a general understanding of the transtheoretical model of behavioral change serves as a great resource for identifying appropriate interventions to motivate and sustain change. To dive fully into the transtheoretical model of behavioral change is beyond the scope of this section; however, a brief review of its six stages follows. To learn more, see the Web Resources section at the end of the chapter and the original sources (Prochaska & DiClemente, 1983; Prochaska & Velicer, 1997).

Behavioral change begins with the stage of *precontemplation*. Clients must first be aware that a behavior is even a problem. For medical clients with a comorbid disorder, they must accept that behaviors such as eating fatty food, having a sedentary lifestyle, or drinking alcohol in excess is negatively affecting their health. Likewise, clients who are aware of behaviors that negatively impact their health, yet refuse to change those behaviors, are also in the precontemplation stage of change. Counselors need to prepare themselves for clients who may have no intention of changing their behaviors. However, educating clients on how behaviors can impact health and illness can be powerful in this stage, as well as education on how the stages of change can help normalize clients' feelings regarding the process. Sometimes you have to prepare the soil even before planting a seed.

The second stage is *contemplation*. Clients at this stage are thinking about change but have not yet begun the process. They are often ambivalent and weighing the pros and cons of change. An example of a client in the contemplation stage is one who knows he may need to lose weight for health reasons but does not feel he can truly commit to the dietary changes and increased physical activity such a goal would require. Counselors can be effective by developing clients' pros and cons concretely and identifying barriers to pros and supports for cons.

The third stage is *preparation*. Clients in this stage are ready to take action but have not acted. They may engage in what is known as preaction, the first step before actual action. This can take the form of marking a start date on the calendar, scheduling an appointment, or informing others that they plan to change. Counselors can be effective by providing support and encouragement and assisting clients in engaging in as many preaction steps as necessary. This builds client confidence and develops their self-efficacy.

The fourth stage is *action*. In this stage, clients are actively engaged in work. Whether that is no longer smoking or drinking alcohol, actively participating in physical exercise, or getting involved in a support group, clients are expending energy that directly relates to the changed behavior. Counselors can help clients commit to the change process through teaching them how to monitor their progress, set realistic goals, and establish pathways to prevent reverting to the old behavior.

The fifth stage, *maintenance*, is characterized by a state of equilibrium. Clients have not engaged in the previous behavior for a period greater than 6 months. Clients at this stage have reached a huge milestone. Counselors can assist clients in establishing a relapse prevention plan. A **relapse prevention plan** outlines step by step a client's possible triggers (e.g., stimuli, persons, situations, events, environmental settings) and a systematic course of action if a client is faced with a potential relapse; successful plans are detail oriented, specific, and realistic. Furthermore, clients in this stage should have a well-developed repertoire of coping skills and be able to implement them with a high degree of self-efficacy. Finally, although not a stage, *relapse* is often identified when discussing stages of change. Relapse occurs when clients revert to a previous stage and engage in a previously stopped behavior. Relapse is not the end of the world; however, clients can easily feel as though it is. Counselors can be most effective when relapse occurs by normalizing it but not sanctioning it and helping clients to identify the trigger(s) that caused relapse and strengthen their coping skills. Although the transtheoretical model of behavioral change can serve as a wonderful educational tool in understanding the processes (see Prochaska & DiClemente, 1983; Prochaska & Velicer, 1997, for a detailed discussion on

the 10 processes of change) and stages of change, we need to understand the internal and external motivational factors that contribute to clients' self-regulation.

### Internal Self-Regulation

To truly understand human behavior, you must first identify what motivates it (Spiegler, 2016). Intrinsic motivators are factors internal to a person and can either occur out of necessity (e.g., the need to connect with others, desire to satisfy sexual urges) or be learned (Seifert, Chapman, Hart, & Perez, 2012); they are refined by personal values, beliefs, and cultural background (U.S. National Research Council Committee on Aging Frontiers in Social Psychology, Personality, and Adult Developmental Psychology, 2006). When working with clients with comorbid disorders, it is important to understand the internal constructs that influence motivation. These include decision-making processes, perceived self-efficacy, attitude regarding change, and the ability to project oneself into the future (Bandura, 2001; Gollwitzer, Fujita, & Oettingen, 2004). Sawyer, Miller-Lewis, Searle, Sawyer, and Lynch (2015) collectively identified these internal processes as a person's capacity to self-regulate, that is, the ability to control thoughts, behaviors, and emotions in response to the perceived environment. Self-regulation is a developmental phenomenon and begins early in childhood; it paves the way for observed behaviors in adulthood (Choe, Olson, & Sameroff, 2013). For clients with comorbid disorders, failure to self-regulate results in dire consequences, such as exacerbated symptoms associated with mental illness, engagement in risky behaviors, and early death. Counselors can assist clients in identifying their current methods of internal self-regulation and modify those that result in unhealthy behaviors. More specifically, counselors can help clients identify how they respond to environmental stressors, develop strategies for emotion regulation and self-control, and reframe negative thought orientation. Researchers have identified cognitive, behavioral, and combined cognitive-behavioral therapy (e.g., Beck & Fernandez, 1998a, 1998b; Emmelkamp, 1994; Hollon & Beck, 1994); rational-emotive behavioral therapy (e.g., Pynchyl & Flett, 2012); and dialectical-behavioral therapy (Sampl, Wakai, Trestman, & Keeney, 2008) as effective approaches in assisting clients in modifying internal methods of self-regulation. However, evidence indicates that once a behavior is enacted it becomes more difficult to intervene due to gratification (Beck & Fernandez, 1998a, 1998b). Thus, to fully understand self-regulation, we need to explore external motivators that impact it.

### External Self-Regulation

External factors that influence motivation occur outside the person (Ryan & Deci, 2000). These include rewards (e.g., money, promotion at work), punishments (threats that result from a behavior), and social factors that influence self-regulation. Some clients with comorbid disorders may have no desire to change a particular behavior (zero intrinsic motivation) unless external forces are involved. For example, clients with little motivation to quit smoking are less likely to do so when barriers stand in their way such as being surrounded by others who smoke, being unable to afford smoking cessation treatment, and fear of gaining weight. Likewise, to offer clients a reward- or punishment-based system of motivation is not only unfeasible and potentially harmful, it often results in a process known as overjustification. **Overjustification** occurs when the external source of



motivation diminishes the internal source of self-regulation. This could result in clients engaging in a behavior as a result of an incentive or threat of punishment; however, once the external force is removed the behavior often stops. So, how can counselors effectively promote external self-regulation? Case Illustration 10.3 explores the case of Henry.

## CASE ILLUSTRATION 10.3

Henry is a single 37-year-old male who self-identifies as Hispanic. He comes from a well-to-do family and graduated from a prestigious university. He recently broke up with his girlfriend of 5 years, which is causing him to experience bouts of sadness and depression. To cope, Henry has previously engaged in risky behaviors (i.e., occasional drug use, unprotected sex with strangers) but reports that this is no longer an issue. Henry's most recent concern is that he continues to feel sad and depressed and is unable to control his eating and excessive weight gain. He has tried to lose weight on his own but has not been successful, causing him to feel even more depressed. He is beginning to isolate from friends and family, lacks motivation to exercise, continues to eat fattening foods, and has very little insight into how his depression and weight gain are linked. Henry seems to lack any mechanism for self-regulation. Internally, his decision-making skills regarding his eating habits are poor, he has limited self-efficacy to engage in exercise, and he is unable to recognize how his current behaviors are exacerbating his symptoms of depression and

his outlook on life. Henry's external motivators of wanting to manage his depression and control his weight are not greater than the gratification he receives from eating fatty foods and isolating from others. In fact, those behaviors diminish the value of his external motivators to self-regulate and serve as barriers to change. In working with Henry, counselors would be most effective by removing those unnecessary barriers. Assisting Henry in understanding the link between his depression and eating and developing a realistic exercise regimen and diet plan could strengthen his external motivation for wanting to feel less depressed and get in shape. This goal is to improve Henry's source of external self-regulation through removing barriers that may thwart his decision to engage in healthy behaviors. In doing so, Henry will begin to make healthier eating choices, exercise more often, and feel less depressed. By removing these barriers, Henry's external sources of self-regulation will improve and, over time, so will his internal sources of self-regulation (i.e., self-efficacy, decision-making abilities, attitude, and foresight into the future).

Although we have discussed internal and external mechanisms of self-regulation as if they occur exclusively from one another, the exact opposite is true. At the onset of treatment, clients with comorbid disorders may verbalize the desire to change but show little action in doing so. This is because numerous perceived barriers stand in their way and moderate their external sources of self-regulation (e.g., desire to lose weight, seek help for depression). Counselors can be most effective in teaching clients how to overcome those barriers and in doing so, strengthen clients' ability to externally self-regulate, which ultimately advances their internal ability (i.e., decision-making ability, self-efficacy in completing tasks, having foresight into the future, attitude) to do the same. Remembering that internal and external motivators to self-regulation work in tandem and are what promotes and sustains behavioral change across the life span is vital to the success clinical mental health counselors experience with their clients.



## Keystones

- Behavioral medicine is a multidisciplinary science that integrates knowledge from various fields related to health and illness; practitioners apply this knowledge in the treatment and prevention of illness through targeting behaviors that impact overall health and well-being. The behavioral medicine approach is grounded in the philosophical principles of the biopsychosocial model. Illness formation and health promotion is best conceptualized as the product of three interacting factors: biological, psychological, and social. A practical application of the behavioral medicine approach can be observed in integrated care treatments.
- To better manage behavioral and mental illness in medical clients, many clinical mental health settings have begun to offer integrated care treatment. Integrated care treatment is the systematic approach to treating both behavioral and primary health care needs concurrently. The strength of integrated care treatment results from the level of service integration between providers from both behavioral and primary health care settings. Service integration occurs along a continuum: coordinated, co-located, and fully integrated.
- The therapeutic alliance conceptualized from the integrated care treatment approach includes the relationship between counselor and client but also hinges on the relationship between the client and all providers in the continuum of care, as well as the relationship between all providers. Effective communication with clients and between providers occurs when the therapeutic alliance is attended to throughout the treatment process. Among providers, effective communication is facilitated when providers show respect for one another, integrate others' professional language when communicating, have a clear understanding of their and others' roles and responsibilities, and partake in cross-training. Effective communication is facilitated between clients and providers when providers respect their client, create a caring environment, engage in conversation with clients, and effectively use verbal and nonverbal communication skills.
- Successful client interviews require counselors to be competent in using the basic interview skills: active listening, empathy, open- and closed-ended questions, and attending to nonverbal body language. Client interviews follow a systematic approach, which generally occurs across six stages. Although a systematic approach to interviewing is used, counselors need to be aware of unanticipated incidents that may arise during the interview process.
- Motivating medical clients with comorbid behavioral and mental illness to engage in and sustain behavioral change can be challenging. Remember that behavioral change is a temporal process, and by educating clients on the stages of change, counselors can mitigate many of the barriers (e.g., lack of awareness, resistance, relapse) clients may experience as they proceed to alter deep-rooted behaviors. Effective self-regulation is critical to clients sustaining behavioral change across the life span. Counselors need to work with clients in identifying the processes of both internal (i.e., decision-making process, perceived self-efficacy, attitude, forethought) and external (i.e., rewards, punishments, social factors) mechanisms of motivation. Effective motivation removes immediate barriers inhibiting behavioral change but does not diminish a client's internal self-regulation.

## Key Terms

Active listening 255	Closed-ended questions 257	Open-ended questions 256
Behavioral medicine 242	Continuum of care 244	Overjustification 265
Biomedical model 242	Empathy 256	Reflection of content 256
Biopsychosocial model 242	Integrated care treatment 245	Reflection of feeling 256
Client-centered care 251	Nonverbal body language 257	Relapse prevention plan 264

## Web Resources

Aims Center: Evidence-Based Behavioral Interventions in Primary Care (<https://aims.uw.edu/evidence-based-behavioral-interventions-primary-care>)

International Society of Behavioral Medicine ([www.isbm.info](http://www.isbm.info))

National Institutes of Health, Office of Behavioral and Social Sciences Research (<https://obssr.od.nih.gov>)

Society of Behavioral Medicine ([www.sbm.org](http://www.sbm.org))

Substance Abuse and Mental Health Services Administration: Integrated Care ([www.integration.samhsa.gov](http://www.integration.samhsa.gov))

Transtheoretical Model of Behavioral Change ([www.health.gov.au/internet/publications/publishing.nsf/Content/drugtreat-pubs-front9-wk-toc-drugtreat-pubs-front9-wk-secb-drugtreat-pubs-front9-wk-secb-3-drugtreat-pubs-front9-wk-secb-3-3and](http://www.health.gov.au/internet/publications/publishing.nsf/Content/drugtreat-pubs-front9-wk-toc-drugtreat-pubs-front9-wk-secb-drugtreat-pubs-front9-wk-secb-3-drugtreat-pubs-front9-wk-secb-3-3and) <http://mdquit.org/health-behavior-models/trans-theoretical-model-ttm>)

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