INTERVIEWING TIP #1: THE BEHAVIORAL INCIDENT

The Problem
All sorts of resistances may predispose a patient to provide distorted information including anxiety, embarrassment, protecting family secrets, unconscious defense mechanisms such as rationalization and denial, and conscious attempts to deceive.

The Solution
The behavioral incident technique was delineated by Pascal [1], who defined behavioral incidents as any question in which the clinician asks about concrete behavioral facts or trains of thought. Pascal notes that to cut through patient distortions, it often is best for clinicians to make their own judgments based on the behavioral details of the story as opposed to the patient’s opinions about these behavioral details. He cautions that it is unwise to assume that any person, when asked for an opinion, can objectively describe matters that have strong subjective implications. Instead, Pascal suggests focusing upon the behaviors themselves.

There are two styles of behavioral incident: fact finding and sequencing. Let us look at the high-stakes arena of suicide assessment to see the first style of behavioral incident in action. In fact finding, instead of asking the patient for his opinion (eg, “How close do you think you came to killing yourself?”), which can be easily deflected with a quick, “Oh, not that close.”), the clinician asks directly about specific behavioral details: “Exactly how many pills did you take?” or “When you placed the gun to your head, did you take the safety off?” Notice how the information gathered by these behavioral incidents may provide more valid data concerning the actual closeness of “pulling the trigger” or “popping the pills” than provided by the question that sought only the patient’s opinion.
In the second style of behavioral incident—sequencing—the clinician asks the patient to describe what happened next (eg, “What did you do then?”) or what thought or feeling came next (eg, “What were you thinking at that moment?”) This second style of behavioral incident provides a method for uncovering both behaviors and cognitions in a sequential fashion.

By combining both types of behavioral incidents into a series of questions, the interviewer often can recreate the incident in question by creating a walk-through of the dangerous event, whether it be a suicide attempt or an act of domestic violence. Such sequential walk-throughs are remarkably good at triggering forgotten or repressed material while decreasing patient distortion.

Once again the elicitation of suicidal ideation can serve as a prototype for this strategy. The interviewer poses a series of questions after a patient has reported having thoughts of shooting himself: “Do you have a gun in the house?”; “Have you ever gotten the gun out with the intention of shooting yourself?”; “When did you do this?”; “Where were you sitting when you had the gun out?”; “Did you load the gun?”; “What happened next?”; “How long did you hold the gun there?”; “What thoughts were going through your mind then?”; “Did you take the safety off or load the chamber?”; “What did you do then?”; ”What stopped you from pulling the trigger?”

Further examples of fact finding and sequencing behavioral incidents include

1. When you say you “threw a fit,” what exactly did you do? (fact finding)
2. Did you put the razor blade up to your wrist? (fact finding)
3. After yelling at you, what did your father do next? (sequencing)

Clinical Caveat
Behavioral incidents are outstanding methods for uncovering hidden information, but they are time consuming. For tasks such as suicide assessment, the increase in validity gained by their use is well worth the time spent. Obviously the clinician must choose when to use behavioral incidents, with a selective emphasis while exploring sensitive areas such as medication nonadherence, domestic violence, sexual abuse, substance use, and suicide.

INTERVIEWING TIP #2: GENTLE ASSUMPTION
The Problem
A plethora of factors can contribute to a given patient’s fears of stigmatization. Often a patient may feel that the thoughts or behaviors he or she is experiencing are so weird or bad that “nobody else has ever had such thoughts.” One technique for overcoming this obstacle is called “normalization” [2], in which the clinician implies that others have experienced the behavior in question (eg, “Sometimes when people are feeling very depressed, they notice that their interest in sex drops off dramatically. Has this happened to you at all?”) Normalization is a great technique, but I want to share another approach—gentle assumption—that I have found to be particularly effective at uncovering highly sensitive material.
The Solution
When using gentle assumption, the clinician, using a gentle tone of voice and nonaccusatory wording, assumes that the suspected behavior is occurring. This gentle assumption metacommunicates the reassuring message to the patient that the clinician has already encountered the behavior in other patients.

The technique was developed by sex researchers, Pomeroy, Flax, and Wheeler [3], who discovered that questions such as, “How frequently do you find yourself masturbating?” were much more likely to yield valid answers than, “Do you masturbate?” If the clinician is concerned that the patient may be “put-off” by the assumption, it can be softened by adding the phrase “if at all,” as in, “How often do you find yourself masturbating, if at all?” I have found very few patients to be bothered by the use of gentle assumptions if previous engagement has gone well and the tone of voice used with the gentle assumption is nonjudgmental.

The definition of gentle assumption can be clarified by contrasting this technique with questions that are not examples of gentle assumption. Any question that asks whether or not a client engaged in a given behavior (eg, often beginning with words such as “Have you ever . . .”) is by definition not a gentle assumption. For example, when using a gentle assumption to uncover other street drug abuse after having explored the patient’s use of marijuana, the clinician would not ask, “Have you ever used any other street drugs?” Instead, the clinician would matter-of-factly inquire, “What other street drugs have you ever used, even once?” Only the latter type of question demonstrates the technique of gentle assumption.

Other examples of questions that embody gentle assumptions are:

1. What other ways have you thought of killing yourself?
2. What other problems have you had with the law?
3. In the past month how many doses of your medication do you think you may have missed?

Clinical Caveat
No one knows exactly why gentle assumptions work, but they do. Perhaps, as mentioned earlier, they metacommunicate that the clinician is familiar with the area and has seen other people with similar behaviors, indirectly letting the patient feel less odd or deviant. Gentle assumptions also may indicate that, at some level, the clinician may be expecting to hear a positive answer, and it is acceptable to provide one.

Gentle assumptions are powerful examples of leading questions (an attorney on “Law and Order” would be on his feet objecting to each and every one of them). They must be used with care.

More specifically, gentle assumptions should not be used with patients who feel compelled to please the interviewer (eg, a client who has a histrionic or markedly dependent personality disorder) or who might feel intimidated by the interviewer (eg, a child or client with limited intelligence). In such cases gentle assumptions can lead to patients reporting something that is not true, because they feel they are “supposed” to have had the experience or behavior in
question. I believe that gentle assumptions are inappropriate with children when exploring potential abuse issues: in such cases gentle assumptions can lead to the production of false memories of abuse.

Before leaving the technique of gentle assumption, it is worth mentioning that sometimes the effectiveness of these validity techniques can be enhanced by linking them into doublets. For instance one could link the normalization technique briefly mentioned earlier with gentle assumption (eg, “Some of my patients tell me it is easy to forget medications, especially when taking them several times a day [normalization]. In the past month how many doses of the medication do you think you may have missed? [gentle assumption]).

INTERVIEWING TIP #3: SYMPTOM AMPLIFICATION

The Problem
Once an interviewer has skillfully uncovered a problematic behavior, a new task arises: determining the extent of the problem. This task brings the interviewer face to face with a most human, but quite problematic, penchant: minimization. Patients often downplay the frequency or degree of disturbing behaviors such as drinking and gambling. One wonders if there is a way to decrease the distortion caused by patients’ minimization while maintaining engagement?

The Solution
The use of the technique of symptom amplification, developed by Shea, bypasses the patient’s distorting mechanism by setting the upper limits of the quantity in the question at such a high level that, when the patient downplays the amount, the clinician is alerted that there is still a significant problem [2]. For a question to be viewed as symptom amplification the clinician must suggest an actual number.

For instance, when a clinician asks, “How much liquor can you hold in a single night? A pint? A fifth?” and the patient responds, “Oh no, not a fifth. I don’t know—maybe a pint,” the clinician is made aware that there is a considerable problem despite the patient’s minimization. The technique avoids creating a confrontational atmosphere in the interview, even though the client is patently minimizing behavior. Instead, almost in the same way that a martial artist allows the sparring partner’s own momentum to drive the opponent to the mat, symptom amplification allows the client to continue to use his or her natural defense mechanisms (in this case minimization) fully while the interviewer still manages to obtain a more accurate snapshot of the extent of the patient’s problem.

This technique often is useful in obtaining a more valid history of the extent of violence a perpetrator is displaying (eg, in situations of domestic or predatory violence). If a perpetrator of domestic violence is asked, “How many times have you ever struck your wife?” a typical response, after a few seconds of hemming and hawing, is, “Not often—I don’t know—two or three times, maybe.” Contrast this information with that obtained from the very same patient when the interviewer uses symptom amplification, asking, “How many times have you ever struck your wife, you know, in any fashion? Thirty
times? Forty times? Fifty times?” To this question the same client might state, “Oh my gosh, not 50 times. I don’t know. Fifteen times. Ten times. I don’t know. It’s hard to remember.”

It is worth repeating that symptom amplification is used in an effort to determine an actual quantity. It always involves the interviewer suggesting a specific number, set high, with a patient that the interviewer suspects uses minimization as a defense.

Other examples of symptom amplification are

1. How many physical fights have you had in your whole life? Fifty? Eighty? A hundred?
2. How many times have you tripped on acid in your whole life? Twenty-five? Fifty? A hundred times?
3. On the days when your thoughts of suicide were most intense, how much of the day did you spend thinking about killing yourself: 70% of the day, 80%, 90%?

Clinical Caveat

The interviewer must be sure not to set the upper limit at such a high number that it seems absurd or creates the appearance that the interviewer does not know what he or she is talking about. How high the number is set will depend on variables such as the patient’s history of past abuse and cultural milieu.

As we saw earlier, it sometimes is useful to combine validity techniques. Sometimes they can be linked into triplets: “Some of my patients tell me it is easy to forget medications, especially when taking them several times a day [normalization]. In the past month how many doses of the medication do you think you might have missed [gentle assumption]—10, 20, 30 [symptom amplification]?”

STRATEGIC TIPS AND ILLUSTRATIVE DIALOGUE

The three techniques discussed here can be woven into a sensitive and smoothly flowing interview. An example of such an interview, reconstructed from an interview with a patient riddled with antisocial traits, shows these techniques at work.

The following dialogue shows how the strategic use of validity techniques makes it difficult for the interviewee to distort the truth through processes such as the parsing of words or relying upon an idiosyncratic interpretation of a word such as “hit.” Also, note the power of the behavioral incident to cut away both the patient’s distortions and the interviewer’s own assumptions and/or projections that also can cast a mist of distortion on the story being told. In this dialogue this phenomenon is most striking when the patient uses the phrase, “I lost it on her.”

Patient: My wife and I haven’t really gotten along well in years [pause]. Last weekend we really went at it.
Clinician: Tell me what happened. (behavioral incident)
Patient: Well . . . She just started on me about needing to get a job, that’s her big thing now. She wants me to go down to the unemployment office today not
tomorrow. Today. So she starts ragging and yelling and I [pause] I just couldn’t take it anymore so I lost it on her.

Clinician: What do you mean “lost it on her”? (behavioral incident)
Patient: I left. Just took off in a fit of rage. I waited till she went out to the kitchen, and I went out the back door, and I didn’t come back for 2 days. I didn’t call her. I didn’t look for a job. I just bagged it all. Screw her.

Many clinicians, including the author, would interpret the phrase “lost it on her” as meaning physical violence. The behavioral incident dismantles this assumption and uncovers a much less disturbing, albeit still pathologic, behavior. Although this assumption would have been off the mark here, the clinician’s intuition of violence is appropriate, as is soon shown.

Clinician: Sounds like you two really do go at it. At such moments sometimes people have a hard time controlling their emotions [normalization]. How many times have you found yourself stressed to the point that you may have lost your temper and perhaps hit her [gentle assumption]?
Patient: I’ve not really done that.
Clinician: What do you mean “not really”? (behavioral incident)
Patient: Well, I’ve never really ever hit her, not with my fist.
Clinician: Well, have you ever struck her in any way whatsoever? (behavioral incident)
Patient: I slapped her a couple of times.
Clinician: Did you ever slap her hard enough that it caused some bruises? (behavioral incident)
Patient: Not really [pause]. Maybe a black eye once or twice.
Clinician: How many times do you think you have ever hit her? Thirty times?
Forty times? [symptom amplification]
Patient: Hell, not that often. Maybe six, seven times.
Clinician: Has she ever had to get stitches or go to the ER? (behavioral incident)
Patient: Oh no, shit no, never.
Clinician: Billy, you told me earlier about all the abuse your father did to you, and it sounded really bad. Sometimes people find that with abusive parents they have to lie to protect themselves [normalization]. Do you know what I mean?
Patient: Hell yea. After he’d had a drunk on, you’d tell the old man whatever he wanted to hear and then you got your ass out of Dodge. And sometimes I had to lie to protect my Mom or my brother.
Clinician: Some people with similar histories of abuse tell me they keep on lying, almost out of habit, even when they are older and sometimes even when they don’t want to [normalization]. How often do you find yourself in that situation [gentle assumption]?
Patient [smiles]: Well, Doc, I suppose I lie if I need to.
Clinician: Have you become a pretty good liar over the years?
Patient [bigger smile]: Yea, I guess you could say that.

CONCLUDING COMMENTS
The dialogue in the previous section shows the power of these techniques to uncover domestic violence and antisocial behavior. As I stated earlier, these
techniques are of use in a variety of sensitive areas, from obtaining an accurate history of substance abuse to uncovering medication nonadherence.

Perhaps the most practical and sophisticated use of these techniques is in the elicitation of suicidal ideation and intent as used in the Chronological Assessment of Suicide Events (the CASE approach). Earlier we had seen how the use of the behavioral incident could help the interviewer elicit suicidal ideation more accurately. The CASE approach creates a flexible interview strategy that weaves all of the validity techniques discussed in this article into a method of helping patients share their inner world of suicidal turmoil. The CASE approach is designed to garner a more accurate history of the patient’s suicidal ideation over time, including past behaviors, recent planning, and immediate suicidal intent. In the CASE approach, suggestions are made not only for what bits of information may be of use in the clinical formulation of suicide risk, but which of the above validity techniques—and in what sequence—may be best used for eliciting this information in a sensitive and engaging fashion.

For readers interested in learning more details about the CASE approach in clinical practice, see Shea [4–6]. To learn more about its use in the arena of substance abuse treatment, I recommend consulting another article by Shea [7]. Finally, a discussion of how to train clinicians and trainees to use the CASE approach through a method of serial role-playing (macrotraining) can be found online in our Bonus Web Archive at www.psych.theclinics.com by selecting the June 2007 issue, “Clinical Interviewing.”

I hope that you have enjoyed this brief introduction to some of the validity techniques currently in the literature. Over the years, I have found them to be of immense value in my clinical work. I think you will enjoy using them and I have no doubt that they will help you to secure a more valid database in many different areas and, quite possibly, save a life some day.

References