

CHAPTER FIVE

Supportive Skills

THE SKILLS OF HELPING that facilitate engagement with clients; put them at ease; establish a trusting and empathic working relationship; provide comfort, understanding, compassion, and encouragement; and further facilitate the implementation of the assessment and intervention are referred to here, for the sake of simplicity, as *supportive skills*. As noted earlier, the research on the working relationship and basic counseling skills is voluminous, and the evidence for the importance of a sound working relationship is impressive (e.g., Hill, Nutt, & Jackson, 1994; Hill & O'Brien, 2004; Horvath & Greenberg, 1989; O'Hare, 2005; Orlinsky & Howard, 1986; Orlinsky, Grawe, & Parks, 1994; Rogers, 1951; Truax & Carkhuff, 1967). Implicit in the ability to develop and maintain a good working relationship and to engage and motivate clients in the change process is the need for practitioners to master basic interviewing skills (Hill & O'Brien, 2004; Shulman, 1999; Sommers-Flannagan & Sommers-Flannagan, 2003). Although practitioners and theoreticians of good will often disagree about the meaning or theoretical significance of the working relationship, most social workers agree that a sound supportive relationship and essential interviewing skills are a critical dimension of effective care.

The Basic Elements of Supportive Skills: Listening and Communication Skills

Interviewing skills are, perhaps, the most elemental of the helping skills. They are not only essential for the effective use of supportive, therapeutic coping, and case management skills but also necessary to conduct valid

assessments and evaluation. Thus, basic interviewing skills lay the foundation for effectively implementing all social work practice functions. Basic interviewing skills include asking important questions, listening accurately, seeking clarification, accurately identifying feelings, and recounting client experiences. Skillful interviewing creates a level of discourse that encourages clients to be forthcoming about their difficulties, enhances collaboration, and enhances clients' adaptive capabilities. To better understand clients, practitioners must make their best efforts to enter and understand the client's subjective world to better understand who they are, what experiences they have had, how they see themselves and others, how they understand their current difficulties, what they want to achieve, and what they need to do to improve their lives.

At all stages of service provision, from first contact to last, interviewing skills (1) develop and maintain a working relationship with the client; (2) help obtain as accurate a picture as possible of what the client thinks, feels, and does; (3) deepen the practitioner's understanding of the role of people and events that affect the client, both through the client's eyes and by interviewing significant others; (4) encourage the client to engage in the intervention process; and (5) assist the client in monitoring his or her own progress and evaluating the impact of the intervention as best as he or she can. How interviewing skills are used may vary from client to client on the basis of age, the client's presentation style, the client's psychological and intellectual capacities, and the practitioner's own personal style. Nevertheless, there are some basic interviewing skills that have been well researched and honed by years of practice experience. They will be briefly reviewed here before considering other supportive and facilitative skills.

Types of Questions Used in the Helping Interview

There are different types of questions one can use to help clients generate personal narrative and obtain the information necessary for understanding a client's difficulties and adaptive capabilities. A good general approach is to ask questions initially that are somewhat general and then work toward more specific questions that focus on greater detail. This deductive trajectory from the general to the specific is helpful not only in the first few interviews when the practitioner conducts a thorough assessment but also in later interviews when clients are actively engaged in working toward solutions to their problems. Most of what follows regarding basic skills applies to older adolescents and adults. This chapter will also address adapting essential supportive skills to working with children.

Open-ended questions are quite general and allow clients wide latitude to talk about themselves and their situations. By using minimal prompts and little structure, open-ended questions provoke clients to take the initiative to discuss what they think is important. In the first visit, for example, a practitioner may simply begin, "So, what brings you into the clinic today?" For some clients, this opener may be more than enough. At some point, the practitioner may have to interject some modest amount of structure in the discussion to obtain necessary information to conduct the formal assessment (see appendix B). However, for verbally active clients, a little structure and occasional prompts ("So, tell me a little more when you first felt depressed") may be sufficient.

Closed-ended questions offer a more limited range of answers and encourage clients to provide more definitive answers to specific topics. "So, did you drink alcoholic beverages this weekend?" may be a follow-up to a client's vague report on how he or she has been coping since being discharged from a rehabilitation facility. If the client responds in the affirmative, closed-ended, follow-up questions might include "So, how many drinks did you have?" With a court-ordered client, a practitioner might ask: "Have you tried to see your spouse since she had a restraining order taken out on you?" Closed questions are intended to limit the range of possible answers, in this case, to yes or no.

Specific questions are intended to focus the interview in greater detail on important subjects regarding the client's thoughts, feelings, behaviors, or details of a situation or event. These questions are intended to fill in the gaps of a general narrative about especially important events (e.g., "When did your husband hit you? Was this the first time? No? Then, how many times had it happened before? How did he hit you? Was it a slap or a punch? Did he ever use an object or a weapon? What kind of injury did you sustain? What happened after the event was over? Did you call the police? Was anyone else there to witness what happened?). Although in some situations, the interview may sound a bit like an interrogation, this is typically not the case if a sound working relationship has been formed with the client and the practitioner communicates empathic concern. The details of clients' problems and experiences may be critical to understanding exactly what has been going on for them. At times, talking about the events out loud may be the first time a client has had a chance to process thoughts and feelings about a stressful or traumatic event. The opportunity to discuss the events in detail in the presence of an empathic and trusted listener can be inherently therapeutic.

Detailed querying is also critical when recounting a client's experiences in implementing the intervention outside of the fifty-minute hour. Most

effective interventions involve a client's active participation in the treatment during everyday life, whether the purpose is working on communication skills with his or her partner, improving parenting skills with an oppositional child, taking one day at a time to stay clean and sober, or trying to master social anxiety. When client and practitioner meet in session, recounting the client's efforts to implement the intervention in everyday life usually involves some reconstruction of events to gauge whether the client is making progress (e.g., "What opportunities did you make to work on your social anxiety this week?" "For how long did you carry on your conversation with that new woman in your office?" "Did you ask her out for a cup of coffee?" "How did your lunch date go?" "Did you ask her about what she likes to do in her free time?" "What did she say?").

Some counseling texts refer to interviewing styles as either directive (structured) or nondirective (unstructured). The fact is that effective interviewing requires a thoughtful use of both. Nondirective interviewing relies more on open-ended questions, creates ambiguity regarding expectations of the practitioner, and gives clients free rein to take the discussion where they want to go. A directive style introduces more structure into the interview, uses more closed questions that limit response options, and is more purposeful to the task at hand. As for the client recently discharged from rehabilitation, mixing closed and open questions might sound like the following: "So, you had about fifteen drinks on Saturday afternoon. Can you tell me what was going on with you emotionally at that time?" (open question). Then, "Did you make any attempt to cut short your relapse?" (closed question) and "How did you feel about your slip the next day?" (open question). Using only one interviewing approach or the other makes little sense in social work practice. The exclusive use of a nondirective approach would result in puzzling ambiguity and leave many clients eventually wondering what the purpose of the intervention was. Conversely, an exclusive reliance on a directive style would likely leave some clients wondering if the practitioner were even interested in what they thought or felt or were simply carrying out some predetermined agenda of his or her own. Directive and nondirective approaches should be mixed and follow both an inductive (broad information gathering) and deductive (drawing cause-effect conclusions) pattern. The purposes of each interview are guided by the goals of the intervention (previously negotiated between practitioner and client) and the phase of the intervention: completing the assessment, implementing the intervention, or conducting the evaluation. In general, sessions with clients should probably begin on an open-ended note and

move toward a more structured purpose linked to treatment goals. Imbuing each interview with that kind of rhythm helps keep the purposes of the intervention at the forefront.

Adopt a Relaxed and Attentive Posture

Helping a client feel at ease is the result of several processes and is closely intertwined with good interviewing skills: careful listening so the client feels that he or she is being understood accurately, carefully delineating both the practitioner's and client's role; and being relatively nonjudgmental and focusing on an agenda to solve problems and enhance coping in everyday life. Practitioners must be genuine, authentic, and come across in a way that is congruent with who they are so that their professional demeanor does not come across as contrived. Clients feel more at ease when they understand the purpose of meetings and feel they have some input into the treatment agenda. Even court-ordered clients can be given some degree of choice and a sense of control over methods and treatment goals. Clients will also feel more at ease when they feel assured that the practitioner will uphold the informed-consent and confidentiality aspects of ethical practice (see chapter 3). Clients feel more at ease when practitioners communicate that they are knowledgeable, competent, and confident that they have the skills to help the client. Finally, clients feel more at ease when they sense that the purpose of the meetings is to focus exclusively on the agreed-on goals of the intervention and that there is no other competing agenda insinuated into the meeting. Said another way, the express purpose of the meetings is to help the client achieve his or her goals.

Most clients are at least a little nervous when interviewed by a social worker, particularly for the first time. They may suffer from a psychiatric disorder, be investigated for alleged abuse, struggle with a drug problem, or have recently been released from prison. The client may be relieved to have the opportunity to be seen, may be guarded or angry at being coerced into the visit, or may be indifferent. Some clients may suffer from psychoses and be somewhat delusional about the purpose of the meeting, and others may be so depressed they are almost unable to respond to questions. In general, it helps to begin by appearing relaxed and attentive. This presentation will communicate to the client that the practitioner is alert, ready and willing to be of assistance, and interested in hearing what the client has to say. Depending on the cognitive and emotional state of the client, practitioners should be ready to expend the necessary level of energy it

takes to engage each client depending on how much initiative the client takes in the interview. The client recently court-ordered to the interview, for example, may be hostile and give only one-word answers, provoking the interviewer to work harder to engage the client in the assessment. An anxious client may speak rapidly, obsess over every minute detail of a story, or jump from one subject to the next. Practitioners might need to help these clients structure their presentation and focus on more substantive matters. The depressed client may be almost mute, necessitating that the practitioner work hard just to excavate even basic background information. Practitioners should consider being relaxed and attentive a good starting point, but they should be flexible and ready to engage the client according to his or her needs, abilities, and expectations.

Nonverbal Communication

For the most part, in Western cultures, making eye contact is a powerful form of communication in that it demands the other person's attention and communicates a form of psychological engagement. When you look into the client's eyes, it says that you are paying attention to them. However, not all clients are comfortable being stared at for a lengthy period of time. Clients who are shy or otherwise anxious, feel unduly scrutinized, are ashamed, or are hiding something they feel uncomfortable about may begin to chafe under a social worker's unwavering gaze. In some cultures, it may be simply impolite or even an affront to make steady eye contact. Practitioners should take notice to determine whether a client is comfortable making consistent eye contact; if not, practitioners should perhaps break off the constant gaze by taking occasional notes or looking down or away from the client between questions or points of discussion. Some practitioners have been known to position their chairs in such a way that they need not look directly at the client if the client seems uncomfortable. Being flexible about seating arrangements and providing choices for clients can help them be more comfortable during the interview.

If one pays attention to everyday conversation (in line at the check-out counter, at home with family, with friends, or at work), one would readily become aware that much of what passes for conversation is nonverbal. *Nonverbal behaviors* refer to nonword vocalizations and physical gestures that convey fairly specific meaning in everyday discourse. Nonverbals are, essentially, powerful shorthand vocalizations and gestures that facilitate communication. The classic *uh-huh* encountered in popular media portrayals of therapy is, indeed, a common utterance. It is simple, easily recognized in everyday conversation (though not in all languages), and is

infinitely flexible to provide nuanced indication of interest in what the client is saying. *Uh-huh* can suggest keen interest, boredom, humor, disapproval, concern, or compassion with the slightest inflection. The same can be suggested about *hmm*, *aha*, or other nonverbal expressions. Practitioners should pay careful attention to these almost automatic utterances and note how clients respond to them, as their meaning can be ambiguous.

Other nonverbal utterances include facial expressions, another powerful form of communication. Generally, social workers do not receive the kind of training that, for example, professional actors do. So they may not be keenly aware of what they are communicating through facial expressions. But facial expressions can clearly communicate any of the following, often in a more primal and compelling way than words can: concern, compassion, disgust, anger, sarcasm, pity, ridicule, alarm, fear, and so forth. Spending some time in front of the mirror may not be a bad way for a practitioner to examine how he or she expresses the full range of emotions, and being aware of how one wears one's feelings on his or her face is critical to becoming aware of communicating emotional responses to clients. For example, after several months of this author working with a depressed young woman going through a divorce with an apparently difficult man, she remembered little about what I had said during our sessions but recounted in her last session: "All I had to do while talking about how things were going at home was to look at your face, and I knew that I wasn't the crazy one!" Fortunately, my ingenuous communications of alarm and puzzlement at their encounters validated for her that her husband's behaviors were somewhat extreme, unfair, and sometimes hostile, and that the failure of the marriage was not all her fault.

But nonverbal behaviors go well beyond facial expressions. Sitting back, relaxed with one's legs crossed comports with the earlier suggestion to be relaxed and attentive. At some point, however, such a posture would seem bizarre, when, for example, a client recounts a time when he or she was sexually assaulted or contemplating suicide. Physical posture communicates an emotional response, and practitioners must be aware of what they are trying to say with their physical presentation. Again, practicing in front of a mirror may help beginning practitioners define extra concern (e.g., leaning forward in a chair to listen with extra care), such as reeling back slightly with a single clap of the hands to express surprise at a fortuitous outcome or joy at a client's courageous breakthrough. Leaning sideways in one's chair and scratching one's head to communicate a bit of confusion can be an effective way of saying, "Your version of the story seems to contradict what you were telling me last week. Perhaps I'm not getting this right." Although traditional approaches to psychotherapy long extolled the

virtues of adopting a somewhat impassive, blank-slate posture on which clients would project (displace) their deepest feelings about others in their life, this posture not only can seem contrived and artificial but also can be easily interpreted by some clients as apathy. Because most social work encounters are relatively brief (e.g., three to twelve visits), there is little benefit in creating such a level of ambiguity and confusion. When it comes to communicating with clients, practitioners should assume that everything they say or do, even silence, is a form of communication. The question is, What is it you are trying to say to your client, and is it in his or her best interest (i.e., does it help the client move toward intervention goals)?

Reflection, Tracking, and Clarifying

Effective communication between two people is generally considered a process of developing mutual understanding of each other's thoughts, feelings, intentions, and behaviors. Most theoretical communication models are represented as feedback loops: one person communicates a message, and the other person receives it, analyzes it, and sends back a communication. The first person acknowledges the response and demonstrates that he or she understood the second person's response—and the cycle continues. Understanding someone you know well or are especially close to can seem almost automatic. At times, you feel that you can anticipate what that other person is about to say. Sometimes friends, family members, or intimate partners can communicate and be fully understood with a gesture. People sometimes talk at each other simultaneously (breaking all the rules of good communication), or finish each other's sentences and, amazingly, can still find mutual understanding at a deep level.

Working with clients is another story, and little should be taken for granted about clear communications. The helping relationship is a professional and somewhat contrived one whereby relative strangers are expected to divulge personal information in a relatively short amount of time at scheduled intervals. As such, professional helping interviews are a special kind of relationship and require more purposeful communication skills. Understanding what your client is trying to tell you and helping them understand your responses can be much more difficult, and these skills must be cultivated with much practice. Helping the client feel understood is a task that often must be accomplished in a relatively short amount of time, not over weeks, months, and years. Practitioners facilitate communication by demonstrating that they really comprehend what the client is trying to get them to understand. Practitioners are primarily responsible

for seeing that the communication feedback loop is completed on a consistent basis. In addition to careful listening, the practitioner can ensure that the communication process is complete by consistently testing the clarity of the signal between practitioner and client.

Reflecting, tracking, and clarifying are related communication skills that are used to focus on one major goal: to gradually string together a clear, accurate, and understandable client narrative and to help the client confirm for him- or herself that you have understood. Reflecting, tracking, and clarifying are three related skills used to continually test the hypothesis that you, as practitioner, understand what the client says. *Reflecting* simply means repeating in a somewhat different way what the client said to see if your meaning is congruent with the client's meaning. This, of course, may take a bit of practice and may require a process of gradual approximation. Clients generally appreciate that you make the effort to accurately reflect what they say before you move the conversation forward. One way to quickly lose a client's tenuous commitment to the working alliance is to behave as though you knew what the client meant when, in fact, you did not. The client might sense that you did not understand him or her and failed to make an effort to clarify what was said because of apathy or distraction. Making a concerted effort to understand exactly what the client meant shows respect, empathy, and a real commitment to helping the client. Clients have to feel, first and foremost, that you are willing to try hard to listen and understand what they are saying from their point of view. Practitioners may develop their own points of view, and may later (after a working relationship has developed) share their perspective with the client. But, especially early in the helping process, practitioners must demonstrate that they are willing and able to listen and reflect back to the client an accurate understanding of what the client is trying to say.

Accurate reflection is more challenging with some clients than with others. Young children, for example, might not have the verbal capacity to express their thoughts and feelings or to describe others' behaviors or intentions clearly or accurately. Adolescents may use language that is comprehensible only to their immediate social group. Many clients may struggle with their host country's language. Other clients may have difficulties expressing themselves verbally as a result of poor education, learning disabilities, or other developmental disabilities. Clients suffering from serious mental illnesses might use idiosyncratic language or have difficulty expressing themselves because of a thought disorder. Practitioners, whatever the circumstance, should be prepared to be flexible and resourceful in finding ways to communicate with clients. In many circumstances, such as with younger children, people who primarily rely on a nonnative language,

or people with specific problems with verbal expression, practitioners should be prepared to obtain specialized training so they can fully communicate with clients.

After demonstrating that you can accurately reflect what the client is saying, track what the client says, which means demonstrating that you can follow the narrative along from one point to the next. For clients who express themselves in clear, organized, linear fashion, tracking the narrative may be relatively easy. However, many clients encountered in social work practices struggle with emotional distress or cognitive impairments as a result of substance abuse, mental disorders, or other learning disabilities. Tracking what clients say may involve more than just following along, but it may take considerable effort on the part of the practitioner to help clients construct their narrative both temporally (i.e., connecting time and dates related to key events) and sequentially (i.e., sequencing cause and effect over time). This process of helping the client track the time line and causal sequence of events often requires some directive interviewing but must be done with a minimum of interference.

Clarifying combines the best of both reflection and tracking. Clarification is accurately communicating to the client that you understand not only specific facts or expressions of feelings but also how the client's experiences evolved over time and across situations. When practitioners clarify, they do not simply make sure that they understand each individual fact of the client's narrative; they show that they are beginning to get the big picture (i.e., put the facts in a broader context) and to connect the dots. The elements of your clients' experiences are related to all facets of their experience: thoughts, feelings, behaviors, and situations, especially those involving other people in their lives. As a result of clarification and understanding, an intricate picture of a client's experience begins to emerge. To use a more contemporary metaphor, accurate clarification of a client's experiences is similar to the emergence of a picture from a digital camera: the clearer is the electronic signal (i.e., the more pixels), the clearer is the whole picture. Clarification is, essentially, a descriptive exercise, not an interpretive one. A good test of whether you have achieved clarification is an unambiguous confirmation from the client, such as when he or she exclaims, "Yes, that's exactly what I mean!"

At times, practitioners must confront clients with known facts or the practitioner's professional opinion regarding something that potentially affects the client's well-being or the well-being of others. The term *confrontation* often brings to mind the stern or disapproving admonishments of an authority figure. In the working relationship, confrontation skills give

clients accurate feedback for several purposes: (1) the practitioner might have information that points out incongruities or apparent falsehoods in what the client has stated and maintained (e.g., evidence of child abuse, drug use, violence toward a partner, other harmful or unethical behaviors); (2) the practitioner might feel the need to point out something about the client's behavior that puts him or her at risk (e.g., repeating behaviors that put the client at risk of harm in a relationship, behaviors that put the client at greater risk of relapse with drugs or psychiatric symptoms). There are many other reasons why practitioners sometimes have to express opinions to clients that they may resist accepting. For confrontation to be effective, however, a sound working relationship must be in place. For example, if a young woman with a history of dating verbally and sometimes physically abusive men says, "I know he's been violent before, but I really think I can change him!" the practitioner might respectfully muster the relevant facts of the client's past relationships and present them in a straightforward manner: "Abbey, from our previous discussions, it sounds to me like you're about to make the same mistake you've made several times before. Each time, you thought you could change abusive men by loving them. And each time, you have ended up being disappointed or, even, abused again. I think we need to examine more closely why you seem to believe you have this power to change abusive men and why you confuse their efforts to control you with love or passion. Maybe we should talk about this some more before you plunge ahead. What do you think?"

For a young man struggling to abstain from alcohol and other drugs, confrontation may take the following form: "Joe, you've been in and out of rehab three times now. Each time, you've made an attempt to hang out with the same group of guys that like to party a lot. How is this time going to be different?"

Practitioners should develop their own styles with regard to confrontation. However, confrontation is a skill to be implemented with a balance of straightforward honesty and sensitivity. Being ambiguous, tentative, or overly sensitive is likely to be both confusing and ineffective. Real compassion requires the ability to be honest and explicit when the practitioner judges that the client is ready to receive accurate feedback. Being sensitive does not mean being ineffectual. Navigating the path toward an effective confrontation takes practice, and confrontations should be used sparingly and only after a sound working alliance is established. Although the client role brings with it some expectation that the client will receive some feedback from their practitioner, that feedback needs to be communicated in a way that shows empathy for the client's ongoing struggle.

Adapting Basic Interviewing Skills to Work with Children

As a function of age and cognitive development, children see the world differently than do adults. Thus, interviewing children requires special skills and a solid understanding of what cognitive competencies they have at each age. Practitioners who work with young children should especially have a solid grasp of modern child developmental psychology. Particularly young children (younger than age six, more or less) often have very different ideas about human relationships, the passage of time, and difficulty sorting out the concrete from the abstract. Children may have good memories of specific events, but the experience of the interview itself may significantly affect the retrieval and understanding of the memories. Children also have many fears and anxieties, some realistic and some not. They are quite susceptible to the vagaries of their imaginations in response to things they are told by others, see on television, hear in bedtime stories, or see in the movies. The phenomenology of young childhood is quite different from that of older children, adolescents, and adults.

It should also be understood that there are different purposes to interviewing children in social work practice: clinical assessment (to describe the problem and understand the factors related to the problem to prepare an intervention) and forensic assessment (to determine whether a crime has occurred). Many of the basic principles of interviewing described in relation to adults apply to children as well: careful listening, empathic attunement, putting them at ease, reflecting, tracking, and clarifying are all essential skills for interviewing a child. However, perhaps even more critical information is obtained through observation of children not only in the consulting room but also in the classroom, at day care, and during structured after-school activities. Possibly the most critical information is acquired from parents, guardians, and other adults (e.g., teachers, coaches, other responsible caretakers) who have ample opportunity to observe the child.

Nevertheless, there are some essential data that can be obtained from young children in the traditional one-on-one interview. Focus on their agenda, not yours. Listen with minimal prompts as needed and allow the child to communicate his or her inner world and version of events from his or her own point of view. Wilson and Powell (2001) suggest some ground rules for basic listening, tracking, and clarifying with children. Practitioners should take care to communicate to a child the following: "Let me know if I misunderstand you," "Tell me everything you can about what happened," "Let me know if you don't understand something I've said and I'll try again using different words," "Saying 'I don't know' or 'I

don't remember' is OK," "Tell me everything you remember but don't guess; just tell me what you are sure about," "Even if you think I already know something, tell me anyway," "Only talk about things that you know really happened," "You may use whatever words you want to use," "I promise I'll not get upset or angry at anything you say to me" (pp. 35–36).

A variety of aids can be enlisted to facilitate interviewing with a child, including the use of games, toys, and dolls (Morrison & Anders, 1999). When playing with children, use figures or toys that do not overly constrict play or themes that they might elicit. Put children at ease, get down on the floor at their level, and participate in a way that encourages them to play. Be a participant observer. Build rapport with the child, explore general themes, and then delve into promising areas with increasingly greater specificity. Be flexible in the way you approach the interview. Young children are not usually linear in communicating their story.

Research on the validity of using these methods suggests that simple games or activities that put children at ease and enhance communication with the practitioner are helpful. These activities include playing games or using dolls to re-create or remember events which may be a cause for concern (e.g., physical abuse, sexual abuse). However, practitioners should avoid drawing firm conclusions from children's utterances in response to symbolic play. Young children are suggestible, can be easily led, and often do not understand the significance of what the practitioner is driving at. Interpreting a child's unconscious motives or inferring abuse from symbolic play with toys, games, or drawings is risky, and there is little evidence that such interpretations are valid. Interpreting children's play or artwork is no substitute for more objective evidence when attempting, for example, to determine some external cause of their depression, anxiety, or other behavioral problem. As discussed in chapter 4, only through the collection of multidimensional data from multiple sources can a practitioner begin to make reasonable but tentative hypotheses about allegations of abuse, neglect, or other events that may negatively affect a child's mood or behavior.

Wilson and Powell (2001) provide some guidelines for the structure of the basic interview with children that reflect a similar approach to interviews with adults: establish a basic rapport, introduce the topic for discussion, elicit a free narrative account using open-ended questions, and use prompts minimally to keep the conversation on track. Practitioners should use simply worded, specific questions to clarify inconsistencies and obtain sufficient detail. The interviewer should then close with a brief summary and the interviewer should make an effort to provide the child with a chance to correct any mistakes or misunderstandings.

Putting Basic Interviewing Skills to Work: Developing the Working Alliance and Facilitating Change

Communicating Positive Regard and Respect

To successfully engage clients in a working alliance, communicating basic respect for them is essential. Treating a client with positive regard means that the practitioner communicates in words and behavior that he or she believes the client to have inherent value as a human being. Treating the client with respect means communicating through one's words, intonation, and other nonverbal expression that the client has inherent dignity and is worthy of concern and assistance. This assumption on the part of the practitioner may seem, at face value, to be an obvious prerequisite for practicing social work. However, practitioners, at times, should expect to find this assumption a challenging one to maintain with every client.

It has been commonly observed in the helping professions that some practitioners find that clients who are more verbal, better educated, and have better incomes seem to be more appealing to work with than are clients who are more marginalized or stigmatized in society. Voluntary, educated, and self-sufficient clients tend to be more personally engaging, are better socialized into the purposes and processes of psychotherapy services, are less likely to have serious mental illnesses, tend to place a priority on relationship problems, and are generally less stressful to work with. It is understandable that many practitioners cultivate their practice with clients who appear more amenable to voluntary, private social work services.

Some practitioners view clients who are less economically and educationally advantaged, are less sophisticated in the ways of talk therapy, are more likely to have serious mental health problems and chronic addictions, or have perhaps run afoul of the law as less desirable to work with. Many of these clients are considered involuntary, are less amenable to the role of client, and are more likely to be considered resistant and difficult to treat. Many of these clients have been in prison, and some have committed serious crimes, including domestic violence, physical and sexual abuse of children, rape, assault and battery, and gun-related offenses. Some practitioners may find that maintaining a position of positive regard and respect for clients who have engaged in serious antisocial behaviors or are otherwise stigmatized is very challenging indeed.

Practitioners, particularly those starting out in their social work careers, should be honest with themselves if they experience a strong degree of ambivalence regarding work with difficult-to-treat or antisocial clients. To work with involuntary clients, it is essential that practitioners sort through that ambivalence early on and be willing to distinguish clients' harmful

behaviors from their inherently good qualities as people. Understanding the contributions of genetic risk factors, the developmental impact of years of physical or sexual abuse, and the enduring effects of other environmental stressors can sometimes promote empathy and help practitioners maintain respect and positive regard for the client. At some point, the client may have been a good son or daughter, friend, or parent or may have contributed to the community in some meaningfully positive way. However, differentiating people from behaviors (while holding them accountable for their offenses) may not be easy for some practitioners. Beginning practitioners who choose to work with clients who have engaged in harmful and antisocial behaviors should honestly explore their feelings about working with such “unattractive” groups and admit any serious reservations they might have. The social work profession serves many needy populations, and practitioners should work with clients with whom they can establish a commitment and consistently maintain a feeling of respect and positive regard.

Being Genuine and Authentic

Genuineness and authenticity are achieved when one’s professional persona is congruent with who one really is as a person. Many clients can instinctively sense when a social worker is not being him- or herself, comes across as playing a role, or presents an image that simply does not ring true. Being authentic and genuine, however, does not mean self-confession or self-disclosure with a client. Being honest does not mean saying everything on one’s mind. Such excesses on the part of the practitioner can actually make the client uncomfortable (e.g., “Who is the client here anyway?”). All practitioners are somewhat different in the way they present themselves, in their sense of humor, in their comfort level with different clients, and in their style of professional decorum (formal vs. informal). What matters most is that a practitioner maintains good boundaries with the client, communicates a genuine empathy, and keeps the professional purposes of the work together clearly in mind.

Communicating Empathy, Compassion, and Understanding

Communicating empathy means demonstrating verbally and nonverbally that you understand, as best you can, how the client feels. Clients are likely to sense whether what you say and how you say it truly communicates empathy. Empathy should not be confused with agreeing with what the

client says or condoning a client's behavior. Empathy should also be distinguished from compassion, an expressed feeling that reflects a sense of shared, often painful human experience. You may express empathy for a man who has acted violently toward his family ("I can understand your sense of frustration and sense of powerlessness") without communicating compassion. On the other hand, a practitioner may be more likely to feel and communicate compassion for a client who has just lost a child to a terminal illness. Compassion goes beyond empathy, beyond merely communicating an understanding of the client's feelings and experience. Expressing compassion lets the client know that, as a person, you can imagine sharing in disappointment, loss, or other source of emotional distress.

Engendering Trust through Consistency and Attending to Client Needs

Many clients have had negative experiences with people in their lives. Many clients have been physically and sexually abused by people they otherwise trusted, betrayed by someone with whom they had an intimate relationship, abandoned by a mother or father, financially exploited, discriminated against, victimized by crime, rejected by fellow citizens after risking their lives for them in combat, or deeply harmed in some other way. Why should they expect a social worker to be any more reliable? Mutual trust is a condition between two people that must be developed, cultivated, and nurtured over time. It is not an assumed condition of the relationship between social worker and client. Trust implies constancy and congruency. Clients are more likely to trust social workers when they say what they mean clearly and directly, do not hide behind vague answers or use ambiguous, pseudo-professional language (i.e., psychobabble), do not pretend to know things for which they cannot give a well-informed answer, and consistently focus on clients' needs.

Practitioners can engender trust in a client by empathizing with the client's feelings regarding experiences in which he or she has been betrayed and by being trustworthy as a practitioner. Being worthy of trust means being consistent, reliable, and honest with your client, and always keeping the client's well-being in mind by keeping the main purpose of the intervention in the forefront.

Providing Encouragement and Enhancing Motivation

Clients come to receive social work services with different levels of motivation and readiness to make changes. Many clients experiencing personal

problems, mental illnesses, substance use disorders, eating disorders, family problems, and the like, generally do not feel enthusiastic about asking for help. Some may not feel they have a problem and resent having been coerced into social work services through the child welfare, mental health, or criminal justice system. Some clients may be difficult to engage initially but often participate more when they feel they have some say in how the intervention will progress and realize that participation may yield some personal benefit.

Other clients are highly motivated: they want to feel better and want their situation to improve. Such clients are more readily engaged in the beginning, though considerable ambivalence might emerge later as they realize they may have to work hard to make some changes to feel better. Seriously depressed clients may have a hard time even getting out of bed in the morning, but they might feel the need to work hard because of obligations to those who depend on them. The person struggling with an addiction wants to stop drinking or using other drugs, but the initial success is often short lived. A young angry adolescent might be tired of getting into trouble but also does not want to give in to the demands of adults around him or her. The mother investigated by child welfare struggles with her commitment to give up smoking marijuana daily but does not want to lose custody of her children. All these clients know that they must make an effort to improve their situation, know that change might be hard, and struggle with their commitment to change.

In recent years, practice researchers have focused their efforts on reaching difficult-to-engage clients. Because of an increased emphasis in social work on work with involuntary (e.g., court referred, treatment mandated) clients, practitioners are more likely to deal with clients who do not believe that they have a problem, do not believe that psychosocial interventions are of any value, or simply disagree with practitioners about the nature of the problem or necessity for intervention. They may feel strongly (rightly or wrongly to some degree) that it is the system that is unfair.

Supportive and facilitative skills that focus on enhancing motivation are now considered essential for engaging clients in the early process of change (Miller & Rollnick, 2002). Perhaps one of the better-known assessment frameworks for identifying a client's readiness to change is that developed by James Prochaska and colleagues (Prochaska & DiClemente, 1984; Prochaska, DiClemente, & Norcross, 1992) at the University of Rhode Island. Their research team stipulates five stages of change: precontemplation, when clients do not agree that they have a problem, may see others as the cause of their difficulties, or may feel coerced into treatment by the courts or significant others; contemplation, when a client is aware of a

problem and may want to find out whether therapy can help; preparation, when the client takes some initial steps toward change; action, when a client may take more significant steps toward working on the problem and actively seek help in the change process; and maintenance, when clients have already made changes with regard to a problem and have sought treatment to consolidate previous improvements. Clients may cycle through these stages of change or proceed in a trajectory of one step forward, two steps back. The stages-of-change model has been employed with a range of problems including smoking cessation, substance abuse, and other mental health and health-related problems.

As the stages of change imply, clients are usually not clearly in one stage or another and may feel considerable ambivalence in the change process (O'Hare, 1996). If stages of change suggest when clients are ready, motivational enhancement methods (designed to help clients move beyond ambivalence and through the stages of change) suggest how to help clients engage in the change process (Miller & Rollnick, 2002). Readiness to change is particularly relevant for working with involuntary clients, those more or less coerced into receiving social work services who practitioners often label as "resistant," "hard to reach," "hostile," and "unmotivated" (Rooney & Bibus, 2001). However, the voluntary versus involuntary dichotomy is far from absolute and is better considered a continuum. Strategies designed to help clients move through the stages of change include the following:

- Accept clients' initial reluctance: Empathize with clients' ambivalence about engaging in treatment or making changes, acknowledge that they may have been treated somewhat unfairly without suggesting that you think they are blameless with regard to their current difficulties, and acknowledge that not everyone benefits from social work intervention. Above all, do not argue or try to sell clients on the benefits of treatment.
- Avoid premature confrontation: Again, do not quarrel. Get the facts from clients and other relevant sources. Practitioners should objectively present their summaries to clients and give them a chance to respond and explain their point of view.
- Clarify one's dual role within the social service and/or criminal justice system: Be up front with clients. Let them know you empathize with the situation and want to help with concerns. However, you collaborate with the criminal justice system because a particular client has been convicted of child abuse, drug possession, domestic assault, or some other antisocial act. Communicate the expectation

- that clients have an obligation to acknowledge the behavior (assuming the accusations are well founded), take responsibility for the behavior, and change the behavior. Social workers not only have an ethical obligation to protect society but also should use contingencies of the courts as therapeutic leverage to help clients meet agreed-on goals of the intervention (i.e., therapeutic jurisprudence).
- Explore clients' perspective on the problem: Encourage clients to suggest intervention goals and ways to pursue them. Recruiting clients as collaborators this way can provide them with some sense of control and choice in developing the intervention plan.
 - List problems by priority: Start with one or two that are more readily resolved; then break each individual problem and objective down to manageable steps.
 - Employ behavioral contracting: Collaborate on agreements, keep them specific, and track them to completion.
 - Avoid overemphasis on clients' irrelevant self-disclosures: Gauge each client's need to open up but do not make it a condition of pursuing intervention goals.
 - Anticipate obstacles to treatment compliance: Look down the road with clients and help them identify scenarios that may interfere with successfully reaching agreed-on goals.
 - Involve significant others when at all possible: Encourage clients to recruit people in their lives who have a vested interest in the client's compliance with intervention goals.
 - Actively enhance motivation: Help clients visualize the benefits of working toward intervention goals and consequences of returning to the previous problem behaviors, list the pros and cons of changing versus not making progress, and empathize with the difficulties of change but communicate optimism about positive change and the benefits that might accrue.

Enhancing Clients' Confidence and Morale

Improving self-confidence, overall morale, or self-efficacy with regard to coping with some specific problem is not something that a practitioner can readily impart to a client. Clients must earn that feeling from graduated experiences of success. Relating positive testimonials of other clients struggling with similar difficulties or reporting relevant outcome-research findings might be helpful ("You mean, I'm not hopeless?"), but there is no substitute for success. For positive success experiences to occur, however, practitioners must be skilled in clearly identifying the problem and helping

clients break it down into manageable objectives. The intervention methods used must be targeted toward achieving modest but substantive objectives so clients can gradually gain back a true sense of confidence. This linking of client behavior and increased self-efficacy (i.e., the belief that one can cope in a given situation) is where the practitioner's ability to cultivate a supportive working relationship facilitates effective therapeutic coping skills. The working relationship, in many cases, makes it possible for clients to take the risks necessary to make real changes and experience success. The practitioner and the working relationship he or she cultivates become a catalyst for change.

Clarifying Roles of the Practitioner and the Client

The practitioner has the primary responsibility of being the expert; that is, the practitioner, not the client, is the one who has the requisite credentials, gets paid for the service, is liable for providing services within established standards of care, and is held accountable for delivering ethical and effective interventions. Clients expect social workers to be knowledgeable about the problems they treat and skilled in the interventions they provide. Thus, in the practitioner-client relationship, the practitioner is responsible for certain roles: conducting informed assessments, implementing interventions that have been shown to be effective in current outcome research, and evaluating the results of those efforts.

Although practitioners bear much of the responsibility for implementing professional services, clients have responsibilities as well. They should be expected to show up on time, make an effort to participate constructively in treatment, and cooperate with arranging for insurance and initially agreed-on out-of-pocket payments. Also, clients can forfeit their rights to confidentiality and informed consent when they threaten to harm themselves or other people during the course of the intervention.

Clarifying the role of the practitioner and that of the client, however, can be confusing at times. For example, for most social work agencies, maintaining fiscal integrity (i.e., balancing the budget) is critical for the agency to continue serving the public. Sources of income for agencies can span the continuum from private to public funding and often combine both sources. The manner in which these conditions influence practitioners, however, can influence intervention planning decisions. For example, in a busy clinic where a combination of state funding and private insurance pays for services, should the extent of coverage determine, in part, clients' length of stay? Even with the most ethical of behavior (e.g.,

avoiding conflicts of interest) on the part of practitioners and administrators, there are external influences that have a subtle but real impact on how social workers define their role in relation to clients.

Defining the client's role can be difficult at times. A more challenging situation concerns involuntary referrals. *Voluntary* and *involuntary* is a matter of degree—perhaps representing a level of willingness to engage in treatment. If a court-diversionary program, for example, offers a client the choice of drug treatment or jail, who is the client? The overloaded criminal justice system or the person who arrives for treatment? If a distraught and depressed middle-aged woman arrives for her first session, and it becomes clear that she is there because she does not know what to do about her alcohol-addicted husband but wants to get him to come for treatment, who is the client? If a young woman is referred for mental health treatment as a condition of having child custody reinstated by the courts via the approval of child welfare and mental health professionals, who is the client? Practitioners can help clients define their role by helping them sort out the reasons why they sought treatment and how those reasons are contingent on the behavior of other people in their lives or other institutions. Although many of these circumstances involve mixed motives in the client, these must be drawn out: “Is there any reason why you don't want to be here?” “Do you feel that you are being forced here against your will?” “Is there any reason why you think this might be helpful to you despite the fact that you don't really want to be here?” Helping clients sort out mixed agenda can go a long way toward helping them define their role as client, a necessary step in defining mutually agreed-on intervention goals and engaging in the change process.

Collaborating with the Client on the Assessment, Intervention, and Evaluation Plan

Defining practitioner and client roles also necessitates determining shared responsibilities. One of the most supportive aspects of effective helping is cultivating a shared feeling of collaboration, the sense that client and practitioner are “in this thing together.” True, one does not want to ignore the power differential: the practitioner has the responsibility to implement effective care and has some prerogatives that the client does not (e.g., the practitioner can hospitalize clients against their will; the practitioner can breach confidentiality should a client threaten to harm him- or herself or others; the practitioner may be bound to report client information to the courts). However, the practitioner can underscore the importance of collaboration in the following manner: “We both agree that you want to work on

Topic A, and that we will first do that by trying Intervention B and then see how it goes.” To transcend some of the ambivalence about receiving social work services, clients must feel that, on some level, they voluntarily participate in (and take responsibility for) the course of the intervention. This collaborative relationship, again, does not obviate the power differences in the relationship, but it does establish a common ground on which practitioner and client can base a productive working relationship.

As part of the intervention, however, the practitioner also recruits the client into activities. Clients provide the information to complete the assessment. Clients might also spend some time on their own completing assessment instruments, such as self-report scales, charts, or diaries to help with the assessment and monitor treatment progress. Practitioners might also have clients carry out some of the intervention during the time when they are not in session. For example, people struggling with addictions may attend mutual help meetings, psychoeducational classes, or a family gathering (later on in recovery)—at which they know family members are likely to drink—to practice relapse-prevention coping strategies. A family with a conduct-disordered adolescent may have to spend time in brief family meetings to negotiate guidelines for doing homework and increasing prosocial activities. Clients, in effect, become collaborators with practitioners to implement interventions successfully. They are not passive recipients of treatment. The shared feeling that exists between practitioner and client that they are collaborating on the assessment, intervention, and evaluation plan together is the glue that holds the working alliance together.

Maintaining Clear Boundaries

Defining clear boundaries and collaborating effectively on the intervention requires that the practitioner take the responsibility for maintaining clear professional boundaries over the course of the intervention. Boundaries are best kept in sight not by maintaining a pseudo-professional, aloof posture but by continuing to communicate empathy and respect and by continually focusing on the goals of the intervention contract. To stay on track, good working questions for every practitioner are, Is what I am doing in the meeting with the client today likely to enhance this client’s progress? and, Am I helping the client move toward the agreed-on goals? Practitioners also need to model behavior that reinforces good boundaries to reassure the client about the respective roles of practitioner and client. Clients should be encouraged to express their feelings, participate in the intervention during the session, put what they have learned into action

outside of sessions, and help evaluate whether things are getting better. In other words, for both practitioner and client, the mutual focus should be on getting the work done together.

Clients sometimes have strong feelings about their practitioner. How should practitioners handle these feelings? For a variety of reasons, the helping relationship creates, at times, an ambiguity about the nature of the relationship whereby the client may interject a variety of feelings (e.g., love, hate, anger, envy, jealousy, gratitude) into the relationship. The client may communicate these feelings in a variety of ways, both directly and indirectly. These feelings may spring from a variety of sources. In the psychodynamic tradition, feelings displaced or projected onto the practitioner (i.e., transference) were often assumed to be feelings that the client felt about his or her mother or primary caretaker in the past. Although one's parents may be a source of such feelings, there are many other possible sources as well, including how the person actually feels about the relationship with the practitioner (e.g., the client may be justified in feeling angry with the practitioner). Other sources of these feelings may stem from experiences the client had with some other person with whom they had or currently have a close relationship (e.g., spouse, friend, employer). Other legitimate feelings may be evoked from racial, cultural, or socioeconomic differences and tensions. A young African American man who has had negative experiences with white authority figures may feel suspicious and resentful about a white social worker; a woman who has been abused by men in the past may be predisposed to feel a mixture of anger and shame or other feelings toward a male practitioner; an older client may feel either nurturing or resentful feelings toward a younger social worker; a male client from a culture where women are dissuaded from achieving educational or professional success may feel disdain toward a female social worker. Because a professional helping relationship is not a naturally occurring relationship (e.g., friendship, marriage, parent-child, coworkers), ambiguities abound and clients will find a way to fill in those ambiguities, accurately or otherwise. It is the practitioner's job to explore those ambiguities and help clients deal with them realistically and with minimal distortion.

Likewise, practitioners make interpersonal misattributions (O'Hare, 2005) toward some clients. Practitioners can experience a range of feelings that potentially obstruct the helping process. These may include anger, disgust, sexual attraction, a parental need to nurture, and so on. Mild feelings of genuine affection or caring are usually not a matter of concern and may enhance the helping process. However, other feelings toward clients can become a serious obstacle to effective intervention. Anger can lead to

punitive behavior toward a client, premature termination, or abandonment; attraction or infatuation can lead to overtures for sexual relations. Practitioners are obliged to identify for themselves what they feel, determine whether the way they deal with their feelings helps or hinders the working relationship, and take responsibility for feelings and subsequent behaviors toward the client. Practitioners often sort these matters out for themselves or in discussion with colleagues; if the problem is not readily resolved, the practitioner can seek professional consultation. Whatever method practitioners use to cope with these matters, keeping the client's well-being in mind should be the foremost priority. Maintaining clear boundaries means continually returning to the key question: Is what I am about to say or do in the client's best interest?

Summary

Supportive and facilitative skills incorporate basic interviewing methods in the service of cultivating a sound working alliance, enhancing motivation, and helping the client engage in a collaborative change process. However, although supportive skills are essential for establishing the working alliance, the practice process research has clearly shown that they are usually not sufficient for helping clients with more serious and complex problems. To conduct more advanced interventions with clients with moderate to severe psychosocial disorders, expert use of therapeutic coping skills is essential.