Culturally Conscious Adult Therapy Intake and Case Conceptualization for Training Clinicians (CC-ATICC)

Kelly L. LeMaire, Ph.D., Allyn R. Kurup, M.S., Keisha D. Novak, M.A., Daniel W. Oesterle, B.S.
About the Authors

Kelly LeMaire, Ph.D., HSPP (she/her) is a licensed clinical psychologist, Clinical Assistant Professor, Assistant Director of the Purdue Psychology Treatment and Research Clinics, and the Co-director of the Diversity, Equity, and Inclusion Science Consortium at Purdue University. She obtained her doctorate from Marquette University and completed her internship and post-doctoral training at Duke University Medical Center. She has expertise in evidence-based cognitive behavioral therapies, multicultural consciousness training, trauma, and allyship and prejudice reduction.

Allycen R. Kurup, MS (she/her) is currently a doctoral student in clinical psychology at Purdue University. Her clinical and research interests pertain to multiculturally conscious mental health and social interventions, especially for LGBTQIA+ adolescents and emerging adults.

Keisha D. Novak, MA (she/her) is a doctoral candidate at Purdue University and psychology pre-doctoral intern at San Francisco VA Medical Center. She is a clinical psychophysiologist, utilizing EEG and neuroimaging methods with aim to better understand etiology of schizophrenia spectrum disorders and those at clinical high risk. Clinically, her interests include evidence-based treatments for severe mental illness, integrating multiculturally-conscious and trauma-informed approaches.

Daniel W. Oesterle, B.S. (he/him/his) is a clinical psychology doctoral student at Purdue University. His research focuses on examining affective, behavioral, and cognitive risk factors for sexual aggression etiology, prevention, and treatment. He is also interested in the role of alcohol and substance use as a primary risk factor for intimate partner aggression.

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This tool is meant to be open access and free for use for anyone who may benefit in their training within clinical settings. The authors ask that you notify Dr. Kelly LeMaire that you are using the tool so that they may track the tool’s use: klemaire@purdue.edu.
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General Introduction

This tool is meant to guide intake assessments and early case conceptualization with adult therapy clients for junior clinicians in training settings. It is meant to be a guide for considering broad areas to assess in an intake interview, rather than comprehensively assess each area of context, functioning, or potential diagnosis to the fullest extent. Therefore, it is likely ideal to administer this tool in a first meeting with a therapy client and choose additional interviews or self-report measures to garner more specific information about particular areas of interest (e.g., mood functioning).

Unlike some interviews that are developed to be structured and delivered word-for-word, this tool is meant to be administered with some flexibility. While it is not wrong to administer it word-for-word (that would absolutely work!), a clinician does not have to administer it completely as written and in this particular order. This means that the tool can be used to broadly structure intakes and inspire a clinician's language and session flow, AND is also meant to help train clinicians to eventually rely less on this tool to conduct a comprehensive intake independently.

The tool offers a number of domains to assess as well as sample language for how to evaluate each, especially as junior clinicians may struggle with generating this type of language in early clinical experiences.

The tool covers 13 domains:
- Identifying information
- Presenting concerns
- Mood and emotions
- History and current trauma
- Medical history and health
- History and current risk
- Alcohol, tobacco, and other substance use
• Educational history/current education status
• Occupational history/current status
• Family status
• Social and romantic relationships
• Recreational activities
• Impact of other current stressors and other areas of concern

Each domain includes sample language for key questions and prompts, along with notes to the interviewer that explain the purpose of the section, important aspects to listen for and consider, and suggestions for potential ways to follow up on certain information given by the client. The tool can be administered in order; however, junior clinicians and supervisors have flexibility in choosing the order of the sections as well. For example, some may feel more comfortable beginning with the presenting concern. That is in no way discouraged. Further, at times in the clinical interview, it may be appropriate to skip to another section based on information the client is providing in order to maintain flow of the session. For example, if a client is discussing the nuances of their relationship difficulties with their family, it might be helpful to ask the remaining questions related to family and social support at that time rather than returning to the content area.

Generally, the intake tool is formatted with questions to ask on the left-hand side of the form. On the right-hand side of the form are some additional prompts, examples, information to consider, and/or potential follow-up questions. These are meant to be guiding support for the clinician as they move through the intake. More detailed information on each of these domains may be found within the preface. It is recommended that the preface be read prior to the first time using the tool with a client as it will contain generalized tips for the intake as well as more detailed explanations of the principles behind the questions being posed. Although, this reading and preparation will take some time, and will likely improve a clinician’s confidence and flow with using the tool with a client.

This tool can be administered as a stand-alone, comprehensive intake tool. It could also be used to supplement a clinic’s standard intake procedure. For example, perhaps the standard clinical intake tool that is used in a particular clinic could be enhanced by adding in some of the trauma-informed or identity-specific questions. In this case, the clinician may choose to supplement the existing intake by also asking the questions in those two sections. Further, it is noteworthy that asking each and every question in this tool may take a clinician about 90 minutes to 2 hours (based on data gathered from sites that piloted this tool). It is encouraged that supervisors and junior clinicians discuss the tool before using it to determine if there are specific sections or questions to prioritize given the needs and limitations, including time limitations, of their specific clinical setting. Additionally, clinicians noted that they did find the administration went faster (closer to 60 to 90 minutes) and was easier the second time they administered the tool. Depending on the setting and experience of the clinician-in-training, it may be helpful to practice using the tool with a peer before administering it with a client.
Interviewing Style

Reflection and Open-ended Questions

Clinicians may modify wording and add in clarifying questions based on client responses. When possible, it is helpful to use the client’s own words when asking follow-up questions. For example, if the client says they have been “feeling low and disconnected,” it is usually most helpful to ask questions using that language rather than follow up questions such as, “How long have you been experiencing depression and numbness?”

Additionally, most of the time in intake interviews, and in therapy, asking open-ended questions can be most helpful in gathering detailed and nuanced information about a client’s life and experiences. Open-ended questions often cannot be answered with a “yes” or a “no” or other one-word responses. Instead, they are designed to elicit more detailed information. Examples of open-ended questions might include:

- “Tell me about X” (e.g., how you experience anxiety; your work; your relationship with x)
- “What is X like for you?” or “What was X like for you?”
- “What are your strengths?” or “What kinds of things would you say make your relationship strong?”

Although open-ended questions are generally encouraged to elicit more information, there may be times it is helpful to ask close-ended questions in order to gain information quickly. Be mindful that close-ended questions may not provide the nuance in responses that might be most helpful for case conceptualization, although they can be effective in some cases. For example, if a particular client is rather talkative or time is running low in the session, you might choose to ask some questions in a close-ended format rather than skip the information all together.

Clinicians are also encouraged to add reflections of the client’s statements as well as other forms of validation throughout the interview in order to build rapport. Don’t forget to use nonverbal signals to reflect to the client that you are actively listening throughout the session; these signals may include body language (e.g., orienting toward the client, open body posture), eye contact (to a comfortable degree for the client), and facial expressions (e.g., allowing your expressions to be consistent with the content of the session; smiling when the information is lighter or the client makes a joke, perhaps more somber or demonstrating empathy when they share something personal and painful).

Some examples of reflection statements might include:

- “Ok, I am hearing that you have been struggling with (presenting concern in their own words), since you were in middle school.”
  - You then might fold this into the next question, for example, “Were there specific things that happened around that time that you see being connected to (presenting concern)?” and/or “Were there periods when it was better or worse over the years, or has (presenting concern) been pretty consistent?”
- “That really does sound scary. It sounds like you are feeling insecure and worried about being judged when you are around your friends.”
  - Again, you might fold this information into a follow-up question. Perhaps, “How long has this been happening for you?” or “Do you find similar things happen with family or strangers? Tell me about that.”
- “So, you have really had repeated experiences of important people betraying your trust, including your family members and your previous provider. It makes a lot of sense that it is difficult to trust others.”
• Depending on where you are in the interview, there are many potential follow-up questions that may be appropriate to gather more information. For example, “Given these experiences, I wonder how you think it may impact/affect our work together.” or “I also heard you say you were feeling lonely and want more community, which is probably very difficult given that it is understandably hard to trust. Is this something you would want to work on together in treatment? What would you ideally like to see as the outcome from this work?”

• Depending on whether you have administered the trauma section or not, it might be helpful to segue into that section because the client is discussing items that might be consistent with betrayal traumas.

If at any point a client declines to answer a question or states a preference not to talk about a particular subject, in general, it is likely helpful to simply acknowledge the request, state that you appreciate them letting you know, and move on to the next subject area. With most topics, it is okay to come back and explore it further when more rapport and trust is built in the therapeutic relationship. Respecting the client’s wishes may also encourage them to trust you more.

In some cases, you may feel more strongly about getting some level of information about a topic. For example, it may be concerning if a client is unwilling to answer questions about risk behaviors. In these cases, you may try to gently explain the purpose of the questions and how you will use the information, and address any concerns or questions they have.

You may say something like, “I can totally understand why these questions might feel sensitive or even scary to answer. I want to assure you that I ask these questions to everyone and my intention is only to better understand how you are doing and whether we should consider addressing any concerns about safety together.” (You may also consider normalizing the experience of SI and being explicit about limits of confidentiality here.) “I’m curious what you think about that and if you have any questions for me?” (If so, address those questions).

After the client’s questions have been addressed, you may consider asking if they would be willing to answer any questions about safety now. Although the clinician can use validation and psychoeducation to help encourage a client to feel safe, ultimately the power to disclose remains with the client and they should not be forced.
Validation

Some examples of validating language might include:

- Reflections of what you heard the client say using their own words
  - “I heard you say that you are really stressed by all of your recent transitions and new work schedule. I wonder if you might also be feeling disappointed (or even a little demoralized) given that you said you were hopeful this move would provide you more balance, and yet you are feeling so overwhelmed.”

- “It makes so much sense to me that you are experiencing (presenting concern and/or ineffective behavior) given that you (list a few contextual reasons this may have developed).”
  - EX: “It makes so much sense to me that you are experiencing low mood and low motivation given your experiences of often feeling criticized, working so many long hours, and having recently lost a relationship that was important to you.”

Examples of what might be invalidating (and why):

- “You’ll get through this...”
  - While the intention here is to induce hope, a statement like this may be invalidating, especially when first meeting a new person.
  - Instead, consider something like, “I know (or can see) this is really painful right now and it might be hard to imagine it being different. I also want to let you know that we do have some fabulous therapies that I think might be really helpful to you.”

- “Oh, so you’ve only struggled in X way for so long”
  - We want to be mindful not to minimize the client’s experiences. In this case, using the word “only,” along with the phrasing, implies that their experiences are “not that bad.”
  - Instead, reflect what you have heard, “I am hearing that you have had this experience for X months now.”

- Assumptions about a client’s experiences (e.g., emotions, thoughts, presenting concerns, identity).
  - In many ways, it is our job as clinicians to “put the pieces together” and assist a client in more deeply understanding their experiences. And we even use skills like “mindreading” as validation strategies to demonstrate that we are listening for what is not being said. In order to reduce the likelihood of mindreading being invalidating, always check in with the client to ensure that you are “on the right track” and allow them space to give you corrective feedback when necessary or provide the conceptualization in the form of a question.
  - EX: “It sounds like this experience was incredibly painful for you. I think I might also be hearing some anger in the way you talk about this. Is that right?” OR “I wonder if this experience of being openly teased was even more impactful given that you had recently come out to your friends.” OR “It sounds like you may have been telling yourself that you should have been able to get away or prevent this from happening and that you might be being hard on yourself about that now. What do you think about that?”

Note that the above examples all extend what a client may have said before while adding additional conceptual information. They also allow the client space to correct the clinician if the conceptualization does not fit or provide a different perspective.

Sometimes in intake sessions it is important to balance practicing validation and being mindful of time spent on a particular topic. There is a lot of information to cover in any given intake, and it is an important skill to practice moving to the next topic in a way that is not invalidating or makes the client feel “cut off.” Below are a few samples that may be helpful:
Validate and tie it into the next concept.

- For example, if you were assessing the presenting concern and they were discussing low mood, you might say something like, “You have been feeling down and low for a few years. Sometimes when people feel low like that they also experience... (choose one of the following or other similar prompt: changes in relationships, feeling worried about lots of things, desires to drink more, sleep difficulties, thoughts of being better off dead).” In this example, you could choose any of those depending on the information you already have and where it may be helpful to go next in terms of information gathering.

Bring up and ask more about a topic they previously mentioned in the context of the conversation.

- For example, if you have gathered enough information in one realm and need to move on to another topic, you can choose one that was in some way mentioned previously but not yet explored. You may say something like, “You mentioned earlier that (specific concern) impacts your relationships with your roommate and friends. I would like to ask a little bit more about your friends (or living situation).” You can then pivot to any of the questions in that section.

Validate the need/want for more time AND the need to move to the next topic.

- “This (X topic) is really important and I want to hear more about it, and at the same time, we have a lot of different things to talk about today. In the interest of time, let’s move on to Y (topic) and we will make sure to come back to X during the next session/in the near future.”
- “I know there is so much to cover with us just getting to know each other. Although, we will talk about a lot of different things today, and I assure you, we will have time over the coming sessions to discuss X.”

Clinical Lens

A general attitude of empathy and non-judgmental stance is beneficial in conducting clinical work. This means being open and listening to clients with a genuine curiosity and the understanding that essentially everyone is doing the best they can with the skills, resources, and knowledge that they have, even when some of the behaviors they are engaging in are less helpful in the long-term. It can be helpful to try to view the world from the perspective of the client, AND be aware that given everyone’s unique experiences and culture (very broadly defined) we will never truly know the experiences of another. Do your best not to make assumptions about a person’s experiences and ask questions with kind, genuine curiosity.

Please note, it is important to be discerning as a clinician. This means it is essential to be listening for key information and to evaluate this information against various objective standards. For example, it is often important for clinicians to gauge whether endorsed experiences meet criteria for a particular diagnosis. We would differentiate discernment from judgmentalness such that discernment is about comparing something to a standard to decide whether they are congruent. Judgmentalness includes evaluating a person, behavior, attitude, object, or experience as “good” or “bad” or forming other opinions about the type of person someone appears to be. Although it may be “natural” to form evaluative judgments, they can often get in the way of clinicians’ case conceptualizations and work with a client 1–3; therefore we recommend clinicians note and attempt to reframe judgments when they notice them and to seek support from supervisors or their clinical team when these judgements may be impacting a clinician’s work with a client.

For example, it is not uncommon for some providers to view individuals who meet criteria for Borderline Personality Disorder in judgmental ways. Clients with this diagnosis are often viewed as “emotionally unstable and manipulative” 4,5. These judgments are likely unhelpful given that they imply intentionality, lack of credibility, perhaps even a lack of willingness or ability to change, which may all be untrue. In attempts to reframe these unhelpful judgments, we recommend trying to describe the behaviors and situations in nonjudgmental terms. It is likely also helpful to assess how the client’s behaviors and experiences “make sense” given
their history and unique contexts. It may be the case that some of their behaviors prompting judgment from others may be ineffective, especially in the long-term, AND this client is likely still doing the best they can with the skills and resources currently available to them. For example, it may be the case that the way a client is expressing intense emotions and attempting to ameliorate their pain could be ineffective and even causing damage to their relationships. At the same time, this behavior may have also been learned and may be the only way a client currently knows how to attempt to meet their needs.

Not dissimilar, sometimes clinicians may make judgments about a client’s experiences because they are different than their own. For example, it is possible that a clinician may label a person of color as having a psychotic disorder or paranoia when the client reports significant difficulty trusting others and especially those in positions of authority. However, it is important to consider that this client’s experiences with individuals in authority may be very different than the clinician’s. It is certainly possible that the client may meet diagnostic criteria for a psychotic disorder and may have experiences of paranoia. It is also possible that the client’s difficulties with trust may have originated from chronic experiences of interpersonal and institutional betrayal trauma. Further, they may be influenced by intergenerational and vicarious trauma (e.g., historical experiences of systemic oppression and particular current and/or historical experiences of people of color being mistreated by those in authority and even by professionals in the medical and mental health field). If this is the case, it may not be appropriate to label the client’s experiences as a psychotic disorder. Instead, it may be more appropriate to consider a Trauma- and Stressor-related Disorder.

Cultural Humility

Principles of cultural humility are important to keep in mind when conducting clinical work. Cultural humility encompasses the “ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important to the [person]” and has three key features.

First, it emphasizes principles of lifelong learning and self-evaluation. This means that we acknowledge that we are never done learning and never reach a destination of full “competency” in this domain. We strive to continuously examine our biases and remain humble and flexible in our learning and practice.

Second, cultural humility also means being mindful and attempting to ameliorate power imbalances. There are nearly always power dynamics to navigate in therapy. One to be mindful of is the power a clinician has due to being viewed as an expert. However, clients are the experts on their own lives and ought to be viewed as such. Clinicians are encouraged to view their clients as collaborators and active participants in their treatment decisions and progress. Note that these dynamics can be somewhat different in training clinics with junior clinicians, in that clients (and sometimes others) may question their expertise. Regardless, clinicians still hold significant power in the therapeutic relationship, as they hold a lot of sensitive information about the client and have the ability to make evaluations of the client’s mental health. Further, there may also be power dynamics related to holding more, fewer, or different marginalized identities than clients. Cultural humility entails acknowledging and making effort to address and reduce whatever power imbalances arise.

Last but not least, cultural humility emphasizes developing partnerships and advocacy work. This means seeing the work as larger than ourselves and advocating for system-level change where possible. It may include, but certainly is in no way limited to, examining and improving the way our systems, including our clinics, operate and serve our community. This may mean listening for ways you may be able to advocate for a client during an intake (e.g., with another provider or within this institution) or may also mean working to promote best practices within your department. Perhaps there are ways that your program as a whole can engage in active learning and providing culturally conscious services.
Addressing Microaggressions

Microaggressions are “brief and commonplace, daily verbal and behavioral indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative slights and insults that potentially have harmful or unpleasant psychological impact on the target person or group”\(^{15,16}\). Research suggests that they are frequent experiences in daily life for people who hold marginalized identities; they can also occur in the therapy setting.

There are many different forms of microaggressions that are specific to therapeutic settings, which include but are not limited to \(^{17-20}\):

- Assumption that marginalized identity is the cause of a client’s presenting concerns
- Avoiding or minimizing (the impact of) a marginalized identity
- Attempts to over-identify with marginalized clients (i.e., be “buddy-buddy” with a client)
- Making stereotypical assumptions
- Expressions of sexist/racist/cisgender/ageist/heterosexist/xenophobic/etc. bias (implicit or explicit)
- Assumption that all people with marginalized identities need psychotherapy/treatment simply due to having one or more marginalized identities
- Warnings about the dangers of identifying oneself with that marginalized identity (e.g., sexual orientation or gender identities such as trans, non-binary, or gender fluid)
- Ascription of intelligence (e.g., model minority; stereotyping based on identity)
- Expressions of “colorblindness”
- Expressing happiness/surprise at a person’s intelligence or speech (“being so articulate”)
- Inaccessible or less welcoming spaces (e.g., no gender-neutral restrooms available, forms, procedures, or policies are not affirming)

Clients’ experiences of microaggressions in therapeutic intakes and treatment can have significant impacts on their therapeutic relationship with the clinician and treatment outcomes\(^{21-23}\). Therefore, it is important that clinicians are mindful of their language and behaviors in sessions, in order to reduce the likelihood of harm via microaggressions.

It is important to remember that intentions and impact can be different, meaning that while someone may have not intended to microaggress or say/do something harmful to another person, the impact of particular behavior may still be hurtful to the person. We are all human and will therefore make mistakes. If you realize that you may have microaggressed against a client, consider doing the following to address the situation:

- Try not to be defensive.
- If you or the client catches it in the moment, label it (as a microaggression, insensitive, etc.) and apologize.
- If you catch it later, consider making time next session to talk about it or potentially even reach out by phone before the next session, if that seems appropriate given the potential for relationship rupture or level of impact.
- Explore the potential impact with the client and address the potential impact as best as you can.
- Perhaps, state what you meant to say another way, AND be thoughtful about your tone so your correction does not negate the apology or come across as defensive.

- For example, one might say, “Gosh. I am sorry, I think what I just said was insensitive. When I said ‘lame,’ what I meant was ‘uncool;’ however, I realize that word could have been hurtful.” You may pause to wait for their response or say, “I am concerned (that may have felt rude or that may have been uncomfortable for you) (depending on the situation). Would you be willing to share your experience with me?”
After the client shares their experience, you can decide how to repair any damage if possible. Sometimes just acknowledging it is enough. You may also consider a second apology and stating that you will be more mindful in the future.

If a client microaggresses against you, you may consider whether or not to address it. In doing so, it may be helpful to contemplate:

- The impact on you (the more impactful to you and/or the therapeutic relationship, the more you may consider addressing it)
- Whether it is an established pattern of behavior (in the therapy room or outside of it)
- Whether it is consistent with the client’s goals to address concerns such as these (e.g., if the client is working on interpersonal skills and improving relationships, it may be even more relevant)
- Timing (to address it in the moment or at a later time after some reflection or planning)
- What the desired outcome may be from addressing it (e.g., therapeutic interpersonal feedback; asking for it not to happen again or setting another kind of limit)
- If it would be helpful to talk with a supervisor or peer first for consultation, or if you may need supervisor support in addressing it if you don’t feel comfortable and safe doing so yourself (likely in the case of more severe events).

Additional recommendations to consider:

- Ask clients how they conceptualize their concerns. Listen to them and do not dismiss their conceptualizations. When your perspectives differ, discuss both perspectives and attempt to develop a shared narrative.

Be mindful of the physical space of the therapeutic environment (e.g., Are there safety signals? What books are on the shelf? Is the room inviting for individuals of various backgrounds, sizes, and ability and disability statuses? Are the forms that are being used affirming of all identities and allow for a client to use self-identifying language?).

Validate the experiences of prejudice, oppression, and discrimination (e.g., that they happen and normalize that they impact people). When helpful, consider using a trauma-informed lens when discussing these impacts.
Identifying Information

In this section, we want to identify and understand the social and personal identities that the client holds, to begin to contextualize their experiences and presenting concerns in their broader sociocultural environment. We want to be mindful that no one identity exists “in a vacuum,” meaning that each influences each other. A person’s experience of their race is also influenced by their gender, sexual identity, socioeconomic status and more. As you are asking about identities, be mindful of this and consider asking follow-up questions in order to better understand the person’s unique experience.

A person’s social identities may not be germane to their presenting concerns; however, it is important to get to know the client as a whole individual within their given circumstances. Be mindful not to pathologize anyone’s minority status or social identities and do not make assumptions about how the client’s identities impact their presenting concerns. Instead, be curious and assess basic demographic and identity-related areas to get to know the client holistically. Alternatively, the client may assert that they hold no important or salient identities. If this is the case, it is still helpful to check in about different aspects of identity while not over-emphasizing the relevance of these identities or inadvertently invalidating the client’s experience that social identities are not salient to them.

Use open-ended questions to give the client a chance to self-disclose any identities that are salient for them, so that you can begin to build rapport, demonstrate that you view the client as an expert in their own experiences, and indicate that you respect and value what they express as important. You could follow up by asking any other questions to determine what this identity means to them and what is salient to them about it. If it is not clear by their descriptions, it might also be helpful to ask about each identity and how important or salient it is for the client. This will help you to start to get a picture of this person as a whole being in a sociocultural context.

Although this section is first in the intake document, it may be administered in another order. Some may choose to ask these questions after the presenting concern section. You are encouraged to talk with your supervisor and try it multiple ways in order to see what works best. Further, depending on what the client highlights as salient, you might skip to the relevant part of the intake tool to discuss that topic now (e.g., medical history, family status, work, or education).

You might also say something like, “Thank you for sharing this important part of your identity with me. If it is okay with you, I’d like to ask more in-depth questions about this identity at a later point in the interview, after we talk more about what brought you to therapy.”

We all bring to the therapy room our own culture, background, and experiences. We want to be sure to create a safe space for the client to openly discuss their thoughts, perceptions, and experiences in a non-judgmental, affirming, and accepting environment. As we all hold identities that may be similar or different from others, it is important that we check our assumptions and biases by generating a dialogue about domains that may often have gone overlooked by many other healthcare professionals, potentially invalidating the experiences of the individual.

The questions in this section are meant to be broad and elicit whatever information the client wishes to share. If you are unfamiliar with any terms they use, please gently and humbly ask for clarification.

For example, “I have not come across the term Blasian before. Would you be willing to describe to me what this means to you?” Or “Agnostic can mean different things to different people; would you mind sharing what it means to you?”

There may be times (in an intake or after) that it is helpful to acknowledge similarities and differences in your personally held identities and experiences from those of the client. This may provide space for a client to reflect on their thoughts and feelings about working with a therapist who may be similar to them in some ways and different in others. This may be particularly relevant when one or more identities are very salient to the client and/or their presenting concerns.
For example, one might say, “As a person (with X particular identity, e.g., a white woman), I cannot ever really know what it is you have experienced and are currently experiencing because I have not faced the same kind of discrimination. I want you to know that it is important to me to understand as best I can, and welcome you to talk with me about it.” In other circumstances when discussing identity-related experiences, a clinician might check in with the client by saying something like, “Thank you so much for sharing that with me. I am wondering what it is like for you to talk with me, (having X particular identity; e.g., identifying as heterosexual and cisgender) about (Y particular experience; e.g., "coming out" or socially transitioning)?”

It may also be important to assess concealment of any marginalized identities that the client holds. Concealment refers to the need to keep a particular aspect of identity secret in order to avoid discrimination, harassment, or oppression. For example, a person with a minoritized gender or sexual orientation may conceal this from their conservative family or community to avoid social harm. Similarly, a client who (or whose family) immigrated to the states may conceal this identity to avoid systemic discrimination. Be mindful of the identities that the client wishes to be disclosed in their medical record and which they do not intend to disclose.

Presenting Concerns

In this section, we strive to obtain as much detail as we can about what led to the client seeking mental health services at this particular time. It is helpful to remain genuinely curious about their experiences and the impact they have had on their quality of life. Once presenting concerns are made clear, be sure to gather information about

1) frequency of the concern
2) how intense the experiences are
3) identifiable prompting events or other patterns that seem to coincide with the concern
4) how the client views the concern
5) how family, friends, or community views their concerns.

Generally, it is important to think about the client’s goals for therapy continuously throughout the intake and while gathering information. Throughout the intake, you will ask many detailed questions about the client’s life. It is not uncommon for additional concerns (over and above the main presenting concern) to be voiced. In these instances, be sure to inquire whether the client would also like to make these concerns a focus of therapy.

We want to gain clarity about what the client is most concerned about, their personal understanding of the concerns, and the impact these concerns are having in their life. Remember to use open-ended questions, while reflecting and summarizing the client’s story with their own language. Be mindful of the language you use so as not to invalidate the experiences or feelings of the client.

- Example of language that might be invalidating:
  - “They wouldn’t have hit you if they didn’t have a reason. You must have done something to provoke the fight.”
  - This language is judgmental (imparting one’s opinion of the client’s “goodness” or “badness”) and suggests that the problem is partially the client’s fault, thus implying any feelings the client is experiencing are less valid/minimized.
Example of language that might be validating:

- “Wow, it sounds like you felt betrayed by someone with whom you thought was a good friend. It makes a lot of sense that you would feel angry and hurt.”
- This response is neutral such that there is no judgment about the incident itself, focusing instead on the client’s distressing experiences—potentially the reason they are seeking help.

**Discussing Expectations and Barriers to Treatment**

It is likely helpful to take the time up front (either at the end of the intake session or after the therapeutic assessment is complete) to have a discussion about what the client can expect while working with you, and things you will ask of the client while working together. This might mean giving them information about the type of therapies and other resources that you and/or your clinic offers. It may also mean telling the client a little bit about your therapeutic style (e.g., expectations about home practice assignments, perhaps how you view change through therapy).

It might also be helpful to have a discussion about therapy interfering behaviors or processes (TIBs)

Therapy interfering behaviors or processes include anything that can get in the way of therapy being successful. This might include client factors or behaviors, including potential difficulty completing home practice, having an overly full schedule that makes attending appointments difficult, or a tendency to be very talkative or quiet in session. It may also include therapist or supervisor factors such as lack of experience working with a presenting concern or similar clients, clinician burnout, and a lack of consensus on treatment targets. Environmental or system level factors can also impact therapy moving smoothly. These might include, but are not limited to, difficulty connecting clients with other needed support such as medical providers, limitations on the number of sessions a client can have, lack of childcare resources, or limited or no access to parking or public transportation. Of course, these are just some examples and multiple therapy interfering behaviors or processes may be impacting therapy at the same time.

It is important to acknowledge that it is not uncommon for a client’s presenting concerns to manifest in processes or behaviors that might interfere with therapy. In fact, we should expect this. For example, a client who is struggling with depression might have difficulty with getting out of bed on time and making it to the therapy session or may have trouble motivating themselves to engage in treatment or complete home practice. Similarly, a client who is coming to therapy for help managing ADHD may get distracted in session, forget appointments, or come late to sessions. It would be strange if the things impacting the client outside of session never showed up in session! As such, it will likely be helpful to acknowledge that these types of things may happen, normalize the experience, and express an attitude that you see them as an opportunity to intervene on the symptoms or behaviors that are challenging to the client outside of session. It is likely not effective to assign blame or judgment to therapy interfering processes and behaviors. Things can impact and “get in the way” of therapy in nearly every therapeutic relationship. Recognizing this and seeing the therapy interfering process or behavior as an opportunity to personally grow and/or help the client problem solve barriers, will likely be more helpful. We recommend talking about these potential experiences early on in treatment (e.g., in the intake, during the therapeutic assessment, or in the feedback or treatment planning stages). When doing so, it will likely be helpful to orient the client to your general understanding that things may at some point “get in the way” of treatment, identify what those barriers may most likely be, and discuss how you and the client can most effectively acknowledge and address them when they arise.
Mood and Emotions

This section helps clinicians explore some of the more common emotional and mood experiences that we often see clinically. This may be particularly helpful in gaining a deeper understanding of a client’s emotional experiences, understanding the impacts of the presenting concern (or how mood and emotion states impact the presenting concern), as well as narrowing down potential mood or emotion-related diagnoses. We want to assess the client’s view of their clinical concerns by discussing and coming to an understanding about a shared narrative. If, in your clinic, you standardly assess all clients with the same diagnostic interviews, such as the Mini International Neuropsychiatric Interview 38 (MINI) or the Structured Clinical Interview for DSM-5 39 (SCID 5), you may be able to skip or shorten this section. Although, if this is the case, we still recommend reviewing best practices for inquiring about mood and emotions in a culturally conscious manner. If, in your clinic, you select therapeutic assessment measures more specifically for each client, this section will likely help you to narrow your selection to the most relevant potential diagnoses prior to administering a more thorough diagnostic assessment.

Throughout this intake, we want to be mindful about cultural norms different from our own. As such, it is strongly encouraged to refer to the Cultural Formulation and Glossary of Cultural Concepts of Distress sections in the DSM-5 40. While assessing mood and emotions, it is important to remember that many words commonly used in Western culture to describe mental health experiences may not be shared by other cultures. For example, while “depression” in Western culture typically reflects experiences such as hopelessness, worthlessness, sadness, guilt, and loss of motivation, similar experiences in Eastern cultures may be expressed as somatic disturbances.

Example terms used to describe mental health experiences across various cultures 40:

- **Nervios (“nerves”):** A common word used among the Latinx community to describe distress that is experienced emotionally and physically, and impedes one’s ability to function.
- **Dhat Syndrome:** Term commonly used among South Asian communities to describe young men who experience a wide variety of symptoms such as anxiety, depressed mood, weakness, and impotence, among others. These symptoms are attributed to semen loss.
- **Taijin Kyofusho (“interpersonal fear disorder”):** A Japanese cultural syndrome that reflects symptoms of anxiety and avoidance of social contexts as a result of a belief that personal behaviors or appearance may be considered offensive to other individuals. This syndrome encompasses two subtypes: a sensitive type, and offensive type.

Additionally, some cultures understand the self through familial and social relationships as opposed to an individualized psychological state. As such, it is important to assess experiences of mood and emotional states through various lenses. For example:

- “Some people may explain (insert client identified concern) as the result of something bad that may have happened in your life, difficulties getting along with others, physical sensations or ailments, or a spiritual reason. I’m curious to hear what you think may have caused or worsened (identified concern).”
- “How might your friends, family, or others in your community explain (identified concern)?”

While assessing mood and emotions, be sure to continue to use the client’s language and explanations of their experience. Below are some additional examples of emotions to potentially assess in a way that is applicable to the client:

- **Hopelessness:** Do they feel that there is “no point” in engaging in everyday activities, including personal hygiene, personal relationships, eating, and performance at work or school?
**Avolition:** Do they feel very tired or as though they do not have energy? Do they feel like they lost motivation to engage in activities or routines that they usually do on a typical day?

**Shame:** Assess for thoughts about “being a failure,” “not being good enough,” or other extreme, negative self-beliefs. Are they currently or have they experienced being rejected, ostracized or invalidated by others?

**Guilt:** Assess for experiences of feeling as if something is, or many things are, their fault, not acting in accordance with their values, or taking responsibility for things they did or did not intend to do.

**Anxiety/Worry:** Have there been times when, more days than not, anxiety or racing thoughts have become increasingly frequent or intense? Are these experiences unpredictable? Are they specific to a particular person/place/event? Would friends or family consider them a worrier?

Are there any themes to the worry (e.g., general things, social anxiety, something very specific)? Does the person avoid these situations, suffer through them, or need someone to help them confront the object or situation that causes the worry?

Are they doing anything to cope with this worry, or make the worry less intense? Does the individual do things to suppress unwanted thoughts, impulses, or images? How long has the individual struggled with this worry?

Consider assessing for muscle tension, fatigue, difficulty concentrating, and trouble with sleep, and whether the individual has changed any of their behavior in an effort to avoid these feelings.

**Anger:** Do they notice outbursts of anger with little to no provocation? Do they blame themselves in an unreasonable way? Feeling irritable could be general irritability related to depression, a manic or hypomanic episode, attentional difficulties, sleep, menstrual cycle, or other medical problems.

**Depersonalization/Derealization:** Do they ever feel disconnected from part or all of their body? Have things ever felt detached, strange, or as if they were outside of their body? Do they ever notice that they have lapses in memory not caused by the influence of a substance?

**Unusual Perceptual Experiences:** Have they ever seen or heard things other people could not see or hear? This could be shadows, patterns, people, voices, and special messages through the TV or radio, or visions. Have they ever believed someone was out to get them or hurt them in some way? If so, what evidence do they have to support this belief (sometimes there is actual evidence, such as stalking)?
History and Current Trauma

Trauma is considered both a process and an outcome and can result from a single event, multiple events, or ongoing, chronic experiences. This section will help you assess the client's history of trauma from multiple sources. It is important to observe that the section includes types of potential trauma that are not included in criterion A for a PTSD diagnosis. However, depending on the impact of the trauma and the case conceptualization, it may be appropriate to assess for and give an Other Specified Trauma- and Stressor-related Disorder or Adjustment Disorder diagnosis. If the client endorses a history of previous trauma, consider asking additional questions in the intake or during another point of the therapeutic assessment about other symptoms and impacts of the trauma, including through the use of interviews and self-report measures such as the SCID-5, the CAPS-5 (Clinically Administered PTSD scale for DSM-5), or the PCL-5 (PTSD Checklist for DSM-5). If self-report measures are used, note that these are sensitive measures and are likely best completed at home or in a private therapy room rather than the waiting room before or after a session. Please also remember to follow up on the individual items to ensure you have an idea of their experiences and functioning. Self-report measures should never be used in isolation to determine a diagnosis.

Be mindful that it is not uncommon for clients, and especially people of color, to be misdiagnosed with a mood disorder, personality disorder, or psychotic disorder, when their symptoms and experiences may be better explained by PTSD or Other Specified Trauma- and Stressor-related Disorder. It is important to assess the presence of a trauma history and explore the impact of these events, including the development of mood symptoms and emotion dysregulation. When considering diagnoses, make sure to explore the impact of trauma, the client’s context (including experiences of discrimination and systemic oppression), and ensure that any diagnosis assigned clearly fits the criteria rather than is based on biases or assumptions.

Stylistically, note that assessing trauma is both important and can be extremely sensitive for clients. Be patient, and willing to go slow in this section especially with affirmative responses.

You may want to assure clients that although you will be asking these sensitive questions, they do not have to provide all of the details in the first session or until they are ready. It is typically most helpful to get an overall sense of their trauma histories rather than detailed narratives in the first session given 1) the need to build more rapport and 2) the amount of other information typically needed to gather in an intake. It may be helpful to assess for the different types of traumatic experiences a client has had (e.g., a car accident, chronic verbal and physical abuse from a partner, and/or experiencing a hate crime) and the general timeline (e.g., during freshman year in college or from ages 5-10).

If the client does choose to disclose more, be mindful and validating. Remember, research suggests that the way people respond to trauma survivors during disclosure (especially first and early disclosures) matters for their long-term prognosis.

Consider:

1. Explicitly saying something that conveys that you believe them and that it wasn’t ok that it happened to them. For example, “I am sorry this happened to you. No one deserves X.”

2. Being mindful of your body posture. Perhaps it could be helpful to lean in but remain quieter, allowing them the time and space they need to disclose.

3. Ensuring them that you are there to listen AND they do not have to tell you everything right away if they are not ready to.

4. Normalizing the traumatic response. This means noting that symptoms and changes experienced after trauma make sense given what the client experienced.

5. Letting them know there are effective treatments and resources.
6. It may go without saying, but be mindful not to use language that implies blame (e.g., “Well, why were you there?”), invalidates the experience (e.g., “I am sure they didn’t mean it that way.”), or implies it was not meaningful or potentially traumatic (e.g., “It sounds like you experienced neglect but no physical or sexual abuse. So, it was not good but could have been worse.”) or (“You can’t really call domestic violence traumatic when other people experience combat.”).

Although there may be times it is appropriate to let clients know about resources or options to pursue, we should not (especially in an intake) tell them what they “have to do” (e.g., regarding reporting, etc.). Trauma is heavily related to taking someone’s power and control away52–54, so as clinicians we want to make sure the client feels empowered in their treatment. It may be appropriate to help the client engage in considering pros and cons about pursuing particular types of treatment or even legal action; however, we should be mindful not to place our own values on the client or come across as coercive.

Please be attentive to the language the client uses. In many instances, we don’t (especially in an intake) label the trauma for the client. We may choose to label it traumatic; however, for example, you may not want to label a sexual assault experience as “rape.” Research suggests both pros and cons of labeling and therefore should be done thoughtfully. We want to be mindful that at times providing labels can be validating in some cases (e.g., when it gives a name to and normalizes a client’s experiences) and may not be effective at other times (e.g., when client’s experience labeling as pathologizing).

Below are a few other key concepts that might be helpful when assessing for trauma. Please note that it is uncommon for people to label these types of trauma in these ways, but not uncommon for clients to disclose these types of experiences.

- **Microaggression**55,56: More subtle forms of discrimination that are experienced by many on a daily basis. (e.g., someone saying “I am not racist. I have a Black friend.” when someone assumes a quality about a person because of an identity they have (e.g., gay men like fashion or women are all emotional)). Microaggressions are not events that would fit in criterion A 61 for PTSD and therefore it would not be appropriate to give a PTSD diagnosis if these experiences are the only or primary traumatic experiences concerning the client. However, a trauma-informed case conceptualization can still be applied to understand and validate the impact of chronic discrimination.

- **Intergenerational trauma**55: Trauma that happens to many people in a generation (or multiple generations) that often impacts future generations (e.g., children). For example, major disasters, wars, slavery, genocide, the Holocaust, and other events may impact generations and then subsequent generations’ experiences. These types of generational experiences can have psychological, social, biological, financial, and other impactful consequences that can and do affect these individuals and their children for many years to come.

- **Vicarious trauma**56,57: Being impacted by witnessing or empathizing with the trauma of others. For example, EMT workers, doctors, or those working for child protective services might experience vicarious trauma. It may also occur when witnessing someone with a shared identity being hurt, abused, or killed. Vicarious trauma can result in symptoms consistent with PTSD or an Other Specified Trauma- and Stressor-related Disorder and is often linked to significant burnout when the trauma is linked to the person’s work.

- **Moral injury trauma**58,59: Moral injury trauma may be present when a person either acts outside of their values or fails to act (omission) within their values, and when this has a very significant impact on themselves or others. It may also fit when someone else close to them (including authority figures or institutions) that they are aligned with do so. For example, a veteran may experience moral injury trauma when they have been a part of a mission when innocent civilians were killed. You may notice more guilt, moral disgust, and anger in these cases.
Medical History and Health

A person’s physical health might be impacting their mental health. Assessing a client’s medical history and current health-related behaviors may provide additional perspective into their current functioning, presenting concerns, as well as potential additional treatment targets.

Comprehensive intake assessments also take into consideration a client’s medical history. One important element of doing so is assessing how and when our clients have sought help in the past. Be mindful that clients may have sought help from multiple sources other than therapists and these preferences and experiences are also important to explore, especially as mental health care is often stigmatized. In this section, explore the client’s previous experiences with seeking help as well as specific details about what was most helpful and less helpful or unhelpful to them. This information may be useful in developing a treatment plan that is most beneficial and affirming to the client.

Be mindful to be sensitive and not make assumptions about a client’s ability status based on appearance. Assess for acute and chronic illnesses, pain, and disabilities.

Although medical history likely comprises a wide variety of domains, focusing on the following areas would be most relevant during an intake assessment. These include but may not be limited to:

- Prior hospitalizations (including psychiatric hospitalizations)
- Major illnesses, injuries, or chronic medical conditions, chronic pain, disabilities
- Medication usage (including supplements and herbal remedies) and their impact on the client

Current health behaviors to consider assessing:

- **Sleep**: Has sleep changed over the past month/6 months/year? What does this look like for the individual, and how is this a change from their typical schedule? Do they have trouble sleeping every night? If yes, is this difficulty falling asleep, or staying asleep, sleeping excessively, waking up frequently in the middle of the night, and/or early morning wakening? How many hours of sleep do they get per night? Per day? Is this a change from the amount of sleep they typically get when they feel differently?

- **Exercise**: What types of exercise is the client able to engage in, if any? What types of exercise do they engage in? How does this exercise impact their mood, levels of pain, quality or quantity of sleep, or other experiences? Have they had significant changes in their activity level recently or at the onset of the presenting concern?

- **Nutrition/Eating**: Has there been a notable change in appetite and weight since the onset of symptoms? Has there been a change in appetite? An increase or decrease? Has there been an unintentional increase or decrease in weight? Is the person engaging in behaviors to restrict the amount or types of food they eat? Are they eating as a way to manage stress or other emotional experiences? Are they afraid of gaining weight?
**History and Current Risk**

Broadly, this section intends to assess a client’s prior history of having suicidal ideation, thoughts of self-harm, prior engagement in non-suicidal self-injury, suicidal behaviors and attempts, as well as factors that may protect against engaging in self-harm or suicide.

As with most of the domains of this intake, clinics and individual clinicians often assess self-harm, suicidal ideation, and suicide in their own ways, while some clinics/clinicians may use standardized approaches of assessment. If your clinic uses a standardized measure to assess risk with all of the clients in the clinic, including, but not limited to the Columbia-Suicide Severity Rating Scale (C-SSRS) or the Linehan Risk Assessment and Management Protocol (LRAMP), you may skip this section of the intake.

There are some general guidelines to help facilitate information gathering in this domain. First, the more information obtained in this section, the better. It is important to remember that you will not prompt the idea of suicide by asking about it. The more details you have, the better you can prepare a proper treatment plan and/or crisis plan. It is also critical to consider asking about the specific thoughts and behaviors (the what), timing (when and how often), how (means, methods, etc.), and prompting events (why they engage in the behavior/have the thoughts).

Another important guideline related to the content assessed in this section is the importance of having frequent and ongoing discussions with your supervisor on their limits and the limits of the institution with taking on cases with risk of harm to self for outpatient therapy, ideally before meeting with clients. Supervisor training, community resources, and institutional limits may all impact how and where clients can be best helped. Please also discuss with your supervisor what types of thoughts and/or behaviors would warrant you seeking them or another more senior clinician to aid in the intake. For example, the supervisor may want to be notified right away if the client endorses intent or somewhat detailed planning but not if a client endorses passive ideation alone.

There are also some important nuances to each of the sections within the risk assessment domain. Responding to suicidal ideation can often be scary for junior clinicians, so having a plan of how you will respond to clients who endorse these items can help you be in the moment for the client during these sensitive disclosures. Clients first respond to risk assessment questions by indicating thoughts they have about death, dying, or wishing to be dead. It is helpful to have clients vocalize the types of thoughts they have. We are looking for whether the thoughts are active (e.g., “I want to die;” “It would be better if I kill myself”) or passive (e.g., “I don’t want to be here;” “I wish I could just not exist;” “It would be ok if I just didn’t wake up.”). In general, active thoughts may indicate a stronger desire to die or commit suicide, but some research suggests they present similarly as risk factors. Passive thoughts may signal more of a desire for the pain to end, although this is not always the case. You can clarify this by asking something like, “If you had to say, which one feels more true to how you feel?: Do you want to end your life and die or are you wanting the pain to end and it’s difficult to see another way out of the pain?”

If the client endorses current and previous thoughts, it might be helpful to ask “What is the worst these thoughts have ever been?” and “When was that?” (if not already clear). For clients indicating prior suicidal ideation or thoughts of death/dying, it can be helpful to understand:

1. The content of the thoughts (What specifically are they thinking?)
2. How often are they having these types of thoughts (once in a while, most nights, multiple times throughout the day)?
3. What is their reaction to the thoughts (e.g., Are the thoughts comforting/relieving? Are they scary? Are they so common they feel “normal?”)?

It is also important to assess self-harm behaviors. These behaviors may or may not be linked with experiences of suicidal ideation or desire to die. It is important to understand what the specific type of self-harm behavior(s) are and how dangerous they could be. In assessing
the behaviors, ask about potential prompting events for the behavior (e.g., “What types of things or events “caused” or happened before you (engaged in specified self-harm behavior)?” “What led to (engaging in specific behavior)?”). It may also be helpful to understand whether the actions were planned out or impulsive (e.g., “When you (engaged in specific behavior) had you planned on doing that for some time? Or was it more something that happened quickly in response to (prompting event)?”). This may give you additional insight into how to best treat these behaviors.

We also want to assess the emotional and other reactions our clients have had in response to engaging in these behaviors (consequences of the behavior). This may include, but is not limited to feeling “better” afterwards (relief, reduction in numbness, or reduction in intense distress) or helping them express their emotions or communicate their distress to others in the environment. It is also possible that the client disliked the experience for some reason or noticed longer-term harm or distress because of the actions. In order to assess this, consider asking, “What did you experience as a result of (engaging in specific behavior)?” (If needed,) “For example, some people feel relief. Others feel it helps them express themselves, or demonstrate their distress to others more effectively. Some also say that while it helps in the short-term, there are things about it they don’t like. How about for you?”

In this section we will also want to assess if the client has developed a plan to commit suicide in the past or currently has a plan. While assessing this, we want to get a sense of how detailed this plan is/was as well as how dangerous/lethal it is. This means that we want to know if there was one or more specific methods, a date and/or time, and what prompting events have led them to engage in planning. As with other parts of the risk assessment section, the more detailed, thought out, and/or imminent the plan is, the higher the degree of concern. We also want to inquire about whether they previously or currently have any intention of harming themselves or ending their life.

Endorsing detailed plans and/or current intention should warrant very thorough safety planning, and may require a client to be assessed for hospitalization at the ER. If at any point you believe the client may be at imminent risk for severely harming themselves or ending their life, please notify your supervisor and crises helpers (e.g., depending on your clinic policy, 911 or local authorities) to help you manage the situation and ensure the client’s safety.

If the client endorses any thoughts, plan, intention, or urges or behaviors related to suicide or self-harm, assess for potential protective factors. This means, explore with the client their reasons for living and for not engaging in harmful behaviors. You might start by simply asking the client what kept/keeps them from engaging in those behaviors.

If the client is unable to list protective factors spontaneously, list some or all of the following to see if any of them fit for the client: friends and/or family, pets, fear of pain or dying, hope for the future, having major things they would like to accomplish, not wanting to hurt others, wanting to live, religious or spiritual beliefs, fear of disapproval of others for themself and/or their family, responsibilities they believe are important. This list is not exhaustive but gives multiple examples that may be relevant for a client. 

**NOTE:** Even if it is not protocol in your clinic to administer risk assessments with every client, in instances when the client discloses thoughts that indicate more than passive suicidal ideation, it might be worthwhile to consider administering a comprehensive assessment such as the LRAMP61, the C-SSRS68, or another standardized measure and developing a crisis safety plan. These approaches can help keep you on track during a time which might be emotionally heightened, allowing you to gather all of the necessary information to help the client best.

Although occurring less frequently than suicidal ideation, it is important that we understand if our clients are experiencing homicidal ideation, meaning thoughts of harming or killing someone else69–71. A similar approach as to how suicidal ideation is assessed can be taken to assess homicidal ideation. Sequentially, assessing whether or not our clients have these thoughts, their reaction to these thoughts and the emotions that accompany them, whether or not our clients have a plan, and protective factors for engaging in these behaviors are assessed. As with suicidal ideation, understanding your supervisor’s preferences and institutional limits for content assessed in this section is critical.
Alcohol, Tobacco, and Other Substance Use

This section is designed to get an accurate picture of how substance use fits into the client’s life. When talking with clients about substance use, the style a therapist uses to communicate is critical to consider. It is recommended that clinicians take a non-judgmental stance when talking about substance use, and increase their interpersonal warmth. Additionally, much research suggests that Motivational Interviewing techniques tend to be helpful with assessing substance abuse. For example, it is usually useful to assess both pros and cons with regard to using alcohol or other substances. Remember, that even when the substance use is causing or is linked with other difficulties in the client’s life, there are always some short-term, if not long-term, positive consequences that reinforce the use. Exploring them can be helpful in ultimately creating a treatment plan that includes other ways of meeting these needs or desires that have fewer long-term negative consequences.

To understand how substance use fits into the clients’ lives, we first want to understand what substances they currently use, and the quantity and frequency that they use said substance. Often, it can be challenging to determine the actual amount of alcohol that clients drink or use of other substances. To ensure that everyone has shared language to communicate about amounts being consumed or used, it is recommended that clinicians and clients review (preferably together) standard alcoholic drink sizes and quantities used. The following charts may be helpful visuals to incorporate.

For alcohol, one standard drink is considered:

- 12 ounces of regular beer, which is usually about 5% alcohol
- 5 ounces of wine, which is typically about 12% alcohol
- 1.5 ounces of distilled spirits, which is about 40% alcohol

For more information on how the National Institute of Alcoholism & Alcohol Abuse defines what a standard drink is, please use the following link:


For marijuana, here are some standard measurement comparisons to help the client identify how much marijuana they use:

- 1 gram = size of a grape
- 3.5 grams = size of a kiwi
- ¼ oz = size of an apple
- ½ oz = size of a grapefruit
- 1 oz = size of a coconut
- 1 lb = size of a watermelon

For more information on helping the client identify how much marijuana they use, please use the following link:

https://www.my420tours.com/weed-measurements-complete-guide/

Clients, especially those with problematic substance use, may be anticipating some sense of clinical reaction and surprise when disclosing the amount of substance used. It is recommended to take a non-judgmental approach, validating when a client discloses, and even affirming how difficult it must have been for them to disclose their use to you. Given societal stigma associated with substance use (which includes using alcohol, tobacco, and other substances both legal and illegal), it is possible the client may exhibit some degree of defensiveness with this section of the intake. Using open-ended questions can help you...
create an environment that is respectful and safe, while allowing rapport to be built, which in turn may decrease defensiveness. Keeping most of these questions open-ended will also allow clients to explain and contextualize their current use, so you will be better positioned to understand factors that led to a client’s previous decisions and further explore their substance use from their perspective.

Various colloquial terms and labels may be used by clients during this section. One example might be that the client is curious if they are an “alcoholic,” “addict,” or “binge drinker.” In these cases, it may be helpful to ask questions to understand what those labels mean to the client and provide psychoeducation on clinical definitions and/or what research suggests can be clinically meaningful or have undesired impacts. We do not recommend specifically placing these types of labels on clients. Instead, we recommend talking about behaviors and whether the behaviors are effective in the short- and long-term as a means to not place a value judgment on the client. It is noteworthy that some clients may prefer to use these types of terms (e.g., addict) to refer to themselves and that may be helpful for them in conceptualizing their struggles.

NOTE: Problematic alcohol use standards currently differ by sex assigned at birth. For gender non-conforming, transgender, and nonbinary clients, consider asking which standards they believe are most helpful to reference (those for cisgender men, women, and/or both) when determining whether they may be engaging in binge drinking. There is some evidence that suggests individual differences in the number of enzymes responsible for metabolizing alcohol (i.e., alcohol dehydrogenase) is more closely related to sex assigned at birth than gender identity; however, it is important to be affirming rather than make assumptions about the client’s body or behavior, particularly given the numerous biological processes that contribute to alcohol metabolism.

For many individuals, particularly those holding marginalized identities, substance use, stress, and mental health concerns are intrinsically tied, so it could be possible that a client’s substance use is directly impacting other domains you have already assessed. Keeping information gathered from other sections in mind, as the clinician, you can tactfully integrate this knowledge (when applicable) with their presenting concern. For instance, in the case of a patient who has been experiencing depression or low mood, you may ask: “I’m curious how you think alcohol use might be impacting your depression, if at all?”

Additionally, it will be important to understand how the client’s substance use may have changed over time. This can include when they first started using the given substance as well as when they have found themselves using it the most and the least. It’s also possible that although the client may have used substances (even problematically) in the past, they are not now. These instances provide a great opportunity for us to understand more positive and protective factors that keep them from using. Consider asking, “What led you to stop using X substance and how have you managed this?” This may give insight into potential strengths that you can continue to build upon.

Substance use might be a more widely acceptable behavior in some communities and in others, it may be heavily discouraged and stigmatized. Various parts of a person’s identity may also impact a person’s perceptions of substance use. For example, a person’s gender, religious identity, or socioeconomic status might influence their perception of the acceptability of substance use and how normalized it is by their community. Be careful not to make assumptions about how “normal” or problematic the use is without in-depth assessment. Be mindful that a person’s experiences of minority stress might also be related to their substance use in some cases, although we should not make the assumption that it is.

Finally, ending with a brief pros and cons of substance use can be beneficial when it appears that the client may be using one or more substances in a way that may be problematic for them. Given that many of our clients might be ambivalent over changing their substance use (most often going from some use to less use or no use), the negatives of substance use often serve as powerful motivators of change, whereas the positives often reinforce their current patterns of use. Therefore, we recommend closing this section out by starting with pros, but ending with cons/negatives of substance use, as a potential way to shift toward the possible benefits of changing their behavior(s).
Educational History/Current Education Status

This section should focus on understanding the role of education in the client’s life. For some individuals, education may be a privilege, while others may view education as non-negotiable. It is important to understand factors that may have impacted the client’s achieved or desired education level. This is also a time when indicators of family dynamics, cultural factors, and SES may arise. For example, the client may have aspirations to achieve an education level, though financial stressors dictated that the client obtain employment instead. Alternatively, academic achievement may be highly valued by the client’s family, though the client may have preferred to enter the workforce instead, leading to strained familial relationships. It is possible that the presenting concern may be related, in some way, to these factors. For example, the client may present to the clinic with concerns of feeling low and unmotivated at work during the day. In this case, you may consider inquiring about how fulfilled the client feels by their position, and, in an ideal world, what the client would be doing with their time.

Remember, education can be formal (schools, institutions, degrees), informal (learning family’s native tongue, learning to cook), and non-formal (skills learned through organized groups, community-based resources, vocational training).

This is also an appropriate time to assess generational poverty (family living in poverty across at least two generations). Research has shown that the best predictor of escaping poverty is education. However, those who experience poverty are the least likely to obtain a college education. Among individuals who experience poverty, it is likely that as children, learning to survive was essential, whereas formulating educational aspirations was not. Here you may also consider assessing history or current welfare status, disability pay, and migrant work.

Occupational History/Current Occupational Status

In this section we want to identify what, if any, aspects of the client’s life they consider work. Remember, work can look different for many people. Some may view work as a way to pursue fulfillment and achieve their goals. They may be focused on building a career and career advancement. For others, work is much less about personal achievement but rather a means to survival and to maintain safety and security. Access to various types of work and careers is not equitable, nor is the process of “moving up” in socioeconomic standing. Additionally, not all work is paid. This includes, but is not limited to, internships, parenting, and other forms of caregiving (e.g., for elderly family members). Probe for indicators whether employment provides sufficient financial support for the individual and their needs (family, community).

It may also be helpful to assess cultural considerations, such as identity norms (e.g., gender), which may have impacted the client’s occupation. Inquire about how fulfilled the client feels in their position, and if they have other occupational aspirations or needs.

Also, it is important to remember not to impart our own values as clinicians (e.g., work/life balance) on the client. It is possible that the client may not have the choice as to how much or how often they work. Remain neutral and genuinely interested in the life and history of the client.
**Family Status**

Family can be defined in various ways and may include biologically related individuals or chosen/found family. You may ask about any of the following individuals as is relevant to the client:

- Parents/caregivers
- Siblings
- Extended family, e.g., grandparents, uncles, aunts, cousins, nieces/nephews
- Children, grandchildren
- Partners (though you may wish to save follow-up questions about partners for the next section)
- Any significant chosen or found family members, including close friends and neighbors.

This section should be focused on gaining an understanding of the client’s familial context and what factors may need to be considered during treatment (e.g., barriers to childcare which may require flexibility in where and when treatment is delivered; acculturation and cultural tension across family generations). If asking about parenting a younger child, inquire about childcare availability and whether this would be a barrier to attending sessions. You can also ask about their experiences with parenthood and/or their adjustment to parenthood.

Probe for indicators of SES during childhood (caregivers’ work/education, what type of area they lived in) and any tension or difficulties in the home like domestic disputes or legal involvement. This might be a good opportunity to inquire about family history of mental health difficulties.

When asking about family of origin, if there is a recent history of immigration, try to get a sense of any differences in acculturation, assimilation, or potential value differences between the client and their older generations.

**Social and Romantic Relationships**

Relationships can take many forms and each is unique. Remember to use the terms with which the client identifies. Relationship statuses can include single, dating, partnered, separated, widowed, and others. Relationship structures can vary. Some common types include monogamy and non-monogamy. Non-monogamy can include polyamory, open relationships, and many other orientations. Be mindful not to pathologize non-monogamous partnerships, or assume infidelity or non-seriousness.

Try to use terms like “partner” when assessing clients’ relationship experiences and statuses, instead of gendered terms like “husband,” “wife,” “boyfriend,” and “girlfriend,” unless the client personally uses that language. Also, try to use terms like “relationship” or “partnership” rather than “couple.”

For people with minoritized gender identities, sexual orientations, or relationship orientations, a stressor could include both historical and present experiences of discrimination or invalidation. It may be important to assess for the impact of these issues. For example, you might ask something like, “How fairly do you feel you are treated by others because of your sexuality/relationship status?” or “People who share your relationship status have and continue to be marginalized for this. How does this impact you and your experiences?”

It may be important to assess any mismatches in cultural or other social identities between the client and their partner(s). For example, you could ask questions like, “What values do you and your partner(s) share? What values are different for you? How do you and your partner(s) deal with any cultural or values-based differences?”

Clients may have already disclosed experiences of intimate partner violence or domestic abuse (in the trauma history section), but here is another area to probe for this if they have not indicated such. It can be helpful not only to assess for the presence of physical or sexual violence but also experiences related to control, threats, coercion, humiliation or other hurtful relationship dynamics.
For friendships, you may also probe into their level of trust and closeness with these individuals. If the client has minoritized identities or experiences, you may consider asking about whether that is something they have shared with their friends. You may also inquire about how challenging or easy it is for the client to make friends.

Recreational Activities

This section is critical to identify aspects of life that are positive for the client and that they truly enjoy engaging in. Be mindful to consider the client’s overall level of activation. Are they engaging in a lot of different activities including work/education, social activities, fun activities, health behaviors (e.g., sleeping, exercising, etc.) and others? Or do they appear to be under-activated in one or more areas of functioning? Being able to establish strengths is also important as we can build upon those in the therapeutic relationship.
Impact of Other Stressors and Areas of Concern

If there are large scale, local, or important current/recent events that are impacting people, you may also consider asking clients how they are managing. Examples might include but are not limited to: local events (including extreme weather), social and political events, natural disasters, wars and acts of violence in the US and other countries, hate crimes, and epidemiological events (e.g., Covid, severe flus).

Example language to consider:

• “I want to acknowledge recent events regarding (violence/discrimination/hate) toward (specific person or group; e.g., Black and Brown individuals). I also know this type of violence is unfortunately not new on a larger scale, and at the same time when these events happen, it has an impact. How has it been impacting you?”

  • You can name the specific recent incidents when discussing this with clients.

• “There have been a lot of strong opinions and feelings related to the election. How are you doing with that?”

• “How are you doing with everything going on with Covid? How has it impacted you?”

Case Conceptualization Tool

This part of the tool is meant to be used after the intake and therapeutic assessment is complete. If there are additional elements to the therapeutic assessment process in your clinic (e.g., diagnostic assessments, personality assessments, self-report measures), complete those before filling in the case conceptualization form. The purpose of this section is to help you integrate all of the information you have gathered throughout the intake and therapeutic assessment process and utilize it to develop a deeper understanding of the client. It is also meant to help you and your supervisor to analyze potential interventions that might be helpful in addressing the client’s presenting concerns.

The first section will help you to consider client identity factors that might be impacting their experiences. Remember to consider how these sociocultural identities influence each other to impact the client’s lived experience.

Next, you will be asked to consider their presenting concerns, including your understanding of factors that contributed to these concerns developing and their impact on the client’s life and functioning. Consider factors that led to improvement or worsening of symptoms or other experiences as well as take-aways from their previous experiences with help-seeking (both things that were helpful and less helpful), to inform your current treatment plan. You will also be asked to consider symptoms or experiences the client endorsed within specific domains, including mood and emotion difficulties, trauma history, substance use, risk factors, and health conditions and concerns. Client’s strengths and social support structures should also be considered.

In the functional analysis section, you will be asked to explore more deeply your conceptualization of the development of their presenting concerns and how they are/were influenced by the client’s context. You will also be asked to explore factors contributing to the maintenance of these experiences as well as their consequences.31,32
Before moving on to the treatment planning portion of the tool, potential diagnoses can be explored. Although diagnoses are not utilized or needed in all clinics, it may still be meaningful to practice thinking about what diagnoses may be most appropriate given that many settings require diagnoses (especially those that utilize insurance for billing purposes). For clients who have endorsed experiences consistent with multiple diagnoses, consider whether it is appropriate to assign multiple diagnoses or whether some of the symptoms could be better explained by one disorder. For example, a client might endorse experiences consistent with both PTSD and Social Anxiety. For some, it may be that both diagnoses are appropriate because their experiences with social anxiety appear to be above and beyond what we might anticipate given their trauma history. For others, it may be more appropriate to give a PTSD diagnosis alone if the social anxiety started or significantly increased after the trauma and appears to be better accounted for by significant changes in trust and increases in hypervigilance, avoidance, and physiological symptoms.

In the treatment planning section, you can compile the client’s presenting concerns and goals for treatment, and identify any common elements or processes that may be beneficial to target in therapy. For example, a client might endorse avoidance behaviors more broadly across presenting concerns, which might give you additional direction when planning treatment options. After compiling these potential targets, consider what techniques, treatments, and modalities might address these concerns as well as ways to effectively prioritize treatment goals.

Last but not least, you will have the opportunity to explore potential factors that might impact treatment or prevent it from progressing as effectively as possible. As you explore potential therapy interfering behaviors or processes, remember that they are likely to happen in some shape or form in most cases and this is natural. You will also have the opportunity to problem-solve potential ways of managing these experiences so that you can address them earlier, rather than after they have already negatively impacted treatment.
In starting the intake, you may first give the client some relevant information including but not limited to:

• A little bit about you and your training
• Your supervisor’s name and training
• The clinical setting and its policies and procedures, including informed consent and confidentiality (if not already covered)
• More details about how therapy might look in future sessions (number or frequency of sessions to expect).

○ (If introducing yourself for the first time) “Hello, my name is __________ and my pronouns are ________. In today’s session I will start by talking to you a little bit about me, our clinic, and the general policies and procedures. This session will feel a little different than future sessions, in that I will be talking a bit more and asking a lot of direct questions. Please ask questions at any point throughout this interview. Then I would like to spend the majority of the session getting to know you and what brings you to therapy today. What questions do you have so far? What else would you like to make sure we cover today?”

○ Be sure to check in with the client as you’re reviewing policies, e.g., “What questions do you have?”

○ After introductions and policies: “Thank you for going through all of that with me. For the rest of the session, I will be asking lots of different types of questions to get to know you and how we can work together to address your concerns. Some of these questions may really fit for you and others may not; we’ll spend more time on the things that you think are important.”

○ “We have a lot to cover today. At times we might talk about something in a lot of detail. I may also move us along more quickly at other times. This does not mean the current topic isn’t important; it would only be in the interest of time and making sure we don’t miss other pieces. We can return to any topic in future sessions. I will probably also ask some clarifying questions throughout to make sure I really understand what you are telling me.”
“Some of these questions might be a little more sensitive than others. If there are any you feel uncomfortable answering, let me know and we can move on from there. How does that sound?”

“It is important for me to understand each client as a whole person, which can include their culture and identities. Is it ok if we start with some questions about that?”

- “Please share with me whatever you feel comfortable. It is helpful for me to know your answer to each question but it is your choice whether to answer them.”

- “What is your age?”

- “With what race do you identify?”

Identifying information

Reminders:
- If you are unfamiliar with any terms the client uses, gently and humbly ask for clarification.
- Use the client’s language when you are reflecting back to them (e.g., only refer to a person as “gay” or “queer” if they use that specific word to describe themselves, not simply if they report a marginalized sexual orientation).
- As may be relevant, consider asking the client about potential concealment and how they would like you to refer to them in the medical record system (given that other providers or caregivers may have access, or could request access later).
- Do not make assumptions about how a person identifies or how important any given identity is to the client based on appearance or expression.

NOTE: if you have any of this information from an intake form used at your clinic, you can just confirm the information you have using the language of the client (e.g., “You said you identify as a Black cisgender woman. Is that right?”)

You can choose to ask an open-ended question here, such as “Tell me about yourself,” or “What identities are important to you?” or “How do you describe yourself?” If clients hesitate, you can ask specific questions as listed.
**And what ethnicity?**

**How do you describe your gender? What are your pronouns (if you don't already know)?**

**How do you describe your sexual orientation, regardless of your prior sexual experiences?**

It may be helpful to provide examples of what is meant by ethnicity (e.g., Jamaican, West Indian, Indigenous/First Nations/Native American, Palestinian).

If they need examples of gender identities, you can say, “For example, man, woman, gender fluid, gender queer, or nonbinary.” Similarly, if they need examples of pronouns, you can say, “How do people refer to you without using your name (in the second person)? For example, he, she, they, ze, or any other pronoun.”

If they need examples of sexual orientation, you can say, “For example, straight or heterosexual, gay, lesbian, bisexual, pansexual, asexual...” You could also say, “By sexual orientation I mean who do you find yourself romantically or sexually attracted to?”

You may also spend time inquiring about the process of coming out to friends or family as it is relevant to their presenting concerns.

“Tell me a little bit about where you were born and where you have lived.”

“What language(s) do you speak fluently? What language(s) do you speak at home?”

“Tell me about any concerns you have about language barriers or misunderstanding each other.”

“Tell me a little bit about that. How important is spirituality to you?”

“There are many other important parts of identity. I am going to ask about some later on including ability and disability, education, work, and family status. However, if you prefer, we could talk about any of those or other identities now. Are there other parts of your identity or culture you would like to tell me about now?”

(If unclear from client’s descriptions)

“What parts of your identity and culture are particularly important to you?”

“Are you religious or spiritual? Tell me a little bit about that. How important is spirituality to you?”

This question is meant to gather more information about their nationality, acculturation status, generational status, etc. Consider following up about immigration status for their parents and other family members as well.

When assessing potential concealment of immigration status, you might ask, “I am curious if most people in your life are aware of your (or your family’s) immigration status? How, if at all, does their knowing or not knowing affect you?”

Consider assessing changes over time, if religion or spirituality is a source of stress, strength, etc.
Presenting Concerns

Reminders:

- This section is focused on gaining clarity about what the client is having difficulties with, their personal understanding of their concerns, and the impact these concerns are having in their life.
- We want to get a general sense for why the client is seeking treatment, and what occurred to bring them into the clinic at this time.
- The more information we have about the concern (e.g., when it started, how it impacts their life) the more tailored the treatment plan can be.
- Be sure to use open-ended questions, while reflecting and summarizing the client’s story with their own language. Remember to validate the experiences and feelings of the client.

“Tell me about why you decided to come to therapy. What brings you in?”

- Probe further as needed to understand “How long have you been experiencing (presenting concern)? When did you first notice (presenting concern)? When was the most recent recurrence?”
- “Have there been times that (presenting concern) has been better or worse?”
- (If not already clear) “Was there something specific that was happening at that time that might be connected to (presenting concern)?”

If the client is coming to therapy involuntarily (e.g., court ordered, strong suggestion from family), consider asking:

- “Tell me about your understanding of why you are here today.”
- “How do you feel about engaging in therapy?”
- “Do you think therapy might be useful to you? If so, tell me how you think it could be useful.

In reflecting, you might use phrases such as:

- “What I’m hearing you say is that (insert relevant information here), and it’s making things difficult for you by (insert information). Am I understanding this correctly?”

(If not already clear) “How does (presenting concern) affect you?
- Would you say it impacts your family and loved ones? Does it impact your work or school performance? Does it impact you in other ways?”
- “Have you noticed any change in physical or medical wellbeing?”
- “How would your friends or family describe what you are going through?”

“Typically, when we are faced with circumstances we don’t like, we find ways to make things easier or less painful. What are some of the ways you have tried to cope with this? What has worked for you? What have you tried but found to be more difficult?”

- “What are you hoping to change/see differently as a result of participating in therapy?”

“It sounds like things have been quite difficult for you. Let me see if I heard you correctly….”

Is this a new problem? A recurring problem? What things seem to prompt these symptoms?

- How is the presenting concern affecting relationships, self-worth, conflicting values, avoidance, safety, security, self-care? Does it impact ability to perform at home, work, school, socially?

Examples of coping strategies include: exercise, alcohol, other substances, distraction, avoidance, sleeping, mindfulness, challenging thoughts, planning ahead…

It’s important to maintain an open dialogue throughout therapy, so asking about the client’s expectations can help to keep you both on the same page.
“Do you have any feelings or emotions that are distressing? How would you describe some of the feelings or emotions you often experience? What would you call it, if you were to give this experience a name?”

(If needed) “For example, some people struggle with sadness, fear, anger, guilt, shame, anxiety, numbness, or other emotions. How do these fit with your experience?”

Mood and Emotions

Reminders:

- An important part of cultural consciousness is using the client’s words to describe their mental health concern. For example, the terms “depression” and “anxiety” are not universal idioms of distress. Please see preface for examples of alternative language to use.
- Please see Risk Assessment section for language should the client endorse suicidal ideation.
- Remember to evaluate the level of impairment they experience in day-to-day life for each concern.

“Some people have mentioned that parts of their culture or identity have impacted (presenting concern). Does this fit at all with your experience?”

“What are your views of mental health treatment? What do your family and friends think about mental health and treatment?”

Probe for information regarding financial stress, acculturation stress, discrimination experiences, challenges with concealment.

You might decide to gather general data here, then pivot to a more detailed interview such as the SCID-5 or MINI.

It is important to ask for examples and how these symptoms may have impacted their functioning in daily life.
- Is this a change from how they functioned previously?
- Does it distress them?
- How long has it been going on?
- Was there an event that coincided with worsening of symptoms?

Some people have mentioned that parts of their culture or identity have impacted (presenting concern). Does this fit at all with your experience?”

“What are your views of mental health treatment? What do your family and friends think about mental health and treatment?”
(If not already discussed) “Have you ever experienced a period of time when you were feeling sad, down, or depressed (insert client’s language)?”

• (If yes) “Tell me about that. During that time did you lose interest in things you used to enjoy?”

• Consider asking about other symptoms of depression (e.g., hopelessness, guilt, changes in appetite, changes in sleep, psychomotor agitation or slowing, etc.) and/or assessing low mood via the use of a diagnostic interview such as the MINI or SCID.

• “How long did that period last?”

• “Have you ever felt much less interested in most things, or less able to enjoy things you used to enjoy?” (If yes) “Tell me about that.”

• “About how many times have you had a period of at least 2 weeks when you were feeling depressed or down, more days than not?”

• This item is necessary to broadly assess for history of depressive episodes. The critical diagnostic criteria for depression include feeling sad, empty, or hopeless, less able to enjoy things they used to enjoy, most of the day, nearly every day for at least two weeks.

Examples: Have they been missing work as a result of feeling unmotivated? Are they withdrawing from friends or family? Did they stop participating in activities (e.g., recreational sports, social events, hobbies, self-care) that they used to find enjoyable?

• If there is indication that the individual may have experienced a depressive episode in their lifetime, probe for more information. Assess for current symptoms, as well as past or lifetime symptoms.

• We want to be sure to assess whether these symptoms have lasted most of the day, nearly every day, for at least 2 weeks.

• “Have you ever experienced a period of time when you felt as though you had an excess of energy (e.g., feeling up, high, or active and full of energy)? (If yes) How was your sleep during that time? Did you feel rested when you woke?”

• “How long did this last? When in your life did you first notice these symptoms?”

• “Do you ever find yourself worrying about various things?” (If yes) “Are there themes to the worry? How often would you say you feel worried? Are there times when you notice the worry is more or less intense?”

• Throughout the interview you can also be attentive to the client’s emotional and affective states.

• Take note of slowed speech, length of time between questions and answers that seems atypical.

• Does it seem to take the person longer than average to process information or deliver a response, even to relatively simple questions? Conversely, do you notice that the individual is fidgeting, seems restless, or is having difficulty sitting still?

• Assess if these anxieties are present most days and if this impairs their ability to get things done. For example, do they spend so much time worrying that they are late to work, or they avoid going places or doing things?
“Do you feel on edge, anxious, or tense often or in certain situations?” (If yes) “What is that like for you? Tell me more.”

“Do you ever experience irritability? How about anger?” (If yes) “Tell me about that.”

“Are there other types of emotions or moods that you struggle with such as guilt, shame, loneliness, or feeling nothing at all? (If yes) Tell me about those.”

You may also consider assessing broader difficulties with emotion dysregulation or other mood or emotion disorders.

• “Sometimes people say they feel things very intensely and their emotions can change frequently. How, if at all, does this apply to you?”

• Consider asking about other symptoms of anxiety (e.g., tension, rumination, difficulty managing uncertainty, nervousness, sweating, nausea and gastrointestinal difficulties, panic attacks, anxiety when around other people, etc.) and/or assessing anxiety via the use of a diagnostic interview such as the MINI or SCID.

“How has (expressed difficulty) affected your life? Your ability to function in work, school, at home, and in your relationships? Have these concerns ever gotten in the way of something you wanted or needed to do?”

“What are some ways you have tried to cope with these experiences? How effective has that been?”
Lots of people have had traumatic or very difficult experiences in their life. Sometimes people experience a significant accident, a natural disaster, or other life-changing experiences. People may also experience physical, sexual or emotional abuse, or neglect. Sometimes trauma also takes the form of ongoing experiences like discrimination or intimate partner violence. What experiences like these, if any, have you had?

- If they endorse any of the above
  “Would you be willing to tell me just a little bit about it? You don’t have to tell me a lot of details now if you are not comfortable with that. If you are comfortable, would you tell me generally what happened and when it happened?”

If the client is hesitant to discuss these topics, provide validation and reassurance. For example, “I understand this can be difficult to talk about, especially with someone that you are just meeting. It is okay to just say what you are comfortable with, even if it’s just ‘yes, I have had some of these experiences but don’t want to go into detail now.’ We can always come back to this topic later.”

If the client does choose to disclose more, be mindful and validating. Consider:
- Conveying that you believe them and that it wasn’t okay that it happened to them.
- (If not disclosed above) “Have you ever witnessed violence, a serious accident, or something else traumatic?” (If yes) “If you are comfortable, would you tell me generally what happened and when it happened?”
- “Trauma can also be the accumulation of more subtle, daily experiences like microaggressions, can be passed down like intergenerational trauma, or could be things like stalking, harassment, or incarceration that might stretch across time. Have you experienced things like this?” (If yes) “Tell me about that.”
- “Sometimes people also experience significant betrayals when important people or even institutions that are supposed to protect and care for them fail to do so. For example, this might occur when you are significantly hurt by someone you love or being treated unfairly by people in authority. Have you ever had an experience like that?” (If yes) “Tell me about that.”

For example, “I am sorry this happened to you. No one deserves X.”

- Being mindful of your body posture
- Lean in but remain quieter, allowing them the time and space they need to disclose.
- Ensuring them that you are there to listen AND they do not have to tell you everything right away
- Normalizing the traumatic response
  - Note that symptoms and changes experienced after trauma make sense given what the client experienced.
- Letting them know there are effective treatments and resources

Do not blame the client or suggest they were to blame for the trauma (e.g., asking the client why they were in the situation).

Please be attentive to the language the client uses. We don’t (especially in an intake) label the type of trauma for the client in many instances (e.g., calling an experience “rape” when the client does not use that language).
“Sometimes people are also impacted from witnessing or learning about trauma that happened to others. This is especially possible when it happens more than once, or even over and over again, or when the individuals impacted firsthand are close to us or share similar identities to us or those we love. Would you say you have been impacted by this kind of trauma?” (If yes) “Tell me more about that.”

If the client endorses experiencing trauma, you might consider assessing other trauma symptoms (e.g., avoidance, changes in mood, hypervigilance, intrusive symptoms).

Definitions and examples that may be helpful if the client asks for clarification:

Microaggression: More subtle forms of discrimination that are experienced by many on a daily basis.
- “I am not racist. I have a Black friend.”
- Assuming a quality about a person because of an identity they have (e.g., gay men like fashion or women are all emotional).

Intergenerational trauma: Trauma that happens to an entire generation (or multiple) that often impacts future generations.
- For example, major disasters, wars, slavery, genocide, the Holocaust, and other events may impact generations and then subsequent generations’ experiences.

Vicarious trauma: Being impacted by witnessing or empathizing with the trauma of others.
- For example, EMT workers, doctors, or those working for child protective services might experience vicarious trauma. It may also occur when witnessing someone with a shared identity being hurt, abused, or killed.

Moral injury trauma occurs when a person acts against or fails to act in line with their morals or values.
- For example, hurting others may be traumatic for some.
People can seek support, help, and healing from many different people including therapists, medical doctors and psychiatrists, religious or spiritual leaders, and others. Have you ever sought therapy, another kind of treatment, consultation, or some other form of help before?

- (If yes) “Tell me a little bit about that and why you sought support”
- “What did you find most helpful and less helpful?”
- “Are there things you learned from (source of support) that you still use?”

Medical History and Health

Reminders:
- This section focuses on understanding the client’s medical and treatment history broadly, including what worked and didn’t work in previous therapeutic (or similar) settings.
- Also ask questions about general health behaviors (sleep, eating, exercise, and the use of medications). These items may give you more information about the client’s overall health and may help elucidate additional treatment targets.
- In this section, you may also want to explore disability status and how that impacts the client.

“Did you experience any challenges with your previous helpers (can use their own words; e.g., doctor, pastor)? This could be for any reason including not responding to the treatment/support, not seeing “eye-to-eye” with your provider (or you can use their language for this helper), discriminatory experiences, or other challenges.” (If yes) “Please tell me about that.”

“Have you had or do you have any serious illness or injuries, including head injuries, hospitalizations, or ongoing medical conditions or disabilities?” (If yes) “Tell me about that.”
- Consider asking if unclear: “How has this impacted you?”

“Are you currently taking medications, supplements, herbal remedies?” (If yes) “Please tell what types and what they are for.”
- Ask for each medication, supplement, or remedy:
  - “How long have you taken (name of medication)?”
  - “Who prescribes (name of medication)?”

Be mindful that some injuries, illnesses, and medical experiences may have been traumatic for the person.
• “How helpful do you find (name of medication)?”
• If unclear, “Do you notice any side effects from (name of medication)?”
• “Have you ever been hospitalized for psychiatric reasons?” (If yes) “Tell me more about that. What happened? When was that?”
• “Tell me a little bit about your sleep.
  • About how many hours per night do you typically sleep?
  • How is the quality of your sleep?
  • Do you ever have trouble falling asleep, waking up too early, sleeping too much or too little, having nightmares, or feeling tired throughout the day?” (If yes) “Tell me more about that.”
• “Tell me a little bit about what a typical day of eating looks like for you.”
  • “Do you ever worry or have others in your life expressed worry about how much or little you are eating, or notice changes in your appetite?” (If yes) “Tell me more about that.”
• Tell me a little bit about what exercise looks like for you.”
  • What types of exercise do you do?
  • About how often do you exercise?

If appropriate, consider using a sleep hygiene assessment to further assess sleep difficulty.

If appropriate, consider utilizing the semi-structured eating disorder examination, or the EDE questionnaire.

It may be appropriate to skip the exercise question if it is clear from what they previously said that they cannot exercise.

History and Current Risk

Reminders:
• Note, you can likely skip this section if your clinic uses the Columbia-Suicide Severity Rating Scale (C-SSRS), the Linehan Risk Assessment and Management Protocol (LRAMP), or another standardized measure or protocol for risk assessment.
• Remember, in general, more information here is better. You will not prompt the idea of suicide by asking about it. The more details you have, the better you can prepare a proper treatment plan and/or crisis plan.
• Consider asking about the specifics of thoughts and behaviors (the what), timing (when and how often), how (means, methods, etc.), and prompting events (why they engage in the behavior/have the thoughts).

NOTE: If you get a “no” to the starting question you can skip to the next item.
• “Now I am going to ask you some questions I ask everyone. Sometimes people say they have thoughts about death, dying, or not wanting to be here anymore. Sometimes people also think that others would be better off without them or about going to sleep and never waking up again. Have you ever experienced these thoughts?” (If yes) “When was the last time you had these types of thoughts? Tell me more about those thoughts.”

Although it may be tempting to skip the whole section if you get a “no” to the first question, it is recommended that you still follow up about thoughts, intention, plans, and actions for both harm to self and others.

If the client endorses current and previous thoughts, it might be helpful to follow up, “Tell me about when those thoughts were at their worst or most intense.”
• “Have you ever had thoughts about wanting to kill yourself or end your life?” (If yes) “When was the last time you had these types of thoughts? Tell me about them.”
• “Have you ever taken any steps or made plans to end your life?” (If yes) “Tell me about that.”
• Follow up as necessary to understand:
  • “When did this happen?”
  • “How many times have you made plans or acted on plans to end your life?”
  • “Have you ever researched ending your life with (described method)?”
  • (If not clear already) “Do you own or have access to (described method)?”
  • (If unknown) “Do you have a firearm or have easy access to one?”
• “Have you ever intended to end your life?” (If yes) “Tell me about that.”
• Again, try to get a sense of timeline, what led to intent, and whether they acted on the intent to die. What prevented them or stopped them (if applicable)?

For all suicidal or homicidal thoughts or intent endorsed, make sure to assess:
• The content of the thoughts (what they are thinking).
• How often they are having these types of thoughts (once in a while, most nights, multiple times throughout the day).
• What their reaction to the thoughts is like (e.g., are they comforting/relieving? Are they scary?).

If a plan is disclosed, get a sense of:
• How detailed this plan is/was.
• How dangerous/lethal it is/was. Was there one or more specific method(s)? A date in mind?
• What prompting events led them to engage in planning?

• If not already clear, “Have you ever tried to end your life?” (If yes) “Tell me about that.”
• “What happened that led you to do that?”
• “When was this?”
• “How did you attempt to end your life?”
• “What happened after that? (What stopped you from ending your life?)”
• “Have you ever injured yourself without intending to die including things like cutting, burning, hitting your head or other parts of your body, or other things that might hurt or leave a mark?” (If yes) “Tell me about that.”
• Assess frequency, type of self-harm, the intended results of the behavior.
• For example, “People engage in (described behavior) for many different reasons. Some people might do it to reduce their distress, to feel something when they are numb, to communicate distress, and many other reasons. Tell me about why you (engage in described behavior).”

• If actions or attempts have been taken in the past to self-harm or end their life, consider asking:
  • “What led to (engaging in behavior)?”
  • “When you (engaged in behavior) had you planned on doing that for some time? Or was it more something that happened quickly in response to something?”
  • “What did you experience as a result of (engaging in behavior)?”
  • (If needed) “For example, for some people they feel relief; others feel it helps them express themselves, or demonstrates their distress to others more effectively. Some also say that while it helps in the short-term, there are things about it they don’t like. How about for you?”
• If they endorsed any current or previous thoughts, intent, or plan to harm themselves ask, “What sorts of things keep you from acting on these thoughts? In other words, what things keep you going or give you good reasons for being here?”

• “Have you ever had thoughts about seriously harming someone else?” (If yes) “When was the last time you had these types of thoughts? Tell me more about those thoughts.”

• Get a sense of how long they have experienced the thoughts, the content of the thoughts, and the frequency of the thoughts.

• “Have you ever intended or planned to harm someone else?” (If yes) “Tell me about it.”

• “Have you ever significantly physically harmed another person?” (If yes) “Tell me a little bit about what happened.”

This item is meant to assess protective factors. If the client cannot spontaneously list any, you can offer examples.

• E.g., friends and/or family, pets, fear of pain or dying, hope for the future, having major things they would like to accomplish, not wanting to hurt others, wanting to live, religious or spiritual beliefs, fear of disapproval of others for themselves and/or their family, responsibilities they believe are important.

Especially if the client is endorsing more than passive SI, consider administering a comprehensive assessment (e.g., LRAMP, C-SSRS), and developing a crisis/safety plan for the client to use if distress increases.

Assess for homicidal thoughts, plans, and actions in a similar manner to assessing suicidal thoughts, plans, and actions. Further risk assessment and safety planning should also be done. Follow up as necessary to understand:

• When did this happen?

• How many times have they made plans or acted on plans to harm another person?

• If they have not acted on plans, what stopped them?

• Have they ever harmed others without intending to do so?

• (If not clear already) Do they currently have intent or plans to harm another person?

• Do they own or have access to (described method) of harming the other person (including access to this person)?

It is possible that harm inflicted upon others may be difficult for the client to discuss. If this is the case, you can remind them that they don’t need to share all of the details with you today.
Alcohol, Tobacco, and Other Substance Use

Reminders:
- This section broadly assesses quantity and frequency of current alcohol and other substance use.
- Use standardized measures of alcoholic drinks and other substances to get a more accurate impression of client’s substance use.
- If the client engages in substance use that negatively impacts them, non-judgmentally assess both the pros and cons of alcohol and substance use, starting with the pros/positives and ending with the cons/negatives.

“How does alcohol currently fit into your life?” (If they use any amount of alcohol)
- “How frequently do you drink alcohol?”
- “About how many drinks do you consume on days when you do drink?” **review standard drink chart**
- “Where do you typically drink?”

“Were there times in your life that you drank more than you do now?” (If yes) “Tell me about that. When was that?”
- “How has your drinking changed?”
- “How frequently did you drink at the time?”
- “How much alcohol did you consume on days you drank?”

Common undesirable consequences that might occur from substance and alcohol use include:
- Doing things that they wouldn't have done if sober
- Missing work or other responsibilities
- Spending more time than they wanted thinking about or acquiring substances
- Spending more time recovering from the effects of alcohol/drug use
- Having greater conflict with family members and friends
- Spending more financially than they were willing/wanting to on alcohol or drugs

“What sort of difficulties have you experienced in limiting the amount of alcohol you drink when you do drink, if at all?” (Follow up if difficulties are disclosed):
- “Do you ever have a strong desire or urge to drink?”
- “Is it sometimes hard to stop thinking about drinking?”

“How has alcohol impacted you at work, in school, personally, or in your relationships?” (If at all) “Tell me about that.”

“What other substances, if any, do you use, including caffeine, tobacco, marijuana, and prescription drugs not prescribed to you or not taken as prescribed, if any?” (Inquire for each.)
- “About how frequently do you use (described substance)?”
- “How much of (described substance) do you consume at one time?” **Try to get specific**
- “Where do you typically use (described substance)?”

Common prescription drugs that can be misused include:
- Opioids (Vicodin, oxycodone, codeine)
- Amphetamines/stimulants (Adderall, Vyvanse, Ritalin, Concerta)
- Benzodiazepines (Xanax, Klonopin, Ativan, Valium)
- Sleep medications (Ambien, Lunesta)

- Physical injury
- More frequent experiences with anxiety and depression when sober
“Were there times in your life that you used substances more than you do now?” (If yes) “Tell me about that. When was that?”
• “How frequently did you use (described substance) at the time?”
• “How much of (described substance) did you use back then?”

“How has using (described substance) impacted you at work, in school, personally, or in your relationships?” (If at all) “Tell me about that.”
• “What consequences have you experienced as a result of (described substance) use?”

If the client endorses any problematic substance use, including alcohol: “What are some of the positives of using alcohol and/or (described substance) for you?” “How about the negatives?”

For clients whose substance use may have looked differently in the past than it does now, inquire:
• “What has changed with your substance use? What do you think may have contributed to that change?”
• “What does your ideal substance use look like?”

More ways to assess pros/cons of substance use include:
• “I’m curious to hear from you what are some of the things you like about using (described substance) and what you don’t like about (described substance). Let’s start with the positives. What are those for you?”
• “How about the negatives or things you don’t like so much about (described substance)? What are those?”

“Are you currently in school?” (If yes) “Tell me about it. How is it going for you?”
• Consider asking about how many years they have been in school, how many years they have left in school, their major and/or degree they are seeking.

(If not in school or it is unclear from previous answer) “What was the highest degree you completed?”
• “Tell me about your experiences in school. How did you do? How did you feel about school?”
• Do you intend to return to school?

“How did/does your family/community view school?”

Culturally, education can be valued or devalued for an individual. Asking some of the following questions can give us a clearer picture of cultural implications of education:

“Different people value education differently. How would you say your culture values education? How are your goals aligned with or different from that?”

Education can be:
• Formal: Institution-based, degree seeking
• Informal: Within the community, e.g., learning to repair automobiles from a parent
• Non-formal: Skills acquired via “real life,” e.g., caretaking skills
Remember, it may be helpful to assess whether the client has experienced generational poverty (poverty that is “passed down” from previous generations).

Additional questions to consider if school/education is an important aspect of life to explore for this client (in that it is related to their experience of presenting concerns):

• “How might one of your teachers describe your academic performance?”
• Consider asking about types of instruction. For example, did the person receive mainstream instruction, learning support, emotional support, gifted instruction, public/private? Was there a need to repeat a grade?

“Are you currently doing paid work, (if they are a parent, in school, or caring for others) in addition to parenting/school?”

(If yes) “What is your job?”
• “How long have you been working there? Do you enjoy your work?”
• “Do you work full time/part time?”
• “Does the job provide you with sufficient financial support for yourself and anyone else you may support?”
• “How might (presenting concern) interfere with your work, if at all?”

Additional questions to consider if career is a particularly important aspect of life to explore for this client include:

• “How would you describe the quality of your work relationships?”
• “What aspects of the job do you enjoy? What do you find most challenging?”
• “When did you start working?”
• “Do you volunteer?”
• “Have you ever been asked to step down or leave a job?”

Occupational History/Current Occupational Status

Reminders:
• This section should focus on understanding the values and necessity of work.
• The degree to which a client feels able to make decisions about work may directly impact factors to consider during treatment (e.g., ability to take time off for therapy, access to care, financial stability, chosen versus expected occupational roles).
• Sometimes cultural expectations and financial security may govern how much an individual must work and the type of employment they hold.
• Be careful not to impose personal values (e.g., work/life balance) onto the client, and instead remain thoughtful and empathetic to all individual and collective influences.
(If no) “Are you interested in looking for work? What kind of work do you see yourself doing?”

“Did you work in the past?” (If yes) “What type of work did you do in the past? What led to your decision to leave that position?”

“Have you ever served for the armed forces?” (If yes) “Tell me a little about your experience.”

- United States? Another country?

**Family Status**

**Reminders:**
- Family can be defined in various ways and may include biologically related individuals or chosen/found family.
- This section should be focused on getting to understand the client’s familial context and what factors may need to be considered during treatment (e.g., barriers to childcare which may require flexibility in where and when treatment is delivered; acculturation and cultural tension across family generations).

“Tell me about your family.”
- “What does family mean to you?”
- “How important is family to you?”
- “How are these people involved in your social support system?”

“Who currently lives in your home?”
- “What are your relationships like with them?” (Could be parents, other caregivers, siblings, extended family, children, chosen family, etc.)
- “Does your family know you’re coming to therapy? What have they said about it?”

(If relevant) “Tell me about your experiences with parenting and being a parent.”

Feel free to reference any information you’ve already gathered to naturally probe for more information, e.g., “You told me earlier that you are experiencing difficulties in your relationship with your daughter. Tell me more about your relationships with your children.”

You may consider asking about any of the following individuals:
- Parents/caregivers
- Siblings
- Extended family, e.g., grandparents, uncles, aunts, cousins, nieces/nephews
- Children, grandchildren
- Partners (though you may wish to save follow-up questions about partners for the next section)
“Tell me about your family growing up.”
• “Who lived in the home?”
• “Where did you live growing up?”
• “What was the environment overall like for you growing up?”
• “What did your parents/caregivers do for work?”

• Any significant chosen or found family members (e.g., close friends or neighbors that the client considers family)

If asking about parenting a younger child, inquire about childcare availability and whether this would be a barrier to attending sessions.

When asking about family growing up, listen for indicators of SES (caregivers’ work/education, what type of area they lived in) and any tension or difficulties in the home like domestic disputes or legal involvement. This might be a good opportunity to inquire about family history of mental health difficulties.

If there is a recent history of immigration, try to get a sense of any differences in acculturation, assimilation, or potential value differences between the client and their older generations.

Social and Romantic Relationships

Reminders:
• Relationships can take many forms and each is unique. Remember to use the terms with which the client identifies.
• Do not pathologize non-monogamous partnerships, or assume infidelity or non-seriousness.
• Try to use terms like “partner” instead of gendered terms like “husband,” “wife,” “boyfriend,” or “girlfriend” unless those are the words the client uses to describe the people in their life. Also, try to use terms like “relationship” or “partnership” rather than “couple.”

If partnered or in romantic relationship(s): “Tell me about your relationship with your partner(s)/spouse(s)/etc.” (ask about each if client is in multiple relationships).
• “What is (are) your relationship(s) like?”
• “How long have you been together?”
• “How satisfied do you feel with your relationship(s)?”
• “How would you say you and your partner(s) work together, problem-solve, and make decisions?”
• “How supportive is(are) your partner(s)?”

Instead of asking the questions as they are written, you can use information you gathered earlier to ask new questions. For example: “Earlier you mentioned that your husband has been very supportive to you during this time. Tell me a bit more about your relationship.”

To assess relationship-related validation/discrimination, you may ask:
• “How fairly do you feel you are treated by others because of your sexuality/relationship status?” Or
• “People who share your relationship status have and continue to be marginalized for this. How does this impact you and your experiences?”
“All romantic partners fight sometimes – what are your fights like with your partner(s)? Do the fights ever become physical?”
- “Do you ever feel controlled by your partner(s)? Have they ever threatened you, your family, or something else important to you?”
- “Have you ever felt coerced to engage in sexual behaviors with them?”

“Tell me about your friendships.”
- “How close are you with those friends?”
- “How supportive are those friends?”

“How important is having friends/romantic relationships to you?”
- (If social support is low) “Do you desire to have more of these relationships?”

You may assess mismatches in cultural or other social identities between the client and their partner(s) by asking:
- “What values do you and your partner(s) share?”
- “What values are different between/among you?”
- “How do you and your partner(s) manage any cultural or values-based differences?”

If already disclosed and assessed in the trauma section, you can skip items about domestic violence.

For friendships, you may also probe into their level of trust and closeness with these individuals.

You could also inquire about how challenging or easy it is for the client to make friends.

Recreational Activities

Reminders:
- “Tell me about some of your hobbies and interests.”
- “What types of things bring you happiness or enjoyment? A sense of peace?”
- “What do you see as your strengths?”
- “What are some things you like best about yourself? What are you most proud of?”
- “If you have free time to relax, how do you do so?”

If the client has trouble listing strengths, you can consider listing one or more that you noticed during the interview, if it feels genuine, in order to enhance some rapport (e.g., resilience, openness, honesty, bravery, care for others, drive/ambition, willingness to grow and change).
Impact of other Stressors and Areas of Concern

- “I am curious if and how (particular recent event) has impacted you?”
  
  Or

- “(Particular event) has been stressful for a lot of people; how are you coping with it?”

- “What other important things have we missed that you think we should discuss today?” Follow up questions as needed.

- If there are current impactful events, it may be helpful to name the event(s) and then simply ask how it has affected or impacted the client.

- Consider recent local, national, and international events.

- Feel free to return to other sections of the intake document if the client discloses relevant information, for example, additional details to the presenting concerns, other areas of risk, and other traumatic experiences.

Wrapping up the Intake

As you are ending the session, consider:

- Providing a summary of the presenting concerns and other important pieces of information you covered in the interview.

- Reiterate the client’s goals for treatment.

- Discuss a plan for the coming sessions (further assessment, giving an approximate timeline for the assessment process and treatment if possible, plans for weekly or biweekly, monthly, etc. sessions).

- If applicable, provide brief, generalized information about potential treatment modalities or frameworks.
  
  - For example, “Our clinic focuses on Cognitive Behavioral Therapies or CBTs. Have you ever heard of CBT? What that means is we focus on understanding the link between our thoughts, emotions, and behaviors...” (Provide additional, easy to understand detail about potential modalities, whether they are broad frameworks or more specific protocols.)
Identities and culture:

Pronouns: _______________________________________________________________

Age: _________________________________________________________________

Race: _________________________________________________________________

Ethnicity: _____________________________________________________________

Nationality: ___________________________________________________________

Gender identity (including whether they identify as transgender): ______________

_______________________________________________________________________

Sexual orientation: _____________________________________________________

Religious/spiritual identity/beliefs: ________________________________________

Ability/disability status: _________________________________________________

Socioeconomic status (including access or lack of access to resources): __________

_______________________________________________________________________

Education: ______________________________________________________________

Work: __________________________________________________________________

Additional important identities and/or cultural practices: _______________________

_______________________________________________________________________

_______________________________________________________________________

_______________________________________________________________________
Which cultural practices and identities are most important for this client? Do their identities impact their presenting concern(s)? If so, how?

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Did the client report experiencing discrimination (and in what ways) with regard to their identities and/or culture? In what ways are they or might they be experiencing minority stress (e.g., systemic levels, interpersonal levels, internalized stigma).

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What social privileges does the client endorse holding? How does this impact their sociocultural experiences?

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**Presenting concerns:**

What are the major presenting concerns for the client? How long has this been happening? What may have prompted the concern(s)? What has made it better or worse? Make sure to include ways client sees the concerns that are both similar and different to how you see them.

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What is the impact of these concerns on their functioning? Friends and family? Work/school?

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_______________________________________________________________________
_______________________________________________________________________

What types of support/help/healing have they sought before? What did they find most and least helpful?

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_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
What strengths are the client bringing with them to treatment?

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_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

Mood and emotional symptoms/difficulties:

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_______________________________________________________________________
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Trauma history:

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Risk behaviors/factors (including current and historical SI, self-injurious behaviors, HI, violence toward others):

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_______________________________________________________________________
_______________________________________________________________________
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_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
Significant physical/health conditions, concerns, and/or illnesses (current or historical; medications):

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_______________________________________________________________________

Substance use (current and historical):

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Social functioning:

Describe client’s relationships in the following domains (consider sources of stress as well as strength, the quality of the relationships, and frequency of contact with others):

• Partner(s)/spouse(s): ____________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

• Family: ______________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

• Friends: _____________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

• Co-workers/schoolmates: ______________________________________________
_______________________________________________________________________
_______________________________________________________________________

Who is/are the strongest source(s) of support for client?
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

What activities/interests does client find enjoyable/pleasant?
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

_______________________________________________________________________
Functional analysis:

Why do the client’s symptoms and behaviors “make sense” given their history and current context? Even if their behaviors are less effective now, why might they have been adaptive in the past? (For example, “shutting down” may not be working in the context of their current relationship, but may have been adaptive and protective in their childhood environment, and may still feel protective now.)

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_______________________________________________________________________
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_______________________________________________________________________

What factors appear to have contributed to the development of their concerns?

_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

What factors appear to maintain their current difficulties (e.g., thoughts, behaviors, environmental factors, historical context, desirable consequences such as temporary relief)?

_______________________________________________________________________
_______________________________________________________________________
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_______________________________________________________________________

What are the short- and long-term consequences of these experiences and/or behaviors that negatively impact the client (i.e., why might change be helpful)?

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_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
Preliminary diagnoses:

What diagnoses appear to best fit the client’s experiences based on all of the information gathered (include information gathered from the intake interview, diagnostic assessments, personality assessments, cognitive assessments, and/or self-report measures)? Why is this your clinical impression (e.g., what symptoms did they endorse)?

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_______________________________________________________________________
_______________________________________________________________________
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Are there any additional diagnoses you are considering? If so, which one(s) and why? What additional information do you need to determine if it fits?

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_______________________________________________________________________
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_______________________________________________________________________

Are there one or more diagnoses you consider to be “primary,” meaning best representing the client’s concerns and symptoms? Which diagnosis(es) and why? How will this impact your treatment planning?

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_______________________________________________________________________

Treatment Planning

Goals:

What are client’s goals for therapy?

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_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

Are there additional treatment targets or goals you would like to suggest/consider with the client? If so, what are they and why might they be important to address?

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_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

Presenting concerns (list; also note which of the difficulties may be beneficial to prioritize):

1.  ____________________________________________________________________
2.  ____________________________________________________________________
3.  ____________________________________________________________________
4.  ____________________________________________________________________
5.  ____________________________________________________________________
Common elements of the presenting concerns (e.g., struggling with inhibition or emotion dysregulation more generally, etc.):

1. ____________________________________________________________________
2. ____________________________________________________________________
3. ____________________________________________________________________
4. ____________________________________________________________________
5. ____________________________________________________________________

Treatments/interventions that are effective for these presenting concerns, common elements, and/or reaching the client’s goals (This might include entire treatment protocols/modalities or particular interventions):

1. ____________________________________________________________________
2. ____________________________________________________________________
3. ____________________________________________________________________
4. ____________________________________________________________________
5. ____________________________________________________________________
6. ____________________________________________________________________
7. ____________________________________________________________________
8. ____________________________________________________________________

Given all of the above, which treatments might you recommend to treat their presenting concerns, common elements connecting the problems, and/or for reaching the client’s goals? Which might you prioritize and why (e.g., life-threatening behaviors/safety concerns, common mechanisms, particular difficulties, such as mood, that are contributing to other problems)?

_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

Therapy interfering behaviors and processes:

What might get in the way of therapy being successful either in the sessions or generalization outside of the therapy room? Remember, just because these behaviors or processes might impact therapy, that does not necessarily mean that they are anyone’s fault or that it “should” be different.

Related to client’s circumstances and/or presenting concern (including but not limited to: potential difficulty completing home practice, having an overly full schedule, tendency to be very talkative or quiet, emotional intensity or numbness, crisis experiences, etc.):

_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

Related to the therapist/supervisor (including but not limited to: lack of experience working with this presenting concern, similar clients, burnout, lack of consensus on treatment targets, etc.): Are there biases, personally held identities, or personal history that might impact the therapists’ ability or experiences working with this client? If so, what might impact therapy?

_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

(NOTE: This item may be sensitive to discuss with others including a supervisor or others on the treatment team. It is encouraged that clinicians be mindful of these factors AND observe their own limits with whether and how much to discuss it with others.)

Related to the environment (including but not limited to: lack of access to needed resources, less social support than desired, difficulty obtaining support of other professionals, etc.):

_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

Related to the institution (including but not limited to: limitations on number of sessions offered in an institution, lack of resources for childcare, parking/public transit access, expense of services, etc.):

_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
Potential ways to mitigate/target these therapy interfering behaviors and processes:

• Related to clients:______________________________________________________
  _______________________________________________________________________
  _______________________________________________________________________
  _______________________________________________________________________

• Related to clinician/supervisor:____________________________________________
  _______________________________________________________________________
  _______________________________________________________________________
  _______________________________________________________________________

• Related to the environment:______________________________________________
  _______________________________________________________________________
  _______________________________________________________________________
  _______________________________________________________________________

• Related to the institution:________________________________________________
  _______________________________________________________________________
  _______________________________________________________________________
  _______________________________________________________________________

Other things to consider about treatment:

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________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
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________________________________________________________________________
Key Multicultural Terms and Ideas

• Acculturation: “The processes by which groups or individuals adjust the social and cultural values, ideas, beliefs, and behavioral patterns of their culture of origin to those of a different culture.” This may not include adopting the mores and norms of the dominant culture, but rather adjusting one’s viewpoint to understand/preserve their culture of origin in context of the dominant culture.

• Culture: “Belief systems and value orientations that influence customs, norms, practices, and social institutions, including psychological processes (language, care-taking practices, media, educational systems) and organizations (media, educational systems). Culture has been described as the embodiment of a worldview through learned and transmitted beliefs, values, and practices, including religious and spiritual traditions. It also encompasses a way of living informed by the historical, economic, ecological, and political forces on a group.”

• Disability: “A lasting physical or mental [condition] that significantly interferes with an individual’s ability to function in one or more central life activities, such as self-care, ambulation, communication, social interaction, sexual expression, or employment.”

• Discrimination: “The unequal allocation of goods, resources, and services, and the limitation of access to full participation in society based on individual membership in a particular social group. Systemic discrimination is reinforced by law, policy, and cultural norms that allow for differential treatment on the basis of identity.”

• Ethnicity: Groups of people who identify with each other based on shared attributes such as a common set of traditions, ancestry, language, history, society, culture, nation, religion, or social treatment in context of their geographical, cultural area.

• Gender: “Attitudes, feelings, and behaviors that a given culture associates with a person’s biological sex.” Gender can encompass identities, expression, roles.

• Identity concealment: the need to keep a particular aspect of identity secret in order to avoid discrimination, harassment, or oppression. For example, a person with a minoritized gender or sexual orientation may conceal this from their conservative family or community to avoid social harm. Similarly, a client who (or whose family) immigrated to the states may conceal this identity to avoid systemic discrimination.

• Intergenerational trauma: Trauma that happens to many people in a generation (or multiple generations) that often impacts future generations (e.g., children). For example, major disasters, wars, slavery, genocide, the Holocaust, and other events may impact generations and then subsequent generations’ experiences.

• Intersectionality: “The way these citations look differs throughout this section. Could we have them all be same such that the numbers are next to the last word in the sentence and then the period. In the case that there is a quotation mark, could we have it go so the number goes first, then the quotation mark, and then the period? The way it looks in Intersectionality is correct.”

• Marginalization: “A process of social exclusion in which individuals or groups are relegated to the fringes of a society, being denied economic, political, and/or symbolic power and pushed towards being ‘outsiders’.”

• Microaggressions: “Brief and commonplace daily, verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative slights and insults to the target person or group.”

• Moral injury trauma: May occur when a person either acts outside of their values or fails to act (omission) within their values, and when this has a very significant impact on themselves or others. It may also occur when someone else close to them (including authority figures or institutions) that they are aligned with do so. For example, a veteran...
may experience moral injury trauma when they have been a part of a mission when innocent civilians were killed.

- Multicultural competence: "Obtaining the awareness, knowledge, and skills to work with people of diverse backgrounds in an effective manner".

- Nationality: "A people having a common origin, tradition, language, and capable of forming or actually constituting a nation-state; an ethnic group constituting one element of a larger unit (such as a nation)".

- Oppression: "Superiority exercised by a group with social power over other groups through laws, policies, cultural norms, and everyday practices that produce and reproduce societal inequities. Structural forms of oppression inhibit the ability to develop one’s full potential and may result in negative physical, psychological, and social outcomes." "Discrimination + Social Power = Oppression".

- Power: "the control exercised by one group or organization (or its members) over the actions and/or the minds of (the members of) another group, thus limiting the freedom of action of the others, or influencing their knowledge, attitudes or ideologies".

- Prejudice: "A judgment or belief that is formed on insufficient grounds before facts are known or in disregard of facts that contradict it. Prejudices are learned and can be unlearned." "Unearned special rights, immunities, and societal advantages that are granted on the basis of membership in a dominant social identity group. Privilege represents an expression of power. Through cultural norms and values, privilege oftentimes is invisible to those who possess it".

- Stereotypes: "Fixed, overgeneralized beliefs about a group or community. These beliefs can relate to different aspects of diversity such as age, gender, race, ethnicity, national origin, sexual orientation, ability status, language, religion, and social class. Stereotypes..."
shape attitudes and behaviors toward various sociocultural groups and contribute to discrimination”.

- Vicarious trauma: Being impacted by witnessing or empathizing with the trauma of others. For example, EMT workers, doctors, or those working for child protective services might experience vicarious trauma. It may also occur when witnessing someone with a shared identity being hurt, abused, or killed.

References


