

Chapter 2

Assessment Stage: Data Gathering and Structuring the Interview

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2.1 Introduction

The aims of the assessment in cognitive-behavioral therapy (CBT) are to derive a detailed and shared formulation of the person's presenting problems and, together, to develop an individualized treatment plan. As in the traditional psychological assessment, the main goals of cognitive-behavioral assessment are to diagnose disorders, discuss with the patient the goals of the treatment, plan the treatment, and try to facilitate positive changes in the patient starting from the first encounters with the therapist. An essential part of the assessment is the process of data gathering. Without collecting good information, it will not be possible to understand the patient's problem(s), and consequently his or her collaboration and trust may be compromised. Communication is therefore a key element in this stage of the therapy and represents the bridge between the patient's perspective and the therapist's theoretical framework.

Using communication skills appropriately allows the therapist to obtain more information on the presented problem, increases the reliability of the collected information, signals an interest in the patient's views and experiences, stimulates the patient's participation and collaboration, and, finally, makes the consultation more effective. The communication style (both verbal and nonverbal behaviors) can be viewed as a sort of therapist's visiting card, probably one of the stronger criteria through which patients judge the therapist's attitude to listen and understand their problems and test the therapist's ability to provide help and support. Communication skills are also important tools to help patients to better understand their problem(s) and cope with them.

This chapter aims to provide information on the communication skills that can be helpful to clinicians in assessing patients in psychotherapy. As previous studies

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on this matter have been conducted predominantly in medical settings, we will first describe some theoretical background and findings from research on communication in this field. Second, we will try to give some practical suggestions and examples that can make interactions with patients more effective and efficient. More in detail, the chapter is organized in three main sections. In Sect. 2.2 we will describe the main theoretical models of doctor–patient communication and mention some research studies in a medical context (see also Chapter 1). In Sects. 2.3 and 2.4 we will describe and discuss communication skills useful for gathering information in the assessment stage and for structuring the interview, respectively.

2.2 Knowledge and Evidence on Doctor–Patient Communication in Medical Settings

2.2.1 Theoretical Background

In the last 30 years, a great amount of literature has been written on doctor–patient communication in medical settings, leading to several theoretical frameworks that have progressively defined the essential elements of an effective medical interview. Specifically, the following models can be considered as key issues that have contributed to change the traditional paternalistic approach: (a) the biopsychosocial model (Engel 1977); (b) the process model of stress and coping (Lazarus and Folkman 1984); and (c) the patient-centered approach and the integrated model (Smith et al. 2002). We will give a brief description of them here.

- (a) *The biopsychosocial model.* This model was developed by Engel, who theorized that biological, psychological (e.g., beliefs, relationships, stress), and social factors all play a significant role in the onset, progression, and outcome of illness. This model includes the person with the disease (e.g., emotions, theories, impact on everyday life) as well as the disease itself, because it integrates the psychosocial and social dimensions with the biomedical aspects. This concept emphasizes that body and mind are not separable and that the modern health provider can best understand the patient only as a whole person. This position was in contrast with the traditional biomedical model, according to which a good health status simply depends on the absence of any specific illness. The patient is considered as an integrated joining of biological, psychological, and social components and he or she undertakes an essential role in his or her own care as a precious source of relevant information able to complete clinicians' knowledge. Doctors' competence and patients' experiences integrate each other, equally contributing to achieve an accurate diagnosis, greater health outcomes, and humane care. The primary aim has shifted from “cure” to “take care of” the patient, the patient's point of view is actively explored, and he or she is more engaged in the therapeutic process (see also Chapter 1).

- (b) *The process model of stress and coping.* Illness can be considered a stressful life event with psychosocial consequences (crisis) to cope with. Richard Lazarus and Susan Folkman suggested a framework for evaluating the processes of coping with stressful events. According to the model, the impact of stressful experiences depends on the transaction between people and the environment (Transactional Model). Specifically, the ability to manage stressful events depends on how each person evaluates the stressor (e.g., positive, controllable, challenging, irrelevant) and on individual awareness and assessment of all the available resources to deal with the event. Therefore, the level of stress following an event may be attenuated by changing individuals' perceptions of stressors and by improving their confidence in their ability to implement a successful coping strategy. Considering illness as a stressful event, the model of stress and coping can constitute a valuable basis for describing patient responses in critical care.
- (c) *The patient-centered approach and the integrated model.* Several articles have been published on the patient-centered approach as opposed to the traditional doctor-centered (paternalistic) approach (Lesser 1985; Pendleton and Hasler 1983; Smith 1997; Stewart et al. 1995; Smith et al. 2002). Good patient care and cure require that the physician explores at the same time both the biomedical and psychosocial dimensions of illness. Psychosocial variables may influence the onset and course of a disease as well as biological variables and therefore become essential factors in order to define a therapeutic plan that is specific for each single patient and that is supported by his or her motivation (Rimondini et al. 2003; Weston et al. 1989). According to this, the patient-centered and medical-centered approaches are complementary and should be integrated in the interviewing process to elicit both personal and symptom data (Smith et al. 2002). In such an approach, open-ended questions are largely used as well as acknowledgment of patients' feelings, emotions, beliefs, and opinions, and active patient participation is strongly encouraged (Smith et al. 2002).

In order to better understand this approach, it is fundamental to become familiar with the concept of *agenda* (Tate 1994). When approaching a medical encounter, each patient has in mind specific issues he or she would like to discuss, but also expectations, beliefs, ideas, fears, and worries related to these issues. Other important information includes life events and the impact of symptoms on quality of life. All these essential pieces of information represent the *agenda of the patient*. Peltenburg et al. (2004) introduced the term *emerging agenda* in order to define all the "concerns or issues not expected to be on the agenda by either the patient or the physician before the consultation." Eliciting these unexpected themes becomes essential in order to contextualize the problems presented by each patient and develop a personalized and effective therapeutic plan. Patients often introduce their agenda by expressing cues and concerns. Concerns are a clear and unambiguous expression of an unpleasant current or recent emotion, with or without related issues (e.g., "I feel frightened" or "I am worried about my high blood pressure"). Cues are verbal or nonverbal hints that suggest an underlying unpleasant emotion

and therefore would need to be clarified or explored by the health provider. Understanding and eliciting patients' agenda is essential to implementing the patient-centered approach and requires that physicians use several communication skills.

Starting from these theoretical backgrounds, Cohen-Cole (1991) developed the *three-function model of the medical interview* (see also Chapters 1, 3, and 4). The model has been designed in order to supply a tool able to translate into clinical practice the previously described theoretical models. The author identifies three fundamental components of the interview:

1. building the relationship and responding appropriately to the patient's emotions (relational skills);
2. collecting all relevant data to understand the patient's problem (data-gathering skills);
3. educating the patient about her illness and motivating her to adhere to treatment (information-giving skills, negotiating and motivating strategies).

Biological as well as psychological, emotional, and relational aspects need to be considered all together as different parts of the same problem and need to be fully explored, understood, and appropriately managed (function 2). In spite of the paternalistic model, where the patient was just a passive recipient of a doctor's prescription, the patient-centered approach allows the patient to play an active role in his own care, providing him with all the information/instruments necessary to take part in the therapeutic decisions (function 3). While functions 2 and 3 represent different stages of the medical encounter, function 1 passes through the whole interview since each step of the medical interview should be based on an efficacious therapeutic alliance built up with a series of relational skills (see Chapter 3). According to the offered theoretical background, it is possible to identify the criteria of an efficacious doctor-patient interaction. The patient is guided by the doctor to offer in a precise and reliable way, and in an adequate timeframe, the maximum amount of relevant information necessary to understand his health and life problems. The patient and the healthcare provider work as partners in order to find an agreement and get a shared idea on what the main problem is. The patient is offered the opportunity to have an active role in her own care and is stimulated by the physician to be involved, to participate and collaborate in treatment decisions. In this way, the patient feels understood and sustained by the healthcare provider and feels free to express emotions.

2.2.2 Research Findings on Doctor-Patient Communication

An accurate and detailed information-gathering process, together with the implementation of a collaborative relationship, is essential to achieve greater health outcomes. Specifically, improved health outcomes occur when patients feel free to express topics of perceived immediate importance, and when physicians pay

appropriate attention to what the patient wants or needs to convey (Smith 2002; Stewart et al. 1995). The patient-centered approach is a valid tool to get such an open dialogue between the doctor and patient. Several studies have shown the benefits of the patient-centered approach on outcomes of patient care. These advantages are higher patient satisfaction (Williams et al. 1998; Safran et al. 1998; Kinnersley et al. 1999), better recall and understanding of information (Roter et al. 1987; Hall et al. 1988), improved adherence to treatment (Butler et al. 1996; Safran et al. 1998; Svensson et al. 2000), more efficient coping strategies with disease, improvement of the health status (Ryff and Singer 2000; Ong et al. 1995; Stewart 1995; Maly et al. 1999; Mead and Bower 2002; Eijk and Haan 1998; Bodenheimer et al. 2002), and a decrease in referrals to other specialists (Stewart et al. 2000; Little et al. 2001). A growing body of evidence supports the importance of health provider–patient communication in the interview and its role on both biomedical and psychological outcomes of care. The need to improve the doctor–patient communication has been widely recognized also for psychiatric patients, and communication skills have been proposed as “core skills” in the curriculum of psychiatrists (Scheiber et al. 2003; Walton and Gelder 1999). Studies on communication skills in psychiatry have remained rare despite the observations that psychiatrists needed training in interviewing skills (Maguire 1982; Goldberg et al. 1984; McCready and Waring 1986; Rimondini et al. 2006). Some studies evaluating the effects of training (Maguire et al. 1984; Lieberman et al. 1989; Harrison and Goldberg 1993) found that training in interview skills is indeed useful for psychiatrists even if individual outcomes differed, not all psychiatrists improved, and some undesirable behaviors, such as close-ended questioning, proved resistant to change. Such findings present a challenge to communication research in psychiatry, which only recently has been taken up again (Nuzzarello and Birndorf 2004; Rimondini et al. 2010).

All these findings suggest that specific communication skills are also important in psychotherapy and that they can play an essential role in improving patient–therapist relationship and outcomes.

2.3 The Data-Gathering Process

Data gathering is an essential part of the cognitive-behavioral assessment, which generally occurs during the first phase of psychotherapy. Some authors debate the existence of a clear-cut distinction between the assessment and the therapeutic stage: where the planned intervention “officially” starts and the therapist, through the use of cognitive-behavioral–specific techniques, focuses on the management/treatment of the emerged problems.

In this section we will focus mostly on the first assessment encounters, even though information gathering can also occur later on during the therapy, and the clinician should be able to go back and restart the data gathering at any time.

2.3.1 *Setting and Barriers*

To facilitate the data-gathering phase and the relationship building, therapists should also consider the setting in which the interview is conducted. Therapists should be aware of the potential communicative barriers that can have a negative impact on the interaction (such as noise, lack of confidentiality, elements in the room that may suggest a hierarchy between the therapist and the patient) and they should make an effort to remove or minimize all obstacles, the clear ones as well as those that are less evident. The interview should be conducted in a silent and private room, with both the patient and the therapist comfortably seated in chairs of equal height, without being separated by a desk or table. If a desk or a table is needed in the room, it could be placed against the wall with the therapist and the patient sitting to the side. The therapist and patient can also sit at the corners of the table so that they can look at each other without obstacles in the middle. Moreover, if it is possible, they should not sit exactly opposite, with an adequate distance between the two parties, so that the patient can choose either to look directly at the therapist or to look at something else without feeling too uncomfortable. If the therapist needs to take notes, he or she should be aware of the potential negative impacts of this on the relationship (e.g., the patient may feel not listened to) and should be able to manage it (for example, by taking just the essential notes or by not losing eye contact during important emotional moments).

Language and cultural barriers are others important obstacles that may interfere with the data-gathering process, leading to incomplete or an inaccurate amount of information. The therapist should avoid jargon and should try to make the patient feel at ease, for example, by making empathic comments when a patient seems to be worried about his ability to clearly explain the problem(s) (e.g., “It might be not easy to talk freely about our feelings. Every word coming up in your mind may be useful and important to try to better understand what you are feeling in this situation”). Differences in socioeconomic and cultural background are also obstacles that might be difficult to overcome since age, gender, education, economic position, religion, and so forth are unchangeable. The therapist should create a nonjudging atmosphere where these differences can be made explicit and accepted. A useful strategy to overcome these unremovable and unchangeable barriers is commenting on them while using an empathic, not critical, and open attitude (e.g., “I’m wondering whether our age difference may be a problem for you”). For a further description of nonverbal components potentially affecting doctor–patient interaction, see Chapter 5.

2.3.2 *The Data-Gathering Process: Aims and Contents*

The role of the therapist in this stage is to listen carefully and, if necessary, to guide patients through their story-telling. The process of gathering information therefore has the following aims:

- understanding the patient's problems from the patient's point of view (exploring the patient's agenda);
- understanding the patient's problems from the therapist's point of view and inserting them in the cognitive-behavioral framework (formulation);
- considering in which direction the interpersonal style of the patient (if in the direction of an attachment deficit in personal relationships, or toward a deficit of autonomy, of personal efficacy) is evolving and building the therapeutic relationship;
- listening attentively, allowing the patient to complete statements without interruptions and leaving her space to think before answering or going on after pausing;
- checking if information gathered about both views (the patient's and the therapist's) is accurate, complete, and mutually understood;
- promoting the patient's trust and collaboration also by picking up cues and concerns (see Chapter 3);
- structuring the interview to ensure efficient information gathering;
- using concise, easily understandable language.

As in a medical context, in psychotherapy the patient's agenda may differ substantially from the therapist's agenda (Fig. 2.1).

The contents of the *patient's agenda* to be explored are similar to those in the medical context, even if they are more focused on psychosocial aspects. It is important to check with the patients for their ideas on the possible cause of their problem (*patient's theory*) and the reasons why the problem has been maintained during time. It is a common and natural tendency to give a meaning to what happened to us in our life both to events and to distressful experiences. People tend to search for meaning even when no causal events have occurred. The patient's theory can also be a good starting point to explore his cognitive functions. The way in which clients explain the nature and possible causes of their problem provides the therapist with good information for the cognitive-behavioral formulation. It is possible to discover naive theories, particularly if there are severe symptoms that compromise the reality testing. Sometimes patients can attribute their illness to particular events, resulting in misleading attribution. Again, for the cognitive-behavioral therapist, this is important information that can help her to better adjust and structure the psychotherapy. Another content area to be explored is the *patient's expectations*. Whether it is the first contact with a mental health provider or he has already had previous experiences, the client may approach the interview with several preconceived notions or questions about psychotherapy. Media can also influence the image of mental health providers, such as psychologists and psychiatrists. Cognitive-behavioral therapy prescribes an open and directive style of the interview, and patients might be surprised by that. For the clinician it is therefore useful to take into account these beliefs and expectations that may influence the patient's responses. In those cases where there is a pharmacological treatment or previous treatment/therapy experiences, it is necessary to explore the effects and duration of the past treatments and to discover if patients are

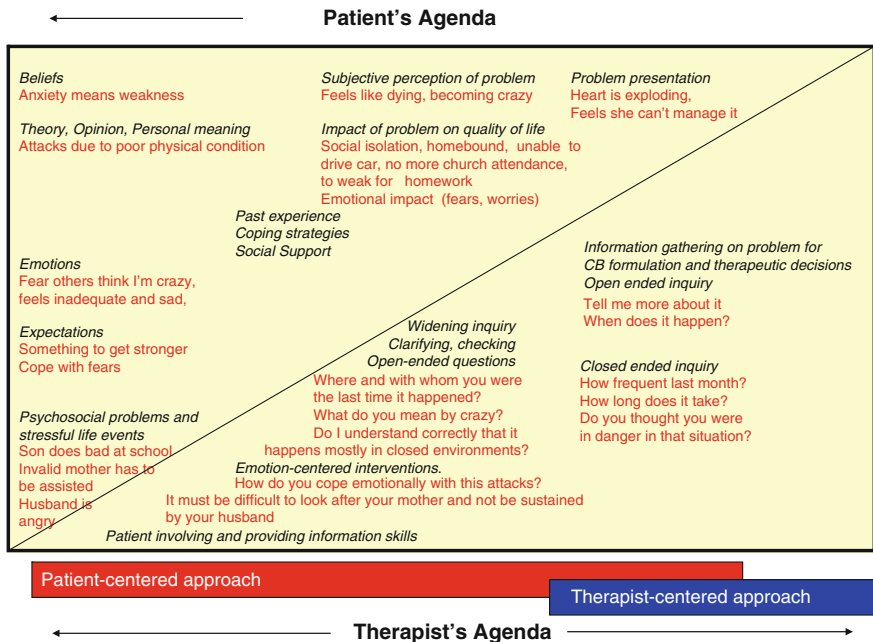


Fig. 2.1 Patient's and therapist's agendas with examples (modified from Tate 1994)

experiencing any side effects that may represent distressful symptoms (e.g., nausea, drowsiness, anxiety, sexual dysfunction).

The therapist should ask also about the *impact* of patients' problems on daily life, for example, in their ability to work, to cope with day-to-day chores, to pursue their hobbies, leisure, and social activities. In particular, the impact on relationships and social context should be carefully assessed (e.g., friends, family). The therapist can discover that problems are acute (for example, a low mood that compromises social activities) or that they are related to a more stable personality trait that has created difficulties at times and they are now more evident. Another important aspect to explore is patients' perception of practical and emotional *support* received from important key persons, such as relatives, friends, and others. Family and social context reactions can vary from being too protective to completely disinterested or even intolerant. Once again, these aspects are very useful information, to know both patients' coping strategies and their possible problematic relationships. In conclusion, collecting the patient's agenda is helpful for several reasons: It provides a more precise idea of his problem from his/her perspective; it contributes to relationship building; and it also provides useful information to complete the therapist's agenda and to conceptualize the case from a cognitive-behavioral perspective.

On the other hand, the aim for the first sessions of the psychotherapy in the *therapist's agenda* is to build on a general assessment of the background, current

circumstances, and mental state of the patient. The links among feelings, thoughts, and behaviors have to be tested out. Symptoms should be explored following a dimensional approach that examines the degree and nature of distress (if any) and the frequency, amount of preoccupation, and effect on the individual's functioning. Understanding the content of the dysfunctional beliefs is necessary to discuss and debate them later. Yet, in the early stage of the assessment, it is necessary to extract particular issues to focus upon, using a cognitive ABC formulation (Ellis 1962) to understand activating events (e.g., "My boss might yelling at me"), beliefs (e.g., "It would be terrible if . . ."), and consequences (e.g., fear and guilt with behavioral avoidance), and subsequently challenge them. The ABC formulation should be considered, however, as a general mental scheme that the therapist bears in mind in the entire data gathering. It can also be used in the conduction of the functional behavioral assessment, where it is important to describe in detail the problematic behavior (behavioral unit: B), in which situations this behavior occurs (antecedents: A), and what happens after its occurrence (consequences: C). Also, the goals of the treatment should be openly discussed and agreed with the patient at the beginning of the treatment, just at the end of the assessment process. An empirical study (Rossi et al. 2008) has demonstrated that this prescription has a value for the technique itself, but also to limit the drop-out phenomenon, which could be considered a key outcome indicator in psychotherapy.

2.3.3 Data-Gathering Process: Communication Skills

At the beginning of the interview, it is more useful to adopt an open inquiry so the therapist can let the patient's narrative express freely. The therapist should be careful not to interrupt the patient too soon, as the first problem described may not be the most important one. Going too deeply too soon can lead to the risks of both losing information and compromising the relationship. On the other hand, the order in which events, memories, concerns, and other psychological themes are verbalized is never accidental. Mathematicians have known for a long time that it is impossible for any person to generate prolonged sequences of random numbers, as they soon fall on significant schemas. The mind prefers order to chaos, and the same happens to the patient's narrative.

Several communication skills are useful for the information-gathering process. We will provide a brief description with some general examples of the following: listening, facilitations, reflections, clarifications, open- and close-ended questions, checking, summarizing, and reformulations. Therapists can feel more natural and spontaneous using certain skills, whereas for others they need more practice in order to feel comfortable with their use. Extending the foundation of knowledge and abilities can result in a significant improvement in therapist-patient communication. Chapters 6 and 7 offer many examples of the application of these skills in psychotherapy sessions.

2.3.3.1 Listening

Listening abilities are the basic skills for information gathering but also for building and reinforcing the therapeutic alliance. The effective use of listening skills allows, on one hand, the patient time to think and to contribute more without being interrupted and, on the other hand, the therapist to have time to listen, think, and respond with more flexibility. Without the listening skills that signal the therapist's interest in the patient, the patient may remain uncertain about his or her real attitude toward the patient's problems. For these reasons, listening is more important than speaking when we try to give voice to things that have been previously locked up. Through silence, the therapist invites the patient to fill in the emptiness, and makes the patient feel that she has permission to do it, not according to an external rule or someone's else desire, but following her more intimate nature (Bara and Cutica 2002). The goal of listening is also to respond to what the patient is saying, through actions such as eye contact or brief vocal utterances, which clearly indicate that the therapist is attentive to the patient's story. Listening abilities include giving space to the patient and following his pace. Because of this, listening can be more passive or more active.

Passive Listening

Passive listening includes the appropriate use of silence and use of nonverbal and verbal facilitation (see later in the section). Waiting time, brief silence, and pauses can very easily and naturally facilitate the speaker to tell more. Longer silences are also appropriate with expression difficulties or if it seems that the patient is about to be overwhelmed by deep emotions. The aim here is to assist the patient to express thoughts or feelings that are occurring inside her mind at that time. Sometimes silence can be a source of anxiety for both the patient and the therapist. If this occurs, it is up to the clinician to interrupt it and create a more comfortable situation.

Much of our attitude toward listening is signaled through our *nonverbal behavior* (see Chapter 5), which immediately gives the patient strong cues to our level of interest in him and his problem(s). Nonverbal behaviors include posture, movement, proximity, direction of gaze, eye contact, gestures, effect, vocal aspects (e.g., tone, volume, and rates), facial expression, touch, physical appearance, and environmental aspects. We can convey listening to, and therefore interest for, the patient's story through all these nonverbal behaviors, but particularly important is eye contact. The way the therapist looks at the patient while listening can be something that encourages the patient to talk freely, but it can also be misinterpreted. Misinterpretation can be due both to the therapist's attitude or to patient pathology (e.g., suspiciousness) and can inhibit therapist-patient communication and compromise their alliance. Another important thing to keep in mind is that it is necessary to give congruency between the verbal and nonverbal messages. We cannot express interest in another person while looking out the window.

Moreover, we know that in psychotherapy the first impression is important and can contribute to generate dysfunctional interpersonal processes, which the therapist should be able to recognize and appropriately manage (Safran and Segal 1990).

Active Listening

Active listening can be defined as an approach that requires intense concentration on the patient's verbal and nonverbal expression and is aimed at understanding and responding to the patient's feelings and fears and at understanding the links between the illness and the patient's life. It is as much an attitude of mind as a specific interviewing technique (Ford et al. 2000). Active listening signals interest in the patient, to listen carefully to her story, to prevent the therapist from making a premature hypothesis, to observe the patient for verbal and nonverbal cues (see Chapter 5). Active listening is therefore the result of all the therapist's efforts and of the atmosphere he is able to create with patients in order to understand them.

Examples

The patient experiences thoughts racing through her head. The therapist may observe flight of ideas and find it difficult to follow what the patient is saying or to interrupt her because of the swiftness and quantity of speech.

Pt: I have so many other things to tell you . . .

Th: I see. . . . You are thinking too many different things, all at once. Maybe we can try to focus our attention on one of them, perhaps the most important one to you at the moment.

2.3.3.2 Facilitations

These skills encourage patients to say more about the topic, indicate that the therapist is interested in what they are saying, and let them continue freely in their narrative. Using these skills at the beginning of the interview allows the patient's agenda to emerge. Facilitation can also be used to recognize and pick up cues to feelings and emotions and to make the patient feel understood and sustained. Facilitations are simple and neutral expressions such as, "Hmm," "ah," "I see," "yes" to go with body movements and facial expressions, such as nodding and smiling. Even something as simple as a slight eye movement can be effective if used properly. All these simple expressions following the patient's speech facilitate his narrative and make him feel listened to, understood, and supported. Through these brief actions patients can see and feel that the therapist is listening, following, and understanding their narrative.

Examples

Pt: I feel a little bit down.

Th: Hmm (looking at the patient and nodding).

Pt: I have been feeling down since my husband lost his job.

Th: Please go on.

2.3.3.3 Reflections

These statements are used to signal listening, to help patients continue in a particular direction, and to facilitate them in their narrative. The goal is to let them know the therapist is listening, by reflecting back what they have just said. Reflections encourage patients to clarify further or expand the information and allow the therapist to check that he has accurately understood what has been said. Listening to the therapist repeats what she just said gives the patient the chance to reconsider things, assess if the information is accurate, reflect on feelings and thoughts, and become more aware of her inner psychological process. As facilitations, reflections can also be used for recognizing and picking up cues to feelings and to make the patient feel understood and sustained (see Chapter 3). Reflections can be simple repetitions of words or a longer part of what the patient has said (echoing). This echoing skill can be very efficient in letting patients go on in their narrative, but can also be used to direct them to a particular topic of interest. The therapist can actually decide what phrase, word, or part of the speech he wants to repeat, underlining particular content and/or emotion. Reflections confirm that the therapist is listening and attentive and are more well constructed than the simple facilitation. In addition, reflections convey to patients that their role in the data-gathering process is important and valued. As this skill gives a direction to the patient's narrative, it can be considered slightly more directive than simple facilitation or silence. We also label reflection skills when the therapist completes the patient's sentence. This kind of mind reading can be very effective for building a relationship, as well as to facilitate the patient's narrative.

Examples

Pt: I have some problems with my partner and I feel very guilty.

Th: feel guilty (echoing). *In this case we expect that the patient will continue to talk about her feelings and emotions regarding her partner.*

Th: some problems (echoing). *In this other case, we expect the patient will continue to talk about the sort of problems she has with her partner.*

Pt: I don't know what to do in this situation. *(The patient stops talking and gazes intently at the therapist.)*

Th: You look a little bit worried. . . *(Reflection of a possible emotion-educated guess)*

Pt: In this particular situation I feel like I'm . . .

Th: in a cage. . . *(completing patient's statement)*

Pt: Exactly, it is a very hard situation and I don't know how to deal with it.

2.3.3.4 Clarification

The patient's choice of words, or expression, can often have different meanings, and it is important to ascertain which one is intended. Clarification is therefore useful to check statements that are vague or need amplification. Used when the patient has chosen words with a confusing, vague, or unclear meaning, clarification prompts the patient for more precision, clarity, or completeness.

Examples

Pt: I'm feeling upside down.

Th: What do you mean by "feeling upside down"?

Pt: My husband is ignoring me.

Th: What do you mean by "ignoring" . . . ?

2.3.3.5 Open-Ended Questions

In the first part of the interview, the use of open questions may have more advantages compared with closed questions. Open-ended questions are those beginning with "what, who, when, why," etc., which allow the patient to answer in an open way. They therefore encourage patients to freely tell their story more freely and give the therapist time and space to listen and to think about the patient's problem and story rather than thinking of what to ask or explore next. Open-ended questions help the exploration of problems from both the patient's and the cognitive-behavioral therapist's point of view. In the early stage of the assessment, it is worthwhile to ask patient-centered open questions in order to prioritize the client's perspective and let her direct the narrative. Sometimes this may lead to an initial lack of specific information necessary for a well-defined cognitive-behavioral formulation (preceding scenario of an unpleasant emotion, avoidance behaviors, thoughts and feelings during unpleasant moments). The collection of these data will be necessarily postponed in the phase of the assessment that is more centered on the clinician's agenda (see Sect. 2.4.1), where closed and open questions will be used in order to complete missing or too generic descriptions.

Moreover, these skills represent the first step for patient involvement, as they foster his collaboration and participation. Open-ended questions are therefore important, to open the interview, to facilitate free patient expression, to help in defining problematic areas, and to explore new topics introduced by the patient. As the interview proceeds, the therapist may need to become more directive in exploring certain areas in more detail; she can say, for example, "Tell me more about this feeling guilty." Open-ended questions allow more details but also discourage irrelevant elaborations by patients. By using these interventions, the therapist can complete the patient's agenda. For several reasons, patients may not have in mind all their problems or they may not consider it important to mention some particular aspects. It is therefore important that the therapist checks whether there are other problems that have not yet been mentioned. These issues can be noted but not immediately explored. The clinician can first carry on with questions about further problems until the patient indicates that there are no more and leave the problem's exploration until later on in the interview. Open questions not only invite patients to open up but also show that the therapist values and respects their observations and encourages input and participation (see also Chapter 4), promoting an active patient role, which is essential in cognitive-behavioral

psychotherapy. A more active role in therapy can contribute to increasing patients' sense of control over the interaction, which often leads to a better outcome.

Questions for the cognitive-behavioral therapist are used both in the information-gathering stage and in the more therapeutic stage as a cognitive-behavioral-specific technique, such as in, for example, the Socratic dialogue (Freeman et al. 2005), or to educate patients to pay more attention to their emotions and thoughts and on their consequences in everyday life.

Examples

Th: Would you tell me in your own words what has brought you here today? (*Starting the interview*)

Th: What else about your feelings in this situation? (*Completing the patient's agenda*)

Th: What kind of problem have you experienced with this medicine? (*Exploring patient's agenda: treatment*)

Th: How is your low mood affecting your life at the moment? (*Exploring patient's agenda: impact*)

Th: How do you feel about the support you are receiving in this situation by your family? (*Exploring patient's agenda: social support*)

Th: What do you think was the starting point of your problems? (*Exploring patient's agenda: patient theory*)

Th: When you came in today, you probably had some idea of how I could help you. (*Exploring patient's agenda: expectation*)

Th: What has been your experience with this problem over the last year? (*Exploring patient's agenda: coping strategies*)

Th: How would you describe your relationship with others? (*Exploring therapist's agenda*)

Pt: During lunch my husband was talking to a friend on the phone and ignored me completely.

Th: What did that mean for you? (*Exploring therapist's agenda*)

Pt: Probably that I am not an interesting person to talk to.

2.3.3.6 Closed Questions

Closed questions are those that imply a yes or no answer or a forced choice between two or more options. They are therefore specific and focused, and they discourage the patient from talking. As the interview proceeds, it is important for the therapist to become gradually more focused on his agenda. This can be done initially by using more topic-oriented open questions in order to direct the interview to a specific area of interest (e.g., interference of symptoms with the quality of life). In a second step, the clinician needs to move to closed questions to elicit fine details and to better understand the problem from the cognitive-behavioral perspective. Moving from open questions to more closed questions can be done by using transitions and summarizing (see Sect. 2.3.1). For example, the therapist can say, "Now I'm going to ask you several questions that can help us to focus better on your problem." Closed questions are therefore necessary to investigate specific areas and to analyze symptoms in detail. Closed questions can be very useful if skillfully used. They can give quick and narrowly focused information that can be tremendously important at some stages of the assessment. These interventions are

generally used after the patient-centered data collection to complete the patient's problem(s) in more detail. They also allow hypothesis testing, and by restraining the patient's spontaneous information flow, they therefore reduce patient participation. A possible risk of using too many closed questions is to force the patient into prepackaged answers. It is possible that during hypothesis formulation, the therapist thinks too fast and wants to test a premature hypothesis. For example, the therapist can assume that in a certain circumstance the patient feels an unpleasant emotion. Instead of asking, "How do you feel?" he may ask, "Do you feel inadequate in that situation?" If the answer is "no," the therapist might think that there are no unpleasant emotions linked to that particular situation. Attention should particularly be paid to depressed patients, who are generally very passive or with patients who want to please the therapist, such as those with dependent personality traits. If closed questions are used too early in the interview, patients can become passive and reluctant to share information and the therapist runs the risk of appearing authoritarian, controlling, and superior, with little interest in having a partnership with the patient. Too many closed questions moreover can give the impression that the therapist is rushing through the interview, being disinterested in the patient's story. Therefore, closed questions should be well balanced and used in the interview only after the patient's agenda has been widely explored and a good relationship established.

2.3.3.7 Checking

The aim of this communication skill is to check, test, or verify the accuracy of the therapist's subjective understanding of the patient's narrative. Specifically, the clinician makes a statement that represents her inner understanding of a patient's concept, expression, or phrase and asks the patient for feedback or correction. This skill allows a bidirectional exchange of information (from the patient's initial statement, through the therapist's comprehension, to the patient's correction) that avoids misunderstandings and helps the therapist when in doubt, confused, or too overwhelmed by the patient's narrative. Misunderstandings can have a negative impact on the therapeutic alliance and on the motivation to psychotherapy and need to be identified and corrected as soon as possible. A misunderstanding may lead the clinician to misinterpret the patient's problems and provide a formulation not adapted to the patient, with negative consequences on the entire therapeutic process.

There are other reasons that make this skill essential for the good outcome of psychotherapy. First of all, a patient who feels that the therapist is doing his best to understand the patient's problems, emotions, and opinions will have more trust and be more willing to continue the psychotherapy. Moreover, describing problematic situations or unpleasant feelings can be a difficult task for patients. They might be worried they are not able to clearly express what they feel and/or think. Meeting a therapist who gives the opportunity to reword a concept in order to get a shared comprehension on it may be very helpful for them to achieve this challenging task. Finally, checking makes the patient feel that his perspective on the problem is taken

into great consideration and actively searched, which makes him feel involved in the therapeutic process and increases his commitment to psychotherapy.

According to what we have said, when checking, it is important to pay attention to both the form and the content of the statement. Efficacious checking needs to be short and concise, but at the same time exhaustive and emphatic. It may be useful starting with an introduction like, “What you are telling me is that . . .” using a pleasant tone of voice and giving the statement the intonation of a question, not a judgment. These expedients will help the patient feel free to correct the therapist. Moreover, the clinician should be able to decide which content needs to be checked and focused on.

Examples

Th: You told me that you experienced anxiety in the supermarket. Is this correct?

Th: Help me to be clearer on this. You said . . .

Th: You are sure . . . you never experienced this before?

Th: Just to see if I’ve got this right, you went to that conference in Boston and started to feel confused in front of the people sitting there.

Pt: I feel so depressed. . . . I’ve never felt like this. . . . And I fear that things could get worse. . . . But psychotherapy is such a big commitment. . . . I don’t know. . . .

Th: You are telling me that despite the fact you are feeling pretty bad, you are not sure about psychotherapy?

2.3.3.8 Summarizing

Summarizing is the deliberate step of making an explicit verbal summary of the information gathered so far. We know that there are several sources of possible distortions in communication that can occur. They can be related to the patient, to the setting, or to the therapist. In any case, summarizing can facilitate the comprehension and improve patient–therapist communication. Clinicians cannot take for granted their understanding without checking the accuracy of the gathered information, and direct feedback from the patient is the best guarantee. The therapist should therefore be able to summarize the patient’s problems, by using the patient’s words when possible, to verify her own understanding of what has been said and to invite patients to correct the interpretation or provide further information. Summarizing, if used frequently throughout the interview, is a good method of ensuring the accuracy and completeness of information gathered. It also signals listening to the patients and facilitates them to go further with explanations of their problems, but at the same time it brings them back to the point and prevents them from becoming lost. Summarizing is a useful skill because it increases the clarity and completeness of the information, provides space to think about review, and helps to formulate hypotheses. It allows the ordering of thoughts and clarifies in the therapist’s mind what aspects he wants to explore in more detail. Moreover, it allows the patient’s perspective (or agenda) to be integrated with the cognitive-behavioral framework (or the therapist’s agenda). It is therefore important to summarize all the information gathered from both the patient’s and the therapist’s points of view. The patient can agree on his summarized vision and start to become familiar with the new framework, laying the foundation for patient involvement in the therapeutic process.

Summarizing can also be used to structure the interview, as described in more detail below.

Examples

Th: You told me your wife began to change some years ago. You suspected she had a love affair with a friend of yours. Since then, you've started to feel down, with this persistent thought in your mind about your wife. Now she is pregnant and you still have a lot of doubts about the real father.

Th: I'd like to sum up with you what you said so far: The panic attacks started three months ago when your husband was rushed to the hospital for respiratory problems. This event made you think about the possibility of losing your husband and raising your children alone. Moreover, you are going through a difficult financial situation. These thoughts have become more and more serious and are still present even though your husband has recovered well.

2.3.3.9 Reformulation

Reformulation lies between data gathering and information giving. It can be considered a more specific cognitive-behavioral technique rather than a simple communication skill. Reformulation means to restate with the therapist's own words the content or emotion expressed by the patient; therefore, it is mostly related to the content expressed. In this paraphrasing the therapist can add some educational or therapeutic messages, for example, showing the linkage between events and emotions. Reformulation differs from simple summarizing, because the clinician adds something new, potentially helpful for the therapeutic process. Reformulation combines elements of clarification, facilitation, summarizing, and reflections. The patient's explanation is redefined in terms of a measurable construct that will be incorporated in a cognitive-behavioral model of treatment.

Examples

Pt: I don't know what would happen if my wife really needed my help. . . . She is so demanding . . .

Th: In other words, it sounds as if you are worried that you might be overwhelmed by the situation.

Pt: I feel stupid. . . . I shouldn't have said all those bad things to him. . . . I should have waited before answering. . . . Now he does not want to talk to me anymore. . . . I always act like that . . . faster than my thoughts . . .

Th: What you are telling me is that you have the impression that your impulsiveness sometimes impairs your relationships . . .

2.4 Structuring the Interview in Psychotherapy

The goal of the assessment interview in cognitive-behavioral therapy is to collect all the relevant information in order to achieve a better understanding of patient's problem(s) and together with the patient to make some decisions on how to deal

with the problem(s) (plan a therapeutic program). The therapist's abilities to provide the consultation with a clear organization and to orient the patients throughout the entire assessment phase become fundamental for the single interview and for the duration of the psychotherapy. These abilities become part of a process and are based on several different skills, such as the agenda setting, the use of orienting expressions, summarizing, transitions, and sign-posting. The assessment phase can be divided into four different stages with specific goals. In the first stage, the therapist helps the patient to explore, define, and clarify the problem(s) (exploring patient's agenda); in the second stage, the therapist explores the patient's problem from a cognitive-behavioral perspective, referring to theoretical models (exploring therapist's agenda); in the third stage, the therapist provides the patient with all the relevant information regarding his problem(s) and tries to incorporate the cognitive-behavioral theories and models with the patient's agenda (developing a new perspective-reformulation); finally, in the fourth stage, the therapist and the patient set reasonable therapeutic goals and decide how to achieve these goals (decision making). These stages seldom occur all together during the first consultation, and sometimes the therapist needs several encounters to assess the patient before starting the more specific and technical therapeutic phase. The clinician should always be aware of these different stages during the process of assessment. This awareness helps to give clarity to the interview and assists the therapist in organizing the sessions according to the specific aims that need to be achieved.

The interview structure should to be shared with the patient, too. First of all, the clinician should elicit the goal of the assessment phase (e.g., "Before deciding whether to start psychotherapy, I'll need some preliminary meetings to collect information about your current problem(s). Only in a second time we will decide together what we need to work on."). Moreover, the patient also should be made aware of the shift from one stage to another when it occurs within the same interview or between different sessions. The therapist can close an interview's stage with a brief summary followed by a transition to introduce the new stage (e.g., "Up to now we have agreed upon some goals you consider important for your welfare. Now and in the next session I would like to start to discuss with you what can be done to achieve these goals.").

Each session of the assessment phase therefore needs to be structured according to its specific aims. The following steps may help to ideally structure assessment appointments: (a) opening the interview, which includes greetings and elicitation of the goals of the consultation (if it is the first encounter, this will be to assess the reason for coming); (b) gathering information, with particular attention to the patient's agenda; (c) exploring the patient's problem(s) from the therapist's perspective; (d) sharing information and decisions; and (e) a closure phase (Fig. 2.2).

In our opinion, such a clear and ordered approach, with transitions and summaries, allows accurate and efficient data gathering and facilitates patient participation, also having a positive effect on the therapeutic alliance and on the patient's motivation for psychotherapy. Organizing the available time is also useful, especially with patients who tend to wander from one subject to another. Obviously, it is important that the therapist follows these steps only as a suggestive guide that does

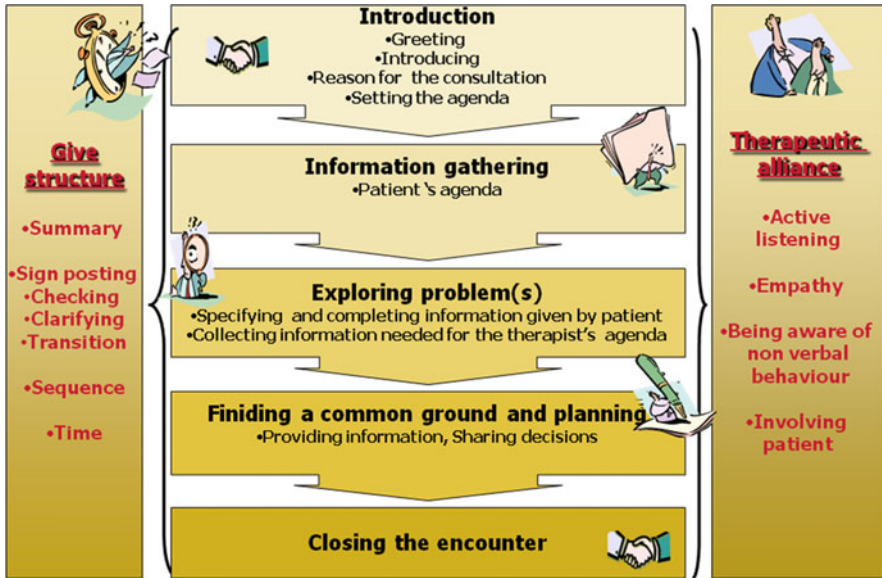


Fig. 2.2 The structure of the interview (modified from Silverman et al. 1998)

not need to be strictly applied, but they have to be changed if necessary and/or adapted to the specific needs of each patient (e.g., a patient who is too anxious may not be able to listen and understand the therapist's information in that particular moment; the therapist therefore should be able to recognize and handle the emotion and to postpone the information giving, even if it was previously agreed).

2.4.1 Structuring the Interview: The Goals

The goals of structuring are organizing the session(s), orienting the patient throughout the session, reviewing, recognizing possible missing data, and consistently ordering the gathered information (from both the patient's and the therapist's perspective). Providing structure to the interview and eliciting it with patients facilitates their overall comprehension and gives them a chance to become more active in the therapy. Structuring the interview therefore ensures efficient information gathering and enables the patient to feel involved in the therapeutic process.

Most people asking for psychological help can have preconceived ideas about psychologists, psychotherapists, and psychiatrists, and sometimes they may even ignore the differences among these professionals. Providing initial information about what is going to happen during the interview can help patients reduce unpleasant emotions related to their expectations and reduce their uncertainty. Moreover, structuring the interview together with asking patients' opinions can

help to promote patient involvement, essential for the following stages of the psychotherapy; while combining it with handling emotion can aid relationship building (see Chapter 3).

To organize both the single interview or the different stages of the psychotherapy, therapists should therefore be able to (a) summarize at the end of a particular point (this could happen at the end of a specific issue or during/at the end/at the beginning of a session) to check both the therapist's and the patient's understanding before moving on to the next section or to next step of the therapy, (b) move from one stage of the interview (or from an encounter) to another, using agenda setting, time framing, transition, and sequencing skills. The therapist should be able to achieve these tasks while keeping attention on listening, following the patient's flow and narrative at the same time.

2.4.2 Communication Skills for Structuring the Interview

There are several helpful communication skills to provide both the interview and the assessment phase with a clear structure. We will present a brief description with some examples of the following: setting the agenda, time framing and sequencing, orienting expressions, and summarizing.

2.4.2.1 Setting the Agenda

Setting the agenda can be done just after the introduction phase and orients the patient about the duration and the aims of the session. Explaining what the therapist intends to do during the session is also essential for building the relationship. Stating the purpose of the interview aids the patient to prepare for the direction of the interview, for example, knowing the available time for the interview helps patients to better focus on the more distressful problems and to put all their effort into expressing their agenda by the end of the consultation. Setting the agenda makes it less likely that the patient will miss talking about important issues and reduces the risk of being overwhelmed by irrelevant aspects. It is important to check with the patient if the amount of time is enough for him. Sometimes patients think the time is too short, so the therapist can explain that although everything may not be completed in only one session, the patient can have more time during the following session to go into the problem(s) thoroughly. Setting the agenda contributes also to reinforcing the patient's trust through a clear expression of the therapist's intents. This can be useful also with suspicious patients, such as paranoid personality disorder. If therapists are used to audiotaping the interview or taking notes, these activities should also be explained from the very beginning. The therapist can explain the reason why she is doing this and remind the patient that all the material collected is personal and confidential. Most patients are reassured by seeing the therapist writing down notes, as they feel they are more

taken into consideration. An exception can be represented by the suspicious patient, who may disagree with these procedures and ask the therapist not to do it. In this case the therapist can explore the reasons for asking this and take the chance to better explore these mistrustful feelings. This open attitude, shown from the beginning, improves patients' participation and collaboration.

Sometimes clients are referred by third parties (e.g., family doctor, psychiatrist, relatives, friends) to the therapist's attention. In these cases some personal information may already be available before the consultation, and so a good practice is to start the interview by summarizing these data briefly.

Setting the agenda in the second and subsequent sessions can start with summarizing problems raised during the last encounter and asking the patient which problem he would like to start talking about first.

Examples

Th: Generally, the first session will last about 45 minutes. In this available time I would like to have a general idea of your problem(s). So first of all, I will ask you some questions about the main reason for coming in today.

Th: During the last session you mentioned some distressful events that happened in the last year and some difficulties you have at work and with your husband too. I'd like to talk more about these topics today. Which of these would you like to tell me more about first?

Th: After you tell me more about these depressive feelings, I will share with you my ideas about how the therapy can be helpful.

2.4.2.2 Time Framing and Sequencing

Time framing refers to all the abilities helpful in arranging the patient's talk in order to give a logical and temporal sequence to the reported events. The therapist needs to know when each problem started, as some symptoms can be an expression of acute distress while others can reflect more personality traits. Moreover, it is important to find out whether there is a temporal sequence between events and emotions or distress and thoughts. This makes it possible to explain to the patient, even in the following stages, the possible link between these aspects from a cognitive-behavioral framework or the role of life events as triggers of illness. Patients can date events and problems accurately if they are encouraged and educated to do so. This can be helpful also in the subsequent stages, when the therapist will ask the patient to do homework (e.g., ABC exercises). The therapist may wish to inquire about time-sequence issues, by asking the patient what occurred immediately before or after a given event, with particular attention to emotions, thoughts, and behaviors. *Sequencing* means to structure the interview by developing a logical order, accepted also by the patient, and by providing a rationale for doing and saying particular things during the sessions. Sequencing also means to design appropriate turn-taking in speaking, pacing, and using the available time efficiently. The therapist should be able to tactfully limit peripheral and unproductive discussion and pace the session appropriately for the patient, allowing other slots of time to explore others aspects of care if necessary.

Examples

Th: What was happening while you were experiencing anxiety peak?

Pt: Nothing.

Th: I know this might be difficult, but try to remember ...

Pt: Hmm. . . . Maybe I was starting to think that my heart was beating too fast. I was worried I was having a heart attack.

Th: I was wondering if it could be possible that your anxiety is related to this sort of dangerous thoughts.

2.4.2.3 Orienting Expressions (Transitions and Sign-Posting)

These expressions are used to progress from one session of the interview to another and to explain the rationale to talk or ask about a particular issue. Orienting expressions are explanations of the reasons why the therapist has decided to move toward another topic, to return to a previous one, or to change stage during the interview. Transitions can also be used to move from the patient's agenda to the therapist's agenda. This skill also orients the interview, and facilitates the collaboration, encouraging the patient's involvement in the therapeutic process and his active role-taking. Orienting expressions facilitate the patient's understanding about the aims of the interview and about the reason behind certain therapist interventions. In this way the patient can feel that she is playing an important part in the therapeutic process, which can foster the therapeutic alliance.

Transitions can also be used to move from one content item to another. Transitions can be simple, brief orienting words or phrases or motivated explanations for changes in interview content.

Examples

Th: Now I need to ask you about . . .

Th: I want to go back to . . .

Th: I want to ask you more about your feelings in that specific situation you told me about.

Th: You mentioned the important role of your family during your childhood . . .

Th: We have 10 minutes left before the end of this session.

2.4.2.4 Summarizing

Summarizing has already been described in the previous chapter for its important role in structuring the interview. It helps the therapist to feel more comfortable with the gathered information, and not to become lost, particularly with patients who give confused descriptions or give incoherent and unintegrated narratives. Summarizing is essential to put all the information together, to make order, and to give a logical sense to the data collected. It aids the therapist in bringing patients back to their point, increasing the quality of the gathered information, and better structuring patients' narrative. This intervention supports both the patient and the therapist in improving the quality of their communication and provides an opportunity for

them to work cooperatively in achieving a better understanding of the patient's problems and trying to solve them. It is helpful also because it allows the therapist to realize what areas need further exploration and to consider in which direction she wants to go next. Summarizing can facilitate the identification of the most important problem for the patient. When too many issues have been raised for just one session, the therapist and patient negotiate and agree on what will be addressed in the next sessions and when they will consider the deferred issue (see Chapter 4).

Examples

Th: You told me you were scared in that situation because you thought that others could harm you. I would like to ask you more about what happened.

Th: I have written down the goals you would like to achieve with this therapy; they are to improve your self-esteem, to increase your public relations skills, and to become less shy.

Th: Today we have talked about your current problem. In the next session I will ask you more about your social background and your family.

2.5 Conclusion

In a cognitive-behavioral perspective, an essential part of the assessment phase is the process of data gathering. Without collecting good information, it will not be possible to understand the patient's problem(s), and consequently her collaboration and trust may be compromised. Communication is therefore a key element in this stage of the therapy and represents the bridge.

Using communication skills appropriately allows the therapist to obtain more information about the presented problem, increases the reliability of collected information, signals interest in the patient's views and experiences, stimulates the patient's participation and collaboration, and, finally, makes the consultation more effective. An accurate and detailed information-gathering process, together with the implementation of a collaborative relationship, is essential to achieve greater health outcomes.

At the beginning of the interview, it is more useful to adopt an open inquiry so the therapist can let the patient's narrative be expressed freely. The role of the therapist in this stage is to listen carefully and, if necessary, to guide patients through their story-telling. Moreover, providing structure to the interview and eliciting it with the patients facilitates their overall comprehension and gives them a chance to become more active in the therapy. Structuring the interview therefore ensures efficient information gathering and enables the patient to feel involved in the therapeutic process.

Several communication skills are useful for the information-gathering process and for structuring the interview. We have provided a brief description with some general examples of the following: listening, facilitations, reflections, clarifications, open- and close-ended questions, checking, summarizing, reformulating, setting the agenda, time framing and sequencing, and orienting expressions. Therapists can feel more natural and spontaneous using certain skills, whereas for others they

need more practice in order to feel comfortable with their use. Extending the foundation of knowledge and abilities can result in a significant improvement in therapist–patient communication.

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Communication in Cognitive Behavioral Therapy

Rimondini, M. (Ed.)

2011, X, 273 p., Hardcover

ISBN: 978-1-4419-6806-7