Patterson et al. (2009) Essential skills in family therapy. New York: Guilford.

CHAPTER 3

The Initial Interview

It is 5 minutes to the hour when she looks anxiously at the clock, just before the first session. For what feels like the thousandth time, she mentally rehearses exactly what she wants to say at the beginning of the session. She is worried that she will forget something important because of nervousness. She desperately wants to make a good impression. It is now 2 minutes to the hour—if only the butterflies in her stomach would disappear, she might feel ready. She looks at the door, and wishes for a brief second that she could leave. She takes a deep breath as the door to the therapy office opens . . .

Did you imagine this to be the client or the therapist waiting for the first session to begin? Either could be true. For therapists and clients alike, beginning therapy can elicit feelings of fear, excitement, and nervous anticipation. Each client will take you on a different journey. This chapter covers the basic issues that must be addressed in the initial interview to ensure that your journey gets off to a good start.

STAGES OF THE INITIAL INTERVIEW

Many beginning therapists find it helpful to think of the initial interview in stages. In the first stage, the therapist welcomes the client, couple, or family to therapy. The goal of this stage is to do introductions and put the clients at ease. Administrative issues are addressed in the second stage. The purpose of this stage is to ensure clients have a clear understanding of the therapy process, including confidentiality, videotaping, and fees. After covering administrative issues, the therapist

can transition to the goal-setting phase. Here the therapist learns what the clients hope to accomplish through therapy. Once a good understanding of client goals and expectations for therapy has been reached, the therapist can begin the assessment phase, which typically extends beyond the first interview.

The length of time devoted to each phase can vary greatly from client to client. Often the first two stages of the initial interview, welcoming the client and handling administrative issues, can be accomplished within the first 10–15 minutes. In some cases, however, clients may have a lot of questions about the therapy process, which may extend the second stage. The length of the goal-setting stage can depend upon several factors. Some clients will be able to succinctly state their concerns, while others will go off on tangents or long stories about the presenting issues. The time devoted to goal setting will also depend upon the number of clients being seen. Soliciting everyone's perspective on goals within a family will generally take longer than working with an individual. In most cases the therapist will be able to devote some time to assessment in the initial interview. However, with some clients, simply being able to establish goals for therapy is a realistic expectation.

You will need to accomplish several important tasks to make the initial interview successful. Some tasks, like goal setting, will fit nicely within a particular stage. Other tasks, however, may not fit easily within a particular stage, or may require attention across multiple stages of the initial interview. For example, you should be working on building your relationship with your clients, at each stage of the initial interview. Important assessment information may also come out at any point in the first session, even before the therapist has begun a more formal assessment phase.

DEVELOPING A CONNECTION: HOW TO JOIN WITH CLIENTS

The most crucial task in the first session is for you to successfully join with your clients. *Joining* means that clients feel a sense of connectedness with you, which usually arises when they feel that you understand, respect, and care about them. The importance of joining cannot be overstated: It is the foundation for future work. Failure to successfully join with your clients will hamper all of your efforts, from assessment to treatment. For example, clients will be reluctant to share sensitive information if you have not established a safe and secure relationship with them. Likewise, clients may become highly resistant to or defensive toward suggestions if you have not created a strong therapeutic

relationship with them. Ultimately, failure to join with clients will likely lead to premature termination of therapy.

Joining is a process that should be carefully attended to throughout the entire initial interview. It begins in the first moments of therapy, as clients are welcomed into your office. You should attempt to put your clients at ease, since they are most likely anxious about coming to therapy. You might engage in some brief social talk with them to break the ice before discussing problems. You might ask them, for example, what kind of work they do or what they like to do for fun. Besides making your clients feel comfortable talking with you, this approach demonstrates your personal interest in them. You might also share some information about yourself so that the clients can get to know you. Ideally, you will be able to identify something you have in common with your clients that will help develop a sense of connection.

Joining can also take place at other points throughout the initial interview. For example, joining can occur when you respectfully listen to and address questions your clients have about confidentiality, fees, and other issues. Likewise, giving each of your clients an opportunity to tell his or her story can facilitate joining by allowing each person to feel heard and understood. Reflective listening, maintaining direct eye contact, or leaning forward can also reinforce to your clients that you are interested in and concerned about what they are saying. Concluding the initial interview with a positive message for your clients can be another way to strengthen your connection. For example, a husband who resists coming to therapy can be complimented for caring enough about his relationship to come despite his strong reservations about therapy.

Although skills to facilitate joining can be learned, it is important to recognize that developing a relationship with another person cannot be reduced to a recipe or set of techniques. In fact, the greatest asset any therapist brings to the process is him- or herself. Your personality, attitudes, life experiences, and mannerisms become a part of and help create the relationship.

Although the therapist's personality is usually an asset to promoting joining, there are times when therapist characteristics can create a barrier to developing a connection. Therapists who have prejudices or negative preconceptions about people based on race, ethnicity, sexual orientation, socioeconomic status, or religious orientation will likely have difficulty establishing a connection with clients who have these characteristics. Likewise, therapists may have a difficult time joining with a client who reminds them of someone with whom they had a painful relationship (perhaps a parent or spouse). Therefore, you should be vigilant in assuring that personal issues or prejudices do not interfere with your developing a relationship with your clients.

HANDLING ADMINISTRATIVE ISSUES

One of the early tasks in an initial interview is to address administrative issues so clients understand the therapy process. Although these matters are typically called administrative issues, it is important to recognize that therapeutic issues are frequently played out through them. One client who was adamant about not being videotaped was discovered through further assessment to have a high level of distrust toward people, which became a key area of focus in therapy. Therefore, the therapist who is attuned to the process and not just the content when handling administrative issues may discover important opportunities for assessment or even intervention.

Confidentiality and Release of Information

You should always address the issue of confidentiality with your clients. They need to be informed not only of the confidential nature of therapy, but also of the possible circumstances in which confidentiality will be broken (e.g., threat of harm to self or others, child abuse, elder/dependent abuse). As discussed in Chapter 2, information on confidentiality may be included on a client information form that can be mailed to clients prior to the first session, or read by them in the office before the first session.

Therapists working with couples and families must also consider how confidentiality among family members will be handled. Some therapists, for example, will conduct individual sessions as part of a couple's treatment. Likewise, a therapist may meet individually with a child or adolescent in addition to family treatment. The therapist must address the extent to which information obtained during these individual sessions will be kept confidential or shared with other family members. Some therapists insist on a "no-secrets policy" between family members, while others allow information learned in individual sessions to remain confidential. Regardless of one's position, it is best to offer clear written and verbal guidelines as to the bounds of confidentiality at the beginning of therapy.

You will frequently want to consult with other individuals or institutions connected with particular cases, such as previous therapists, psychiatrists or physicians, school officials or teachers, lawyers, courts, and parole officers. In these cases, you will need to have clients sign a release of information form, such as the one depicted in Figure 3.1, to permit communication between you and the other parties. The signatures of all participants in therapy are required for the release of information. For example, you should obtain *both* the husband's and wife's

To: _____
(practitioner, hospital, etc.)

I have been informed that under _____ (state) law, communications between a client and his or her therapist are privileged and may not be disclosed by the therapist unless the client consents. I also have been informed that client records maintained by a therapist may not be disclosed to third parties except with the client's consent or through legal process.

I authorize _____ (name of therapist) to share information and/or records about my therapy to _____ (name of person or entity to whom the disclosure will be made).

I am permitting authorized disclosure of information about my therapy for the following purposes:

_____

_____

_____

I am permitting authorized disclosure of the following types of information (choose one):

__ All information or records related to my therapy

__ Only the following information (please specify)

_____

_____

_____

This authorization shall remain in effect until _____ (date). I understand that any cancellation or modification of this authorization must be in writing.

_____
Date

_____
Client name (printed)

_____
Client signature

_____ _____
Witnessed by Date

FIGURE 3.1. Authorization for release of information.

signatures if both have been participants in the course of therapy. If others contact you about your clients, you should not even acknowledge that they are in therapy unless you have obtained the appropriate release of information.

Therapeutic issues may arise when discussing confidentiality with clients. For example, if a husband or wife in couple therapy inquires if the court can obtain therapy records, you might suspect that one of the partners is seriously thinking of divorce.

Videotaping and Observation

Beginning family therapists are frequently instructed to videotape all or some of their sessions for supervision purposes. The vast majority of clients agree to be videotaped if they are approached properly about it. Explain why the videotaping is beneficial to both therapist and client, and address issues of confidentiality regarding videotaping. You can tell your clients that you regularly consult with other therapists, and that videotaping allows them to witness firsthand what happened in therapy. You can then explain that consulting with therapists in this manner is helpful to both you and your clients since "two heads are better than one." You can add that videotaping allows you to review what happened in previous sessions and perhaps have a new insight, much like people notice something new when watching a movie for the second time. Finally, point out that videotaping the session allows the couple or family to see how they interact when they watch a replay.

You should inform the client of who will view the videotape, emphasizing that videotapes are considered confidential information. Indicate as well what will happen to the tapes after the completion of therapy, assuring clients that videotapes are not kept permanently, but are regularly erased or recorded over. Clients should be asked to sign a form giving their consent for videotaping. The form should outline the purpose of the videotaping, who will view the videotape, and what will happen to the tapes after therapy is completed.

In a small number of cases, clients may be reluctant to be videotaped. You should carefully explore their reasons with them. In many cases, clients may simply be hesitant due to self-consciousness. Most of these clients will be agreeable to being videotaped if assured that their reaction is a common one and that people generally forget about the camera in a short time. You should pay careful attention to clients who are insistent about not being videotaped since they are the exception rather than the rule. These clients often have sensitive information that they wish to protect or keep secret. For example, one client who

refused to be videotaped disclosed indirectly that he had engaged in illegal activities. In some cases, clients will agree to be videotaped if you will turn off the video camera when they indicate that they are ready to disclose particularly sensitive information. If a client is not open to videotaping under any circumstances, you should respect this decision in order to avoid damaging the therapeutic relationship and possibly precipitating a premature termination of therapy. Clients may agree to be videotaped once they have established greater trust in you or the therapeutic process.

If therapy will include live supervision or the use of observing/reflecting teams, discuss this with your clients. Most of them will agree to this format if they are told why the supervision or team benefits both therapist and client. It is often helpful to allow clients, at their request, to meet supervisors or team members who observe the sessions from behind the one-way mirror.

Fees

Determining the client's fee can be an uncomfortable process. It is difficult to assign a monetary value to therapy, and therapists often feel uneasy about charging fees while acting in a helping role. Therapist anxiety about fees can easily be transferred to clients and can create conflict and stress in therapy. Comfort in handling fees will increase with therapeutic experience and confidence in your ability to provide a worthwhile service.

It is helpful if the therapist can approach discussing fees in a clear, matter-of-fact manner. Some agencies offer guidelines for fee setting based upon the client's income. The term "customary and usual" is used to identify the typical fee in a particular area. Customary fees will vary based upon the geographic area. Most programs or clinicians establish a minimum fee and then work within a range. Some clinicians prefer to deal with fees in the beginning of the session when handling other administrative issues, while others feel it is best done toward the end of the initial interview.

In addition to setting the fee, you should discuss acceptable forms of payment, when the fee should be paid, and the fee for late cancellation or "no-show" appointments, if applicable. It is often useful to have a written agreement that discusses the fees and policies regarding fees. If a third party is responsible for payment, their terms for payment should be clearly understood by therapist and client. Often third-party payers limit the number of sessions, or the types of presenting problem or diagnoses they will reimburse. For example, many third-party payers will not reimburse for couple counseling or "problems of living"

such as those listed in the "V" codes of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR; American Psychiatric Association, 2000). If a third-party payer is involved, the therapist should verify insurance coverage at the outset of therapy. Issues concerning provider eligibility, annual deductible, rate of reimbursement, and limitations on the number of sessions and types of treatments covered need to be addressed. Usually a DSM-IV-TR diagnosis will need to be assigned to the insured patient.

As with other administrative issues, working out the details for payment can be part of the diagnostic process and help to clarify the family's expectations of and responsibilities for therapy. In discussing fees you might learn, for example, that a client is unable to pay the full therapy fee due to specific hardships, such as medical expenses. Alternatively, a client's unwillingness to pay the full therapy fee may reflect low motivation for therapy, a strong sense of entitlement, or a victim mentality. Generally, free services tend not to be valued by clients. A fee provides some incentive to make effective use of services.

Other Administrative Issues

Several other administrative issues need to be addressed with clients. In some cases, therapists may be required to discuss with clients their professional qualifications. For example, California law requires that all unlicensed family therapists identify themselves to their clients as trainees or interns. Many agencies and practitioners have clients read and sign an informed consent statement that generally includes a brief description of what therapy is, including the potential risks, such as being asked to examine painful issues. Informed consent statements also summarize many of the issues discussed in this chapter, such as confidentiality and payment of fees. Permission to videotape may be included in this or a separate statement. Figure 3.2 is a basic informed consent form that covers some of these issues.

DEFINING CLIENT EXPECTATIONS FOR THERAPY

Another important task in the initial interview is to define clients' expectations for what therapy will accomplish and how it will proceed, in order to ensure that clients' needs are compatible with what you, as the therapist, can or are willing to offer. In some cases, you may determine that you are not the appropriate therapist for the clients, and you will need to make a referral. In addition, clients' goals must be

I understand that treatment at _____ (name of treatment facility) may involve discussing relationship, psychological, and/or emotional issues that may at times be distressing. However, I also understand that this process is intended to help me personally and with relationships. I am aware of alternative treatment options available to me.

My therapist has satisfactorily answered all of my questions about treatment at _____ (name of treatment facility). If I have further questions, I understand that my therapist will either answer them or find answers for me. I understand that I may leave therapy at any time, although I have been informed that this is best accomplished in consultation with the therapist.

I understand that at _____ (name of treatment facility):

1. Master's or doctoral students in family therapy conduct therapy under close supervision by licensed therapists.
2. Therapy sessions are routinely videotaped and/or observed by supervisors or other therapists on the treatment team. I agree to have my sessions videotaped for the purpose of supervision or consultation with the treatment team. I understand that the videotapes are erased at the end of my treatment.

I understand that what is discussed in therapy will generally remain confidential unless I give written permission to share information from my sessions by signing a release of information. However, the therapist may share information about or videotapes of my therapy with the supervisor or treatment team in the interests of providing quality care. My therapist has also informed me that there are other possible exceptions to confidentiality, which may include, but are not limited to the following:

1. Disclosure of child abuse
2. Disclosure of elder or dependent abuse
3. Threats to harm oneself
4. Threats to harm others
5. If a court issues a subpoena
6. If you are required to be in therapy or be evaluated by a court order
7. If you claim harm to your mental or emotional state in a legal proceeding

The fee for each session will be _____, and is to be paid at the time of the therapy session. I have been informed of the cancellation policy, which states that I will pay half of the normal fee if I fail to show for the appointment or cancel a session with less than 24 hours notice.

In the event of an emergency, I have been instructed to call the Crisis Center hotline at _____ (phone number) or go to the nearest hospital emergency room.

To be signed by all participating members.

Signed: _____ Date: _____

Signed: _____ Date: _____

Signed: _____ Date: _____

Signed: _____ Date: _____

Signed: _____ Date: _____

Signed: _____ Date: _____

FIGURE 3.2. **Basic informed consent form.**

integrated with therapist goals to develop an effective treatment plan, which is discussed in Chapter 5.

Defining Client Goals for Therapy

The first step in defining expectations is to ask your clients what they would like to accomplish through therapy. An effective way to introduce this subject is simply to ask questions such as "How can I be helpful to you?" or "What are you hiring me to do?" Generally clients will initially respond by describing what they see as the primary problems or issues. Clients hope that you will be able to fix these problems. Individuals will often say what they want to eliminate ("I want Dad to stop nagging me") and have a harder time articulating what they want ("I want Dad to tell me I'm doing a good job"). Encourage your clients to describe desired changes in positive language (the presence of something) rather than in negative language (the absence of something).

It is important that each family member be given the opportunity to be heard when discussing problems and goals. This is obviously helpful in joining with each individual. In addition, you may discover there is disagreement about the problem itself or who has the problem. You want to give yourself the opportunity to see the problem from different perspectives, and each person will provide some information that other family members will not. An issue that can arise during this process is one family member monopolizing the conversation. It is absolutely critical that you provide enough structure to interrupt this process in order to provide space for other family members. You don't want to anger the person who talks excessively, but if you fail to interrupt this behavior the other family members may lose faith in your ability to lead the session.

In defining goals, a number of challenges can arise. Your clients may identify multiple problem areas, with little distinction of priorities. Some couples, for example, may have a "laundry list" of complaints about each other or their relationship. In these cases, you will need to obtain your clients' perspective on the relative importance of their problems. For example, you might ask, "Of the issues you have presented, which is most and which is least important?"

In other cases, your clients may not have a clear idea of what the problem is or what their goals for therapy are. In these situations you may need to contract for a limited number of sessions to explore and define problem areas and goals. Another potential problem is that clients may have unrealistically high expectations or goals. One husband, for example, expressed his belief that the couple should be totally free from any conflict after therapy. In these cases you may want to validate

the client's goal and then reframe it so that it is more realistic and obtainable.

Further, setting goals may be complicated by the unstated agenda of a client, an aim that he or she feels is not appropriate to disclose. For example, a couple may come into therapy with the stated goal of working on the marriage. Later you may discover that the husband entered therapy to make sure you would take care of his wife after he informed her of his intention to leave the marriage. Sometimes, even the clients may not be totally aware of their reasons for seeking therapy. For example, a woman was eventually able to recognize that she probably was not invested in working on the relationship with her husband. Rather, she acknowledged that her motivation to try marital counseling was probably a desire to alleviate feelings of guilt about ending the marriage.

Alternatively, individuals in couples or families may define goals that initially appear incompatible. In these situations, you may need to creatively reframe the goals in such a way as to make them compatible or link them together. For example, parents may want to see their adolescent behave in a more mature and responsible manner, while the adolescent wants greater freedom. A therapist could potentially link these goals together by discussing how both the parents and adolescent have a common desire to see the adolescent become successfully launched as an adult, also pointing out that becoming an adult carries with it certain privileges as well as responsibilities. The therapist can then work with the family to help the adolescent achieve more freedom and privileges consistent with his or her ability to manage responsibility.

Another common scenario involves one partner wanting to make the relationship work, while the other individual seriously contemplates divorce. One possible approach is to suggest the need to evaluate the relationship much like a house inspector would go through a structure to determine which areas have strengths and which areas need attention. To the partner invested in the marriage, the marital evaluation could be explained as a necessary step in determining what needs to be changed if the marriage is to be saved. To the partner seriously considering divorce, the marital evaluation can be presented as a means of illuminating why this marriage failed and of helping the individual to avoid making a similar mistake in future relationships if the couple does divorce.

Once you have a clear understanding of what your clients want or expect from therapy, you need to decide whether it is appropriate for you to take on the case. First, you must assess whether the case is within your scope of practice, that is, whether the clients are expecting

help for issues that would be considered appropriate for a family therapist to treat. For example, offering legal or medical advice would not be within your scope of practice, but working with a couple on their marriage obviously would be. In many cases, the scope of practice may be defined for therapists by the laws that license or certify therapists in that state. If the case falls outside your scope of practice, you will need to be able to refer your clients to an appropriate professional.

Second, you need to assess if the case falls within your scope of competence. In other words, do you have the necessary skills, training, or experience to effectively treat the issues? If not, you need to refer the clients to another therapist who has the appropriate skills or qualifications. For example, a referral would be necessary if your client wanted hypnosis but you did not have any training or experience with the technique. In some cases, you may be able to treat clients provided you take appropriate measures during treatment to gain the necessary competence. For example, a therapist who has never worked with encopresis could do a literature review on treating this condition and seek supervision on the case.

On rare occasions, the client's goals for therapy may be so incongruent with your own values that you may need to make a referral. For example, most therapists would be uncomfortable helping a client achieve the goal of convincing the partner that having extramarital affairs should be allowed in the relationship. Similarly, a pro-life therapist may have difficulty working with a client who is trying to decide whether to have an abortion.

Additional Expectations for Therapy

Many clients not only bring in expectations about what therapy will accomplish, but also about *how* therapy will do so. For example, clients who have had previous therapy may assume you will do therapy in a similar manner. If the previous therapist assigned homework, your client may also expect that of you. Whenever a client has had previous therapy, it is generally quite helpful to explore what that experience was like, as it can strongly shape (both positively and negatively) a client's expectations regarding therapy.

You need to explore with your clients what they expect to happen in therapy on a number of dimensions, including how long therapy will be and who will be involved in it. Some clients may expect therapy to be only one or two sessions, while others may expect the process to last a year or more. Likewise, an individual who expects to be seen alone may be surprised when you ask him or her to invite other family members to therapy. Clients can also have expectations about their

level of involvement or that of the therapist. For example, some parents bring a troubled child to therapy with the expectation that the therapist will "fix" the child with little involvement on their part. Others expect to be an active part of the therapy process. It is critical to spell out the nature of the therapy at the outset.

You must also assess whether client expectations will impede the therapeutic process. For example, one couple stated that they did not want to look at family of origin issues since they felt this had been unproductive in previous therapy. Yet many of the couple's concerns seemed intimately tied to difficulties with their parents. In a case like this, you would need to determine how rigid the couple is in their desire to avoid family of origin exploration. If they persisted in this stance, you would have to decide how flexible you are willing to be to accommodate their desire. In some instances, you may decide against continuing therapy because the expectations are too restrictive and would severely limit your ability to be effective.

BUILDING MOTIVATION

Much of the previous discussion has assumed that clients have some voluntary interest in coming to therapy. Although many clients are motivated, you may quickly discover that not everyone willingly comes to therapy or seeks change. Some clients come to therapy because they have been mandated by the courts to do so because of substance abuse, juvenile delinquency, child abuse, or other issues. Others are forced to come to therapy by family members. A spouse may be threatened with divorce if he or she does not attend therapy; adolescents may be compelled by their parents to go to therapy. Although the therapist cannot motivate everyone, there are strategies for assessing and building motivation.

When assessing motivation, it is helpful to conceptualize it as existing on a continuum from high to low. Where clients are on the Stages of Change Cycle (Prochaska, Norcross, & DiClemente, 1994), for example, may determine their motivation for change. This cycle recognizes that clients spend a great deal of time (precontemplation and contemplation stages) thinking about changing before they decide to change and take action. In addition, the cycle recognizes that maintaining changes, such as not drinking alcohol again, can be challenging. Thus, relapse is part of the process leading to permanent change.

A client's overall level of motivation will be based on a number of factors, the assessment of which can guide you in choosing interventions that increase motivation. Motivational interviewing (Miller &

Rollnick, 2002) suggests that the therapist's job is to help the client resolve his or her ambivalence about change. Instead of using confrontation, the empathic therapist validates the client's perspective and freedom to decide. In addition, the therapist listens for the client's own self-motivation statements.

A logical time to assess motivation is when you are defining goals for therapy. Answers to the question "What brings you to therapy?" will differentiate motivated from unmotivated clients. The former usually respond by describing the problems or growth areas they would like to see addressed. If a client responds by saying that someone asked or insisted he or she come to therapy, problems with motivation may be anticipated. Nevertheless, some of these clients can become quite committed to therapy as they experience its benefits.

You should also inquire who first suggested therapy or called for the appointment. Generally this person is the most motivated for therapy. A good question to ask your clients is what led them to come to therapy now, rather than sooner or later in their lives? The answer may provide clues to your clients' motivation, as well as important assessment information, such as precipitating events.

Clients will have little motivation for therapy if they do not believe there is a problem, or if they feel that the problem is not serious. You will need to carefully assess whether a problem does indeed exist, and, if it does, why the clients refuse to acknowledge it. You may need to educate a client about the problem and the possible negative consequences of not addressing it. For example, you might warn a client that a failure to heed a partner's complaints could lead to the eventual breakup of the relationship.

Sometimes clients will deny that a problem exists out of fear of consequences or injury to their self-image. Child molesters will frequently deny or minimize the molestation to avoid legal consequences as well as to sidestep admitting to themselves that they are child molesters. In these cases, building motivation for therapy will be entwined with working with the client's denial.

If a mandated client refuses to acknowledge that a problem exists, you can suggest that there is at least one—he or she is being told to come to unwanted therapy. If your client agrees (which is typically the case), then you can explore what needs to happen so that therapy can be successfully terminated. This approach allows you to join with your client, but at the same time work on intermediate goals that address the problem.

Some clients may have poor motivation because they do not anticipate any benefit from therapy, believing that therapy is useless or the situation is hopeless. For some, creating a basis for hope will help build

motivation. Noting exceptions to the problem might begin to instill some hope. Or, a positive experience in therapy during the initial session might spark hope. Of course, feelings of hopelessness and lack of motivation could be a symptom of depression. As this condition is treated through medication or other interventions, depressed clients frequently develop more energy and enthusiasm for therapy.

Other factors might also reduce clients' motivation for therapy. For example, there may be psychological barriers to therapy, such as a client having difficulty trusting others. Some clients may have practical barriers, such as difficulties with transportation, finances, or work schedules.

Using these strategies does not guarantee client motivation. You may still have a poorly motivated client, particularly in court-ordered cases in which the client can avoid prosecution by participating in therapy (for example, cases of sexual abuse or battering). In these situations, you need to become comfortable with using the leverage for change provided by the courts. For example, you may need to inform the client that therapy will be terminated and the termination reported to the courts unless satisfactory progress is maintained.

A common struggle that beginning therapists may face is when they are more motivated than their clients. At times, clients fail to show up for appointments, come late, have little to say, or do not complete their homework assignments. In these situations, the therapist may end up working much harder than the clients. This dynamic suggests that the therapist needs to step back, review the reasons for therapy, and once again evaluate the clients' motivation.

At times, clients might seem motivated "for the wrong reasons." For example, a client only quits smoking in response to a life-threatening illness. A depressed client wants to die but restrains herself because of the impact her suicide could have on her children. In couple therapy, couples may state that they are only trying to preserve their marriage "for the sake of the children." You don't need to agree with the clients' motivations. Usually, it is enough that clients, for whatever reason, will face the demanding process of change.

ESTABLISHING CREDIBILITY

Beginning therapists often fear their clients will ask, "How long have you been doing therapy?" Similarly, questions about one's marital status or parenthood may be dreaded by unmarried or childless therapists because all of these questions reflect a key issue that the beginning

therapist must frequently deal with in the initial session—the issue of credibility.

In order for clients to have hope or an expectation of change, they must see the therapist and therapy as credible, or they may prematurely terminate therapy, if they begin at all. Therefore, it is important for you to assess early on any issues of credibility that need to be addressed. First, do the clients see therapy as an effective way to solve problems? Or, do they believe that therapy is only for crazy people? Second, do the clients see you, in your role as the therapist, as being competent or credible? Clients may question a therapist's ability to help them because he or she looks too young, or a parent may question a childless therapist's ability to understand and help.

If you suspect there is a credibility problem, you should attempt to pinpoint where and why credibility is lacking. For example, one beginning therapist described how a woman came into the first session saying that she wanted a gay or lesbian counselor. The therapist indicated that she was not a lesbian, and that she had very few friends who were either gay or lesbian. However, she expressed a willingness to learn more about these issues. At the end of the session, when the therapist asked how the woman felt about continuing in therapy with her, given her desire for a gay or lesbian counselor, the woman indicated she was quite comfortable about continuing with the therapist. Through further discussion, the therapist discovered that what initially had appeared to be concern about the therapist's experience working with gay or lesbian issues was actually a fear on the client's part that she would be unfairly judged by a "straight" person. When the therapist expressed an open and accepting stance toward the woman, she was able to earn the client's trust and respect. The more precise your understanding of why the client does not see you or the therapy as credible, the more likely your intervention will be on target in addressing this issue.

In cases where clients are resistant to therapy in general, you may be able to reframe the process in a way that builds its credibility. For individuals who think therapy is only for crazy people, you must work to reduce the stigma. You can compare therapy to coaching, in that even the best athletes, such as Olympians or professionals, use coaches. Therapy could also be compared to consulting work, with clients likened to businesses that hire someone with special expertise to help them.

When clients question a specific therapist's credibility, they usually focus on the lack of some critical professional or life experience. Often you can redefine for the client what type of experience is needed to be helpful. For example, a parent may doubt a therapist's ability to be