Clients' Personal Histories

Collecting Helpful Information

Using the *Your Personal History* Workbook
to Gather Essential Client Details for
Intake and Treatment

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- Practicing clinician, author, consultant, trainer
- 40+ years in the field
- Program design, supervision and management, Psychosexual Evaluations, Intake/pre-treatment assessments, individual and group therapy, clinical supervision, consultation, training, research

Objectives

As a result of this training, participants will be better able to:

- Facilitate client self-disclosure to aid in the treatment of sexual aggression
- Collect essential data for comprehensive assessments using a personal history workbook
- Employ personal history information in preparation for treatment.
- Incorporate a client's history into pre-treatment self-assessment of personal strengths, attachment style, openness to treatment change.

Personal Data Collection For Intake or Evaluation

- Various situations
  - *Evaluation – no ongoing therapy relationship*
  - *Intake - no ongoing therapy relationship with intake clinician*
  - *Intake – followed by ongoing therapy relationship with intake clinician*
- What to collect? Why?
- Various methods – interview, self report questionnaires, testing, external reports
- How to collect data, data preservation methods
- How to collect client data and attend to the working alliance
- Challenges and other issues…

"A Qualitative Study Examining The Quality of Working Alliance as a Function of the Social Identities of Clients and Therapists During the Mental Health Intake"

- *Across all client and therapist interviews, we identified eight central themes detailing different qualities of the working alliance: (1) feeling understood, (2) feeling comfortable, (3) openness and cooperation, (4) trust, (5) empathy and identification, (6) frustration and disappointment, (7) anger and hostility, and (8) emotional disengagement*

- (Nakash et al., 2021)

“Assessment Of Diagnostic Information And Quality Of Working Alliance With Clients Diagnosed With Personality Disorders During The Mental Health Intake”

- *Conclusions: Therapists do not collect sufficient explicit diagnostic information to base their PD diagnostic decisions. Yet, the presence of PD diagnosis affects their rapport with their clients as early as the intake.*

- (Nakash & Nagar, 2017, pp. 314-321)

“How Should I Do It’’? Clinical Dilemmas Therapists Struggle With During The Mental Health Intake”

- *The main themes that emerged from the data were: (1) systematic collection of diagnostic information versus uninterrupted flow of speech; (2) collection of sufficient diagnostic information versus attendance to client's emotional state; (3) structural limitations of intake versus client's flow of speech; (4) therapists' versus clients' goals for the intake; (5) focus on psychiatric assessment versus use of rapport-promoting techniques during intake; (6) prior data documented in the client's medical chart versus diagnostic information collected during the intake.*
- *Our findings stress the need for providing therapists with strategies to deal with time trade-offs to best use the restricted time allocated to them during the intake to complete a thorough diagnostic assessment while allowing their clients tell their personal unique story.*

- (Nakash et al., 2019)

More Topics About Intake Processes

- Race and ethnicity
- Working alliance
- Gender
- Implicit judgements
- Social identities

Attachment and Trauma

C - Compassion

A – Autonomy

R - Respect

E - Empathy

S - Safety

How a Workbook Aids in Addressing Challenges

- Data collection separate from client's emotional needs
- Allows opportunity for naturalistic client expression and self assessment
- Data preservation
- Systematic data collection unimpeded by immediate client needs
- Frees intake time to attend to therapeutic alliance

For Clinicians Addressing Challenges

- Underlying theory and use of the workbook
  - *Increase self-awareness*
  - *Increase sense of control*
  - *Reduce Defensiveness*
  - *Engage Memory*
  - *Dynamic risk factors, personality traits, DSM Dx symptoms,*
  - *Motivation*
    - Expectancy issues

Expectancy theory

In essence, individuals make choices based on estimates of how well the *expected* results of a given behavior are going to match up with or eventually lead to the *desired* results. This process begins in childhood and continues throughout a person's life. Expectancy theory has three components: expectancy, instrumentality, and valence.

- ***Expectancy*** *is the individual's belief that effort will lead to the intended performance goals. Expectancy describes the person's belief that "I can do this." Usually, this belief is based on an individual's past experience, self-confidence, and the perceived difficulty of the performance standard or goal. Factors associated with the individual's expectancy perception are competence, goal difficulty, and control.*
- ***Instrumentality*** *is the belief that a person will receive a desired outcome if the performance expectation is met. Instrumentality reflects the person's belief that, "If I accomplish this, I will get that." Instrumentality is low when the outcome is vague or uncertain, or if the outcome is the same for all possible levels of performance.*
- ***Valence*** *is the unique value an individual places on a particular outcome. Valence captures the fact that "I find this particular outcome desirable because I'm me." Factors associated with the individual's valence are needs, goals, preferences, values, sources of motivation, and the strength of an individual's preference for a particular outcome.*

Primary Use of the Workbook

- Pre-treatment intake: personal data, self assessment, dx screen
- Evaluation: data collection, dx screen
- Before individual or group therapy: self assessment, increase self awareness, raise questions to review in therapy
- Benefits
  - *Preserve intake data for future review, verification*
  - *Saves time*
  - *Client perspective to cross check in interview*

For Clinicians

“This client self report workbook is designed to be completed by the client prior to intake or evaluation or prior to treatment. It is designed as a source of data collection for the clinician or evaluator, and an opportunity for life and history exploration by the client, which can then be further examined during the evaluation or during treatment. The beginning of each section is organized data collection on topics that include self description/self esteem, personal history, family of origin, relationships, alcohol or drug use and abuse, gender dysphoria, mood disorder, personality disorder traits, and sexual history. These topic specific questions are followed by more open-ended questions in each section that allows the client to expand on topics or particular questions in their own words. This exploration can serve as a “primer” for treatment, and can be used to formulate individualized and treatment plan and goals.”

For Clients

“If this is to be a true story of your life, it is important that you answer all of the questions honestly and to the best of your ability, and that you take time to reflect on what you write and the answers that you give. Trust that the time and effort you put into compiling this information will help you to better understand yourself and your current situation. And most importantly, it will contribute to your care and help you get the most benefit out of the evaluation or counseling program where you are getting help.”

For Clients

- Benefits:
  - *Have some control over the assessment/intake process by providing information on their terms*
  - *Able to answer questions in their own words, and to offer their unique perspectives in open-ended questions*
  - *Builds treatment readiness and the self-reflection mindset*
  - *Begins to address some expectancy issues prior to therapy*

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Workbook Methods

- This workbook is comprised of a series of questions and exercises that will help clients to reflect on and describe their self perceptions and their lives. It will help clients to provide important information for the clinician or evaluator. The exercises are designed to help examine personal history, relationships, family, school and work history, significant life events and sexuality and sexual behaviors
- Open ended, closed Yes/No, True/Not True, fill in the blank
- Age /Grade in School reference table for all questions

SECTION 1

PERSONAL AND HEALTH INFORMATION

- Basic demographic information
- Current health information
- Family traits, early life developmental issues
- “In your own words…”

SECTION 2

REFLECTIONS ON YOUR LIFE SO FAR

- Series of yes/no questions and some sentence completion
- Current emotional state of mind self descriptions
- Best and worst
- “In your own words…”

Section 3

FAMILY OF ORIGIN HISTORY AND YOUR LIFE GROWING UP

- Details about biological family or family where client was raised
- Relationship with family
- Family boundaries
- Childhood characteristics self assessment/dx screening
- “In your own words…”

Section 4

RELATIONSHIP HISTORY

- Current and past marriages or significant relationships
- Relationship characteristics/strengths/problems
  - *Degree if intimacy*
  - *Children*
- Close friends
- Relationship style/attachment
- “In your own words…”

SECTION 5

EMPLOYMENT / WORK HISTORY

- Type of work and duration
- Positive and negative qualities
- Coworkers and bosses
- “Dream job”
- “In your own words.”

SECTION 6

EDUCATION HISTORY

- Years of education and detailed chronology
- Type of student
- School activities and behaviors
- “In your own words”

SECTION 7

LEGAL HISTORY

- Any and all contact with the law
- Outcomes of convictions
- Current legal status details
- “In your own words…”

Section 8

ADDICTIONS AND PROBLEMATIC USE OF ALCOHOL, DRUGS, AND GAMBLING

- Alcohol use/abuse

  Dx screen
- Illegal drug use
- Prescription drug use
- Gambling
- “In your own words….”

Section 9

MENTAL HEALTH, COUNSELING, AND PERSONAL ABUSE HISTORY

- Mental health treatment episodes
- Prescriptions current and past
- Personal history of any kind of abuse
- Emotional life (dx screening for anxiety and depression)
- “In your own words…”

Section 10

PERSONALITY SELF-ASSESSMENT

- Self assessment of personality traits
- “How You Are Doing in Your Life” self assessment
- “Type of person” true/not true - dx screen
- “In your own words….”

SECTION 11

SEXUAL HISTORY

- Early exposure and education
- Orientation, dx screen for dysmorphia
- Pie chart for self description of attractions to male/female/adult/child
- Sexual activity and behaviors - abusive, harmful, compulsive (“never” to “often” scale)
- “In your own words…”

SECTION 12

IN YOUR OWN WORDS

"This final section gives you an opportunity to put the most significant pieces of your life into a story. It can be a helpful way to take a step back and look at the events of your life from a different perspective. There are no guidelines in this exercise other than to write a story about the most positive and most negative events in your life and whatever else is important to you in your life that was not yet asked about or that you have not written about on any of these pages. You can include whatever you think is most important".

- This section asks the client to express only in their words, from their unique internal worldview…

Appendix a

OTHER SIGNIFICANT INFORMATION

- Adverse Childhood Experiences (ACES)
- Resiliency

APPENDIX B

OPTIONAL DETAILED SEXUAL HISTORY

- Includes Section 11 and extends into much more detail, including illegal behaviors

Summary

- Multiple uses
- Range of types of questions
  - *Yes/No, fill in the blank, open narrative*
- Self assessment
- Dx screen questions – anxiety, depression, substance use, sexual compulsivity
- “In your own words” allows clients to explain themselves and tap into their own language and personal reference points unique to them