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Review

Build rapport and collect data: A teaching resource on the clinical interviewing intake

Travis J. Pashak[1] · **Michael R. Heron**[2]

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Abstract
This paper is an overview of the intake process for mental health helping professions. We intend for this piece to serve as a teaching resource, useful as an intake primer for novice clinicians in psychology, social work, counseling, or psychiatry, but perhaps also as a helpful review for experienced clinicians as well. We define and describe the clinical interviewing intake, discuss its history, and conceptualize it as an endeavor toward building rapport and collecting data. Specific topics we explore include: adopting an appropriate clinical attitude, engaging in cultural humility, considering practical factors about conducting the intake, viewing interviewing as an art, evaluating tools of data collection, discussing psychometric considerations in intakes (e.g., reliability, validity, standardization, and sources of data), and identifying topics to assess in-session and how to explore them. The paper closes with some summary thoughts and overall advice to those soon to embark on their first clinical interviewing intake.

Keywords Intake · Rapport · Assessment · Psychotherapy · Interviewing

> *Of all interviews I most look forward to the first one. It is exciting and challenging—full of hope and expectation.* (Benjamin, 2001, p. 23).
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> *Once therapists gain experience, they rarely follow a systematic checklist of questions in the great bulk of their work in psychotherapy. Collecting data becomes intuitive and automatic. It does not precede therapy but is a part of the therapy itself.* (Yalom, 2003, p. 206–207)

Where to begin? How to start? This piece is a contribution to the special issue titled "Advances in Clinical Interventions" in the new journal *Discover Psychology*, which we hope can be a useful resource as the readership audience becomes established. This paper is primarily directed toward readers who are newer to the mental health helping professions, but perhaps it may also prove informative for more experienced folks. We envision that this may be a pertinent open-access reading to assign in an undergraduate course such as Clinical Interviewing, Introduction to Clinical Psychology, Theories of Counseling, Abnormal Psychology, or perhaps even as a primer on the topic of intakes for graduate/professional students in psychology, social work, counseling, psychiatry, or other fields. Ultimately the intent of this paper is to provide an overview of the considerations relevant to intakes which is practical, atheoretical, evidence-based, cross-culturally flexible, and appropriate across sub-field specialties. Especially given Moustafa's (2021) commitment to diversity and cross-disciplinarity in the development of *Discover Psychology* as a platform, the intent here is to discuss intakes inclusively to the myriad forms they take. This paper will define intakes, discuss how to build rapport (including adoption of an effective clinical attitude, cultural humility, consideration of key practicalities, and a perspective of interviewing as

✉ Travis J. Pashak, tjpashak@svsu.edu | [1]Department of Psychology, Saginaw Valley State University, University Center, MI, USA. [2]Department of Social Work, Saginaw Valley State University, University Center, MI, USA.

artistic), discuss how to collect data (including an overview of useful tools, psychometric themes, relevant topics, and a method to approach such topics), and conclude with pithy recommendations for clinicians.

Why write this piece? Student-clinicians with an upcoming appointment scheduled for their first therapy session, whether real or a mock-intake for training purposes, often ask "how do I get started?" This paper aims to help answer their question and serve as a useful teaching resource. Despite being a rather obvious topic, this has not been written about extensively—at least not in this sort of format. Most information about the conduct of mental health intakes seems to be housed in reference books, textbooks, handbooks, and clinician's guides of various sorts. Input can also be found in online sources (e.g., discussions among therapists on social media platforms or forums). However, a focus upon intake sessions is relatively rare in the peer-reviewed journal article realm. Most papers with "intake" in the title or key words deal with consumption of food, use of psychoactive substances, admission to incarceration settings, initiation of emergency medical care, or bodily functions such as respiration (i.e., oxygen intake). And of those papers which do address counseling/psychotherapy intake issues, many are exploring topics involving logistics (e.g., factors which predict attendance versus no-show of the intake) and psychometrics (e.g., factor analyses of the distress screeners used at intake), which are important but do not offer quite as much practical assistance to clinicians aiming to conduct an initial interview themselves. Meyer and Melchert aptly note that "very little is known about the actual intake assessment practices of therapists providing mental health care in the community" despite the practical and pedagogical importance of this information (2011, p. 70). Thus, as a pair of professors and licensed clinicians who teach undergraduate-level courses on interviewing skills (one psychologist and one social worker), we aim here to provide a concise overview of the mental health intake, in an open-access format, for the benefit of those in the helping professions or aspiring toward them, and in a style which is both scientific and accessible to broad readership.

1 What is an intake?

In the standard lingo of the helping professions, an "intake" is the first major encounter between the professional(s) and the individual(s) seeking services. Any psychological intervention must have a starting point, any therapy relationship must have a first moment, and any assessment process must have an initiation—the intake is such a juncture. Owing to the idea that one can *take in* something, "intake" has for centuries referred to the process of an interviewer *taking in* the client and their story. The earliest recorded instance of this use of "intake" in both the PsycINFO and PsycARTICLES databases is a paper from the early 1900's on evaluating prognosis of child therapy cases, based upon parent behavior at initial contact—and the term already seems commonplace at that time (Witmer, 1933). Akin terms could include "orientation," although this denotes more of a teacher-learner relationship than a helper–helpee relationship, as well as "admission" and "admittance," but those differ in that they often imply a physical stay at a location whereas an intake can be relatively brief, out-patient format, and even conducted remotely via telehealth platforms. The intake is not necessarily the very first exchange of words, because perhaps a quick phone call took place beforehand to schedule the intake appointment; and the intake is not necessarily the very first exchange of data, because perhaps the client filled out some paperwork for the clinician prior to the intake appointment—but the intake is the first point of synchronous meaningful interaction between the two or more parties involved, typically comprising a detailed conversation of some kind. Thus, for the purposes of this paper, a working definition of "intake" is adopted such that *it is the first substantial interaction of the persons involved in a professional mental health service.*

More complex than defining the notion of an intake is describing what it entails. Intakes are immensely diverse in their style, goals, and conduct—one could argue there are as many ways to do an intake as there are clinicians and clients. However, for the purposes of outlining what is common, we will argue that *intakes must involve two tasks: building rapport and collecting data*. The relative weights of these two processes vary based on numerous factors. For instance, in Greenspan's (1981) approach to conducting intakes with children, the primary focus is to observe, learn about the child, and gather information. Secondary to data collection, then, "a subsidiary goal is to establish rapport" (Greenspan, 1981, p. 109). Meanwhile, Jacobson and Margolin (1979) prioritize rapport in their account of marital counseling intakes. According to them, "the most desirable goal of an initial interview is not to gather assessment information but rather to set the stage for therapeutic change by building positive expectancies and trust" (Jacobson & Margolin, 1979, p. 51). In any case, building rapport and collecting data are surely the two most crucial endeavors of the intake session. Other professional responsibilities overlay these two tasks, including adherence to ethical standards, developing a functional case conceptualization, pursuing setting-specific goals, and exhibiting cultural competence (more recently argued by

Lekas, Pahl, and Fuller (2020) as the evolution to cultural humility), but nevertheless we view alliance and assessment as core to each of these pursuits.

2 How does one build rapport?

To build rapport with a client is to establish a positive therapeutic bond. This connection with the patient is sometimes called rapport, therapeutic alliance, working relationship, empathetic relationship, or other such terms indicating that there is trust, warmth, respect, and care exuded between the parties involved. Rapport does not necessarily mean that the clinician and patient *like* one another, that they would be friends outside the therapy setting, or that they share various identity characteristics. Rather, rapport is a special harmony shared by two or more people willing to authentically engage with one another, to work hard toward mutual goals, to interact with vulnerability and rawness, and to feel a sense of commitment to one another. How is this achieved?

2.1 Clinical attitude for rapport

An appropriate *clinical attitude* or therapeutic mindset is important to adopt prior to beginning an intake, and while conducting any session for that matter (Kramer et al., 2014). Mental health professionals, of any sub-field specialty, should generally be open-minded inquisitive individuals who enjoy connecting with others, care deeply about humanity, find value in exploring peoples' lived experiences, and wish to help spur growth, healing, or other important changes in those they treat (Kottler, 2010). Given that most folks drawn toward the helping professions already embody these values, perhaps the simplest advice about the appropriate clinical attitude is to *be yourself*. If one can show up to the intake ready to offer their sincere human self, with a genuine interest in the client, rapport is already a relatively likely outcome. However, this is easier said than done.

There are many barriers to effective interviewing which can be especially salient at the intake stage. As Benjamin notes (2001), it is easy for therapists—especially early career folks—to be thrown off course by their own thoughts during the interview. Clinicians can be distracted internally by self-criticism (e.g., "I didn't word that question very well"), imposter feelings (e.g., "I'm not good enough to be doing this"), or supervisory concerns (e.g., "I need this to go well for the upcoming video review with my mentor"), as well as external/interpersonal blockages to the therapy process such as defensiveness (e.g., "her story is making me sad and I can't let her see that"), overly focusing on test results (e.g., "their distress screener had a high anger score so I must focus on that even though they seem to want to discuss drinking"), or authoritative needs to control (e.g., "I'm in charge so I'll direct him in the conversation"). These and many other clinician-based barriers can each significantly dampen the likelihood of strong rapport developing during the intake. The interviewer may even be too tired, too stressed, too caffeinated, or otherwise too uncomfortable to offer their best self. Therefore, part of the clinical attitude is to arrive at the intake with calm poise and an unburdened mind, having taken care of oneself prior to attempting to care for others. Especially in challenging circumstances (e.g., increasing institutional demands, understaffing, working through a pandemic, facing burnout), it is crucial that clinicians, expert interviewers included, return to the basics of self-care when needed.

Other aspects of the clinical attitude which foster rapport include an awareness of what the client is experiencing in the intake itself. Patients arriving for their first psychotherapy visit are facing a daunting set of tasks: to describe themselves openly and accurately, to offer vulnerability to a complete stranger, to discuss personal topics often of a heavy nature, and to do all this whilst evaluating whether they might wish to return and see this clinician again in the future. Clients are asked to face their demons with an audience present—*this is not easy*. And so, the intake clinician who recognizes all this, empathizes with the helpee's situation, and responds appropriately—with an attitude of respect and reverence for the special role they are given—is taking steps toward healthy rapport. Be warm, polite, curious, professional, and human. Be accepting of the client, exactly as they are, while also joining them in hope for change.

In addition to approaching the intake with authenticity, a clear mind, and empathy for the client's role in the conversation, an effective clinical attitude also includes a client-centered perspective. For instance, Hilsenroth and Cromer (2007) conducted a thorough review of therapist intake behaviors related to alliance, and found that trends could be summarized in three themes: *framing* session around collaboration, depth, and clear communication; *focusing* on a client-led approach which highlights affect, clarifies concerns, and facilitates exploration; and *feedback* given regarding assessment findings, interpersonal insights, and collaborative treatment goals. Flückiger, Znoj, and Vîslă (2016) similarly argue that a client-centered approach is crucial, in their exploration of potential clinician biases at intake. For instance, it can be easy

for therapists to see a score on a distress screener above a certain cutoff and then head into the intake session mentally geared toward a discussion about that particular phenomenon (e.g., depression) when in fact the intake might be much more beneficial if the client is allowed to steer toward topics of their greatest concern. Lastly, Rosen and colleagues (2012) found that enhanced complementarity/harmoniousness between client and clinician was tied to numerous clinical interpersonal skills including clear communication and a shared focus upon mutually set goals. Client-centeredness in the intake naturally allows the client to have a voice in the goals and direction of the conversation, thus aiding rapport.

2.2 Cultural humility for rapport

A surefire way to erode potential for rapport is to approach the client with bias, stereotyping, prejudice, or outright discrimination, based on various aspects of their identity (e.g., sexual orientation, gender identity, social class, religion, nationality, race, ethnicity, ability) and the intersections of these identities. Avoiding these problems may sound easy, but it is important to remember that bias can be both conscious and unconscious. To work toward culturally-attuned rapport, interviewers ought to be open and accepting of the client's identities and work toward an understanding of how those identities inform their lived experience, including within the therapy relationship itself. To culturally accept the client is not to hold a "colorblind" mindset, rather, it is acknowledging the differences/similarities in experiences of power, oppression, and privilege between helper and helpee and inviting those topics for explicit conversation in intake as well as follow-up treatment sessions. Cultural humility is a sensitivity to identity factors which not only aims to maximize understanding while minimizing generalizations, but also goes further to recognize that the client is the expert of their own experience and the practitioner is the learner. For example, social work education standards in cultural competence have been described this way:

> There is general consensus that the ability of social work students to be culturally competent or practice competently with diverse client groups is a process that includes three components: development of an awareness of one's own cultural values, biases, power, and position, and how these factors affect a social worker's relationships with clients; understanding the client's worldview (including the ability to elicit the client's cultural beliefs); and development of culturally appropriate interventions (Jani et al., 2016, p. 312).

Ecklund and Johnson (2007) similarly provide guidance for enhancing cultural skills in intakes with children and families, building their recommendations around four themes: assess the client's cultural identity; investigate ways in which the client's cultural background informs their explanations of their presenting problem; become aware of the client's psychosocial environment and how these factors impact functioning (both in protective and in risk-elevating ways); and *openly explore* the cultural aspects of the client–clinician relationship. Their article also stands out for providing actual examples of questions/prompts which could be used in an intake to highlight cultural issues and connect to the client's identity, such as "How does your family understand what is going on?" or "Who helps you? What activities/groups make it better?" and "Does the family experience oppression? How has it affected the child?" (Ecklund & Johnson, 2007, p. 362).

Much like the clinical attitude, adopting a stance of cultural humility is a constant work-in-progress. Therapists cannot simply learn some static set of facts about various cultures and then assume that they are well prepared for every intake—this is a career-long endeavor toward understanding identities, practicing a humble curiosity about cultures, exploring ways one holds biases (conscious or unconscious), and working toward greater sophistication in how macro lenses are applied in the intake interview.

2.3 Practical considerations for rapport

While the clinical attitude and cultural humility are somewhat abstract aspects of building rapport in an intake, there are certainly some pragmatic aspects to be noted as well. Many decisions in this realm will seem like 'common sense' or will be made for the interviewer based on the setting or by the specific needs of the service being conducted—nevertheless they are relevant and important. To list just a few basics, consider that: the intake interview should start punctually and not vary too much from the anticipated length; the seating should be comfortable and age-appropriate; the room should be private and relatively distraction-free; the interviewer should arrive prepared with whatever materials necessary; and the clinician's relevant code of ethical conduct should be clearly followed. Note that while obvious at face value, these basic suggestions vary widely in implication based on context and goals—a school psychologist conducting an on-campus assessment with a fifth-grader is dealing with much different rapport-related issues from a medical social worker in the emergency department of a hospital.

One major practical consideration for building rapport is *who* conducts the intake. We argue that whenever possible, the intake clinician should be the same individual planned to provide the ongoing service—regardless of whether that be a counseling/psychotherapy relationship of some kind or a detailed assessment with feedback/consultation. This too may sound obvious, but in fact many agencies attempt to farm out the intake phase of care due likely to the fact that there is much information to absorb and often a great deal of paperwork. For instance, training centers often assign entry-level clinicians (e.g., first-year clinical graduate students) the task of conducting intake interviews, only to hand off the clients to more advanced trainees thereafter. Other clinics will have an administrative assistant or secretary conduct a detailed phone-intake prior to assigning the client to a clinician. In the worst-case scenarios, a client may have had to 'reopen wounds' numerous times across several pseudo-intakes while being shuffled around by managed care. While in many cases there are at least a few pieces of background information required before getting started (e.g., name, demographic information, insurance coverage, reason for seeking service), we argue that the intake should generally be conducted by the same professional handling ongoing services. And this is not just a hunch, empirical evidence supports this stance. Nielsen and colleagues (2009) found that so-called "discontinuity clients" (i.e., those seeing a different clinician for intake versus follow-up) were far more likely to end treatment prematurely and showed slower therapeutic progress. In essence, farming out the intake task to another provider, while perhaps streamlining the process of collecting client data, appears to disrupt or delay other aspects of psychotherapy including rapport-building.

Another practical consideration is how to view the purpose and scope of the intake. Some therapists take the stance that there are two distinct phases of therapy: assessment and intervention. In such a framework, the assessment phase is seen as a comprehensive collection of all relevant information about a client's life, after which the actual treatment can finally begin. And in complex cases, the assessment phase can be numerous sessions, even weeks of interviewing, testing, scoring, and interpreting findings prior to a single therapeutic utterance. We advocate against this model. The intake need not be treated as separate from therapy or some sort of pre-intervention effort. It is, in itself, the *beginning* of the professional service. For instance, a case study by Iwakabe, Edlin, and Thoma (2021) showcases the profound potential for healing in even just the first session of psychotherapy when the intake is conducted well.

2.4 Rapport as an art

Okun argues simply that "a warm smiling welcome is the best way to begin any interview or session" (Okun, 1992, p. 82). Rapport building is as much an art as a science (Benjamin, 2001). A practitioner must learn and hone the behaviors required to build rapport such as eye-contact maintenance, body positioning, question delivery, head nodding, affect expression, etc., but the application of these behaviors is as diverse as clients are. These physical behaviors may be easy to quantify, but what amount differentiates steady eye contact as affirming versus intimidating, a leaned-in posture as engaged versus invasive, a furrowed brow as inquisitive versus judgmental? This is the art of the matter. Garrett agrees that interviewing is an art, stating that although "probably everyone starting to interview wishes there were a list of rules," it is ultimately the case that "interviewing takes place between human beings who are much too individualized to be reduced to a formula" (Garrett, 1942, p. 7). In the same vein, Morrison jokes that if "interviewing only involved getting patients to answer questions, clinicians could assign the task to computers and spend more time drinking coffee," but that automated intake methods "cannot begin to perceive the nuance of feeling, or assess the hesitation or the moist eye, that alerts a live clinician to yet another fruitful line of inquiry" (Morrison, 2008, p. 1).

Concepts like trust, warmth, respect, and care can only be put into practice if the science is tempered by the art. We are articulating here that rapport is an intersubjective, phenomenological, idiographic issue. No set of nomothetical empirical findings, no matter how thorough, can guide every clinical situation appropriately. There is no perfect number of smiles to deliver in session to guarantee rapport. There is no such thing as a flawless question or a fully ideal gesticulation—interviewing is faulty expression from one fallible human to another. Empirical evidence can guide clinicians away from clearly ineffective behaviors, but honing in on one's optimized clinical self is an ongoing artistic pursuit. This creative imperfection is ultimately part of what makes the process therapeutic. Good therapy is as much science as it is poetry, and this begins at the intake.

3 How does one collect data?

Assessment involves, essentially, the non-judgmental judgment of another person. In addition to building a warm genuine connection with the client, part of the intake is indeed an attempt to *judge them* (i.e., figure them out, so to speak; thoroughly analyze their personality, capacities, situations, identities, and experiences) while avoiding *judgmentalism* (i.e., fault-finding, condescension, disapproval, criticism; the inability to be accepting). The intake is a structured approach to the unstructured task of learning about someone. To learn as much as possible, we recommend holding an attitude of curiosity and gentle skepticism about everything presented, while also accepting the client and their story exactly as is.

Data collection in the intake holds several purposes which are likely self-evident, including serving as the background for a functional case conceptualization and informing the ongoing counseling conversations with contextual details. Another important part of the clinical assessment process worth unpacking here is working toward the ability of *prediction* (Wiggins, 1973). The data being gleaned from the client (with the client) allow the interviewer, hopefully, to predict numerous future outcomes including: how safe they will be against self-harm or other serious issues; how likely they are to succeed in meeting their treatment goals; how likely they are to fit with various styles or approaches to therapy; and how likely they are to require more or less intensive treatment offerings. These decisions can hold enormous weight for the eventual wellbeing of the patient. In this sense, clinical assessment is also an ongoing activity—assessment occurs at every interaction with the client, because predictions continue to be made about how treatment or other services should progress over time. However, for the purposes of this instructional paper, we are focusing on the unique contributions of intake assessments to the initiation of psychological services.

So, how does an effective clinician collect client data during the intake process? The verbal interview conversation is clearly a focal source of material, but there are numerous other considerations. Here we frame this discussion around the tools used to aid the intake; psychometric considerations such as the reliability, validity, standardization, and sources of intake information; and finally what topics to explore and how to harvest them in the intake session.

3.1 Tools of data collection

The equipment of the intake varies widely. In some agencies, clinicians have no prior contact until the patient arrives and begins session (e.g., crisis care, on-call services, emergency "walk-in" treatments), hence the toolkit is solely the interview and perhaps any paperwork administered thereafter. Other counseling scenarios may involve a screening process of some kind (e.g., phone call, mailed forms, online survey), and still others may have a very thorough series of steps between initial contact and the session. At the helper's disposal in many situations is a semi-standardized set of prompts, a background form(s) for the helpee to fill out, and one or more measures of symptoms/personality or capacity/intelligence to be administered.

Settings and goals of the professional service often dictate the assessment instruments involved. As a very general rule, intakes leading into a treatment relationship which is voluntary, lower in urgency, lower in psychopathology/severity, lower in diagnostic/conceptual complexity, lower in meeting frequency, and greater in client autonomy/insight tend to require less intensive use of data collection instruments. For instance, a routine counseling outpatient intake for a highly functional adult experiencing mild anxiety may sometimes be handled perfectly adequately with a verbal interview alone. More data is almost always better, but the time and costs of assessment endeavors are not to be ignored. Oppositely, intakes leading into treatment or assessment relationships which are mandated, higher in urgency, higher in distress, higher in symptomatology, higher in meeting frequency, and lower in client functioning tend to require greater use of data collection instruments given the sensitivity of the issues at hand. For instance, a court-mandated assessment and treatment protocol with a teen struggling with attention-deficit, antisociality, and suicidality could warrant more detailed intake assessments using more tools than other scenarios.

Examples of specific intake tools are myriad. The most basic of them all is the blank notepad, used to document details of the verbal intake session conversation. Another very common tool is a set of paperwork clients are asked to complete, often before the intake session, which requests qualitative details on various aspects of their lives (e.g., identifying demographic information, reason for seeking care, core aspects of life story)—such a form is sometimes called a "biopsychosocial," "background questionnaire," "intake survey," "patient history," or "client narrative." In any case, these forms tend to be idiosyncratic to the clinic, agency, or institution using them—highlighting certain prompts as relevant to the context (e.g., a college counseling center's intake form may ask "what is your major?" while a community outpatient clinic's intake form may ask "what is your career?"). These sorts of materials do not replace the importance of

taking time to get to know the client with personal connection, but offer shortcuts about the details of their lives which can aid efficiency of intake conversation.

Finally, the last set of data collection instruments commonly used for intake purposes are the structured objective (and occasionally projective) psychological assessments. Individually called a "measure," "test," "inventory," "screener," "scale," "instrument," "survey," "battery," or other names, these forms of data collection are an official process of some kind, typically backed up by numerous research publications and/or copyrights, which purport to quantify or qualify a particular characteristic or set of characteristics within a client's psyche. There are quite literally thousands and thousands of assessment instruments available for an extremely wide array of psychological attributes, with more being created every year as the science progresses. Thus, a full review of all psychological assessment tools is far outside the scope of this paper, but we can mention a few common tools popular for intakes. The Brief Symptom Inventory (BSI; Derogatis, 1993), Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983), and the 45-Item Outcome Questionnaire (OQ-45; Wells et al., 1996) are each frequently used distress screening instruments common to outpatient or hospital-based psychotherapy/counseling centers. These forms allow clients to check boxes indicating their symptoms (or degrees of severity of various symptoms), and scoring rubrics are available by which clinicians can view their clients' status with reference to large-sample norms. Assigning to an abstract concept (e.g., depression) a value level of some kind (e.g., a score ranging from 0 to 21 on the HADS) can, hypothetically, aid in building a normed understanding of the client's difficulties. Other sorts of objective tests exist for concepts relevant to neuropsychological assessment (e.g., memory, executive functioning), school psychological assessment (e.g., learning, attention), forensic assessment (e.g., malingering, antisociality), and more. Further, a family of instruments known as "projective" tests purport to measure aspects of personality which reside in unconscious or implicit realms, such as inkblot tests, relational image interpretation tests, and incomplete sentence blanks. Again, thousands upon thousands of psychological tests exist, and intake clinicians have a wide array of options with regard to how they conduct their information-gathering at the beginning of a psychological service.

3.2 Psychometrics of intake data

Intake assessment data should always be as *reliable* as possible. Reliability refers to the truth, accuracy, correctness, preciseness, and exactness of information collected (Crocker & Algina, 2008; Kaplan & Saccuzzo, 2017). The opposite of reliability is error or mistake. To be unreliable is to be wrong. So, if we imagine that a hypothetical client experiences a "true" social anxiety level of 70%, and a psychological test of social anxiety yields a score of 60%, the difference between true and obtained scores is the amount of error occurring in the assessment—or the lack of reliability. This obviously applies to variables commonly measured in *quantitative* fashion (e.g., level of intelligence, depression, self-esteem), but it also applies to *qualitative* variables (e.g., cultural identity, relationship to parents, style of emotional expression). Regarding psychological tests, reliability is maximized by choosing those tests which have the best available test construction evidence in the scientific literature fitting with the population being assessed (i.e., a given test is never universally reliable, it can be reliable in application for a certain set of users). Meanwhile, interview reliability often relies upon well-established rapport (e.g., appropriate embodying of the clinical attitude and cultural humility help prevent defensiveness, lying, or otherwise inaccurate client responses). No matter the issue, an intake clinician should be mindful of reliability issues and aim for the lowest amount of error possible.

Intake assessment data should also always be as *valid* as possible. Validity refers to the meaningfulness, usefulness, helpfulness, relevance, and utility of information collected (Crocker & Algina, 2008; Kaplan & Saccuzzo, 2017). The opposite of validity is extraneousness or superfluity. To be invalid is to be futile. So, if we imagine that a hypothetical client is hoping to discuss their negative body image and worsening pattern of restricted eating, and their assessment process ignores those phenomena and instead focuses on measuring their extroversion, leadership skills, and creativity, then surely the intake data collected would not be of highest importance—hence lacking validity. To some extent, one could argue that nothing is truly irrelevant to the clinical assessment because any data about the client can facilitate a better understanding and connection, but given time constraints and a desire to conduct an efficient and effective intake, some data are certainly more valid than others. If unsure how valid a certain construct/topic is for a given intake assessment, we recommend simply considering how well it ties back to the client's reason for seeking service (i.e., "presenting problem"). If a test or question helps foster depth, strengthen rapport, spark insight, or otherwise uncover layers of the target for therapeutic change, then it is probably valid. Again, no test or question is universally valid, but validity can occur in application to a specific client and situation. For instance, an otherwise great question asked in age-inappropriate format (e.g., a prompt delivered too abstractly or with too much sophistication for a child to understand) will lose its validity (Ivey et al., 2018). Clinicians should always strive to collect the most valid data possible.

To *standardize* assessment procedures is to conduct them identically each time they are administered (Kaplan & Saccuzzo, 2017). For certain forms of data collection, including most all psychological tests, this is crucial—meanwhile for interviews there are situations which call for standardization and others which invite much flexibility. Some of the factors to standardize would include administering a test with the same instructions, materials, demeanor, and emphasis upon effortful and honest responding each time, no matter the client—and this indeed is very important for tests such as distress screeners, intelligence batteries, and broadband personality inventories. Standardization of these and other factors will help ensure the reliability of data collected. Imagine for instance that one client completes an aptitude test with a calm and supportive clinician in a quiet room free of disruptions, while another client completes the same test with a rushed and detached clinician in a crowded noisy setting. The former is likelier to score up to their best potential, while the latter is at risk of under-representing their true score and inviting error into the assessment. Other sorts of data collection, such as the intake interview itself, do not necessarily require the same degree of standardization—it is perfectly fine in many settings to have an unstructured interview approach which follows the client's lead (and as argued earlier, we believe this often helps aid rapport). As long as numerous key points are addressed, they could vary in the order they are presented, the wording used to ask, and the level of depth. Some interviews do require standardization however, such as structured interviews for research screening purposes or diagnostically structured interview protocols. As a general rule, test administration should be highly standardized whereas interviews may vary depending on the individual needs of the client(s).

The *source* of intake data collected is one more psychometric factor to consider in building an initial assessment of a patient. Certainly, self-report is at the core of the intake insofar as the client provides data about themself (e.g., verbally answering questions, filling out background forms, completing psychological tests). However, whenever possible and ethically appropriate, it is advantageous to collect data from a variety of sources in order to best capture the most reliable and valid data. What other sources may be helpful? Depending upon the nature of the referral question and goals of therapy, the following individuals in the client's life may prove informative: spouse/partner, parent, child, other family member, friend, employer, primary care physician, psychiatrist, teacher, parole officer, prior therapist, and others. Collateral objective data of various kinds can also be useful, including academic transcripts, occupational records, medical charts, and treatment summary documents. In addition to helping the therapist learn about the client, these various sources of information can also become collaborative partners in the treatment. Importantly, consent from the client (or from the parent/guardian for minors) is necessary prior to collecting any information not directly from the client, given the professional and ethical bounds of confidentiality. In adult outpatient psychotherapy/counseling settings, arguably the most common forms of collateral data sourcing are prior therapists and current medical care providers—but again, more data is almost always better.

3.3 Topics and tactics of interview intake data

What to ask, and how? This is often the nascent intake therapist's biggest concern. The setting will dictate some of the topics, and the client will likely bring many topics to the conversation of their own volition, but there does ultimately rest some responsibility on the interviewer to ask the right questions. Sundberg's seminal text *Assessment of Persons* (1977) recommends a list of particular intake topics, and Sonne's *PsycEssentials* intake chapter (2012) similarly provides a detailed approach to identifying relevant prompts. Further, Meyer and Melchert's article on intakes (2011) astutely frames the scope of conversation subjects around the biopsychosocial model. Table 1 borrows and summarizes those three sets of intake interview inquiry topics here.

As shown, the three sets of recommendations have a great deal of overlap, indicating that perhaps the core characteristics of a good interviewing intake have not drastically changed in the past several decades. Mental health helpers encountering a helpee for the first time have an enormous amount of information to take in, but keeping some of these checklists in mind may help lessen the overwhelm. Further, thinking in terms of the biopsychosocial model helps structure the topics into meaningful layers which each have their separate realms but also inform and connect to one another.

How should this wealth of topics be explored? As mentioned above, the intake is both an art and a science. The science is the foundation as it is paramount in collecting reliable and valid data about the client, and budding clinicians often feel most comfortable when clinging to a sort of scientifically manualized approach to intakes—closely following a "road map" of topics through the conversation toward the goal of a comprehensive understanding. This is an adequate starting point, but the intake of the seasoned practitioner crafting their art becomes less and less reliant on a structured set of topics—the road map is read with decreasing frequency as the journey becomes more familiar. Eventually, the

Table 1 Topics to assess during intake

Sundberg (1977)	Meyer and Melchert (2011)	Sonne (2012)
Identifying data	**Biological domain**	Identifying information
Reason for coming	General medical history	Presenting problem
Present situation	Medications	Recent treatment efforts
Family constellation	Childhood health history	Past psychological history
Early recollections	**Psychological domain**	Current health status
Birth and development	History of present illness	Health history
Health	Individual psychiatric history	Substance use/abuse
Education and training	Suicidal ideation	Family history of problems
Work record	Childhood abuse history	Early developmental history
Recreation and interests	Mental status examination	Social history
Sexual development	Psychological traumas	Spiritual/religious history
Marital and family data	Personality styles and characteristics	Educational history
Self-description	Behavioral observations	Employment history
Choices and turning points	Individual developmental history	Military experience
View of the future/goals	**Sociocultural domain**	Legal history
Any further material of interest	Employment	Leisure and recreation
	Legal issues	Compulsive/ritualistic behavior
	Current living situation/arrangement	Trauma history
	Education history	
	Religion	
	Family history	
	Multicultural issues	
	Financial resources	
	Military history	
	Personal activities, interests, hobbies	
	Spirituality	

practitioner will be able to gather most all data needed for the intake by simply soliciting the client's experiences or story. The skills used in rapport building largely become the method to gather that narrative.

Instead of canned questions coming from the practitioner, taking on a biographical feel of interview, the intake can become a conversation with spontaneity, helping put the client at ease along the way. Starting open-ended (e.g., "How are you?" "What brought you in?" "Tell me about yourself." "How would you describe your life story?" "What goals and desires do you have for this therapy experience?") and simply following the client's lead from that point forward can often fill in the majority of the intake details without ever needing to refer back to a cheat-sheet. Ultimately, we argue that an intake session conducted organically in this way, with conversation ebbing and flowing to new topics naturally, is often the best way to maximize both rapport building and data collection.

4 Conclusions

The intake process can be exciting but also intimidating for newcomers to the clinical interviewing professions, as well as those with more experience. There is so much to learn, and so many ways to be surprised! In Bruch's text on learning basic psychotherapy skills, her concluding note on intakes matches our sentiment:

> Beginners are often worried about not knowing enough, about not being able to explain things immediately. This account of a first interview describes clearly the essential task: to listen with an honest and open mind, to convey to a patient that one is available for his journey of self-discovery but with the implication, from the very beginning, that this journey can be successful only when both take part in the work of this journey together (Bruch, 1974, p.18).

In this teaching-oriented paper, we hope to have shared a relatively thorough review of the primary considerations in conducting a mental health initial session, framed around the two primary themes of building rapport with clients and collecting data from clients. To conclude our paper, we offer a very brief set of key take-away points here—a set of suggestions which every intake clinician should strive to accomplish:

1. Always focus on rapport building and data collection.
2. Be human, warm, respectful, and genuine. Be yourself.
3. Adopt a clinical attitude of curiosity and empathy.
4. Engage in cultural humility and sensitivity to intersectionality.
5. Arrive relaxed, integrated, congruent. Get out of your own way, it's not about you.
6. Know that potential for intervention is immediate; the intake is therapy.
7. Behave ethically.
8. Pursue reliable and valid data, wisely choosing tools and sources and prompts.
9. Conceptualize the client within each layer of the biopsychosocial model.
10. Embrace the uncertainty. It's an artistic organic process, just give it your best!

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Declarations

Competing interests The authors declare no competing interests.

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