

Facilitic Supervision and Schematics: The Art of Training Psychiatric Residents and Other Mental Health Professionals How to Structure Clinical Interviews Sensitively

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Every day, live theater unfolds as two strangers step into the roles of clinician and patient to engage in a brief but complex interaction—the initial interview. This unscripted play may have remarkably important ramifications. As the players collaboratively create the script, the clinician is responsible for gathering a daunting amount of material that may be of use in relieving the pain of the patient.

The interviewer must uncover the patient's presenting problems, perspectives, symptoms, and diagnostic complexities. In addition, the interviewer must be able to explore information regarding an array of social supports and circumstances that may be hindering the patient or may prove to be of potential use in helping the patient. Unlike an actor, however, the clinician's task is not to create a role but sensitively to help the patient drop the many social roles that can prevent the patient from sharing the intimate details of his or her story. To magnify the task further, all of this material must be gathered in roughly 50 minutes while establishing and maintaining a powerful therapeutic alliance.

Put succinctly, good clinicians cannot afford merely to listen empathically; they also must learn to explore actively in a comprehensive yet sensitive fashion. Indeed, gifted clinicians have the knack for exploring this vast database in such a fashion that patients come away feeling that they have been participating in an engaging conversation with a caring human being rather than having been interviewed by “some shrink with a clipboard.”

This critical ability to gather a useful database while simultaneously enhancing engagement is one of the most difficult clinical skills to master, but painfully

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little time is spent in many a clinician's training regarding its mastery. In the mid-1980s, when I was developing the interviewing course at Western Psychiatric Institute and Clinic at the University of Pittsburgh [1,2] (also described in detail elsewhere in this issue), I quickly realized that one of the problems facing interviewing mentors was that no supervision language existed with which one could easily discuss, model, and teach these elusive structuring skills.

Supervision languages existed for talking about a variety of interviewing skills, such as recognizing defense mechanisms and the use of specific types of clinician responses (eg, open-ended questions and empathic statements). Moreover, broad fields of study had been delineated regarding important non-verbal considerations such as proxemics [3] (the study of how people use space) and kinesics [4] (the study of how people use gestures and body motion), but no language had been developed to understand and describe how interviewers structure and shape interviews as they gather data.

At Western Psychiatric Institute and Clinic we developed a new field of study and a supervision language with which to explore this field [5]. "Facilics" is the study of how interviewers structure interviews while gathering data (eg, what topics they choose to explore, how they go about exploring those topics, how they make transitions from topic to topic) and the manner in which they approach this task while managing time constraints. The term "facilics" is derived from the Latin root *facilis*, indicating grace in movement.

In addition to the baseline definitions and principles created for this study of how clinicians go about the task of structuring interviews, a schematic shorthand was developed that allows a supervisor to note the flow of the student's interview quickly and unobtrusively. After the client has left the room, the supervisor can share this "map" with the student, visually, in a fashion that is easily understood and can shed light immediately on the student's strengths and weaknesses.

Facilic supervision proved to be the single most popular teaching tool that we used with residents in their interviewing training [1]. Facilics also can be used to study the structuring of any type of interview, from clinical interviews to newspaper interviews to an attorney's deposition to a late-night television host chatting with a celebrity. Facilics is not a way to interview; it is a way to capture and study how ably someone structures an interview.

Absolutely all interviews have a structure. Sometimes this structure is fluid. Sometimes it is awkward. Sometimes the interviewer is consciously aware of creating the structure. Sometimes the interviewer does not have the foggiest idea that a structure is being created. Nevertheless, a structure inevitably unfolds as any two people—in this case a clinician and a patient—try to navigate the other's defenses while communicating about intimate topics that are filled with nuance and shadows.

As supervisors we can use an understanding of facilics to give our students a refreshing, and sometimes surprising, self-awareness of how each of them possesses a characteristic style of structuring interviews. Through our use of facilic principles and schematics we can show students the myriad of creative

options that they can use to facilitate communication with their patients and to weave clinical interviews that move with the easy flow of an everyday conversation.

Facilic provides one more valuable framework, among the many already useful supervision languages, for our students' use as they diligently work at developing an ever-more-active observing ego. An understanding of facilic principles enhances the resident's approach to self-observation by providing an additional lens for understanding the mysteries of the interviewing process. This powerful new lens shows trainees methods for sculpting interviews so that important databases are gathered in an engaging fashion, minimal information of use in helping the client is missed, sensitive material is shared more readily, and the client is more likely to show up for a second appointment and/or to follow up with the recommendations of the clinician.

Facilic supervision is composed of two activities: (1) the "tagging" of the student's style of structuring for purposes of self-awareness, and (2) the clinical application of facilic principles and language to give the student practical suggestions on how to structure interviews more effectively.

Parts of this monograph were adapted from the chapter, "The Dynamic Structure of the Interview," in the second edition of *Psychiatric Interviewing: The Art of Understanding* [6], which provides a thorough introduction to the use of facilics for trainees. The chapter introduces trainees to the facilic tagging system and provides practical suggestions on how to structure interviews in a conversational fashion that optimizes interviewers' data gathering and their ability to enhance engagement.

Even more comprehensively than the chapter in the book, this monograph focuses on the first activity of facilic supervision: how to use the language to tag the student's style of structuring. The goal is to give the reader a solid understanding of the language of facilics, securing a more effective use of the language for use during supervision. We hope the monograph will enable the reader to "hit the road running" with an approach that is faithful to the model and simultaneously will help the mentor communicate the model quickly and clearly to students. The monograph also looks at some topics not covered in the book chapter, topics that focus specifically on creative methods for optimizing the use of facilics as a supervision tool and for communicating one's own opinions on how to structure interviews in a powerful and persuasive fashion. In short, you are holding a teacher's manual.

In addition to my use of facilic supervision at the Western Psychiatric Institute and Clinic, the Dartmouth Interviewing Mentorship Program, described elsewhere in this issue, has provided a lively clinical laboratory in which my co-author and I have had the privilege of using this tool for the past 17 years. We hope that, with our combined experience of nearly 40 years in using facilic supervision, we can provide the interested supervisor with a matter-of-fact introduction comprehensive enough to be applied immediately to clinical training.

The facilic supervision system described in this article has well-established face validity and has been used extensively. During the past 25 years, facilic

techniques have been translated into a variety of languages including Chinese, French, and Spanish. Facilics has been used in graduate programs both nationally and internationally across numerous disciplines including psychiatry, nursing, counseling, clinical psychology, and social work. Its principles have been presented at the annual meetings of the American Association of Directors of Psychiatric Residency Training and the American Psychiatric Association and in a variety of major clinical symposia including the Cape Cod Symposia, the Santa Fe Symposia, the Door County Institute, and the Muskoka Summer Seminar Series sponsored by McMaster University.

Despite the widespread use of facilics, a practical manual has never been available to guide supervisors new to the system and its application. This monograph was created to fill this gap in the clinical education literature.

Our approach in the monograph is fourfold: (1) to introduce the basic facilic definitions and terminology, (2) to describe the facilic schematic system, (3) to share tips and strategies for using facilic supervision more effectively, and (4) to provide a programmed text in the Appendix that will expand and consolidate the reader's knowledge of both the principles of facilic supervision and the use of the facilic shorthand. By the end of this article and its Appendix, we hope that the reader will have enough familiarity with the facilic system to be able to use it immediately as a supervision tool.

DEFINITIONS OF FACILIC SUPERVISION TERMINOLOGY

Facilics focuses on the following series of concepts: the topics being explored during an interview (called "regions"), the method of exploring these topics once they are entered (a process referred to as an "expansion"), and the methods of making transitions between topics (an interviewing structure called a "gate"). Regions are divided further into two types, content regions and process regions.

Content Regions

A content region is any area of an interview in which the primary focus of the interviewer is on the delineation of a specific database (naturally, the interviewer is attending simultaneously to rapport). For a clinical interview the following 10 regions are often focused on in no specific order:

- History of the present illness

- Diagnostic regions (areas in which symptoms are elicited relating to specific *DSM-IV-TR* diagnoses)

- The patient's perspectives and goals (understanding the patient's views on his or her problems, the patient's ideas about what might help, and his or her fears, pains, and expectations)

- Mental status examination (Many elements of the mental status are evaluated simultaneously with the exploration of the other regions. The more specialized cognitive mental status, in which a clinician examines orientation, attention span, memory functions, and general intellect, tends to form a more discrete region that is easily identifiable during an interview.)

- Social history

- Family history

Elicitation of suicidal/homicidal history, ideation, and intent
Past psychiatric history and treatment
Developmental and psychogenetic history
Medical history and review of systems

This brief survey shows that despite the immensity of the database culled in an initial interview, the contents tend to fall into relatively discrete regions. Some of these regions tend to overlap. In general, however, a given section of an interview tends to focus on a single region, much as an everyday conversation tends to focus on a single topic at a time. In the following excerpt the content region concerning drug and alcohol abuse is readily apparent.

Clinician: So right now you haven't been using alcohol?

Patient: No.

Clinician: You talked about using drugs in the past. I'm wondering what kind of things you used then and now.

Patient: Right now I'm only using pot. I don't mess around with anything else.

Clinician: Are you using it everyday?

Patient: Almost every day.

Clinician: How many joints might you have in a day?

Patient: Maybe split two; me and Jack might split two.

Clinician: Uh, huh.

Patient: Because it really does calm me down. It doesn't make you sick like alcohol can make you sick, or give you a bad head the next day. It just relaxes you.

Clinician: Any type of pills you're taking now?

Patient: No.

Clinician: Nothing but the marijuana . . . What kinds of drugs were you using in the past?

Patient: Well, I never got into any one drug real heavy.

Clinician: Uh, huh.

Patient: But I have taken LSD, speed, different goofballs, and stuff . . . but I never injected any drugs like dope.

Expansion of Content Regions

Different trainees may display a broad range of skill in how skillfully and gracefully they can expand a specific content region such as the elicitation of the diagnostic criteria of a major depression or the exploration of a social history.

Speaking broadly, two styles of gathering any given database can be observed, and these styles represent opposing extremes: "stilted expansions" and "blended expansions." (In actuality these styles represent a continuum of skill.) In stilted expansions, the expansion lacks a feeling of conversational flow. Instead, the client is asked a series of questions that seem somewhat forced because the interviewer is rigidly attempting to get specific answers. This type of expansion may cause a client to experience the unpleasant feeling mentioned earlier that he or she is "being interviewed" rather than talking with

someone. To describe stilted expansions more vividly, we sometimes call them a “Meet the Press” type of interview. Rigidly structured interviews sometimes foster this style of expansion, as illustrated here:

Patient: The pressures at home have really reached a crisis point. I’m not certain where it will all lead; I only know I’m feeling the heat.

Clinician: What’s your appetite like?

Patient: I guess it’s okay. . . .

Clinician: What’s your sleep like?

Patient: Not too good. I have a hard time falling asleep. My days are such a blur. I never feel balanced, even when I try to fall asleep. I can’t concentrate enough to even read.

Clinician: What about your sexual drive?

Patient: What do you mean?

Clinician: Have you noticed any changes in how interested you are in sex?

Patient: Maybe a little.

Clinician: In what direction?

Patient: I guess I’m not as interested in sex as I used to be.

Clinician: And what about your energy level? How has it been?

Patient: Fairly uneven. It’s hard to explain; but sometimes I don’t feel like doing anything.

This particular trainee seems doggedly intent on rigidly expanding the depression region, specifically the neurovegetative symptoms of depression. This style of expansion exhibits a mechanical quality, as if the interviewer has a list of questions to reel off. Such rigidity characterizes stilted expansions.

As a contrast, in a blended expansion the interviewer once again focuses on a specific region of data. In this expansion, however, the interviewer attempts to blend the questions into the natural flow of the conversation. Instead of the feeling that they are “being interviewed,” this type of expansion creates in clients a sense of gentle flow that tends to foster the engagement process. Moreover, by decreasing the anxiety of the patient, this type of more naturalistic interviewing may enhance both the quality and validity of the database.

In the following excerpt, a blended expansion unfolds, once again exploring the depression region:

Patient: The pressures at home have really reached a crisis point. I’m not certain where it will all lead; I only know I’m feeling the heat.

Clinician: Sounds like you’ve been going through a lot. How has it affected the way you feel in general?

Patient: I always feel drained. I’m simply tired. Life seems like one giant chore.

Clinician: What about your sleep? Has that been affected as well?

Patient: Absolutely. Perhaps that’s the reason I’m drained. I just can’t rest. My sleep is horrible.

Clinician: Tell me more about it, what it actually feels like.

Patient: I can’t fall asleep. It takes several hours just to get to sleep. I’m wired. I’m wired even in the day. And I’m so agitated I can’t concentrate, even enough to read to put me to sleep.

Clinician: Once you’re asleep, do you stay asleep?

- Patient: Never, I bet I wake up four or five times a night. And about 5:00 AM I'm awake, as if someone slapped me.
- Clinician: How do you mean?
- Patient: It's like an alarm went off, and no matter how hard I try, I can't get back to sleep.
- Clinician: What do you do instead?
- Patient: Worry . . . I'm not kidding . . . My mind fills with all sorts of worthless junk.
- Clinician: That sounds really unpleasant.
- Patient: Yea, it is.
- Clinician: We might be able to help you with that.
- Patient: That would be super.
- Clinician: You mentioned earlier that you were also having problems with concentration. Tell me a little more about that.
- Patient: Just simply can't function like I used to. Dictating letters, reading, writing notes, all those things take much longer than usual. It really disturbs me. My system seems out of whack.
- Clinician: Do you think your appetite has been affected as well?
- Patient: No question. My appetite is way down. Food tastes like paste . . . really very little taste at all. I've even lost weight.
- Clinician: About how much and over how long a time?
- Patient: Oh, about 5 pounds, maybe over a month or two . . .

This section of interviewing explores the same region as the previous interview, but this time the questioning seemed to flow more naturally, generating an increasing flow of information, peppered with moments of empathy and requests by the clinician to hear more about specific symptoms that suggested both interest and caring. The trainee's questions seemed to relate directly to what the patient was saying, thus creating a sense that the trainee was "with" the patient.

A further point to consider concerning the expansion of regions is whether or not, once a supervisee enters a specific content region, the supervisee finishes the entire region before leaving it. Sometimes it is useful to leave regions before completion (a process called a "split-expansion"), and many times it is not. Facilics allows us, as supervisors, to monitor this particularly telling trait of the supervisee objectively and to point out to the trainee whether it was advisable to use a split-expansion with a particular patient at a particular point in the interview.

For instance, while expanding the diagnostic criteria for the generalized anxiety disorder region, the patient may mention the use of diazepam (Valium). At this point, the clinician may choose to expand the medication history, after which he or she can return to the anxiety disorder region to complete its expansion. Sometimes a clinician may choose to split even a single expansion multiple times before finishing it. Although they sometimes are indicated, split-expansions often can lead to serious omissions if the clinician does not keep track of what information has been gathered and subsequently fails to return to seek the needed information.

On occasion, a clinician may expand simultaneously two regions whose contents are similar in nature. For instance, one could expand the anxiety disorder

region and the affective disorder region in a parallel fashion (called a “parallel expansion”), because the symptoms in these disorders frequently overlap. Such parallel expansions are a bit tricky: it is easy to miss important data, because the clinician must keep track of two sets of diagnostic criteria simultaneously. This task is not always easy and almost never is easy for a novice interviewer.

The overriding point remains the clinician’s need to develop an active and conscious awareness of the data flow while simultaneously creating the sensation of a natural flow of conversation. An understanding of *facilics* allows a trainee to do just that. As supervisors we find it useful to remind trainees in an ongoing fashion of the following points regarding expansion of content regions (an example of the second aspect of *facilic* supervision: applying *facilics* to communicate tips for improved structuring):

1. Generally speaking, an effort should be made to achieve blended expansions as opposed to stilted expansions; such blended expansions move with the patient.
2. Techniques such as split-expansions and brief excursions can be useful as long as one remembers to monitor the completeness of his or her database, but they need to be used judiciously. Otherwise, significant errors of omission can occur if the interviewer “gets lost” in the wanderings of the patient and does not return to finish compiling important material in prematurely exited content regions.
3. The interviewer always should attend to engagement on both a verbal and a nonverbal level during the expansion of content regions.

Process Regions

In addition to focusing on content, thereby gathering a prespecified database, interviewers often need to shift focus to the actual process of the interview on a meta-level. For instance, while uncovering a drug and alcohol history, an interviewer may inadvertently offend the client. At that point the interviewer must attend directly to the engagement process by addressing the potential anger of the client. In a broad sense, in *facilic* language, all expansions that are not content expansions (eg, focused primarily on the gathering of a specific database) are called “process expansions.”

Thus classic situations in which one is focusing on the process of the interview (eg, specifically enhancing engagement, addressing resistance and anger, and exploring psychodynamic processes or defense mechanisms) are depicted as process regions. In addition, other regions that do not focus primarily on data gathering but are not directly related to the meta-process of the interview are also still called process regions. Examples of this type of process region are periods of crisis intervention or sections of time devoted to providing psychoeducation. For purposes of illustration, three of the classic process regions are discussed in more detail.

“Free facilitation” process regions

The “free facilitation” process region remains one of the foundations of all interviewing. It is the traditional method of nondirective listening. In it, the

interviewer invests effort in creating an atmosphere that is optimally conducive for the client to feel safe enough to begin sharing his or her problems. The client is able to wander freely to whatever topics he or she chooses, while the interviewer maintains a nondirective attitude. The major interventions of the interviewer are usually facilitating head nods, “uh-huhs,” and simple facilitative statements.

These free facilitation regions can occur at any point in an interview and often are a useful method of enhancing engagement. For instance, during the opening phase of the interview, clinicians frequently use a series of free facilitation regions. Naturally, most content regions have many attributes in common with free facilitation regions; but a free facilitation region differs in the goal of its use, which remains the strengthening of the engagement process. The patient may reveal surprising amounts of useful information during these unstructured facilitation regions, but it is without specific direction by the interviewer.

A brief example may help to clarify when a section of an interview can be labeled as a free facilitation region.

Patient: I don't know what's coming over me. . . I just feel sort of crazy.

Clinician: What do you mean?

Patient: All my thoughts seem to be mixing like a wet rainbow; distinctions are blurred, people distorted . . . [pause] I feel this way when I'm with my mother. She . . . [pause]

Clinician: Go on.

Patient: She always seems so oppressive, so large, like a giant machine always pushing, always pulling. Honestly, I don't know where to go with her.

Clinician: In what sense?

Patient: She wants me to be a success, Lord knows what that means. I think she wants me to be a college professor or some dean of this or that. But she's not interested in what I need, never was. A baby without a bottle, that's what I am . . .

This type of nondirective interviewing frequently helps enhance engagement. It also sometimes brings out responses from patients that may hint at an underlying psychotic process as this excerpt illustrates.

“Transforming resistance” process regions

In a resistance transformation region the interviewer actively attempts to decrease a specific resistance to the engagement process. Such resistance may arise from any number of factors, including the interviewee's fears, expectations, or unconscious processes. The resistance may show itself as an angry comment or perhaps an awkward and personally intrusive question from the client. Without a resolution of these resistances, the validity of the subsequent data and the power of the therapeutic alliance may be jeopardized. In any case, the defining characteristic in a resistance region is the interviewer's conscious attempt to resolve a resistance shown by the patient.

In the following selection we see an interviewer in the midst of a resistance region:

Patient: My boss was really into my work and thinks I may be a little... you know... I don't really think I ought to go on. Do you have a supervisor around?

Clinician: You seem concerned about something.

Patient: Well, I'd just feel a little better if I were talking to someone a little older.

Clinician: What do you think an older clinician would be able to do to help you?

Patient: He'd understand what I'm going through better, that's for damn sure.

Clinician: You know, it's true I'm younger than you and consequently, I haven't experienced the same things, but I can try to gain some understanding of what you're experiencing. You could help by telling me a little more about how people have been pressuring you about your age.

Patient: Well if you must know, it all started with my wife. She left me about 3 years ago for a younger man.

Psychodynamic process regions

In a psychodynamic process region the interviewer asks questions in which the clinician is more interested in how and why the patient responds to the clinician than in the content of the patient's answers. In general, the clinician attempts to answer questions such as the following:

How reflective is the patient?

Does the patient have much insight?

How does the patient respond to interpretive questions?

How good is the patient's observing ego?

Answers to these questions may help determine the suitability of the patient for specific types of time-limited psychotherapy, as well as provide insight into the patient's intellectual development, ego strength, defense mechanisms, self-concept, or genuine readiness to engage in treatments such as substance-abuse counseling. To answer questions in a psychodynamic region, the patient must reflect and offer an opinion.

The following excerpt may clarify when a psychodynamic region is occurring:

Patient: My father always kept a strangle hold on me. He wanted to know my every move. God pity the boy who wanted to take me out. It was like a Gestapo interview for the guy.

Clinician: What kind of impact do you think your father's behavior has had on you?

Patient: He's made me scared. I'm afraid of him, and who knows, maybe I keep my distance from him because of it... Sort of strange, because when I was a kid I always wanted to be around him. I even would wait for him when he was at work.

Clinician: Go on.

Patient: Oh, it's sort of silly, but I wondered if he had a toy or something for me... I remember a small doll he brought home once, with big black eyes. Just a little doll, but important to me.

Clinician: Go on.

Patient: Not too much more to say, except that it's sort of sad the way things have turned out between us.

Clinician: What are you feeling as you talk about your father right now?

Here, content is clearly taking a second place to process. The client's responses suggest a willingness and a certain degree of proficiency at self-exploration. This type of region can occur anywhere in an interview, often appearing between content regions.

The Scouting Region: A Unique Combination of Content and Process

Now that we have a good understanding of the differences between content regions and process regions, it is a good time to look at an outlier—the scouting phase. It is a stage of a clinical interview ripe with potential for both problems and opportunities. The facilic term “scouting phase” is used to describe the opening 7 minutes or so of an interview, in which the interviewer introduces himself or herself and proceeds with the opening phase of the interview. There is a premium on free facilitation regions and the engagement process itself. Open-ended questions and an empathic statement or two are classic foundation blocks of the scouting phase. On the other hand, as much as the scouting phase emphasizes the use of process regions, invariably much valuable data will be forthcoming from the client. The clinician does little to structure this data; nevertheless, clients often spontaneously share critical aspects of the database early in the interview. Thus the scouting phase is a unique type of region: it is both a process region and a content region at once, with a relatively equal emphasis on process and data gathering.

Gates: The Pathways of Transition

As a conversation or an interview passes from one topic to another, different types of transitions occur. In facilic supervision, we refer to the actual statements joining two regions as “gates.” Although numerous types of gates exist, five major forms are the most common: (1) the spontaneous gate, (2) the natural gate, (3) the referred gate, (4) the implied gate, and (5) the phantom gate. An understanding of the use of these gates gives trainees a simple but elegant method of gracefully maneuvering an interview.

The trainee's habitual use of gates—and they generally are used out of habit—may well be the single most powerful indication of how conversational or awkward a trainee's interviews will feel to patients. Helping trainees identify their own gating and subsequently helping them master ways of using the other types of gates flexibly (because all types of gates have their advantages and disadvantages) is, in our opinion, one of the greatest gifts we can give a trainee. Such self-knowledge and the resulting flexibility in style it provides are frequently the difference between a trainee who would have gone on to a career of “Meet-the-Press” interviews and one who has a career of powerfully engaging clinical interactions. Let's take a look at each of the gates and how they manifest in actual interviews.

Spontaneous gates

The spontaneous gate, as its name suggests, unfolds without any effort by the interviewer. Instead, the gate results from a change in topic unilaterally taken by the patient. These gates occur when the patient spontaneously moves into a new region (called a “pivot point”), and the clinician proceeds to ask a follow-up question in this new region. The patient does the shifting here. The clinician merely follows, sometimes with phrases as simple as “Tell me more about that,” or “How do you mean?” In the following example, a spontaneous gate provides an essentially imperceptible movement out of an expansion of depressive symptoms and into a new content region. See if you can spot it.

Patient: The past 2 months have been so horrible. I think it’s the worst time of my life. I just can’t get away from the feeling.

Clinician: What feeling are you referring to?

Patient: The sadness; the heaviness.

Clinician: What else have you noticed when you’re feeling sad and heavy?

Patient: Nothing seems worth doing. It’s late November and my yard is covered with leaves. Usually they’d all be gone into neat little piles, like a little farm, but not now . . .

Clinician: Besides not having energy for chores, do you find you can still enjoy your bridge club or other hobbies?

Patient: Not really. Things seem so bland. I haven’t even gone to bridge club for several months. It is all so different from before. In fact, there were times in the past when I could barely keep still, I was so active. I was a super dynamo.

Clinician: How do you mean?

Patient: Oh, I used to be incredibly active, into bridge, tennis, golf, and everything. It was hard to find people who could keep up with me.

Clinician: Did you ever move too fast?

Patient: In what sense?

Clinician: Oh, sometimes one can get so energized that it gets difficult to get things done.

Patient: Actually, there were a couple of odd times when people kept telling me to “slow down, slow down.”

Clinician: Tell me a little more about one of those times.

Patient: About a year ago I got so wound up I hardly slept for almost a week. I’d stay up most of the night cleaning the house, washing the car, and writing furiously. I didn’t seem to need sleep.

Clinician: Did you notice if your thoughts seemed to be speeded up then?

Patient: Speeded up. I was flying. Everything seemed crystal clear and moved like lightening. It was strange . . .

In this example, two content regions are discussed sequentially. In the first region, the interviewee’s *DSM-IV-TR* symptoms of depression are being explored. In the course of this exploration, the interviewee brings up a statement that enters a different diagnostic region dealing with mania. The transition statement was, “In fact, there were times in the past when I could barely keep still, I was so active. I was a super dynamo.”

The interviewer then followed this movement into a region exploring manic symptoms by simply asking, “How do you mean?” Once within the diagnostic region of a mania, a blended expansion was begun. This movement into a new topic was practically imperceptible.

Spontaneous gates create movement that seems unblemished by effort or resistance. In this sense, a clever interviewer frequently will make use of such gates whenever transitions into new regions are desirable. But herein lies a potential pitfall, mentioned earlier when discussing split-expansions: frequently it is not desirable to leave a region before it is fully expanded.

In this light, pivot points represent critical areas in which the interviewer should decide consciously whether to redirect the patient gently back into the current expansion and complete it or move with the patient into the new region the patient just entered. If the clinician can become aware of such pivot points, he or she will gain considerable control over the flow of questioning. One does not and should not follow every pivot point with a follow-up question into a new region. Once within the body of the interview, if a patient needlessly wanders out of a content region, it is often best to gently bring them back to finish gathering any missing important information from the region. Such gentle structuring can significantly decrease errors of omission.

Indeed, the concepts of spontaneous gates and pivot points provides us with a way of conceptualizing wandering interviews in which little information of importance is uncovered. These interviews occur when the clinician follows pivot points whenever they appear, resulting in a consistent pattern of incomplete split-expansions with a subsequently weak database.

At times a clinician may decide wisely to follow a pivot point into a spontaneous gate even in the middle of an incomplete expansion. Such situations include the following: (1) the patient may have unexpectedly related emotionally charged material that needs to be ventilated; (2) the patient may have spontaneously mentioned sensitive material that may best be approached immediately, such as suicidal ideation or incest; and (3) specific memories, such as screen memories, dreams, or traumatic events, may warrant immediate follow-up.

With the use of *facilics*, supervisors can point out the appropriate and inappropriate instances of following pivot points into new regions through spontaneous gates. Indeed, helping trainees become routinely aware of pivot points as they arise in interviews—providing them a chance to decide consciously whether to leave a region or gently refocus a wandering patient back into a region—can be the key in helping trainees to structure interviews effectively and sensitively.

It can be a revelation to trainees to learn experientially that clinicians can exercise significant choice as to the structural pattern any given interview will take as long as the clinician recognizes the pivot points and purposefully decides whether or not to follow them into new topics through the use of a follow-up question (a spontaneous gate). By understanding *facilics*, a trainee can learn first-hand that interviewers are not merely at the whim of a client’s

wanderings. Sensitively structured interviews do not just happen—they are created.

Natural gates

The natural gate consists of two parts: the cue statements and the transitional question. The cue statements represent the last one or two sentences (usually the last one) made by the interviewee that may contain content material that the interviewer can relate creatively to a new region. If the interviewer takes cues from these statements to enter a new region, the interviewee will feel that the conversation is flowing from his or her own speech, as indeed it is. Such a transition seems both natural and caring to the interviewee.

The transitional question represents the actual question asked by the interviewer that creates a bridge from the cue statement into the new region. As distinguished from the spontaneous gate, the clinician, not the patient, is moving the conversation into a new region.

In the following excerpt we see a transition from the region covering depressive symptoms into the drug and alcohol region. This smooth transformation is made through a natural gate.

Clinician: Have you been able to enjoy your poker games or your shop work?

Patient: No, I just don't feel like doing anything since I've been feeling depressed. It's a really ugly feeling.

Clinician: Tell me more about what it feels like.

Patient: Really pretty miserable. Life doesn't seem the same. I'm tired all the time; no sleep.

Clinician: How do you mean?

Patient: Over the past several months sleep has almost become a chore. I'm always having trouble getting to sleep, and then I wake up all night. I must wake up five times and it took me 2 hours to fall asleep in the first place.

*Clinician: Have you ever used anything like a nightcap to sort of knock yourself out?

Patient: Yeah, sometimes a drink or two really relaxes me.

Clinician: How much do you need to drink to make yourself sleepy?

Patient: Oh, not too terribly much. Maybe a couple of beers. Sometimes more than a couple of beers.

Clinician: Just, in general, how many drinks do you have in a given day?

Patient: Probably...Now, I'm just guessing, but probably a six-pack or two, maybe three. I hold liquor pretty well. I don't get plastered or nothing.

Clinician: What other kinds of drugs do you like to take to relax?

Patient: Well, I might smoke a joint here or there.

In this excerpt, the cue statement was, "I must wake up five times and it took me 2 hours to fall asleep in the first place." Note that the patient's cue statement is still within the region of depression. But the clinician, wanting to change content regions, sensed that this statement could be used as a springboard into a new topic. The succeeding transition question (indicated by an asterisk)

smoothly achieved this desired transition into the drug and alcohol region with the phrase, “Have you ever used anything like a nightcap to sort of knock yourself out?”

From the perspective of the second aspect of facilic supervision—applying facilics to communicate tips for improved structuring—transitions of this sort are seldom perceived as focusing mechanisms, because the patient generally feels as if he or she brought up the new topic. This type of smooth transition can greatly enhance a conversational feeling in the interview, slowly bringing the patient into a more powerful sense of safety and spontaneity. The interview begins to take on a self-perpetuating momentum, unique to its own nature.

Fig. 1 demonstrates the immense power of the natural gate. We shall assume that the expansion of the stressor region has been winding down. The patient then provides a cue statement that the clinician can use to enter one of any number of new content regions as illustrated. The flexibility of the natural gate is limited only by the awareness and creativity of the clinician.

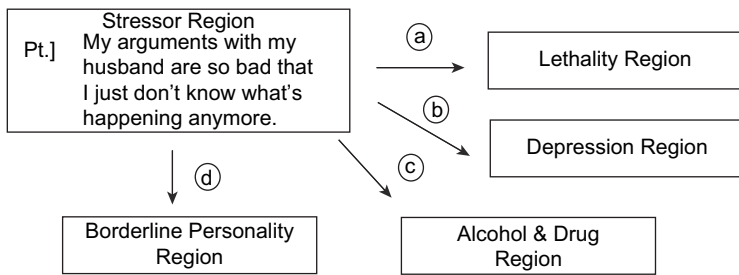


Fig. 1. Natural gates utilized as smooth transitions. Transition questions: (a) With all these tensions mounting, have you had any thoughts of wanting to kill yourself? (b) How have all these stresses affected your mood? (c) With all these stresses, have you been drinking at all in an effort to calm yourself? (d) Some people hold all their anger in and others really let it out, maybe even throwing things like glasses or plates. How do you handle your anger? (From Shea SC. *Psychiatric Interviewing: The Art of Understanding*, 2nd edition. Philadelphia: WB Saunders Co., 1998; with permission.)

Referred gates

A referred gate occurs when the interviewer enters a new region by referring back to an earlier statement made by the interviewee. Typical referred gates begin with phrases such as, “Earlier you had said ...” or “I want to hear more about something you mentioned before ...” To the interviewee, a referred gate metacommunicates, “I have been listening very carefully to you; moreover I want to learn more about something you said to see if I can help.” It is a wonderful example of a structuring tool that is also an engagement technique. It allows the interviewer to enter a fresh region smoothly at almost any place in an interview. It also is extremely useful for re-entering a region that was not completely expanded earlier. Structurally, a referred gate lacks an adjacent cue statement, because the cue has been taken from an earlier segment of the interview.

In the following illustration we enter the interview at the end of a psychodynamic process region in which the patient's feelings about his siblings have been explored. As this process region winds down, the interviewer, by referring to something said earlier in the interview (but not shown in this transcript) enters the content region dealing with psychotic phenomena by using a referred gate.

Clinician: What was it like for you when your brother would come home from college?

Patient: Sort of odd; a little bit like a trespass. You see, when he was gone I had the room all to myself, even the phone was mine alone. As soon as he came back, boom, the room was his again.

Clinician: What other feelings did you have?

Patient: Some excitement. I really did look up to him, and when he'd come home he'd tell me all about college, frat parties, smoking grass; and it was exciting.

*Clinician: Earlier you had told me that sometimes when you were alone you'd have scary thoughts. Tell me a little more about those moments.

Patient: Okay. It's sort of like this. I might be sitting late at night listening to some music and things seem sort of weird, almost like something bad is going to happen. And then I have thoughts that keep coming at me and they tell me to do things.

Clinician: Do the thoughts ever get so intense they sound almost like a voice?

Patient: They are voices. They seem very real. In fact, sometimes I try to cover my ears. I just don't know. I don't know...

Referred gates, such as the one indicated by the asterisk in this dialogue, are unobtrusively powerful. They can be used to enter new regions essentially at will and to re-enter incompletely expanded regions. Clinicians can use referred gates to enter potentially disengaging regions (eg, the cognitive mental status) gracefully.

While asking questions about orientation and checking digit spans or serial sevens, novice clinicians frequently worry that patients will feel insulted by the simplistic nature of the questions. To this end, they may use phrases such as, "I'm going to ask you some silly questions now, I hope you don't mind," or "Now I have to ask you some routine questions that I have to ask everybody." These phrases usually are accompanied by an apologetic tone of voice or an insecure rustling of the clinician in his or her chair.

The irony of such introductions lies in the fact that, rather than dispelling anxiety in the patient, they sometimes create it. The patient senses that the clinician feels insecure with the subsequent questioning. All that remains for the patient to wonder is why the clinician needs to apologize. What do these routine questions mean, and why does a professional ask questions if they are silly? In short, the clinician's sudden obsequiousness signals to the patient that something odd is afoot.

Here one of the many uses of the referred gate becomes apparent. By referring to earlier statements by the patient concerning problems with

concentration or thinking, the interviewer can enter the cognitive examination smoothly and without a need to apologize. Quite to the contrary, the interviewer's interest indicates a sincere concern to the patient as well as a display of professional expertise. The use of the referred gate metacommunicates to the patient that these questions are being asked for a specific reason—to clarify collaboratively the degree of cognitive impairment, a point of interest to both the clinician and the patient. Let us take a look at such an approach in action. The patient is suffering from an agitated depression and had complained earlier in the interview of “problems concentrating”:

Patient: Overall, I know it's all my fault. I should never have retired, it's ruined everything. But life goes on. I only hope I feel better some day.

Clinician: What do you see for yourself in the future?

Patient: Hopefully, some pretty good stuff. I've always wanted to travel and my wife is interested in doing so as well, so, I think we will probably do a little traveling. And, I also used to paint a little bit, maybe I'll do a little of that too.

Clinician: That sounds pretty neat. I hope it works out for you.

Patient: Yeah, me too.

Clinician: You know, a little earlier, you had mentioned that one thing that was bothering you was your lack of concentration and some problems with memory. I have some questions that would give us both a clearer idea exactly how much your concentration and thinking have been affected by your depression. Some of the questions will be very simple, while some of them may get fairly challenging. Why don't we start with some of the simple ones first?

Patient: Sure.

Clinician: What day of the week is this?

Patient: I think it's Wednesday.

Clinician: That's correct. What city is this?

Patient: Pittsburgh.

This interview dyad has gracefully moved into the cognitive mental status examination with a sense of purpose and no hint of uneasiness on the part of the clinician.

Phantom gates

A phantom gate seems to come from nowhere. It lacks a cue statement and also lacks previous referential points, unlike referred or natural gates. In short, it jolts the spontaneous flow, as the following example shows:

Patient: I haven't felt the same for months. I'm always down and I'm sick of it.

Clinician: What does it feel like to be down?

Patient: Very unsettling. I'm like a slab. I don't want to do anything. I miss doing things with my best friend, silly as that may sound. I really haven't been the same since she died.

*Clinician: Was your father an alcoholic?

Patient: No . . . [pause] I don't think he was. He drank every once in a while.

Clinician: What about your brothers, sisters or blood relatives? Have any of them had drinking problems?

Patient: Not that I know of.

Clinician: What about depression? Have any of your relatives been depressed?

This interviewer's sudden leap into the family history region certainly seemed abrupt and ill timed. Obviously, if such phantom gates (indicated by the asterisk) occur frequently throughout an interview, engagement can be seriously hampered. Even in milder forms, they can quickly produce the "Meet the Press" feeling discussed earlier, especially if accompanied by stilted expansions. They often pop up toward the end of interviews, when interviewers suddenly realize there are several things they forgot to ask, and they are running out of time. If indeed important regions have been incompletely expanded, a supervisor can point out that a referred gate, rather than a phantom gate, usually can be used without substantially interrupting the flow of the interview.

In the meantime, a phantom gate placed here and there probably will not cause much of a problem, especially if the engagement seems to be high, and the content of the question is not sensitive in nature. In general, however, one should avoid phantom gates, because it seems senseless to risk damaging the flow of the interview.

Implied gates

To complete our summary of transitions used during the body of the interview, we turn our attention to implied gates. Implied gates are structurally similar to phantom gates: they do not cue off the patient's immediately preceding statements; they do not refer back to earlier statements; and the clinician, not the client, initiates the movement into the new topic. There is one important difference between an implied gate and a phantom gate: the implied gate enters a region that is topically similar to the previous region.

Put slightly differently, in an implied gate, the movement into a new region is characterized by asking a question that seems to be generally related to the region already under expansion. Thus, it is somewhat "implied" that the interviewer is simply expanding a topic already germane to the interviewee. Consequently, implied gates tend to be much less disruptive to flow than phantom gates.

In the following example, movement is made from the region dealing with immediate stressors into past social history. The transition (indicated by an asterisk) seems relatively smooth, an effect that is secondary to the similarity in content between these two regions.

Patient: We're living in a fairly nice house now. It has three bedrooms and a couple of acres. Believe me, we need the space with our four kids.

Clinician: How are the kids getting along?

Patient: The two oldest, Sharon and Jim, get along pretty well, on different tracks. They stay out of each other's way. But the two little ones—oh my! They live to torture each other . . . Pulling each other's hair, yelling, screaming. It's a zoo.

Clinician: I'm wondering if, with all those mouths to feed, money is a problem?

Patient: In some respects, yes; but my husband is a lawyer and is doing well. In fact, if anything, our income has increased recently.

*Clinician: Tell me a little bit about what it was like for you when you grew up back in Arkansas.

Patient: First of all, I came from a large family of eight children. So we sometimes, many times, had to do without. I remember all the hand-me-downs, and, believe me, I appreciated them. My mother was a loving woman, but beaten down by life. She was tough, but her pain showed through.

Clinician: Do you remember a specific time when her pain showed through?

Patient: Oh, yes. I was about 5, I think, and . . .

For purposes of review, keep in mind that, unlike a natural gate, an implied gate does not cue directly off the preceding statement. Furthermore, unlike a referred gate, the interviewer does not directly refer back to earlier statements. And, in contrast to the phantom gate, the implied gate seems to fit in fairly naturally with the current flow of the dialog. Indeed, when the newly entered region appears very similar to the preceding one, an implied gate is practically imperceptible and rivals a natural gate for smoothness of transition.

As the regions connected by the gate increase in disparity, the implied gate becomes progressively more abrupt. Thus, with regard to smoothness, implied gates range on a continuum between natural gates and phantom gates. When the two regions are closely related, implied gates approach the gracefulness of natural gates. On the other hand, if the topics are poorly related, an implied gate may approach the awkwardness of a phantom gate.

At this junction, we have completed our introduction to the core terminology of *facilics*. *Facilics* provides a simple language with which to follow the complex structuring techniques of both interviewers and those they supervise. Once a clinician understands the principles of *facilics*, the interview can be developed and altered almost at the whim of the interviewer. These tricks of the trade can increase the engagement with the patient, the effectiveness of the data gathering, and ultimately the validity of the database itself.

Initiated by the conscious decisions of the interviewer, the clinical dialogue can unfold in a more graceful and effective manner. With each unfolding, the initial resistance of the interviewee gradually recedes, because the interviewer, instead of opposing this resistance, moves with it. Using natural gates and blended expansions, the trainee can create interviews that move with the gentle dynamics of a collaborative conversation. The patient feels more relaxed, defenses drop, and the interviewer discovers a rich field of pertinent information opening before him.

Once familiar with the basic *facilic* terminology, a supervisor can map out an entire interview from front to back. We have not found any structural situations that cannot be mapped using this system. (There are a few *facilic* anomalies, such as “introduced gates,” in which the clinician literally states, “I’d like to spend some time asking about . . .,” and “observed gates,” in which the clinician makes note of a client’s nonverbal communication, as with, “It looks like you are starting to well up,” for which there is not space for a thorough discussion in this article). Armed with this introduction, you are ready to use the system. There is only one more critical aspect of *facilics* that you need to

know before beginning: the facilic shorthand. Let's take a look at it. It is delightfully straightforward.

AN INTRODUCTION TO THE FACILIC SCHEMATIC SYSTEM: A SHORTHAND FOR SUPERVISORS

Facilic schematics allow a supervisor to make a permanent record of the supervisee's interview quickly and provide a concrete, visual springboard for immediate feedback. The flow of the trainee's interview can be captured graphically in a way that brings the interview to life for the trainee while presenting an easily understood map of the trainee's explorations of major topics and the transitions used to connect them. This system of "shorthand" can be used in direct supervision, class discussion, and videotape supervision.

The idea for the system originated from a most unlikely source. One hot summer day I was perusing a book on modern dance. To my surprise, when I came upon the Appendix, I found several "dance notation" systems created by various choreographers to capture on paper the flows of their dances. Thus, a dance created at a summer festival, once notated, could be resurrected by an entirely new group of dancers a decade later.

If the complicated movements of a modern dance could be encoded simply, surely the structural movements of an interview could be represented as well. Facilic schematics were born.

Subsequently, these facilic schematics have become one of the most popular aspects of the facilic system, and some would say they are key to its practical application in supervision. We certainly have found them to be invaluable in training.

Two complementary systems are available. In a longitudinal facilic "map," the interview and its transitions are followed from start to finish chronologically. This technique is the backbone of the system, providing a detailed but easily followed description of the trainee's expansions, gates, and flow. We make a longitudinal map for our trainees whenever we have an opportunity to view their interviews directly, whether within the interview room, behind a one-way mirror, or by videotape.

The second system is called a "cross-sectional map," a fancy name for a simple pie diagram, which depicts the interview as being divided into four quarters of time. These cross-sectional maps do not track the specific structural techniques of the trainee but do allow a graphic look at how the trainee managed time, providing a powerful complementary tool to the fundamental longitudinal facilic map.

Making a Longitudinal Facilic Map: Tricks of the Trade

Before beginning our description of facilic schematics, we should mention that, on rare occasions, a student may misconstrue the purpose of the system, thinking that the schematics are a graphic system drawn by the interviewer during the interview to track the information he or she has gathered. Remind your student that facilic symbols are not intended to be made by the interviewer: they

are a shorthand for the supervisor, who later will share the map with the student after the interview.

The first convention is that a content region is shown as a rectangle, with the abbreviated name for the region within it. Thus, as you follow the flow of the interview, if the trainee is exploring the *DSM-IV-TR* diagnosis of major depression, you simply jot down a rectangle with “Maj. Dep.” written inside it.

The degree of thoroughness in expanding any given content region is depicted by slash marks at the corners of the rectangle. One slashed corner represents that the trainee explored 25% of the needed information, two slashed corners represent 50%, three slashed corners represent 75%, and four slashed corners represent a completely expanded region. Thus, if the trainee leaves the region of major depression prematurely with 50% of the criteria not explored, this split-expansion is noted simply by making a single slash mark at any two corners of the rectangle as soon as the dyad leaves the area. This notation immediately tells the supervisor that the resident needs to return to this region at some point later in the interview to finish the expansion to avoid errors of omission.

You always makes these slashes depending on the database you, as a supervisor, think should be covered within the specific region. The completeness is determined by the task at hand. Keep in mind that the requisite data for the task at hand can vary depending on the setting and type of interview being done by your trainee, even though the content region is the same.

For example, in a classic initial 50-minute interview, when expanding the region related to major depression, it would be expected that most of the criteria for a major depression would be covered. If the interviewer touches on all these criteria, the supervisor would mark the rectangle with four slashes representing 100% completion of the task at hand.

In a busy emergency room, in which the entire interview might only be 20 minutes, it would be inappropriate for the clinician to cover all these criteria. Instead, criteria for several major depressive symptoms (with a close look at suicidal ideation) would be covered, with a special emphasis upon the severity of the symptoms, because it is the symptoms' severity that may best help the emergency room clinician make a safe triage for the patient (outpatient versus inpatient).

When supervising an emergency room interview, if the trainee covered only a handful of the symptoms of a major depression but carefully explored their severity and the client's extent of suicidal ideation, once the trainee left the region of major depression the supervisor would make four slashes, indicating that all the appropriate data points had been covered for the task at hand (an emergency room assessment) . Indeed, if in that hectic emergency room, the clinician carefully covered all the criteria for major depression (thus losing precious time on data that will not help with the triage of the patient), the supervisor would make a fifth and possibly sixth slash on the rectangle indicating that too much information was gathered for the task at hand. The resident must learn to be more flexible in making data-gathering decisions.

As you follow split-expansions, when the dyad re-enters the expansion you simply draw a rectangle again, with the appropriate topic abbreviated inside, and immediately mark the same number of slashes as it already had, because, obviously, that amount of data has already been covered. Once the dyad leaves the region, the supervisor adds slashes as deemed appropriate for any new information that has been covered.

You can see that if a trainee has a tendency to expand regions incompletely, resulting in numerous errors of omission at the end of his or her interviews, this problematic tendency will be displayed clearly in the facili maps by a bevy of incomplete expansions. The power of the facili map to highlight the problem visually helps residents see the extent of the problem more readily and, ideally, be motivated to change it.

Process areas (such as psychodynamic inquiries and areas in which resistance is transformed) are represented by circles. Once again the correct title of the process region is abbreviated within the circle as with “Dynam.” or “Resist.”

The scouting phase is indicated by the combination of a rectangle and a circle (eg, a rectangle with a half circle on each end as shown in the illustrative facili map) (Fig. 3).

All gates are depicted as shown below in Fig. 2 and are placed between two successive content or process regions to form a continuous map of linked figures that accurately represent the flow of the interview:

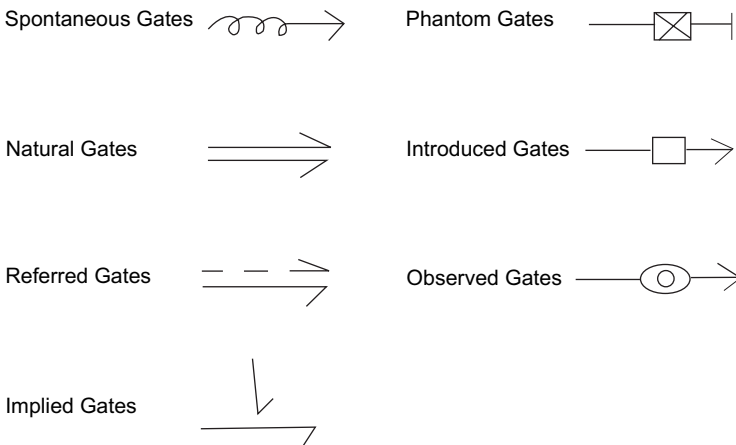


Fig. 2. Transitional gates. (From Shea SC. *Psychiatric Interviewing: The Art of Understanding*, 2nd edition. Philadelphia: WB Saunders Co., 1998; with permission.)

The entire interview and its flow can be captured permanently using this small set of symbols. In contrast to writing several sentences to capture the complexities of a single transition by a trainee, the facili shorthand allows the supervisor to minimize the amount of time spent making supervision notes and focus more attention on the interview itself.

We think that, with some practice, you will be pleasantly impressed with the degree of complex information about the trainee's structuring style that can be captured quickly.

With videotape facilic supervision, the supervisor first watches the tape alone and subsequently reviews it with the trainee. When first watching the tape, the supervisor uses the facilic schematic system to note the flow of the interview while adding comments about any other technical aspects of the interview, such as engagement techniques and psychodynamic concerns. The duration of the interview in minutes and the videotape counter number (if available) are noted periodically. This ability to identify sections of the videotape that represent particularly important teaching points allows the supervisor to turn to them quickly during the supervision itself, maximizing the quality of the supervision hour. The system also provides a permanent outline of the trainee's interview that can be referenced in future sessions of supervision by both the supervisor and the trainee. An example of part of a longitudinal analysis of an actual trainee's interview is shown in Fig. 3.

The asterisks represent areas of videotape that it may be useful to view with the trainee. This clinician tends to overuse abrupt transitions (as evidenced by many phantom gates) and to leave content regions prematurely (as evidenced by many split- and never-completed expansions). These errors may weaken the thoroughness of the database needed in this particular style of intake assessment, in which a complex triage was to be determined and a full diagnostic evaluation was requested. Numerous positive comments highlighting the skills of the clinician also were made in the actual supervision.

The facilic map merely provides a framework for discussion. In fact, as illustrated in Fig. 3, another advantage of the system is that it provides an easily accessible visual record that helps the supervisor remember points of interest related to all aspects of the interview (not just points related to structuring), including nonverbal communication, psychodynamic considerations, and methods of handling resistance.

To annotate points in the interview that the supervisor intends to comment on later or to describe the exact wording of the interviewer's gates, a circled letter of the alphabet is placed on the facilic map with the accompanying supervision point listed below the map as shown in Fig. 3. The supervision itself is characterized by spontaneity, humor, and discussions of both dynamic and personal feelings related to the interview. The trainee also may request that certain areas of the tape be viewed in case the trainee had questions about areas of the interview the supervisor did not highlight.

The second type of facilic map, a cross-sectional schematic, provides an illuminating view of the actual use of time in the interview. Thirty minutes of a cross-sectional analysis are shown in Fig. 4.

Facilic maps, whether longitudinal or cross-sectional, help make interviewing skills that at first glance often appear nebulous and confusing to a young trainee more real and manageable. We have found that the behavioral specificity of the

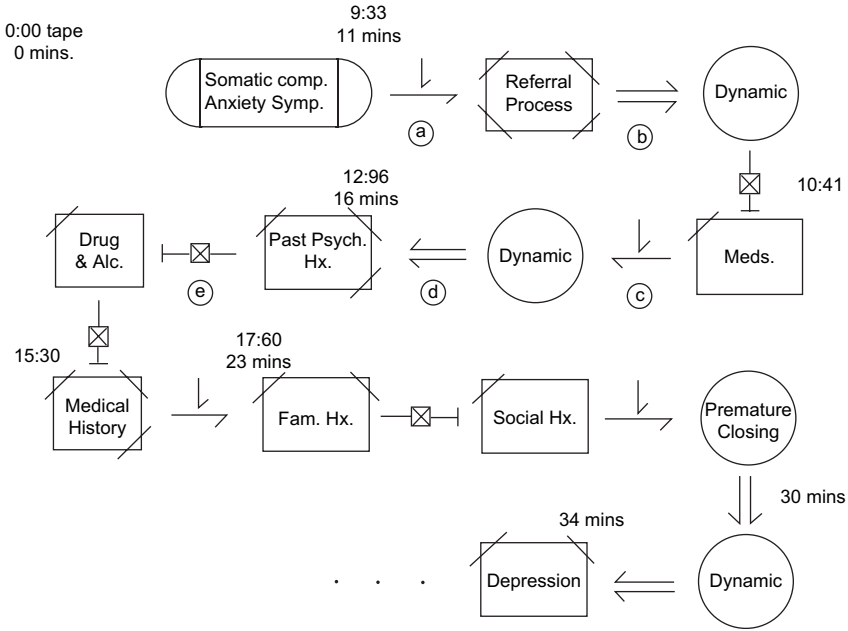


Fig. 3. Counter settings.

I. Transitions (gates)

- What made you come to our clinic today?
- What were some of your feelings about coming here today?
- What role do you think your actions play in some of these problems?
- Have you ever seen a psychiatrist before?
- Are you a problem drinker?

II. Teaching points

- Scouting phase is appropriately unstructured and free-floating but is too long
- Too much detail and time spent in the referral process region
- Good psychodynamic questioning.
- Decrease use of phantom gates (ask clinician what he was feeling at this point of the interview)
- Explore use of chronology as a reference framework
- Good use of empathy: "Sounds like the world was caving in on you back then"
- Use behavioral incidents when delineating the drug and alcohol history. I think this patient was providing invalid information. (Also comment on note taking—too much.)
- Here's a series of type A validity errors including multiple questions and negative questions

(From Shea SC. *Psychiatric Interviewing: The Art of Understanding*, 2nd edition. Philadelphia: WB Saunders Co., 1998; with permission.)

system enhances the likelihood that tangible and enduring changes in interviewing technique will result from supervision. These tangible changes, once perceived by the trainee, often trigger a renewed fascination and respect for the art of interviewing itself.

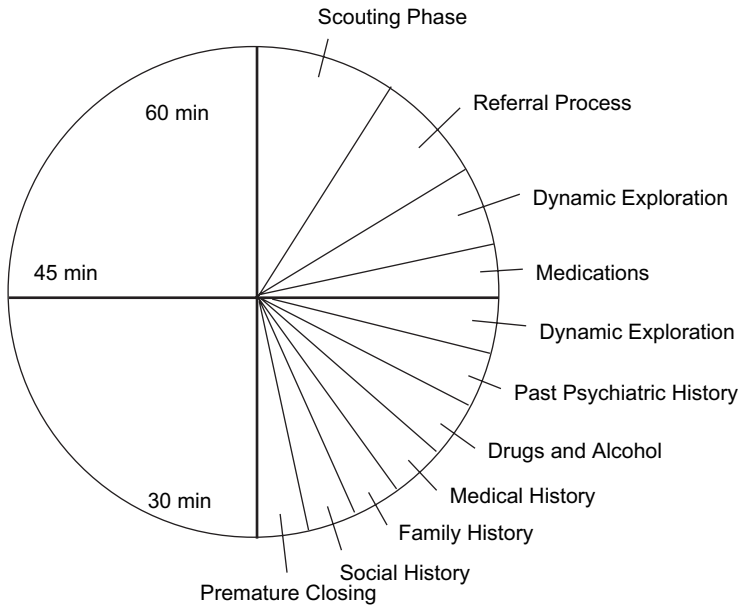


Fig. 4. Cross-sectional schematic. (From Shea SC. *Psychiatric Interviewing: The Art of Understanding*, 2nd edition. Philadelphia: WB Saunders Co., 1998; with permission.)

IMPORTANT NOTE: At this point, we recommend pausing from the body of this article and turning to the Appendix. There we have provided a programmed text that gives the reader a chance to practice using faciliic schematics. This exercise will expand and consolidate your understanding of faciliic schematics in a way that we hope is both fun and efficient. After completing the programmed text in the Appendix (which requires about 40 minutes), you will have a significantly better, hands-on understanding of the principles of faciliic supervision and the use of the faciliic shorthand. **PLEASE COMPLETE THE PROGRAMMED TEXT IN THE APPENDIX OF THIS MONOGRAPH BEFORE PROCEEDING.**

TIPS AND STRATEGIES FOR USING FACILIC SUPERVISION MORE EFFECTIVELY

In closing our introduction to faciliic supervision, we want to comment on a few tricks of the trade that we have found useful over the years. These tips include:

1. Preparing the trainee to use the system effectively
2. Using past faciliic maps to re-enforce progress
3. Variations on making longitudinal faciliic maps
4. Common structuring errors made by trainees
5. Combining faciliic supervision with role-playing and other educational tools

6. Using the presence of phantom gates to spot emotional or countertransferential responses in trainees
7. Using faciliic schematics in a classroom setting

Preparing the Trainee to Use the System Effectively

To help prepare the trainee to use the system, we begin by having the trainee read the chapter from *Psychiatric Interviewing: the Art of Understanding* [6] mentioned earlier in this article. We recommend providing a brief, informal didactic presentation on the topic as well. After the reading of the chapter and the didactic follow-up, we strongly recommend providing the trainee with the self-programmed text provided in the Appendix of this article. We have used this programmed text with residents regularly, and it is well received.

In addition to being read by a single resident, the programmed text can be done together as a group as part of your didactic presentation on faciliics. In a group setting a selected resident draws his or her answer on a whiteboard followed by a group discussion as to its correctness. By the end of a single session, we have been pleasantly surprised how well the residents know the system, allowing its rapid use in individual mentoring.

We also recommend that, before using faciliics in supervision, you ask the student to draw the symbols for the different gates while you watch. If the student cannot draw the symbols, the student does not really know the system and will not get much out of the supervision (but the student probably will pretend to follow what you are saying). By informally testing the student's understanding of the system before using it, you can spot foggy areas of understanding and provide immediate education to clarify the system.

Using Past Faciliic Maps to Re-enforce Progress

We want to emphasize the usefulness of keeping a file with all of the faciliic maps generated during the course of longitudinal supervision. An occasional review of this file by the supervisor can significantly increase the objective tracking of progress, jar the supervisor's memory of interviewing techniques that were going to be addressed but may have gotten "lost in the shuffle," and suggest moments when past files can be shared productively with the trainee to show the trainee areas of improvement in a graphically concrete fashion.

By way of illustration, let us picture a trainee who, at the beginning of the year, frequently follows wandering patients, leaving content regions prematurely, with the result that there routinely are major gaps in the trainee's database at the end of the interview. As mentioned earlier, this problem would be strikingly apparent in the faciliic maps of these interviews (incomplete split-expansions throughout the map). Now let us picture that, as the year proceeds, the trainee makes significant progress in correcting this problem.

In such situations, by pulling out past faciliic maps the supervisor can provide immediate, visual, and compelling positive feedback with comments such as, "Mary, just look at your earlier interviews where you were often missing important information. Split-expansions all over the place. Now take a look

at the interview you just did. Fantastic! Every single region was explored fully. Four slashes everywhere! You can really feel good. You have made excellent progress in your ability to gather a comprehensive and useful database sensitively, and it is your patients who will benefit.”

Variations on Making Longitudinal Facilic Maps

The facilic mapping system can be used any way you see fit. We invite flexibility. Facilic schematics are a tool to be fashioned as you choose.

For instance, when making a longitudinal facilic map, we prefer making the map as described earlier, in which the facilic map is placed at the top of the first page, and annotations are placed below the map.

One of our colleagues prefers a different approach. He marks out a column on the left-hand side of his supervision notes page. As the interview proceeds, he follows the facilics by writing schematics down the column (not across the page). As he goes down the column, he usually has room to mark one gate and the region into which it led per line. Directly to the right of these facilic schematics, he makes all of his notations, annotating the interview as it proceeds. Such a system has advantages and disadvantages. You can experiment and see which style of placement of the facilic maps works best for you or best for your trainee.

Common Structuring Errors Made by Trainees

Certain errors in structuring that we find to be particularly common with residents are the focus of the fourth tip. Sometimes, such as when we are reviewing a videotape and tracking its facilics, we have found it useful to have a list of these “errors to be on the look-out for.” We thought you might find the list useful. Feel free to add other common errors to it.

1. Scouting phase errors
 - a. Scouting phase is too short—trainee is structuring prematurely before engagement is secured.
 - b. Scouting phase is too long—a very common error in which the trainee lets the patient ramble on far too long before beginning to structure effectively. We have seen scouting phases go on for 30 minutes!.
2. Expansion errors
 - a. Trainee uses stilted expansions.
 - b. Trainee uses too many split-expansions and does not return to gather important information.
3. Gating errors
 - a. Trainee does not recognize pivot points and therefore does not take an active part in structuring the interview.
 - b. Trainee uses too many phantom gates (the “Meet the Press” interview) when natural and referred gates could be used much more effectively to create a conversational flow.
 - c. Trainee does not use enough natural and referred gates on a routine basis.

Combining Facilic Supervision With Role-Playing and Other Educational Tools

The power of facilics to enhance videotape supervision has already been discussed.

In addition, facilics provides a particularly useful method for annotating an interview while you are watching it live (either in the room with the interviewing dyad or behind a one-way mirror). During such supervision, we sometimes take a break from the interview (patients always are forewarned that such breaks may occur for supervision purposes), share with the trainee (outside the room) the graphics of his or her facilic flow, make suggestions for change, and then have the trainee return to the room to practice implementing the suggested changes. Similarly, facilic maps can be used with the “bug in the ear” method commonly employed in family and group supervision from behind one-way mirrors.

Another advantage of actually being in the room with the resident is that the supervisor has the chance to demonstrate more effective facilic structuring techniques directly by interacting with the patient. Such modeling can be a powerful learning experience for a trainee. Thus, after pointing out (in a break taken outside the interview room) with the facilic diagrams that a patient is wandering, the mentor can offer to go back in and act briefly as the interviewer modeling directly how to structure an overly loquacious patient effectively.

Facilics also can be coupled effectively with role-playing techniques. If a resident persistently uses stilted expansions when exploring diagnostic criteria, the trainer can use reverse role-playing (in which the student plays the client, and the trainer conducts the interview) to model the technique of using a blended expansion. (See the article by Barney and Shea in this issue for a guide to effective role-playing techniques such as reverse role-playing.) Sometimes before modeling the correct method, we actually use a series of phantom gates (stilted expansion) to let the trainee see how unpleasant such an expansion feels. This demonstration highlights, by contrast, the subsequent modeling of the blended expansion. After effective modeling, the student can practice being the interviewer, using blended expansions with various patients that we present with diagnoses ranging from major depression to posttraumatic stress disorder.

Let us wrap up with an example of one of our favorite uses of facilics in combination with both videotape and role-playing: helping residents who rely excessively on phantom gates discover experientially alternative and more conversational ways of making transitions. If you spot a phantom gate on the videotape, you ask the trainee if he or she can think of a gate that would provide a smoother transition, usually a natural gate or a referred gate. If the trainee can create a more conversational gate, you provide positive feedback on the suggestion and immediately have the trainee try out the more engaging gate by directly role-playing the interview segment with the patient just seen on the videotape.

If initially the resident cannot generate alternative gates, you can provide concrete examples of smoother gates and demonstrate them by a reverse

role-play (you play the clinician, and the trainee plays the patient). After you model the alternative type of gate, you have the trainee practice the technique using standard role-playing in which you play the patient. In this fashion, facilic supervision, videotape, and role-playing often can be used together quite powerfully.

Using the Presence of Phantom Gates to Spot Emotional or Countertransferential Responses in Trainees

If a trainee who seldom used phantom gates during previous observation suddenly uses one for no apparent reason, it sometimes indicates that the trainee, at an unconscious level, did not want to continue exploring the topic. For example, when a trainee who usually creates nicely flowing interviews using natural and referred gates starts exploring substance abuse, he or she might tend to short-circuit the expansion abruptly with a premature exit using a phantom gate. In such situations, you can show the trainee the segment of the videotape where the phantom gate was used and ask what the trainee was experiencing, a technique known as “interpersonal process recall” [7]. The resulting discussion may reveal important information (eg, that the trainee was abused by an alcoholic father) that is useful for the trainee to understand and ultimately bring to resolution (in work with one of the trainee’s psychotherapy supervisors, where this type of information is more typically processed, or perhaps in personal therapy).

Using Facilic Schematics in a Classroom Setting

Facilic shorthand can be a popular tool with groups of students in a classroom setting in which videotapes or live interviews are being watched and discussed. The class can map out the facilics of the interviewer while the interview is done or the video is watched.

During subsequent discussion, different students can be asked to draw the facilics of certain parts of the interview on a whiteboard. The class then can use this visual as a springboard for discussion: “How do you guys think this gate worked here? Does anybody have any other ways of maybe making this transition? Could you draw that alternative way up on the board here? What do people think of Mary’s idea of using a referred gate here instead of an implied one? Which gate feels more conversational to you?” I have found such use of facilics to be excellent in generating animated classroom discussion and interaction.

SUMMARY

We hope you find facilic supervision to be as enjoyable and effective to use as we have over the years. It provides a lens for studying and understanding one of the most complex of interviewing tasks, gathering large databases in a timely and sensitive fashion. As stated in the introduction, every clinical interview is as complex as a play, vastly more unpredictable, and potentially life changing. The skilled use of facilic supervision and facilic schematics can

optimize the likelihood that trainees understand the dynamics of these plays and that they can create stages on which compassion and healing can emerge more easily.

APPENDIX

EXERCISES FOR CONSOLIDATING THE UNDERSTANDING AND USE OF FACILITATOR SHORTHAND

The following 12 exercises, adapted from a manual created at the Training Institute for Suicide Assessment and Clinical Interviewing [8], present excerpts from different interviews, exactly as you might encounter them while observing a supervisee interviewing live or watching a previously videotaped interview.

Below each exercise (or on a separate piece of paper if viewing this article from our Web archives), draw in the appropriate schematics for the first region being explored, the gate used by the student as the region is left, followed by the correct schematic for the subsequent region being entered.

Remember that the regions can be either of the content type (signified by a rectangle) or the process type (signified by a circle). No matter which type of region you draw, be sure to abbreviate within it the type of content or process region that it happens to be.

Use the appropriate symbols for the gates, as shown earlier. This process is exactly the one you will follow when using the shorthand during actual supervision sessions. As an aid to get you started, an asterisk appears before the interviewer statement that is a gate. In the following exercises, the only thing that you cannot indicate is the completeness of the expansions of the content regions (normally done by placing slashes at each corner of the rectangle), because you are not shown enough of the dialogue in each region to make such a determination.

This section is designed as a programmed text to maximize the learning experience for the reader. Each exercise is followed immediately by the correct answers and a brief explanation as to why they are correct. We hope you will enjoy the exercises and that they are as much fun to do as they were to create.

Exercise #1

Patient: I've been feeling very sad. . . what with my wife's illness and all the rushing back and forth to the hospital for radiation therapy, it's tough; no real rest.

Clinician: Yea, it sounds tough, and it sounds like you've been a great support for your wife. I'm wondering how it's impacting on your energy.

Patient: What energy? [patient smiles]

Clinician: And how about your concentration?

Patient: As you can imagine that's pretty bad too. You know, I try to avoid crying, because I want to be strong for her, but it's tough.

Clinician: I bet you can't sleep either. Is it rough to fall asleep?

Patient: Oh yeah; I'd say it takes a couple of hours, unless I take some of my clonazepam.

*Clinician: Roughly how much clonazepam are you taking a day?

Patient: I think it's one tab three times a day.

Clinician: Do you know how many milligrams each tab is?

Patient: Yea, I think it's 5.0 mg, no, no, it's 0.5 mg

Clinician: What other medications are you on?

Patient: Oh, I got a bunch. I've been taking Cymbalta for a couple of months.

Directions

Draw the first and second region connected by the appropriate gate below.

Answer to exercise #1

Depression content region followed by a spontaneous gate into the content region of the medication history as mapped below (Fig. 5).

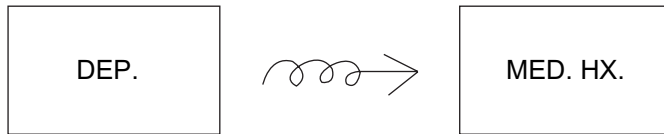


Fig. 5.

Discussion

In this exercise we see a nice example of an interviewer recognizing an opportune time to enter the medication history, because the patient introduced the topic by mentioning his clonazepam. Notice that it is the patient who brought up a new region spontaneously by mentioning the medication. The interviewer then simply used a follow-up question, “Roughly how much clonazepam are you taking a day?” that functioned as a spontaneous gate. Most likely, once within the topic of the patient’s medication history, the interviewer will finish it fully using a blended expansion. If the diagnostic region of depression has not been completed (a split-expansion for that topic), the interviewer could use a referred gate back into the depression region to complete the diagnostic exploration of depression after having explored the patient’s medication history thoroughly.

Exercise #2

Patient: It’s been a long haul. Besides all those short hospitalizations, I also wound up in the State Hospital in 2006.

Clinician: How long were you there?

Patient: Oh, about 3 months.

Clinician: Any other times you've been in a hospital specifically for your depressions?

Patient: No, that about does it. When I was at the State Hospital, I seemed to get a little better; I'm not really certain why. Maybe it was something they did.

*Clinician: Have you felt like people are out to kill you?

Patient: No, not really.

Clinician: What about hearing voices?

Patient: I don't think so, except maybe a time or two.

Clinician: Tell me more about that.

Patient: A couple of times back home, maybe late at night I'd be watching TV, and I'd think I'd hear my son call my name.

Clinician: What would he say?

Patient: Oh, he'd just call out my name.

Clinician: Have you ever felt like people were poisoning your food?

Directions

Draw the first and second region connected by the appropriate gate below.

Answer to exercise #2

Past psychiatric history followed by a phantom gate moving into the content region of psychosis (Fig. 6).

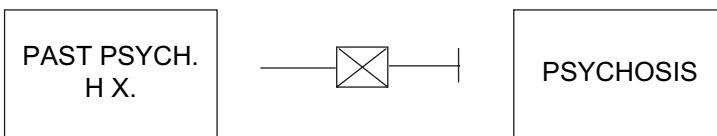


Fig. 6.

Discussion

In the first section of this excerpt, the patient was describing his previous history of treatment related to his depressions. He was relating some past relief that occurred while being at the State Hospital when—out of nowhere—the student asked about paranoia. As with all phantom gates, no cue statement suggesting the presence of a new region to explore was present. The student unwittingly compounded the awkwardness of this transition by proceeding to explore the psychotic region in a stilted fashion, asking questions in a rigid sequence. To the patient, this exchange could hardly have been reassuring. Let's see a different interviewer working with the same patient.

Exercise #3

Patient: It's been a long haul. Besides all those short hospitalizations, I also wound up in the State Hospital in 2006.

Clinician: How long were you there?

Patient: Oh, about 3 months.

Clinician: Any other times you've been in a hospital specifically for your depressions?

Patient: No, that about does it. When I was at the State Hospital, I seemed to get a little better; I'm not really certain why.

*Clinician: Do you think any of the medications they used might have helped?

Patient: I think that one might have... I think, I think it's called Paxil.

Clinician: Do you remember how much you were taking?

Patient: I think it was about 20 mg in the morning.

Clinician: How do you think it helped?

Patient: I didn't feel as overburdened. I really felt brighter, more energized, more alive [pause]. I just felt better.

Clinician: Have you ever tried any other antidepressants?

Patient: A slew of them,

Clinician: Do you remember some of their names?

Directions

Draw the first and second region connected by the appropriate gate below.

Answer to exercise #3

Past psychiatric history followed by a natural gate moving into the content region of the medication history (Fig. 7).

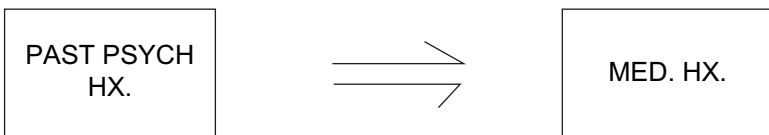


Fig. 7.

Discussion

In contrast to the trainee in the previous exercise, this trainee is moving with the patient nicely. The patient had mentioned that he had gotten better (notice that he did not say anything about medications or treatment, as would have been the case with a spontaneous gate). The trainee cued directly off this last statement by the patient, building a naturalistic bridge into the content region of medication history. Nothing fancy here; just a smooth transition created by the effective use of a natural gate.

Exercise #4

Patient: I just don't feel like doing anything since I've been feeling depressed.

Clinician: Tell me more about what that feels like.

Patient: Really pretty miserable. Life doesn't seem the same. I'm tired all the time; no sleep.

Clinician: How do you mean?

Patient: Over the past several months sleep has almost become a chore. I'm always having trouble getting to sleep, and then I wake up all night. It's miserable.

*Clinician: Have you ever used anything like a nightcap to sort of knock yourself out?

Patient: Yea, sometimes a good belt really relaxes you.

Clinician: How much do you need to drink to make yourself feel sleepy?

Patient: Oh, not too terribly much. Maybe a couple of beers. Sometimes maybe more than a couple of beers.

Clinician: Just, in general, how many cans do you drink in a given day?

Patient: Probably ... Now, I'm just guessing here, but probably a six-pack or two. I hold liquor pretty well. I don't get drunk or nothing.

Clinician: What's your favorite size can of beer, 12 ounces, 16 ounces, 24 ounces?

Patient: Usually the bigger ones, they're a better deal for your money, Doc [patient smiles].

Clinician: What other kinds of drugs do you like to take to relax.

Patient: Well, I might smoke a joint of two here or there [smiles again].

Directions

Draw the first and second region connected by the appropriate gate below.

Answer to exercise #4

Depression content region followed by a natural gate moving into the drug and alcohol history (Fig. 8).

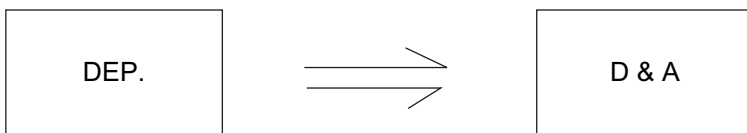


Fig. 8.

Discussion

We enter this interview when the dyad had been discussing the patient's depressive symptoms for a while (depression had been the patient's chief complaint). In this excerpt the trainee had finished the depression region. When the patient started to complain of severe sleep difficulties, the interviewer smoothly slipped into the drug and alcohol region. By bridging directly off of the client's last statement, "I'm always having trouble getting to sleep, and then I wake up all night. It's miserable," the trainee used a natural gate to move the conversation into a new topic. Notice that with a natural gate it is the interviewer, not the patient, who introduces a new topic. This particular use of a natural gate was both smooth and clever, because it allowed the interviewer to enter a somewhat sensitive topic (eg, drinking habits) unobtrusively.

This trainee displays some very good interviewing skills. Note how she astutely asked the patient for the size of beer can—there's quite a difference between a six-pack composed of 12-ounce cans and one composed of 24-ounce cans. No wonder the patient was smiling! Without this question, this important bit of information probably would never have surfaced.

Exercise #5

Patient: Even though my sister was much older, she still had an impact on me.

Clinician: In what kind of way?

Patient: She was always an extrovert, and I'm pretty quiet. Consequently, she was always popular, and I was . . . well . . . just not with the "in crowd," if you know what I mean. Good grades, class president—you name it, she was it.

Clinician: What kind of impact did this have on you?

Patient: Not good . . . I sort of hung out . . . That's all I really did. I was afraid to be compared, so I kept out of the limelight.

Clinician: If you had to do it again, how would you handle those years?

Patient: I'd like to think I'd tell her to "shove off," in my mind. I'd like to think I'd be more aggressive in doing what I like doing. I'm not my sister. I'm me. But I'm not so sure I would; I'd guess that's one of the reasons I'm here . . .

*Clinician: Earlier you had mentioned that you were afraid that drugs were holding you back. What did you mean?

Patient: Since dropping out of school, I've picked up some bad habits. One of them is popping a couple of tabs of speed every day.

Clinician: Do you use anything to bring yourself down?

Patient: Sure, sure. 'Ludes and Valium, if I can get a hold of them.

Clinician: How long have you been using speed?

Directions

Draw the first and second region connected by the appropriate gate below.

Answer to exercise #5

Psychodynamic process region followed by a referred gate moving into the content region of the drug and alcohol history (Fig. 9).

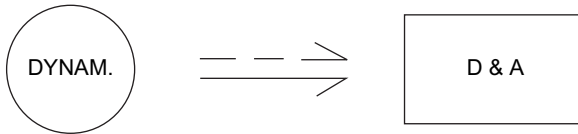


Fig. 9.

Discussion

In the first section, the interviewer was probing in a “psychodynamic” sense, asking questions that require a significant amount of reflection and self-observation on the patient’s part. Indeed, the patient shows a fairly facile ability to look at herself with some degree of insight, a good sign for the potential to refer her to psychotherapy. Because we see only a segment of this interview, it is possible that this dynamic process region, indicated by a circle, may have been going on for quite some time. It may have originally evolved out of specific content regions, such as the social history or the family history. In any case, at this point our interviewer has decided to move on.

Instead of using a potentially disengaging phantom gate, the trainee wisely opts to enter the new region by referring back to an earlier statement made by the patient; hence the gate is correctly identified as a referred gate. Notice that the patient quickly picked up on this referred gate and animatedly joined in a naturalistic expansion of the content region related to the elicitation of a drug and alcohol history.

Exercise #6

Patient: Then my damn aunt came . . . What a turkey! . . . She’s always coming over. She’s got this disease and that disease. One day she’s got cancer and the next day she’s sure I have it. Then she’s telling me about what I should eat. Honestly . . . it drives me nuts.

Clinician: Sounds frustrating.

Patient: Frustrating! You better believe it. She’s God’s gift to busybodies.

Clinician: Is she like anybody else in your family?

Patient: A little bit. My mother doesn’t always mind her own business . . . but I live with her. She supports me, so I don’t think I should complain.

*Clinician: Do you have any medical problems?

Patient: No, not exactly.

Clinician: What do you mean?

Patient: Well, I’ve had my tonsils out.

Clinician: When was that?

Patient: Back in 1960.

Clinician: Any other hospitalizations?

Patient: No.

Clinician: Have you had to see your doctor about your heart or lungs?

Directions

Draw the first and second region connected by the appropriate gate below.

Answer to exercise #6

Content region of the social history followed by a phantom gate moving into the content region of the medical history (Fig. 10)

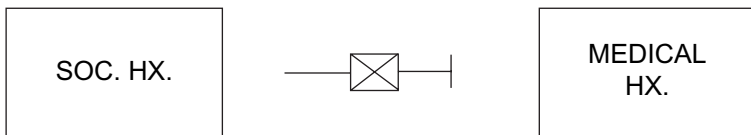


Fig. 10.

Discussion

Needless to say, the transition by this trainee was not the smoothest one on record. The client had been discussing various aspects of family relations, when—out of nowhere—the trainee switched topics. The reason for the subsequent questions, and their apparent urgency, was certainly unclear to the client, especially because she had been discussing a bit of her social history that was emotionally important to her. Let's see an alternative approach.

Exercise #7

Patient: Then my damn aunt came ... What a turkey! ... She's always coming over. She's got this disease and that disease. One day she's got cancer and the next day she's sure I have it. Then she's telling me about what I should eat. Honestly ... it drive s me nuts.

Clinician: Sounds frustrating.

Patient: Frustrating! You better believe it. She's God's gift to busybodies.

Clinician: Is she like anybody else in your family?

Patient: A little bit. My mother doesn't always mind her own business ... but I live with her. She supports me, so I don't think I should complain.

*Clinician: You know, you had mentioned that your aunt almost drives you nuts worrying about your health as well. Have there been any things in your health that might have prompted any of her fears?

Patient: No, not really. I have had some problems, but all minor league. Although even minor league problems can get her going.

Clinician: What kinds of problems have you had?

Patient: Well, I had my tonsils out, when I was 6.

Clinician: How did that go?

Patient: Oh, no problem; just a good way to get some ice cream.

Clinician: Any other hospitalizations?

Patient: I had my wisdom teeth pulled out; and—oh yea—I was in a car accident and broke my leg. . . .

Directions

Draw the first and second region connected by the appropriate gate below.

Answer to exercise #7

Content region of the social history followed by a referred gate moving into the content region of the medical history (Fig. 11).

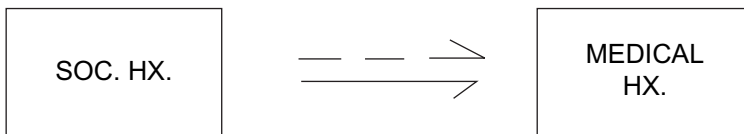


Fig. 11.

Discussion

What a difference it can make to replace a phantom gate with a more flowing gate such as the referred gate used here. Unlike the trainee in exercise #6, this trainee wanted to move into the same new region—medical history—but strategically used a referred gate that gently moved the conversation into the medical history region. Sometimes referred gates refer back to patient comments made long ago in the conversation, and sometimes, as in this example, the referred gate points back to a relatively recent patient comment. More distant comments can be referred to just as easily and seem just as natural and conversational to the patient, once again metacommunicating that the clinician has been listening carefully. Let's see yet another direction the interview with the above patient could have taken.

Exercise #8

Patient: Then my damn aunt came . . . What a turkey! . . . She's always coming over. She's got this disease and that disease. One day she's got cancer and the next day she's sure I have it. Then she's telling me about what I should eat. Honestly . . . it drives me nuts.

Clinician: Sounds frustrating.

Patient: Frustrating! You better believe it. She's God's gift to busybodies.

Clinician: Is she like anybody else in your family?

Patient: A little bit. My mother doesn't always mind her own business . . . but I live with her. She supports me, so I don't think I should complain.

*Clinician: What makes you say that you don't think you should complain?

Patient: It's sort of complicated, you know, but if I depend on my mother for food and shelter, well, who the hell am I to complain? But I hate this feeling . . . this feeling of being dependent, owing her something. I'm almost 26; I ought to be on my own.

Clinician: Any ideas about why you haven't left?

Patient: Maybe I'm scared . . . I used to get scared when I was away at college, you know, homesick. There's still a lot of little girl in me.

Clinician: What role does this little girl play in you?

Directions

Draw the first and second region connected by the appropriate gate below.

Answer to exercise #8

Content region of the social history followed by a natural gate moving into a psychodynamic process region (Fig. 12).



Fig. 12.

Discussion

Notice that the trainee felt she was done with the social history and cued directly off of the patient's last statement (ie, ". . .but I live with her. She supports me, so I don't think I should complain") by using the natural gate, "What makes you say you don't think you should complain?" With this skillful use of a natural gate the trainee almost imperceptibly guided the interview into a psychodynamic region. Note that, as opposed to a free facilitation region, in a psychodynamic region the interviewer peppers the region with interpretive questions rather than just "letting the interviewee go."

Naturally there can be some overlap between free facilitation regions and psychodynamic regions. Sometimes while free facilitation regions are being used, important dynamic considerations pop up spontaneously as the patient talks freely. But the difference in the two regions can be found by looking at the primary intent of the interviewer. In a free facilitation region the main intent is purely engagement. In a psychodynamic region the main intent is to use interpretive questions to see how the patient responds, what defense mechanisms appear, and the extent of the patient's own observing ego.

Exercise #9

Patient: The situation at work is not good. My boss is short staffed and is pushing the work on me. And I can't do it all. He wants to bring in 150 new clients for the program, simply impossible.

Clinician: How does he put the pressure on you exactly?

Patient: Basically, by asking me to do his work. That's what really bothers me. He might sit in the recreation room shooting pool, while I'm supposed to miss lunch.

*Clinician: Earlier you said that you were feeling constantly "wired" at work. I'm wondering if you ever get the chance to relax?

Patient: Occasionally. But even at home I feel pretty uptight.

Clinician: How do you mean?

Patient: Even when I'm watching TV, I feel restless and worried about work, or maybe the kids.

Clinician: Do you view yourself as a worrier?

Patient: Oh, God, yes! I'm the original worrywart. I spend a lot of time each day just pacing around.

Clinician: Do you ever have times when you feel your heart racing?

Patient: Oh yea; that's common, especially if I'm upset. The other day, when I was mad at Johnny about his grades, I thought my heart would explode.

Clinician: Besides things like your heart racing, how often do you get back-aches, headaches, or other tension-related pains?

Directions

Draw the first and second region connected by the appropriate gate below.

Answer to exercise #9

Content region of the social history followed by a referred gate moving into an exploration of generalized anxiety disorder (Fig. 13).

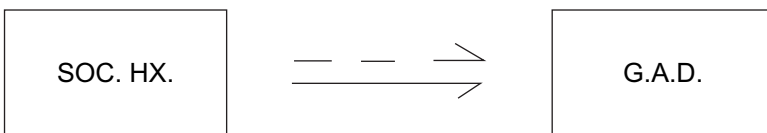


Fig. 13.

Discussion

In this example, two content regions are bridged nicely by a referred gate. This time the statement made by the patient, and subsequently referred to by the trainee, apparently appeared much earlier in the interview and does not show up in this brief excerpt. This trainee also has increased the effectiveness of the transition by using a referred gate that demonstrates his active concern (ie, “Earlier you said that you were feeling constantly ‘wired’ at work. I’m wondering if you ever get the chance to relax?”) All in all, this transition was engaging and conversational.

Exercise #10

Patient: The depression just seems to get worse and worse.

Clinician: How long has it been going on?

Patient: Ever since I got back from Christmas vacation. This semester is a lot harder than I was expecting. I’m finding calculus much more difficult than algebra.

Clinician: It sounds real tough. Are your symptoms with you all the time?

Patient: Yea, I can’t shake them . . .

Clinician: Has it impacted on your sleep?

Patient: You bet! Can’t fall asleep, can’t stay asleep, and I wake up early and all gunked up. Of course, it doesn’t help that my suitemates are big party guys.

*Clinician: Are you worrying a lot?

Patient: Almost constantly. I’ve always been a worrier. My Mom used to tell me, “Just go in the corner and worry for 5 minutes and be done with it. Don’t waste the day fretting, it won’t help anything.”

Clinician: [smiles] Sounds like your Mom had some good advice?

Patient: [smiling] Yea, she still does.

Clinician: What about relaxing, can you ever relax, you know, say on a Saturday?

Patient: Not really. I’m always wound up tighter than a kite, and I’ve been that way even before I got depressed.

Clinician: When did that begin?

Patient: Probably since around September.

Clinician: Hmm . . . so your anxiety has been around for a while. Does it cause you to have aches and pains, like backaches and headaches?

Patient: Oh yea. I get tension headaches all the time. Those started almost as soon as I started my Freshman year here.

Directions

Draw the first and second region connected by the appropriate gate below.

Answer to exercise #10

Content region of major depression followed by an implied gate moving into an exploration of generalized anxiety disorder (Fig. 14).

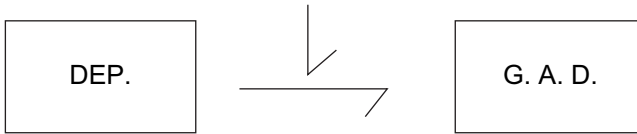


Fig. 14.

Discussion

This is the first example of an implied gate in these exercises. The early conversation focused on an exploration of depressed symptoms, which had been going on some time before the excerpt begins. After feeling that she had completed expanding the major depression region, the trainee decided to enter the expansion of generalized anxiety disorders merely by asking, “Are you worrying a lot?” There is significant overlap between depressive symptoms and anxiety symptoms, so clinicians often use implied gates to move from one to the other with barely a noticeable change in pace. Implied gates can be used any time two adjacent regions are so congruent in topic that the transition seems appropriate.

In contrast to a spontaneous gate, in an implied gate the clinician initiates the change of topic, not the patient. Unlike a natural gate, the implied gate does not cue directly off the preceding one or two statements by the patient. Unlike a referred gate, the interviewer does not refer directly back to a previous statement by the patient. Finally, in contrast to a phantom gate, the implied gate seems to fit naturally.

When the new region is extremely similar to the preceding region, as in this example, an implied gate can be almost imperceptible and rivals a natural gate for smoothness of transition. If the connected content regions are less similar, an implied gate becomes less smooth and eventually approaches the abruptness of a phantom gate.

For instance, the clinician could have said, “Tell me more about your stressors,” instead of, “Are you worrying a lot?” This inquiry would have represented an implied gate into the content region of the patient’s current stressors, although it would not have flowed quite as well as the previous example of an implied gate, because the topics are not as similar in nature.

In summary, implied gates range in smoothness on a continuum between natural gates and phantom gates. When the two regions are closely related, implied gates approach the gracefulness of natural gates. On the other hand, if the topics are poorly related, an implied gate can approach the awkwardness of a phantom gate.

Before leaving this example, it is worth noting that, after entering the generalized anxiety disorder region, the trainee did a nice job of exploring the region using a blended expansion by conveying reassuring nonverbal communication (such as smiling) and using engaging comments (“Sounds like your Mom had some good advice”).

Exercise #11

In the following example, the reader should be on the lookout for three regions connected by two gates.

Patient: I keep getting the same thoughts over and over. I really don't understand it.

Clinician: What types of thoughts have been bothering you?

Patient: I can't get it out of my head that I have germs on my hands.

Clinician: How do you mean?

Patient: I hate shaking people's hands. If I shake somebody's hands I will absolutely have to go the bathroom to wash them. I won't be able to stand being in the room, until I do.

Clinician: How many times might you wash your hands in a day?

Patient: At least 100 times. I'm not kidding.

Clinician: Are there other actions that you find you have to keep doing over and over?

Patient: This is sort of embarrassing to talk about, but I have a hard time dressing.

Clinician: How do you mean?

Patient: Sometimes, when I'm dressing, I have to take my pants off and on 20 times. I count it out. Sometimes it might take me 30 minutes to dress, I get so anxious.

*Clinician: Do you want to kill yourself?

Patient: No, not really. I just want to stop worrying and doing these crazy things.

Clinician: But have you had any thoughts of hurting yourself?

Patient: Uh [pause] No.

*Clinician: Does anyone in your family have a serious mental illness?

Patient: How do you mean?

Clinician: Has anyone in your family been depressed?

Directions

Draw all three regions and their connecting gates below.

Answer to exercise #11

Content region of obsessive-compulsive disorder followed by a phantom gate moving into an exploration of suicidal ideation followed by a phantom gate into the content region dealing with family history (Fig. 15).

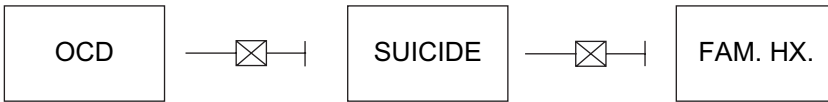


Fig. 15.

Discussion

The early phase of this excerpt illustrates the expansion of a content region dealing with obsessive-compulsive disorder. This region is being expanded in a reasonable fashion, when, without any warning, the trainee abruptly asks about suicide, a clear-cut example of a phantom gate.

This trainee seemed particularly intent on disrupting the conversational flow here, because he no sooner enters the suicide region than he exits, using yet another phantom gate into the family history region with the question, “Does anyone in your family have a serious mental illness?” Such strings of phantom gates may leave the patient wondering if the clinician knows what he is doing and certainly can contribute to a “Meet the Press” style interview. In the next example, the interviewer tries a different approach with the same patient.

Exercise #12

Patient: I keep getting the same thoughts over and over. I really don’t understand it.

Clinician: What types of thoughts have been bothering you?

Patient: I can’t get it out of my head that I have germs on my hands.

Clinician: How do you mean?

Patient: I hate shaking people’s hands. If I shake somebody’s hands I will absolutely have to go the bathroom to wash them. I won’t be able to stand being in the room, until I do.

Clinician: How many times might you wash your hands in a day?

Patient: At least 100 times. I’m not kidding.

Clinician: Are there other actions that you find you have to keep doing over and over?

Patient: This is sort of embarrassing to talk about, but I have a hard time dressing.

Clinician: How do you mean?

Patient: Sometimes, when I’m dressing, I have to take my pants off and on 20 times. I count it out. Sometimes it might take me 30 minutes to dress, I get so anxious.

*Clinician: That sounds very upsetting and painful. When your worries torment you like this, do your thoughts ever get so disturbing that you think of killing yourself to escape it all?

Patient: Sometimes I do wonder if it’s all worth it. I mean, why bother, when you really get down to it? But those thoughts seem to pass quickly.

Clinician: When you do get those thoughts of perhaps taking your own life, what exactly do you think of doing?

Patient: One time, about a month ago, when I was really upset, I thought of taking some pills . . .

Directions

Draw the first and second region connected by the appropriate gate below.

Answer to exercise #12

Content region of obsessive-compulsive disorder followed by a natural gate moving into an exploration of suicidal ideation (Fig. 16).

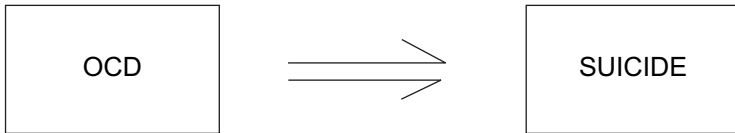


Fig. 16.

Discussion

This exercise is the last one in this Appendix, and it highlights the powerful difference the choice of a single gate can make in engagement, conversational flow, and even in the validity of the patient's answers. Unlike the previous interviewer, this trainee manages to bring up the topic of suicide while simultaneously communicating empathy through the skillful use of a natural gate cueing directly off the pain expressed in the patient's immediately preceding comments. Note the remarkably different history related to recent suicidal ideation that results secondary to the difference in engagement between the clinician and the patient in the two examples. Technique counts, and faciliic supervision effectively teaches technique combined with compassion.

You have finished the programmed text. We hope it has been of value. Please return to the main body of the article.

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