

# Macrotraining: A “How-To” Primer for Using Serial Role-Playing to Train Complex Clinical Interviewing Tasks Such as Suicide Assessment

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## DEDICATION

This monograph is dedicated to Allen E. Ivey.

Teach by doing whenever you can, and only fall back upon words when doing it is out of the question.

Rousseau (1712-1778), *Emile; or, Treatise on Education*

There are few clinical tasks in all of medicine and mental health more complex, nuanced, and of immediate consequence to the care of our clients than clinical interviewing. And there are few clinical tasks more daunting to learn. To learn how to effectively interview, the student must attentively watch someone who knows how to do it well, then do it themselves repeatedly while having someone who knows how to do it well coach them so that the student can learn how to do it even better. There is no other way. Whether we are doing the doing or the student is doing the doing, Rousseau got it right almost three centuries ago.

As we stated in an earlier article on designing interviewing training programs in this issue of *Psychiatric Clinics*, clinical interviewing is a profoundly complex “procedure.” One cannot teach a student how to perform a procedure from a podium. By way of example, let’s look at a very common procedure that we must all learn, a most useful, yet potentially dangerous procedure—driving a car. You can’t teach someone to drive a car by giving a lecture or telling the student to read a book. These educational venues can help, but the bottom line is simple—to teach driving, the student must watch you drive first; then you must watch the student drive. So it is with clinical interviewing—a behavioral

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task vastly more complex than driving a car, and when it comes to tasks such as performing a suicide assessment, equally critical to master.

Unfortunately, when one is attempting to master the myriad of specific interviewing tasks in which a good clinician must show proficiency (such as eliciting a drug and alcohol history, exploring domestic violence and incest, performing a differential diagnosis, eliciting suicidal ideation, taking a sexual history, and talking with patients effectively about their medications and providing other psychoeducation), interviewing training is often a bit of a haphazard process. A young clinician may or may not get a chance to see a specific interviewing task, such as exploring incest, done well. Even if they do, students may go months or years, if ever, before an experienced clinician watches them do the task while providing effective feedback and subsequently makes a determination that the student has performed the interviewing task competently.

Even mock oral boards do not guarantee adequate observation of the trainee's skill level by the residency. For instance, essentially every patient in a mock board will require a differential diagnosis, providing an opportunity for this interviewing skill set to be directly observed. But not every mock board patient has a complicated history of incest requiring a sensitive inquiry by the interviewer. Consequently, a resident could graduate from a psychiatric residency program without ever being observed performing this specific skill set by an experienced faculty member—the level of competency of the resident being both untested and unknown. Macrotraining was created to address these problems.

Macrotraining is an educational strategy for training complex clinical interviewing skills *in a single session* to such a degree of clarity that the trainee can *perform* the task to a level of predetermined competency by the end of the session. The foundation of macrotraining is the use of serial role-playing both to teach the skill and then carefully and methodically consolidate the skill for the trainee so that, at the end of the session, the trainee clearly “gets it” and can readily *demonstrate* the skill. It is the “doing,” as Rousseau would state, that makes macrotraining so effective. In short, in a macrotraining session the students not only learn the skill, they practice it to the point of competency and are then tested on it. Depending on the complexity of the task, a macrotraining session usually lasts from a half hour to 4 hours.

Macrotraining can be used to train any clinician, ranging from a novice student (to get the critical basics down) to an experienced clinician (to perfect advanced nuances of the desired interview strategy) in any of the aforementioned interviewing tasks and many more. As long as the interviewing skill set has the following criteria, then macrotraining can be used to train the student to a level of competency: (1) There is a specific goal with a concrete optimal database to be uncovered (such as exploring incest or eliciting suicidal ideation); (2) Specific questions or statements, which are well defined and can be modeled for the student, are delineated; and (3) Effective ways of flexibly sequencing the questions or statements are clearly operationalized for the student (a flow sheet can be created to help the student understand the how and why of the sequencing of the questions).

Originally designed to train psychiatric residents and other mental health graduate students, including counselors, social workers, substance abuse specialists, and clinical psychologists, as well as to train any staff handling crisis calls, macrotraining can also be used with medical students, nursing students, physician assistant students, and clinical pharmacy students. In fact, its use may not be limited to the “helping professions,” for we feel it could be equally useful in the training of newspaper reporters, employment interviewers, lawyers, and police.

In addition to our belief that macrotraining can be unusually effective for training clinicians to perform complicated interviewing tasks, on a more personal note, we should add one more thing—macrotraining is one of the most fun and rewarding styles of training the authors have ever had the pleasure to employ. The sessions are often peppered with laughter, shared learning, and the pleasure (for both trainer and student) of directly observing the trainee gain skills “right before one’s eyes.” This is a monograph for all those who love to teach.

The monograph is intended to pass on, in a no-nonsense fashion, the nitty-gritty on how to use macrotraining in your psychiatric residency or graduate program or at a clinic or call center. It is neither a research paper nor an academic review. It is written to be an informal and immediately practical primer for anyone interested in trying out macrotraining as an educational tool. If you have any questions (or if you discover ways of improving macrotraining or new uses for it), please contact us at the website for the Training Institute for Suicide Assessment and Clinical Interviewing at [www.suicideassessment.com](http://www.suicideassessment.com). It is also our hope that the monograph will spur research on macrotraining, for although the seed research has been quite promising, macrotraining is ripe for comprehensive empiric study, especially regarding its efficacy in passing on critical skills such as eliciting suicidal ideation.

In the following article, we hope to provide a clear enough description of the macrotraining paradigm that an interested reader could actually begin to use the technique. To enhance the process, we decided to actually pick a specific and critical interviewing skill—eliciting suicidal ideation—as a model for illustrating the use of macrotraining. Indeed, macrotraining was originally developed to train clinicians in this specific skill, and the authors have more than 25 years of experience in using macrotraining to teach the elicitation of suicidal ideation, planning, intent, and behavior.

To accomplish our task, we will use a five-point approach: (1) provide a brief history of macrotraining; (2) delineate the core principles of macrotraining; (3) describe an innovative method of eliciting suicidal ideation—the Chronological Assessment of Suicide Events (the CASE Approach)—that nicely illustrates an interviewing strategy that can be readily taught by macrotraining; (4) illustrate the step-by-step use of macrotraining to teach the CASE Approach; and (5) provide specific tips on how to use macrotraining more effectively to teach suicide assessment skills and other interviewing tasks.

## HISTORY OF MACROTRAINING

To understand the history of macrotraining, one must go back 4 decades to the highly innovative work of Allen E. Ivey [1,2], who developed a methodology—called *microcounseling*—that has revolutionized interviewing training. Ivey quickly realized that, as Rousseau described in our opening epigraph, the secret to teaching was doing. He also realized that interviewing was a procedure composed of innumerable smaller procedures—individual questions or statements. He decided that, to effectively teach interviewing, one must start by training the student at the smallest level of procedure (for example, an open-ended question or a reflecting statement). He further realized that providing didactic teaching would not be sufficient to pass on a behavioral skill; one must also address the skill through the use of modeling and role-playing, while ensuring competence in the skill by direct observation of the student demonstrating it.

Because of the focus on the training of single interviewing techniques, the isolated educational format used in the overall process of microcounseling is sometimes called “*microtraining*.” In classic microtraining, the interview question or behavior to be trained must be behaviorally well defined and is usually described in a manual as well as modeled on videotape. Some students may be able to “test out” of the session, if they can already demonstrate the skill in question. But for those who do not know the skill, a microtraining session is used. In the specific session, the trainer focuses on a single skill. After a brief reading and a few minutes of didactics enhanced by modeling (often by watching a videotape), the trainee learns the specific skill via the use of role-playing until the trainer is comfortable that the trainee can demonstrate the skill to a level of competence. In a brief period, often 6 to 7 minutes, the trainee will practice the newly acquired skill using role-playing as many times as possible to consolidate the skill. At other times, new role-plays with different types of clients are introduced subsequently to see if the trainee can generalize the newly acquired interviewing skill to different types of clients.

Subsequent research has shown that these skills, if consolidated well during the microcounseling session, can be further generalized into later interviews with real clients [3]. This ability to use various types of clients in role-plays has also been advantageously used to help teach culturally specific interviewing techniques [4].

In my residency and early years as an interviewing mentor at Western Psychiatric Institute and Clinic in Pittsburgh, Pennsylvania, I was utterly fascinated by the work of Ivey, for I feel one would be hard pressed to find an educational technology that has been better studied empirically. Microcounseling works.

To be more specific, the evidence base for microcounseling has been building for decades [5]. A review paper by Daniels [6] describes the results of more than 450 different studies done on microcounseling. In addition, nicely designed models for conceptualizing the use of microcounseling in supervision have been developed—such as the Microcounseling Supervision Model (MSM) of Russell-Chapin and Ivey [7]—to provide guidance in the everyday use of microcounseling by interviewing mentors.

We have spent some time emphasizing the impressive research behind microtraining because microtraining is the fundamental building block in macrotraining. Indeed, *macrotraining* is the serial use of *microtraining* techniques to train clinicians to perform complex interviewing sequences. Although macrotraining has not been studied empirically, it is our hope that this paper will jump-start its study both qualitatively and quantitatively. As we await the results of such research, it is reassuring to know that the key component of macrotraining—*microtraining*—has been repeatedly proved to be effective, a fact that lends support to our seed research and our direct observation that macrotraining is also highly effective. The beauty of macrotraining is that each training session is, in essence, its own qualitative research study, for the trainee can either do the interview strategy correctly or not by the end of the session. If the trainee can, then it has been proved that macrotraining—with this particular trainee—has worked. Let us see what it is all about in more detail.

At Western Psychiatric Institute and Clinic, I was the Director of the Diagnostic and Evaluation Center (DEC) from 1984 through 1988. The DEC was both an emergency department and an assessment center that also contained a telephone triage center. We ran a comprehensive interviewing training program, as described elsewhere in this issue of the *Psychiatric Clinics*. As we studied the art of clinical interviewing, we began to realize the complexity of the art itself. Although an interview is composed of individual techniques, these techniques do not exist in isolation in the real world of clinical interviewing; they are always integrated into specific interviewing tasks.

Such tasks often, though not always, revolve around the gathering of a specific database while maintaining engagement with the client. Typical interviewing tasks might include gathering a symptom picture to make a differential diagnosis, eliciting information related to a drug and alcohol history, uncovering information related to interpersonal functioning and social history, and eliciting suicidal ideation. Especially with sensitive topics such as domestic violence, incest, and suicidal ideation, it becomes critical for the clinician to be able to ask questions about difficult-to-share material while at the same time carefully attending to and nurturing the therapeutic alliance.

While watching trainees from psychiatry to clinical psychology, we found some trainees who would approach these challenging interviewing demands in a fashion that was highly engaging, but very poor in uncovering the information needed to help the patient. On the other end of the continuum, we found trainees who seemed to “cover the right bases” with regard to the critical database, but did so in a fashion that was painfully disengaging (often yielding invalid data as well). The trick was to train students to do both well—to uncover a comprehensive, valid, and useful database while simultaneously carefully attending to and enriching their engagement with the client.

Microcounseling is effective at teaching individual interviewing techniques, especially those techniques vital to engagement, such as attending behavior, communicating empathy, and using open-ended questions, reflecting statements, and summarizing statements. We began to wonder if one could delineate

a complex interviewing task—such as eliciting suicidal ideation—into single small steps that eventually flowed into a larger sequence of questions and ultimately blended into collections of sequences that would uncover a specific database in a valid and sensitive fashion. If so, could this operationalization of the complexities of a real-life interviewing task—such as uncovering incest—be amenable to the serial use of microtraining on each of the steps of the process, until the trainee could perform the entire interview flexibly and accurately?

The promise of such a training strategy—built directly on the shoulders of an educational technology (microtraining) that was already well established as effective—was enticing. We felt that with regards to some tasks—such as eliciting suicidal ideation and uncovering domestic violence—we might be able to help clinicians save lives by training them to be more effective interviewers in traditionally difficult arenas. Macrotraining was born.

For macrotraining to work, several questions needed to be answered in the positive: (1) Could complex interviewing tasks such as eliciting suicidal ideation (which sometimes might require many questions by the clinician, whose wording and sequencing could have critical impacts on uncovering valid information while securing ongoing engagement) be simplified and clarified into a language that could be easily “picked up” by trainees? (2) Would the use of serial microtraining steps allow the trainee to master and remember complicated interviewing strategies that might contain more than 30 questions? (3) Could macrotrainers maintain the sharpness and clarity of mind to intensively train a single student in sessions that might prove to be hours in length, as might be the case when training particularly complicated interview strategies? and (4) Would the student be able to maintain concentration and enthusiasm over such extended periods of time and enjoy the process while doing so? We were intent that the macrotraining sessions be fun and unfold within a safe “interpersonal space,” for the first priority of any supervisor must be to ensure the welfare of the trainee [8].

Thankfully, the answers to all of these questions proved to be “yes.” Let us take a more detailed look at the art of macrotraining.

## **CORE PRINCIPLES OF MACROTRAINING**

Macrotraining was developed to train clinicians to perform specific complex interviewing tasks flexibly. It not only allows the trainer to teach specific types of questions—both their wording and sequencing—but also allows the trainer to ensure that the questions are asked in an engaging fashion (by directly observing the interviewer’s timing, tone of voice, and use of other nonverbal communications). Thus, while teaching the sequencing of a complex interview strategy, the trainer can ensure that all of the critical basic engagement skills—those classically taught in microtraining—are still employed effectively. If a specific sequence of questions is used correctly, but not in an engaging fashion, then the role-play is repeated until the trainer is comfortable that engagement skills are used routinely by the student throughout the specified sequence of questions.

Naturally, the specific questions, their sequencing, and the frequency with which it is expected each question should be used are completely determined by the trainer. Each of us might come up with a slightly different way of eliciting a drug and alcohol history, for there are many effective ways to do so. Generally speaking (there may be exceptions when a rigid ordering of questions is demanded), it is important to communicate to the trainees that they are *not* being taught *the* “right way” to elicit a specific database, but a “reasonable way.”

It is expected that they will learn to perform this reasonable way to a level of competence and will then be urged to flexibly change the questioning as meets the needs of each unique client and interview situation encountered in the future. In a similar fashion, medical students learn how to do a complete physical examination to a reasonable level of competence. They subsequently learn how to adapt the extent and style of the physical examination to the needs of the patient and his or her presentation of symptoms. Macrotrainers consistently communicate that engagement, flexibility, and creativity are the cornerstones of clinical interviewing.

Three definitions are of immediate value at this point. An “interview technique” is a single question or statement, such as an “open-ended question” or a “behavioral incident” (a specific style of question used to improve the likelihood of receiving a valid answer from a client, which we will describe later in this article). An “interview sequence” is a series of two or more interview techniques in which the style of the questions (which may include their content and/or their exact wording) and their sequencing (the order in which they are asked) is clearly delineated. An “interview region” is a specified database pertaining to the interviewing task at hand. An interview region could be composed of a single interview sequence or multiple interview sequences strung together to obtain the necessary clinical information. Thus an interview region could be as short as two questions (a region that contains only a single two-question interview sequence) or could contain 10, 20, or more questions (a series of interview sequences). Armed with these three simple definitions, one can readily understand the core principles of macrotraining.

For the purposes of illustration, let us assume that we are trying to train a student in how to elicit a history of physical and sexual abuse in a comprehensive and sensitive fashion. Let us assume that the prototypic strategy we are proposing has three contiguous databases that we have delineated as three specific interview regions: Region #1—current abuse; Region #2—recent abuse over the past year; and Region #3—past abuse. Let us further suppose that within each of our regions we have two or more interview sequences of questions that we feel are important in sensitively uncovering a valid abuse history. Using this prototype, let us see how a macrotraining session might proceed.

In the first step, the macrotrainer will provide a succinct, and hopefully interesting, overview of the entire interview strategy. (If the macrotrainer has an article describing the interview strategy for uncovering physical and sexual abuse, he or she will have asked the student to have read it before coming to the macrotraining session.) The trainer might choose to discuss why the

elicitation of an abuse history is both so important and so sensitive in nature. The trainer would show the overall flow of the three regions, moving from immediate to recent to past experience, and why this flow is viewed as useful. A brief description of some of the information to be gathered in each region might be offered.

In the next step the macrotrainer will focus entirely on teaching the skills used in Region #1 (current abuse). The trainer will describe in detail each of the interview questions/statements that are to be used in each of the interview sequences found in Region #1. Flip charts, whiteboards, etcetera may be particularly useful in enhancing this interactive didactic section.

After the didactics, the macrotrainer will ask questions to test whether the trainee really understands the interview techniques and their sequencing. Any areas of “fogginess” regarding the theory and the sequencing of the interviewing techniques are then immediately clarified by the trainer.

Following testing/clarification, all the interview sequences for Region #1 (we will assume that there are just two interview sequences in Region #1 of our prototype) are modeled by the trainer. The best method is to have a premade videotape of a skilled interviewer competently and sensitively doing Region #1 *with an actual patient*. This videotape metacommunicates to the trainee that the interview strategy is both engaging and effective in gathering the desired information in the real world of everyday practice. The videotape also provides a powerful mental model for the trainee, which can work as both a conscious and unconscious visualization (much as a professional golfer visualizes his or her swing before actually striking the ball) and can help guide the student during the subsequent role-playing. This videotape can also be viewed again, later in the macrotraining session, at any point where clarification of interviewing technique or more modeling is deemed useful. If no video is available, the interview region can be demonstrated by role-playing, although this is far less desirable (a significant down-side is that the trainee’s attention must now be shared between creating the role of the client and trying to observe effective technique).

After the videotape has been observed, the first role-play is done, focusing *on just the first interview sequence* of Region #1. This sequence is performed until it is done to a level of competency.

Active feedback is provided in two ways. If an error is made, the role-play can be interrupted by the trainer with a “time out,” signified by an agreed-on hand signal. At this point the training dyad breaks out of role and discusses what is going on, and errors of technique are corrected. Occasionally, a trainer may take a moment to reverse roles in the role-play to model the correct technique directly (this exercise, called a “reverse role-play,” not only accomplishes its primary goal—demonstrating the technique correctly—but also often allows the trainee to see how the technique feels to the client, providing a powerful experiential demonstration to the student that engagement can be enhanced even while data is being gathered). The dyad then returns to the role-play to implement the now-corrected interview techniques. A second time to provide feedback is at the end of the role-play.



In either case, once the student effectively demonstrates the first interview sequence of Region #1, it is important that a new role-play be done in which the student must now correctly perform the first interview sequence from front to back (remember that such sequences are usually only about two to five questions in length), thus consolidating the learned skill.

It is now time for the macrotrainer to teach the second of the sequences in Region #1. (If you will recall, in our prototypic interview strategy, Region #1 has only two interview sequences.) A brief verbal description and rationale of the second interviewing sequence are given (notice that, if the student appears unclear, you can always watch the videotape of this sequence again). A role-play is now performed with the “same originally role-played patient,” picking up where the first interview sequence of Region #1 stopped. The exact same procedures are done as in the training of the first interviewing sequence, until the student can do the second sequence correctly.

After much positive feedback, the student is then asked to perform the two sequences of Region #1 back to back, without stopping, with an entirely “new” role-played client provided by the macrotrainer. Feedback is given until the student can do Region #1 to a level of competence. The training of Region #1 for eliciting the current abuse history is now completed. Not only does the student understand the interviewing strategy for eliciting a current abuse history, but the student has demonstrated that he or she can actually do the strategy in an engaging fashion—a vastly different proposition altogether.

Notice how many times the student has repeated the specific interview sequences with different role-played patients. This repetition firmly consolidates the skill set for the trainee. Repeated role-plays of already “learned” interview sequences are the heart and soul of macrotraining. It is this serial repetition that allows students to learn complex interview skills in such a fashion that the skills “stick” and the likelihood of the students’ demonstrating continued competency months and years later is, in our opinion, greatly enhanced.

Doing role-plays so that they appear natural and prove to be effective—whether as isolated illustrations or in systematic microtraining or macrotraining—is no easy task. It is both a set of skills and an art. Consequently, we have provided online in this issue of the *Psychiatric Clinics* an entire article devoted to tips for improving and mastering role-playing as an educational tool, should a more in-depth knowledge be of interest (See “The Art of Effectively Teaching Clinical Interviewing Skills Using Role-Playing: A Primer” at [www.psych.theclinics.com](http://www.psych.theclinics.com)).

The macrotrainer is now ready to teach the student how to explore Region #2—recent abuse (over the past year). Let us assume that this region is composed of three interview sequences. The exact training flow, as illustrated earlier in teaching Region #1, is used until the student can do all three sequences of Region #2 in a row (and without stopping) to a level of competency.

At this point, if things have gone well, we have had a lot of success. The student has learned and demonstrated that, as Rousseau would say, they

can “do” in a sensitive and reliable fashion two entire regions related to uncovering an abuse history. And it is here that our emphasis on consolidating skills through serial role-playing once again plays a critical part in effective macrotraining.

At this stage, the trainee is asked to do Region #1 followed by Region #2 without error and without stopping with a newly created role-play. This is done until the student performs the task to a level of competence. Most students by this point in macrotraining are “having a blast.” It is empowering to be able actually to see oneself gaining interviewing skills in the immediate here and now. Moreover, good macrotrainers are gifted at providing positive feedback and using humor effectively.

We are now ready to teach Region #3. The exact same training flow is used as in Regions #1 and #2. Once competence is gained in Region #3, the student is asked to “pass the test.” In short, the student must now demonstrate how to do all three regions of the elicitation of an abuse history sequentially, without stopping and without mistakes, while demonstrating effective engagement skills. Any errors are corrected and sound technique consolidated until the student can demonstrate the entire series without flaw. Thus the length of a session of macrotraining is dependent not only on the complexity of the skills being taught but on the rapidity with which a specific trainee picks them up. Sometimes a second macrotraining session must be set up because the student cannot demonstrate competence in a single session, but this is rare.

At this stage, let us move from the use of macrotraining to teach a theoretic, prototypic interview to the “real McCoy”—an interview strategy designed to accomplish a critical clinical task (uncovering suicidal ideation and intent) that has been operationally defined, that has been refined over the course of 20 years, that has been presented in the clinical literature, that has demonstrated sound construct and face validity, and that can be readily taught to your own trainees—the Chronological Assessment of Suicide Events (the CASE Approach).

## **INTRODUCTION TO THE CHRONOLOGICAL ASSESSMENT OF SUICIDE EVENTS (THE CASE APPROACH)**

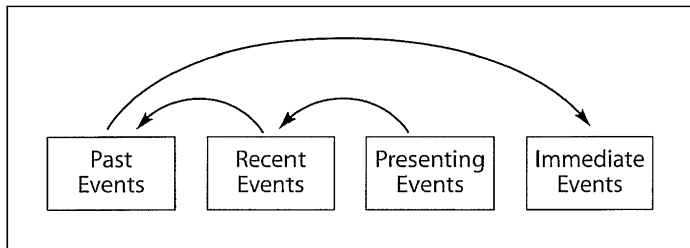
The CASE Approach is a flexible, practical, and easily learned interview strategy for eliciting suicidal ideation, planning, and intent, designed to help the interviewer explore both the inner pains of the client and the suicidal planning that often reflects these pains. The CASE Approach—along with macrotraining—was first developed at the Diagnostic and Evaluation Center of Western Psychiatric Institute and Clinic at the University of Pittsburgh, Pennsylvania, in the 1980s for use in emergency rooms, assessment centers, inpatient and outpatient settings, or any type of crisis intervention done over the phone. It was further refined at the Dartmouth Medical School, Hanover, New Hampshire, and in front-line community mental health center work during the 1990s. Final development and refinement of the CASE Approach (and of macrotraining) were done at the Training Institute for Suicide Assessment and Clinical Interviewing [9].

The CASE Approach was first described in the literature in 1998 by Shea [10,11] and has subsequently been received enthusiastically by mental health professionals, substance abuse counselors, school counselors, primary care clinicians, and the correctional profession [12–18]. The CASE Approach is presented routinely as a core clinical course at the annual meetings of the American Association of Suicidology [19]; it is described in the 1-day suicide assessment competency course (Assessing & Managing Suicide Risk) co-sponsored by the Suicide Prevention Resource Center (SPRC) [20] and the American Association of Suicidology, and it is recommended as a resource for telephone crisis workers by the National Suicide Prevention LifeLine [21].

It was designed to increase validity, decrease errors of omission, and increase the client's sense of safety with the interviewer while discussing intimate details regarding suicidal ideation, intent, and behaviors. In the CASE Approach, clinicians are trained to flexibly uncover suicidal ideation and intent using a sophisticated set of questions and interview strategies, as opposed to asking a simplistic set of rote questions on the presence of suicidal plans. The techniques and strategies of the CASE Approach are concretely behaviorally defined; consequently it can be taught readily, and the skill level of the clinician may be tested easily and documented for quality assurance purposes.

In the CASE Approach, the interviewer explores the suicidal feelings, ideation, plans, intent, and actions of the client over four contiguous time regions—hence its name. First, the clinician begins by sensitively and carefully exploring the client's presenting suicidal ideation/actions during the last 48 hours (Region #1—Presenting Suicide Events). Second, the clinician explores the client's suicidal ideation/actions during the previous 2 months (Region #2—Recent Suicide Events). After the clinician completes this exploration, Region #3 (Past Suicide Events), consisting of the past suicidal ideation/actions, is explored. Finally, the clinician explores Region #4 (Immediate Suicide Events), consisting of the client's immediate suicidal ideation/actions/intent. This region of immediate ideation is defined as those suicidal thoughts potentially arising during the interview itself and the client's views on possible future suicidal thoughts—and what to do if they arise (Fig. 1).

A hallmark of the CASE Approach is the flexible use of four specific interviewing techniques, designed to increase the validity of the elicited data while



**Fig. 1.** Chronological Assessment of Suicide Events (CASE) Approach.

exploring each of the four chronological regions just described. These four validity techniques—the behavioral incident, gentle assumption, symptom amplification, and denial of the specific—were culled from the pre-existing clinical interviewing literature in the fields of counseling, clinical psychology, and psychiatry.

There is no space in this article to describe the details of the CASE Approach (appropriate resources for a complete review of the approach will be provided later). But we want to share enough of the strategy so that the reader can see how macrotraining can be effectively employed to train clinicians in its use. To accomplish this goal, let us look at one of the validity techniques used in the CASE Approach—“the behavioral incident”—and how it is used in Region #1 of the CASE Approach (eliciting suicidal ideation, intent, and behaviors in the last 48 hours).

Regarding any type of sensitive material—not just suicidal ideation—a client may provide distorted information for a number of reasons, including anxiety, embarrassment, protecting family secrets, unconscious defense mechanisms, conscious attempts at deception, and fears of the possible consequences if one tells the truth (such as hospitalization or the contacting of social service agencies if abuse is uncovered). These distortions are more likely to appear the more the interviewer asks a patient for opinions rather than behavioral descriptions of events.

“Behavioral incidents”—an interviewing technique originally described by the clinical psychologist Gerald Pascal [22]—are questions that ask for specific facts, behavioral details, or trains of thought, as with “How many pills did you take?” or that simply ask the patient to describe what happened sequentially, as with “What did you do next?” By using a series of behavioral incidents, the interviewer can sometimes help a patient enhance validity by recreating, step by step, the unfolding of a potentially taboo topic such as a suicide attempt or an act of domestic violence.

As Pascal states, in general, it is best for clinicians to make their own clinical judgments based on the behavioral details of the story itself, rather than relying on clients to proffer “objective opinions” on matters that have strong subjective implications. Some typical behavioral incidents are listed below as they might appear when uncovering any area of sensitivity, such as a history of incest, a substance abuse history, or the elicitation of suicidal ideation:

Prototypes:

1. Did you put the razor blade up to your wrist?
2. When you say that “you taught your son a lesson,” what did you actually do?
3. Have you ever missed a day of work because of a hangover?
4. What did your father say then?
5. Tell me what happened next.

Let’s see how this specific interviewing technique—the behavioral incident—is used to form an interviewing sequence for use in Region #1 of the CASE

Approach. This interviewing sequence can be easily taught—via macrotraining—in the same fashion that we taught the two interviewing sequences in Region #1 of our prototypical interview for uncovering abuse, described earlier.

In the CASE Approach, during the exploration of Region #1 (the Presenting Events), the interviewer asks the patient to describe the suicide attempt incident from beginning to end. During this description the clinician gently, but persistently, uses a series of behavioral incidents, guiding the patient to create a “verbal videotape” of the attempt step by step. Readers familiar with cognitive behavioral therapy will recognize this strategy as one of the cornerstone assessment tools of CBT—“behavioral analysis.”

If an important piece of the account is missing, the clinician returns to that area, exploring with a series of clarifying behavioral incidents, until the clinician feels confident that he or she has an accurate picture of what happened.

This serial use of behavioral incidents not only increases the clinician’s understanding of the extent of the patient’s intent and actions but also decreases any unwarranted assumptions by the clinician that may distort the database. Creating such a verbal videotape, the clinician will frequently uncover a more accurate picture of the suicidal behavior and the suicidal intent it may reflect in a naturally unfolding conversational mode, without much need for memorization of specific questions.

When there has not been a specific suicide attempt, the serial use of behavioral incidents can be particularly powerful in uncovering the extent of action taken by the patient regarding suicidal planning—an area in which clients frequently minimize. Keep in mind the goal of the interviewer—to uncover a valid understanding of how close the client came to actually attempting suicide, a realization that the client may not want to admit to the interviewer (or perhaps even to himself or herself) because of stigmatization or shame. The resulting information can have critical implications for safe triage and collaborative planning to help the client be safe in the days to come.

For example, the series of behavioral incidents used to create the “verbal videotape” may look something like this, in a patient who actually took some actions with a gun: “Do you have a gun in the house?” “Have you ever gotten the gun out with the intention of thinking about using it to kill yourself?” “When did you do this?” “Where were you sitting when you had the gun out?” “Did you load the gun?” “What happened next?” “Did you put the gun up to your body or head?” “Did you take the safety off or load the chamber?” “How long did you hold the gun there?” “What thoughts were going through your mind then?” “What did you do then?” “What stopped you from pulling the trigger?”

In this fashion, the clinician can feel more confident of getting an accurate picture of how close the patient actually came to attempting suicide. The resulting scenario may prove to be radically different—and more suggestive of imminent danger—from what would have been relayed by the patient if the interviewer had merely asked, “Did you come close to actually using the

gun?”—to which an embarrassed or cagey patient might quickly reply, “Oh no, not really.”

Also note, in the aforementioned sequence, the use of questions such as “When did you do this?” and “Where were you sitting when you had the gun out?” These types of questions, also borrowed from CBT, are known as “anchor questions,” for they anchor the patient in a specific memory as opposed to a collection of nebulous feelings. Such a refined focus will often bring forth more valid information as the episode becomes more vivid to the patient.

The exploration of Presenting Suicide Events can be summarized as follows. The clinician begins with a statement such as “It sounds like last night was a very difficult time. It will help me to understand exactly what you experienced if you can sort of walk me through what happened step by step. Once you decided to kill yourself, what did you do next?”

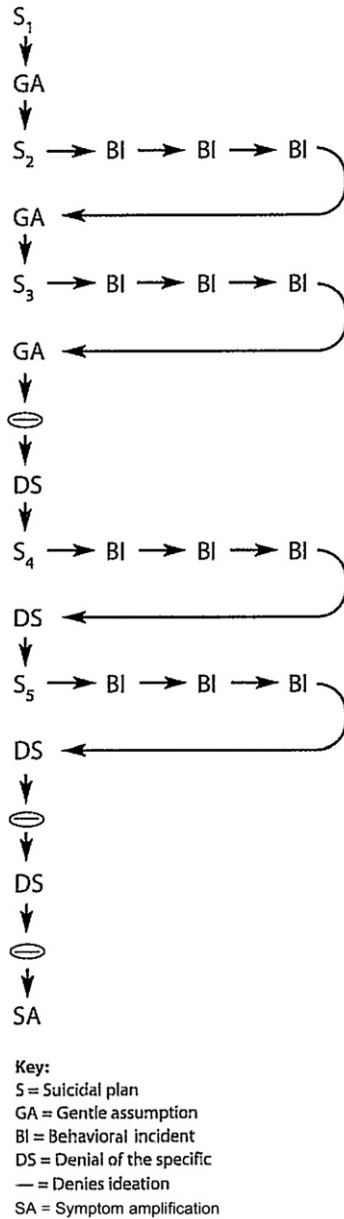
As the patient begins to describe the unfolding suicide attempt, the clinician will use one or two anchor questions to maximize validity. The interviewer will then proceed to use a series of behavioral incidents that make it easy for the clinician to picture the unfolding events—our so-called “verbal videotape.” The strategy and the metaphor of “making a verbal videotape” have been quite popular with residents and graduate students, for the clinical task seems clear and is easily remembered even at 3:00 AM in a busy emergency department.

Perhaps one of the most sophisticated uses of the validity techniques (and, we think, one of the most useful) occurs in Region #2 (Recent Suicide Events—including suicidal thoughts, plans, and behaviors over the past 2 months). In this region of the CASE Approach, all four of the validity techniques—the behavioral incident (BI), gentle assumption (GA), denial of the specific (DS), and symptom amplification (SA)—are flexibly interwoven to uncover hidden suicidal intent and behaviors (Fig. 2).

Without a knowledge of the definitions and uses of all the validity techniques, Fig. 2 may not make a lot of sense, but all the reader needs to glean from it, for our purposes, is that a series of interviewing sequences is used that are composed of well-defined interviewing techniques, making the region amenable to macrotraining.

By the way, if you are not familiar with the CASE Approach, it cannot be emphasized enough that it is not presented as the “right way” to elicit suicidal ideation. It is presented merely as “a reasonable way.” Once they have learned how to use the CASE Approach, clinicians can subsequently adopt what they like and reject what they do not like.

Moreover, the CASE Approach is intended to be creatively and flexibly altered to fit the needs of each unique client and his or her presentation. In complicated presentations of suicidal potential, the entire CASE Approach may be valuable. When the interviewer is less suspicious of suicidal potential, bits and pieces of the CASE Approach can be used as indicated. The goal is not to present a cookbook way of interviewing but to excite the clinician to discover his or her own way of strategically eliciting suicidal ideation and to provide the clinician with the tools—the validity techniques—to do so.



**Fig. 2.** Exploration of recent suicidal ideation.

To become familiar with the CASE Approach, your psychiatric residents, graduate students, and staff—whether face-to-face clinicians or phone staff—have a variety of options. We believe that the best single article on the practical use of the CASE Approach is “The Delicate Art of Eliciting Suicidal Ideation” [23], an excellent introduction to be read before a session of macrotraining on the CASE Approach. The most comprehensive description of its use, which also shows how to effectively integrate the CASE Approach with all the other critical aspects of suicide assessment, from risk factors and clinical formulation to documentation, can be found in the book *The Practical Art of Suicide Assessment: A Guide for Mental Health Professionals and Substance Abuse Counselors* [24].

We will now use the teaching of the CASE Approach as an illustration of how to use macrotraining in the real world. It is our hope that such training can provide a psychiatric resident or graduate student with the tools to competently elicit suicidal ideation. Macrotraining of the CASE Approach also allows a residency director to rest assured that the trainee has been directly observed applying a reasonable method of eliciting suicidal ideation by an experienced faculty member, a quality-assurance measure that may someday save a life.

## **MACROTRAINING THE CHRONOLOGICAL ASSESSMENT OF SUICIDE EVENTS APPROACH: HOW TO DO IT**

The macrotraining of the CASE Approach begins before anyone enters the room. As a prelude to the training, the student is asked to read the article “The Delicate Art of Eliciting Suicidal Ideation,” mentioned earlier. The article is easy to read and lays out the fundamentals of the CASE Approach clearly. The article also contains a section—“The Importance of Eliciting Suicidal Ideation”—that goes beyond the obvious reasons, providing some surprising and sophisticated beneficial ramifications of gathering a thorough database on suicidal ideation, intent, planning, and behaviors. We have found this section tends to motivate students and generates an excitement about the upcoming macrotraining session.

After appropriate introductions and a settling in period (often accompanied by some coffee and doughnuts), the trainer asks about questions concerning the article and shows how each of the trainee’s questions will be addressed carefully and experientially in the training session.

In the next step, using a 4×6 whiteboard, the trainer maps out the four regions of the CASE Approach (Region #1—Presenting Suicide Events over the past 48 hours; Region #2—Recent Suicide Events over the past 2 months; Region #3—Past Suicide Events; and Region #4—Immediate Suicide Events during the interview). The naturalness of the flow between regions is described. We also emphasize that frequently we see an increase in engagement as the CASE Approach is performed with clients. This beneficial increase in rapport seems to occur because clients are sharing material they have often kept to themselves because of shame, and the fact that the CASE Approach interviewer neither underreacts nor overreacts to the client’s suicidal thoughts is often reassuring.



The trainer then briefly addresses the structure of the day, indicating that each of the four regions will be addressed individually. Within each region the trainee will learn what data bits are important to gather, see suggested validity techniques for uncovering this information, and even be able to learn methods of sequencing these validity techniques that might help uncover potentially dangerous hidden information.

The trainer subsequently turns attention solely to the teaching of Region #1 (Presenting Events). A brief didactic is given using the whiteboard and flip charts to review the validity techniques used in this region (there is only one—the behavioral incident) and the interview sequences used in Region #1 (there is only one—the creating of a “verbal videotape” using sequential behavioral incidents). The presence of only one validity technique and one type of interviewing sequence in Region #1 turns out to be an unplanned blessing in macrotraining the CASE Approach. Learning this region is simple enough that it almost functions as a warm-up for the trainee. Success in it is almost guaranteed, resulting in an increased confidence and excitement as the trainee moves into Region #2.

After providing the didactics, the macrotrainer asks some questions to test the trainee’s understanding. Any areas of “fogginess” are clarified before proceeding. Once the trainer is comfortable with the student’s understanding of the structure of the behavioral incident and its sequential use to create a verbal videotape, the student is shown a videotape of a skilled clinician doing Region #1. It can be a videotape of you or any faculty member who knows the technique, but it should be with an actual patient. After answering any questions regarding the tape, the trainer moves on to the first role-play.

Given that there is only one sequence in Region #1, after reviewing the behavioral incident sequence used to create a verbal videotape, the trainee is asked to perform this interview sequence in a role-play in which a client has overdosed. Any errors are corrected either by “timing out” during the role-play for immediate feedback or after the role-play is completed. Role-plays are sometimes “timed out” to provide purely positive feedback, such as “You just did a great section using behavioral incidents—couldn’t be done any better. Let’s pick up where we left off and see what else you uncover as you continue the verbal videotape. Great job!”

Once the behavioral incident sequence has been done to perfection with a client considering an overdose, we suggest two consolidating role-plays be performed: a client with a gun at home and a client considering hanging. Each is done to a level of competency before one moves to the next one. These role-plays also allow you to see how well the trainee can generalize the use of the behavioral incident to other methods of suicide. At this point we recommend repeating the role-play of a patient contemplating an overdose (using a new patient) to see how well the trainee has maintained the skill level.

At this juncture in the macrotraining, trainees are often enthusiastic. It’s fun to succeed. They realize that what they are learning may help them to save

a life. Motivation levels are usually high as we enter the training of Region #2, arguably the most complex arena of interviewing in the CASE Approach.

But training in Region #2 is not really as hard as it looks at first glance. Take a look at Fig. 2 again. You will see that Region #2 is actually composed of three discrete interviewing sequences. The first sequence is composed of the use of a gentle assumption (GA)—such as “What other ways have you thought of killing yourself?”—followed by the creation of a “verbal videotape” of the extent of planning and action taken on another method, if one is reported by the client. The trainer portrays a client until the trainee shows competence in this interviewing sequence, exactly as was done in Region #1.

Note that part of this simple first sequence—making a verbal videotape—is actually composed of an interviewing sequence in which the trainee has already gained competence, for making a verbal videotape was the core interviewing sequence used while exploring Region #1.

The second interviewing sequence in Region #2 is nothing more than the first sequence repeated multiple times. (Please refer to Fig. 2.) Specifically, the clinician repeatedly uses a gentle assumption followed by a series of behavioral incidents to create a “verbal videotape,” until the client responds to the gentle assumption of “What other ways have you thought of killing yourself” with a negative such as “None.” At this point the trainer and trainee return to the role and pick up where they left off. The trainer portrays a patient who has been contemplating multiple methods of killing himself or herself, and the trainee is expected to keep posing gentle assumptions with follow-up verbal videotapes until this second interviewing sequence is performed to a level of competence.

In the third interviewing sequence (please refer to Fig. 2), the interviewer employs a series of denials of the specific, which are followed by the making of a verbal videotape if a new method of suicide is proffered by the client. Finally, a different validity technique—symptom amplification—is used to figure out the intensity and frequency of the suicidal ideation across all contemplated plans. At this point, this third and final interview sequence of Region #2 is role-played to competence by returning to the same spot where this patient’s role-play was interrupted.

You will readily understand the nature of and reasoning behind all these specific validity techniques and their sequencing after you read the article “The Delicate Art of Eliciting Suicidal Ideation.” What is important now for our understanding of macrotraining is merely that even this relatively complex series of interview questions can be conceptualized as three simple interview sequences, which are very amenable to microtraining. It is now time to ask the student to do all three sequences of Region #2 in order and without stopping to ensure their competence and to further clarify and consolidate the learning so far in Region #2.

Once the student has mastered Region #2, and after much positive reinforcement (students are often quite impressed that they have been able to master a relatively complex interview strategy so easily), we have reached a critical juncture in the macrotraining. As stated earlier, the heart and soul of

macrotraining is the serial repetition of learned interview sequences until perfected. The trainer now creates a completely different patient, who has been thinking of multiple suicide methods and taken some action on at least three of them in the past 2 months. In this role-play, the student is asked to do both Region #1 and Region #2 back to back and without stopping until a level of competence is reached.

It may be close to an hour since the student was microtrained on Region #1, so requiring the student now to do both Regions #1 and #2 contiguously not only offers a chance for the student to consolidate his skills but also allows the trainer to ascertain whether the student has retained what was taught earlier. Any decrement in the techniques for Region #1 can be addressed if necessary.

Also notice how often, in the course of the macrotraining thus far, the student has practiced making a “verbal videotape,” using behavioral incidents with a variety of different types of clients to ensure generalization of the skill set. We find the consolidation effect of these repeated role-plays to be powerful, hopefully enhancing the likelihood that months and years later the student will still be employing this strategy with skill.

The rest of the macrotraining session follows the exact same protocol. After successfully demonstrating the ability to do Regions #1 and #2 contiguously, the student is trained to do Region #3 (past suicidal ideation, plans, and behaviors) to a level of competence.

It is then critical that the student be asked to do a serial consolidation role-play in which a brand-new patient is presented and the student does Regions #1, #2, and #3 without stopping and to a level of competence. We think you will be pleasantly surprised at how many students can do this well.

The macrotrainer now proceeds to teach Region #4 (immediate suicidal thoughts and intention during the interview itself), once again starting with a brief didactic, followed by watching the model videotape and proceeding with the serial role-playing. Once the student has demonstrated the ability to explore Region #4 to a level of competence, the macrotraining is over, except for one major part.

As one would expect, it is now time for the student to “pass the test” by demonstrating the ability to do the CASE Approach through all four regions without stopping and to a level of competence with yet another role-played client.

We have found that the vast majority of trainees find the macrotraining sessions to be both fun and valuable. Many are surprised at how much they learned and how much of it will be of immediate practical use to them. It also tends to stir excitement about the interviewing process, convincing residents of something that experienced clinicians already know about clinical interviewing—namely, technique counts. In addition, there is a perk to the macrotraining session. Psychiatric residents are very appreciative of the time spent with the faculty (or chief resident) during the training. It may prove to be the most intensive one-on-one attention they will get in their residency experience.

The time spent—roughly 3 to 4 hours (including breaks)—may at first glance look substantial, but when put in perspective, it is well worth the investment.

To devote 3 to 4 hours of time, in a 4-year psychiatric residency or graduate program in counseling, to one of the most critical of all clinical skills (and a forensically high risk area) is hardly inordinate. Moreover, the macrotraining achieves a level of behavioral competence in eliciting suicidal ideation that is simply unobtainable using lectures and readings.

If you are at a clinic, hospital, substance abuse center, or crisis call center and want to train your staff to a level of competency in eliciting suicidal ideation (or perhaps other interview strategies of particular interest to your needs—crisis intervention techniques, eliciting a substance abuse history, uncovering the extent of domestic violence), macrotraining can be invaluable and fun.

A particularly clever occasion to do macrotraining is with newly hired staff during their “orientation.” Orientation periods are frequently viewed as “sort of boring” by many personnel. The inclusion of a macrotraining session is often quite refreshing and also helps ensure the quality control of your program. For both quality-control and forensic purposes, it is nice to have documented that all new staff has been trained in eliciting suicidal ideation in a rigorous fashion. Such “orientation macrotraining” sessions also provide an early and close-up look at a new employee and how readily he or she responds to supervision.

## **A FEW FINAL TIPS FOR EFFECTIVELY USING MACROTRAINING**

### **Tip #1: Establishing “Buy-In” to Macrotraining—The Real First Step**

Macrotraining represents a significant investment in time for the student, no matter what interview task is being taught. It also involves role-playing, which can be intimidating to some students, for the trainee’s errors are made immediately apparent to an observer. Consequently, it is critical to address these issues before beginning to teach—to establish the student’s “buy-in” before proceeding with actual training. A good macrotrainer knows how to pitch the product. The goal is to establish early on a sense of safety, excitement, and motivation about the session itself, creating in the student a belief that “I am about to do something special that few students ever get a chance to do.”

After chit-chat and a doughnut or two, we like to begin by asking what, if anything, the student has heard about macrotraining. Once you have been doing macrotraining at your center successfully, many students will arrive already excited about the session, for they will have heard good feedback about the experience from colleagues. By contrast, if for some reason they heard something negative, it is best to have this hesitancy out on the table immediately so that one can potentially transform it.

Selling the product effectively can be enhanced by remembering three goals: (1) Establish credibility and excitement about macrotraining by giving a bit of its history; (2) Establish credibility and excitement about you as a macrotrainer by sharing some of your personal successes with the method; and (3) Decrease any anxiety related to the unknown by concisely outlining the day.

With regard to the first goal, consider sharing with the students information about Allen Ivey and microtraining, emphasizing the large amount of

research supporting the power of microtraining. Proceed to emphasize how macrotraining is based on the serial use of Allan Ivey's microtraining. Let students know a little bit about how macrotraining was developed at a leading interviewing training center (WPIC) and has been in ongoing refinement for more than 20 years. Credibility is also enhanced by sharing that macrotraining was developed by the author of several popular textbooks for psychiatric residents and graduate students across all disciplines [10,24,25], some of which the students may already be using in their graduate program, a fortuitous circumstance that can greatly enhance pre-session enthusiasm.

If you happen to be macrotraining the CASE Approach, give a little information on its wide acceptance both nationally and internationally. Touch on how important eliciting suicidal ideation can be. And perhaps the most powerful endorsement is a personal one—if you have one—such as “I have found the CASE Approach to be invaluable for me in my own practice. I think it has helped me to save a life or two.”

One can achieve the second goal—establishing one's own credibility—by sharing some of your successes in macrotraining and your own “pleasant surprise” at its power. Perhaps even more importantly, share how much fun you have doing it and that you too will learn from the process, for it always involves a shared learning experience.

Concerning the third goal—decreasing the fear of the unknown—lay out the day in a concise form. Be sure to emphasize that the day is designed to be enjoyable. Moreover, “We will move together at whatever pace is comfortable to you.”

Finally, keep in mind that in the long run, the single most powerful tool you have for establishing “buy-in” is not the content of the approaches just described, but the warmth and personal excitement with which you communicate them.

### Tip #2: Proactively Transforming Fears About Role-Playing

To a student who has not done a lot of role-playing (or to a student who has experienced role-playing done poorly), the idea of doing 3 hours of it is not exactly appealing! Causes of hesitancy can include the idea that role-playing is threatening (as mentioned earlier), is hokey, is silly, is not realistic—or all of the above.

During the introduction to the macrotraining session, we suggest routinely asking whether the trainee has ever done role-playing and, if so, what the experience was like. Responses vary remarkably, from students who love it to those who dislike it intensely. If you find a student who voices significant dislike of role-playing, we often begin by going with the resistance, using comments such as “Well, to tell you the truth, sometimes role-playing is frustrating. I've had some role-plays done when I was a student that didn't seem to work for me either. You know, the trick is that role-playing can be done well or done poorly by a trainer. I've had some good luck with it over the years, and I've gotten better and better at making it feel more real. And

there is one thing I know it provides that no other training situation can match. It allows us to look repeatedly at a specific difficult interview situation so that we can try new ideas, something you just can't do repeatedly with a real patient. You'll have to see what you think, and let me know as we go along, because I want this to be enjoyable for you as well as being a great way to learn how to elicit suicidal ideation. By the way, if you think that my acting skills are not the stuff of Oscars, just let me know." This last statement, said with a gentle smile and a twinkle in the eye, can result in a real "breaking of the ice." The use of humor is crucial to successful macrotraining throughout the session.

And here we come to one of the single most important tips for successful macrotraining: *Remember that the main goal of the very first role-play is to make sure that the trainee is comfortable with role-playing and enjoyed the experience with you.* Actual learning about interviewing technique takes a distant second place in the first role-play. The goal is to establish a safe learning environment for the trainee.

You may encounter a few trainees who have significant anxiety related to role-playing. And, in a rare instance, a trainee may have a true social phobia with an intense fear of "performing" any task in which he or she will be observed directly. If you ever encounter such a situation, macrotraining may be counterproductive; the teaching of the intended interview strategy may be best approached in less directly observed ways, while you help the trainee to seek professional help for the ongoing social phobia.

### Tip #3: Using Role-Plays Designed to Generalize Skills to Different Interview Tasks

So far in this article, role-playing has been used to teach a new interviewing skill, to consolidate the learning of an immediately learned skill, or to see if the skill can be transferred to a "new patient," a situation in which the same skill needs to be used *for the same task but with a patient who presents a bit differently.*

Every once in a while it can be useful to do a role-play that has nothing whatsoever to do with the stated goal of the macrotraining session. The need to generalize the skill to a new type of clinical task can, paradoxically, enhance the learning of the skill for which the macrotraining is being done, for such radical generalization can ensure that the trainee understands *why* the interviewing technique or strategy works.

Let me clarify with an example from macrotraining the CASE Approach. When teaching the student how to make a "verbal videotape" during the exploration of Region #1, if time permits, I might suggest the student make a verbal videotape of a completely different situation so that he or she can see the power of the behavioral incident to uncover the truth.

For instance, I might ask the student to use behavioral incidents to create a verbal videotape regarding an act of domestic violence—one that is being reported by a victim of the violence, who may be prone to minimizing its extent (perhaps to protect the perpetrator). I will then role-play the victim and share more and more of the truth of the extent of the violence as the interviewer

gently walks me through what happened step by step using behavioral incidents, an exercise that can vividly show the trainee the power of using behavioral incidents.

Such “off-task” generalizing role-plays can provide a series of benefits: (1) The trainee learns to apply the interviewing technique or sequence even more effectively, because the exercise forces the trainee to think more creatively about how to use the technique (the trainee will have seen no model of this use of the creation of a verbal videotape); (2) The unusual role-play brings a refreshing break in the focus of the format; (3) The student learns through personal experience that this particular validity technique—the behavioral incident—may be useful in many clinical situations other than eliciting suicidal ideation (and is much more likely to try using it in creative ways once the macrotraining session is over); and (4) The discovery of the new uses of the behavioral incident (or any of the other validity techniques, such as gentle assumption and symptom amplification) in other clinical situations frequently enhances immediate enthusiasm about the macrotraining of the CASE Approach, for the resident now sees unexpected benefits coming from the session.

#### Tip #4: Communicating the Critical Importance of Flexibility

Many of the interview strategies that can be taught using macrotraining, such as eliciting a drug and alcohol history or uncovering incest, are creatively adapted and modified to the unique circumstance of the client at hand and the variables of the interviewing environment and immediate goals of the interview. For instance, with a seasoned street junkie, one is going to lean toward using a detailed uncovering of substance use, abuse, and experimentation. Validity techniques such as gentle assumption (“What other street drugs have you used, even just one time?”) may be repeatedly used by the interviewer.

By contrast, if, as the history unfolds, the interviewer sees little supporting evidence of street drug abuse, and the patient—when asked several prompting questions about street drug use—comments, “No, I’ve never even smoked a cigarette; I don’t believe in using street drugs and never have,” then there is no need to continue with an exhaustive inquiry about all the classes of street drugs. Obviously, such a detailed inquiry could seem odd to the client and potentially be disengaging.

Although flexibility is taught throughout any macrotraining session, after the student has mastered the interview strategy, we believe it is important to re-emphasize the need for flexible application of that strategy, providing concrete examples (as I just did) of circumstances where it should be markedly decreased in scope.

We find this to be particularly true with the macrotraining and subsequent use of the CASE Approach. After the student has “passed the test” of demonstrating the entire CASE Approach, emphasize the critical importance of flexibly adapting the technique to the unique client being interviewed, whether the interview is taking place in an outpatient setting or emergency room or during the handling of a crisis call.

By way of illustration, as we near the end of a session of macrotraining the CASE Approach, we point out that we have been role-playing patients who present with multiple thoughts of suicide, who have taken action on at least one of these methods, who show significant risk factors, who report few buffering factors, and of whom we have an intuitive suspicion that—secondary to feelings of shame or fears of stigmatization—they are hesitant to share the vital information we need to ensure safety and effective collaborative treatment planning. In our opinion it is here, in these particularly dangerous (and relatively infrequent) situations, that the full implementation of the CASE Approach may be life saving.

Point out to the trainee that the CASE Approach is greatly modified and shortened in most other situations. We leave nothing to chance here, and make a point of providing clear examples of what we mean. Thus we describe a situation in which a client speaks earlier in the interview of being quite distressed (and may be intermittently tearful) but relates minimal risk factors for suicide and describes excellent buffers (perhaps speaking spontaneously of future plans and a strong social support system). In such a situation, the screening for suicidal ideation may go as follows:

Clinician: “With all of the stress and pain you’ve been going through, have you had any thoughts of killing yourself?”

Client: “No, I haven’t.”

Clinician: “How about recently, over the past couple or so months: Have you had even fleeting thoughts of killing yourself?”

Client: “You know, it just doesn’t cross my mind.”

Clinician: “How about in the past? You had told me about some very serious episodes of physical abuse when you were growing up; have you ever had any thoughts of killing yourself or perhaps even tried?”

Client: “You know, with all I’ve been through, you would almost think that I would have, but for some reason it has just never seemed like an option to me, thank God.”

The entire screening with the CASE Approach was completed with this client with just three questions in less than a minute’s time. It would be inappropriate to use gentle assumptions, denials of the specific, and symptom amplification in Region #2 of the CASE Approach (recent ideation over the past 2 months). It’s just not necessary, and would appear odd to do so. Also note that Region #4 (immediate suicidal ideation in the interview itself) is not even covered with such a client.

Even if a client admits to some suicidal ideation (perhaps mentioning fleeting thoughts of overdosing or hanging), when exploring Region #1 (presenting suicidal ideation), unless the client has been extensively planning the attempt, has taken some actions on it, or presents with an unusual array of risk factors, the CASE Approach will once again be markedly shortened. Suppose, when such a client is asked as the clinician enters Region #2, “Have you been having any thoughts of killing yourself over the past couple of months? he or she



comments in a convincing and genuine fashion, “No, not at all. It’s just not an option for me.” Then validity techniques such as gentle assumption, denial of the specific, and symptom amplification are once again not used.

The importance of such flexibility may seem like a “no-brainer” to the reader, but we have found that it is very important to emphasize this point with examples at the end of the macrotraining session, for some conscientious students with a strong desire to do the CASE Approach “well” may come away mistakenly using it in a cookbook fashion. This potential problem can be easily prevented by the actions described above. Indeed, if time permits, after discussing the need for creativity and flexibility in detail, we like to role-play a client in which the CASE Approach is greatly reduced in extent, to make sure the student “gets it.”

### Tip #5: Communicating the Importance of Timing—When to Ask About Suicidal Ideation

Suicide remains one of the most taboo of all subjects, and people can have significant feelings of shame and guilt attached even to having ideas of killing oneself. Consequently, it becomes critical that clinicians time the inquiry in such a way as to maximize the likelihood of uncovering the intimate thoughts of the patient regarding their suicidal intent or planning in a sensitive fashion. Many a clinician has “lost the truth” through the poor timing of the inquiry, sometimes also resulting in the permanent loss of engagement.

Perhaps the single most common timing problem is asking about suicide too early in the interview, an action sometimes generated by the interviewer’s “need to know” or the desire to “get the tough questions out of the way.” Such premature inquiry into such a critically sensitive topic can be off putting, disengaging, and artificial sounding; it may lead to significant breakdowns in the alliance, with a potentially dangerous loss of valid information and willingness to collaborate with recommendations for safety and follow-up. Consequently, as the macrotraining session draws to a close, we recommend addressing this common problem. At what point in the interview should you use the CASE Approach?

The optimum time for raising the topic of suicide may be conceptualized as the intersection of three factors [24], which can help guide the interviewer: (1) sound engagement, (2) presence of affective discharge in the client, and (3) the client hints at the topic (a factor that is not always present). Let’s look at each of these in more detail.

(1) Engagement, engagement, engagement. Because people are much more likely to share sensitive material with someone with whom they feel comfortable talking and have already established a safe environment, if the interviewer happens to be the first to raise the issue of suicide, it is generally best to wait until engagement is maximized. Such patience can significantly enhance the likelihood that the client will share openly. Naturally, such maximization frequently occurs fairly deep into the interview, after the client has had the chance to interface in an engaging fashion with the clinician on a variety of other topics, such as the presenting crisis, stressors, painful symptoms, etc.

Sometimes in phone intervention, the inquiry occurs even later than in face-to-face interventions, for communication of factors such as empathy, as the noted social scientist Edward Hall has commented, are often tied in to nonverbal communications and cultural rhythms as opposed to the words we speak [26]. The lack of many nonverbal communicators puts telephone interviewers at a distinct disadvantage in creating rapid alliances compared with face-to-face interviewers (a single warm smile may communicate more empathy than a dozen empathic statements).

(2) In addition to waiting until engagement has been maximized, it is useful to time the raising of suicidal ideation to a moment in the conversation when the client is experiencing and expressing significant emotional pain. At such moments of intense affective discharge, the defense mechanisms and prohibitions regarding stigmatization are often overwhelmed by the pain, once again resulting in a more open sharing of the extent of ideation and suicidal intent.

(3) Although not always present, a third indicator of an excellent time to raise the topic is when the patient not only is engaged and affectively charged, but also hints at the possibility of suicide with comments such as “I’m not even sure whether it is worth going on” or “Maybe my kids would be better off without me.” Obviously, the timing of raising the topic is unique to each client and should never be approached in a cookbook fashion at a predesignated time in the interview.

Another common problem in eliciting suicidal ideation is the misconception by students that all elements of the “suicide assessment” occur at one time in the interview or in a direct linear fashion. A suicide assessment seldom unfolds in such a neat fashion. Statistical risk factors (such as age, sex, presence of medical illness, or alcohol abuse) and external risk factors (presence of an interpersonal crisis, domestic violence, poor social network, and social isolation) may appear spontaneously throughout the interview. Such statistical and external risk factors may even appear in the early minutes of the interview, a time when clients often give information regarding immediate stressors and interpersonal problems. Indeed, as an interview proceeds, it is the careful weighing of these risk factors (as well as buffers) that can help the clinician make a decision about how detailed an elicitation of suicidal ideation will be required later in the interview once rapport is well-established.

By contrast, the internal (eg, phenomenological) risk factors, such as suicidal ideation, intent, desire, past actions, current planning, feelings of isolation, hopelessness, and despair (the exact factors on which the CASE Approach focuses and which it was specifically designed to uncover) are generally explored in a naturalistic and flowing fashion during the optimal moment of the interview for such inquiry, as described earlier.

## SUMMARY

It is our hope that with this article, the reader can begin his or her own forays into macrotraining. Whether you are a psychiatric residency director, a director

of any other type of mental health graduate program (including counseling, clinical psychology, psychiatric social work, and psychiatric nursing), or a faculty mentor responsible for the training of clinical interviewing skills at your program, we believe you will find that macrotraining can be effectively used to train a variety of different types of interview.

Outside academic centers, macrotraining can be used by supervisors in myriad arenas, including emergency rooms, inpatient units, community mental health centers, and crisis call centers (staffed by either professionals or volunteers), to teach a variety of interviewing skills, including crisis transformation strategies, engagement strategies, and uncovering specific databases—such as differential diagnosis and eliciting suicidal ideation and histories of physical and sexual abuse—in creative, flexible, and engaging fashions.

With this paper, and by reading the paper suggested earlier in the description of the CASE Approach, supervisors can begin to use macrotraining to achieve a vibrant and enjoyable training of students and staff in eliciting suicidal ideation, planning, intent, and behaviors more effectively. Although there is not time in this monograph to describe the variants of macrotraining, it has also been applied to larger groups of trainees, in which pods of four participants break out of the larger group to use variations of macrotraining to teach the CASE Approach.

It is hoped that the CASE Approach may prove to be a valuable addition to the ongoing attempts to improve the quality of suicide assessments and the training of all the clinicians from various disciplines who perform them. Since its appearance in the literature in 1998, the Approach has been well received among mental health professionals, substance abuse counselors, crisis clinicians, school counselors, and primary care clinicians. Perhaps someday all graduates of training programs in mental health will be taught to a level of competence to elicit suicidal ideation using the CASE Approach—or an even better method, if one emerges from future research. The ramifications for suicide prevention may even encompass disciplines outside the training of mental health professionals, such as volunteer crisis line workers, primary care clinicians (including physicians, nurses, and case managers), and clergy.

A practical example highlights the promise of the CASE Approach in this regard. It is well documented that at least 50% of patients who kill themselves have seen a primary care clinician within 1 month of their death [27]. A typical primary care clinician is seeing patients who warrant a suicide assessment on a daily basis. To prepare medical students for this future task—as part of the numerous behavioral skills they are currently required to demonstrate in front of faculty before graduating—every student could be asked to learn and effectively demonstrate the use of an interview strategy for eliciting suicidal ideation, such as the CASE Approach.

It is likely that such medical students would be more reliably competent in eliciting suicidal ideation than the typical medical graduate of today. Perhaps even more importantly, because the students would both understand the importance of asking for suicidal ideation and feel comfortable and skilled in

doing it, they might be considerably more active in seeking it out in their future primary care settings. The result could be a tangible decrease in the death rate related to suicide.

Moreover, the behavioral specificity of the CASE Approach makes it ideal for rigorous empiric study, which could confirm the validity of the strategy or demonstrate the superiority of other strategies. Such research could provide the foundation for an evidence-based model for effectively eliciting suicidal ideation, much in the same fashion that CPR was developed. As with CPR, such an evidence-based interviewing strategy could be used as the basis for certifying clinicians across disciplines throughout the country. The resultant effects on the rate of suicide are unknown—but the possibilities are exciting.

Whether macrotraining is used to teach clinicians effective ways sensitively to uncover thoughts of suicide or the unsettling memories related to ongoing sexual abuse or to teach them how better to talk collaboratively with patients about their medications, it holds much promise. Its strength lies in its clarity and in the “doing” so dear to Rousseau, for a macrotrained clinician is one who has shown not just theoretic knowledge but demonstrable behavioral competence in performing a complex clinical interviewing task.

As educators we come from a hallowed tradition. I am reminded of three well-known admonitions that seem to resonate directly with macrotraining. From the more distant past—the 1600s—John Clarke comments, “Learn one thing first well.” More recently, Glenn Doman wisely commented, “A primary method of learning is to go from the familiar to the unfamiliar.” And finally, from Mark Van Doren of more contemporary fame, comes one of our favorite quotes: “The art of teaching is the art of discovery.” So it is with macrotraining.

In macrotraining, applying the principles of Allan Ivey’s microcounseling, the student learns each small step well. Many of these small steps become bridges to the next, more complicated sequence of interviewing questions, allowing trainees to move from the familiar to the unfamiliar with more confidence because of their ever-growing sense of mastery. Finally, as the student and the macrotrainer delve into more and more complicated role-plays and clinical situations, the student has the excitement of discovering, for himself or herself, through his or her own experiences, the power of language to help clients both to share difficult material and to begin the healing process.

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