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FORENSIC CLINICAL INTERVIEWING

Interviewing forensic mental health patients who have a history of aggression:
Considerations and suggestions.

Abstract

This paper discusses issues arising when interviewing men and women in forensic mental health services, noting that many patients in these settings have significant histories of aggression or violence. The differences between interviews conducted for assessment purposes and those that are conducted as part of treatment are noted. We identify some important considerations for interviewers. These relate to characteristics of the client, characteristics of the interviewer, and features of the mental health setting that might impact on the interview. Some practical recommendations are offered to assist forensic mental health practitioners who conduct both types of interview.

Key words: Violent, Offender, Interview, Therapeutic Alliance

Introduction

Patients of forensic mental health services are those who have both been diagnosed with a mental disorder and broken the law (Mullen, 2000). They include those who have been judged to be incompetent to stand trial or who have been found not guilty by reason of mental impairment, as well as mentally ill prisoners of correctional facilities who require assessment and treatment for mental health problems. In-patient treatment services are typically only offered to those with a 'major mental disorder', a term usually reserved for more serious forms of mental illness such as psychotic conditions, but which also encompasses the effects of brain damage, intellectual disability, and serious personality problems. In practice, beyond the symptoms of mental illness, it has long been known that many forensic patients are admitted with a history of aggressive and/or violent behaviour (Daffern, Howells, & Ogloff, 2007; Mullen, & Reinehr, 1982), and rates of in-patient violence towards staff and patients can be high (Bowers et al., 2011; Maguire, Daffern, Bowe, & McKenna, 2017). Jones, Owen, Tarantello, and Tennant (1998), for example, reported that seventy eight per cent of reported incidents of violence and aggression in their study were directed at nurses. The aim of this paper is to consider the range of factors that potentially influence the way in which the mental health professional might approach the task of interviewing patients who have a history of acting aggressively or violently or who at risk of doing so in the future. Our focus is on interviewing in-patients, although similar considerations will inevitably arise when interviewing forensic patients in the community.

From the outset, we note that there is surprisingly little guidance - at least in the professional and clinical literature - for mental health professionals who are required to interview forensic patients as a part of their work. This may relate to the considerable heterogeneity that inevitably exists in the forensic mental health patient population and the multiple functions that are served by aggression and violent behaviour (Daffern et al., 2007). A further limitation in the extant literature is that there has been little written, and an absence of empirical work, relating to the skills that are required to interview forensic patients, beyond the task of interviewing clients where the sole purpose is to gathering evidence for court (e.g., Faller, 2015) . It is quite possible that a different approach will be needed in in-patient settings where the

aim is to gather information that is required to conduct treatment. Consider, for example, Greenberg and Shuman's (1997) distinction between how someone conducting a forensic assessment interview should conceptualise their role differently to someone providing treatment (Table 1). The need for an awareness of this distinction has also been raised by HM Inspectorate of Probation (2006) in a review of a serious re-offence in the UK, and by the American Psychological Association (2013) in their specialty guidelines for forensic psychology. In this paper though, we talk more generally about the assessment and the treatment interview, whilst acknowledging that the distinction between these different types of interview can be arbitrary at times and that a similar skill set will be needed to conduct both types of interview to a high standard. What follows is an attempt to integrate a narrative review of the (somewhat disparate) literature that has been identified as relevant to interviewing forensic patients, supplemented with a series of observations and recommendations that may be relevant to professional practice with those who present with a history of aggressive or violent behaviour.

<INSERT TABLE 1 ABOUT HERE>

The Forensic Interview

Hunsley and Mash (2008) have identified seven quite distinctive purposes of any mental health assessment interview: (a) diagnosis; (b) screening; (c) prognosis and other predictions; (d) case conceptualisation/formulation; (e) treatment design and planning; (f) treatment monitoring; and (g) treatment evaluation. Of these, it is the first five that are typically the focus of any assessment interview, although a primary task for those who work in forensic mental health settings will also be to assess the risk of violence (both in the short- and the long-term). It is important to note that assessment interviews with mentally disordered patients can differ in important ways from general counselling encounters. For example, the forensic patient's response style may be characterised by positive impression management motivated by strong external incentives, such as efforts to avoid court proceedings or imprisonment, or to secure a discharge from hospital (Kucharski, Toomey, Fila, & Duncan, 2007). The extent to which participation is voluntary is a particularly important consideration and there are various disincentives to openness. For instance, disclosures about violence

may impact on whether leave is granted (or not) or requests to be discharged are supported.

Given the dis-incentives that sometimes exist to open disclosure in the forensic setting, the development of trust is considered particularly important, with feelings of safety also widely considered to be key to therapeutic change in most psychotherapeutic approaches (see Bachelor, Meunier, Laverdière & Gamache, 2010). It follows that an initial goal of any treatment interview will be to provide an emotionally safe environment in which patients are provided with an opportunity to examine threatening aspects of their experience. According to both Kohut (1977) and Linehan (1997) empathic responding is the most effective way to make patients feel safe which, in turn, is thought to promote self-disclosure (Watson, Goldman, & Vanaerschot, 1998).

Relatedly, there is a particular need to acknowledge that experiences of trauma will often act as a key driver of aggressive and violent behaviour. This might involve, for example, the interviewer paying particular attention to how negative life experiences (e.g., removal from families, foster care, juvenile detention, moving back and forth between institutions) and associated traumatic experiences might be relevant to the purpose of the interview. This may include asking about the impact of experiencing or witnessing anger and/or violence, the use of drugs and/or alcohol to cope, and managing feelings such as frustration, being overwhelmed, being trapped, feeling threatened, feeling intimidated, and feeling out of control. Of particular relevance for the interviewer is using the developing understanding of a person's history to inform judgements about how the patient is experiencing the mental health service and the interview itself.

The need to build rapport is often discussed in terms of the need to form a strong therapeutic alliance. The term, therapeutic alliance, is used to describe the dynamic process of establishing and maintaining a collaborative relationship and has been identified as an important determinant of both treatment outcome (Kozar & Day, 2012; 2017; McMurrin & Delight, 2017; Ross, Polaschek, & Ward, 2008). A strong therapeutic alliance will be based on a clear agreement and understanding regarding the goals of treatment, a clear definition and negotiation of the tasks necessary to

achieve these goals, and the development of an affective bond or mutual trust between the parties (Bordin, 1979).

The interpersonal style of the mental health professional may impact alliance and may also impact on the outcome of any interview or therapeutic encounter. Watson, Daffern and Thomas (2017), for example, have reported that sex offenders evaluate their treatment more positively when therapists are perceived as 'affiliative', and weaker when they are viewed as 'controlling'. At the same time, there have also been suggestions that interviewers have to be flexible in their interpersonal approach; adapting their style in line with the interpersonal skills and attachment styles of the patient (McKillop, Brown, Smallbone, & Wortley, 2016). This is not to say that an interviewer should adopt a submissive approach when working with a dominant client so as to achieve complementarity - rather that a firm yet neutral approach (neither overly friendly nor controlling, hostile or authoritarian) is likely to prove more effective with interpersonally dominant patients (Watson et al., 2017).

Characteristics of the patient and the interviewer

It is already clear that various factors will impact on the quality of the forensic interview. It is possible to group these factors into two key domains that apply to both assessment and treatment interviews; those that relate to the patient and those that are relevant to the interviewer. Although these are inevitably inter-related (i.e., the interviewer will influence how the patient responds, which will influence how the interviewer responds and so on), we discuss each in turn, with a particular focus on violence and aggression,

1. Characteristics of the patient.

The first, and perhaps most obvious, patient characteristic that will potentially impact on the interview process is the extent and nature of mental disorder. Howells and Day (2003) have noted, for example, that engagement may be influenced by symptoms of major mental disorder, such as the positive and negative symptoms associated with schizophrenia, or a range of experiences that impact on attention and concentration. There can, of course, be an advantage in commencing the initial assessment interview soon after the patient has been admitted to the service (i.e., often whilst mentally

unwell) as this may help the mental health professional to better appreciate the nature of the person's mental health problems. And their relationship with aggression. However, there are also benefits in delaying the initial assessment interview until the more florid symptoms have resolved and the patient's capacity for reflection and concentration is improved. Ethically, it is also important to wait until the patient has the capacity to consent to the assessment interview.¹

Forensic patients also typically present with a range of co-morbid problems, including substance abuse (and withdrawal from substance dependence) and family dysfunction (Hodgins & Muller-Isberner, 2004), that may distract them from the focus of any interview. It is, however, personality and interpersonal difficulties that are perhaps most commonly identified as challenges to the effective interviewing of violent patients and, in particular, traits of antisocial personality disorder. People who display these traits have been described as hostile, callous, impulsive, irresponsible, and more likely than others to take risks; according to Benjamin (1993, cited by Duggan, 2008), they show a "pattern of inappropriate and unmodulated desire to control others, implemented in a detached manner", having a "strong need to be independent, to resist being controlled by others, who are usually held in contempt" (p. 198).²

Presentations like this can, in our view, be best understood in relation to the two core dimensions of human interaction that comprise the interpersonal circle (Kiesler, 1987; Wiggins & Pincus, 2002), described by Blackburn and Renwick (1996) as *power or status* (ranging from dominance through to submission); and *affiliation* (ranging from hostility through to friendliness). It is thus likely that many violent patients will have traits of personality disorder that reflect an interpersonal style that is both interpersonally dominant and hostile (see Daffern, Duggan, Huband & Thomas, 2008; Dolan & Blackburn, 2006; Doyle & Dolan, 2006; Podubinski, Lee, Hollander, & Daffern, 2017). They are more likely to perceive threat and hostile intent from the interviewer (Anderson & Bushman, 2002), which may then impact upon their level of engagement, willingness to disclose, and ability to build rapport.

¹ Assessments of fitness to be tried may well occur when the patient is unwell and soon after admission to the service.

² Although we note here that these types of traits emerge developmentally (often as a consequence of adverse life events) and are often therapeutic targets in their own right.

It is also important to remember that many forensic patients will arrive with traumatic histories and they are, therefore, likely to experience a range of factors that will heighten their sense of threat (e.g., affect dysregulation, numbing, callousness, avoidance, sensitivity to negative emotion) and influence their interpersonal engagements (e.g., attribution bias, moral disengagement, alienation, rejection sensitivity) (see Burrell, 2013). Childhood mistreatment is also associated with a hostile-dominant interpersonal style (Podubinski, Lee, Hollander, & Daffern, 2015). Considering the meaning of these presentations will, therefore, be a key task in an effective interview, whether it is for assessment or treatment purposes.

Finally, patients will often be very anxious about meeting new staff and it is the interviewer's responsibility to seek to reduce this anxiety. This may involve considering both strengths and weaknesses, rather than focussing solely on problem behaviour, the elucidation of risk factors and/or antisocial personality traits.

2. Characteristics of the interviewer.

There is an emerging interest in the role that therapist qualities, communication styles, and behaviours play in working therapeutically with violent offenders (e.g., Day, Kozar, & Davey, 2013; Daffern, Duggan, Huband, & Thomas, 2010; Ross et al., 2008). These include the interviewer's level of skill, interpersonal style, ability to work with minority groups, and his or her expectations for change – particularly when faced with the challenging interpersonal styles (described above) of some forensic patients. It is, for example, particularly important to be aware of how patient likeableness or vulnerability might influence the interviewer's approach.

In terms of interviewer skill, interviewing might simply be regarded as one of a number of basic counselling skills that every mental health professional should be expected to have acquired, including the ability to use techniques such as attending, affirmations, active listening, clarifications, reflections, and so forth. Although they are generally regarded as micro-skills necessary for establishing an effective counselling relationship, they are also essential to building rapport and encouraging disclosure. Marshall and Serran (2004) have suggested that the most effective interviewing strategies with sex offenders include behaving genuinely, asking open-

ended questions, providing encouragement, showing care and acceptance, and creating opportunities for positive behaviour to be reinforced. They also recommend that encouragement, reward, and ‘directiveness’ – that is, suggesting possible directions or alternatives to problems or behaviours, rather than ‘telling’ patients what to do – should be used judiciously and in moderation. In short, the interviewer qualities that are thought to enhance effectiveness include those that lead the patient to view the interviewer as interested, authoritative (not authoritarian), warm and empathic, and tolerant of the patient’s challenges (see Skeem, Loudon, Polaschek, & Camp, 2007; Serran, Fernandez, Marshall, & Mann, 2003).

Ross et al. (2008) have also highlighted the possible influence of therapists’ expectations on offender treatment outcomes in correctional settings. They suggest that it might be harmful for clinicians to have too high or too low expectations of patients, as they may feel a sense of frustration if their expectations are not met, or be less likely to create opportunities for change if they believe that the likelihood of success is low. Specifically, Ross et al. argue that pre-existing knowledge of certain individual characteristics, such as violence risk level, previous treatment non-compliance or failures, therapy interfering behaviours, and records of negative client labels (e.g., ‘psychopathic’ or ‘personality disordered’), can generate negative expectations and judgements, and thus adversely impact the quality of the therapeutic relationship that can be formed. This in turn can lead to a confirmatory bias on the part of the interviewer, which may negatively impact on therapeutic progress.³

McDermott (2008) has also highlighted the need for interviewers to develop a range of specific skills and strategies when working with people from minority cultural groups. McDermott notes that many health professionals work from models of professional distance, or that they feel required to maintain prescribed therapeutic relationships. He argues, however, that where a power imbalance exists this approach can be seen as one-dimensional, alienating, culturally unsafe, and ineffective. Instead, McDermott identifies reciprocity - or the *sharing* of information - as central to

³ Although we note the position of Ross and colleagues (2008), we do maintain that it is necessary for interviewers to read all available material pertaining to a client before commencing the interview. This is important so that risk is identified and managed, and so that the patient can be properly challenged if discrepancies arise in the account of their past.

establishing rapport in those who identify with collectivist cultures. This contrasts markedly with the training that many professionals receive that encourages them to limit the use of self-disclosure with clients (Tjeltveit, 1999), especially in the forensic context. Nonetheless, McDermott reminds us of how a distant and dispassionate approach might easily be regarded as hostile or authoritarian by those from minority cultural backgrounds.

Other important individual level characteristics that influence how an interview might proceed include gender. Although there are few studies which have compared the impact of male and female interviewers in the same situation, Padfield and Proctor (1996) reported similar responses in research interviews to the questions asked, whether these were asked by a male or female interviewer. However, and despite interviewees expressing no preference in the gender of the interviewer, additional information about personal experience was provided to the female interviewer. These interviews, although not with forensic mental health patients, did concern a sensitive topic similar in some ways to some of the areas that will be covered by a mental health professional who is interviewing a patient about his or her personal history. Gender may also be of particular importance to the selection of the interviewer when the patient has a preference, or history, of harming women.

Related to each of these observations, the specialty guidelines for forensic psychologists (American Psychological Association, 2013) note the ethical obligation for forensic practitioners to recognise “that their own cultures, attitudes, values, beliefs, opinions, or biases may affect their ability to practice in a competent and impartial manner”, and that “when such factors may diminish their ability to practice in a competent and impartial manner, forensic practitioners may take steps to correct or limit such effects, decline participation in the matter, or limit their participation in a manner that is consistent with professional obligations “ (p. 9).

Suggestions for Practice

What follows are four suggestions for how a professional might approach the task of interviewing a forensic patient. These illustrate a broad approach to interviewing which has the general aim of promoting rapport and engagement with forensic

patients who have a history of aggression or violence. This, we suggest, is a pre-requisite for any effective forensic interview:

1. Summarise existing knowledge.

A helpful starting point in any interview, after outlining the purpose of the interview and addressing issues of consent, is to summarise what the clinician already knows about the patient and then ask the patient for feedback (points of agreement and disagreement). This is preferable to simply asking the patient to provide information about his or her past and present situation when the patient has no knowledge of the context and purpose of the interview. It can be irritating and frustrating for patients when they become aware that the interviewer already has access to a considerable amount of information about him or her and the reasons for the admission and/or assessment. Acknowledging information that the clinician already knows also demonstrates openness.

2. Acknowledge the involuntary nature of the interview.

Barber (1991) has proposed a six-step model of what he terms ‘negotiated casework,’ which we suggest provides useful direction to any interviewer who is assessing a forensic patient. Barber starts with the suggestion that the first step is to talk directly about the order or conditions that led to the interview, before identifying any legitimate patient interests or concerns. Then, it is important to identify those aspects of the interview that are non-negotiable and those that can be negotiated (e.g., the length or number of interviews). The next step is to make decisions about the way forward, identifying goals and responsibilities, before seeking agreement on criteria for progress and what will happen if the patient fails to comply with aspects of the interview. This approach can help to clarify the boundaries of the interview, as well as the purposes for which information will be used and address concerns about confidentiality.

3. Demonstrate support, acceptance, affiliation, and hope.

Dowden and Andrews (2004) have identified several ‘staffing factors’ as hallmark features of effective correctional treatment, such as the need to implement clear boundaries, model appropriate behaviour, use reinforcement, and demonstrate warmth

and openness. These, in our view, apply equally to forensic mental health interviews. At the same time, Dowden and Andrews noted that most research studies in this area provide insufficient detail about staff qualities, communication styles, and behaviour, thereby limiting the strength of conclusions that can be drawn about the impact of these staff qualities on treatment outcomes.

When working with those who present with guardedness or ambivalence, Kozar (2010) has recommended that the clinician should always demonstrate support and acceptance in order to develop respect and trust. However, this should be balanced with the need for the client to change and to explore the issues relating to his or her presenting problems. Although their advice is not specific to forensic mental health inpatient services, according to the National Institute of Clinical Excellence (NICE; 2009), treatment providers working with people with antisocial personality disorder should “explore treatment options in an atmosphere of hope and optimism, explaining that recovery is possible and attainable, build a trusting relationship, work in an open, engaging and non-judgemental manner, and be consistent and reliable” (p.8).

We suggest that interviewers should adopt an affiliatory interpersonal style as studies on physician-patient interactions have, for example, shown that this type of interviewing style is positively associated with patient satisfaction (Kiesler & Auerbach, 2003). This may be particularly difficult to achieve when working with patients who, by reason of the problems that potentially bring them into the services, may evoke both pessimism and rejection. Techniques for engagement that have been reported to be helpful include offering choice, information-giving, preparing people for therapy, goal agreement, treatment contracting, building self-confidence and self-esteem and feeding back treatment progress, particularly for those with diagnoses of personality disorder (Clarke, Fardouly, & McMurrin, 2013). More broadly, violent offenders with high levels of entitlement, grandiosity, and superiority may, on occasion, display behaviour that is aggressive (e.g., condescending, sarcastic, dismissive or threatening) in order to establish or re-establish a sense of self-worth or interpersonal control (see Draycott, Askari, & Kirkpatrick, 2011; Elliott, 2006). When facing such behaviours, it is not uncommon for the mental health professional to become irritated, frustrated, angry, frightened or defensive (Gutheil, 2005). The important task for the interviewer here, however, is not to react – but, once again, to

use this type of reaction as information that can help to conceptualise the patient's presenting problem and level of risk. Often this will require the support and advice of another professional, such as a clinical supervisor.

4. Attend to characteristics of the setting.

Given the potential volatility of patients who have a history of violence, it is imperative that interviewers familiarise themselves with the safety procedures of the location in which the interview is taking place. Some important considerations may include carrying a duress alarm, ensuring that the door of the interview room remains unlocked at all times, ensuring other staff are aware of their interview and any potential risks. If risks to personal safety are high, it may be that 'box' visit offices should be utilised, or the interviewer should be accompanied by a second person. When strategies like these are chosen then their impact on rapport and therefore the patient's presentation should be contemplated. Careful planning and seeking the advice of other staff who know the patient well and who are familiar with the patient's present state is prudent. Notwithstanding measures to protect physical safety, it is also important to acknowledge the psychological impact of being in a forensic service where autonomy is limited and the patient is exposed to experiences that may be personally distressing or frustrating. If the patient believes, for example, that he or she has been unfairly detained then this will impact on the way the interview is approached and the way he or she responds to the interview – regardless of the particular skills of the interviewer.

Conclusion

Although Greenberg and Shuman's (1997) suggestion that the forensic assessment interview should be separated from any treatment (because the stance taken in evaluative work [objective and dispassionate] is different from that taken in therapeutic work [collaborative and helpful]), in practice the two are far from clear cut (Day, 2014); the forensic mental health professional who conducts an assessment interview will often also be the person who delivers treatment. Interviewers in forensic mental health services will inevitably need to find ways to be able to accurately and objectively assess risk and ascertain treatment needs, *and* to work in a

manner that leads to the development of the type of relationship that will facilitate treatment.

Interviewing forensic patients who have a history of acting aggressively can be particularly challenging. The patients themselves may present with high levels of hostility or defensiveness that will need to be addressed if the interviewer is to elicit the type of information that is needed to inform the conclusions of any assessment or provide effective treatment. This will inevitably require a high degree of skill from the interviewer, taking account of the way in which the patient presents and the setting in which the interview is conducted, as well as how this impacts on his or her ability to maintain an empathic, supportive, and professional stance. To date, however, there has been little attention paid in the professional literature to the many aspects of interviewing discussed in this paper and there is an obvious need for research that identifies how different interviewing approaches impact on forensic mental health outcomes, particularly for those with a history of aggressive or violent behaviour.

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Table 1: Differences between Therapeutic and Forensic Relationships
(adapted from Greenberg & Shuman, 1997)

Point of Difference	Care Provision (Treatment)	Forensic Evaluation (Assessment)
1. Whose client is the patient?	The mental health practitioner	The attorney
2. The relational privilege that governs disclosure in each relationship	Therapist-patient privilege	Attorney-client and attorney work-product privilege
3. The cognitive set and evaluative attitude of each expert	Supportive, accepting, empathic	Neutral, objective, detached
4. The differing areas of competency of each expert	Therapy techniques for treatment of the impairment	Forensic evaluation techniques relevant to the legal claim
5. The nature of hypotheses tested by each expert	Diagnostic criteria for the purpose of therapy	Psycho-legal criteria for purpose of legal adjudication
6. The scrutiny applied to the information utilised in the process and the role of historical truth	Mostly based on information from the person being treated with little scrutiny of that information by the therapist	Litigant information supplemented with that of collateral sources and scrutinised by the evaluator and the court
7. The amount and control of structure in each relationship	Therapist attempts to benefit the patient by working within the therapeutic relationship	Evaluator advocates for the results and implications of the evaluation for the benefit of the court
8. The nature and degree of "adversarialness" in each relationship	A helping relationship; rarely adversarial	An evaluative relationship; frequently adversarial
9. The goal of the professional in each relationship	Therapist attempts to benefit the patient by working within the therapeutic relationship	Evaluator advocates for the results and implications of the evaluator for the benefits of the court
10. The impact on each relationship of critical judgment by the expert	The basis of the relationship is the therapeutic alliance and critical judgment is likely to impair that alliance	The basis of the relationship is evaluative and critical judgment is unlikely to cause serious emotional harm

Note: the term attorney is used in the US to refer to a lawyer.