Individual and family dynamics in individual therapy :: an analysis of intake reports.

Stéphane I. Jacobus

University of Massachusetts Amherst

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INDIVIDUAL AND FAMILY DYNAMICS IN INDIVIDUAL THERAPY:
AN ANALYSIS OF INTAKE REPORTS

A Thesis Presented
by
STEPHANE I. JACOBUS

Submitted to the Graduate School of the University of Massachusetts in partial fulfillment of the requirements for the degree of
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INDIVIDUAL AND FAMILY DYNAMICS IN INDIVIDUAL THERAPY:
AN ANALYSIS OF INTAKE REPORTS

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Approved as to style and content by:

David M. Todd, Chairperson of Committee

Harold Jarmon, Member

Janine Roberts, Member

Seymour Berger, Department Head
Psychology Department
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Most importantly though, my thanks to Kent, for seeing me through this whole process.

Sigma Xi, the Scientific Research Society, provided a Grant-in-Aid of Research to support this project.
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Clients seeking psychotherapy at an outpatient clinic are often interviewed prior to beginning therapy (the "intake interview"), providing the clinician (the "intake worker") with information on which to base treatment decisions. A summary of the clinician's assessment of the client and her "presenting problems", based on this interview, often becomes the first written record about a client. In these accounts of clients' presenting problems in beginning therapy, an important consideration is the nature of current relationships in the client's life. In the context of individual psychotherapy, this goes beyond just the marital status or living situation of the patient, and will typically include the quality of relationships, degree of conflict and/or support provided by others, and perhaps a history of close relationships. Despite this important feature of clinical assessment, and its use in treatment planning and diagnosis/prognosis, little research has been done on the relational context of people entering individual therapy. The

\[1\]

\[1\]Female pronouns will be used here for both clients and therapists, unless a specific person is being discussed. While the commonly accepted "generic" pronoun is the male pronoun, it seems more fitting in a context where most clients and therapists are female to use the female pronoun.

\[1\]Based on a literature review by this author, and a personal communication from Alan S. Gurman to David Todd, chairperson and director of the larger research project on psychotherapy, of which this thesis is a part.
use of clinicians' written statements about interviews with clients as data for research has also been somewhat limited. This study is an exploration of these documents written by clinicians in an outpatient training clinic and of how they describe and interpret information about clients (and about relationships of clients), based on interviews for referral to individual therapy.

The aspects of an initial intake to be considered here are (a) problem formulation, (b) assessment of the context of the problem in the client's life, (c) the use of history in the assessment of the client's current situation, (d) client-therapist interaction (development of rapport and use of the relationship in assessment), and (e) decision making about therapy. The kind of intake under discussion here is a one-on-one interview, with clients who are pursuing individual therapy. However, the perspective of this study will be to incorporate both intrapsychic views (psychodynamic or object relations) and some family systems views. While the individual is seen alone, and factors such as personality and individual symptoms are seen as important, this perspective will also include interpersonal factors such as family constellation, social networks, and factors in early development related to family of origin. This perspective emphasizes the role of relationships in psychological problems and includes the therapist-client relationship as part of the "relational matrix" in a broadly defined "relational" or "object-relational" framework (Mitchell, 1988, pp. 9, 17-62, and 292).
Clients coming to inquire about therapy usually bring to the initial interview a "presenting problem". The task of the clinician is to assemble information about the client and about the "presenting problem" in order to decide if therapy would help the client and if so what kind of therapy or therapist (e.g. modality, length of treatment, gender of therapist) is most suitable. The presenting problem itself may or may not directly involve relationships with significant others, but the information collected by the clinician is likely to involve the client's relationships in certain ways. Marziali (1988, p.23) includes in information to be collected by the intake worker "information about the client's problematic behaviors, motivations, emotions, supportive relationships, responses to life stresses and pertinent historical data."

Clinicians working with individuals generally formulate an initial "diagnosis" or pattern of symptoms from this interview and may then use information about past relationships and family constellation to further expand this picture. MacKinnon and Michels (1971) describe certain components which the interviewer will consider in a psychodynamically oriented interview. These include: (a) psychopathology, which includes "defects in the [client's]"

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While some writers use the word "patient", the word "client" will be used here throughout.
capacities for functioning"; (b) psychodynamics, which attempts to explain the client's "psychic development" and includes "symptoms", "character pathology" and "personality strengths"; and (c) transference, the understanding of the client's patterns of interacting with others that emerge in the interaction with the intake worker. Generally, family systems work has not included diagnosis and assessment of individual "psychopathology". Often, family systems theorists have rejected such "classifications" as "irrelevant" (Haley, 1980, p.1) but instead focus on the relationships between family members. The initial interviews to be considered here are, however, more of the psychodynamic variety, so there will be some discussion of "diagnosis" and individual "symptoms".

Through the course of the initial interview, the clinician poses questions and helps the client understand how their concerns may fit together and how they may eventually be used as the basis for therapy. The initial interview may have a therapeutic quality in that the clinician may identify patterns of behavior or relationships and then share these impressions with the client. Marziali (1988, p.27) describes this as the "demonstration of treatment interventions that contribute positively to the first encounter and that illustrate to the client how treatment works." The clinician may also use her clinical skills to assess how the client is reacting to her and she to the client. In a psychodynamic framework, this information (about a relationship) may also be brought back into the context of the session to help in
problem formulation. Davis (1986) documents the "(re)formulation" of a presenting problem into "an issue suitable for further psychotherapeutic work" in an individual interview (p.44). This occurs through the use of formulations which include the subjective information the intake worker has gathered from her experience of talking with the client. MacKinnon and Michels (1971, p.9) identify this as the "inspective data" - the information which "involves non-verbal behavior of the [client] and the interviewer." They differentiate this from the introspective data - the client's "report of his feelings and experiences."

While Davis' (1986) description of problem "(re)formulation" takes place in an individual therapy context, this kind of adaptation of the problem to the therapy may take place in a variety of settings. Wynne (1988) also considers the importance of the formulation of the "presenting problem", but using a family therapy framework. His view is that families will not initially see interactions between family members as "the problem" (but the family therapist presumably will) and that family work should be "considered an option regardless of how or what problems are initially presented," (p.92). From this perspective, the problem (re)formulation would be shifting the focus from the individual to the family dynamics, in contrast to Davis' point about individual therapy, which is that it transforms an individual's "complaint" into a formulation about a general relational style. Again, the context of this study is a clinic
which emphasizes an individual psychotherapy perspective, so individual problem (re)formulation is likely to be more common.

The Relational Context as Part of the Initial Interview

An important feature of the intake interview is to determine who is in the client's life and who besides the client is involved in the problem currently. While this is an implicit (and at times explicit) part of interviewing from a psychodynamic perspective', it is one which has been explored explicitly primarily by those working directly with several family members in therapy. Pinsof (1983) refers to this extended view of who is involved in the problem as "the patient system". According to Pinsof, the patient system "consists of all the human systems (biological, individual-psychological, familial-interpersonal, social occupational, etc.) that are or may be involved in the maintenance or resolution of the presenting problem," (p.20). In a similar way, Anderson, Goolishian, and Winderm (1986, p.7) discuss the individuals "organized around" a problem as the "problem determined system." From their perspective, the discussions that clients and therapists have about the problem(s) lead to an understanding of who is involved in the problem; "the definition of a problem marks the context, and therefore the

'For example, Sullivan (1954) and MacKinnon and Michels (1971) mention the gathering of family information as part of a "standard" interview with an individual.
boundaries, of the system to be treated," (p.7). Kerr and Bowen (1988, p.54) describe the "emotional field" of the family grouping which influences an individual. In their description of systemic evaluation, they note that a difference between individually oriented evaluation and systemic evaluation is that the latter "broadens the field of focus to include an examination of the harmony and balance of the 'patient's' relationship system," (p.56). While the work of these writers focuses primarily on families, these ideas can be used in work with individuals to help uncover who in the individual's life is part of the "problem determined system". This might involve finding out who, in addition to the individual client, believes there is a problem and how they are involved in discussing the problem. This exploration may include family of origin, partners, children, teachers, religious or spiritual helpers, past therapists, as well as friends or members of the community. A part of this research then is to discover how intake workers note in their written reports the influence of these other members of the system.

A family systems view written about by Carter and McGoldrick (1980) is that each individual (as part of a family system) is at a particular stage in the family life cycle (i.e. adolescence, new couple, aging parents). The presenting problem may, from this perspective, have different meanings depending on where the client is in terms of the family life cycle. In addition, knowledge of events in the family which coincide with the onset of client's difficulties may have
implications for understanding the presenting problem. Kerr and Bowen's (1988) evaluation approach also includes this life cycle element. They see differentiation from the family of origin as a central part of development and as a way of characterizing individual functioning based on the understanding of an individual's family of origin.

Wachtel and Wachtel (1986), in attempting to bridge the gap between individual and family therapy, use a "cyclical psychodynamic" model when working with individual clients. They view interpersonal patterns as a central part of how the "intrapsychic world is maintained" and view the "inner world" as "at once a product, a symbolization and a cause of the interaction pattern in which the person engages," (p.18).

In developing a "relational model" of "mental life" (an integration of concepts from several object relations theorists), Mitchell (1988, p.9) rejects the idea that "interpersonal interactions are merely an 'enactment' of a more psychologically fundamental world of internal object relations or 'representations'." His relational model instead "encompasses both intrapsychic and interpersonal realms". From this perspective "the person is comprehensible only within this tapestry of relationships, past and present" (Mitchell, 1988, p.3). Thus, in this framework, interpersonal dynamics are likely to be important in the conceptualization of the problem as well as in the steps involved in being a therapy client, even in individual therapy.
The Involvement of the Relational Context in Psychotherapy

Clients' current relationships are important to the clinician in the assessment phase, but may also play a role in the therapies that clients enter into. This may be the case if others become part of the therapy or if they remain outside of the consulting room but continue to have an impact on the client's life.

Choice of Modality of Treatment

Part of the intake clinician's job is to determine what kind of therapy to offer a client based on information gathered during an interview (assuming that different options are available). Differential therapeutics, a term used in medicine to talk about choice of therapy given a certain presenting problem, is not a concept applied to psychotherapy as readily. Perhaps problems are not as readily defined in the psychological realm and at the same time, varieties of therapies may not clearly match up with particular presenting problems. In research literature, one stumbling block has been the difficulty of comparing different therapeutic techniques. Controlled studies pose ethical problems, and standards for outcome measures are difficult to agree upon across different types of therapies (Hazelrigg, Cooper, and Borduin, 1987). Consequently, little is known about what features in a therapy would be most helpful given a certain presenting problem.
Although certain research begins to address this question, little is known about the process by which clinicians make decisions about what therapy to offer to a particular client. Francis, Clarkin, and Perry (1984), Sander (1985), and others have written about the need to examine factors which can determine the choice of therapeutic format (individual, family, couple or group).

Gurman and Kniskern (1978) reviewed the results of various studies where clients with marital problems received individual or conjoint marital therapy. In this influential paper and in a subsequent revision (1986), Gurman and Kniskern questioned the efficacy of individual therapy for marital problems, while they concluded that there is evidence that conjoint marital therapy is useful to couples. While this question is far from resolved (Wells and Giannetti, 1986), these researchers have begun to set the stage for research on treatment outcome of different modalities given similar presenting problems. To do this kind of research, they advise, the minimal unit of assessment of outcome should start at the level of the individual symptomatology, but must include the level of the marriage, as well as the level of the total family system. The current research is a first step in that direction, being an examination of how the second and third levels of assessment (the marriage and the family) are addressed in descriptions of presenting problems of individual therapy clients.
Family therapists already include the level of relationships in the marriage and family system in their units of assessment. However, given that individual therapy is the predominant form of therapy provided by psychologists, a starting point would be to examine how issues of relationships are addressed in problem formulation with a client seeking individual therapy. One possible question to examine would be how individual work affects the family system, even when the family is not part of the therapy. Clinical evidence, as described by Barcai (1977) indicates that individuals in therapy can produce changes in other family members. Researchers have found that family members of individuals in therapy do feel the impact of therapy (Hatcher and Hatcher, 1983, Brody and Farber, 1989). The work of family therapists has also brought to light how family members can have impact on the "identified patient" within the family (Hazelrigg, Cooper and Borduin, 1987). Significant others are important in the referral process and decision making about therapy as well, as discussed by Kadushin (1969).

The Connection Between Problems and Relationships

Individuals seeking therapy may vary widely in the presenting problems they describe. In a study of why clients seek psychotherapy, Kadushin (1969) compiled and categorized
presenting problems into biosocial problems, inner emotional problems, and social problems. Social problems ranged from problems with a "love object" to occupational problems and general social adjustment problems. More general interpersonal problems were categorized in terms of movement toward people (dependency), movement against people (hostility), and movement away from people (isolation). These categories, developed by Horney (1945), may reflect potential diagnoses or client styles, which may be reported by intake clinicians in a variety of ways. Kadushin also presents another categorization system: psychiatric problems, performance problems, and projected problems. Kadushin concludes that "most emotional (psychiatric) problems...are related to difficulties in performance" (p 103), or in other words most intrapsychic problems are in some way related to relationship issues in the current life of the client.

Gurin, Veroff and Feld (1960) found that in their sample of Americans, of the ones who had gone for some kind of counseling, problems with relationships accounted for over 60% of the kinds of problems that brought people to seek help. Gurin et al. also asked members of their sample where the locus of their problem was (if they had sought help in the past). Twenty five percent saw the locus of the problem in another person, while 23% traced the difficulty to a defect in themselves (another 32% fell into the category of general interpersonal problems or locus undefined). All of these people seeking help did not turn to mental health
professionals (about 30% did). Of those who did go to mental health professionals, 47% said that the problems were in their marriage, and 75% fell into all the categories concerned with relationships combined. While these data leave many questions unanswered, they provide more evidence for the hypothesis that the majority of clients will present with relationships as a critical part of their difficulties. While all therapies may not work directly with relationship patterns, assessment of clients during an intake interview generally will provide some information about relationships.

The place of relationships in the presenting problem may vary widely. Some clients will come in with very specific ways that their presenting problem involves others (marital problems, problems with parents, children, etc.) while others will come in with general difficulties in relationships or difficulties getting into relationships. Some will come for therapy when a significant relationship has just ended. Another group will come in because of pressure from others who feel that the client has a problem that the client may or may not see as a problem. Perhaps a smaller group will come in because they feel that someone else in their life has a problem and they seek therapy as one route to solving this problem. Signs of interpersonal difficulties may be seen by a clinician as a primary problem, as a manifestation of other underlying problems, or possibly as a way of expressing the internal problems that they are experiencing (perhaps as the "ticket" into therapy). This may differ along the lines of
which therapy model the clinician uses. For example certain
psychoanalytic views may see all presenting problems as
defenses (or symptoms of other, underlying problems), while
behavior therapists and family therapists may work with
presenting problems involving relationships in a more direct
fashion.

There may be times when a person asks for individual
therapy as a way of avoiding marital or family issues, or asks
for family therapy as a way of avoiding an intrapsychic issue.
Sander (1982) discusses these defensive patterns but concludes
that either format of therapy (family or individual) can
address the problems that clients present. Sider (1984)
questions the ethics of necessarily giving clients the kind of
therapy they ask for, and proposes that clinicians may be
better able to determine what is best for the client. These
issues cannot be resolved here, but present another set of
reasons that current relationships are important in initial
client assessment.

The Intake Interview and Report

Clinicians summarize their findings about clients in
case reports, which can then be examined for information about
relationships. In the clinic which is the site for this study,
the intake interview and a great deal of the written
documentation are up to the clinician's discretion (see
Methods). While general guidelines are provided for
clinicians, the specific information in an individual case report is determined by the nature of the interview and can be assumed to represent qualities of the client and the clinician. Marital status is an obvious category that will probably be listed in every case (there is a place on the form for this information, see Appendix). If it was not reported, this would be important to consider - perhaps the presenting problem loomed so large in a particular case that information of this sort was seen as unimportant. There may also be many kinds of relationships that are not included in a simple categorization of marital status. Partners who are not spouses may be just as important as legal spouses. Family of origin may be the source of important relationship(s) for some clients. Some clients with children may find them to be central to their coming to therapy.

Case reports may be distinguished by who the clinician describes as important in the client's life as well as how available they might be to the client, perhaps indicating how available they would have been had a family format been chosen. There may be a natural grouping of reports where the presenting problem is defined as involving another person and those where it is not. Many or all clients may give some indication of involvement with others, as intake clinicians regularly ask about social networks (see "Intake worker interviews").
The Use of Clinical Narratives

This study will be using clinicians' reports based on initial interviews. The perspective of this study will be that these reports are a documentation of an interaction between two people, and it is this "narrative" constructed by the intake worker that is the "data" of the study (Mishler, 1986). It will not be possible (or necessary) to separate how much the clinician is reporting the nature of the relationships as it was told, or how much the clinicians inferences have shaped the report. It is the clinicians inferences though that shape the eventual treatment, and for this reason the clinician's thought processes in evaluating the client are seen as an important part of this research. This study will also include the "expansion" of this information through the gathering of material from a set of cases and adding to this a description of the context in which the information was collected (Mishler, 1986).
CHAPTER 2
METHODS

This study uses reports written by clinicians who are part of an intake team at the Psychological Services Center. The Psychological Services Center (PSC) is the training clinic for the graduate program in Clinical Psychology at the University of Massachusetts. It is a theoretically diverse outpatient clinic which serves members of the University and general community. The intake team screens incoming requests for therapy and makes assignments to therapists. One member of the team meets with the client for about an hour to define the problem and to determine whether the case is appropriate for the center, keeping in mind that it is a training clinic and that 24 hour emergency services are not available. Following this interview the clinician writes up a summary of the presenting problem and its history which is included in the initial intake form (see Appendix). The form includes identifying information, living situation, occupation, names of prior therapists, and an initial formulation of the problem (generally taken to mean diagnosis) in addition to the longer summary. After the intake team discusses the case, the case is assigned to a therapist. For the new therapist, this form serves as the main communication of information about the client. Some therapists also meet in person with the intake

1The form used for these reports was changed in September 1988 as a result of ongoing research on psychotherapy at the Psychological Services Center.
worker to clarify what is known about the client. This summary then serves to consolidate what the intake worker has learned about the client, and as a basis for decision making for the intake team (who read a condensed version of this form) as well as the primary force in shaping the first interaction between the therapist and client.

Sample Selection

The sample was selected from the set of cases entered in the clinic database from the time cases began to be entered (January 1986) until June 1987. The cases selected were those that met all of the following criteria:

1. Cases where there had been an in-person intake interview.
2. Cases that had actually become therapy cases (that did not drop out before treatment began).
3. Cases that had become individual therapy cases.
4. Cases that had a complete record (including a "brief history of the presenting problem" text).
5. Cases that involved clients eighteen years or older.

This initial group included 82 cases. From this list it was determined that a small number of cases had intake reports written by other than one of the group of "regular" intake workers, and these cases were omitted from the sample. Several other cases were omitted at this time because the reports were
found to be incomplete or written from a telephone interview. The revised list was a set of 67 cases. From this list, groupings were made on the basis of sex of the client and marital status. The marital status groups were defined as follows:

1. "Partnered", those that were married or living together.

2. "Un-partnered", those that were not currently living with a (romantic) partner (either single or divorced).

3. "In transition", those that were either separated or engaged and not living with a partner.

In these groupings there were 15 "partnered" females, 22 "un-partnered" females, 5 females "in transition", 4 "partnered" males, 19 "unpartnered" males, and 2 males "in transition". (See Table 1) It was then decided that in order to be able to look at intake worker variables, an attempt would be made to select cases to have a mixed sample of intake workers, while selecting evenly from the marital status and gender groups. Using this criteria, it was then possible to select 8 "partnered" females, 8 "un-partnered" females, and 8 "un-partnered" males. There were, however, only 4 "partnered" males. In addition to this group it was decided to select two male and two females from the "in transition" group in order to get a broader sample of clients in different kinds of relationships (See Table 1).
Table 1

**Distribution of Sex and Partner Status in the Sample of 32 Cases and in the Larger Group of Cases From Which These Were Selected.**

The Study Sample:

<table>
<thead>
<tr>
<th>Partner Status</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partnered</td>
<td>4 (28.6%)</td>
<td>8 (44.4%)</td>
</tr>
<tr>
<td>Un-Partnered</td>
<td>8 (57.1%)</td>
<td>8 (44.4%)</td>
</tr>
<tr>
<td>In Transition</td>
<td>2 (14.3%)</td>
<td>2 (11.1%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>14</strong></td>
<td><strong>18</strong></td>
</tr>
</tbody>
</table>

The Larger Group of Adult Individual Therapy Cases:

<table>
<thead>
<tr>
<th>Partner Status</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partnered</td>
<td>4 (16.0%)</td>
<td>15 (35.7%)</td>
</tr>
<tr>
<td>Un-Partnered</td>
<td>19 (76.0%)</td>
<td>22 (52.4%)</td>
</tr>
<tr>
<td>In Transition</td>
<td>2 (8.0%)</td>
<td>5 (11.9%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25</strong></td>
<td><strong>42</strong></td>
</tr>
</tbody>
</table>

20
These groupings reflect three primary concerns of this study: (a) to examine the extent to which current relationships are considered to be part of the presenting problem, and to include how current relationships may be relevant for those not reporting a "marital" relationship; (b) to consider possible sex differences in presenting problems and how they relate to relationships in the client's life; and (c) to consider the effect of the interviewer and writer of the reports on the content and style of the reports.

The Analysis of the Texts

These case summaries were reviewed, looking primarily at the information in the longer text labelled "brief history of the presenting problem", but also considering information in other parts of the form such as family information included in other parts of the form, age, living situation, the initial formulation written by the intake worker, and information about past therapies which may have been included in another section of the form.

The Initial Questions

The initial questions to be addressed were the following:
1. Are significant others mentioned in the summaries? If so, who are the significant others? Do all cases in this group include mention of significant others? Are these depictions of relationships sufficient to get a sense of the nature of the relationship? (for example, the meaning of the term "partner" varies with additional information, such as "client is in a new relationship where she sees her partner once every couple of weeks" or "client is in an enmeshed relationship where the two spend all their free time together").

2. How do these summaries portray the interplay of significant others and the presenting problems? Are there patterns which may show a continuum of "involvement of others" in the presenting problem?

3. Is the issue of whether family therapy was an option for this individual addressed directly in the reports? What factors in these summaries give information about this question? Can the availability of significant others for family therapy be assessed through these summaries? Are the clients reported to be living with members of their family of origin?

4. What gender related patterns emerge from this data set? What hypotheses are suggested? For example, do men (women) appear to have presenting problems more closely related to their current relationships?

Other questions that were to be considered were the following:
5. How does information about early development and family context get incorporated into the description of the presenting problem and into the description of current relationships?

6. How do issues of loss, abandonment, isolation and loneliness fit in with the juxtaposition of presenting problem and current relationship?

7. Do styles of reporting emerge which may be due to clinician's orientation or prior training? How are relationships between clinician and client portrayed?

This work involved reading the intake notes with these questions in mind for the purpose of summarizing what might be learned from this process about the information gathered and reported by clinicians at intake.

The More Refined Set of Questions

After reading the reports several times and taking detailed notes, a group of more specific questions emerged that seemed relevant for this group of reports. These questions were the following:

1. Demographic questions. (The age and sex of the client)

2. Current relationship (romantic relationship) questions. (What is the marital/partner status of the client. Does the client have children? Who does the client live with?)
Is there a romantic partner mentioned? Is there mention of a break up of a romantic relationship?)

3. Family of origin questions. (Is the family of origin mentioned? Does the client have a current, ongoing relationship with their family as it is described in this report? Is "leaving home" an issue for this client, as it is described by the intake worker? Is the information about family of origin used as a description of the client's past history (a developmental summary) or as a description of a current relationship (part of the current context)? Does the report mention concerns about problems being "passed on" from one generation to the next? Is the client described as being an adult child of an alcoholic?)

4. Questions about presenting problems. (What is the presenting problem? Is isolation or loneliness mentioned? Is the client characterized as seeking help with relationships? Is the current problem characterized as being related to relationships in the clients life in a general way - as being a problem of "patterns" in relationships? Is the current problem characterized as being related to a problem in a relationship with a specific person? Does the intake worker mention non-relational problems? Is there mention of any physical manifestations? Is there a description of a recent loss?)

5. Intake worker variables. (Do reports differ depending on which intake worker interviewed the client? Is
the client's style towards relationships described? Is the relationship to intake worker discussed?)

6. Questions about decision making about therapy. (Is there a description of past treatment? Is there mention of problems that others in the client's life have? Is there a description of a client being "pushed" into treatment by someone? Is there a sense that this could have been a family therapy case (are family members available)? Is there a discussion of the option of family therapy for this case?

From these questions, a set of data about the reports was generated, which led to the formulation of the results section of this paper. During the writing of the results section the themes developed were again retested by using the original case reports, and examples were drawn from them.

Confidentiality and the Researcher's Role

At no point did the researcher know the identities of the clients whose reports were used for the study. Nor did the researcher know what the outcome of therapy was for any of these clients. The author was, however, a "participant observer" (Lofland and Lofland, 1984) in this study, as she is currently an intake worker in the clinic. Some of the information about the context of the interviews and reports therefore comes from this experience.
The Interviews

As an additional part of this work, the eight intake workers who wrote the reports and the supervisor of the intake team were individually interviewed for further information about the intake process.

The Intake Worker Interviews

These interviews were short, informal discussions in which the researcher asked questions similar to the following:

1. Describe your own clinical experience before becoming an intake worker. Did you do outside practica? Which ones? Which supervisors did you work with in the clinic?
2. How would you describe your theoretical orientation?
3. How did you learn to do intakes? Intake reports? Is there any training you would recommend?
4. What is the purpose, in your view, of the intake reports? What is the purpose, in your view, of the question which asks for a "brief history of the presenting problem"? Do you have an audience in mind when you write these?
5. Are there things you always include in an interview? In a report about an interview? Are there things you might leave out? What determines how long a summary you write?
6. Do you have a format to how you write the summaries?
7. How does the relationship you develop with the client influence the intake process? How might it influence the written version of the intake?

The intake workers were contacted, either in person or by phone (many of the intake workers now lived in other states) and all were willing to be interviewed. An important consideration in evaluating the results of these interviews is that for many of these former intake workers, it had been several years since they had graduated and left the clinic setting.

The Intake Supervisor Interview

The intake supervisor was also interviewed, and asked questions such as the following:

1. What kinds of changes have you seen in the procedure for intake over the last five years?

2. Describe the training the intake workers receive.

3. What are your expectations of the intake interviews and of the intake reports? Do you have in mind certain things that the intake workers should always include, or always not include? Do you have a format in mind that they should follow?

4. What is your theoretical orientation?

5. Do you read the intake reports? Do you give feedback to the intake workers? What kinds of things would you give feedback about?
6. What do you see as the audience of the intake reports? What is the role of the reports in the clinic?

7. Do you think that part of the intake worker's role is to talk to the therapist who gets assigned the case?

The information from this last interview was a valuable part of the assessment of the context in which the reports were written. However, specific answers to questions from this interview did not add to the information from the intake worker interviews, so these answers will not be considered separately. The intake worker interviews will be considered as a group, with examples from particular workers when appropriate. This section of the study is intended to provide context and meaning for the central piece of the work, which is the analysis of the intake reports.
The following will be a discussion of these thirty two reports - their contents and the context in which they were written. The emphasis of the data analysis will be on the "brief history of the presenting problem" texts, which ranged from one half to two type written pages.

The first section will examine the uses of the reports in the clinical context, and will give an overview of the kinds of information to be found in the reports.

The next section will provide specific kinds of information found in the group of reports, including groupings of reports that emerged from the analysis of the sample. In this section, numbers of reports that seemed to fit certain categories will be presented (e.g., 12 reports used family information in the following way...), but it is important to keep in mind that these "categories" are imperfect characterizations and not absolute entities. The numbers are presented to give a sense of the proportion of the entire sample that may fit a certain "category" as it is defined. Throughout this section, age and sex of clients were considered in each subsection. However, these were only reported when there seemed to be some influence of these variables on the category under discussion. The organization of this section will be to begin with general information about clients in the sample, and then to discuss the
relational contexts of clients in the sample - are partners and families described and what do we know about them? This will be followed by a discussion of presenting problems and how they involve others. The final two subsections here will include information that emerged from the reports about why people might seek psychotherapy, whether they had seen therapists before, and how the intake workers write about the use of subjective information in understanding clients.

The third section deals specifically with the issue of gender as it relates to the clients.

The fourth and fifth sections discuss the intake workers, the writers of the reports. First is a discussion of the differences between intake reports written by different intake workers. This is followed by the results of the intake worker interviews.

The sixth and final section is a discussion of the implications of this study.

An Overview of the Reports

This section will describe the kinds of information to be found in these reports, and outline the functions of the reports as they became apparent in the texts.
The Reports in the Clinical Context

These reports were written in the context of a clinic, and their importance as documents and as a method of communicating within the agency can be seen in the following examples.

The Screening Function

One function of the intake interview is to screen out clients who are inappropriate for the setting or who would be better served elsewhere. While the reports of the clients who were deemed inappropriate are not included in this sample, information about some of the variables that went into considering this set of clients "appropriate" are apparent.

Concern about suicidality is one variable in selecting clients who are appropriate to the clinic. This comes up in the case of Robert', who the intake worker describes as having considered suicide. He apparently made one attempt several years ago, which the intake worker describes (the attempt was an ingestion of a non-lethal dose of pills). The intake worker goes on to describe the Robert's current thoughts about suicide. The end of this discussion, and the end of the text is, "the bottom line, he states emphatically, is that he won't kill himself". This text may serve several purposes here. One

'All the names of clients have been changed, and any specific identifying information has been omitted.
is a record of what the client said at the time of intake, perhaps to remind the intake worker or the intake team why the client is appropriate for therapy at the clinic. Another reason may be to document that these questions were asked, perhaps for legal or ethical reasons, and to document for the future what kind of answers the client gave. This text also serves as a warning to the future therapist about the level of the client's suicidality and to notify the therapist that the intake worker was concerned enough about this to ask these kinds of questions.

In another case, the issue comes up slightly differently. In the case of Thomas the intake worker describes a period of Thomas' life when he was very depressed. The intake worker goes on to say "he denied ever feeling suicidal or self-destructive, both in terms of this depressive time of his life and also...when he talked about [a break up of a romantic relationship]." Here the text verifies that these questions were asked, and that the answers led to the intake worker's decision that the client was "appropriate" for the clinic.

Alcohol or drug abuse are other reasons that clients may be deemed inappropriate for the clinic. In the case of Mike the issue of alcoholism came up, but the intake worker writes that the client reports not having had alcohol for 8 years. This case also might be an example of the use of the report to document that certain questions were asked, and the kind of answer that the client gave.
Another concern that intake workers may have about incoming clients is that they may be too "difficult" for clinicians-in-training to work with. Again, clients that are deemed too disturbed by the intake staff would not have become part of this sample, but information about this issue emerges in a few of these reports nonetheless. An example is Mary who was described by the intake worker as someone who is "very sophisticated psychologically and may be challenging to a training therapist...". This might be a cue to the intake team (this information was probably reiterated in the intake meeting) that a therapist who can handle this degree of difficulty should be chosen. This may also be a message to the future therapist that they should anticipate this kind of difficulty. The intake worker continues "...but she also seems responsive to supportive interventions," which indicates that the intake worker did not find this client impossible to work with and therefore one can assume that the intake worker found the client to be "appropriate" for the clinic.

As this case points out, the matching of clients to therapists is another function of the intake, and to some extent, of the intake report. Another case where this came up was the report about Carolyn. Here the intake worker writes: "although Carolyn does not necessarily prefer to see a woman therapist, she does feel it would be important that whomever she see be sensitive to certain roles women fill in this culture that are generally devalued." Often clients will state in the intake interview certain preferences for a kind of
therapist or, more often, for the gender of the therapist. This information may be included in the intake report for at least two reasons. One reason might be to note the preference for decision making at the intake meeting. Another reason might be that the stated preference may provide information about the client that will be useful to the future therapist.

An important part of the intake process is to make a preliminary assessment of the "severity" of the problems of the client. While formal DSM-III-R diagnoses are not used in the intake report, information which would help a therapist reach these kinds of conclusions is included in the text. As already described, clients would not be admitted into the clinic who the intake worker feels are too severely disturbed to be appropriate for a training therapist. Those who are included in the sample are therefore only cases that are less severely disturbed, or to put it another way, cases in which the client is able to function well enough to profit from once a week outpatient therapy. An example of this discrimination appears in the case of Carlos. He was described as having had a "manic" episode, but his condition was described as "stabilized", and the report mentions the name of the psychiatrist who will be monitoring his need for medication. He was also described as "showing potential to benefit from psychotherapeutic work". Given the potential severity of the diagnostic category "bipolar" (the DSM-III-R term for manic-depressive), the intake worker may have felt that this
clarification was necessary to indicate why this client was appropriate for the clinic.

**Communication to the Future Therapist**

The primary audience of the intake reports may be the future therapist for the client. One way that this becomes apparent is the fact that often in the closing paragraph of the "brief history" text the intake workers include suggestions and warnings for the future therapist. In this sample of intake reports, there seem to be three forms of comments to the future therapist: (a) interpretations about what the client has said, which may further the future therapists understanding of the case; (b) an account of the intake worker's experience of being with the client followed by a recommendation; and (c) recommendations of what the therapist should pursue in working with the client.

An example of an interpretation given by the intake worker to assist the future therapist can be seen in the case of Nancy. This client was reported to say that she wanted to be seen more than once a week (this does not typically happen in the clinic, but occasionally an exception is made). The intake worker interprets this as "a therapeutic issue related to Nancy's overall sense of deprivation and neediness". This comment seems to be intended to give the future therapist some material to work with in discussing this issue, perhaps directing the future therapist to take some time to discuss
the possibility of more frequent sessions at length rather than making an immediate decision.

In some of the reports, the intake worker comments on her experience with the client, and follows this with a recommendation. One intake worker writes about Dan that he has a "tendency to run on tangential issues and I found I had to redirect him and structure our interaction a good deal. From our brief interview I did not get a good sense of the level of his disturbance and I recommend that this be carefully evaluated in the context of therapy."

Some intake workers give direct recommendations. The most explicit of these was given in the report about Mr. Diamond', where the final paragraph of the report was: "Recommendations: pursue Mr. Diamond's tendency to be entertaining and charming but more basically disengaged and self-focused within the context of the therapeutic relationship." This is most probably based on the experience the intake worker had with the client, but this is not stated as explicitly as in the case of Dan, above.

Record Keeping

The intake reports also serve as the basis for the permanent record in the clinic about the client until the time of assignment to a therapist. The therapist then writes

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1Last names are used here when they were used by the intake worker in the written report. The actual names have of course been changed.
contact notes about each session and writes an in-depth "Initial Psychotherapy Report" after meeting with the client several times. If the client does not get assigned to a therapist immediately, but is instead put on a wait list, the report serves as a reminder of the information collected at the time of intake, and may help to assist in therapist assignment at a later date. Some clients who go through the intake process do not continue past this point and either are referred elsewhere or do not choose to attend therapy sessions once they are arranged. For these clients this report becomes the only record of the clinic's involvement.

Andrea was apparently put on the wait list at a time when no therapists at the clinic were available. The final paragraph of the intake report text documents this. The intake worker writes that she would be contacting the client to let her know how long the wait might be.

One way that the report may be used is to document particular issues that need to be followed up on by the intake worker or the future therapist. An example is Diane, who had questions about whether her sessions would be covered by her student health insurance, and this was documented in the text of the report.

The intake report is also a record of an interaction between the intake worker and the client. Intake workers commonly include comments about this interaction. The intake worker who interviewed Mr. Ramirez noted that he made no eye contact for the 45 minutes of the interview. In the report
about Ted, the intake worker recommends to the future therapist "not to let Ted's easy going style and basically 'together' appearance lull him or her into minimizing Ted's level of distress or difficulty." The intake worker continues with: "I almost made the mistake of ending the interview prematurely. When I asked him if he had any other things he might want to tell me, he came forth with some crucial details that would have been missed."

This kind of analysis of the function of the intake reports based on the content of a sample of reports can suggest what is valued and/or needed by those who write and read the reports. The examples mentioned above show the importance of the reports as lasting documents for the clinic and as communication to the future therapists (the therapist to be assigned in the clinic or perhaps even as a document for other subsequent therapists). The reports in this sample also illustrate the importance placed on documenting the interaction between the client and the intake worker as a sign of how the client will respond to a future therapist. As will be discussed in greater detail later, many of the intake workers include comments about their interactions and reactions to the clients. The intake reports also emphasize the importance placed by the intake workers on client's styles of interacting with others, in the therapeutic situation as well as in the rest of their lives.
Information about Clients to be Found in the Reports

The intake report can be used by the future therapist to obtain certain kinds of information about the client. The report itself will always contain information such as the client's age, marital status and occupation. In addition, the text labelled "brief history of presenting problem" will typically provide a much more rich notion of where the client is in the life cycle. For example, the text will at times include information about past marriages and relationships, whereas the initial section of the form would only mention current marital status (See Appendix). The text will also tell something, in most cases, about the nature of the relationships the client has with her family of origin. The question of how the client is currently connected with her family of origin is not one that is addressed systematically in these texts, but can often be inferred by the kinds of information given and the importance placed on that information by the intake worker's organization of the material. The elaboration of information provided in the "brief history" text gives a sense, often, of who the client is and how she is are connected to other people. For example, a client might be described as being socially isolated. Another client might be described as having difficulties with friends at school. From this kind of information, the future therapist can learn something about the day to day life of the client.
The future therapist will also get information about the presenting problem from the intake report. The presenting problems of the clients were depicted by the clinicians in two sections of the intake reports, the initial formulation and in the "brief history" text.

In the "initial formulation" section, the intake worker synthesizes their understanding of the problems that the clients presented with their own (the intake worker's) conceptualization of the "diagnosis" or main themes that may be brought into therapy. The initial formulation could also include the following:

(a) past problems or brief history of mental health services,
(b) information about family members' involvement in the client's problems,
(c) a brief description of a client's interpersonal style, and
(d) an assessment of the severity of the problems. These statements varied to the extent that they included these four variables, and some reports had no initial formulation at all.

The presenting problems were also usually restated in some form in the "brief history of presenting problem" texts. For example, as described by the intake worker, Dan's "presenting complaints are dissatisfaction with school and depression characterized by anxiety, social isolation, and checking compulsions". In these texts the intake worker often explicitly described the client's understanding of the

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"The intake worker supervisor said to the author that "the initial formulation is basically the DSM-III-R diagnosis in prose."
problems.' The presenting problems are often elaborated on by the intake worker with information about the context of the problem, which may include information about the history of the problem and of other factors or people involved in the problem. The history of the problem was often depicted in terms of how long particular symptoms or problems had gone on, again with some mention of the severity of the problems. Interpersonal aspects of problems were often elaborated on here. Sometimes the "problem" depiction was separated from the descriptions of who was important in the client's life, and how those relationships affect the client. These depictions often elaborated on the more technical terms used in the initial formulation. For example Charles, who was described as "socially isolated" in the initial formulation, was described in the longer "brief history" text as never being close to anyone in his life except for his sister and his wife. The clinician also noted that Charles had never had a relationship with anyone before his marriage, and that when he was a child he was rejected by peers. His relationship with his father was also noted as involving verbal criticism from his father.

The future therapist reading an intake report might also find out if there were other problems that the client discussed that may not clearly be the "presenting problem". The reports may contain information about physical symptoms

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'As will be discussed later, it is often difficult to pinpoint one presenting problem from these texts. It would be more accurate at this point to say that intake workers write about presenting problems.'
experienced by the client, for example. The reports may contain information about intergenerational issues, such as alcoholism in other generations, or mental health problems in other family members. This information may be included because of possible genetic predispositions as well as for use in describing psychological development. The report may mention other family members or significant others who might be affected by the therapy.

In the text of the report, the future therapist might also find information about past therapies and their influence in the current life of the client. If there was a direct referral to the clinic by another professional, this information is often at the beginning of the text.

The intake workers often include information for the therapist about what they expect will happen in a therapy, or what they think should happen. In a sense, this is similar to a statement of "prognosis" in a medical report. The prognosis is at times a prediction of what will happen in the therapy, and less often a prediction of how the client's life will evolve.

Information Not Found in these Reports

There is also information that the future therapist (and the future researcher) will not find in the reports. When a client first calls the clinic, the first interaction the client has with a clinician is a brief screening and short
conversation about the reasons the client is seeking therapy. This interaction is noted in a log book. In this short note, the client's initial statements about "what the problem is" are often noted. Then, following the hour interview, the intake worker (sometimes the same one who spoke with the client on the phone and sometimes not) writes up the intake report. These often do not contain these statements of the client's initial request, but instead summarize a conversation about problems, which includes input from the intake worker. Thus the intake report itself will not give a "pure" version of what the client thought the problem was before treatment. (This has been changed somewhat at the clinic, since now clients fill out a questionnaire which asks them to describe why they are seeking treatment, among other things)

The question of modality of treatment (individual, couple, family or group), while interesting to this researcher, was apparently not relevant to these intake workers. They did not, for the most part, discuss how the decision was made, either by the client or by the intake worker, that individual therapy was preferred.

Finally, the intake report as a document is only one version of a complex interaction between two people. From this report one can not know what actually happened during the intake interview, only what the intake worker chose to write about that interaction. Different intake workers might have
chosen to write about the interaction with the client in a different way, or might have emphasized different information.

The Meaning of "History" in the Texts

The title of these texts is "brief history of presenting problem" so one function of these texts is to summarize the history information that the intake worker has gathered. This sample of intake workers all did write about some aspect of the history of the problems and/or the history of the individual. However, the meaning of "history" varies in these texts. Some reports point to recent events that brought the client into treatment, for example: "She described the onset of the depression as occurring about 3 weeks ago, when she transferred to [another college]. Her parents divorce was also finalized this month...". Other summaries, however, may focus instead on a history going back several years, outlining the progression of the problem. For example, Peggy, a 33 year old woman, was reported as coming to therapy with the "particular incentive" of the "ending of an 8 year romantic relationship". The history of the relationship is then described in the "brief history" text.

Another meaning of history in some of these texts seems to be a developmental summary of the entire life of the client (or what fragments are known to the intake worker). Thus a great many of the texts have brief sketches of childhood, parental influences, early problems, or perhaps family
constellation. For example: "Ms. Ferrara...the daughter of immigrants...has several younger siblings...as soon as Ms. Ferrara learned to read and write...she was responsible for all financial matters in the household...". Often this kind of historical information is tied in with the immediate problems in the client's life. In the example of Ms. Ferrara, the intake worker reports in the remainder of the text that her problem has to do with her feeling that she "carries an inordinate amount of responsibility in the relationship" (her marriage) and she has difficulty sleeping because she "lies awake thinking about the problems in her marriage". So, it seems that the excerpt from her childhood adds meaning and context to the presenting problem in this case.

These meanings of history are not mutually exclusive. Some texts include many levels of "history", while some contain only one of these. All statements do tackle this task in some way. From this sample of cases it seems that the range is from a summary of major events in the last several years (two seems to be the minimum in this sample) to a string of events beginning from childhood or even infancy.

Consider, for example Robert, who is unable to finish his schoolwork, worries that he will end up like his siblings, despises his father, and came to therapy following a break up with his girlfriend. Here the history begins with "His parents were divorced right after his birth". In contrast, the history of Carlos, who recently had been an inpatient at a psychiatric hospital, begins with his entry into graduate school, within
the last several years. It is mentioned in passing that he is a foreigner in this country. Perhaps the immediacy of his problem led the intake worker to write the report with more detail about the current situation.

The Sample of Reports as a Whole

This section provides the details of the exploration of the 32 intake reports. Beginning with demographics and partner status, the information seen in the reports will be examined, and when possible, categorizations will be developed. At times rough estimates of numbers of clients (or percentages) fitting a certain description will be provided, although primarily the emphasis will be on demonstrating the complexity of categorization, and on pointing the way for how such distinctions could be made. The focus will be on clients' "problems" and clients' "relationships" and how they are linked.

Demographics

The demographic information about clients was limited. Age and student status will be explored here. Job descriptions and references to socio-economic status were included in some reports but this was not systematically collected. Partner status will be considered separately.
Age

The clients in the sample of 32 ranged in age from 19 to 46, with a mean of 26.9. Seventy five percent of the sample consisted of reports written about clients under 30. This is very similar to the mean age of the entire sample of cases entered in the PSC database (all therapy cases with adult clients which were open between January 1986 and January 1989) which was 26.1. The only constraint put on age of clients in the sample is that clients had to be over 18 years old to be included.

Student Status

Information about clients' occupations was not a focus of this study, but it seemed that a great number were college students. From the information available at the time of this study, it seemed that 22 of the 32 were students (undergraduate and graduate), two had graduated from a local college, one was a professor, and two had some kind of affiliation with the university community. The five others seemed to have no affiliation with the university.

Partner status

As previously mentioned, the reports used for this study were selected so as to have fairly equal representation
of different partner (marital) status groups. Twelve of the clients had been designated "partnered", that is married or living with a partner. In this group there were eight women and four men. Sixteen of the clients had been designated "un-partnered", as they were described as being un-married and not living with a partner. In this group there were eight women and eight men. Four other cases were selected for inclusion, where there was difficulty in deciding if they were "partnered" or "un-partnered". The difficulty arose because they were either engaged and not clearly living with a partner, or because they were separated from their partner. These cases can be seen as being between the "partnered" and "un-partnered" categories.

Living Situation

Living situation was fairly well documented for these cases. From the information available it seemed that eleven of the twelve clients that were categorized as "partnered" were living with their partners (the situation of the twelfth case will be described in a later section). Five of these clients lived with children as well as a spouse (these clients were married). Two of the female clients lived with a husband, children, and a member of their family of origin - one with her mother and one with her sister.

The two cases of people who were engaged (one male and one female) but not clearly living together were both living
in close proximity to their fiances. One was living in an apartment in the same building as the fiance and the other was living in the same apartment but not in the same room (other comments in the report indicated their belief that they should not yet be having a sexual relationship).

Those who were categorized as "un-partnered" were living in a variety of circumstances. Eight cases in this group seemed to be living alone and nine were living with roommates or in dorms. One case involved a woman who was living with her children (but was divorced from her spouse).

"Partnered"

One of the questions of this research was how well the traditional categories of "married", "divorced", "separated" and "single" would characterize the clients in this sample, given the information in the reports. Considering that many couples now live together without being married, those who were living together were grouped with those who were legally married for the selection of the sample. This group was called "partnered" and all those who were not living with a partner were called "un-partnered". The question then is how appropriate either of these two systems might be for describing this group of clients.

The "partnered" category seemed to work well at capturing some general information about the relational status
of these clients. Of the twelve, ten were married and two were living with a partner. However, two of the married clients were planning to divorce. One of these was Ms. Patterson, a woman in her late twenties who had been married for ten years, had several young children and said in the intake that she was planning on leaving and divorcing her husband. The intake worker noted that "it is clear Ms. Patterson has decided to leave her husband". In this case, the categorization of "married" was accurate in depicting her current status, but missed an important quality which was described by the intake worker. In a qualitative sense, Ms. Patterson is different from another client who is married and not planning to divorce.

The other client who was categorized as married and planned to divorce was not living with her husband, and apparently had never lived with him. This was Jeanne, a woman in her early twenties who had married against her parents' wishes and had continued to live with her parents after marrying several years before the intake. In the intake report, the worker describes her situation as "in the process of divorcing", a process which began months before the intake. In this case, the categorization of "married" is true in the legal sense, but falls short of describing the complex relationship that Jeanne had to her husband. In this case "separated" might have been a more accurate grouping to begin with. Of the two clients who were categorized as living with a partner, one was engaged to be married and the intake report
elaborated on this relationship. The other was living with a partner, but the intake report did not discuss plans for marriage, and in fact the only mention of this partner was in the section of the intake form asking for living situation. These two differed from the two other cases that were categorized as "engaged" in that in the latter two cases, the couples were apparently not living together in the sense intended by this categorization. It remains a difficult distinction however. When is a couple living together and when is their arrangement just short of what we call living together? Based on this sample, which includes these two cases which are difficult to categorize, the distinctions one might choose to use are: (a) that the couple actually lives in the same house or apartment, (b) that the couple has been involved in a sexual/intimate relationship, and (c) that the couple has made some kind of commitment beyond sharing a house or apartment as "housemates".

In sum, the grouping of "married" worked adequately for most cases where clients described themselves as married, but included a few who were on their way out of the marriage. "Married" did not cover the few who were living together, but joining these two groups into "partnered" could convey some information about these clients (See Table 2). This kind of categorization will lead to somewhat heterogenous groupings that will cover a range of different situations. For example, these groupings did not convey any information about how these people felt about their marriages/relationships, including if
they were planning on leaving their spouse/partner. While Jeanne, the client who was not living with her husband, might have been recategorized, Ms. Patterson is a more complex case which this kind of categorization cannot handle.

Those clients who were planning on leaving their spouses might have been categorized as "separated". The two cases in this sample who had been labelled "separated", were in fact a man and woman separating from each other and coming to the clinic for individual therapy (this was not known at the time of sample selection, but became apparent because of comments in the reports). It is not clear why these two were labelled separated while the woman in the married group, Jeanne, was not. The most likely explanation is error in categorization."

"Unpartnered"

Sixteen of the cases were labelled "unpartnered", which included cases that had originally been categorized as "divorced" or "single". Three of the cases in this group had been labelled "divorced" and the other 13 were "single". Of

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"The categorization was done by the research staff (of which this author is a member) prior to the beginning of this study."
Table 2

Partner Status for the 32 Cases, by Sex and Age

<table>
<thead>
<tr>
<th>Status</th>
<th>Males</th>
<th>Females</th>
<th>Age $\bar{X}$(Range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Partnered&quot;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>4</td>
<td>4'</td>
<td>29.5(22-46)</td>
</tr>
<tr>
<td>Married but plans divorce</td>
<td>0</td>
<td>1'</td>
<td>27</td>
</tr>
<tr>
<td>Living Together and Engaged</td>
<td>0</td>
<td>1</td>
<td>28</td>
</tr>
<tr>
<td>Living Together and Not Engaged</td>
<td>0</td>
<td>1</td>
<td>24</td>
</tr>
<tr>
<td>&quot;In Transition&quot;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Separated (Not living with spouse)</td>
<td>1</td>
<td>2'</td>
<td>26(22-31)</td>
</tr>
<tr>
<td>Engaged and Not living together</td>
<td>1</td>
<td>1</td>
<td>25.5(23-28)</td>
</tr>
<tr>
<td>&quot;Un-Partnered&quot;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Divorced</td>
<td>0</td>
<td>2'</td>
<td>32(24-40)</td>
</tr>
<tr>
<td>Divorced and In New Relationship</td>
<td>1</td>
<td>0</td>
<td>27</td>
</tr>
<tr>
<td>Single (No relationship)</td>
<td>3</td>
<td>3</td>
<td>24.3(19-38)</td>
</tr>
<tr>
<td>Single (Break up of past relationship mentioned)</td>
<td>2</td>
<td>3</td>
<td>26.2(21-33)</td>
</tr>
<tr>
<td>Single and in Relationship</td>
<td>2</td>
<td>0</td>
<td>25.5(23-28)</td>
</tr>
</tbody>
</table>

'Three of the women and one of the men have children

'Has children

'One of these was "miscategorized" in the original groupings.

'One has children
the three divorced clients, each had provided more information which the intake worker noted in their reports. One was Nancy, a 40 year old woman who was divorced and lived with her two children. The divorce took place 5 years ago. Another was Christine, a 24 year old woman who recently divorced. Unlike Nancy's report, which mentions the divorce in passing, Christine's intake report comments on the impact of the recent divorce on Christine's life. The third was Ted, a 27 year old man who had divorced two years ago and was in a current relationship. These three cases, while all categorized as "divorced" are characterized as being in very different stages in relationships.

There were 13 cases which were categorized as "single". Here too, this has many meanings if one looks at the text provided by the intake worker about the context of the client's current life. Two of these had current partners mentioned in the text, including one man, Thomas, who had a recent break up with his girlfriend at the time of the original intake, then returned for a second intake and told the intake worker that he had gotten back together with his girlfriend. Five other cases have mention in the report of a recent break up with a partner. An example of this is Peggy, who was seeing a man for 8 years and broke up with him a year before the intake. While a year may not seem like a "recent" break up, the focus of the intake report was on this relationship, and the tone of the narrative leads one to imagine that the relationship could have ended yesterday. On
the other hand, Andrea's intake report only mentions the break up she had 8 months ago in passing - as a fact about this client, but not as the focus of the intake interview or presumably the therapy that Andrea will engage in. Six other cases seemed to be single and not in a relationship, as the intake worker did not describe any current or recently ended love relationships. (One of these cases mentioned a past relationship described in a way that makes it appear to have been long ago and in addition the client apparently described it as having "little emotional value". On this basis, this seems to be qualitatively different than other more recent relationships mentioned by other clients.)

An attempt to create categories that do contain more information about the relationships that someone is in might lead to the extreme position that one category needs to be developed for each case, as each set of relationships is different. For example, the category of married, which seems simple in some ways, was shown to be complex in this sample, where some clients were described as unhappily married and seeking to leave their marriage. Another element that may separate some marriages from others is the number of years the couple has been married. It might be important for some analyses to differentiate the couple who has been married for one year from the one who has been married for twenty years. It may also be important to know if a marriage is a first marriage or not.
The same difficulties come up in categorizing people who are divorced. One might want to know how long they have been divorced, and if they are now in another relationship. It might also be important to know who initiated the divorce. Another complexity is that some clients may discuss a previous marriage while others will not, leading to some clients being categorized as divorced while others would be categorized as single (or married, when they should have been categorized as re-married).

It is also difficult to decide at what point a relationship becomes part of the categorization system. In this system, it seemed appropriate to include intimate relationships if the client was reported to be living with their partner or engaged. What about relationships of long duration that do not include living together or marriage plans? A similar question comes up with divorce. If one client is categorized as divorced, how would one categorize another client who recently ended a long-term intimate relationship? Then one would wonder how long to include in "recent": a day? a month? a year? ten years? There is an interesting discrepancy in the fact that in traditional categorizations a person who was divorced twenty years ago would still be categorized as divorced, while a person who ended a long-term relationship a week ago would not have a categorization to reflect this.
Perhaps another way to address this problem is to ask a series of questions about the client, rather than to try to get all this information into one question. For example, a series of questions might be the following:

1. Relationship status - legal (married/divorced/never married).
2. Relationship status - current involvement (yes/no?).
3. Living situation - (living with partner/not).
5. Length of time in most recent relationship.

Family of Origin Information

Besides relationships with spouses and intimate partners, the reports also discuss relationships with family of origin. The great majority of reports in this sample included mention of the family of origin of the client. In only four of the thirty two cases was there no mention of family of origin. In about half of the ones where family of origin was mentioned, some form of ongoing, current contact with the family of origin was clearly stated or alluded to (including conflict with family of origin).
The report written about Charles is an example of a case where family of origin comes up several times, yet a current relationship is not described. Charles is described as coming from a family where no one has a college degree except his father. Then later his mother is described as often having been ill and having "numerous physical and emotional problems". He is also described as never feeling "very close to anyone in his life other than his sister and his wife". While several other details are mentioned, it is not stated if the parents are alive, and if so, where they live, or if Charles sees them at all.

Other reports, like the one written about Heidi do include mention of a current relationship with her family of origin. In this report, four recent stressors are mentioned which led to Heidi's decision to seek therapy. One of these was a recent trip to visit her mother and siblings in Wisconsin, during which Heidi found out distressing news about her sister. The intake worker notes that Heidi describes herself as "depressed" and goes on to describe her mother as also being depressed. The report also includes a comment about Heidi's concern that she will wind up like her mother. Here, the client's relationship with the family of origin is described in a way that indicates that the client has current contact with the family members.
Dimensions of a (Family) Relationship

When discussing marital status, one might want to use the traditional categories (married, single, etc.) or a modified version of this, as was used here (partnered, un-partnered). In the preceding section on marital status, the idea that was developed was that there were several different dimensions that might be relevant in creating a more complex and comprehensive picture of the romantic relationships that clients seem to be in. Ideally, it would be helpful for this type of research to develop a system of describing information about family of origin in a similar way to the traditional categories about marital status, but the information in the reports does not lend itself to this kind of categorization for many reasons. One important difference between marital status and "family of origin status" is that there are no legal or cultural beginnings and endings of relationships with family of origin as there are with marital partners. While the family therapy literature uses words such as "enmeshed" or "undifferentiated" to distinguish kinds of relationships that adult clients can have with their families, there are no such terms used in everyday conversation. While a client may speak of "being involved", "going out with someone" or "having a boyfriend" when discussing romantic relationships, no such terms are available for describing how someone relates to their family of origin.
The dimensions that characterize these family of origin relationships lead to a more complex picture than those that characterize romantic relationships. The dimensions that were apparent from the reports were the following:

1. Is the family of origin mentioned in the report? Twenty eight of the 32 reports did mention this.

2. Does the client live with their family of origin? In this sample there were only two clients, already mentioned, who were described as living with members of their family of origin and also lived with a spouse. From the reports it seemed that none of the un-married clients lived with their family of origin in a permanent way, although some of the students may have spent summers with their parents (this information was not generally in the reports).

3. Is the client described as having a current, ongoing relationship with members of their family of origin? As already mentioned, this was not always clear but it seemed that in about half of the reports where there was any description of the family of origin there was some description of a current relationship.

4. Does the report describe the client as being in the process of "leaving home" or separating from the family of origin? There seemed to be several cases where this issue was addressed.

While this last issue might be relevant for clients of any age, this might be particularly relevant in a clinic which does a great deal of work with clients either in college or in
their twenties. In several cases this issue was addressed directly by the intake worker, although it is often not clear if the client brought this up as their own view of where they stood in relation to their family of origin. One case like this involves a woman in her twenties who is greatly distressed by her parents' decision to divorce. While this report does not state explicitly that the client talks about leaving home, the implication is that she is very involved, perhaps too involved, in her parents lives and may in the course of therapy move to a different position. Another case is Ms. Patterson, who is described more explicitly as dealing with the issue of separation from her family of origin. She is a woman in her late twenties who is planning to leave her husband as well as negotiate a different relationship with her family of origin. She is described as "experiencing difficulty in breaking away from her family and 'finding out who I am'."

The Use of Family Information in the Context of the Report

Given that most of the intakes mentioned family of origin to some extent, how is this information used? What kind of family of origin information is used in an intake? Is the information used in a psychodynamic sense, i.e. to explain or understand the person in terms of how they grew up? Or is it used to explain the current situation of the client vis-a-vis their family of origin? Or is it used in both ways?
As mentioned previously, four clients of 32 had no mention of family of origin in the report prepared by the intake worker.

Family of Origin Information as "History" About the Client

Of the 28 remaining clients whose reports did mention family of origin, 12 seemed to include this information as a way of explaining the client's life history, as background or contextual information to understand the current life of the individual client. For example, one client is described as being worried about getting ill and dying, and his mother is described as being ill while he was growing up and once attempting suicide. Several other cases describe histories of alcoholism in the family or of other "psychiatric illness" among relatives. One report, about a client named Liz, describes how the Liz came to live with her father after her mother died (when Liz was an infant). In this group of cases the focus was on the history of the individual in his or her family and very little or no information was given about the current relationship with the family of origin.

In these 12 cases where family history was used as background information (but not as information about a current relationship), 8 were male and 4 were female clients. Six of these cases involved clients who were married, four had partners and two were single with no current involvement. While these cases were written by a variety of intake workers,
one worker, #6\textsuperscript{11}, had all 5 of her cases fall into this group. This would add weight to the idea that the way family of origin information is used is based on the style of the intake worker. Family of origin as background, or as a description of early childhood development would seem to fit certain models of interviewing (or psychotherapy) better than others, particularly a psychodynamic view. A family systems view might also include the past family life of the client in an assessment, but would probably emphasize information about current family functioning, which this group did not. Another way of looking at this, though, is that these clients were presenting with issues in the present that did not involve family of origin. Generally, in this group of reports when relationship issues came up, they were issues of relationships with spouses and partners.

Family of Origin Information as Current Interpersonal Context

Only three reports seemed to have family of origin information included as part of the current context but did not also include family of origin information as part of the history of the individual. Two of these three were written by one intake worker(#1), who included very little detail about family of origin, except for a few words about current relationships. (However three other intakes by this intake worker did include more family of origin information) The

\textsuperscript{11}Intake workers will be referred to here by number (#1-#8).
third is a case where more recent dynamics are described, but patterns from the past are not. These three cases, two women and one man, were describing single individuals (not in a romantic relationship).

Family of Origin Information as Both Current Interpersonal Context and "History" About the Client

The remaining 13 cases were ones where the family of origin information was used both to convey information about the background of the client and to explain something about the current family context of the client. For example, one client, Nancy, is described as being a scapegoat in her family as a result of being the middle child and as feeling criticized by her mother and unprotected by her father. Later, she is also described as having a bout of depression brought on by a visit with her parents. Another client, Jeanne, is described as a parentified child of alcoholic parents, and now feels "uncontrollable rage" toward her father while she is in the midst of a fight with her mother. One striking difference between this group and the ones whose intakes involved primarily family of origin as background information is the sex ratios. Here, 10 of the 13 were females. This might lead to hypotheses about men and women clients' involvement with their family of origin. It seems that women are portrayed as being more involved with their family of origin as it comes across in these intake reports for psychotherapy. It is
possible as well that intake workers' expectations about men and women are part of this equation.

These 13 reports were written by a variety of intake workers, but it is interesting that three intake workers had all or almost all of their cases fall into this group (#4,#5,and #8). Perhaps the way that some intake workers conduct interviews or write reports leads to this format.

These 13 reports included fewer clients who were married and in relationships than those that used information from family of origin in a purely historical way. Three of the 13 cases involved clients who were married or living together. Four of the 13 were recently divorced or separated. Five of the 13 were single and not in a relationship and one client was engaged. In this group of 13 there were many cases who were described as coming to therapy with issues and difficulties in their relationship with their family of origin and few with difficulties in present relationships with partners. This group of clients also seemed to include those with long histories of psychotherapy, while the other group did not (those with historical family of origin information only). From these comparisons it seems that those reports written with both historical information about family of origin and current information about family of origin are somewhat different from those with solely the historical information about family of origin. It seems that the group which did contain information about current family of origin relationships were less likely to include information about
current romantic relationships and more likely to document a history of psychotherapy. One wonders if these clients are more involved in conflicts with family of origin and that this in some way relates to use of psychotherapy or to romantic relationships (or lack of relationships). It seems from this information that intake reports written about clients with partners include less information about current relationships with family of origin than reports written about clients without partners.

Other Information about Families

A number of other characteristics about the clients' families, as described by the intake workers, are worthy of note. Three of the clients had lost one of their parents. Two client's fathers had died, one 10 years earlier, and one 12 years earlier. One client's mother had died when the client was two years old.

Five of the reports mentioned that the client's parents had divorced. One was after the birth of the client, one was when the client was 6 years old, one was when the client was ten years old, one when the client was 16. One report described the recent divorce of the client's parents. Several other reports described conflict in the relationship of the clients' parents. Fourteen of the reports seemed to be describing the relationship of the parents in ways that leads to the assumption that they are a married couple (one of these
reports described the parents' marriage as being "intact"). Ten reports did not comment on whether or not the parents of the client were still (or ever) married. Of those five reports where divorce of the parents was mentioned, two also mentioned step-parents. None of the reports described a client who was known to be adopted.

Several of the reports mentioned the socioeconomic, cultural or religious background of the family of origin of the client. Three reports mentioned the religion of the family. Three mentioned that the family was an American family but included reference to the national origin of the parents (for example, a child of Italian immigrants). Two of the clients were from other countries. Several of the reports included comments that referred to the socioeconomic class of the family of origin. For example, one family was described as "hard working, lower middle class". A few cases mentioned the jobs of the parents. A few other reports described elements of the socioeconomic or current cultural associations of the client. An example was a client who was described as a "well groomed young professional". Another client was described as having features that were "reminiscent of the 1960's". In general, though, the racial backgrounds of the clients were not described. Only one client was described as "white", although in all likelihood most if not all of the clients were caucasian (the geographic location of the clinic and general population of the clients leads to the conclusion that if
members of other races had been clients, they probably would have been described as such).

The Presenting Problems

The "presenting problems" of the clients in this sample were not easy to categorize or reduce to simple groupings. It seems that in these reports intake workers expanded the notion of presenting problem into a more global assessment of themes or sets of issues that might be important in a psychotherapy with the client. The "brief history of the presenting problem" texts included many varied kinds of information about the client, including all kinds of current and past stressors that might be relevant, as well as symptoms and areas of dysfunction which might be bringing the client into therapy at the time of the intake. These may or may not be all the same reasons that the client initially stated as reasons for seeking therapy.

One way of grouping the kinds of problems presented in the intake reports is to look separately at situations that involve others and those that do not.
Presenting Problems Involving Others

Presenting problems involving others can be divided into problems that relate to general relationship issues and problems with specific individuals.

General Patterns of Relationships

At least half of the reports in this sample described problems that involved relationships with others (or lack of relationships with others). Some examples of the kinds of issues that were addressed that seemed to involve others were: social isolation (in three cases), trust/mistrust/intimacy as central issues, patterns in a marital relationship, a client who reports taking too much control, a client who characterizes himself as overly critical, the pattern of choosing a certain kind of relationship, a client who feels overly responsible, a client who avoids conflict, a client concerned about patterns in relationships, a client whose weight interferes with relationships and feels she has difficulty expressing emotion, another who feels it is difficult get close to others, a client concerned about a pattern of choosing irresponsible partners, a client with a sexual issue, a client who feels emotionally shut off, and a client who feels deprived or criticized in relationships. This group of reports described clients as having problems with patterns of relationships or with relationship styles, but a
good number also had relationship problems with particular people (this issue will be addressed later).

An example of a report which describes a client where relationship issues are important is the case of Thomas. Thomas is described as seeking therapy during a difficult time in his relationship with his girlfriend. His girlfriend, Gina, had told him he was "cynical and over critical" and the intake worker describes how Thomas believes this to be the case in many relationships. He apparently felt this in his relationship with one of his siblings. The intake worker also notes that Thomas feels that he is a "perfectionist who expects others to live up to his standards". The intake worker also noted that Thomas wonders if others find him "boring" because he tries not to break norms, and comments later that Thomas feels he has a difficult time making close friends. It seems from these comments that Thomas is in therapy to address issues in his relationships in general, although he also is interested in working on these issues in a particular relationship - the one with his girlfriend.

A different kind of example is the report about Dan. Here, the intake worker reports that Dan does not have any friends (at school) and does not get along with his roommate. In the initial formulation the intake worker describes Dan as "a depressed college student showing evidence of a paranoid, avoidant style of relating to others". Dan was apparently seeking therapy because of anxiety which led to problems in school and other symptoms. No other reports of relationships
were described, although in a short paragraph his parents and sister were described. The only comment about relationships with the family of origin was that Dan "dreads the thought of having to spend his summer" with his parents. In this example the client seems also to have issues that relate to his relationships with others, but the primary feature of this is the lack of relationships. Besides his relationship with his roommate, which does not seem to be the focus of the discussion, the intake worker does not describe particular problematic relationships. Instead the focus is on a style of relating to others which may be a problem for this client.

Some of the reports do discuss a particular relationship which the client is experiencing as difficult, but do not focus in this way on problematic patterns of relationships. An example of this is the report written about Christine, a client who recently divorced from her husband. Christine is described as seeking therapy because she is feeling depressed. Another section of the report describes a recent short term therapy she was in, in which she apparently explored her feeling of anger at her ex-husband. Apparently Christine is angry at both her ex-husband and at other friends. The focus of the intake report, however, is not on patterns of relationships, but on the feelings of depression which cause problems in Christine's life (feelings which seem to be partly caused by her recent divorce). In this report there is no discussion of a life-long pattern of being angry, or of relationship styles which Christine is interested in
working on in therapy. These issues may emerge in a therapy with this client, but they do not seem to be present in the intake report. So, while Christine is described as experiencing a difficult relationship with her ex-husband, she is not described as having problems with relationships in general.

Problems Having To Do With Particular Relationships

While about half of the reports described relationship patterns or styles that seemed to be issues for therapy, many more of the reports described particular problematic relationships in the lives of the clients. Most of these were difficulties in romantic relationships, as in the case of Christine, above. A few mentioned difficulties in relationships to parents, and one or two reports described difficulties in relationships to both parents and a romantic partner. Generally the reports did not discuss problematic relationships with people other than family members or romantic partners. There was one exception to this, the report written about Andrea, who reported difficulties in a relationship with a co-worker. However it seemed that this was a short term stressor which brought up other issues, and it seemed that these other issues were the ones that brought Andrea to therapy.
Family of origin. Seven reports in the sample included mention of a specific problematic relationship with a member of the client's family of origin. An example is Alice who was described as wanting to discuss "major issues in her life" in therapy, issues which she apparently described as causing her "stress and result in excessive eating". The intake worker follows this with a description of "conflicts with an overbearing father (also an overeater and a recovered alcoholic)". The intake worker also includes a description of "a recent and apparent conversion reaction she had in response to her angry feelings about her father". In this case, the "presenting problem" may be seen as primarily the issue of overeating, but after reading the intake report one might want to also include the client's relationship with her father as part of the presenting problem. A quick description of this client as one with an eating disorder might be too narrow a beginning point in working with this client. The function of the intake and the intake report here might be seen as adding in the other dimensions of this problem, which would include the relationship with the father.

All seven of the cases that include a description of a member of the family of origin as being a significant relationship in terms of "presenting problems" (as in the case of Alice mentioned above) were cases where the client was female. Most of these were also women who were not involved in a romantic relationship.
Several of the reports describe which of the parents the client has a better relationship with, or describe a particular problematic relationship with one parent. While one report describes that the client has a problematic relationship with her mother, this is not the typical pattern. Several more cases describe problematic relationships with fathers, and in general it seems that if the client is described as having a preference for one parent (or better relationship with one parent) it is their mother. Several other cases describe problematic relationships with both parents.

**Partners.** Seventeen of the reports mentioned descriptions of problematic relationships with romantic partners. These were about evenly divided between male and female clients. Another interesting trend was that men were described more often as coming to therapy for current relationship difficulties and women were described more often as coming to therapy for relationship issues with ex-partners.

An example of a case where these issues are mentioned is the report written about Ted. Ted is described as being in a relationship with a woman he has been seeing for about nine months. He is depressed, the intake worker notes, because "his girlfriend seems to have become interested in another man". Ted apparently "sees himself repeating a pattern in this relationship which was established in his earlier marriage (which ended in divorce..)". While other issues are mentioned
in this intake report, this relationship issue is described as the "prominent focus".

The report written about Christine describes another problem with a relationship. The first sentence of this statement of the "brief history of the presenting problem" is: "Christine was recently divorced from her husband of one and a half years." The report characterizes her as depressed and discussed the recent losses that Christine has experienced related to this divorce. In both the case of Ted and the case of Christine, the difficulties in their relationships have led to problems in their ability to work (as described by the intake workers). There were several reports in this group (with difficulties in their relationships with spouses, partners and ex-partners) written about clients who had never been in therapy before. This was in contrast to the group as a whole, where there were very few clients who were described as never having sought therapy before. This might lead to the question of how a powerful event, such as loss or threatened loss of a romantic relationship, becomes an important enough reason to seek therapy for the first time.

We should not assume from this discussion, however, that all reports about clients in romantic relationships presented couples issues. Of the 10 reports where the client's presenting problems did not seem to be related to a specific person, 6 had a partner. So in this sample there were at least six reports written about people in couples whose relationships were not presented as the reason for therapy.
There was an interesting difference between the reports which describe a problem in a specific romantic relationship and those that describe problems with members of the client's family of origin. It seems that a good number of cases involved clients who came to the clinic saying that they were experiencing distress over a relationship with a partner. It is less clear though, that clients come to the clinic saying specifically that they are experiencing difficulties with relationships with a member of their family of origin, although it does seem to occur. When clients are described as having difficulties in these relationships, these difficulties are sometimes described as one element in a larger group of problems, sometimes in a way that implies that the intake worker sees this as the etiology or "root" of the problem. The client may or may not have seen this as the reason they were originally seeking therapy. Another aspect of the reports which describe problematic family relationships is that often the parents are described in ways that imply that they themselves have problems. For example, one report about a female client mentioned that "members of her family have had weight problems". Another noted that "father has been inclined toward depression". Another report discussed the client's "alcoholic father". In contrast, these kinds of descriptions of problems existing in other people occurred less frequently in the reports where the conflict was with a partner. Some of the partners were described as having a problem, but often this problem was about the relationship with the client.
Problems not Involving Others

While most of the reports included descriptions of problems that involved others, most also included symptoms or problems that did not involve other people. In some typologies these issues might be considered symptoms, while in others these problems might be considered part of the range of diagnostic differentiations. In trying to examine which issues involve others and which do not, one runs into a number of problems. First it is very difficult in general to discern at which point a problem involves others. When a client is depressed, does one consider this an individual problem or are the client's relationships involved? In addition, in this sample of reports it is not always clear where the voice of the intake worker fits with the voice of the client. So while a client may see a problem as unrelated to others, the intake worker may see interconnections. While these issues can not be resolved, it seemed important to consider problems that intake workers wrote about that might be thought of as non-relational problems.

All but six reports included problems that were not related to relationships with others. In terms of age, sex and marital status, these cases which did not include this information were similar to those who did present these "non-relational problems". These cases did seem to be from certain intake workers (three intake workers prepared these six
reports). All of these cases did seem to indicate that the client was seeking help with relationship issues and that relationship issues were central to the clients request for therapy. Perhaps these seemed more important to the intake worker than any other, non-relational issue they presented. Another possibility is that the clients themselves did not present these kinds of issues. All but one of the reports involved a discussion of a relationship with a partner. Generally these cases were not ones where family of origin played an important role.

Kinds of Non-relational Problems

For those that did have problems mentioned that seemed to be unrelated to others, the problems seemed to fall into four general categories. The first category was depression/lack of self esteem/self destructive behavior. The second was problems with schoolwork/career. The third was anxiety /compulsions /phobias /insomnia. The fourth was physical symptoms including problems with weight.
Depression, lack of self esteem, and self-destructive behavior. In formulating this category, a problem is how to decide if depression is related to others or if it could be seen as a separate problem unrelated to a client's relationships. Taking a psychodynamic model, depression could be seen as relating to early object relations, which could mean that depression will be seen in conjunction with relational difficulties. A family systems approach would see all depression as related in some way to family systems and to relationships with others. On the other hand, a medical approach might view depression as a chemical event. A behavioral approach might look at events just before and after depression, which may include events in relationships. The approach taken here is to use the clinician's description as closely as possible. It is assumed that the clinician's theoretical biases and assessment of how depression, low self esteem and self-destructive behavior fits into the picture of the client's life will necessarily color how this distinction is made.

Depression seems to be very common in this population. Seventeen reports mention directly depression, cyclothymia or dysthymia. Of these, four seem to be mentioning this as a past or potential event, so there seem to be 13 cases where depression may be a reason for seeking treatment. If clinicians had been asked specifically, there may have been even more clients labelled "depressed", judging from what was said in the intake reports.
The first category of "non-relational" problems, as it emerged, included those reports that described problems that involved either depression, self destructive behavior, or low self esteem, but that did not describe these "symptoms" as related to problems with others. These are, in a sense, problems that the clients had in relation to themselves. There seem to be 10 reports that fit this categorization. Two clients were described as having suicidal thoughts (the clinic does not accept actively suicidal clients). Two others were described as having self destructive behavior and mood swings. Another was described as having emotions under tight control as well as being depressed. Two female clients were described as having issues related to low self esteem. Several clients were described as "depressed" in a way that seemed related only to the individual client. One client, for example, thought that she was depressed because she had just stopped taking birth control pills. Four or five of these ten cases seemed to involve clients coming to therapy soon after a loss of a romantic partner. Two more involved losses related to family of origin (one client's parents had recently divorced and another had a mother with cancer). Some of these ten had additional presenting problems related to relationships or relationship issues and some did not. There were very few clients (4) in the entire sample of 32 cases that had not had prior therapy, but among these ten cases three had not had prior therapy. This brings to mind the question whether
issues of depression or lack of self esteem are more likely to lead someone to a first therapy.

**School and career.** The next grouping was one of reports that included problems with school/career issues. There were ten in this category. There were five that mentioned problems with school work. There was one that described the client's assessment of being too depressed to work. There was one that mentioned issues of self confidence in relation to career decisions. There was one client who apparently questioned his commitment to work. There was one case where the client was described as "successful" but questioning his "driven-ness". One other case that seemed to fit into this group was a man who was trying to decide if he should move, based on finances and a recent break up. There were seven men and three women in this group. These too were mixed in terms of some seeking help for issues involving relationships and some not.

**Anxiety, compulsions, phobias and insomnia.** The third group was those that involved anxiety, compulsions, phobias and insomnia. There were eight in this group. Three (male) clients were reported to have problems with anxiety. One report was concerning a client who recently had a manic episode. One client reported having checking compulsions and one was described as having obsessive thoughts. One woman was afraid of the dark and one woman had insomnia (in addition,
one man described as having anxiety also reported insomnia). Seven of the eight were living with a partner (six were married and one involved a client who was engaged and living with a partner). None of these cases involved a description of a recent loss.

**Physical symptoms.** Five reports had problems listed that were related to physical symptoms. Three women were reported to have concerns about being overweight. One woman reported weight fluctuations, P.M.S. and physical reactions to stress, such as hives. One other woman had a disease and concerns about her health. (the two insomniacs could be counted here as well).

An interesting difference between these categories is that it seemed much more difficult to separate out reports that included depression as unrelated to relationships with others than it was to separate out reports that included anxiety in this way. It seemed that the reports that described a client with problems with anxiety generally did not describe these problems as related to what was happening in the client's relationships. One way of explaining this is that depression may color the client's (and the intake worker's) perceptions of everything that happens in the client's life. A depressed person may interpret problems in relationships as part of the characteristics of depression. Another way of looking at this is that depression may actually be more
related to relationships than another problem, such as anxiety.

Presenting problems and relationships

In what ways do clients' problems come to be characterized as being related to their relationships? One way of thinking about this problem might lead to the idea of a continuum of how much the presenting problem involves others. While this idea has a certain intuitive logic, it did not seem to fit the reports in this sample. Instead it seemed that there were different ways that relationships are involved in the problems that clients present (and that clinicians describe). These patterns are as follows:

1. Problems directly related to issues with a spouse or partner. This was by far the most common situation. Close to a half of the sample could be characterized in this way. There were both men and women described in this way, and there were married and unmarried couples in these descriptions. Some of these were cases where the couple had already broken up. In these case reports, parents were often mentioned, but were not involved in a current way in the client's presenting problems.

An example of this situation is the report about Diane. Diane is a woman in her twenties who has recently left her husband who she was married to less than a year. She apparently describes her biggest problem as being her
avoidance of conflict, which was an issue in her marriage. Her parents are mentioned as being supportive of her decision.

Another example of this kind is the report about Mr. Chapman. He is a single man with a new girlfriend, with whom he is having sexual difficulties. The intake worker also discusses his "tendency to ruminate" about previous problems, which is described as being the second of his two problems.

2. The client is described as having several problems, one of which is a problem with a spouse or partner. This is somehow different in quality from the first grouping, although it is difficult to decide where particular cases would fall.

An example of this kind of situation is the report written about Charles. Charles apparently came to the clinic to explore issues of motivation for school work, but the intake report details a number of other problems. One of these is his relationship with his wife, who has apparently lost interest in Charles. While this is described as leading to Charles' feeling rejected, this report does not place this relationship as the central problem in Charles' life.

3. The report describes both current problems in a romantic relationship and current problems in the relationship with the family of origin. There were a few cases that had both kinds of problems. These were all cases involving women clients, and were those that seemed to be having difficulty separating from their families of origin.

An example of this kind of situation is the report written about Ms. Patterson. She is a woman who is planning to
leave and divorce her husband, but the issues of separation from her family of origin seem to be just as central at this point in her life.

4. Problems currently occurring with the family of origin are central to the request for therapy. There were some cases like this and the cases all involved female clients.

An example of this kind of case is the report written about Francis. Francis' parents are apparently in the process of divorcing and Francis is reported to be quite distressed about this. The entire intake report is about her parents and siblings, and Francis' relationships with them.

5. Issues concerning past relationships with the family of origin are described by the intake worker as being central to the reason the client is seeking therapy. About a third of the cases seemed to fit this grouping. Some of these were married or in relationships and some were not, and there was a mix of male and female clients.

An example of this kind of report is the one written about Katherine. Katherine is a woman who came to the clinic seeking help for her problem with her weight, and who is described as coming from a family with long standing concerns about weight. The first paragraph of the intake report describes Katherine's early experiences of how her family handled weight problems.

6. The problem the client is seeking therapy for is not related to particular relationships with other people. There were a few cases like this. Some of these also fit into the
last two categories (7. patterns in relationships and 8. isolation).

Gary is a client who is described in this way. He is described as seeking help for problems with anxiety attacks. He is married and "states that things are going well in his marriage". His family of origin is not mentioned and no problematic relationships are described.

7. The client is seeking help for a problem with patterns in relationships, but is not necessarily having a problem with a particular person.

An example of this kind of situation is the report written about Liz. Liz is described as just having been left by a boyfriend with whom she had a stormy relationship. While the report describes the recent break up and other events related to it as "traumatic", the report also continues with "this recent situation is part of a longstanding pattern of behavior that Liz wishes to explore". The pattern has to do with being involved with "generally irresponsible" people. In this situation, the relationship with the ex-partner is perhaps a main concern for this client, but so too is the pattern of relationships, which has less to do with a specific person.

8. The client is reported to be, or reports himself to be, isolated from others and this lack of relationships is one of the central reasons for the client seeking therapy. There were a few cases like this and they involved male clients.
An example of this kind is the report written about Ed. Ed is described as having such symptoms as depression and anxiety, which the intake worker conceptualizes as due to Ed's isolation. The intake report describes some of the recent history of Ed's life, but no family or significant others are mentioned.

These groupings of ways that the presenting problem and the relationships of clients intersect are not meant to be mutually exclusive. Clients may fit into one or more groupings, or may not seem to fit into any group perfectly. These eight ways that are described do seem to characterize this group of reports.

Other Influences in Leading Clients to Seek Psychotherapy

How do clients come to make the decision to seek therapy? Does someone give them the idea? Are certain kinds of symptoms or problematic situations ones which lead people to seek help? This section will explore these issues.

Referrals

Despite the amount of information presented by intake worker in these reports, it is still difficult to find a definitive answer to the question of why a particular client was seeking therapy on the day that they called the clinic. Some of the reports do mention how a particular client came to
be seen at this clinic, for example if they were referred by the University clinic (S.M.H.)**, or if they were self referred and found the name in the yellow pages. A specific referral from another professional might lead to more information in the intake about that professional's perspective of what the client's "problem" is, or to more information about why the referral was made. An example is Nancy, who was seen at S.M.H. before coming to the clinic. The therapist she saw there apparently "urged" Nancy to seek psychotherapy "to deal with general self-esteem issues and long-standing conflicts with her parents". Further on in the report, the intake worker comments that in the interview "it became clear that the therapy with [the therapist at S.M.H.] was a particularly charged one and that Nancy's depression is to a large extent a reaction to the termination". Another example is Patrick who was seen in couples therapy with his wife at S.M.H., during which Patrick's wife said that she wanted to end the marriage. In these two cases, as in several others in this sample, referrals were made to the clinic apparently because S.M.H. or other agencies were not in a position to offer the services that the client needed. This then becomes part of the information presented at the intake interview. At times this referral will also include recommendations from another therapist as in the case of Nancy.

**Student Mental Health, S.M.H., is the main site for mental health services for the university population of about 30,000. They do mainly crisis intervention and see clients mostly on a short-term basis. They commonly refer clients to the P.S.C. for longer term therapy.
The Question of "Stressors"

A question that intake workers may try to answer in an initial interview with a prospective client is what led to the client seeking therapy now (as opposed to another time). Intake workers try to address this in the report by including "stressors" that currently were affecting the client at the time of intake. What seems to be reported is often a set of stressors, rather than one specific stressor. Perhaps it is the accumulation of stressors that leads a client to seek therapy. It may also be that intake workers, who question a client about many areas of their lives, are left with many possible stressors, and try to include these in their reports. Some reports, however, do not contain these lists of "stressors". Perhaps these clients can be characterized as seeking exploratory therapy, as opposed to relief from a current stressor. It is not so clear though, that the clients could have been separated into two categories on this basis, as the reports are not easily separated in this way.
The Influence of Others in the Social Network on the Decision to Seek Therapy

While some of the reports indicated that the client had been referred by another mental health professional, there were very few that seemed to have been "convinced", "pushed" or even encouraged into therapy by another person. A few cases mentioned physicians who had suggested therapy. For example, Mr. Hamilton was described as having seen a physician about her daughter, following which the physician asked about problems at home. There was also Mr. Ramirez, who was described as having spoken with a clergyman who suggested that he "should look into himself". A few cases mentioned significant others or family members who might have contributed to the decision to enter therapy. One was Thomas, who was apparently encouraged by his girlfriend to look at his role in their relationship. It was also noted that she, the girlfriend, had a long history of mental health interventions. Peter is described as having a brother who is a psychiatrist, who seemed to have encouraged Peter to seek help.

Beyond this, there were several cases where one might wonder if the client would say that it was the interpersonal interaction they described that "pushed" them into therapy. For example Ted and Charles are both reported to have problems with their partners, which seem to be leading them to seek help. On the other hand, Ms. Cook was apparently seeking therapy despite her husband's disapproval.
Intergenerational Issues

Some cases (6-10) mentioned fears about problems being passed on from one generation to another. It seems that this may be one way that families' dilemmas are brought into the therapeutic situation, and that this fear may be one of the factors involved in bringing people into therapy. How would one know if one had a problem? One way would be for someone to compare themselves with a family member who "has a problem". Perhaps when he or she starts looking as "bad" as that person, then it's time to look for help. Another way this might work is that people with young children may be reevaluating their lives and what they want to pass on to their children. Clients may also be aware of the genetic predispositions to certain mental illnesses which researchers in psychology have documented.

These issues seemed to come up in a few cases. A notable one is Katherine, who was described as coming to the clinic for help with weight and self-esteem. Apparently her mother also had a weight problem and took Katherine to doctors when she was young, fearing that she would grow up with weight problems. The intake worker notes that now Katherine has a young child and fears that she will pass on traits to her child. Two other reports about women commented on the women's worries that they might become like their mothers, and two other reports about women commented on the women's worries
about passing traits along to their children. One man worried about ending up like his siblings.

Three cases (including one of the above, who was concerned about passing traits on to her children) mentioned that their fathers had the same problems that they did. One was weight, one was low self esteem and one was a phobia. One other client attributed his problems to being an "adult child of alcoholic" parents.

In this group of clients with "intergenerational" issues, the presenting problems were often characterized in non-relational terms. The kinds of problems found in this group were weight, career problems, depression, anxiety, and phobias (although two cases in these 10 mentioned marital problems as well).

Four of these 10 cases involved adult children of alcoholic parents. These were two of the cases where the client was concerned about problems being passed on to their children (not alcoholism), one case where the client described his father as having the same problem as himself, and the one client who was attributing his problems to being an adult child of alcoholic parents.

All of these cases involved clients who had been in therapy before, so perhaps clients learn how to look at their lives differently as a result of therapy, and are then more likely to see intergenerational issues as important.
Alcohol and Drug Use

Six cases in the sample of 32 reported that the client was an adult child of alcoholic parents. There were five women and one man in this group. Three of the six have children and two of those three mention fears of passing problems on to children. Five of the six cases contained descriptions of conflictual relationships with parents. For example: Jeanne feels "rage" towards her father and "isn't speaking" to her mother, Francis is reported to have said that she "hates" her father. The sixth was a woman who seemed to take a great deal of responsibility for the problems of her parents, but no particular conflict was described (this woman is now apparently married to a man who drinks).

The clinic does not accept clients who are active alcoholics, so none of these clients was currently reported to be an alcoholic, although one was a recovering alcoholic. There were some concerns about alcohol and drugs in the clients who were not adult children of alcoholics. One client worried that her husband might be an alcoholic. One client has a sister with a drug problem and uses alcohol and drugs moderately herself. Another client had a history of drug use when he was younger. One other client had a mother who used pills, including valium, according to the intake report.
Physical Symptoms

Another reason that clients may be predisposed to seek therapy is that they are experiencing physical symptoms. Do clients discuss, and do intake workers document physical symptoms that clients may have? Fourteen reports did not include any physical symptoms or problems. Six reports did include several physical problems. Eight reports included one symptom or problem. Four reports mentioned medications or drugs that the client is taking or has taken, and two of the cases that reported several problems included drugs as well.

Seven reports documented problems with appetite or weight. Five reports listed problems with sleep, including insomnia and sleeping too much. One report mentioned P.M.S. as a problem. One report noted sexual problems the client (male) had with his new girlfriend (the intake worker's comments seemed to rule out physical causes). Other problems mentioned were: car accidents, schistomiasis, malaria, herpes, endometriosis, pneumonia, scoliosis, hives, leg pains, and a hysterectomy. Two reports mentioned medications: one client was apparently on lithium and one was wondering if her depression was linked to birth control pills. One client was an ex-alcoholic and another had a history of drug abuse.

The group of those with physical "problems" seemed to be evenly divided between men and women except that six of the seven cases with concerns about weight or appetite were women. These cases varied in how much the physical problems were
characterized as the reasons that the client sought therapy. For those with weight problems and the one client with a sexual problem this was straightforward, they seemed to say they were coming to therapy for this problem. There was also a client with insomnia where this seemed to be the case. Others were less direct, for example a client with anxiety who also had insomnia, which may be a part of the anxiety. Here the physical aspect of the problem may or may not have been what prompted a request for therapy. The same may be true for a client with depression and insomnia and another client with depression and who was sleeping too much. These "physical symptoms" may qualify as part of the diagnostic picture. Another client had been in several car accidents and had contracted diseases, leading him to worry that he was "self-destructive". Another client was going through a difficult divorce and had many physical symptoms. These clients with physical problems seemed to be involved in relationships as much as the rest of the sample and seemed also to be entering therapy just as much for relationship issues as the rest of the sample. The group with physical problems seemed to be described as more involved with their family of origin, in that the problems described were more likely to be linked in some way to a parent, and that family of origin information was more likely to be part of the current context of the client's life. An example is Heidi, a thirty year old woman who has had numerous health problems, feels depressed and had a recent visit with her family which was very upsetting.
Loss may be another reason that clients seek therapy. Ten clients in this group of 32 were clients who were reported to have had recent losses that involved a break up of a romantic relationship. Four of these were marriages and 6 were non-marital romantic relationships. One of these cases included someone who was also having difficulty ending a therapeutic relationship. Another also had lost several friends who recently left the area. Three of these ten cases were males and the remaining seven were females. All but one of these reports portrayed this break up of a relationship as a main reason for seeking therapy. The one report where this was not the case, described the client as saying that problems with finishing school work were to be the focus of therapy.

Besides these ten, three other cases mentioned past relationships which had ended, but these did not seem to be "recent" losses. There were two other cases that mentioned losses. One was a client whose parents had recently divorced and where the client had recently moved to the area. The other had a mother who was struggling with cancer. Given that these were clients entering therapy, it seemed somewhat surprising that there were not other losses reported in the lives of these clients, for example deaths or loss of a job. Three of the clients had parents who had died some time ago. One client's father died 10 years ago, and another's father died
12 years ago (from the time of intake). One other client's mother had died 19 years previously.

Problems in Other Parts of the Client's Social Network

The other side of the question of who helped bring the client into therapy is who will be affected by the therapy of this client. This question was not addressed directly, but a large number of reports did discuss problems that other people (besides the client) had. The majority (22) of the cases seemed to describe someone else as having some kind of a problem. Twelve cases described problems in members of their family of origin. Ten cases described problems in romantic partners. Another case described a problem in a group of people. (There were two with several problems described)

In the group that described problems in family of origin, three were about siblings, four were about parents in general or both parents, four were about mothers, and two were about fathers.

In the group that described problems in partners, two were about husbands, one was about a wife, and two were about girlfriends. The rest were about ex-partners: one was about an ex-wife, two about ex-husbands, and two about ex-boyfriends.

Descriptions of problems in siblings were varied. A few were given labels, such as schizophrenic, depressed, or having "an inferiority complex". Other problems described were that
one sibling had been hospitalized and one was reported to have a heroin addiction.

The parents were also varied in the problems described about them: one client described having alcoholic parents, another having parents who were just divorced. One set of parents was a mother who was obese and a father who "hated obesity". Another set was a "controlling" mother and a depressed father. Another mother was depressed. A father of one client was low in self esteem, another was "overbearing". Others described relationships they have with their parents: a mother who was not speaking to her child (the client) and a mother who criticized the client.

Of the eleven cases who did not indicate that another person had a problem, seven did have partners (partners where no problem was noted), with 4 of these being married partners and the rest being unmarried romantic partners. So, of the 16 people who had a current partner, 5 described problems that the partner was having, 4 described problems that a parent or sibling was having and 7 described no problems (that others had). These five that described problems in partners are clearly the ones whose relationships are "on the rocks", as the problems that these people have is about these relationships. One report described a woman who is planning a divorce, whose husband "prevents her from leaving the marriage by appearing to be unable to 'make it on his own'". Two other clients who are already separated from their partners were described as having partners who had abused
drugs or alcohol. It might seem from this that when separation has already happened, or is about to happen, the problems in the partner become more clear. When the partner is still there and the problems in the relationship are apparent, that may be what is commented on. In general though, problems described in partners were not the kind of problem one might call a pathology or a description of psychiatric problems.

Parents were described more in terms of "pathologies" or psychiatric problems they had (than were partners). There were 11 cases where problems in the family of origin were noted, and there were 16 other cases where the family of origin was mentioned but no problem in a family member was described.

Not all the reports where problems in parents or siblings are noted describe the relationship with family of origin as an issue of concern for therapy. However, all of those that identify the partner as having a problem do describe the partner relationship as related to the presenting problem.

There may be some difference between clients who see others around them as having problems (and tell this to an intake worker) and those who don't. One possibility is that stating that others have a problem is a way of identifying problems in one's self in an "acceptable" way. It seemed that those people who did not identify significant others as having problems were described differently by the intake workers. These clients were described as ones who drew away, were
withholding, shy, passive, cooperative, mistrustful, disengaged and self focused, avoidant or had difficulty with intimacy. The reports about clients who did describe problems in others differed somewhat in the intake workers' descriptions of the clients. These clients were described as being volatile, needy (two clients were described in this way), suspicious, seeking approval, choosing partners not ready to settle down, throwing herself into relationships, assertive/aggressive, overly responsible (two clients), cutting off feelings, feeling inadequate (two clients), overly critical, overly dependent, controlling, afraid of rejection, engaging, avoiding conflict (two clients), shy, or dramatic. One difference between these two sets of descriptions is in the amount of engagement with others. The second group, the ones that did describe problems in others, seemed slightly more involved in relationships with others based on these descriptions of their interpersonal styles that the intake workers included in the text of the intake report. From this one might develop a hypothesis about people who are more involved with others because of their interpersonal style being more likely to see problems in terms of problems in others.

Therapy, if successful, may change the way the client views herself, and may change relationships with others. These effects on the client may have significant effect on those close to the client as well.
Other Issues

The reports also attended to the issue of how well a client may be able to use therapy. This can be examined by looking at the client's past history of treatment, the kind of therapy to be offered, and the clinician's judgement of how well the client was able to use the intake interview.

Past Therapies

Four of the 32 clients in the sample had never been to a therapist before, according to the intake worker's reports. Twenty eight or 87.5% of these clients had been in prior therapy. Of these, 4 had been hospitalized in a psychiatric hospital. Fifteen or sixteen of the cases seen who had previous therapy had been to Student Mental Health (S.M.H.), the university run clinic for students. These cases are usually short term, crisis oriented, and many were probably referred directly by S.M.H. to the Psychological Services Center for long term therapy. Six had been in counseling with their current partner (one was five years ago, but the others were more recent). Three of those who had been in couples treatment recently were now separating. (Five who had been in individual counseling were now going through a separation from a partner.) Three clients reported having been in family therapy with their family of origin. One had been seen as a
child and one as an adolescent. Two mentioned having been in group therapy.

Of those who had been in previous treatment, there seemed to be a continuum of involvement with mental health providers. At one end were those who had been in numerous therapies, including hospitalizations. Then there were some that had tried several kinds of therapy. These groupings accounted for 9 of the 28 cases. Then there were 19 who had apparently tried one other kind of therapy in the past. A few of these had seen someone for a long time (a year or more), but most had brief exposure to therapy.

Of the four cases that involved clients who had never been in therapy before, all were clients who were described as having problems related to a romantic relationship. None of these four mentioned problems in family of origin relationships. One of these clients disclosed to the intake worker that his girlfriend had been in therapy all her life, for "chemical-biological depression". Later the intake worker stated that the girlfriend "provoked" the client to seek therapy. In very few other cases in the sample did clients seem to be prompted by others to enter therapy. Perhaps for someone who enters therapy for the first time, a romantic relationship is more of a salient reason to try therapy than other kinds of relationships.
Choice of Modality

Only one report in the sample mentioned the possibility of another modality of therapy and why it wasn't chosen. Mike, a man who has been married for eight years, was described as having problems in his marital relationship. However, he was "seeking individual treatment because he feels that most of the problems in the marital relationship are actually his". None of the other cases where family therapy was an option in terms of the information on the intake report, included a discussion of why individual work was chosen.

Another question that might be posed about this is whether the cases in this sample could hypothetically have been family or couples cases. The reports were not written to document this information, but it might be valuable to know how this information did come across in this sample.

Fourteen cases included mention of a partner (i.e. spouse, fiance/e, "girlfriend", or "boyfriend") who lived in the area or seemed to be part of the client's daily life. Perhaps these were partners who would have attended a family/couples session if the client or the therapist had requested it. Two of these included cases where a family of origin member might also have been available. There were two others who seemed to have family of origin members available but did not have partners available. Of course it is much more difficult to tell from this kind of text whether family of origin is available than if a partner is available. The
definition of available used here is that they seem to live fairly nearby, and seem to have some kind of relationship with the client, and no objections to inclusion in therapy are noted. Family of origin seems "available" in cases like that of Jeanne, who has been living with her parents until recently, and has a conflictual (but seemingly close) relationship with her parents. Another example is Ms. Ferrara, who lives with her husband, children and her own mother. In the case of Christine, the intake worker mentions that the family lives an hour away and that Christine keeps in touch with them.

There were cases with ambiguity about who would be available for family sessions. In the cases of Diane and Patrick (who are a couple who recently separated) couples therapy had led them to seek individual therapy at the PSC. Their recent separation leads to the assumption that couples work would no longer be an option. Ms. Cook has a husband who disapproves of her being in therapy, so it is unlikely that he would join her for couples sessions. In the case of Dan, his family may be available as they live within a few hours of the clinic. One could make other assumptions about this case, since he is a young college student who spends summers at home - this might lead to the idea that his parents might be available for family sessions - but no such comments were made by the intake worker.

Twelve cases seemed to be ones where family or couples therapy was not an option, as the report either (a) did not
discuss where the family lived or if there was a current relationship with the family or (b) did mention family contacts but stated that the parents lived far away and (c) did not mention a partner. There were 8 cases where no information was mentioned about the availability of the significant others in the client's life. There were four cases where it seemed that there would not be a family member or partner available for family therapy.

Of the fourteen cases where family or couples therapy was not ruled out by information in the intake report, ten were cases where a current problem described in the intake report was related to the family member or partner who might have been available for therapy. For example, Thomas had current problems with his girlfriend. He contacted the clinic right after a break up with his girlfriend and described problems in their relationship which he wanted to address. He then recontracted the intake worker several days later saying that they had gotten back together, but apparently he was still very interested in individual therapy. From this description, Thomas and his partner might have been candidates for couples therapy, but no mention was made of this possibility. Instead the intake report seemed to focus more on Thomas' problems, such as his tendency to be "cynical and overly critical" of others.

Four of the fourteen cases that might have been candidates for family therapy did not seem to address problems that involved significant others. For example, Carolyn was
described as seeking therapy for help with her fear of the dark, which was described as being related to family of origin issues. Her family of origin was not noted as being available or not available, but the report did note that she was married. The possibility of examining this issue in a family context was not described (Although it turns out that this client was being seen concurrently in family therapy in the PSC. Oddly, this was not mentioned in the intake report).

Intake Workers' Use of Client Interpersonal "Style"

While clinicians are not asked directly about the client's interpersonal style, nearly all the case reports include some kind of information about this, either as a quote from the client, or as part of a warning at the end of the report for the therapist, or as part of the diagnosis. In diagnosis and treatment planning the client's characteristic style toward others is a very important piece of information. In addition, clients who might be too difficult to work with might be referred out because of the nature of a training clinic.

Some of the words and phrases used to describe clients follow: intolerance, limited empathy, entertaining, disengaged, self-focused, seeks approval, needy, feels criticized, avoids conflict, afraid of being abandoned, mistrustful, hypercritical, oversensitive to others'
because of the expectations that we have for men and women (as reflected in the words of the intake workers)?

Intake Workers' Use of the Relationship

A primary part of psychoanalytic versions of interviewing is the development of a relationship between the clinician and the interviewee in order for the clinician to use this information to understand how the client relates to others. Do these clinicians use this information and how do they report it in the intake reports?

Eighteen of the 32 reports did not seem to include information about the intake worker's experience of meeting with the client. Fourteen cases did include this kind of information, although in a few cases it was unclear. An example of a case where it was clear was the report about Louise, where the intake worker found that the Louise would "benefit from...therapy". The intake worker found her bright, engaging and mature, with a "fairly good psychological understanding of herself and a high level of motivation for treatment". This in itself seems to indicate something about the relationship that developed during the intake interview. The intake worker went on to say that "in the intake interview, I found her to be quite open and expressive". This in particular seems to characterize the relationship that developed, and seemed to have had implications for the intake worker's assessment of the client's suitability for treatment.
Another intake worker described a male client, Thomas, this way: "Thomas struck this writer as a staunch New Englander, a man not prone to discuss or express emotion, and a tendency toward introspection". While this does not convey nearly as much of the intake worker's feelings about the client as the first example, the intake worker's experience is still being used to assess the client. Another example is Dan, who was described by the intake worker this way: "Dan was quite anxious and pressured when I met with him. He had a tendency to run on tangential issues and I found I had to redirect him and structure our interaction a good deal." Here the dynamic of what happened in the room is taken as an indication of what would happen with a potential therapist, or as a characteristic of the client. All three of the above examples seemed to be indications of the therapist using the relationship to gather information, then using that information in the intake report. The next example is a bit different. In the report about Katherine, the intake worker states: "When Katherine becomes anxious or uncomfortable in therapy she may have a tendency to withdraw quietly or to put pressure on the therapist to come through with solutions. While her overt presentation is cooperative and gentle, there is apparently some anger which she will have to confront in the course of her treatment." Here, one might wonder where this information about the client comes from and the most logical answer is that it is from the interaction with the therapist. However, the therapist does not state it as such,
but rather incorporates it into the report without stating its source. This comes across more as a summary of information than as a documentation of the process by which information was collected.

All of the intake workers except one (#4) had reports in the group that used the intake worker-client relationship as noted above. One intake worker (#6) had all of her intake reports fall into this group.

Of the fourteen cases that did discuss the client in terms of the relationship to the intake worker, most (11) seemed to involve clients that the intake worker tended to describe in terms of seeking help with relationships (for example the client says she sees patterns in her relationships, where her partner feels she is too dependent and he "moves away" from her). Of the other 18 that did not discuss the intake worker's relationship to the client as part of the intake, only 7 were described as seeking help with relationships. This seems to imply that seeking help with relationships is related to intake workers' commenting on relationships in the interview. This does not mean that one caused the other, however. Intake workers may or may not have thought about and written about relationships to the client because of the issues that the clients discussed. Another explanation is that particular clients evoke such discussion, and that these clients also have particular patterns of relationships. It may also imply that certain intake workers brought out issues of relationships in their interviews with
clients and that these intake workers are the ones that write about relationships to clients. It may also be that clients that evoked descriptions of relationships to intake workers also evoked descriptions in terms of seeking help with relationships.

Sex of Client

There were eighteen female clients and fourteen male clients in the sample of reports. There were four more women than men because no additional cases involving males who were married or living together could be found (See Tables 1 and 2).

There were many more reports about female clients who were described as having a current relationship with their family of origin. So in terms of "family of origin relationship status" more of the female clients were reported to be in current relationships (11 out of 18 for the females, 4 out of 14 for the males). It seemed that the difference was most striking among the clients reported to have a current partner. Many of the reports about females with partners also had mention of a current relationship with their family of origin. None of the males in the partnered group had relationships with their family of origin mentioned in their intake report. Almost all of the reports about females who had no partner did have mention of a current relationship with
family of origin, as did many of the reports about male clients without partners.

The differences between presenting problems described in cases about men versus those in cases about women varied in two areas. Women seemed to be more likely to be described as depressed (11 of 18 women versus 6 of 14 men). Women also were more likely to be described as having problems related to weight (3 women only). There were three women and six men who were described as having problems which affected their school, work or career.

Three men were described as socially isolated and one man as having been lonely in the past. One woman was described as having feelings of loneliness and isolation, one woman was described as having been lonely at the time of the intake, one woman was described as having times of feeling lonely, and one woman was described as being dissatisfied with her social network. The subtle difference here seems to be that men were more often described as being socially isolated and women were described as having feelings of loneliness.

Men and women seemed to be described in equal numbers to be seeking help with general aspects of their relationships with others. However, there was a difference between reports about men and women in terms of who they were described as having current conflicts with (and perhaps were seeking help for that relationship). Seven of the reports written about men described current conflicts with partners where the conflict seemed to be one of the reasons the client was seeking
therapy. Two of these "partners" were actually ex-partners. There were no reports where aspects of relationships with parents of male clients were reported as relevant to therapy. In one report about a male client a conflict with a brother was described. However for reports written about women this was very different. There were six reports involving female clients where conflict was described about an ex-partner which seemed related to the request for therapy. There were three reports where current conflict was described about a current partner. There were six cases involving female clients where parents were described as being in a conflictual relationship with the client that seemed to be related to the request for therapy. There were many more reports written about women where it seemed that the woman was involved in "leaving home" (It seemed to be 8 reports about women as opposed to 3 about men - and the ones with men didn't seem very clearly to be leaving home). Reports about male clients used family of origin information more as background information and reports about females used family of origin information as background information and often as part of the current context of the client's life.

As discussed above, some of the reports described ways that other people in the clients lives may have problems. It seemed that reports about female clients were more likely to have these kinds of comments about parents (eg. mother is obese, father is overbearing) - 8 reports about women describe parents this way, and one report had comments about a sibling.
Only two reports about men described parents as having some kind of problem, and two described problems in siblings. Four of the reports about women seemed to have been ones where family therapy with family of origin could have been possible, whereas none of the reports about men seemed to have been potential family therapy cases with family of origin (but eight of the cases involving male clients could have been cases of couples therapy). Six of the cases involving female clients seemed to have been ones where couples therapy could have been an option.

Given the general statistics on who sees therapists (women do, more so than men), it is also not surprising to see that of the four clients who were reported not to have seen a therapist before coming to the PSC, three were men.

**Intake Workers**

There were eight intake workers that wrote the reports used in the sample. Each intake worker had done from two to six of the intake reports in this sample. One intake worker (#4) did two reports that were included. Two intake workers did three reports each (#3 and #8). Two other intake workers did four reports each (#5 and #7). Two other intake workers did five reports each (#2 and #6). One intake worker was responsible for six reports (#1).

The cases were selected so as to use reports done by "regular" intake workers (ones who had done a large number of
reports) and to attempt to distribute them evenly given the constraint of marital status and gender.

The intake workers were three men and five women. They were advanced graduate students in the doctoral program in Clinical Psychology at the University of Massachusetts (See section on Intake worker interviews).

The intake workers varied in how much they included certain information in their reports. One intake worker, for example, left living situation unclear on two reports, and these were the only two reports in the sample where this was not clearly defined. Another intake worker did not do initial formulations for the majority of his cases. These issues may be related to training as these initial formulations are "required" but it seemed likely that some intake workers were not aware of the importance of these statements. There may also be issues of personal style as well.

Other differences between reports may be due to more subjective differences between intake workers.

Four intake reports in this sample of 32 did not mention the family of origin of the client at all. It turns out that these four reports were written by two intake workers (#1 and #7). These two intake workers did do other reports that included family of origin information however. The one intake worker who had three intake reports with no family of origin information, also omitted from their fourth report information on whether or not there was a current relationship with the family of origin. Among the other intake workers
there was a great deal of variation in whether or not a current relationship with family of origin was mentioned, in other words whether or not this was mentioned did not seem to be dependent only on the author of the intake report.

Other kinds of information did not seem to be related to who did the intake report, such as if the client seemed to be seeking help with relationships, if there was a break up mentioned, if isolation or loneliness was mentioned, if "leaving home" seemed to be an issue, and the issues of if the presenting problem was related to any relationships. Almost all the intake workers reports included descriptions of clients' interpersonal style, and many included descriptions of the relationship between the intake worker and the client.

Three Examples of Intake Workers' Reporting Styles

While differences between intake workers seem elusive, a description of three intake workers' styles will show some interesting similarities and differences:

Intake worker #6 did 5 of the intake reports in this sample. This intake worker followed a pattern in all 5 of these reports, which began with demographic information, and a description of how the client came to be seen at the clinic, followed by history of the problem and of the individual, generally with some information about early history. The final paragraph included interpretations about interpersonal style (or character) and made recommendations for the therapist.
Family of origin was mentioned in all these reports, however, there was generally no information on whether or not the client had current contact with the family of origin (and therefore no information about whether or not family therapy could have been an option). Most of the clients evaluated by this intake worker seemed to be seeking help with relationships, and the presenting problem seemed to be related to relationships with specific people. However, the family of origin was never the focus of the presenting problem or described as a current interpersonal conflict. The way that this intake worker described these cases places importance on early conflicts with the family in the development and understanding of the problems, but not on the current maintenance of the problems. Current relationships with partners seem to emerge as the forms of interpersonal conflict in these clients' lives as described by this intake worker. Few of these reports had focused "non-relational" problems described in them. In addition, this intake worker described the clients relationship to her in each report.

Another intake worker, #7, who did 4 reports in this sample, followed a different pattern. These reports also began with demographic information, and general information on how the client came to be seen at the clinic. Then, these reports discussed the presenting problem and the recent history of the problem. These reports seemed to focus much more on the current functioning of the client and how the presenting problem is affecting that functioning. Many of this intake
worker's reports did not include family of origin information. These reports did not seem to take the life history/developmental view that the other intake worker's reports did, but rather discussed the events and circumstances that led to the presenting problem and the current state of the client. This intake worker also did not address the questions of family of origin influences on the current presenting problem or of current relationships with family or origin in these reports. These four reports included two where the clients were seeking help for problems related to a relationship with a partner and two who weren't. These reports were not ones that reflected problems unrelated to other people. Two of the reports had no "non-relational" problems, and all of them did discuss issues about relationships, even if the client was not described as having current relationships. This intake worker, however, did not describe the client's relationship to him in most of his reports.

A third intake worker's (#5) reports show a somewhat different set of characteristics. There were four reports (in this sample) written by this intake worker. Here, family influence in current problems seemed important in 3 of these 4 reports. Interestingly, all the clients described by this intake worker were described as depressed. This intake worker tended to use a lot of words to describe problems and feelings the prospective client was having. For example, the report about Louise contains this sentence: "She describes herself as a very introspective, thoughtful and self-critical person who
feels plagued by feelings of unworthiness, unloveableness, and inadequacy. This intake worker seemed to follow a pattern of first describing the presenting problem and any referral information, then describing some history of the problem, and ending with advice about what kind of treatment might be helpful to this client. This was not however, clearly advice to therapist; these comments seems to be more aimed to the intake team than to a future therapist.

Gender Differences in Intake Workers

One difference between male and female intake workers was that only female intake workers described cases that could be seen as having issues of "leaving home". None of the male intake workers described cases in this way. In addition, female intake workers were more likely to comment on the relationship they developed with the client than were male intake workers.

An interesting example came up that refers in some ways to the question of the intake worker's influence on the shape of the reports. Patrick and Diane are a husband and wife who just separated due to the wife's decision to leave. The same (female) intake worker did the two intakes, about two weeks apart. The husband, Patrick, was described in a very short intake report (the shortest in the sample) as reacting to a "situational" crisis, and as seeking help in making decisions about where to move following this separation. From what the
intake worker described, he seemed to be in distress. The wife, however, had a much longer statement written up about her, where her leaving her husband was described in the context of her struggle to learn to confront issues that are difficult for her. While the intake worker suggested short term work for the husband, she did not make this kind of recommendation for the wife, leaving one to imagine that a longer treatment might be appropriate. The intake report about the wife also contained information about the client's life as a child, which the report about the husband did not address at all. It is not clear if the wife was seen as being in more distress in the long run (while being less distressed at the intake perhaps), or seeking help in a more clear way, or if her problem was seen as more "serious" because it was linked in some way with her own personality as opposed to being only "situational". One wonders how much gender issues went into this difference: Did the husband's feelings and distress seem un-genuine or temporary to the intake worker? Was the female intake worker identifying with the woman's struggle for independence and assertiveness, and therefore trying to find a way to offer her more help? Perhaps there was a real difference between the man and the woman in how they experienced this separation and in how they presented for therapy.
Intake Worker Interviews

Intake workers were generally advanced graduate students in the doctoral training program in clinical psychology (third, fourth or fifth year students when they began doing intakes).

Intake workers generally had direct clinical experience prior to entering the graduate program and then spent each of their years in the program working with a different supervisor, often with somewhat different orientations. Most of the students doing intakes were, in addition, supervising less advanced graduate students in the clinic. Students were chosen for these positions on the basis of their past clinical work, including evaluations by previous supervisors.

Many of the intake workers had gotten several years of supervision using a psychodynamic model. Most had some experience with family therapy. Only a few had had experience with behavior therapy. While this direct experience varied, most of the students had completed the departmental requirement of one semester's coursework in each of the three treatment perspectives offered by the department (psychodynamic, behavioral, and family systems). Generally the students had also taken a course in assessment. Most of the students had also worked at outside practicum sites either prior to, or at the same time as they did intake work (sites such as a community mental health center, a college counselling center, or a crisis intervention center).
Almost all of the intake workers characterized their theoretical orientation as psychodynamic, and some included mention of family systems models as an influence on their thinking (the exception to this was an intake worker who characterized herself as "eclectic", by which she meant integrating psychodynamic, behavioral and family systems thinking). None characterized themselves as purely behavioral in their orientation.

All the intake workers discussed the training they received from the intake supervisor and from past intake workers. They felt this training addressed mainly the intake process and less the report writing. Several intake workers mentioned their assessment course as a place they learned about writing these reports.

Often, when asked about what went into these reports, the intake workers responded that they included the "standard" elements, although they were less sure about how they knew what the standard elements were. This seems to have come from a sense that the report writing came from the accumulated knowledge they had acquired in their years in training. The report format and length seemed to be somewhat influenced by the form on which the report was written. One intake worker commented that they thought about what they would need to answer based on what was asked on that form.

Several intake workers said that they saw a parallel between the intake report and the format of a report in the "medical model", as in the "history of the presenting illness"
in a medical chart. The descriptions of what was included in a report usually included the "presenting problem" and stressors that might have contributed to the present condition. For example, most discussed family issues, relationship issues, psychiatric history, current functioning of the client and what led the client to seek help at the time of the intake. Several said that they would have included any medical factors relevant to the treatment or the current stressors. Often intake workers said they would also include information about the referral to the clinic. Most also said that they would include characterological information, or how the problem fit into the person's presentation of themselves. One intake worker characterized this as trying to describe "who the person was" for the therapist who would be assigned the case. The intake workers generally also addressed, they felt, what the client was seeking in therapy, and some felt that they commented on what therapy would be like with this client, and what issues would or should be addressed.

Most of the intake workers felt that they used the relationship they developed with the client in understanding the way that the client functioned. Intake workers varied, however, in how they included this information in the reports. Some felt that they included this information explicitly, for example one intake worker said she might include a comment such as "patient appeared anxious, based on sweaty palms when he shook my hand". Another example of this kind was an intake worker who said she would include information such as
"difficult to establish rapport" or "hesitant to talk" in her intake reports. One intake worker referred to using this information in assessing the client as being concerned with what went "boing!" about the client. Others said that they would use this information to help them in reaching a diagnosis, but would not include comments in their written report about how they had felt when they were with the client or specific examples of what had happened in their interaction. Some felt that they would only use this experience in the written report if it seemed important.

Several intake workers said that they used this information more as they had more experience with doing intakes. Several intake workers said that they wrote shorter intake reports as they became more experienced. One described that he felt that as he got used to doing the reports he included less detail and more of the characterization of the person.

The audience that the intake workers felt they had in mind when writing the reports was generally the therapist who would be assigned the case. Although the information gathered at the time of intake was used by the intake team for making decisions about the disposition of the case, the report itself was seen as going primarily to the therapist. A few intake workers felt that, in addition, the audience was themselves, in that writing the report helped them to focus their thinking about the interaction with the client. A few intake workers also mentioned the use of the report as a lasting document for the clinic records. The main purpose though, of the reports,
as this group of intake workers described it, was to assist the new therapist in becoming acquainted with the client. One intake worker said that he imagined the client coming to the clinic door and wrote down what he would have liked to have known if he were the therapist starting with the client. One intake worker felt that this was especially important given that the therapists assigned to the cases were beginners and that they might need more information. Another talked about the therapists more as colleagues, and described his job as that of a consultant, introducing clients to therapists. This same intake worker also felt that part of the job of writing intake reports was being evaluated by peers (the other therapists).

Many of the intake workers said that they communicated with the therapist who was assigned the case in addition to writing the report. One even said that at times he knew which therapist in the clinic had an opening and therefore felt he knew who in particular he was writing the report for. Several intake workers said that they would leave out certain details in a report (such as details about sexual abuse) and perhaps communicate this to the therapist in person. One intake worker said that he would leave out his "countertransference" reactions to the client and communicate these to the therapist in person.
Conclusions and Recommendations

This section will review some of the main points discovered in the analysis of the reports and will provide a set of guidelines for writing intake reports in the style of those in the sample.

Relationships and Presenting Problems

A primary objective of this research was to describe the portrayal of relationships in a sample of intake reports (and specifically in the "brief history of the presenting problem" texts) written by clinicians about prospective individual psychotherapy clients. While there have been attempts to measure the extent to which clients report "relationship issues" as central to their request for therapy (compared to other "non-relational" kinds of problems) (e.g., Horowitz et al, 1988; Yoken, 1988), this study is instead an intensive examination of the ways that relationships, and their connection to presenting problems, are described by intake clinicians in reports.

All of the reports examined in this study mentioned relationships with others, and these relationships were associated with the "presenting problem" in a variety of ways. Initially it seemed that perhaps there would be a continuum of involvement of others in the presenting problems in clients' lives. In this way of thinking, some clients would have "more
involvement" with others and some would have "less involvement", and clients could be fit into this schema at different points along the continuum. This way of thinking did not seem to fit the data well. Instead it seemed that there were different ways that the problem fit in with relationships with others. As described earlier, these categories were as follows: (a) the presenting problem is a relationship with a partner, (b) the presenting problems include a relationship with a partner as well as other issues, (c) the presenting problems involve the client's partner and family of origin, (d) the presenting problem involves the client's current conflicts with family of origin, (e) the presenting problem relates to past history with the family of origin, (f) the presenting problems are described as being unrelated to relationships, (g) the presenting problem concerns patterns in relationships, but not current conflicts with a particular person, and (h) the presenting problem is the client's social isolation. These groupings are not mutually exclusive, nor are they comprehensive for all clients, but they describe the 32 reports in this sample fairly well. Further work in this area might involve using these categories for another set of reports, using multiple raters to determine if these categories could be discerned reliably. It would be interesting to know how these views develop and change over the course of therapy, as these views only capture the clinician's evaluation at the point of intake. For example, a client who sees a pattern of relationship problems at intake
may come to describe a particular person which whom the pattern is being played out. Alternatively, a client who has an issue with a partner now may come to define it as a life long pattern.

It is by no means easy to determine whether problems are relational. Even problems that have no explicit relational aspect (e.g., those related to depression and self-esteem) may be seen in object relations terms as still involving a relationship, although perhaps an internalized one. For example, a client who devalues herself in depression may be engaging in a process which could also exist in relations to others. For this reason, these distinctions about when a problem is "relational" are very difficult to make. This seemed to be particularly true for problems involving depression, which existed in a great number of cases. The finding of depression as a common reason for seeking therapy has been documented elsewhere (Garfield, 1986). It has also been documented that women are more likely to describe themselves and to be described by mental health workers as depressed (Weissman and Klerman, 1981, Robins et al., 1984).

The Definition of Relationships

Another goal of this study was to examine what kinds of relationships are described in intake reports. Many studies give information about marital status in the traditional categories of "married", "single" and "divorced" or separated"
(e.g., Koss et al., 1983). This study has shown that these groupings may have varied meanings, and that much more must be known to really understand the nature of a (partner) relationship and its place in a client's life. For example, in this study there were clients who were labelled "unpartnered" initially but whose presenting problem related to a non-marital partner. These reports also contained examples of cases where an already ended relationship had great importance in a client's life. Of those that were in marital relationships it seemed that there was great variation in what the relationship might mean to the client, and that there may be stages of "getting into" and "getting out of" marital relationships that are just as different from each other as the categories of "married" and "single". While this sample contained few of these cases, there seemed to be very different and individualized meanings for the transitional terms "engaged", "divorced", and "separated". In considering this issue an important element in to consider in this might be the changing nature of "the family" in our society. Since in our society the notions of "married" and "single" do not

"Recently lawmakers have attempted to come up with definitions of family relationships. In California, legislation is underway to grant legal "partner" status to unmarried couples (Bishop, 1989). Because of zoning laws, the issue of what constitutes a family was raised in New York recently, and a group home of "former mental patients" was ruled to be "the functional equivalent of a family" (Gutis, 1989). Messer (1970, pp. 69-70) has attempted to define the qualities of a family with ideas such as "sharing of goals and identity", concern for "physical and emotional needs of its members", and a style of interacting in which the individual does not have to be "on guard". Using these ideas would imply that a very complex evaluation would be needed to decide which people are a "family".

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cover the whole territory of relationships, it may be time for researchers to rethink how to make these categorizations. Further studies might develop and test out these new categories.

In light of Gurman and Kniskern's conclusions from their review study (1978), knowing about client's relationship "status" remains an important consideration in treatment planning. It may also be important to know more about these relationships than "married" or "single", as this might lead to a more complex assessment of what kind of therapy might be applicable for a particular case. This may be true in the clinical setting but in addition, treatment outcome studies might benefit from a more differentiated system. Perhaps certain stages or kinds of relationship patterns are better suited to individual or conjoint therapies.

While "partner" relationships are complex, and traditional labels lead to overly simplistic categorizations, the description of family-of-origin relationships is even more difficult to accomplish. With this set of reports, the one striking pattern was that a number of cases involved clients engaged in separating from their families of origin. As the clients seen in the clinic are often young adults, further studies could examine the desire for therapy as it relates to "differentiation" from family of origin.

In this sample, family of origin and other significant others were clearly described as being connected to many of the problems presented. There was also indication that they
were involved in a few cases in the request for therapy. There may also be ways that others are involved in the course and outcome of therapy (Barcai, 1977, Hatcher and Hatcher, 1983, Brody and Farber, 1989). It would be interesting to follow cases from intake to termination to see how clients and therapists view family involvement over the course of therapy.

Gender Issues

Some clients may come to therapy at times that involve separation and loss. With family of origin this may involve the phenomenon of "leaving home". In romantic relationships, some clients may seek help at the point where a relationship becomes problematic or when it is over. In this sample, women were described as frequently seeking help for problems with romantic relationships that are already over, while several men were described as being currently in problematic relationships when they sought therapy. A way to conceptualize this is that women may seek help to differentiate themselves and re-establish their identity after a loss, while men may seek help to maintain an important relationship.

Recent theories of gender differences (Gilligan, 1982) postulate "relatedness" as a central theme in women's lives and development, while a greater emphasis is placed on "autonomy" in men's lives and development. It seems in line with this thinking that women in this sample were described as
having presenting problems related to family of origin and seemed to have more current contact with members of their family of origin. It also seemed to fit these theories that of the few reports where social isolation was a central issue, all were reports describing male clients. As is the case with all these issues, the clinician's views and their own biases are a part of the findings. Clinicians may have questioned female clients more extensively about their families, whether or not female clients themselves were more inclined to discuss how their families were involved in the presenting problem. Male clients may or may not have been less forthcoming about family of origin issues, and may or may not have been more ready to describe their problem as "social isolation". What was apparent in the reports was that some combination of these forces led to somewhat different descriptions in the reports themselves.

The same issue of relatedness and gender may apply to the clinician. An important tool for the clinician assessing a client is the ability to use one's self and one's emerging relationship with the client as an indication of the client's interpersonal style (as described by Marziali, 1988 and Gomez and O'Connell, 1987). The clinicians who wrote these reports were certainly aware of the importance of this, and used their own reactions in the consulting room and in the reports. It was interesting to discover that for this sample, the evidence of the intake worker's relationships with the clients were more clear in the reports written by women. Again this may
reflect women's greater emphasis on "relational" thinking, or it may reflect a tendency for women to be more comfortable with "subjective" forms of knowledge (Belensky, Clinchy, Goldberger, and Tarule, 1986).

The Clinical Context of the Intake Reports

While this study is an exploration of reports, written about a set of clients, and by a group of clinicians, it is also very much a study of the environment in which it was conducted - the Psychological Services Center. The reports tell a story about the nature of the work that takes place in this clinic, and perhaps also tell of the kind of training that takes place.

The content of the reports revealed several of the forces involved in shaping the reports. The fact that the reports were written for therapists was one of the unexpected pieces of information collected along the way in this study. Another surprise that so many of the clients had engaged in previous therapies (28 out of 32). Future studies could look explicitly at this phenomenon in this clinic.

The meaning of the term "history" in the texts was not an area initially that this study would cover, but this became important in looking at the "brief history" texts. What was most striking was the variety in the length of history included. Some texts included a brief history of the "problem" which seemed to include a minimum of two years background
information. Others included a full biography of the client and the family of origin. This may be reflective of theoretical differences, as a psychodynamic view (favored among the intake workers interviewed) would tend to include information about childhood in developing a formulation. DSMIII-R may also have a role in this, as some diagnoses require a certain period of time before a diagnosis can be made.

Wynne (1988, p.97), in making recommendations for family therapy research, emphasized the importance of including "multiple perspectives" - for example asking both the clients and the therapists to comment on the nature of the presenting problem at intake. The present study used the data from a particular perspective - the intake worker's written summary following an interview with an individual client. Other studies have considered presenting problems described by clients at the point of intake. Horowitz, Rosenberg, Baer, Ureno, and Villasenor (1988) developed a scale which assessed clients' perceptions of having interpersonal problems at the time they requested therapy. From a comparison of this scale with clients' responses to a standardized symptom check-list (SCL-90) they were able to describe the "salience of interpersonal over non-interpersonal distress" in clients seeking psychotherapy. They concluded that "interpersonal problems are among the most frequent complaints that patients bring to psychotherapy" (p. 891). Yoken (1988) also assessed clients' reasons for seeking therapy, using an open-ended
question on a questionnaire. She found the categories of "emotionalness", "self concept and esteem" and "achievement" to be rated more often (than categories related to relationships with others). It may be that when clients are asked to give their reasons for seeking therapy without help from a clinician or a check-list, they will give more symptom based, or perhaps more vague answers. As Davis (1986) has described, clinicians help clients expand and shape their problems into problems suitable for therapy. In the present study, this may have involved questioning about relationships and an inclusion therefore of these ongoing difficulties with others as part of the "presenting problem".

Recommendations for Intake Reports

On the basis of this in-depth review of 32 reports, it is clear that these reports offer valuable resources for clinical and research purposes. The specific pieces of information detailed in other sections of the intake report (age, marital status, previous treatment, etc.) are complimented by the richness and complexity of the "brief history of the presenting problem" texts. While these other sections of the report are in a sense more "objective" bits of information, the "brief history" text and the "initial formulation" are the sections that require more "subjectivity". They are subjective in that they rely on clinical judgment and incorporation of information unique to
the particular interview which occurred. This necessitates the clinician using herself in the process of listening to the information, shaping the interview itself, and compiling the information in a meaningful and concise way. The clinician's personality, individual responses to the client's material (countertransference) and theoretical perspective are bound to have an effect on the outcome of this process and that effect cannot be "partialled out" in the kind of analysis done here. Simply taking the narratives at face value however, an understanding can be reached about some of the essential elements of the intake interview and report. Therefore, based on this review (and my personal experience in the role of intake worker) my recommendations are as follows:

The initial formulation is a separate statement from the "brief history" text, and an important one. A beginning point for the initial formulation is the intake supervisor's definition of this section as the "diagnosis in prose". This is an elaboration of the clinician's understanding of why the person is seeking therapy. The relevant questions might be: what are the current symptoms and complaints and how do they fit together, how severe are the problems, why is the client seeking help at this time, and how does the problem fit into the client's character style and life history. This should be brief and need not include all parts of the client's history, but just the conclusions the clinician has come to about the client's situation.
The "problem history" statement can be likened to drawing a portrait of the client and her problems. In drawing this portrait, there seem to be five important areas to consider.

1. A beginning point might be to elaborate on the context of the problem as it appears now. If the client says the problem has intensified in the last three weeks, this statement should include information about the last three weeks, and include any possible triggers which might have caused the intensification of the problem. It may also be helpful for diagnosis and treatment planning to consider how the client's usual style of coping has influenced the problem, as well as how current circumstances or other people's involvement are related to the problem. This section can be seen as an elaboration of the DSMIII-R axis IV diagnosis, in which the clinician lists the psychosocial stressors related to the onset of the problem.

2. Another function of this report is to provide a general account of where the client is in the life cycle and in relationships. A 23 year old who is married and has two children is in a different position than a 23 year old who is living with her parents and is struggling to complete a college degree. This involves variables of maturity (for the predominantly younger population seen at the clinic), decisions about jobs and relationships with partners and family of origin. For the clinician considering individual psychopathology, this would provide information on how the
client has mastered the areas of "love" and "work". From a family systems perspective, this could provide a picture of the system that maintains the "problem", information about who believes there is a problem, and what resources (people) are available to assist in the therapy and change of the problem. In addition, knowing about a client's relationships and work history helps to put the presenting problem in the context of the client's life, as one does when using DSMIII-R axis V, which asks the clinician to rate the level of functioning of the client at present and the highest level attained in the last year.

3. The report should also include information the clinician has gathered about the childhood or earlier life of the client (including a brief sketch of middle adult years for older clients). While the PSC has addressed this issue somewhat by asking these questions on a Personal History Questionnaire, it seems important that these areas still be addressed in the interview, if only because some clients do not fill in these questions on the questionnaire. Some of the areas to be addressed are the clients position in the family relative to siblings, early losses, illness, problems with the law, and psychiatric history of relatives. While not all areas will be addressed in each report or in each interview, any important information obtained should be noted in the report. It is also important to consider that psychodynamic and some family systems views would see early history as a way to understand current problems. For the future therapist, a
glimpse at some "genetic" hypotheses might be very helpful in knowing how to proceed. For example, a client with many significant losses in her life should be made aware early on if a therapist is to be available for only several months.

4. While this was not done regularly in the cases reviewed, the client's socio-cultural context should be noted in the intake report. Race, ethnicity, religion, and socioeconomic background may all have a large impact on therapy, and future therapists should be sensitive to their own, as well as the client's biases in beginning therapy. In addition, there may be ways that the clinician has misunderstood the client because of these issues. A future reader may be able to pick up on this information if it is available. One would hope that in addition, the clinician writing the report would become more aware of cross-cultural issues if writing about this were part of the intake process.

5. This group of 32 reports often included the clinician's reactions to the client as they related to future treatment, and at times this was elaborated into specific recommendations. The new version of the intake report asks specifically for treatment recommendations. This new section can be used for such recommendations as "individual insight-oriented therapy with a female therapist", while the longer "brief history" text might still be used to elaborate on how the current state or past history of the client might affect the initial encounter with the new therapist. As the intake workers are generally more advanced students than the
therapists, the reports might be helpful in guiding the less experienced therapists. In addition it is at times helpful to have the input of another clinician in situations where a particular response is evoked by the client.

The kinds of reports written will certainly vary depending on who the clinician is - in terms of the clinician's personality, interviewing style and predominant theoretical orientation. It is surprising how little the clinicians reveal explicitly of their own theoretical bias. Perhaps it would be helpful for clinicians to be more explicit about this. Since the training program at the University of Massachusetts generally trains clinicians to have an understanding of at least two or three different theoretical orientations, it may be possible for clinicians to indicate how different perspectives might explain a particular client's situation, or to point the way for different kinds of interventions. This would be helpful in conceptualizing the work for the intake team and to allow more discussion of different assignment possibilities (therapists generally work with one supervisor for the year who may work psychodynamically, behaviorally, with a family systems model, or with a combination of techniques).

From this analysis, it has become apparent that the intake report, and the "brief history of the presenting problem" texts, serve many functions. Perhaps a final suggestion would be to re-label this text "brief history of the presenting problem and additional intake worker comments".
While it is helpful to include subheadings where applicable (as has been done since these reports were written), it is also beneficial to leave room for these lengthier, more subjective and complex statements written by clinicians.
INITIAL INFORMATION SHEET

Date ___________________________  INTERVIEWER ___________________________

Name of client(s) ___________________________  Age ___________________________

Address ___________________________  Last ___________________________  First ___________________________

Marital Status ___________________________  Phone (home) ___________________________

(business) ___________________________

Preferred place and time for client to be reached by phone ___________________________

Referred by ___________________________

Name of person contacting PSC ___________________________

CURRENT LIVING SITUATION

Current Employment and/or School Situation ___________________________

Past Mental Health Intervention ___________________________

Preferred Type of Treatment ___________________________

Initial Formulation ___________________________

INSURANCE COVERAGE

DATE OPENED ___________________________  ASSIGNED TO ___________________________

SUPERVISED BY ___________________________

DATE TRANSFERRED ___________________________  ASSIGNED TO ___________________________

SUPERVISED BY ___________________________

OTHER DISPOSITION ___________________________

STATUS OF CASE AT CLOSE OF INTAKE ___________________________

ADDITIONAL CLIENT CONTACTS:  DATE CONTACT ___________________________

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For Family Referrals:
Members of Household

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Presenting Problem and Brief History

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