

PART ONE

BECOMING A MENTAL HEALTH PROFESSIONAL

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Chapter 1

INTRODUCTION

Philosophy and Organization

It is good to have an end to journey toward; but it is the journey that matters, in the end.

—Ursula K. Le Guin, *The Left Hand of Darkness*

CHAPTER OBJECTIVES

This chapter welcomes you to the professional field of clinical interviewing and orients you to the philosophy and organization of this book. In addition, you will learn:

- About our teaching philosophy.
- How clinicians from different theoretical orientations approach the interviewing task.
- Basic requirements for clinical interviewers.
- Advantages and disadvantages of being a non-directive interviewer.
- To reflect on your potential cultural biases when interviewing.
- The goals and objectives of this book.

Imagine sitting face-to-face with your first client. You have carefully chosen your clothing and seating arrangements, set up the video camera, and completed the introductory paperwork. You are doing your best to communicate warmth and helpfulness through your body posture and facial expressions. Now, imagine your client refuses to talk, or talks too much, or asks if he can leave early. Imagine she starts crying or accuses you of not ever being able to understand her because of racial or ethnic differences. How will you respond to these situations? What will you say? What will you do?

From the first client forward, every client you meet will be different. Your challenge or mission (if you choose to accept it) is to make human contact with each of these different clients, to establish rapport, to build a working alliance, to gather information, to instill hope, and, if appropriate, to provide clear and helpful professional recommendations. To top it off, you must gracefully end the interview on time. These are no small tasks.

If you are interested in clinical interviewing, you probably want to learn how to begin a productive helping relationship that will lead to positive changes in your clients' lives. So when you imagine yourself sitting with your first client, you probably also want to know how to respond if he or she doesn't talk, talks too much, asks to leave early, starts crying, or complains of racial/ethnic differences. In each of these circumstances, it is difficult to know exactly what to say or do. Be patient with yourself.

As a prospective psychologist, counselor, social worker, or psychiatrist, you face a challenging future. Becoming a mental health professional requires intellect, interpersonal maturity, a balanced emotional life, ongoing skill attainment, compassion, authenticity, and courage. Many classes, supervision, workshops, and other training experiences will pepper your life in the coming years. In fact, due to the ever-evolving nature of this business, you need to be a lifelong learner to stay current and skilled in mental health work.

The clinical interview may well be the most fundamental component of mental health training. It is the basic unit of connection between the helper and the person seeking help. It is the beginning of a counseling or psychotherapy relationship. It is the cornerstone of psychological assessment. And it is the focus of this book.

WELCOME TO THE JOURNEY

This book is designed to teach you basic and advanced clinical interviewing skills. The chapters guide you through elementary listening skills onward to more advanced, complex enterprises such as intake interviewing, mental status examination, and suicide assessment. We enthusiastically welcome you as new colleagues and fellow lifelong learners. Although becoming a mental health professional is a challenging career choice, it is a fulfilling one. As Norcross (2000) states:

... the vast majority of mental health professionals are satisfied with their career choices and would select their vocations again if they knew what they know now. Most of our colleagues feel enriched, nourished, and privileged ... (p. 712)

For many of you, this text accompanies your first taste of practical, hands-on, mental health training experience. For those of you who already have substantial clinical experience, this book may help you place your previous experiences in a more systematic learning context. Whichever the case, we hope this text challenges you and helps you develop skills needed for conducting competent and professional clinical interviews.

In the 1939 book *The Wisdom of the Body*, Walter Cannon (1939) wrote:

When we consider the extreme instability of our bodily structure, its readiness for disturbance by the slightest application of external forces ... its persistence through so many decades seems almost miraculous. The wonder increases when we realize that the system is open, engaging in free exchange with the outer world, and that the structure itself is not permanent, but is being continuously broken down by the wear and tear of action, and as continuously built up again by processes of repair. (p. 20)

This observation seems equally applicable to the psyche. This structure is also impermanent, permeable, and constantly interacting with the outside world. As most of us would readily agree, life brings many challenging experiences. Some of these experiences psychologically break us down and some build us up. The clinical interview is the entry point for most people who have experienced psychological or emotional difficulties and who are looking for a therapeutic experience to build themselves up again.

Teaching Philosophy

Like all authors, we have underlying philosophies and beliefs that shape what we say and how we say it. Throughout this text, we try to identify our particular biases and perspectives, explain them, and allow you to weigh them for yourself.

We have several biases about clinical interviewing. First, we consider clinical interviewing to be both art and science. This means you need to exercise your brain through study and critical thinking. Further, you need to develop and expand personal attributes required for effective clinical interviewing. We encourage academic challenges for your intellect and fine tuning of the most important instrument you have to exercise this art: yourself. Second, we believe that, from the client's perspective, the clinical interview should *always* be on the building-up or reparative side in the ledger of life experiences. Reasons for interviews vary. Experience levels vary. But as Hippocrates implied to healers many centuries ago: As far as it is in your power, never allow the clinical interview experience to harm your client.

We also have strong beliefs and feelings about *how* clinical interviewing skills are best learned and developed. These beliefs are based on our experiences as students and instructors and on the state of scientific knowledge pertaining to clinical interviewing (Hill, Stahl, & Roffman, 2007). The remainder of this chapter provides greater detail about our teaching approach, philosophical orientation, and the book's goals and objectives.

Learning Sequence

We believe interviewing skills are acquired most efficiently when you learn, in sequence, the following skills and procedures:

1. How to quiet your *self* and focus on what your client is communicating (instead of focusing on what *you* are thinking or feeling).
2. How to develop rapport and positive working relationships with a wide range of clients—including clients of different ages, racial/cultural backgrounds, sexual orientation, social class, and intellectual functioning.
3. How to efficiently obtain valid and reliable diagnostic or assessment information about clients and their problems.
4. How to identify and appropriately apply individualized counseling or psychotherapy methods and techniques.
5. How to evaluate client responses (outcomes) to your counseling or psychotherapeutic methods and techniques.

This text is limited in focus to the first three skills listed. Extensive information on implementing and evaluating counseling or psychotherapy methods and techniques is not in the scope of this text, but we do touch on them as we cover situations that clinical interviewers may face.

Quieting Yourself and Listening to Clients

To be effective interviewers, mental health professionals need to learn to quiet themselves; they need to rein in natural urges to help, personal needs, and anxieties. This is very difficult, but necessary for you to be able to listen to the client, rather than to your own internal chatter and biases. Quieting yourself requires that you be fully present to your client and not distracted by your own thoughts or worries. Some students find that it helps to arrive early enough to sit still for a few minutes, clearing the mind and focusing on just breathing and being in the moment.

In most interviewing situations, listening nondirectively is your first priority, especially during beginning stages of an interview. For example, as Shea (1998) notes, “. . . in the

opening phase, the clinician speaks very little. . . . there exists a strong emphasis on open-ended questions or open-ended statements in an effort to get the patient talking” (p. 66).

Quieting yourself and listening nondirectively will help your clients find their voices and tell their stories. Unfortunately, staying quiet and listening well is difficult because, when cast in a professional role, many new interviewers find it hard to turn off or turn down their mental activity. It is common to feel pressured or even hyper because you want to help clients resolve problems immediately and prove you can be helpful. However, this can cause you to unintentionally become too directive or authoritative with new clients, and may result in them shutting down rather than opening up.

When students (and experienced practitioners) become prematurely active and directive, they run the risk of being insensitive and nontherapeutic. This viewpoint echoes the advice that Strupp and Binder (1984) give to mental health professionals: “. . . the therapist should resist the compulsion to do something, especially at those times when he or she feels under pressure from the patient (and himself or herself) to intervene, perform, reassure, and so on” (p. 41).

In a majority of professional interview situations, managed mental health care notwithstanding, the best start allows clients to explore their own thoughts, feelings, and behaviors. When possible, interviewers should help clients follow their own leads and make their own discoveries (Meier & Davis, 2008; Strupp & Binder, 1984). We consider it the clinical interviewer’s professional responsibility to *encourage* client self-expression. On the other hand, given time constraints commonly imposed on therapy, it is also the interviewer’s responsibility to *limit* client self-expression. Whether you are encouraging or limiting client self-expression, the big challenge is to do so skillfully and professionally.

In our recent work with graduate students who are beginning to learn clinical interviewing skills we’ve noticed many of our students struggling to stop themselves from giving premature advice. Have you ever had trouble sitting quietly and listening to someone else without giving advice or sharing your own excellent opinion? To be perfectly honest, we’ve struggled with this, and we know many very experienced mental health professionals who also find it hard to sit and listen without directing, guiding, or advising. It’s natural for humans to want to give advice—usually advice based on our own narrow life experiences. The problem is that the client sitting in front of you probably has had a very different narrow slice of life experiences and so your advice, especially if offered prematurely and without an adequate foundation of listening, will usually not go well. Instead, remember, giving advice is all about timing and delivery. Also, remember how you felt when your parents (or other authority figures) gave you advice. Did you like it? Did you appreciate your parents or teachers or counselors telling you, “Oh, you should just cheer up and look on the bright side of life!” Did you like it when people would tell you, “Yeah, I’ve got that same problem too?” or “Everyone struggles with procrastination, you’re just normal.”

Developing Rapport and Positive Therapeutic Relationships

Before developing assessment and intervention skills, interviewers must learn how to develop a positive therapy relationship. This involves learning active listening, empathic responding, feeling validation, and other behavioral skills and interpersonal attitudes leading to the development and maintenance of positive rapport (Barone et al., 2005; Othmer & Othmer, 2002b). Counselors and psychotherapists from virtually every theoretical perspective agree on the importance of developing a positive relationship with clients before implementing treatment procedures (Ackerman et al., 2001; Chambless et al., 2006; Goldfried, 2007; Norcross, 2002, 2002a). Some theorists refer to this as *rapport*—others discuss the importance of establishing a strong working or therapeutic alliance

(Clarkson, 2003; Sommers-Flanagan & Sommers-Flanagan, 2007b). It can be difficult to develop skills for establishing rapport with clients from divergent cultural backgrounds and situations (Ivey, D'Andrea, Ivey, & Simek-Morgan, 2002; Vontress, Johnson, & Epp, 1999). However, such rapport-building skills are the mark of a caring and dedicated professional. In Chapters 3–5 we directly focus on the skills needed to develop positive therapeutic relationships.

Learning Diagnostic and Assessment Skills

After learning to listen well and develop positive relationships with clients, professional interviewers should learn diagnostic and assessment skills and procedures. Although psychological assessment and psychiatric diagnosis generate great controversy (Cameron & Guterman, 2007; Szasz, 1970; Szasz, 1961; Wing, 2005), initiating counseling or psychotherapy without adequate assessment is ill-advised, unprofessional, and potentially dangerous (Hadley & Strupp, 1976; Rudolph, 2005; Sommers-Flanagan & Sommers-Flanagan, 2007). Think about how you would feel if, after taking your automobile to the local repair shop, the mechanic simply began fixing various engine components without first asking you questions designed to understand the problem. Of course, clinical interviewing is much different from auto mechanics, but the analogy speaks to the importance of completing assessment and diagnostic procedures before initiating clinical interventions. About two decades ago, Phares (1988) concluded that the need for diagnosis before intervention is standard practice in psychology:

Intuitively, we all understand the purpose of diagnosis or assessment. Before physicians can prescribe, they must first understand the nature of the illness. Before plumbers begin banging on pipes, they must first determine the character and location of the difficulty. What is true in medicine and plumbing is equally true in clinical psychology. Aside from a few cases involving blind luck, our capacity to solve clinical problems is directly related to our skill in defining them. (p. 142)

In summary, interviewers should begin using specific counseling or psychotherapy methods and techniques only after three conditions have been fulfilled:

1. They have quieted themselves and listened to their clients' communications.
2. They have developed a positive relationship with their clients.
3. They have identified their clients' individual needs and therapy goals through diagnostic and assessment procedures.

Additionally, beginning interviewers should obtain professional supervision when using specific therapy techniques.

THEORETICAL ORIENTATIONS

For optimal professional development, you should obtain a broad range of training experiences, both in a variety of settings and from a variety of theoretical orientations. In our own training, we learned important lessons from many different theoretical perspectives. Even Freud, who is perhaps not often remembered for his openness and flexibility is rumored to have once said: "There are many ways and means of conducting psychotherapy. All that lead to recovery are good."

In some ways, at the treatment level, we are dogmatically eclectic. We believe therapists need to be flexible, changing therapeutic approaches depending on the client, the problem, and the setting. Obviously, it is not the client's job to modify his or her worldview and personal preferences to fit the interviewer's theoretical perspective.

As noted previously, when it comes to *learning* clinical skills, we advocate an approach that focuses first on less directive interviewing approaches and later on more directive approaches. Therefore, in early chapters of this text, we emphasize interviewing strategies that are often, but not always, associated with person-centered, psychodynamic, and to some extent constructive perspectives. By beginning less directly, we hope to emphasize the depth and richness of human interaction. Later, as we focus on interview assessment procedures, more directive behavioral, cognitive-behavioral, and solution-focused approaches to interviewing receive greater emphasis.

Although person-centered and psychodynamic approaches are usually considered philosophically dissimilar, both teach that interviewers should initially allow clients to freely talk about their concerns with minimal external structure and direction (Freud, 1949; Luborsky, 1984; Rogers, 1951, 1961). In other words, person-centered and psychodynamically oriented interviewers are alike in that they allow clients freedom to discuss whatever personal issues or concerns they want to discuss. Consequently, these interviewing approaches have been labeled *nondirective* and heavily emphasize listening techniques. (It would be more appropriate to label person-centered and psychodynamic approaches *less directive*, because all interviewers, intentionally or unintentionally, influence and therefore direct their clients some of the time.)

Person-centered and psychodynamic interviewers are nondirective for very different reasons. Briefly, person-centered interviewers believe that by allowing clients to talk freely and openly in an atmosphere characterized by acceptance and empathy, personal growth and change occur. Carl Rogers (1961), the originator of person-centered therapy, stated this directly: "If I can provide a certain type of relationship, the other person will discover within himself the capacity to use that relationship for growth, and change and personal development will occur" (p. 33).

For Rogers, an interviewer's unconditional positive regard, congruence, and accurate empathy constitute the necessary and sufficient ingredients for positive personal growth and healing. We look more closely at how Rogers defines these ingredients in Chapter 5.

Psychoanalytically oriented interviewers advocate nondirective approaches because they believe that letting clients talk freely, through free association, allows unconscious conflicts to emerge during the therapy hour (Freud, 1949). Eventually, through interpretation, psychoanalytic interviewers bring these underlying conflicts into awareness so they can be dealt with directly and consciously.

Similar to person-centered therapists, psychoanalytic therapists acknowledge that empathic listening may be a powerful source of healing in its own right: "Frequently underestimated is the degree to which the therapist's presence and empathic listening constitute the most powerful source of help and support one human being can provide another" (Strupp & Binder, 1984, p. 41). However, for psychoanalytically oriented clinicians, empathic listening is usually viewed as a necessary, but not sufficient, ingredient for client personal growth and development.

Constructive and solution-focused approaches take the position that all interviewers must be directive in one way or another, and so they systematically focus on solutions, sparking (positive) moments in clients' lives, and current beliefs within the client and existing activities and social interactions that are adaptive. Although these approaches are intentionally directive, they also adhere to a position that we regard as crucial to interviewing; that is, they regard clients as the best experts on their own experiences (De Jong & Berg, 2008).

In contrast to person-centered, psychodynamic, and constructive or solution-focused interviewers, behavioral or cognitive interviewers are more inclined to take an expert role from the very beginning of the first clinical interview. They believe that specific thoughts, personal frameworks, and maladaptive behaviors cause mental and emotional distress (Sommers-Flanagan & Sommers-Flanagan, 2004). Therefore, their main therapeutic work involves identifying and modifying or eliminating maladaptive thinking and behavioral patterns, replacing them with more adaptive patterns as quickly and efficiently as possible, thereby alleviating the client's social and emotional problems. Over 20 years ago, Kendall and Bemis (1983) aptly described the cognitive-behavioral therapist's directive orientation:

The task of the cognitive-behavioral therapist is to act as a diagnostician, educator, and technical consultant who assesses maladaptive cognitive processes and works with the client to design learning experiences that may remediate these dysfunctional cognitions and the behavioral and affective patterns with which they correlate. (p. 566)

Despite this description, most cognitive-behavioral clinicians also recognize the importance of empathic listening as necessary, although not sufficient, for adaptive behavior change. Notably, Wright and Davis (1994), in the inaugural issue of the journal *Cognitive and Behavioral Practice*, stated: "We find strong consensus in the conclusion that the relationship is central to therapeutic change" and "Even in specific behavioral therapies, patients who view their therapist as warm and empathetic will be more involved in their treatment and, ultimately, have a better outcome" (1994, p. 26).

We are not suggesting that person-centered, psychodynamic, constructive, or solution-focused approaches are more effective than cognitive, behavioral, or other clinical approaches. In fact, controlled studies indicate that cognitive and behavioral therapies are at least as effective as dynamic or person-centered approaches and sometimes more effective (Beutel, Dippel, Szczepanski, Thiede, & Wiltink, 2006; Leichsenring, Hiller, Weissberg, & Leibing, 2006; Luborsky, Singer, & Luborsky, 1975; Seligman, 1995; Smith, Glass, & Miller, 1980). Instead, in concert with many others (Goldfried, 2007; Hardy, Cahill, & Barkham, 2007; Hubble, Duncan, & Miller, 1999; Norcross, 2002; Shattell, Starr, & Thomas, 2007), we assert that nondirective interviewing skills provide the best foundation for building positive therapy relationships and learning more advanced and more active/directive psychotherapy strategies and techniques. Additionally, we believe that honoring the client as the best expert on his or her own lived experiences is a similarly solid foundation upon which to build more advanced and perhaps more directive clinical skills. A number of important facts support this assertion (see *Putting It in Practice* 1.1).

BASIC REQUIREMENTS FOR CLINICAL INTERVIEWERS

To become an effective interviewer, you will eventually need to acquire a significant set of skills and a broad knowledge base. Of course, this will come with time, practice, supervision, outside reading, and patience! Though the following list may seem daunting, it provides a guide for your ongoing focus:

1. You must master the technical knowledge associated with clinical interviewing. This means you must know the range of interviewing responses available to you and their likely influence on clients. For example, you must know different types of

Putting It in Practice 1.1

Why be Nondirective?

Many famous psychotherapists began with a psychoanalytic orientation, such as Alfred Adler, Karen Horney, Aaron Beck, Fritz Perls, Carl Rogers, Nancy Chodorow, and Jean Baker Miller. These respected theorists and therapists developed their unique approaches after years of listening nondirectively to distressed individuals. An underlying philosophy of this book is that beginning interviewers should begin by listening nondirectively to distressed individuals. Although it is natural for beginning interviewers to feel impatient and eager to help their clients, their safest and probably most helpful behavior is effective listening. As Strupp and Binder (1984) note, “Recall an old Maine proverb: ‘One can seldom listen his way into trouble’” (p. 44). Some advantages of nondirective interviewing follow:

1. It’s much easier to begin interviewing someone in a nondirective mode and later shift to a more directive mode than to begin interviewing in an active or directive mode and then change to a less directive approach.
2. Strategies designed to deliberately influence clients in a particular manner require that interviewers have knowledge of the psychopathology involved to make sound judgments regarding how a given strategy can help clients change. Most beginning interviewers don’t have the foundational training in psychopathology and the supervised psychotherapy experiences needed to implement more directive therapeutic strategies.
3. Nondirective interviewing is an effective means for helping beginning interviewers enhance their self-awareness and learn about themselves (Sommers-Flanagan & Means, 1987). Through self-awareness, beginning interviewers become capable of choosing a particular theoretical orientation and effective clinical interventions.
4. A nondirective listening approach, properly implemented, helps reduce the tension that beginning interviewers feel to perform, to help, and to prove something to their initial clients. In short, nondirective approaches help beginning interviewers effectively cope with that urge to “do something and do it right.”
5. Nondirective approaches have less chance of offending or missing the mark with early clients (Meier & Davis, 2008). Although clinical interviewers often start out working with volunteers, even analogue or role-play clients are real people, with either real or role-played reasons for being interviewed. Nondirective interviewers, who are there only to listen, place more responsibility on clients’ shoulders and can therefore lessen their own fears (as well as the real possibility) of asking the wrong questions or suggesting an unhelpful course of action. In addition, beginning interviewers tend to feel too responsible for their clients; a nondirective approach can help prevent interviewers from feeling too much responsibility.
6. A nondirective listening stance helps clients establish feelings and beliefs of independence and self-direction. This stance also communicates respect for the client’s personal attitudes, behaviors, and choices. Such respect is rare, gratifying, and possibly healing (Miller & Rollnick, 2002).

Our belief that interviewers should begin from a foundation of nondirective listening is articulated by the following excerpt from Patterson and Watkins (1996, p. 509): “Lao Tzu, a Chinese philosopher of the fifth century . . . wrote a poem

titled *Leader*, which applies when *therapist* is substituted for *leader* and *clients* is substituted for *people*.”

A Leader (Therapist)

A leader is best when people hardly know he exists;
 Not so good when people obey and acclaim him;
 Worst when they despise him.
 But of a good leader who talks little,
 When his work is done, his aim fulfilled,
 They will say, “We did it ourselves.”
 The less a leader does and says,
 The happier his people;
 The more he struts and brags,
 The sorrier his people.
 [Therefore,] a sensible man says:
 If I keep from meddling with people, they take care of themselves.
 If I keep from preaching at people, they improve themselves.
 If I keep from imposing on people, they become themselves.

questions interviewers can ask and how clients typically respond or react to them. You must know when the interview situation dictates structured information gathering and when less directive approaches are warranted. You must know ethical guidelines associated with professional clinical interviewing. In other words, you must have an intellectual grasp of the basic tools of the trade.

2. You must be self-aware. You need to know how you affect other people and how others affect you, both those in your own cultural and socioeconomic class and those outside your familiar surroundings. You need to be aware of the sound and range of your own voice, your body or physical presence, perceived level of interpersonal attractiveness, and usual patterns of eye contact and interpersonal distance, because all of these variables influence your clients. Further, you must constantly be willing to learn and grow, addressing blind spots and shortcomings you may have because of your personal and social background.

It is also important that you be aware of how your own culture and social class have shaped your personal values and ways of behaving. You need to become aware that others, both in and outside your culture, may have been taught values and behaviors very different from yours. It is incumbent on you as interviewer to realize when cultural, class, and gender differences may be influencing or hampering effective communication between you and your client. To be a culturally insensitive clinical interviewer is unprofessional and unethical (Fouad & Arredondo, 2007; Paniagua, 2000; Sommers-Flanagan & Sommers-Flanagan, 2007).

3. You must develop excellent observational and assessment skills (to acquire “other-awareness”). Having these skills means that you know of and are sensitive to various individual and cultural values, behaviors, and norms. You also must be able to recognize and appreciate the perspectives of others (this skill is also known as an “empathic way of being”; Rogers, 1961).

Awareness of others is a basic principle underlying interviewing assessment and evaluation. Clinical interviewers must objectively observe client behavior and

evaluate for psychopathology. Assessment and evaluation can involve highly structured procedures such as mental status examinations, suicide assessments, and diagnostic interviewing. Clinical interviewers must be aware not only of client cultural issues, but also of psychological, behavioral, historical, and diagnostic status (Matthews & Walker, 1997; Mezzich & Shea, 1990).

4. To be an effective clinical interviewer, you need ongoing, extensive practice and experience. As you begin to learn about interviewing and how you affect others, you must also begin practice interviews. This usually involves role-playing with fellow students or actors or arranged interview experiences with people you do not know (Balleweg, 1990; Shea & Barney, 2007; Sommers-Flanagan & Means, 1987). Practice interviewing is designed to prepare you for the real thing—the actual clinical interview. To reduce your anxiety and increase your competence, you should have extensive supervised practice before beginning actual interviewing or counseling sessions. Additionally, as you expand your basic skills, reading about and working on understanding people who are culturally, sexually, physically, and socioeconomically different from you is highly recommended (Arredondo & Arciniega, 2001; Sue & Sue, 2008) (see *Multicultural Highlights* 1.1 and 1.2).

Multicultural Highlight 1.1

Pitfalls of Nondirectiveness

Most swords are double-edged, and nondirective listening is no exception. To be blunt (no pun intended), some people simply detest nondirective listening. For example, if you practice too many nondirective listening techniques on them, your friends and family will quickly become annoyed. They will be annoyed partly because you may be unskilled, but also because, in many social and cultural settings, nondirective listening is inappropriate.

As we discuss in later chapters, in some settings, and with some cultural groups, a more directive approach is definitely called for. This does not mean that you must never listen nondirectively to people of certain cultural groups. Instead, it speaks to the importance of recognizing that different techniques help or hinder relationship building in different individuals who come to you seeking assistance.

Additional pitfalls of nondirectiveness include:

1. Clients can perceive nondirective interviewers as manipulative or evasive.
2. Too many nondirective responses can leave clients feeling lost and adrift, without any guidance.
3. If clients come to therapy expecting expert advice, they may be deeply disappointed when you steadfastly refuse to do anything but listen nondirectively.
4. If you never offer a professional opinion, you may be viewed as unprofessional, ignorant, or weak.

When it comes to interviewing clients, often, too much of any response or technique is ill advised. We say this despite the fact that we are beginning by emphasizing nondirective listening skills. Don't worry. We recognize that too much nondirectiveness can be just as troublesome as too much directiveness—especially when it comes to interviewing clients outside mainstream American culture, or in settings that demand more action or input on your part.

Who Do You See?

Existential therapists sometimes use provocative activities to help individuals increase awareness, both of the self and of the world. One such activity involves the following: People sit in pairs and ask each other the same question a number of times. The main rule is that the same answer cannot be used twice. Many types of questions can be used in this exercise (e.g., “What do you want?” or “What’s good about you?”), but a question we have found to be most relevant to beginning interviewers is “Who are you?”

The “Who are you?” question focuses squarely on identity and most of us typically respond with statements of identity related to personal roles, vocational activities, race, culture, religion, and gender. For example, John might say, “I’m a father,” “I’m a husband,” “I’m a psychotherapist,” “I’m on the faculty at the University of Montana,” “I’m a man,” and so on. Interestingly, in our experience, women and people of color often respond sooner than men and Whites with words describing their gender and racial or cultural identities (e.g., “I’m a woman” or “I’m Latina”). Recently, when doing this activity with a young Native American woman, very early in the process, she stated with clarity: “I’m a Native American” and “I’m Navajo and Salish.”

When considering ourselves in light of the diverse array of humans in the world, an interesting variation on this question exercise involves asking “Who do you see?” Imagine that you’ve just met a new client. You see someone sitting in the chair opposite you. Ask yourself, “Who do you see?” and answer. Maybe the first answer is “I see a client,” because that is the context of the encounter. Ask yourself again. Remember, you can’t use the same answer twice. To really get a sense of the layers of identity labels you use to construct your perception of the person you’re with, keep your answers one-dimensional. In other words, stick with “I see a man” instead of doubling up identity labels (e.g., “I see a Black man”).

In most human encounters, most of us first notice how another person is “Like me” or “Not like me.” This is a natural human tendency that is probably more or less hard-wired. But, as the existentialists and multiculturalists would emphasize, whether this tendency is hard-wired or not, it is crucial that we develop an awareness of it.

When working with someone new, keep this exercise in mind. Given all you need to attend to in a beginning interview, you probably won’t be able to take the time in that moment to ask yourself, “Who do I see?” a number of times, but later, as you reflect on the interview, you can use this concept. Ask yourself five or ten times in succession, “Who did I see?” Write your answers down. After you’ve let yourself answer the “Who did I see?” question 5–10 times, double back and analyze your responses. Notice what labels and layers came up. Did you notice a disability? If so, what identity labels did you find yourself using to describe the disability? Did you write “I see a disabled person” or a “I see a handicapped person”? Notice the valence of the labels you used. Were they common? Positive? Neutral? Pejorative? No matter what, don’t be too self-satisfied or too hard on yourself. We all make judgments. We all have residues of racist, sexist, and homophobic values and beliefs. We can all discover within ourselves unfair judgments and sources of bias. Maybe your biases focus on religious beliefs or disabilities or maybe something else. Maybe you feel special negative reactions and judgments toward middle-aged balding men named Ted because of your experiences with an abusive middle-school gym teacher. Or maybe you’ve dealt with all your underlying prejudices and approach each individual with grace and objectivity—although we suspect not, which is one of our biases.

The more diverse interviewing and supervision experiences you obtain, the more likely you are to develop the broad, empathic perspective you need to understand clients from within their world view and experience (Constantine, 2001; Hakim-Larson, Kamoo, Nassar-McMillan, & Porcerelli, 2007; Rivera, Phan, Hadduv, Wilbur, & Arredondo, 2006).

The Perfect Interviewer

What if you could be a perfect clinical interviewer? Of course, this is impossible. But if you could be a perfect interviewer, you would be able to stop at any point in a given interview and outline: (a) what you are doing (based on technical expertise); (b) why you are doing it (based on technical knowledge and assessment or evaluation information); (c) whether any of your personal issues or biases are interfering with the interview (based on self-awareness); and, perhaps most importantly, (d) how your client, regardless of his or her age, sex, or culture, is reacting to the interview (based on other awareness).

Put another way, if you were a perfect interviewer, you could tune in to each client's personal world so completely that you would resonate with the client, as a sensitive violin string begins to move when a matching tone is played in the room (Watkins & Watkins, 1997). You would also be able to see each client clearly and without bias (Hays, 2008; Negy, 2004). You would be able to use this unbiased resonance to determine where every interview needed to go (see *Multicultural Highlight 1.2* to explore your potential biases for or against particular clients).

You would also assess each client's needs and situation and carry out appropriate therapeutic actions to address the client's needs and personal situation—from initiating a suicide assessment to beginning a behavioral analysis of a troublesome habit—all during the clinical interview. One can only imagine the vast array of skills and the depth of wisdom necessary for a clinical interviewer to approach perfection.

We readily acknowledge that perfection is unattainable. However, clinical interviewing is a professional endeavor based on scientific research and supported by a long history of supervised training (Hill, 2004). As a consequence, it is inappropriate and unprofessional to, as an old supervisor of ours used to say, “fly by the seat of your pants” in an interview session (Bornstein, personal communication, January 1982).

In the end, as a human and imperfect interviewer, you may not be able to explain every clinical nuance or every action and reaction. You may not feel as aware and tuned in as you could be, but your interviewing behavior will be guided by sound theoretical principles, humane professional ethics, and basic scientific data pertaining to therapeutic efficacy. Additionally, once you have become grounded in psychological theory, professional ethics, and empirical research, you will be able to add clinical intuition and spontaneity to your clinical repertoire.

GOALS AND OBJECTIVES OF THIS BOOK

The basic objectives of this book are to:

1. Guide you through an educational and training experience based on the previously described teaching approach.
2. Provide technical information about clinical interviewing.
3. Introduce methods for interviewer self-awareness, cultural awareness, and personal growth.

4. Introduce client assessment and evaluation methods (i.e., facilitate acquisition of diagnostic skills).
5. Describe procedures and suggest resources so you can develop skills in interviewing culturally diverse clients and special client populations.
6. Provide suggestions for experiential interviewer development activities.

SUMMARY

This book's underlying philosophy emphasizes a particular approach to learning what it takes to become a competent clinical interviewer. Specifically, students should begin learning interviewing skills from a nondirective perspective, honoring the client as expert, and gradually adding more directive skills as they master the basics of listening. Beginning interviewers should focus on learning to do the following: (a) quiet themselves and listen to clients, (b) develop a positive therapeutic relationship with clients, and (c) obtain diagnostic and assessment information.

Interviewers can benefit from obtaining a broad range of training experiences. It is especially important to learn and practice interviewing from different theoretical perspectives, including person-centered, psychoanalytic, behavioral, cognitive, feminist, constructive and solution-oriented viewpoints. Diverse experiences help interviewers learn about how technical interviewer responses, self-presentational styles, cultural background, and gender affect each client, taking into account the client's own particular problems, biases, cultural background, and gender. Although perfection is impossible, if interviewers base their behavior on sound theoretical principles, professional ethics, and scientific research, they will become competent and responsible mental health professionals.

This book is organized into four parts, moving the beginning clinical interviewer through stages designed for optimal skill development. Because actual practice is necessary for interviewer skill development, each chapter offers suggested experiential activities to help interviewers become more self-aware, more culturally sensitive, and to develop greater technical expertise.

SUGGESTED READINGS AND RESOURCES

It helps if you have some knowledge of personality theory and psychopathology before studying the interviewing process. We recognize, however, that not all interviewing and counseling courses have personality theory and psychopathology prerequisites. For those lacking such background, the following textbooks, articles, and recreational readings on theories of personality, theories and approaches to counseling and psychotherapy, and psychopathology provide a worthwhile foundation for professional skill development.

- Goldfried, M. (Ed.). (2001). *How therapists change: Personal and professional recollections*. Washington, DC: American Psychological Association. This book gives you an insider's look into how professionals have undergone personal change. It gives you a feel for how the profession of counseling and psychotherapy might affect you personally.
- Hays, P. A. (2008). *Addressing cultural complexities in practice: Assessment, diagnosis, and therapy* (2nd ed.). Washington, DC: American Psychological Association. Pamela Hays helps practitioners expand their awareness of cultural complexities in clinical practice. Her writing is highly accessible, and she provides many examples of cultural wisdom. Her chapter "Entering another's world: Understanding Clients' identities and contexts" is the inspiration for *Multicultural Highlight 1.2*.

- Hill, C. E. (2004). *Helping skills: Facilitating exploration, insight, and action* (2nd ed.). Washington, DC: American Psychological Association. Clara Hill is a very well-respected helping skills researcher. This book is an excellent resource for understanding and learning basic helping skills.
- Hubble, M. A., Duncan, B. L., & Miller, S. D. (1999). *The heart and soul of change: What works in therapy*. Washington, DC: American Psychological Association. This book, recipient of a Menninger Writing Award, focuses squarely on the common factors associated with positive change in counseling and psychotherapy. It provides practical suggestions for integrating these common factors into your interviewing practice.
- Ivey, A. E., D'Andrea, M., Ivey, M. B., & Simek-Morgan, L. (2002). *Theories of counseling and psychotherapy: A multicultural perspective* (5th ed.). Boston: Allyn & Bacon. Ivey and his colleagues provide a multicultural slant to the traditional theories of counseling and psychotherapy.
- Prochaska, J. O., & DiClemente, C. C. (2005). *The transtheoretical approach*. New York: Oxford University Press. Although the transtheoretical model has both strong adherents and strong detractors, it is a change model that all helping professionals should understand. Prochaska and DiClemente integrate many theoretical perspectives into a model for determining when and how particular therapy interventions should be used.
- Sommers-Flanagan, J., & Sommers-Flanagan, R. (2004). *Counseling and psychotherapy theories in context and practice: Skills, strategies, and techniques*. New York: Wiley. Of the many “theories” texts out there, this is our personal favorite.
- Yalom, I. (2002). *The gift of therapy*. New York: HarperCollins. In the book, renowned therapist Irvin Yalom describes his top 85 clinical insights about conducting psychotherapy. Each insight is a very short chapter of its own.