

Introduction: Philosophy and Organization

CHAPTER OBJECTIVES

This chapter welcomes you to the professional field of clinical interviewing and orients you to the philosophy and organization of this book. After reading this chapter, you will understand:

- The philosophy and organization of this book.
- How becoming a mental health professional can be both challenging and gratifying.
- The authors' teaching philosophy.
- An effective learning sequence for acquiring clinical interviewing skills.
- How clinicians from different theoretical orientations approach the interviewing task.
- Why and how a multicultural orientation to interviewing can be useful.
- Advantages and disadvantages of being nondirective in your interviewing approach.
- Your potential cultural biases when interviewing.
- The goals and objectives of this book.

Imagine sitting face-to-face with your first client. You carefully chose your clothing. You intentionally arranged the seating, set up the video camera, and completed the introductory paperwork. You're doing your best to communicate warmth and helpfulness through your body posture and facial expressions. Now, imagine that your client:

- Refuses to talk.
- Talks so much you can't get a word in.
- Asks to leave early.
- Starts crying.
- Tells you that you'll never understand because of your racial or ethnic differences.
- Suddenly gets angry (or scared) and storms out.

Any and all of these responses are possible in an initial clinical interview. If one of these scenarios plays out, how will you respond? 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 client, to establish rapport, to build a working alliance, to gather information, to instill hope, and, if appropriate, to provide clear and helpful professional interventions. To top it off, you must gracefully end the interview on time and sometimes you'll need to do all this with clients who don't trust you or don't want to work with you.

These are no small tasks—which is why it's so important for you to remember to be patient with yourself. This is only the beginning of your developmental journey toward becoming a mental health professional.

As a prospective psychologist, professional counselor, psychiatric nurse, social worker, or psychiatrist, you face a challenging and rewarding future. Becoming a mental health professional requires persistence and an interest in developing your intellect, interpersonal maturity, a balanced emotional life, counseling/psychotherapy skills, 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 will need to become a lifelong learner to stay current and skilled in mental health work. But rest assured, this is an exciting and fulfilling professional path (Norcross & Guy, 2007). As Norcross (2000) stated:

... 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)

The clinical interview may be the most fundamental component of mental health training (Jones, 2010). 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 professional activities such as intake interviewing, mental status examinations, and suicide assessment. We enthusiastically welcome you as new colleagues and fellow learners.

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 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 his 1939 classic, *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. The psyche 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 others build us up. The clinical interview is the entry point for most people who have experienced psychological or emotional difficulties and who seek a therapeutic experience to repair and 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. 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 the clinical interview should *always* be designed to facilitate positive client development. Reasons for interviews vary. Experience levels vary. But as Hippocrates implied to healers many centuries ago, we should work very hard to *do no harm*.

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 (J. Sommers-Flanagan & Heck, 2012; Stahl & Hill, 2008; Woodside, Oberman, Cole, & Carruth, 2007). The remainder of this chapter includes greater detail about our teaching approach, theoretical and multicultural 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 yourself and focus on what your client is communicating (instead of focusing on what *you* are thinking or feeling).
2. How to establish rapport and develop positive working relationships with a wide range of clients—including clients of different ages, abilities and disabilities, 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 appropriately apply individualized counseling or psychotherapy interventions.
5. How to evaluate client responses to your counseling or psychotherapeutic methods and techniques (outcomes assessment).

This text is limited in focus to the first three skills listed. Extensive information on implementing and evaluating counseling or psychotherapy methods and techniques (items 4 and 5) is not the main focus of this text. However, we intermittently touch on these issues as we cover situations that clinicians may face.

Quieting Yourself and Listening to Clients

To be effective therapists, mental health professionals need to learn to quiet themselves; they need to rein in natural urges to help, personal needs, and anxieties. This is difficult for both beginning and experienced therapists. We still need to consistently remind ourselves to hold off on giving advice or establishing a diagnosis. Instead, the focus should be on listening to the client and on turning down the volume of our 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 and clinicians find that it helps to arrive early enough to sit for a few minutes, clearing the mind and focusing on 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) noted, “. . . 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 you empower your clients to find their voices and tell their stories. Unfortunately, staying quiet and listening well is difficult because, when cast in a professional role, many therapists find it hard to manage their mental activity. It’s common to feel pressured because you want to prove your competence by helping clients resolve their problems immediately. 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) gave to mental health professionals three decades ago: “. . . 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 the best start involves allowing clients to explore their own thoughts, feelings, and behaviors. When possible, therapists should help clients follow their own leads and make their own discoveries (Meier & Davis, 2011). We consider it the therapist’s professional responsibility to *encourage* client self-expression. On the other hand, given time constraints commonly imposed on therapy, therapists also are responsible for *limiting* client

self-expression. Whether you're encouraging or limiting client self-expression, the big challenge is to do so skillfully and professionally. It's also important to note that listening nondirectively and facilitating client self-expression is not the same as behaving passively (Chad Luke, personal communication, August 5, 2012). Listening well is an active process that requires specific skills that we'll discuss in much more detail (see Chapters 3 and 4).

Students who are beginning to learn clinical interviewing skills often struggle to stop themselves from giving premature advice. Have you ever had trouble sitting quietly and listening to someone without giving advice or sharing your own excellent opinion? To be perfectly honest, we've struggled with this ourselves and know many experienced mental health professionals who also find it hard to sit and listen without directing, guiding, or advising. For many people, it's second nature to want to give advice—even advice based solely on their 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 advice, especially if offered prematurely and without an adequate foundation of listening, usually won't go all that well. Remember how you felt when your parents (or other authority figures) gave you advice? Sometimes, it might have been welcome and helpful. Other times, you may have felt discounted or resistant. Advice giving is all about accuracy, timing, and delivery. The acceptability of advice giving as a therapeutic technique is also related to your theoretical orientation and treatment goals. Focusing too much on advice giving is rarely, if ever, a wise strategy in an initial therapy session.

Developing Rapport and Positive Therapy Relationships

Before developing more advanced assessment and intervention skills, therapists must learn how to establish a positive working alliance with clients. This involves learning active listening, empathic responding, feeling validation, and other behavioral skills as well as interpersonal attitudes leading to the development and maintenance of positive rapport (Barone et al., 2005; Rogers, 1957). Counselors and psychotherapists from virtually every theoretical perspective agree on the importance of developing a positive relationship with clients before using interventions (Ackerman et al., 2001; Chambless et al., 2006; Norcross & Lambert, 2011). Some theorists refer to this as *rapport*—others use the terms “working alliance” or “therapeutic relationship” (Bordin, 1979, 1994; J. Sommers-Flanagan & Sommers-Flanagan, 2007b). In Chapters 3–5 we directly focus on the skills needed to develop positive therapy relationships.

Learning Diagnostic and Assessment Skills

After learning to listen well and develop positive relationships with clients, professional therapists should learn diagnostic and assessment skills. Although psychological assessment and psychiatric diagnosis generate great controversy (Kamens, 2011; Parens & Johnston, 2010; Szasz, 1970), initiating counseling or psychotherapy without adequate assessment is ill-advised, unprofessional, and potentially dangerous (Hadley & Strupp, 1976; R. 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.

In summary, you should begin using specific counseling or psychotherapy interventions only after three conditions have been fulfilled:

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

And of course, you should obtain professional supervision as you begin using specific interviewing and counseling techniques.

THEORETICAL ORIENTATIONS

For optimal professional development, you should obtain (a) a broad range of training experiences, (b) in a variety of settings, and (c) from a variety of theoretical orientations. Although it's good to eventually specialize, having a broad foundation is desirable. Even Freud, who's not often remembered for his openness and flexibility, is rumored to have said: "There are many ways and means of conducting psychotherapy. All that lead to recovery are good."

As instructors, we consider ourselves to be dogmatically eclectic and multi-culturally sensitive. We believe therapists need to be flexible, able to sometimes change therapeutic approaches depending on the client, the problem, and the setting. Obviously, it's not the client's job to modify his or her problems, worldview, or personal preferences to fit the therapist's theoretical perspective.

When it comes to *learning* clinical skills, we advocate an approach that initially focuses on less directive interviewing skills and later on more directive skills. Therefore, in early chapters of this text, we emphasize interviewing strategies that are often, but not always, associated with person-centered and psychodynamic perspectives. By beginning less directly, we hope to emphasize the depth, richness, and potential healing power of authentic human relationships. Later, as we focus on interview assessment procedures, we emphasize more directive behavioral, cognitive-behavioral, and solution-focused approaches to interviewing.

Although person-centered and psychodynamic approaches are usually considered philosophically dissimilar, both teach that therapists should allow clients to talk about their concerns with minimal external structure and direction (Freud, 1949; Luborsky, 1984; Rogers, 1951, 1961). Both person-centered and psychodynamic therapists allow clients to freely discuss whatever personal issues or concerns they might wish to discuss. 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 therapists, intentionally or unintentionally, sometimes direct their clients.)

Person-centered and psychodynamic therapists are nondirective for very different reasons. Person-centered therapists believe that when clients 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, 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 therapists advocate nondirective approaches because they believe that letting clients talk freely allows unconscious conflicts to emerge (Freud, 1949). Eventually, through interpretation, psychoanalytic therapists bring 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 (i.e., narrative and solution-focused) approaches take the position that, although all therapists must be directive in one way or another, clients are the best experts on their own experiences (de Jong & Berg, 2008). Constructive therapists systematically focus on solutions, sparkling (positive) moments in clients’ lives, and adaptive beliefs and actions that already exist within the client’s behavioral repertoire. Although these approaches are intentionally directive, the position of honoring clients as the authorities of their own lives is a position we regard as crucial to effective interviewing.

In contrast, behavioral or cognitive therapists are inclined to take an expert role from the beginning of the first clinical interview. They believe in actively setting an agenda that includes focusing on maladaptive thoughts and behaviors that may be causing mental and emotional distress (J. Beck, 2011). 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. About 30 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’re 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 (Epp & Dobson, 2010; Luborsky, Singer, & Luborsky, 1975; Olatunji, Cisler, & Deacon, 2010; M. L. Smith & Glass, 1977; M. L. Smith, Glass, & Miller, 1980). Instead, we assert that nondirective interviewing skill development provides 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 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*).

PUTTING IT IN PRACTICE 1.1

Why Learn Less-Directive Interviewing Skills?

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 listening nondirectively to distressed individuals. An underlying philosophy of this book is that beginning therapists also should begin by listening nondirectively to distressed individuals. Although it’s natural for beginners to feel eager to help clients, their safest and probably most helpful behavior is effective listening. As Strupp and Binder (1984) noted, “Recall an old Maine proverb: ‘One can seldom listen his [or her] way into trouble’” (p. 44). Some advantages of nondirective interviewing include:

1. It’s easier to begin an interview in a nondirective mode and later shift to a more directive mode than to begin in an active or directive mode and then change to a less directive approach.
2. Nondirective interviewing is an effective means for helping beginning therapists enhance their self-awareness and learn about themselves (J. Sommers-Flanagan & Means, 1987). Through self-awareness, therapists become capable of choosing a particular theoretical orientation and effective clinical interventions.
3. Nondirective approaches have less chance of offending or missing the mark with clients early in treatment (Meier & Davis, 2011). Nondirective therapists, 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.

4. 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 probably healing (Miller & Rollnick, 2013; Rosengren, 2009).

Our belief that therapists 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.

A Multicultural Orientation for Clinical Interviewing

Most of the history of counseling, psychotherapy, and clinical interviewing has involved White people of Western European descent providing services for other White people of Western European descent. We're saying this in a way to be purposely blunt and provocative. Although there are Eastern and Southern influences in the practice and provision of mental health services, the foundation of this process is distinctively Western and White.

This foundation has often served its purpose quite well. Over the years, many clients or patients have been greatly helped by mental health providers. But, beginning in the 1960s and continuing to the present, there has been increasing recognition that counseling and psychotherapy theories were sometimes (but not always) both racist and sexist in their application (J. Sommers-Flanagan & Sommers-Flanagan, 2012). There are many examples of this racism and sexism; we refer readers elsewhere for extensive information on the ways our profession has not always served minority and female clients (Brown, 2010; D. W. Sue & Sue, 2013).

Multicultural orientation and multicultural training is now a central foundational principle for all mental health practice. There are many reasons for this, including, but not exclusively the fact that the United States is growing more diverse. Based on the 2010 Census, of the 308 million people living in the United States at the time of the census, more than 85 million identified themselves as other than White (U.S. Census Bureau, 2011). Additionally, research conducted in the 1970s showed that most minority clients dropped out of therapy after only a single clinical interview (S. Sue, 1977). This finding suggested, at the very least, a poor fit between counseling or psychotherapy as traditionally practiced and the needs or interests of minority clients.

Increased diversity throughout the United States constitutes an exciting and daunting possibility for mental health professionals; exciting for the richness that a diverse population extends to our communities and for the professional and personal growth that accompanies cross-cultural interaction; daunting because of increased responsibilities linked to learning and implementing culturally relevant approaches. The good news is that empirical research indicates multicultural sensitivity training for mental health professionals significantly improves the effectiveness of service delivery for diverse clients (Constantine, Fuertes, Roysircar, & Kindaichi, 2008; L. Smith, Constantine, Graham, & Dize, 2008). In keeping with these research findings, we're placing multicultural sensitivity and competence front and center in your awareness of what's essential for your beginning and ongoing professional development.

Three Principles of Multicultural Competence

Humans are born to families or caretaking groups or individuals that are embedded within a larger community context. This community is essential to survival (Matsumoto, 2007). The membership, values, beliefs, location, and practices of this community are generally referred to as culture. In this way, culture can be understood as the medium in which all human development takes place. Everything we value, know to be real, and assume is "normal" is influenced by our past and present cultures. From a mental health perspective, answers to questions such as, "What constitutes a healthy personality?" or "What should a person strive for in life?" or "Is this person deviant?" are largely influenced by the cultural backgrounds of both clinician and client (Christopher & Bickhard, 2007). More practically, the decision of whether you should practice more or less directive interviewing strategies is also laden with cultural implications (see *Multicultural Highlight 1.1*).

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 detest nondirective listening. For example, your friends and family may become annoyed if you try too many nondirective listening techniques with them. They'll be annoyed partly because you may be unskilled, but also because in

many social and cultural settings nondirective listening is inappropriate. People want to know what you think!

As we discuss in later chapters, in some settings, and with some cultural groups, a more directive approach is warranted. This doesn't mean 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 may perceive nondirective therapists as manipulative or evasive.
2. Too many nondirective responses can leave clients feeling lost and adrift, without guidance.
3. If clients expect expert advice, they may be deeply disappointed when you 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 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.

Both the American Counseling Association and the American Psychological Association are in agreement that the basic principles of multicultural competence include three overlapping dimensions: (1) therapist self-awareness or cultural self-awareness; (2) multicultural knowledge; and (3) culture-specific expertise. We briefly define these dimensions now and return to them frequently throughout this text.

Self-Awareness

Those who have power appear to have no culture, whereas those without power are seen as cultural beings, or “ethnic.” (Fontes, 2008, p. 25)

Culture pervades everything, and so, not surprisingly, culture and self-awareness interface in several ways. As Fontes (2008) noted in the preceding quotation, one dimension of cultural self-awareness is that individuals within the dominant culture tend to be unaware of their own culture while viewing others as different or ethnic. Also, individuals from the dominant culture tend to be unaware of and often resistant to becoming aware of their “invisible” culturally based privilege (McIntosh, 1998). Developing cultural self-awareness is a challenging process for everyone, but it can be especially emotionally laden for members of the dominant culture. For now, consider your awareness of yourself as

a unique cultural being as well as any biases or prejudices you might hold toward minority groups, keeping in mind that minority groups might include individuals who are viewed differently on the basis of sex, age, race, sexuality, disability, religion, social class, or other factors. *Multicultural Highlight 1.2* includes an activity to stimulate your cultural self-awareness.

MULTICULTURAL HIGHLIGHT 1.2

Exploring Yourself as a Cultural Being

The first multicultural competency for both the American Counseling Association and the American Psychological Association focuses on self-awareness. D. W. Sue, Arredondo, and McDavis (1992), expressed it this way:

Culturally skilled examiners have moved from being culturally unaware to being aware and sensitive to their own cultural heritage and to valuing and respecting differences. (p. 482)

For this activity, you should work with a partner.

- A.** Describe yourself as a cultural being to your partner. What is your ethnic/cultural heritage? How did you come to know your heritage? How is your heritage manifested in your life today? What parts of your heritage are you especially proud of? Is there anything about your heritage that you're not proud of? Why?
- B.** What do you think constitutes a "mentally healthy" individual? Can you think of times when there are exceptions to your understanding of this?
- C.** Has there ever been a time in your life when you experienced racism or discrimination? (If not, was there ever a time when you were harassed or prevented from doing something because of some unique characteristic that you possess?) Describe this experience to your partner. What were your thoughts and feelings related to this experience?
- D.** Can you identify a time when your own thoughts about people who are different from you affected how you treated them? Would you do anything differently now? What beliefs about different cultural ethnicities do you hold now that you would consider stereotyping or insensitive? (Carolyn Berger, personal communication, August 10, 2012)
- E.** How would you describe the "American culture"? What parts of this culture do you embrace? What parts do you reject? How does your internalization of American culture impact what you think constitutes a "mentally healthy individual"?

At the conclusion of the activity, take time to reflect and possibly make a few journal entries about anything you may have learned about your cultural identity.

Cultural Knowledge

Cultural self-awareness is a good start, but it's not enough. Culturally competent therapists actively educate themselves regarding different cultural values, behaviors, and ways of being. It's not appropriate to remain ignorant of other cultures. This is partly because remaining ignorant is simply unprofessional, but also because when therapists are culturally uninformed they often inappropriately rely on clients to educate them about specific minority issues. We include many multicultural highlights and issues within this text, but to become multiculturally sensitive and competent you will need to explore additional sources of multicultural knowledge and experience. Outside resources focusing on multicultural knowledge are listed in the Suggested Readings and Resources section at the end of every chapter. Overall, the more diverse interviewing, supervision, and life experiences you obtain, the more likely you'll be to develop the broad, empathic perspective you need to understand clients from within their worldview and experience (D. W. Sue & Sue, 2013).

Culture-Specific Expertise

Of the many cultural skills and techniques available to clinicians, we discuss two general skills here and more specific skills later. Two essential culture-specific skills for mental health professionals that were initially described by Stanley Sue (1998; 2006) include: (1) scientific mindedness; and (2) dynamic sizing.

Scientific mindedness involves forming and testing hypotheses, rather than coming to premature and faulty conclusions about clients. Although there may be universal human experiences, you shouldn't assume you know the underlying meaning of any client's behavior, especially minority clients. As the following case example illustrates, effective therapists avoid stereotypic generalizations when working with all clients.

CASE EXAMPLE

A young woman from Pakistan was studying physics at the graduate level in the United States. She attended a graduate function and, by her description, "had an unfortunate interaction with a male graduate student." After this interaction, she came to the student counseling service for short-term counseling because she was quite upset and could not study effectively. The male counselor met her in the waiting room, introduced himself, and offered to shake hands. The Pakistani student shrank away. The counselor noted this, thinking to himself that she was either shy or had issues with men. He initially believed his hypothesis was correct as the student shared her story about the rude male student at the graduate social gathering.

Scientific mindedness requires therapists to search for alternative cultural explanations before drawing conclusions about any specific behaviors. Without utilizing scientific mindedness and exploring less commonly known and understood explanations, the therapist would
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perhaps not have realized that for a Muslim woman, it's not proper to touch a male—even to shake hands. Her shrinking away had everything to do with her religious practice and nothing to do with the incident she came to talk about. The case illustrates the importance of scientific mindedness as a clinical interviewing principle and practice. If he had not practiced scientific mindedness, the therapist in this case might have inaccurately concluded, based on his initial beliefs, that his Pakistani client was either shy or had “men issues.” Instead, she was behaving in a manner consistent with her religious beliefs.

Dynamic sizing is a second culture-specific skill that Stanley Sue (1998; 2006) articulated. This concept requires therapists to know when generalizations based on group membership are fit and when they don't fit.

For example, *filial piety* is often discussed as a concept associated with certain Asian cultures (Chang & O'Hara, 2013). Filial piety has to do with the honoring and caring for one's parents and ancestors. However, it would be naïve to assume that all Asian people will believe in or have their lives affected by this particular value; making such an assumption can influence your expectations of client behavior. On the other hand, you would be remiss if you were completely ignorant of the power and influence of filial piety and the possibility that it might play a large role in relationship and career decisions in many Asians' lives. When dynamic sizing is used appropriately, therapists remain open to significant cultural influences, but the pitfalls of stereotyping clients are minimized.

Another facet of dynamic sizing involves therapists' knowing when to generalize their own experiences to those of their clients. Sue (2006) explained that it's possible for a minority group member who has experienced discrimination and prejudice to use this experience to more fully understand the struggles of those in other groups who have encountered similar experiences. However, having similar experiences does not guarantee accurate empathy. Dynamic sizing requires therapists to know and understand and *not* know and *not* understand at the same time. This combination of understanding, openness, and humility is a crucial component of culturally competent interviewing.

Multicultural Humility

To this point, consistent with the literature, we've been using the term “multicultural competence.” However, we have reservations about referring to cultural awareness, knowledge, and skills in a manner that implies that individuals eventually reach an endpoint or attain a particular competence level. In fact, it seems that often, as soon as we grow too confident in our abilities to relate to and work with diverse peoples, we've probably lost our competence. We strongly agree with Vargas (2012), who expressed similar concerns:

The focus on cultural competence also worries me. I very much try to be culturally responsive to my clients. But can I say that I am “culturally competent?” Absolutely not! I am still, despite my many and genuine

efforts, “a toro (bull) in a China shop” with all the cultural implications of this altered adage intended. (p. 20)

For these and other reasons, we generally prefer the terms *multicultural sensitivity* and *multicultural humility* and only use multicultural competence somewhat grudgingly (Stolle, Hutz, & Sommers-Flanagan, 2005).

MULTICULTURAL HIGHLIGHT 1.3

Who Do You See?

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

The “Who are you?” question focuses squarely on identity and most of us typically respond with statements 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 within the diverse array of humans in the world, an interesting variation on this questioning activity 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’s 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 human encounters, most of us first notice how another person is “Like me” or “Not like me.” This is a natural human tendency that’s probably more or less hard-wired. But, as the existentialists and multiculturalists emphasize, whether this tendency is hard-wired or not, it’s 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 repeatedly ask yourself,

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“Who do I see?” but later, as you reflect on the interview, you can try it out. Ask yourself 5 or 10 times in succession, “Who did I see?” Write your answers down. After you’ve let yourself answer the “Who did I see?” question 5 to 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 “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 either 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 Perfect Interviewer

What if you could conduct a perfect clinical interview? Of course, this is impossible. But if you could be a perfect interviewer, you’d be able to stop at any point in a given interview and describe: (a) what you are doing (based on technical expertise); (b) why you’re doing it (based on your 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 your assessment skills).

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, similar to how a violin string begins vibrating with the same frequency as a tone played in the same room (Watkins & Watkins, 1997). You would also be able to see each client clearly and without bias (Gallardo, Yeh, Trimble, & Parham, 2011). You would be able to use this unbiased, empathic resonance to determine where every interview needed to go (refer back to *Multicultural Highlight* 1.3 to explore your potential positive and negative biases towards 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 to conduct a perfect clinical interview.

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 (J. Sommers-Flanagan & Heck, 2012). As a consequence, it’s inappropriate and unprofessional to, as an old supervisor of ours used to say, “fly by the seat of your pants” in an interview session.

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

DVD Clip

In the *Introduction* chapter, John and Rita discuss the purpose of the DVD as well as the importance of becoming intentional in your work with clients.



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 strategies for developing 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 opportunities and suggestions for experiential therapist development activities.

SUMMARY

This book is organized to reflect the order in which we believe students should acquire interviewing skills and techniques. In the beginning it can be helpful to learn nondirective interviewing skills, honoring the client as expert, and gradually adding more directive strategies as you master basic listening skills. Additionally, as you begin to engage in this professional activity, you should focus on learning to: (a) quiet yourself and listen to clients, (b) develop a positive therapeutic relationship with clients, and (c) obtain diagnostic and assessment information.

As you develop, you can benefit from obtaining a broad range of training experiences. It's important to learn and practice interviewing from different theoretical perspectives, including person-centered, psychoanalytic, behavioral, cognitive, feminist, and constructive or solution-focused viewpoints. In particular, because we live in a diverse world, learning about and adopting a multicultural orientation to interviewing is essential. A multicultural orientation includes (a) self-awareness, (b) cultural knowledge, and (c) culture-specific expertise. It also helps if you have an overall attitude of multicultural humility. Although perfection

is impossible, if you base your behavior on sound theoretical principles, professional ethics, and scientific research, you can become a competent and responsible mental health professional.

This book is organized into four parts, moving beginning clinicians through stages designed for optimal skill development. Because practice is needed for you to develop interviewing skills, each chapter offers suggested experiential activities to facilitate greater self-awareness, cultural sensitivity, and technical expertise.

SUGGESTED READINGS AND RESOURCES

The following textbooks, articles, and recreational readings provide a useful foundation for professional skill development.

Duncan, B., Miller, S. D., Wampold, B. E., & Hubble, D. (Eds.). (2010). *The heart and soul of change: Delivering what works in therapy* (2nd ed.). Washington, DC: American Psychological Association.

This book 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.

Goldfried, M. (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. (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*.

Kottler, J. A. (2010). *On being a therapist* (4th ed.). Hoboken, NJ: Wiley.

This book includes chapters on the therapist's journey, hardships, being imperfect, lies we tell ourselves, and many more. It offers one perspective on the road to becoming and being a therapist.

Prochaska, J., & DiClemente, C. (2005). *The transtheoretical approach*. New York, NY: Oxford University Press.

Although the transtheoretical model has both strong adherents and strong detractors, it's 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. (2012). *Counseling and psychotherapy theories in context and practice: Skills, strategies, and techniques* (2nd ed.). Hoboken, NJ: 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.