

Diagnostic Interviewing

Daniel L. Segal • Michel Hersen
Editors

Diagnostic Interviewing

Fourth Edition

 Springer

Editors

Daniel L. Segal
University of Colorado at Colorado Springs
Department of Psychology
Colorado Springs, CO 80933
USA
dsegal@uccs.edu

Michel Hersen
Pacific University
School of Professional Psychology
222 S.E. 8th Avenue, Suite 563
Hillsboro, OR 97123
USA
hersenm@pacificu.edu

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Michel Hersen: To Vicki
Daniel L. Segal: To my mother Anne
and late grandmother Harriet who always
supported me and my education.

Preface

The first three editions of this book had Michel Hersen and Samuel M. Turner as its editors. A fourth edition had been talked about by the two original editors, but the untimely death of Dr. Turner intervened. Subsequently, Daniel L. Segal, a long time colleague of Michel Hersen, graciously offered to be involved in the project, and this is the result of his participation.

As stated in the first edition of this book, one of the most difficult milestones in a new clinician's career is the completion of the first interview with a real live client (as opposed to role playing with other students). Generally, such endeavor is fraught with much apprehension. However, if the interview goes well there is much rejoicing. On the other hand, if the interview falls flat, there will be considerable consternation and concurrent negative feedback from the supervisor. Irrespective of the amount of preparation that has taken place before the interview, the beginning clinician will justifiably remain apprehensive about this endeavor. Thus, the first three editions of *Diagnostic Interviewing* were devoted to providing a clear outline for the student in tackling a large variety of clients in the interview setting.

In consideration of the positive response to the first three editions of this book, we, and our editor at Springer, Sharon Panulla, decided that it was time to update the material. However, the basic premise that a book of this nature needs to encompass theoretical rationale, clinical description, and the pragmatics of "how to" once again has been followed. Thus, the reader will find consistencies between this fourth edition and the prior ones that have been published. We still believe that our students definitely need to read the material covered herein with consummate care. We are particularly concerned that in the clinical education of our graduate students, interviewing unfortunately continues to be given insufficient attention. Considering that good interviewing leads to appropriate clinical and research targets, we can only underscore the critical importance of this area of training.

Twenty-six years have elapsed since publication of the first edition, and many developments in the field have occurred, including repeated revisions of the DSM system of classification and diagnosis. However, the basic structure of our new edition remains identical to those of the prior ones, in that Part I deals with general Issues, Part II with Specific Disorders, and Part III with Special Populations. In some instances, the contributors are identical; in others, co-authors have been changed; in still others, we have entirely new contributors. However, all the material

is either updated or completely new. Of the 21 chapters in our book, three are completely new (Chaps. 3, 5, and 21) and seven have been updated (Chaps. 2, 4, 11, 14, 17, 18, and 20). Eleven chapters that originally appeared in the third edition have been written by different authors (Chaps. 1, 6, 7, 8, 9, 10, 12, 13, 15, 16, and 19).

Chapters in Parts II and III generally follow the outline below:

1. Description of the Disorder, Problem, or Special Population
2. Procedures for Gathering Information
3. Case Illustration
4. Standardized Interview Formats
5. Impact of Race, Culture, Diversity, and Age
6. Information Critical to Make a Diagnosis
7. Dos and Don'ts
8. Summary
9. References

Many individuals have contributed to the development and production of this new edition. First, we thank our contributors for sharing with us their clinical and research experience. Second, we thank Carole Londeree, Terri Draper, and Blake Kirschner for their technical assistance and help with the preparation of the index. Finally, we once again thank Sharon Panulla for her appreciation of the need for this fourth edition of our text.

Forest Grove, OR
Colorado Springs, CO

Michel Hersen
Daniel L. Segal

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Contributors

Jay M. Behel, Ph.D.

Department of Behavioral Sciences, Rush University Medical Center,
Chicago, IL, USA

Marina A. Bornovalova, Ph.D.

University of Minnesota, Minneapolis, MN, USA

Yenys Castillo, M.S.

Center for Psychological Studies, Trauma Resolution & Integration Program
(TRIP), Nova Southeastern University, Davie, FL, USA

Caroline Ciliberti, B.A.

Department of Psychology, West Virginia University, P.O. Box 6040,
Morgantown, WV 26506-6040, USA

Michael Daniel, Ph.D.

Psychological Service Center, Pacific University, 511 SW 10-Suite 400-Room
416, Portland, OR 97205, USA

Stacey B. Daughters, Ph.D.

University of Maryland, College Park, MD 20742, USA

Katherine Diskin, Ph.D.

Department of Psychology, University of Calgary, 2500 University Drive NW,
Calgary, Alberta T2N 1N4, Canada

Barry A. Edelstein, Ph.D.

Department of Psychology, West Virginia University, P.O. Box 6040,
Morgantown, WV 26506-6040, USA

Lisa S. Elwood, Ph.D.

University of Missouri-St. Louis, St Louis, MO, USA

William Fals-Stewart, Ph.D.

Department of Psychiatry, Addiction and Family Research & Wynne Center for
Family Research, University of Rochester, 601 Elmwood Avenue, Box SON,
Rochester, NY 14642, USA

Matthew T. Feldner, Ph.D.

University of Arkansas, Fayetteville, AR, USA

Leilani Feliciano, Ph.D.

Department of Psychology, University of Colorado at Colorado Springs,
1420 Austin Bluffs Parkway, Colorado Springs, CO 80933-7150, USA

Yolanda Fernandez, Ph.D.

Sex Offender Assessment Unit, Millhaven Institution, Bath, ON, Canada K0H 1G0

Ryan D. Field, B.A.

Department of Psychology, Rockhurst University, 1100 Rockhurst Road,
Kansas City, MO 64110, USA

John P. Foreyt, Ph.D.

Behavioral Medicine Research Center, Baylor College of Medicine,
Houston, TX 77030, USA

Mary Fran Flood, Ph.D.

Behavioral Medicine Research Center, Baylor College of Medicine,
Houston, TX 77030, USA

Steven N. Gold, Ph.D.

Center for Psychological Studies, Trauma Resolution & Integration Program
(TRIP), Nova Southeastern University, Davie, FL, USA

Christine Gould, M.A.

Department of Psychology, West Virginia University, P.O. Box 6040,
Morgantown, WV 26506-6040, USA

Alan M. Gross, Ph.D.

Department of Psychology, University of Mississippi, PO Box 1848,
University, MS 38677, USA

Amber M. Gum, Ph.D.

Louis de la Parte Florida Mental Health Institute, University of South Florida,
Tampa, FL, USA

Jessica Gureczynski, M.S.

Psychological Service Center, Pacific University, 511 SW 10-Suite 400-Room
416, Portland, OR 97205, USA

David J. Hansen, Ph.D.

Department of Psychology, University of Nebraska-Lincoln, Lincoln,
NE 68588-0308, USA

David C. Hodgins, Ph.D.

Department of Psychology, University of Calgary, 2500 University Drive NW,
Calgary, Alberta T2N 1N4, Canada

Grace S. Hubel, M.A.

Department of Psychology, University of Nebraska-Lincoln, Lincoln,
NE 68588-0308, USA

Philinda Smith Hutchings, Ph.D.

Midwestern University, 19555 N. 59th Ave., Glendale, AZ 85308, USA

Andrea June, M.A.

Department of Psychology, University of Colorado at Colorado Springs,
1420 Austin Bluffs Parkway, Colorado Springs, CO 80933-7150, USA

Michelle L. Kelley, Ph.D.

Department of Psychology, Old Dominion University, Norfolk, VA, USA

Wendy K.K. Lam, Ph.D.

Department of Psychiatry, Addiction and Family Research & Wynne Center for
Family Research, University of Rochester, 601 Elmwood Avenue, Box SON,
Rochester, NY 14642, USA

Jessica F. Magidson, M.A.

University of Maryland, College Park, MD 20742, USA

Meghan A. Marty, M.A.

Department of Psychology, University of Colorado at Colorado Springs,
1420 Austin Bluffs Parkway, Colorado Springs, CO 80933-7150, USA

Marta Meana, Ph.D.

Department of Psychology, University of Nevada, Las Vegas,
NV 89154-5030, USA

Catherine Miller, Ph.D.

School of Professional Psychology, HPC/Pacific University, 222 SE 8th Avenue,
Suite 563, Hillsboro, OR 97123-4218, USA

Ivan R. Molton, Ph.D.

University of Washington Medical Center, 1959 NE Pacific Street, Box 356490,
Seattle, WA 98195-6490, USA

Brian P. O'Connor, Ph.D.

Department of Psychology, Barber School of Arts and Sciences, University of
British Columbia – Okanagan, 3333 University Way, Kelowna, BC,
Canada V1V 1V7

Bunmi O. Olatunji, Ph.D.

Vanderbilt University, 301 Wilson Hall, 111-21st Avenue South, Nashville,
TN 37203, USA

Jason Peer, Ph.D.

Department of Psychiatry, VISN 5 Mental Illness Research, Education and
Clinical Center, University of Maryland School of Medicine, Baltimore,
MD 21201, USA

Mary Ashton Phillips, B.A.

Department of Psychology, University of Mississippi, PO Box 1848,
University, MS 38677, USA

Caroline F. Pukall, Ph.D.

Department of Psychology, Queen's University, Kingston, ON, Canada K7L 3N6

Katherine A. Raichle, Ph.D.

University of Washington Medical Center, 1959 NE Pacific Street, Box 356490, Seattle, WA 98195-6490, USA

Sheila A.M. Rauch, Ph.D.

University of Michigan Medical School, VA Ann Arbor Healthcare System, 2215 Fuller Road (116c), Ann Arbor, MI 48105, USA

Bruce Rybarczyk, Ph.D.

Department of Psychology, Virginia Commonwealth University, Richmond, VA, 842018 23284-2018, USA

Daniel L. Segal, Ph.D.

Department of Psychology, University of Colorado at Colorado Springs, 1420 Austin Bluffs Parkway, Colorado Springs, CO 80933-7150, USA

Erin Smith, Ph.D.

University of Michigan Medical School, VA Ann Arbor Healthcare System, 2215 Fuller Road (116c), Ann Arbor, MI 48105, USA

Rose C. Smith, M.A.

University of Arkansas, Fayetteville, AR, USA

Edouard S. St. Pierre, Ph.D.

St. Joseph's Care Group, Lakehead Psychiatric Hospital, P.O. Box 2930, Thunder Bay, ON, P7B 5G7

Jonathan N. Stea, BSc

Department of Psychology, University of Calgary, 2500 University Drive NW, Calgary, Alberta T2N 1N4, Canada

Risa J. Stein, Ph.D.

Department of Psychology, Rockhurst University, 1100 Rockhurst Road, Kansas City, MO 64110, USA

Wendy N. Tenhula, Ph.D.

Department of Psychiatry, VISN 5 Mental Illness Research, Education and Clinical Center, University of Maryland School of Medicine, Baltimore, MD 21201, USA

Thomas B. Virden, Ph.D.

Midwestern University, 19555 N. 59th Ave., Glendale, AZ 85308, USA

Brian Yochim, Ph.D.

Department of Psychology, University of Colorado at Colorado Springs, 1420 Austin Bluffs Parkway, Colorado Springs, CO 80933-7150, USA

Chapter 1

Basic Issues in Interviewing and the Interview Process

Daniel L. Segal, Andrea June, and Meghan A. Marty

The ability to conduct an efficient and effective clinical and diagnostic interview is arguably one of the most valued skills among mental health professionals. It is during the interview that the clinician learns about the difficulties and challenges experienced by the client and begins to form the foundations of a healing professional relationship. Although the metaphor is not a novel one, the job of the interviewer may be likened to that of a detective trying to collect enough data and organize the clues to “solve the mystery,” in this example, the presenting problem of the client. The most important aspect of this detective metaphor is that effective interviewers (detectives) are served well by their natural curiosity (truly wanting to understand all aspects of the client’s experiences, no matter how painful or uncomfortable) and the thoughtfulness of their approach (being guided by strategies and principles for gathering data while also forming an emotional connection with the client).

Broadly construed, the clinical interview is the foundation of all clinical activity in counseling and psychotherapy (Hook, Hodges, Segal, & Coolidge, 2010). Indeed, one cannot be a good clinician without well-developed interviewing skills. Although specific attention is often paid to the initial clinical interview (or first contact between clinician and client), it is ill-advised to think that clinicians first *complete* an interview and *then* start treatment. Rather, it is more accurate to view the clinical interview as an *ongoing* part of the psychotherapeutic process (Hook et al.). For the beginning clinician, trying to manage the content and process of the interview can seem like a daunting task, one that often evokes considerable anxiety. However, with guidance and practice, clinical interviewing skills typically improve and eventually become second nature, an important part of the clinicians’ repertoire. The purpose of this chapter is to discuss and elucidate some of the factors that can facilitate the interview process for the beginning clinician as well as the more seasoned one. The overview presented in this chapter of the basic issues regarding clinical interviewing will also set the stage for the following chapters in this text

D.L. Segal (✉), A. June, and M.A. Marty
Department of Psychology, University of Colorado at Colorado Springs, 1420 Austin Bluffs
Parkway, Colorado Springs, CO 80933-7150, USA
e-mail: dsegal@uccs.edu

that provide considerable depth in the major areas of clinical and diagnostic interviewing. We begin with discussions of the different settings in which interviews occur, confidentiality, and the basic skills used in interviews. Next, we describe the importance of understanding the impact of client diversity on the interview process and pay targeted attention to the issues faced by mental health professionals who are in the beginning stages of professional development as a clinician and interviewer. We conclude this chapter with a discussion of some dos and don'ts of clinical and diagnostic interviewing.

1.1 The Impact of the Interview Setting

Perhaps the first critical factor that influences the nature of the interview is the setting in which the interview takes place. There are a variety of settings in which interviews may occur and the type of setting often determines how the client is approached. Specifically, the setting will help determine the depth and length of the interview, the domains of functioning that are assessed, the types of questions that should be asked, and the degree of cooperation that can be expected. For example, the level of cooperation that can be expected from a juvenile delinquent forced to participate in court-ordered psychotherapy will be substantially different than that from an adult or older adult who is burdened with responsibilities of caring for an ill spouse or parent and who is eagerly seeking psychotherapy at a community mental health clinic. As such, each interview will require a different approach because of the circumstances of how each client comes to be interviewed and the expectations established for client behavior. To address the issues of the setting on the interviewing process, we discuss emergency and crisis settings, outpatient mental health settings, medical settings, and jail, prison, and courthouse settings.

1.1.1 Emergency and Crisis Settings

Emergency and crisis settings are diverse, and include general hospital emergency rooms, inpatient psychiatric hospitals, and crisis centers. Clients who may be encountered in these settings include individuals with acute medical problems that are compounded by psychiatric factors, people who are brought for psychiatric evaluation by law enforcement or emergency medical personnel, individuals involved in voluntary or involuntary psychiatric commitment proceedings, and people who are experiencing an acute, often volatile crisis situation (Turner, Hersen, & Heiser, 2003). Individuals requiring emergency care may exhibit psychotic disturbances, including active hallucinations and/or delusions (e.g., schizophrenia, bipolar disorder); drug and alcohol problems, including severe intoxication and disorientation; organic brain syndromes, such as a head injury, delirium, or other types of neurological disorders; mood disorders (e.g., severe

depression with psychotic features and/or active suicidal thoughts); and personality disorders, especially those characterized by volatile and impulsive behaviors (e.g., borderline personality disorder).

Because the interview occurs under emergency conditions, clinicians should be prepared to alter the style and format of the traditional interview. Clients in emergency settings are often frightened by their perceptions and feelings, as well as by the surroundings in which they find themselves, and they often exhibit extremes in emotions. They may be too agitated, frightened, or paranoid to provide detailed histories. Thus, the goal in such settings is to gain enough information to make a tentative diagnosis and offer emergency treatment planning. In emergency settings, a careful examination of the client's mental status is more important than a detailed social history or formal psychological testing. Keep in mind that a calm and understanding attitude on the part of the clinician can increase the client's comfort level enough to allow the interviewer to obtain a reasonable sense of the nature of the problem (Turner et al., 2003).

1.1.2 Outpatient Mental Health Settings

Compared to clients seen in emergencies settings, clients served by outpatient community mental health centers and private outpatient practices will have a more varied range of psychopathology. Whereas psychotic disturbances and suicidal ideation may be encountered within this setting, typically clients are more stable and not in severe enough crisis to warrant hospitalization. Therefore, the nature of the interview will be considerably different from that in emergency and crisis settings.

The objective of the interview in this setting is to learn as much about the client's current psychological and emotional functioning as possible, including the client's reasons for seeking psychotherapy, and to fully explore the client's personal history (often called the social history) to put the client's current problems in a proper context. The interview is typically guided by the problems and fortitude of the client, and because there is generally little or no mystery for the client as to the purpose of the interview, there is generally less resistance during the interview. Thus, the interviewer will typically have more time and less trouble in conducting a comprehensive interview, which typically occurs during a 60–90-min session. A thorough understanding of the client's current and past difficulties and the contexts in which the struggles occur is necessary for the clinician to develop an initial conceptualization of the problem and to develop an appropriate initial treatment plan.

Compared to the pressure of emergency settings, interviewers in outpatient settings are usually afforded the luxury of time to establish rapport with the client and lay the groundwork for a productive therapeutic relationship. In outpatient settings, clients may be inquisitive about the nature of their problems or disorders (sometimes requesting a formal diagnosis), the causes of their problems or disorders, and the pragmatics of treatment (e.g., fees, length of treatment, theoretical orientation, or

general approach of the clinician). These questions should be addressed candidly and sensitively to foster trust in the relationship (Faust, 1998). Of course, there is no crystal ball to precisely determine how long treatment will last for a particular client, but it is often helpful to establish a general time frame with the client and to secure an initial agreement to treatment with a plan to review progress in a short period of time: “How would you feel about making an initial commitment to weekly psychotherapy for the next 8 weeks? At the end of that time (if not sooner), let’s evaluate how we are doing together and decide how we should proceed, to determine if we need to contract for another series of sessions.” The manner in which questions about diagnosis and treatment are answered will help the client develop a “proper” perspective on his or her treatment; specifically, what can and cannot be done, and what the long-term prognosis entails (Turner et al., 2003). Even if the client does not request such information, it may be helpful for the clinician to address these types of issues with the client at the end of the initial interview.

1.1.3 Medical Settings

Medical settings (e.g., medical school hospitals, rehabilitation hospitals, Veteran’s Affairs medical centers) present a unique challenge for clinical work. Often, medical patients have not requested to consult with a mental health professional, but rather the referral is the decision of the treating physician. The reason for the referral may or may not have been explained to the patient and therefore the patient may be initially hesitant or reluctant to communicate to the clinician and, in some cases, may even refuse to be interviewed (Faust, 1998). Individuals in this setting frequently do have various medical illnesses and therefore have defined their “problem” as a medical one. As such, they may not understand why a mental health professional has been sent to see them.

It behooves the clinician to be prepared for varying levels of knowledge about and active participation in the referral process, and thus at the beginning of the interview should introduce him or herself, explain the purpose of the consultation, and state who requested it. In general medical settings, the clinician is likely to garner cooperation with the medical patient when the clinician presents herself as an information gatherer and acknowledges the client’s physical condition without immediately suggesting that there is a psychological disturbance, even if one is suspected (Turner et al., 2003). If the clinician is fortunate enough to work within an interdisciplinary team within a medical setting, the interview can be framed as “comprehensive care” which may decrease some of the stigma associated with mental health treatment.

In this setting, clinicians also should be prepared to adjust the format and length of the interview according to the needs of the medical patient. Depending upon the medical conditions experienced by the patient, he or she may be in considerable discomfort which impacts one’s ability to engage in a dialogue and answer questions. Some medical patients may need a period of cultivation (e.g., having a few informal

visits to get to know the patient) before they are willing to delve into emotional concerns or psychological topics, requiring the clinician to be flexible on the number of visits needed to complete the interviewing task. Clinicians in medical settings also need to be mindful of the other professionals working within the facility and the schedules to which these other professionals must adhere. Some flexibility and coordination with the staff helps to ensure the interview sessions and treatment sessions have as few interruptions as possible.

If the clinician is a consultant in the medical setting, it is particularly important to avoid being manipulated into siding with the client against the physician. It is critical to maintain the stance of an investigator with no specific position. Consultant clinicians must remember they are invited by the treating physician to render their expert advice on a particular problem. A major difficulty can arise in this setting if negative statements and judgments about other aspects of the patient's care are rendered by the clinician (Turner et al., 2003). This type of behavior will most certainly have a negative impact on the doctor-patient relationship and the doctor-clinician relationship to work in the best interest of the medical patient.

1.1.4 Jail, Prison, and Courthouse Settings

Depending upon the reason for referral, these settings can have a distinctly unpleasant adversarial tone. Clients may range from being very resistant and defiant of the entire process to being overly attentive and concerned. Some clients, in fact, may honestly want psychological assistance. A client's motivation to be truthful, forthright, and forthcoming with information will also depend upon the perceived referral question and the circumstances of the interview (Faust, 1998).

In this setting, privacy is likely to be limited when conducting interviews as other people (e.g., fellow inmates, guards, attorneys) may be within listening proximity to the interview. Additionally, because many of these evaluations are court mandated, confidentiality of records does not apply (Faust, 1998). In these cases, clinicians should be frank with the client about these limits and the role of the clinician. The clinician may also be restricted by time in this setting. In an emergency hearing, for example, the clinician may have limited time to interview the client and make recommendations. At other times, the clinician will need to coordinate her schedule with others at the jail or prison, limiting flexibility as compared to some other settings.

During interviews in this setting, the clinician may want to look for inconsistencies in the client's behavior and self-report because there may be perceived benefits to the client to either minimize reports of psychopathology or conversely to exaggerate mental health concerns. Interviewing and observing the significant people in the client's life (e.g., spouses, parents, children) may also be informative, when possible (Faust, 1998). For example, referrals concerning adult guardianship involve the court evaluator interviewing both parties vying for guardianship as well as other people involved in the adult's life (e.g., guardian ad litem, the adult protective

agency worker, the adult's children, other kin). These additional interviews can help to verify information, uncover inconsistencies, and ultimately help the clinician determine the most optimal course of action.

1.2 Confidentiality

A hallmark feature of a professional therapeutic relationship is *confidentiality*. Indeed, confidentiality is a critical aspect to address in an interview. Guidelines for psychologists regarding confidentiality are established by the American Psychological Association (APA) in the *Ethical Principles of Psychologists* (APA, 2002). Because a breach in confidentiality is such a serious action, clients must be informed (e.g., verbally or in a written format) of the limits of confidentiality at the onset of a clinical interview, prior to any other information discussed. It is best to take a straightforward approach when discussing and educating clients about the limitations of confidentiality. Although there is no clear answer about whether the conversation should take place at first contact over the phone or at first contact in the session, it is probably best to wait until meeting the client for the first time to fully explain the concept so that the clinician can see the client's response and gauge the client's understanding (Kenny, 1998). However, there may also be times where it is appropriate to discuss such limitations over the phone. For example, if a new client became overly detailed about his or her struggles over the phone, it would behoove the clinician to make attempts to curtail such disclosures until confidentiality has been addressed sufficiently.

Confidentiality is such an important topic that state laws regulating the practice of psychologists typically have provisions about confidentiality and guidelines pertaining to the clinician–client relationship. In short, clinicians must maintain the privacy of their client's communications and records for effective evaluation and treatment to be possible. Caution must be exercised in releasing information to anyone but the client, and it is always best to err on the conservative side (Faust, 1998). If in doubt, do not release information without written consent from the client or court order. Several important factors that may impinge on confidentiality are discussed next.

1.2.1 Age

The age of consent to psychological evaluation or treatment varies among the states. Therefore, a 15-year-old adolescent seeking mental health services without parental or legal guardian consent may be able to do so legally in one state but not the other. In a state where it is legal to provide services to a 15-year-old without parental or guardian consent, all confidentiality laws of that state and professional ethical guidelines would apply. In other states, persons under the age of 18 would be considered

minors, and no services could be rendered without parental or guardian consent. In such cases, the minor client should be informed of this requirement prior to the interview, and the client should also be made aware that his or her parents or guardians have a legal right to all records of evaluation and treatment (Turner et al., 2003).

1.2.2 Confidentiality of Records

Written records of psychological assessment and treatment are confidential documents. These records may not be released to any third party (including other professionals) without written consent from the client. For unlicensed professionals or students in training, the supervisor or clinical supervision team will be privy to the information, and the client should be duly informed of this. It is the responsibility of each professional to maintain up-to-date, detailed, and accurate records of treatment and to provide safeguards for such material. Given the number of people who could potentially access records (i.e., whomever the client releases the information to, third-party payers, those issuing court orders, legal guardians, etc.) it is prudent to take care when documenting in the record. It would be wise for clinicians to imagine that judges, attorneys, insurance company personnel, physicians, and the client him or herself are looking over their shoulder while documenting treatment (Faust, 1998). Alternatively, whereas one must be careful and prudent when documenting in charts, records should have enough detail to facilitate treatment planning and meet the requirements for reimbursement from third-party payers. Certain aspects of the clinical record (e.g., dates of sessions, diagnoses) may be released to a third-party payer for reimbursement. Maintaining adequate records is particularly important should the client transfer to another agency or clinician in the future. Although malpractice claims or lawsuits arising from interviews or treatments are relatively uncommon, an appropriately detailed record may also be important part of the clinician's defense.

The security of client records is the responsibility of the treating clinician. Written information should never be left unattended and should be filed promptly and properly when not being used. Written records should be kept in locked files with limited access. New challenges face those who are transitioning to the use of electronic media to store mental health-care information. This is an increasingly important issue, and the interested reader is referred to Gellman (2000) for a detailed review of how technologies may affect confidentiality and the delivery of mental health services. At a minimum, electronic records must be stored on a password protected computer in a locked office.

1.2.3 Duty to Warn and Protect

One of the limitations of confidentiality is the legal and ethical responsibility of mental health professionals to protect their clients and members of society from imminent danger.

Although clinicians are legally and ethically required to maintain confidentiality between themselves and their clients, clinicians also have an obligation to protect dangerous clients from themselves (i.e., suicide) and to protect potential victims from dangerous clients (i.e., homicide, child or elder neglect or abuse). This blurring of the responsibility of confidentiality occurred because of the landmark *Tarasoff vs. Regents of University of California* case in 1976. In this landmark case, the California Supreme Court required clinicians to take steps to protect individuals who are potential victims of their clients. Therefore, should a client inform a clinician that he or she has a specific and imminent homicidal plan with an identified potential victim, the following actions may need to be taken: the clinician has a duty to warn an intended victim, the clinician may need to commit the client to a psychiatric facility, and the clinician may need to notify the police about the client's plan (Faust, 1998). Consultation with supervisors or professional colleagues is clearly advised during these types of situations to think through the necessary steps one must take to protect clients and members of society. Further guidance about the duty to warn and protect is provided by Werth, Welfel, and Benjamin (2009).

1.2.4 Managing the Temptation to Discuss Cases

Information gathered from clinical interviews should not be the topic of casual conversation under any circumstances. Even anecdotal de-identified information can be highly identifiable if the situation is distinct. Describing a client during the course of a conversation with professional colleagues in what may seem to be a private setting may actually include unintended listeners who can identify the client's information due to the distinguishing features of the story. Novice clinicians may be more prone to discussing aspects of therapeutic experiences with peers in inappropriate settings (e.g., restaurants, lounges, etc.). They may also be compelled to discuss clients in areas of the treatment setting where other listeners may be present (e.g., at the front desk, elevators, hallways). Remember that confidentiality is the rule for information gathered in a clinical interview and not the exception and that respect for confidentiality is one of the important elements in forging an open and honest dialogue. Violation of the client's confidentiality without just cause is a serious offense, both legally and ethically, so great caution is always advised.

The issue of confidentiality is serious and complex with many potential ramifications. It can be tricky to navigate and must be handled with care. One simple rule of thumb is to avoid saying anything to anyone about the client that the clinician would be uncomfortable saying to them in front of the client, the client's attorney, and the clinician's supervisor. The intent of this section was simply to alert the clinician to the primary issues. For more complete coverage on confidentiality, the reader is referred to Bersoff (2008), Levin, Furlong, and O'Neil (2003), Knapp and VandeCreek (2006), and the Ethical Principles of Psychologists and Code of Conduct (APA, 2002).

1.3 Interviewing Basics

In this section, we provide a broad overview of some of the foundational concepts and skills that impact the clinical interview.

1.3.1 *Establishing Rapport*

Establishing rapport refers to creating an open, trusting, and safe relationship with the client. Of course, this is easier said than done, but establishing a therapeutic alliance with the client is an important requisite for effective interviewing and ongoing psychotherapy. Indeed, for clients to participate in psychotherapy, it is vital that they feel at ease with the clinician as they discuss the most intimate and personal struggles they are facing. Remember that, initially, many clients do not know what to expect from psychotherapy or from the clinician. Clients are faced with the task of being expected to reveal private and emotionally sensitive information to a veritable stranger! As such, they may be apprehensive, embarrassed, or downright terrified at the beginning of the first interview. Some clients find it difficult to ask for help because of the stigma associated with mental illness and psychotherapy. Others may have been in psychotherapy before but did not find it useful and therefore are cautious and skeptical of what the clinician can offer.

Faced with these challenges, the role of the clinician is to convey to the client an appreciation of their feelings and a willingness to listen without judgment to whatever the client may present. If the clinician keeps in mind that the client must be permitted time and patience for the establishment of trust, favorable results are likely to follow (Johnston, Van Hasselt, & Hersen, 1998). As important to the establishment of trust is the client's belief that the psychotherapy will provide new perspectives, change, and the possibility for growth. If the clinician can demonstrate this hope, clients will likely experience the freedom and security to explore their problems. The course of establishing an effective client–clinician relationship will be varied but an overarching goal of the clinician is to establish a trusting and respectful alliance with the client.

1.3.2 *Being Empathic*

A fundamental skill for any clinician is the ability to empathize with another person's experiences and convey such empathy through validation and understanding. Empathy is the ability to perceive and understand a client's feelings "as if" the clinician were experiencing them and to communicate that accurate understanding to the client (Faust, 1998). Always keep in mind that no two clients are the same and the clinician should be attuned to the subtleties of the client's feelings, experiences, and behaviors.

A distinction to be made is that empathy is understanding, not sympathy. By responding empathically, the client knows that the clinician is accepting, understanding, and joining his or her “world” without judgment, rather than just “feeling bad” for the client (Johnston et al., 1998). This empathic understanding enhances trust and increases the likelihood that the client will reveal intimate details of his or life, possibly details that the client has never previously revealed to anyone.

Empathy can be conveyed in many ways (e.g., nonverbal behaviors, such as listening attentively, nodding, showing a concerned facial expression; verbal communications of understanding and support) allowing the clinician to choose a style that is most comfortable for him or her. It is hard to do any of these things while taking notes, so keep note-taking to a minimum. Other important strategies for conveying empathy and validation include tone of voice, time and rate of comments and questions, and the area of questioning. When used correctly, these latter, seemingly trivial, strategies can be critical in conveying warmth and understanding.

1.3.3 Using Reflection

Reflection statements address what the client has communicated (verbally or non-verbally) and are typically used to highlight a specific point. A reflection statement, however brief, usually marks a specific feeling or point of information, and thus can be divided into *reflection of feelings* or *reflection of content*. Liberal use of both, throughout clinical interviews, is advised. Indeed, reflection is an important tool for any interviewer. When a clinician reflects a client’s feelings or the content of what a client is saying, or both simultaneously, this accomplishes two important tasks. First, it conveys a sense of empathy to the client by sending a message that the client is accurately understood, which strengthens the therapeutic bond. Second, it provides a mirror image for the client of what they are feeling and saying. This “clinician mirror” is an invaluable method for the client to learn about him or herself (Johnston et al., 1998). Reflection is a skill that assists clients to monitor and identify different feeling states and also to express those states in a healthy way.

Mastery of this skill does not mean that the clinician mimes or mimics the responses of the client. Reflection of feeling can be delivered in a simple phrase, such as “Sounds like you are feeling...,” “You must be feeling...,” or “I hear that you are feeling...” Reflection of content means that the clinician accurately paraphrases or summarizes the client’s statements, reflecting the “essence” of what the client communicated but not using the exact words or phrases. Think of this skill as helping the client in “getting to the heart of the matter” (Johnston et al., 1998). In summary, reflective statements can aid in the development of rapport as clients perceive that they are being truly and deeply understood. In turn, the client may relay more information that further strengthen the bond and ultimately assists the clinician in determining appropriate interventions.

1.3.4 Paying Attention to Language and Avoiding Jargon

An integral part of a successful interview is the communication between clinician and client. To arrive at an accurate diagnostic picture, the clinician must communicate to the client what is being asked of him or her. The clarity and comprehensibility of the questions will facilitate identification of pertinent information while enhancing rapport and trust in the client–clinician relationship (Faust, 1998). A common mistake that new clinicians sometimes make is their use of jargon or nonfamiliar vocabulary. The clinician’s use of vocabulary heavy in psychological terminology often hinders effective communication. For example, a graduate student asked her new client, “What kind of boundaries do you have with your mother?” The term *boundaries* may mean something completely different to the client than it does to the clinician. In this example, the student clinician risks her client answering without a clear understanding of what is being asked and possibly hindering development of an accurate case formulation. Similar risks are possible with respect to unfamiliar language. A client’s level of education, intelligence, background, and geographical location should be taken into account during any interview (Faust, 1998). This does not mean that the clinician should “talk down to” the client in any way. It does mean that words should be chosen with consideration.

1.3.5 Using Humor

The image of the stoic, impersonal, unflappable, and humorless clinician who is devoid of feelings is an outdated one. Certainly, being able to see the humorous elements even in the most challenging situations in one’s life can be an adaptive coping strategy for clinicians and clients alike. In the interview setting, humor has the potential to “take the edge” off a discussion of particularly painful material and can serve to release physical tension. Smiling or even laughing together can be a source of bonding between clinician and client. These positive aspects of humor notwithstanding, some judicious caution in the use of humor is advised. For the clinician, the use of jokes or humor should be done sparingly and with caution before a therapeutic relationship is solidly formed. Although the intention of the clinician may be to lighten the mood, a humorous remark is typically not appropriate during the course of an initial clinical evaluation. When clients show the pattern of habitually using humor, sarcasm, or jokes as a way to distance themselves from feelings that are too painful or scary, the clinicians’ reaction should be dependent on the context of the situation. At times, the clinician may choose to offer a gentle interpretative statement, such as “I have noticed that when you start to experience or discuss very painful feelings, you sometimes seem to make a joke to get away from those feelings. Have you noticed this in yourself?” Like all interventions and tactics, humor has its place in the clinical interview, especially if it is timed correctly and not overused. Regardless of when humor is used, it is most imperative that clinicians *laugh with clients* and not at them or their predicaments.

1.3.6 Responding to Questions from Clients and Managing Self-Disclosure

How one responds to questions from clients depends on the clinician's level of training and the types of questions being asked. In the early stages of training, beginning clinicians should generally be cautious about offering diagnostic or disposition information without first discussing the topic in supervision. For example, if during an interview a client asks "Do you think I have schizophrenia?" the clinician should address the client's feelings that are associated with the label, but delay answering the question directly until after a consultation with the supervisor has occurred. Questions of a pragmatic nature, for example about agency policies, should be answered directly (e.g., questions about billing, payment, or times the clinic is open).

Some clients ask clinicians to reveal personal information which can be a difficult situation to navigate. Should clinicians self-disclose and if so, what kind of details and how much should they reveal? Whereas clinicians have highly divergent opinions on the potential costs and benefits of self-disclosure, an occasional sharing of personal information can facilitate the interview and enhance rapport (Knox & Hill, 2003). However, like the use of humor, self-disclosure must be timed appropriately and used limitedly, and perhaps most important, the "shadow side" of self-disclosure must be carefully considered.

One negative impact of revealing personal details is that it frequently switches the focus of the interview from the client (where it rightfully should be) to the clinician. In some cases, clients prod clinicians for self-disclosures to test the limits of the psychotherapy relationship. Therefore, clinicians must always ask themselves about the intent and impact the disclosure could have on the client's progress toward his or her identified goals. An inappropriate disclosure can also burden the client. As such, beginning clinicians should generally keep self-disclosure to a minimum. One rule of thumb is to freely disclose details one would not mind seeing printed in the local newspaper, such as one's age, level of training and education, and the name of one's supervisor. Clinicians should be cautious about disclosing details of a more personal nature. When a personal disclosure is made, the clinician should be able to articulate to the supervisor the reason why the disclosure was made including the goal the clinician was trying to accomplish specifically by the disclosure. Clinicians should also ask themselves "Could the goal have been accomplished in another fashion that does not carry the risks associated with self-disclosure?" If not, another general rule of thumb is to disclose feelings rather than facts: "I know what it feels like to be hurt by somebody I trusted" rather than "I also felt hurt when my ex-spouse cheated on me." Should clients press for a self-disclosure (e.g., "Have you ever been raped?"), it is advisable to reflect the client's curiosity and try to understand what is behind the question, to illuminate the client's assumptions or concerns about the clinician. It also helps to refocus the discussion back to the client. Under no circumstances is it appropriate for the clinician to self-disclose about any current personal problems.

1.4 Diversity and the Interviewing Process

Culture refers to a common sense of beliefs, norms, and values among a group of people. Culture impacts whether individuals seek help, what type of help they seek, what types of coping styles and social support are available, and how much stigma is attached to mental illness (US Department of Health and Human Services (DHHS), 2001). The main purposes of a diagnostic interview are to establish a therapeutic relationship with the client and to begin to formulate a clinical diagnosis. Failing to consider issues of diversity can negatively impact both the relationship and the diagnosis, which can ultimately reduce the effectiveness of psychotherapy. Diversity, as it is discussed here, includes all aspects of cultural identity such as age, gender, geographic location, physical ability, race and ethnicity, religious preference, sexual orientation, and socioeconomic status. Consideration of cultural issues is particularly important given the increasing diversity of the United States and the likelihood of clinicians encountering clients from cultural backgrounds different from their own, sometimes markedly so. Three major domains of cultural competence are (1) awareness of one's own assumptions, values, and biases, (2) understanding the worldview of culturally diverse clients, and (3) knowledge of culturally appropriate intervention strategies and techniques (Sue & Sue, 2008). Next, we briefly touch upon each of these domains with the caveat that this section provides a general overview of the issues and therefore is not intended to provide the necessary background material for clinicians to adequately assess clients from different cultural groups.

1.4.1 *Impact of Diversity on the Therapeutic Relationship*

As we have highlighted earlier, a good working alliance is crucial for psychotherapy to be effective. Particularly during the first few sessions, clinicians must create good rapport and establish their credibility in a way that is sensitive to the client's culture. Dana (2002) describes a process by which African-American clients may "size up" a mental health clinician, and suggests that African Americans look for signs of genuineness, authenticity, and approachability in mental health clinicians. Individuals from other racial or ethnic groups may find it important to maintain formality with professional helpers. The clinical and diagnostic interview is often a client's first experience with the mental health-care system; therefore, it may be necessary to spend time during the interview exploring the client's expectations regarding psychotherapy. For instance, different meanings for the term *clinician* can be found across different cultural groups, ranging from physician, to medicine man/woman, to folk healer (Paniagua, 2005). Understanding the client's definition of clinician will enhance the clinician's ability to help the client manage his or her problem.

The field of psychology can function as a culture since it provides a lens for viewing the world. Clinicians must be aware of the assumptions and biases of diagnosis and treatment in the practice of traditional psychology. Sue and Sue (2008) describe

several culture-bound values of psychology including: focus on the individual; preference for verbal, emotional, behavioral expressiveness; insight; self-disclosure; scientific empiricism; distinctions between mental and physical functioning; ambiguity; and patterns of communication. Nonverbal communication, such as bodily movements (e.g., eye contact, facial expression, posture), the use and perception of personal and interpersonal space, and vocal cues (e.g., loudness of voice, pauses, rate, inflection) can vary depending on cultural factors (Sue & Sue, 2008). Clinicians should be aware of their own communication style and anticipate how it may affect clients with a different communication style. To facilitate rapport with clients of a different culture, it may be helpful for clinicians to match the client's rhythm and pace of speech, maximize awareness of their comfort level with eye contact and physical distance, show respect for hierarchy in the family and extended family, and use appropriate metaphors and symbols (Ingram, 2006).

Adjustments can be made to the interview that may help to increase the comfort level of the client and serve to strengthen the therapeutic relationship. For example, clients with a visual impairment may require large print questionnaires and informed consent forms. Alternatively, the clinician could offer to read printed materials aloud. Hearing amplifiers can be offered to those clients with a hearing impairment. Interpreters can be used when the clinician and client do not share the same language. An interpreter can help to facilitate a client's sense of belonging at the treatment site, as well as increase client trust in the clinician and the psychotherapeutic process (Paone & Malott, 2008). Professional interpreters should have training in mental health. Due to privacy and confidentiality concerns, use of a client's family member as an interpreter for psychotherapy is generally not recommended (Paone & Malott, 2008; Sue & Sue, 2008).

Modifications in the diagnostic interview may also include clinicians being more flexible in their role and shifting the traditional boundaries of "clinician." For example, for a client who has difficulty getting to the mental health clinic because of lack of transportation, the clinician may conduct the interview outside of the office, such as in the client's home or another convenient location. Having a more active style by offering concrete advice and assistance may be necessary, such as providing information on obtaining social services if they are needed by the client. Consulting family members and paraprofessionals or folk healers may be appropriate in some cases in order to better understand the struggles of culturally diverse clients (Paniagua, 2005). It is important to determine external factors related to the presenting problem for clients who have suffered from discrimination such as racism and sexism, in some cases for many years. Finally, assessing the positive assets of culturally diverse clients, such as family, community resources, and religious organizations is essential as well.

1.4.2 Impact of Diversity on Clinical Diagnosis

Clinicians must be sensitive to cultural issues not only to more effectively establish a therapeutic relationship, but also because of the impact of diversity on clinical diagnosis.

An accurate diagnosis is essential, as it facilitates communication, dictates the nature of treatment, and provides an indication of the likely prognosis and course of the disorder (Segal & Coolidge, 2001). During the clinical interview, clinicians use the client's description of the frequency, intensity, and duration of the symptoms; signs from a mental status examination; and the clinician's own observations and judgment of the client's behavior to determine a formal diagnosis of a mental disorder. The final diagnosis depends on the clinician's belief about whether the client's signs, symptom patterns, and impairment of functioning meet criteria for a given diagnosis, as set forth by the American Psychiatric Association (APA, 2000) in the *Diagnostic and Statistical Manual of Mental Disorders*.

Although the symptoms of mental disorders are found worldwide, diagnosis can be challenging because the manifestations of mental disorders vary with age, gender, race, ethnicity, and culture (DHHS, 2001). Culture can account for variation in the ways in which clients communicate their symptoms, which symptoms they report, and the meanings they attach to mental illness. Clinicians who are unfamiliar with a client's frame of reference may incorrectly diagnose as psychopathology variations in behavior, belief, or experience that are particular to and normative within the client's culture. For example, speaking in tongues, hearing the voice of God, or witnessing spiritual beings should probably not be considered pathological for individuals from certain religious communities, whereas it may be considered a problem from someone who is nonreligious (Johnson & Friedman, 2008). Some have suggested that the use of structured and semi-structured interviews can reduce clinician bias with regard to diagnosis (Aklin & Turner, 2006).

The most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; APA, 2000)* provides an outline designed to assist clinicians with developing a culturally appropriate clinical formulation. Clinicians are encouraged to explore and provide a narrative summary for each of five categories, which include:

1. Cultural identity of the client: ethnic or cultural reference groups, degree of involvement with both culture of origin and host culture, language abilities, use, and preference.
2. Cultural explanations of the client's illness: predominant idioms of distress, meaning and perceived severity of symptoms in relation to norms of cultural group, local illness category used to identify the condition, perceived causes of the illness, preference for and past experience with sources of care.
3. Cultural factors related to psychosocial environment and levels of functioning: culturally relevant interpretations of social stressors, available social supports, levels of functioning and disability.
4. Cultural elements of the relationship between the client and the clinician: differences in culture and social status between the client and the clinician and the problems that these differences may cause in diagnosis and treatment.
5. Overall cultural assessment for diagnosis and care: discussion of how cultural considerations influence diagnosis and care.

The guidelines are meant to “supplement the multiaxial diagnostic assessment and to address difficulties that may be encountered in applying DSM-IV criteria in a multicultural environment” (APA, 2000, p. 897). The DSM-IV-TR also provides a glossary of 30 culture-bound syndromes, which are “localized, folk, diagnostic categories” generally limited to specific societies or cultures and may or may not be linked to a specific diagnostic category (APA, 2000, p. 898). Becoming familiar with the categories listed in the glossary can assist clinicians with recognizing culture-specific conditions that may be apparent in an intake interview and integrated into a diagnostic formulation.

Appraisal of client’s cultural background should be a standard part of any clinical or diagnostic interview. However, a word of caution with regard to issues of diversity: “Although it is critical for clinicians to have a basic understanding of the generic characteristics of counseling and psychotherapy and the culture-specific life values of different groups, overgeneralizing and stereotyping are ever-present dangers” (Sue & Sue, 2008, p. 154). While generalizations are guidelines for behaviors, they should be tentatively applied in new situations and open to change and challenge (Sue & Sue, 2008). In addition, because each person has multiple identity dimensions, clinicians should be cognizant of the many within-group differences that can exist between members of a cultural group, which can sometimes outnumber the between-group differences. For example, differences between individuals considered to be in the same racial or ethnic group can be due to any number of factors, such as varying national origin, socioeconomic class, level of acculturation, age, or gender, to name a few. Moreover, clinicians should not automatically assume that the problems of culturally diverse clients are necessarily related to cultural experiences or background. For example, it would be erroneous to assume that an 85-year old-client is depressed because of age alone.

Readers are encouraged to consult a number of sources that cover issues of diversity more comprehensively: DHHS (2001); Paniagua (2005); Pedersen, Draguns, Lonner, and Trimble (2008); and Sue and Sue (2008).

1.5 Issues Specific to Emerging Professionals

The process of learning how to conduct a comprehensive clinical interview can be exciting, but also anxiety provoking. Many emerging professionals feel overwhelmed by the task and lack confidence in their knowledge and skills. Conducting an effective interview is a skill that can only be developed over time and, in the beginning, errors are likely to be made. In fact, struggling with one’s first several interviews is to be expected and therefore should not be a source of undue anxiety for the emerging professional. Common issues specific to emerging professionals in the context of clinical interviewing include managing anxiety, obtaining the appropriate breadth and depth of information, overlooking the process (i.e., the interaction between client and clinician) of the interview, premature advice-giving, interacting with clients with diverse characteristics, and handling personal questions.

Clients can often sense a clinician's anxiety or lack of control; therefore, it is essential for emerging professionals to learn to manage their nervousness during interviews. Frequently, clients are anxious at the interview as well and might not know what to expect, depending on whether or not they have had previous experience with psychotherapy. It can be helpful to ease into the initial interview by engaging the client in small talk before delving into the client's concerns. Emerging professionals can reduce their own anxiety regarding interviews by activities such as observing more experienced clinicians conduct diagnostic interviews, practicing mock diagnostic interviews with peers, and reviewing ahead of time any information gathered about the client and the client's pressing concerns. In addition, the beginning of one's career is a good time to learn to engage in adequate self-care. Regular exercise, a sufficient amount of sleep, and use of relaxation exercises and meditation are all ways of maintaining an overall sense of well-being and control, which will likely have a positive impact on one's level of professional confidence.

Emerging professionals tend to worry about getting "all" of the necessary information in the initial interview and struggle with asking too many superfluous questions (Faust, 1998). This can make the interview feel like an interrogation rather than a conversation between the clinician and client. However, in a sense, the entire course of psychotherapy with a client can be thought of as an "intake" process. Clinicians continue to learn more about the client as the psychotherapy progresses so, whereas it is important to obtain as much relevant information as possible, getting all of the information in one or two interviews is not necessarily a requirement. On the other hand, emerging professionals may struggle with not exploring sensitive areas out of the belief that it is impolite to explore certain aspects of clients' lives (Faust, 1998). Avoidance of socially sensitive topics has the potential for communicating to the client that certain areas are "off-limits" and should not be explored in psychotherapy. For example, young clinicians may be hesitant to discuss sexuality with an older client, even when it is central to the presenting problem. In addition, avoiding sensitive topics in an interview could be life-threatening if a client has suicidal or homicidal ideation or is dealing with domestic violence or substance abuse.

Some emerging professionals focus so much on the *content* of the interview that they end up overlooking the *process* of the interview. Many clinics use interview outlines or checklists to assist emerging professionals with obtaining relevant information. However, this can lead to an excessive amount of note-taking in an attempt to make sure every blank on the intake form is filled in. This may give the impression to clients that the clinician is more interested in filling out paperwork than getting to know them as individuals, which can negatively impact the development of rapport. If diagnostic interviews are audio- or video-taped for the purpose of supervision, clinicians can use those to ensure no vital information was overlooked. Emerging professionals may become frustrated if there are significant gaps in the information obtained during a diagnostic interview, in spite of repeated attempts to get pertinent answers. Difficulty with obtaining information from a client is often important diagnostically. For example, it could reflect the client's ambivalence about psychotherapy, personality style, cognitive impairment, or a poor therapeutic alliance. It is often useful to address this difficulty directly by checking in with the client

about how he or she is feeling about the interview, about the clinician, and about disclosing personal information.

Many emerging professionals struggle with the impulse to “fix” the client (Ingram, 2006). At times it may be necessary to take action during an interview, for example, to ensure the safety of a suicidal client or assist a low-income client with obtaining financial assistance for basic needs such as food or electricity. However, advice-giving often evolves from the interviewer’s experiences and perspective, rather than the client’s (Faust, 1998). Some clinicians feel a sense of pressure to “do something” to demonstrate their competence to a client early in the interview or treatment process and may be tempted to offer simple advice. We encourage clinicians to resist this temptation and discuss it in supervision. Often clients enter psychotherapy only when they have tried every other solution to address their problems and none of those solutions have been effective. It is likely that the clinician who gives advice without adequate exploration will make suggestions that have already been tried, adding to a sense of hopelessness and frustration on the part of the client and undermining the client’s confidence in the clinician’s abilities. Simple solutions for complex problems simply do not work! Emerging clinicians can assure themselves that providing empathic listening and emotional support for the client are active strategies that are known to be beneficial.

Some emerging professionals are uncomfortable interacting with clients from diverse backgrounds, and one’s level of comfort with diverse characteristics will determine how issues of diversity are handled (Faust, 1998). Consultations with supervisors and peers who are more knowledgeable about issues of diversity as well as attending workshops and continuing education programs can better equip clinicians to work with diverse populations (DHHS, 2001). In addition, clinicians should constantly strive to be aware of their own biases and stereotypes to ensure they are not impacting the interview process or impairing the therapeutic relationship. Clinical supervision and the clinician’s personal psychotherapy are appropriate environments in which to explore one’s own biases, stereotypes, and areas of discomfort. Clinicians should be willing to do extra research after meeting with a new client if there is a knowledge deficit in a particular area. If a clinician determines that he or she is not competent to work with a specific client, that client should be referred to another clinician who is.

Dealing with personal questions such as the clinician’s age, ethnic background, marital status, or whether or not the clinician has children can be especially difficult for emerging professionals. There are several reasons for why a client might ask a clinician a personal question. Sometimes clients who ask personal questions are looking for a way to “bond” or become more comfortable with the clinician by seeking common ground, for instance, by asking where the clinician grew up. Alternatively, clients may be unaware of the unique nature of clinician–client relationships and how this professional relationship is different from relationships with family or friends. Other times, clients are unsure whether the clinician has the expertise or life experience to adequately understand their struggles and assist them with finding solutions to those struggles. For example, an older client might ask about the clinician’s age because the clinician seems “too young” to be helpful. As we noted earlier, answering these types of factual questions in a nondefensive way