Chapter 1
Basics and Beyond in Clinical and Diagnostic Interviewing

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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 therapeutic 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 and diagnosis 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; Segal, Maxfield, & Coolidge, 2008). 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., 2010). 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, feedback-informed practice, and a good deal of self-reflection on one's clinical strengths and still-developing

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skills, many beginning clinicians find that they are able to refine their interviewing skills over time and become much more comfortable with the process. Indeed, when successfully mastered, clinical and diagnostic interviewing skills become an important part of the clinicians' repertoire. The purpose of this chapter is to discuss and elucidate some of the key factors that can facilitate the interview process. The overview presented in this chapter of the basic issues regarding clinical interviewing will also set the stage for the following chapters in this volume that provide considerable depth in the major areas of clinical and diagnostic interviewing, including many disorder-specific approaches. 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.

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 a frail family member 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.

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 (including those in acute pain), 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. Individuals requiring emergency care may exhibit psychotic disturbances, including active *hallucinations* (false sensory experiences, such as hearing voices when none are objectively present), *delusions* (false beliefs, not supported by one's culture, such as paranoid ideation), and *disorganized thinking and speech* (incoherent, confused, rambling, or tangential thinking and speech, along with decreased problem-solving ability); drug and alcohol problems, including acute intoxication and disorientation; organic brain syndromes, such as a traumatic brain injury, delirium, or other types of neurological disorders; depressive 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, including whether to hospitalize the person or not. One primary focus should be a thorough assessment of dangerousness, including suicidal or homicidal ideation or plans. Some emergency departments in the USA have enacted a universal screening approach to suicidality, which has resulted in greater screenings and greater detection of those at risk for suicide (Betz et al., 2015). Nevertheless, challenges remain even in these settings, including barriers to lethal-means assessment (Betz et al., 2018) and some disparities in screening and treatment for older adults (Arias et al., 2017; Betz et al., 2016).

In emergency settings, a careful examination of the client's current mental status is more important than a detailed social history or formal psychological testing. It is helpful to strive to try and pinpoint how and why the client is in the current state of crisis and what the immediate precipitating events were (Dattilio & Freeman, 2010), although the full story may not always be easy to discern. 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. Collateral interviews with concerned others are usually important in emergency settings, especially if the client is unwilling or unable to participate in the interview.

Outpatient Mental Health Settings

Compared to clients seen in emergency 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-minute 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, and the theoretical orientation or general approach of the clinician). These questions should be addressed candidly and sensitively to promote transparency and 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 an informed perspective on his or her treatment, specifically, what can and cannot be done and what the long-term prognosis entails. 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.

Medical Settings

Medical settings (e.g., medical school hospitals, rehabilitation hospitals, Veterans Affairs medical centers, integrated care settings) present a unique challenge for clinical work. Often, medical patients do not request 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 have various medical illnesses and therefore have defined their "problem" as solely a medical one. As such, they may not understand why a mental health professional has been called to see them.

It behooves the mental health clinician in medical settings to be prepared for varying levels of knowledge about and active participation in the referral process among patients, 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 medical settings, the clinician is likely to garner cooperation with the medical patient when the clinician presents himself or 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. If the clinician is fortunate enough to work within an interdisciplinary team within an integrated care setting, the interview can be framed as "comprehensive care" which may decrease some of the stigma associated with mental health treatment.

In these settings, 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 other care providers help to ensure the interview sessions and treatment sessions have as few interruptions as possible.

If the clinician is a consultant in a 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. 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.

Jail, Prison, Corrections, and Courthouse Settings

There are certain aspects of correctional facilities which present unique challenges to the clinical interviewer including population factors, limits to confidentiality, and environmental factors. 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). Jail and prison settings have higher rates of mental disorders compared to the general population. As such, mental health screens are particularly important in these settings (Abram, Teplin, & McClelland, 2003; Fazel & Seewald, 2012). Without adequate assessment for potential mental disorders and subsequent treatment, inmates may be at risk of harming themselves or other inmates, may become a target for violence, or may become disruptive to prison operations (Lee, 2015).

In these settings, 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 clear and honest 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. Prisons tend to have rigid schedules, and clinical interviewers often have little-to-no control over the schedule or time allotted for the interview. At other times, the clinician will need to coordinate his or her schedule with others at the jail or prison, limiting flexibility as compared to some other settings. Safety is another important concern in these settings. It is important for clinicians to be aware of their surroundings and to avoid exposure to vulnerable positions as much as possible (Lee, 2015). Although most inmates are not aggressive or violent toward clinicians, certain inmates may need to be left in restraints throughout the interview, and often a prison guard will remain present or just outside the door throughout the interview process (Lee, 2015).

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. When possible, interviewing and observing the significant people in the client's life (e.g., spouses, parents, children) may also be informative (Faust, 1998). For example, referrals concerning adult guardianship often require the court-appointed clinician to interview 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. It is especially important for clinicians to evaluate their personal biases and reduce judgment which may occur when working in prison settings. Clinicians may naturally have more negative views about inmates than the general population, especially those inmates who have committed especially heinous crimes such as child sexual abuse or murder. Negative reactions to the interviewee may cause the clinician to lose objectivity; this may lead to difficulty exploring all relevant areas or missing diagnoses.

Inmates are also often expecting judgment and therefore may be more sensitive to changes in the clinician's demeanor which may suggest negative feelings toward the inmate. This will damage rapport and make diagnostic interviewing more difficult and less effective (Lee, 2015). Clinicians should be careful to assess their biases and maintain a nonjudgmental attitude, no matter the population.

Confidentiality

A hallmark feature of a professional therapeutic relationship is *confidentiality*, which is the requirement that mental health clinicians protect their client's privacy by not revealing the contents of psychotherapy or counseling. Indeed, confidentiality is a critical aspect to address in an initial interview. Guidelines for psychologists regarding confidentiality are established by the American Psychological Association (APA) in the *Ethical Principles of Psychologists and Code of Conduct* (APA, 2017). Specifically, the APA ethical principle (standard 4.01) states that "Psychologists have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium, recognizing that the extent and limits of confidentiality may be regulated by law or established by institutional rules or professional or scientific relationship."

Because a breach in confidentiality is such a serious action, clients must be fully and dutifully informed of the limits of confidentiality at the onset of a clinical interview, prior to any other information discussed (see Table 1.1 for common limitations to confidentiality). Such disclosure is almost always done verbally with the client and provided in written form, as part of an informed consent document. We advise taking 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. However, there may also be times where it is appropriate to discuss such limitations over the phone. For example, if a new client

Table 1.1 Common limitations to confidentiality in counseling and psychotherapy

Clinicians may disclose private information without consent in order to protect the client or the public from serious harm, for example, when a client discusses serious plans to attempt suicide or to harm another specific person
Clinicians are commonly required to report child abuse or neglect, elder abuse or neglect, and abuse or neglect of persons with intellectual and developmental disabilities
Clinicians may release confidential information if they receive a court order from a judge. This event may occur when a client's mental health comes into question during legal proceedings

Note: The client's right to confidentiality has legal as well as clinical implications. Laws pertaining to confidentiality vary from state to state, so mental health clinicians should refer to their state's specific laws as well as their discipline-specific code of ethics

became overly detailed about his or her struggles over the phone, it would behoove the clinician to make attempts to respectfully 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 in order 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.

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 may 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.

Confidentiality of Written 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, usually in writing in the informed consent document. 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, 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 himself 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 an important part of the clinician's defense.

The security of client records is the responsibility of the treating clinician. Written or printed information should never be left unattended and should be filed promptly and properly when not being used. Written or printed records should be kept in locked files with limited access. As most records are now created and stored digitally or electronically, this has resulted in new challenges, for example, ensuring that computers and servers are physically secure and that no data breaches occur. Indeed, the safety of electronic records is an increasingly important issue. At a minimum, electronic records must be stored on a password-protected computer in a locked office. However, more secure methods of storing records electronically are preferred. Often, this includes use of encryption software or a secure medical record system. Electronic medical record systems make it easier and more convenient for mental health providers to document and access client medical and mental health records. They also can add more security to client information than was previously offered with written records. Confidentiality concerns may arise with electronic medical records though, especially in settings where interprofessional collaboration is common or where access is not heavily restricted (Richards, 2009). Clinicians may need to be particularly mindful of information they include in a client's chart, especially if that information may be available to other providers. However, as technology advances, developers are adding new ways to control who can access client information, as well as where, when, and how they are able to access the information (Nielsen, 2015). As with all record keeping, clinicians should be mindful of the information they include in the chart as well as mindful of who may potentially have access to those records.

Duty to Warn and Protect

As noted above, one noteworthy limitation 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 v. 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. This law held that psychotherapists in the state of California have a duty to protect intended victims of their patients if their intended conduct "presents a serious danger of violence to another." Since this ruling in 1976, 33 other states have formally established similar laws (Bersoff, 2014). 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.

A full assessment of suicidal and homicidal ideation or thoughts should be a part of most, if not all, clinical interviews with a new client. New clinicians may avoid asking about suicidal or homicidal ideation for fear of the response and added responsibility. However, failing to assess for either suicidal or homicidal ideation is dangerous, and a clinician could be held liable if someone is hurt and the clinician had failed to reasonably assess the client. Before addressing thoughts of suicidal or homicidal ideation, it is important to discuss the limits of confidentiality. Limits to confidentiality must be discussed thoroughly at the start of treatment to ensure clients are aware of them and choose what information to disclose accordingly (APA, 2017). In some cases, clients who have been told these confidentiality limits may choose not to disclose information concerning suicidal or homicidal thoughts. If thoughts of harm are suspected the most a clinician can do is communicate concern and emphasize the importance of client safety. Further guidance about the duty to warn and protect is provided by Werth (2017).

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, bars, 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, not the exception, and that respect for confidentiality is one of the most 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. Whereas the intent of this section was to alert the clinician to the primary issues, for more in-depth coverage of confidentiality, the interested reader is referred to Knapp, VandeCreek, and Fingerhut (2017), Koocher and Keith-Spiegel (2016), and the *Ethical Principles of Psychologists and Code of Conduct* (APA, 2017).

Interviewing Basics

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

Establishing Rapport

Establishing rapport refers to creating an open, trusting, warm, and safe relationship with the client. Of course, this is easier said than done, but establishing rapport with the client is an important requisite for effective interviewing and ongoing psychotherapy. Indeed, research has consistently identified that a positive therapeutic relationship is essential to the success experienced by most clients (see through review by Norcross, 2011). The therapeutic relationship is one of the so-called "common factors" of psychotherapy that robustly contributes to the benefits of treatment (Wampold, 2015).

At the most basic level, for clients to participate in psychotherapy, it is vital that they feel at ease with the clinician, which facilitates the clients in disclosing and discussing intimate and personal details of their lives. 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 disorders and their treatment. 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. Indeed, trust must be earned and should not be automatically

expected. Critically 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 more fully disclose and explore their problems. The course of establishing an effective client-clinician relationship will be varied, but two overarching goals of the clinician are to establish and maintain a trusting and respectful therapeutic relationship with the client.

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 was 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 thoughts, feelings, behaviors, and lived experiences. 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, Van Hasselt, & Hersen, 1998). This empathic understanding enhances trust and increases the likelihood that the client will reveal intimate details of his or her 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 communication 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.

Using Reflection

Reflection statements address what the client has communicated (verbally or nonverbally) 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 himself 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) but not parroting back to the client exactly what he or she said. 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 strengthens the bond and ultimately assists the clinician in determining appropriate interventions.

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. Clinicians should consider the client's level of education, intelligence, age, background, and geographical location (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.

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.

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. In contrast to emotionally laden or complicated questions, simple 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 guiding principle 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 guiding principle 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 ongoing personal problems or problems with other clients.

Diversity and the Interview 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 supports are available, and how much stigma is attached to having a mental disorder (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 multicultural issues is particularly important given the increasing diversity of the USA and the likelihood of clinicians encountering clients from cultural backgrounds different from their own, sometimes markedly so. Three major domains of

multicultural 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, 2016). Culturally sensitive and competent clinicians intentionally work to understand the worldview of others without negative judgments (Fawcett & Evans, 2012). Moreover, as Chung and Bemak (2012) state, "social justice is at the very core of multicultural counseling competencies" such that clinicians must understand ecological factors that influence clients and pose the skills to challenge any systemic barriers that impede growth to enhance well-being. 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. Recommendations for additional reading are provided at the end.

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. Among refugee populations and other minority groups who have experienced significant oppression, trust may not be as easily established as with White American clients (Chung & Bemak, 2012; Ward, 2005). For example, 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. It is often necessary to spend time during the clinical and diagnostic interview to discuss, define, and clarify roles of the client and psychologist and to explore the client's expectations regarding psychotherapy; this may be especially true for clients from non-Western cultures, where personal problems are not usually shared with people outside the family network (Chung & Bemak, 2012). 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, 2014).

Moreover, in some cultures, confidentiality may mean that family members or close friends may have access to the client's personal information, so it is important for the clinician to ensure a workable definition that the client feels comfortable with and agrees upon (Chung & Bemak, 2012). Individuals from more collectivistic cultures may also experience confusion about the "distance" or "coolness" of the Western counselor who defines the social and professional relationship more narrowly and refuses social invitations to family events (Chung & Bemak, 2012).

Traditional psychological intervention strategies are often bound by the Western cultural norms and practices with which they were created. The culturally competent counselor is able to adapt, alter, and modify these techniques to meet the needs

of the diverse client. Sue and Sue (2016) 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, 2016). 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. Translators or interpreters may be used when the clinician and client do not share the same language, although such practice is not without notable complications. Paniagua (2014) cautions that the use of translators introduces a third person into the psychotherapeutic process, which can lead to miscommunications or misunderstandings, and that the use of a translator may be perceived negatively by some clients, who would prefer to speak to a clinician who understands their language. If translators must be used, and no better options exist, then professional translators should have formal training in mental health and culture-related syndromes and also share a similar level of acculturation as the client. Due to possible privacy and confidentiality concerns, use of a client's relative or friend as a translator for psychotherapy is cautioned and should be considered and discussed within the client's definitions of these concepts (Paniagua, 2014).

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 and sources of resilience of culturally diverse clients (Paniagua, 2014). Where traditional talk therapy may not be the natural means of resolving problems, culturally competent clinicians will be open to incorporating alternative techniques (Chung & Bemak, 2012).

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 *Diagnostic and Statistical Manual of Mental Disorders, 5th edition* (DSM-5; American Psychiatric Association, 2013).

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 the mental disorder. 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). Aklin and Turner (2006) suggested that the use of structured and semi-structured interviews can reduce clinician bias with regard to diagnosis, and we agree since structured and semi-structured interviews provide a standardized way to assess thoroughly all the diagnostic criteria for all of the major mental disorders in the DSM system (Segal & Williams, 2014).

The DSM-5 (American Psychiatric Association, 2013) 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 (see Table 1.2). The DSM-5 also includes the Cultural Formation Interview (CFI), a 16-item assessment tool that may be used to gain information about the impact of culture on an individual's presentation and care plan. Developed as a brief semi-structured interview, it emphasizes four domains of assessment: cultural definition of the problem; cultural perceptions of cause, context, and support; cultural factors affecting self-coping and past help seeking; and cultural factors affecting current help seeking. Finally, clinicians should become familiar with the Glossary of Cultural Concepts of Distress in the DSM-5, which provides information on nine culture-specific conditions that may or may not be linked to a specific diagnostic category.

Table 1.2 Aspects of a cultural formulation

Cultural identity of the individual: Describe the individual's racial, ethnic, or cultural reference groups that may influence his or her relationship with others, access to resources, and developmental and current challenges, conflicts, or predicaments. For immigrants and racial or ethnic minorities, the degree and kinds of involvement with both the culture of origin and the host culture or majority culture should be noted separately. Language abilities, preferences, and patterns of use are relevant for identifying difficulties with access to care, social integration, and the need for an interpreter. Other clinically relevant aspects of identity may include religious affiliation, socioeconomic background, personal and family places of birth and growing up, migrant status, and sexual orientation
Cultural conceptualizations of distress: Describe the cultural constructs that influence how the individual experiences, understands, and communicates his or her symptoms or problems to others. These constructs may include cultural syndromes, idioms of distress, and explanatory models or perceived causes. The level of severity and meaning of the distressing experiences should be assessed in relation to the norms of the individual's cultural reference groups. Assessment of coping and help-seeking patterns should consider the use of professional as well as traditional, alternative, or complementary sources of care
Psychosocial stressors and cultural features of vulnerability and resilience: Identify key stressors and supports in the individual's social environment (which may include both local and distant events) and the role of religion, family, and other social networks in providing emotional, instrumental, and informational support. Social stressors and social supports vary with cultural interpretation of events, family structure, developmental tasks, and social context. Levels of functioning, disability, and resilience should be assessed in light of the individual's cultural reference groups
Cultural features of the relationship between the individual and the clinician: Identify differences in culture, language, and social status between an individual and the clinician that may cause difficulties in communication and may influence diagnosis and treatment. Experiences of racism and discrimination in the larger society may impede establishing trust and safety in the clinical diagnostic encounter. Effects may include problems eliciting symptoms, misunderstanding of the cultural and clinical significance of symptoms and behaviors, and difficulty establishing or maintaining the rapport needed for an effective clinical alliance
Overall cultural assessment: Summarize the implications of the components of the cultural formulation identified in earlier sections of the outline for diagnosis and other clinically relevant issues or problems as well as appropriate management and treatment intervention

Note: Adapted from the DSM-5 (APA, 2013)

Appraisal of the 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, 2016, p. 154). 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: Chung and Bemak (2012); Paniagua (2014); Pedersen, Lonner, Draguns, Trimble, and Scharron-del Rio (2016); and Sue and Sue (2016).

Issues Specific to Emerging Professionals

The process of learning how to conduct an effective and thorough 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 discomfort; 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 brief discussions of "lighter" topics (e.g., "Tell me a little bit about where you are from or where you grew up") before delving into the client's significant 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 ongoing "information-gathering" process. Indeed, clinicians continue to learn more about the client as psychotherapy progresses. As such, although 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. Clinicians who are anxious or hesitant to explore certain topics with their clients should certainly discuss their fears with a trusted supervisor or colleague.

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 recorded for the purpose of supervision, clinicians can use those recordings to ensure no vital information was overlooked. Emerging professionals may become frustrated if there are significant gaps in the information obtained during an initial 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 with greater expertise.

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 social 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 that reassures the client of one's professional competence can lessen the client's concerns. It may also be useful to discuss with the client the reason behind the question. Exploring the client's concerns can facilitate the therapeutic alliance as well as provide further diagnostic information.

Clinical Interviews: Dos and Don'ts

Although there is great flexibility in the manner in which clinicians conduct clinical and diagnostic interviews, we gently offer the following guidance regarding some positive strategies that clinicians may endorse and some tactics that they may wish to avoid. Beginning with the "dos" of the interview, do focus as much on developing rapport as on gathering data. Whereas the two primary goals of the clinical interview are to develop a working alliance with the client and to gather relevant data about the personal background of the client and the types of problems he or she is experiencing, the first goal of establishing rapport is arguably the more important of the two. Indeed, without the development and ongoing nurturance of a positive

therapeutic relationship, the act of gathering information about the client is pointless if he or she does not return for ongoing treatment (Hook et al., 2010).

Do provide structure and direction in the interview as needed (Segal et al., 2008). Whereas advantages of a non-structured clinical interview include its flexibility, which allows for discussion and exploration of topics that may not necessarily be covered by a structured interview, and its provision of extensive opportunities for empathizing with the client and developing a strong therapeutic alliance, a potential hazard is that the interview may stray excessively. A general guiding principle is that if clients provide appropriate structure to the interview (moving appropriately from topic to topic), then no active structuring is required by the clinician. However, if clients struggle with providing their own structure (e.g., spending too much time on topics of little or questionable relevance to the problems at hand), then the clinician must provide more guidance. Regarding the diagnostic process, do have a solid knowledge of the symptoms and requirements for diagnosing a wide range of mental disorders from the DSM-5 to be able to assess for the full range of cardinal and associated symptoms as part of a comprehensive diagnostic process. This knowledge will also be of help when crafting case conceptualizations and initial treatment plans.

Do pay special attention to the final moments of the initial interview (Segal et al., 2008). There is a lot to accomplish during the first interview, and this includes the last 5–10 minutes as well. Rather than end abruptly, the clinician should attend to the sensitive information that has been shared and may want to thank the client for sharing personal, potentially upsetting experiences. The ending of the interview is also an opportunity to review important themes addressed, and, as a means for offering a sense of hope, clinicians can suggest some of the ways that psychotherapy could be helpful in addressing the presenting complaints.

Conversely, there are a number of things to avoid during the interviewing process. Don't become overly committed to an initial diagnostic hypothesis; instead, maintain multiple hypotheses (Segal et al., 2008). Although knowledge of a previous diagnosis and initial impressions of the client are useful, it is important to keep an open mind. If clinicians are not flexible in diagnosing, they may be closed off or dismissing of information that does not align with that first hypothesis. One strategy is to always consider at least five diagnostic possibilities or hypotheses and systematically rule each one in or out as part of a full differential diagnostic process. This so-called Rule of 5 prevents clinicians from settling too quickly on the most obvious diagnosis, which is sometimes incorrect, and encourages a more thorough assessment. Maintaining multiple hypotheses is essential in making accurate diagnoses and subsequently providing an effective treatment.

Don't make assumptions (Segal et al., 2008). It is tempting to believe that we understand the client's symptoms when they use labels. For example, when someone says that they have been experiencing "panic attacks," it is easy to imagine increased heart rate, sweating, and the intense fear that he or she is going to die or have a heart attack. As another example, when someone says that they are "codependent," it likely conjures an image of a person who exhibits overdependence on people, behaviors, or things, such as a spouse who supports addiction by excusing,

denying, or concealing evidence of the partner's alcohol misuse. At first blush, these labels seem reasonable. However, without specific inquiry and the gathering of *specific examples of behaviors*, it is unclear whether the clinician and client define the problem or symptoms in the exact same way. It is possible in fact that the clinician and client are thinking of quite different experiences, which would hinder appropriate and effective treatment.

Finally, it is important that clinicians do not let their opinions or values unduly factor into the interview (Segal et al., 2008). There will be instances in which the clinician feels at odds with the client's decisions and behaviors; however, with the exception of illegal and harmful actions, it is important to provide an environment for the client that is free of the clinician's biases and values. This is especially challenging if the client has done things the clinician feels are reprehensible or disgusting. In these cases, it can be helpful to try to understand and empathize with "a person who has done awful things" rather than with "an awful client," so try to conceptualize the person as not equivalent to their behavior. Because we are not always immediately aware of our own biases and judgments, we suggest that clinicians pay special attention to their emotional reactions to the content of interviews and psychotherapy sessions. In the event that a clinician's opposition to the client's behaviors, values, or decisions is intense or distressing, the clinician should discuss the issue with a colleague or supervisor, and if the feelings continue to intrude into the treatment, the clinician should refer the client elsewhere if ongoing psychotherapy is needed.

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