Praise for Clinical Interviewing

"I'm a huge admirer of the authors' excellent work. This book reflects their considerable clinical experience and provides great content, engaging writing, and enduring wisdom."
—**John C. Norcross, Ph.D., ABPP,** Distinguished Professor of Psychology, University of Scranton

"This text is outstanding. Well-grounded in theory and research, it brings to life real challenges confronting mental health professionals. Especially impressive is the integration of cultural competence and cultural humility in the interview process. This is an awesome book."
—**Derald Wing Sue, Ph.D.** Department of Counseling and Clinical Psychology, Teachers College, Columbia University

"This is a 'must-have' resource that belongs on the bookshelf of every mental health counselor trainee and practitioner."
—**Barbara Herlihy, PhD. NCC, LPC-S,** University Research Professor, Counselor Education Program, University of New Orleans

Fully-updated guide to proven, practical strategies for conducting effective interviews

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Clinical Interviewing

Sixth Edition

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CLINICAL INTERVIEWING

Sixth Edition

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Sixth Edition

John Sommers-Flanagan
Rita Sommers-Flanagan

WILEY

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CONTENTS

This is for the many and diverse students who are choosing to dedicate their lives to helping others. May your skills develop throughout your lifetime, and may they always be used for improving the lives of individuals, couples, and families.

PREFACE

Clinical interviewing is the cornerstone of virtually all mental health work. It involves integrating varying degrees of psychological or psychiatric assessment and treatment. The first edition of this text was published in 1993. We remain in awe of the continuing evolution and broad practical application of clinical interviews in mental health settings.

Language Choices

We live in a postmodern world in which language is frequently used to construct and frame arguments. The words we choose cannot help but influence the message. Because language can be used to manipulate (as in advertising and politics), we want to explain some of our language choices so that you can have insight into our biases and perspectives.

Patients or Clients or Visitor

Clinical interviewing is a cross-disciplinary phenomenon. While revising this text, we sought feedback from physicians, psychologists, social workers, and professional counselors. Not surprisingly, physicians and psychologists suggested that we stick with the term *patient*, whereas social workers and counselors expressed strong preferences for *client.* As a third option, in the Mandarin Chinese translation of this text, the term used was *visitor.*

After briefly grappling with this dilemma, we decided to primarily use the word *client* in this text, except for cases in which *patient* is used in previously quoted material. Just as Carl Rogers drifted in his terminology from *patient* to *client* to *person,* we find ourselves moving away from some parts and pieces of the medical model. This doesn't mean we don't respect the medical model, but that we're intentionally choosing to use more inclusive language that emphasizes wellness.

Sex and Gender

Sensitivity to multiple gender perspectives has complicated how gender is referred to in conversation and in writing. Consistent with tradition and contemporary perspectives, when possible, we used plural language (i.e., *them, their, they*). When speaking in the singular (as in case examples), we use *him* or *her,* based on the identified gender of the person in the case. As appropriate, we occasionally use the plural *they* when describing individuals whom we know or suspect wouldn't ascribe to a binary gender designation.

Interviewer, Psychotherapist, Counselor, Therapist, Clinician, or Practitioner

Sometimes it feels as though there are far too many choices in life. Because this text was written for aspiring mental health professionals across several disciplines, we've chosen not to rein in our choices. Consequently, we alternate in a random and whimsical way from *therapist* to *clinician* to *interviewer* to *counselor* to *psychotherapist,* and occasionally we throw in *practitioner.* Our hope is for everyone to feel included.

What's New in the Sixth Edition?

The sixth edition has new content and new citations, and is consistent with cutting-edge clinical interviewing research and practice. It's also 15% leaner than its predecessor. This trimming was in response to reviewer feedback. The outcome is increased clarity and instructional efficiency.

Cultural Content

Because culture and diversity are ubiquitous, we have integrated culture and diversity throughout the text. Instead of finding multicultural content primarily in one chapter, you'll find it everywhere. In addition:

- The multicultural competencies are reworked to integrate the latest research and policy.
- Cultural humility, a new cultural orientation concept, is featured.
- More case examples reflect cultural diversity, including LGBTQ-related issues.

Essential Skills, Reorganization, and Advanced Skills

This text has always taken a unique approach to bridging foundational clinical/counseling skills with advanced interviewing and assessment. From

our perspective, advanced assessment interviewing should always rest on a foundation of basic skills, and students should explicitly learn how the two are integrated. To help meet this instructional goal, we have made two organizational changes in this edition.

1. The former Chapter 6, An Overview of the Interview Process, has been moved to Chapter 3. This gives students an earlier view of the big interviewing picture.
2. We have divided the former Chapter 4, Directives: Questions and Action Skills, into two chapters. The result: expanded skills coverage in Chapter 5, Directive Listening Skills, and Chapter 6, Skills for Directing Clients Toward Action. This change strengthens and deepens coverage of specific clinical skills that facilitate client insight and action.

Definitions and Clarity

The definition of clinical interviewing has been reworked and moved to the very beginning of Chapter 1. There's also a new and informative discussion of the difference between clinical interviewing and counseling or psychotherapy.

Case Examples to Facilitate Learning

There are more short case examples than ever. These concrete examples help students "see" and apply interviewing skills and concepts.

Learning Objectives

Every chapter has reformulated and rewritten learning objectives to facilitate active learning.

Ethics

Ethical issues are more prominent and integrated throughout the text. New and updated discussions on clinician values, person-first versus disability-first language, and clinician social behavior are featured.

Neuroscience

As appropriate, neuroscience concepts are discussed to help readers make deeper links between what might be happening in the brain and clinical interviewer and client behaviors.

Technology

Chapter 15 includes updated information on technology-based interviewing. There's also a new section in Chapter 2 on using technology for note taking.

Clinician Stress Management and Self-Care

We have included more information and resources pertaining to the importance of clinician self-care.

Suicide Assessment

Consistent with contemporary research and practice, the suicide assessment chapter de-emphasizes suicide risk factors as a means for suicide prediction. Instead, there's a stronger emphasis on clinician-client relational factors as foundational to suicide prevention. In particular, methods for talking with clients about suicide ideation, previous attempts, and other suicide-related issues are clearer than anything we've seen in the literature.

Diagnosis and Treatment Planning

ICD-10-CM and *DSM-5* are fully integrated into the diagnosis and treatment planning material. In addition, the treatment planning section features new evidence-based information on how to match client factors with treatment strategies and techniques. This information will help clinicians develop evidence-based treatment plans.

Couple and Family Interviewing

New content and case examples consistent with emotionally focused couple therapy and the Gottman approach are provided.

All Chapters

Every chapter has been revised and edited using feedback from dozens of graduate students and professors from various mental health disciplines throughout the United States. In addition, every chapter also has new citations and is updated to be consistent with the latest trends in clinical interviewing research and practice.

Access to the Enhanced eBook

This edition comes with access to additional features via the enhanced ebook version, which contains dynamic content to further enrich your understanding of the text. Follow the instructions inside the back cover of the book for access details. This interactive e-text features the following interactivities:

Videos

Every chapter is supported with an extensive set of new videos introduced by us and featuring counselors and clients demonstrating the techniques described in the text. We've provided them to help you "see" and apply interviewing techniques in different environments.

Practice questions

At the end of each chapter within the etext, you will have the option to test your understanding of key concepts by going through the set of practice questions supplied. Each of these are tied back to the Learning Objectives listed at the start of each chapter.

Using the Online Instructor's Manual and Ancillary Materials

This text has an online instructor's manual and ancillary materials to help make teaching clinical interviewing more pleasant and efficient. Through your John Wiley & Sons sales representative or via the Wiley website, adopting this text gives you access to the following instructional support:

- An online instructor's manual, with supplementary lecture ideas, discussion questions, and classroom demonstrations and activities
- A test bank with more than 40 test items for each chapter
- A downloadable set of generic PowerPoint slides geared to the textbook chapters

Acknowledgments

Even on our bad days, we're aware of our good fortune as authors, professors, and therapists. We not only get to hang out with each other and write books but also get to publish with John Wiley & Sons. That's pretty close to being born on third base.

This is where we're supposed to thank, acknowledge, and honor everyone who made this book possible. But because this is the sixth edition of *Clinical Interviewing,* by now we're indebted to nearly everyone we've ever known. So we begin with a general thanks to the many people who have lightened our burdens, provided input and guidance, and offered emotional support.

More specifically, we want to thank our Wiley editors, Tisha Rossi and Rachel Livsey. You've both been steady, responsive, and immensely helpful. Thanks also to Stacey Wriston, Mary Cassells, Melissa Mayer, and other members of the Wiley publishing team. We've never had a question unanswered or a request denied.

In addition to our remarkable Wiley team, the following list includes individuals who have contributed to this or other editions in one significant way or another. You all rock.

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Obviously, that's quite a list. We hope all that help translates into this being quite the book!

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Photo courtesy of Todd Johnson, University of Montana.

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Rita Sommers-Flanagan, PhD, is professor emeritus at the University of Montana. Her diverse interests include professional ethics, women's issues, and spirituality and its connections to science and human well-being. She is the author or coauthor of more than 40 articles and book chapters, and most recently contributed a chapter titled "Boundaries, Multiple Roles, and Professional Relationships" to the *APA Handbook on Ethics in Psychology.* She is also a published poet, essayist, and clinical psychologist, and has worked with youth, families, couples, and women for many years.

John and Rita live and work in Montana. In their spare time, they write, irrigate, create art, garden, and restore old buildings on the family ranch. They hope to eventually establish a Stillwater River retreat center for writers, therapists, and peacekeepers.

CLINICAL INTERVIEWING

PART ONE

FOUNDATIONS OF CLINICAL INTERVIEWING

CHAPTER 1

AN INTRODUCTION TO THE CLINICAL INTERVIEW

Chapter Orientation

Clinical interview is a common phrase used to identify an initial and sometimes ongoing contact between a professional clinician and client. Depending on many factors, this contact includes varying proportions of psychological assessment and biopsychosocial intervention. For many different mental health–related disciplines, clinical interviewing is the headwaters from which all treatment flows. This chapter focuses on the definition of clinical interviewing, a model for learning how to conduct clinical interviews, and multicultural competencies necessary for mental health professionals.

LEARNING OBJECTIVES

After reading this chapter, you will be able to:

- **Define clinical interviewing**
- **Identify differences (and similarities) between clinical interviewing and counseling or psychotherapy**
- **Describe a model for learning how to conduct clinical interviews**
- **Apply four essential multicultural competencies**
- **Describe multicultural humility and why stereotyping is natural, but inadvisable**

VIDEO 1.1

Welcome to the Journey

> We took for granted that honesty and kindness were basic responsibilities of a modern doctor. We were confident that in such a situation we would act compassionately.
>
> **—Atul Gawande, *Being Mortal,* 2014, p. 3**

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

- Immediately offends you with language, gestures, or hateful beliefs

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

These are all possible client behaviors in a first clinical interview. If one of these scenarios occurs, how will you respond? What will you say? What will you do?

Every client presents different challenges. Your goals are to establish rapport with each client, build a working alliance, gather information, instill hope, maintain a helpful yet nonjudgmental attitude, develop a case formulation, and, if appropriate, provide clear and helpful professional interventions. Then you must gracefully end the interview on time. And sometimes you'll need to do all this with clients who don't trust you or who don't want to work with you.

These are no small tasks—which is why it's so important for you to remember to be patient with yourself. Conducting clinical interviews well is an advanced skill. No one is immediately perfect at clinical interviewing or anything else.

Becoming a mental health professional requires persistence and an interest in developing your intellect, interpersonal maturity, a balanced emotional life, counseling/psychotherapy skills, compassion, authenticity, and courage. Due to the ever-evolving nature of this business, you'll need to be a lifelong learner to stay current and skilled in mental health work. But rest assured, this is an exciting and fulfilling professional path (Norcross & Karpiak, 2012; Rehfuss, Gambrell, & Meyer, 2012). As Norcross (2000) stated:

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

The clinical interview is the most fundamental component of mental health training in professional counseling, psychiatry, psychology, and social work (Jones, 2010; J. Sommers-Flanagan, 2016). It is the basic unit of connection between the helper and the person seeking help. It is the

beginning of a therapeutic relationship and the cornerstone of psychological assessment. It is also the focus of this book.

This text will help you acquire foundational and advanced clinical interviewing skills. The chapters guide you through elementary listening skills onward to more advanced, complex professional activities, such as mental status examinations, suicide assessment, and diagnostic interviewing. We enthusiastically welcome you as new colleagues and fellow learners.

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

What Is a Clinical Interview?

VIDEO 1.2

Clinical interviewing is a flexible procedure that mental health professionals from many different disciplines use to initiate treatment. In 1920, Jean Piaget first used the words "clinical" and "interview" together in a manner similar to contemporary practitioners. He believed that existing psychiatric interviewing procedures were inadequate for studying cognitive development in children, so he invented a "semi-clinical interview."

Piaget's approach was novel at the time. His semi-clinical interview combined tightly standardized interview questions with unstandardized or spontaneous questioning as a method for exploring the richness of children's thinking processes (Elkind, 1964; J. Sommers-Flanagan, Zeleke, & Hood, 2015). Interestingly, the tension between these two different interviewing approaches (i.e., standardized vs. spontaneous) continues today. Psychiatrists and research psychologists primarily use structured clinical interviewing approaches. *Structured clinical interviews* are standardized and involve asking the same questions in the same order with every client. Structured interviews are designed to gather reliable and valid assessment data. Virtually all researchers agree that if your goal is to collect reliable and valid assessment data pertaining to a specific problem (or psychiatric diagnosis), a structured clinical interview is the best approach.

In contrast, clinical practitioners, especially those who embrace postmodern and social justice perspectives, generally use unstructured clinical interviews. *Unstructured clinical interviews* involve a subjective and spontaneous relational experience. This relational experience is used to

collaboratively initiate a counseling process. Murphy and Dillon (2011) articulated the latter (less structured) end of this spectrum:

> We mean a conversation characterized by respect and mutuality, by immediacy and warm presence, and by emphasis on strengths and potential. Because clinical interviewing is essentially relational, it requires ongoing attention to *how* things are said and done, as well as to *what* is said and done. The emphasis on the relationship is at the heart of the "different kind of talking" that is the clinical interview. (p. 3)

Research-oriented psychologists and psychiatrists who use structured clinical interviews for diagnostic purposes would likely view Murphy and Dillon's description of this "different kind of talking" as a bane to reliable assessment. In contrast, clinical practitioners often view highly structured diagnostic interviewing procedures as too sterile and impersonal. Perhaps what's most interesting is that despite these substantial conceptual differences—differences that are sometimes punctuated with passion—both structured and unstructured approaches represent legitimate methods for conducting clinical interviews. A clinical interview can be structured, unstructured, or a thoughtful combination of both. (See Chapter 11 for a discussion of semi-structured clinical interviews.)

Formal definitions of the clinical interview emphasize its two primary functions or goals (J. Sommers-Flanagan, 2016; J. Sommers-Flanagan, Zeleke, & Hood, 2015):

1. Assessment
2. Helping (including referral)

To achieve these goals, all clinical interviews involve the development of a therapeutic relationship or working alliance. Optimally, this therapeutic relationship provides leverage for obtaining valid and reliable assessment data and/or providing effective biopsychosocial interventions.

With all this background in mind, we define *clinical interviewing* as . . .

> a complex and multidimensional interpersonal process that occurs between a professional service provider and client. The primary goals are (a) assessment and (b) helping. To achieve these goals, individual clinicians may emphasize structured diagnostic questioning, spontaneous and collaborative talking and listening, or both. Clinicians use information obtained in an initial clinical interview to develop a case formulation and treatment plan.

Given this definition, students often ask: "What's the difference between a clinical interview and counseling or psychotherapy?" This is an excellent question that deserves a nuanced response.

Clinical Interviewing versus Counseling and Psychotherapy

VIDEO 1.3

During a clinical interview, clinicians simultaneously initiate a therapeutic relationship, gather assessment information, and, in most cases, begin therapy. It is the entry point for mental health treatment, case management, or any form of counseling. Depending on setting, clinician discipline, theoretical orientation, and other factors, the clinical interview may also be known as the (a) intake interview, (b) initial interview, (c) psychiatric interview, (d) diagnostic interview, or (e) first contact or meeting (J. Sommers-Flanagan, 2016).

Although it includes therapeutic dimensions, the initial clinical interview is usually considered an assessment procedure. However, beginning with Constance Fischer's work on individualized psychological assessment in the 1980s and continuing with Stephen Finn's articulation and development of therapeutic assessment in the 1990s, it's also clear that, when done well, clinical assessment is or can be simultaneously therapeutic. (See Suggested Readings and Resources for works by Fischer and Finn.)

Some theoretical orientations ignore or de-emphasize formal assessment to such an extent that the initial clinical interview is transformed into a therapeutic intervention. In other cases, the clinical setting or client problem requires that single therapy sessions constitute an entire course of counseling or psychotherapy. For example,

> In a crisis situation, a mental health professional might conduct a clinical interview designed to quickly establish . . . an alliance, gather assessment data, formulate and discuss an initial treatment plan, and implement an intervention or make a referral. (J. Sommers-Flanagan, Zeleke, & Hood, 2015, p. 2)

From this perspective, not only is the clinical interview always the starting point for counseling, psychotherapy, and case management, but, due to a variety of factors and choices, it also may be the end point.

There may be other situations where an ordinary therapy session must transform into a clinical assessment. The most common example of this involves suicide assessment interviewing (see Chapter 10). If clients begin talking about suicide, the standard practice for mental health and health care professionals is to shift the focus from whatever was happening to a state-of-the-art suicide assessment interview.

Thus, even though a clear demarcation might be preferable, everything that happens in a full course of counseling or psychotherapy may also occur within the context of a single clinical interview—and vice versa. The entire range of attitudes, techniques, and strategies you read about in this text are the same as what's necessary for conducting more advanced and theoretically specific counseling or psychotherapy. In addition, some practitioners refer to every therapy session as a clinical interview.

Several key dimensions of clinical interviews are described next:

1. The nature of a professional relationship
2. Client motivations for therapy
3. Collaborative goal-setting

The Nature of an Ethical Professional Relationship

All professional relationships involve an explicit agreement for one party to provide services to another party. In counseling or psychotherapy, this explicit agreement is referred to as *informed consent* (Pease-Carter & Minton, 2012). Using an explicit informed consent process ensures that clients understand and have freely consented to treatment (Welfel, 2016). Informed consent is discussed later in this chapter.

Professional relationships typically include compensation for services (Kielbasa, Pomerantz, Krohn, & Sullivan, 2004). This is true whether the therapist receives payment directly (as in private practice) or indirectly (as when payment is provided by a mental health center, Medicaid, or other third party). In some situations, clinical services are provided on a sliding fee scale or at no charge. Professional and ethical practitioners provide consistent, high-quality services, even in situations in which clients are paying reduced fees or no fee at all.

Professional relationships involve power differentials; the professional is an authority figure with specialized expertise. Clients are in need of this expertise. The power differential can be heightened when professionals are from the dominant culture and clients are from less dominant cultures or social groups. Because clients often view themselves as coming to see an expert who will help them with a problem, they might be vulnerable to accepting unhelpful guidance, feedback, or advice. Ethical professionals are sensitive to power dynamics both inside and outside the therapy office (Patrick & Connolly, 2009).

Professional relationships imply some degree of emotional distance and objectivity. In fact, if you look up the word *professional*, you'll find the word "expert" as a possible synonym. Also, the word *clinical* is associated with

words like "scientific" and "detached." But mental health professionals are generally not detached experts. Instead, the therapeutic relationship established also includes mutuality, respect, and warmth. This may cause you to wonder if it's possible for a clinician to establish a professional relationship based on expertise and objectivity that also includes mutuality and warmth. The answer is yes; it's possible, but not necessarily easy. Effective mental health professionals are experts at being respectful, warm, and collaborative with clients, while retaining the necessary professional distance and objectivity. Maintaining this balance is challenging and gratifying (see Putting It in Practice 1.1).

PUTTING IT IN PRACTICE 1.1: DEFINING APPROPRIATE RELATIONSHIP BOUNDARIES

Although we don't often think about them, boundaries define most relationships. Being familiar with role-related expectations, responsibilities, and limits is an important part of being a good therapist. Consider the following potential deviations from usual professional relationship boundaries. Evaluate and discuss the seriousness of each one with your classmates. Is it a minor, somewhat serious, or very serious deviation from a professional boundary?

- Having a coffee with your client at a coffee shop after the interview
- Asking your client for a ride to pick up your car
- Going to a concert with a client
- Asking your client (a math teacher) to help your child with homework
- Borrowing money from a client
- Sharing a bit of gossip with a client about someone you both know
- Talking with one client about another client
- Fantasizing about having sex with your client
- Giving your client a little spending money because you know your client faces a long weekend with no food
- Inviting your client to your church, mosque, or synagogue
- Acting on a financial tip your client gave you
- Dating your client
- Writing a letter of recommendation for your client's job application
- Having your client write you a letter of recommendation for a job

Why Clients Choose Therapy

Why do people seek mental health assessment and assistance? Usually, for one of the following reasons:

- The client is experiencing subjective distress, discontent, or a problem that's limiting in some way. (Note: Client distress might be in response to a relationship problem.)
- Someone, perhaps a spouse, relative, or probation officer, insisted on counseling. Usually this means the client has irritated others or broken the law.
- Personal growth and development.

When clients seek therapy because of subjective distress, they often feel demoralized because they haven't been able to fix their own problem or cope with their relationships (Frank, 1961; Frank & Frank, 1991). At the same time, the pain or cost of their problems may stimulate motivation for change. This motivation can translate into cooperation and hope.

In contrast, sometimes clients end up in therapy with little motivation. They may have been cajoled or coerced into scheduling an appointment. In such cases, the client's primary motivation may be to terminate therapy or be pronounced "well." Obviously, if clients are unmotivated, it will be challenging to establish and maintain a therapeutic relationship.

Clients seeking personal growth and development are usually highly motivated. Working with these clients can seem far easier than working with less motivated clients.

Solution-focused therapists use a similar three-category system to describe client motivation (Murphy, 2015). Their system consists of the following:

1. *Visitors to treatment:* Clients who attend therapy only when coerced. They have no interest in change.
2. *Complainants:* Clients who attend therapy at someone else's urging. They have a mild interest in change.
3. *Customers for change:* Clients who are especially interested in change—either to alleviate symptoms or for personal growth.

Many researchers and clinicians have written about subtle ways therapists can nurture client motivation (Berg & Shafer, 2004; W. R. Miller & Rollnick, 2013). In Chapter 3 and again in Chapter 12, we discuss client motivation, readiness for change, and the stages of change in counseling and psychotherapy (Prochaska & DiClemente, 2005). Understanding these concepts is essential to clinical interviewing.

Collaborative Goal-Setting

Collaborative goal-setting is a common clinical practice that should occur within the course of an initial clinical interview (Tryon & Winograd, 2011). The positive outcomes associated with collaborative goal-setting likely involve interactive discussions with clients, not only about specific problems and worries but also about personal hopes, dreams, and goals (Mackrill, 2010). Depending on the therapist's theoretical orientation, this process may rely more or less on formal assessment and diagnosis.

From a cognitive-behavioral perspective, collaborative goal-setting is initiated when therapists work with clients to establish a problem list. Making a problem list helps illuminate client problems, provides an opportunity for empathic listening, and begins transforming problems into goals. J. Beck (2011) provided an example of how a cognitive-behavioral therapist might initially talk with clients about goal-setting:

> Therapist: *(Writes "Goals" at the top of a sheet of paper.)* Goals are really just the flip side of problems. We'll set more specific goals next session, but very broadly, should we say: Reduce depression? Reduce anxiety? Do better at school? Get back to socializing? (p. 54)

J. Beck (2011) also noted that making a problem list with clients helps clients begin framing their goals in ways that include greater personal control.

Collaborative goal-setting is a process that contributes to positive treatment outcomes regardless of theoretical perspective. Mackrill (2010) described collaborative sensitivities required from an existential perspective:

> The therapist needs to be sensitive to the isolation and perhaps vulnerability of the client who expresses goals for the first time. The therapist needs to be sensitive to the fact that considering the future may be new to the client. The therapist needs to be sensitive to the fact that focusing on goals and tasks may confront the client with his or her sense of self-worth or his or her sense of influence on the world. The therapist needs to be willing to talk about such challenges with the client, in the knowledge that this may be central to the therapy. (p. 104)

When client and therapist agree on client problem(s), establishing therapy goals is relatively easy. However, sometimes clients and therapists don't agree on goals. These disagreements may stem from a variety of sources, including (a) poor client motivation or insight; (b) questionable therapist motives or insight; and (c) social-cultural differences.

Throughout the process, both therapists and clients have expertise they contribute to their interactions.

Therapist as Expert

Therapists are culturally accepted experts in mental health and have the responsibility to evaluate clients professionally before proceeding with treatment. A minimal first-session evaluation includes an assessment of the client's presenting problems and problem-related situations or triggers, an analysis of client expectations or therapy goals, and a review of previous problem-solving efforts. In most cases, if an initial assessment reveals that a therapist is unable to help a client, a referral to a different therapist or agency may be provided. However, ethical referrals are typically offered when therapists are lacking skills or competence and not when therapists and clients have culture or values differences (Herlihy, Hermann, & Greden, 2014).

Several factors can lead clinicians to become more authoritative and less collaborative. Sometimes, after years of training and experience, clinicians become overconfident that their approach to counseling is the right approach. Other times, clinicians feel pressured to fix clients' problems quickly, and offer premature interventions based on inadequate assessment. In such cases, a number of negative outcomes might occur (Castonguay, Boswell, Constantino, Goldfried, & Hill, 2010):

1. Therapists may choose an inappropriate approach that's potentially damaging (e.g., client anxiety is increased rather than decreased).
2. Clients may feel misunderstood and rushed and could conclude that their problem is too severe or that the therapist isn't competent.
3. Clients may follow the therapist's narrow-minded or premature guidance and become disappointed and frustrated with therapy.
4. Therapists may recommend a remedy that the client had already tried without success. This can diminish therapist credibility.

Wise and effective therapists collaborate with clients. Collaboration involves establishing rapport, listening carefully, evaluating client problems and strengths, identifying reasonable goals, and soliciting client input before implementing specific change strategies.

Client as Expert

It's important to acknowledge and affirm that clients are their own best experts on themselves and their experiences. This is so obvious that it seems odd to mention, but, unfortunately, therapists can get wrapped up in their expertness and usurp the client's personal authority. Although

idiosyncratic and sometimes factually inaccurate, clients' stories and explanations about themselves and their lives are internally valid and therefore should be respected.

CASE EXAMPLE 1.1: GOOD INTENTIONS

Recently, I (John) became preoccupied about convincing a client—who had been diagnosed years ago with bipolar disorder—that she wasn't really "bipolar" anymore. Despite my good intentions (it seemed to me that the young woman would be better off without a bipolar label), there was something important for her about holding on to a bipolar identity. As a "psychological expert," I thought it obscured her many strengths with a label that diminished her personhood. Therefore, I tried valiantly to convince her to change her belief system. I told her that she didn't meet the diagnostic criteria for bipolar disorder, but I was unsuccessful in convincing her to give up the label.

What's clear about this case is that, although I was the diagnostic authority in the room, I couldn't change the client's viewpoint. She wanted to keep calling herself bipolar, and maybe that was a good thing for her. Maybe that label somehow offered her solace? Perhaps she felt comfort in a label that helped her explain her behavior to herself. Perhaps she never will let go of the bipolar label. Perhaps I'm the one who needed to accept that as a helpful outcome.

In recent years, practitioners from many theoretical perspectives have become more outspoken about the need for expert therapists to take a backseat to their clients' lived experiences. Several different approaches emphasize respect for the clients' perspective and deep collaboration. These include progress monitoring, client-informed outcomes, and therapeutic assessment (Finn, Fischer, & Handler, 2012; Meier, 2015).

When your expert opinion conflicts with your client's perspective, it's good practice to defer to your client, at least initially. Over time, you'll need your client's expertise in the room as much as your own. If clients are unwilling to collaborate and share their expertise, you'll lose some of your potency as a helper.

A Learning Model for Clinical Interviewing

VIDEO 1.4

Clinical interviewing competence is based on specific attitudes and skills. We recommend that you learn, in the following order:

1. How to quiet yourself and listen well (instead of focusing on what *you* are thinking or feeling)

2. How to adopt a helpful and nonjudgmental attitude toward all clients
3. How to use specific clinical interviewing behaviors to help you establish rapport and develop working relationships with clients of different ages, abilities and disabilities, racial/cultural backgrounds, sexualities, social classes, and intellectual functioning
4. How to efficiently and collaboratively obtain valid, reliable, and culturally appropriate diagnostic or assessment information about clients and their problems, goals, and sense of wellness
5. How to individualize and apply counseling or psychotherapy interventions with cultural sensitivity
6. How to evaluate client responses to your counseling or psychotherapy methods and techniques (e.g., outcomes assessment)

This text primarily focuses on the first four skills listed. Although we intermittently touch on items 5 and 6, the implementation and evaluation of counseling or psychotherapy isn't the main focus of this text.

Quieting Yourself and Listening Well

To be an effective clinician, you need to quiet yourself and listen to someone else. This is difficult. Giving advice or establishing a diagnosis is hard to resist, but it can usually wait. Instead, the focus needs to be on listening to clients and on turning down the volume of your own internal chatter and biases. Some students and clinicians find it helpful to arrive early enough to sit for a few minutes, clearing the mind, focusing on breathing, and being in the moment.

PUTTING IT IN PRACTICE 1.2: LISTENING WITHOUT GIVING ADVICE

Have you ever had trouble sitting quietly and listening to someone else without giving advice or sharing your own excellent opinion? We know many experienced mental health professionals (including ourselves) who also find it hard to sit and listen without directing, guiding, or advising. For many people, giving advice is second nature—even advice based solely on their own narrow life experiences. The problem is that the client sitting in front of you probably has had a very different slice of life experiences, so advice, especially if offered prematurely and without a foundation of empathic listening, usually won't go all that well. Remember how you felt when your parents (or other authority figures) gave you advice? Sometimes, it might have been welcome and helpful. Other times, you may have felt discounted or resistant. Advice giving is all about accuracy, timing, and delivery. The acceptability of advice giving as a therapeutic technique is also related to theoretical orientation and treatment goals. Focusing too much on advice giving is rarely, if ever, a wise strategy early in therapy.

If you can quiet yourself and listen, your clients will be empowered to find their voices and tell their stories. In most clinical interviewing situations, the best start involves allowing clients to explore their own thoughts, feelings, and behaviors. When possible, you should help clients follow their own leads and make their own discoveries (Meier & Davis, 2011). It's your responsibility, at least in the beginning, to *encourage* client self-expression. On the other hand, given time constraints commonly imposed on counseling and psychotherapy, you're also responsible for *limiting* client self-expression. Whether you're encouraging or limiting client self-expression, the big challenge is to do so skillfully and professionally. It's also important to note that listening without directing and facilitating client self-expression are not the same as behaving passively (C. Luke, personal communication, August 5, 2012). Listening well is an active process that requires specific attitudes and skills (see Chapters 3 and 4 and Putting It in Practice 1.2).

The following guideline may be useful for you: No matter how backward it seems, begin by resisting the urge to actively help or direct your client. Instead, listen as deeply, fully, and attentively as you can. Doing so will aid your client more than if you offer premature help (W. R. Miller & Rollnick, 2013; Rogers, 1961).

CASE EXAMPLE 1.2: I NEED SOMEONE TO LISTEN TO ME

Jerry Fest, a therapist in Portland, Oregon, was working at a drop-in counseling center for street youth (Boyer, 1988). One night, a young woman came in. She was agitated and in distress. Jerry knew her from other visits and greeted her by name. She said, "Hey, man, do I ever need someone to listen to me." He showed her to an office and listened to her incredibly compelling tale of difficulties for several minutes. He then made what he thought was an understanding, supportive statement. The young woman immediately stopped talking. When she began again a few moments later, she stated again that she needed someone to listen to her. The same sequence of events played out again. After her second stop and start, however, Jerry decided to take her literally, and he sat silently for the next 90 minutes. The woman poured out her heart, finally winding down and regaining control. As she prepared to leave, she looked at Jerry and said, "That's what I like about you, Jer. Even when you don't get it right the first time, you eventually catch on."

This young woman articulated her need *to be listened to, without interruption.* We offer this example not because we believe that sitting silently with clients is an adequate listening response. Instead, the case illustrates the complexity of listening, how clients who are sensitive or in crisis may need to have someone explicitly follow their directions, and how the nonverbal presence of a professional in the room can be powerfully meaningful.

Adopting a Helpful and Nonjudgmental Attitude Toward All Clients

Having and holding a nonjudgmental attitude—toward all clients—is impossible. This is because clients will engage in behaviors and hold values in stark contrast to your behaviors and values. Some clients will report enjoying heavy use of alcohol and drugs. Others will tell you about sexual practices far outside your personal comfort zone. Still others will embrace and articulate personal belief systems (e.g., Satanism) that you may find abhorrent. Yet the expectation remains the same: Maintain a helpful and nonjudgmental attitude toward all clients.

In his classic 1957 article titled "The Necessary and Sufficient Conditions of Therapeutic Personality Change," Carl Rogers identified sample statements characteristic of unconditional positive regard. These statements included the following:

- I feel no revulsion at anything the client says.
- I feel neither approval nor disapproval of the client and his statements—simply acceptance.
- I feel warmly toward the client—toward his weaknesses and problems as well as his potentialities.
- I am not inclined to pass judgment on what the client tells me.
- I like the client. (p. 98)

Even the best mental health professionals are intermittently judgmental. What's important is to manage judgmental thoughts and feelings so that they don't "pop out" as behaviors that contribute to negative outcomes. We address this essential attitudinal component of clinical interviewing throughout this book, but especially in Chapters 3 and 6.

Developing Rapport and Positive Therapy Relationships

Establishing a positive working alliance with clients is the foundation on which all mental health interventions rest. This involves active listening, empathic responding, feeling validation, and other behavioral skills as well as cultural sensitivity and interpersonal attitudes leading to the development and maintenance of positive rapport (Rogers, 1957; Shea & Barney, 2015). Counselors and psychotherapists from virtually every theoretical perspective agree on the importance of developing a positive relationship with clients before using interventions (Norcross & Lambert, 2011). Some theorists refer to this as *rapport*—others use the terms "working alliance" or "therapeutic relationship" or "counseling relationship" (Bordin, 1979, 1994;

Wright-McDougal & Toriello, 2013). In Chapters 3 through 6 we cover the attitudes and skills needed to develop positive therapy relationships.

Learning Diagnostic and Assessment Skills

All mental health professionals need training in assessment and diagnosis. This is true despite the fact that psychological assessment and psychiatric diagnosis are controversial (Hansen, 2013; Szasz, 1970).

The primary purpose of assessment and diagnosis is to aid in treatment planning necessary to help clients move from a problem state toward positive solutions or growth. However, the process of assessment + diagnosis + treatment plan = goal attainment isn't linear or unidimensional. If an authoritative clinician reaches diagnostic and treatment planning conclusions in isolation, then goal attainment is unlikely. It has become increasingly clear that effective assessment, diagnosis, and treatment planning work best when implemented in a collaborative and respectful manner (Meier, 2015; Norcross, 2011).

Even if only one session with a client is likely, clinicians should begin using specific interventions only after the following four conditions have been met:

1. They have quieted themselves and engaged in empathic listening.
2. They have adopted a helpful and nonjudgmental attitude.
3. They have developed a positive therapeutic relationship or working alliance.
4. They have used a collaborative, respectful, and culturally sensitive assessment and diagnostic process to identify their clients' individual needs and therapy goals.

VIDEO 1.5

Multicultural Competencies

> The world is in the midst of a multicultural revolution that touches everyone and offers possibilities for a richer, more interesting, and sustainable future. (Hays, 2013, p. 2)

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

This foundation has often served its purpose quite well. Over the years, many clients have been greatly helped by mental health providers. But, beginning in the 1960s and continuing to the present, there has been increasing recognition that counseling and psychotherapy theories were sometimes (but not always) racist, sexist, and homophobic in their application (J. Sommers-Flanagan & Sommers-Flanagan, 2012). We refer readers elsewhere for extensive information on the ways our profession has not always been sensitive, inclusive, and empowering of various minority groups (Brown, 2010; Shelton & Delgado-Romero, 2013; D. W. Sue & Sue, 2016).

Having a multicultural orientation is now a central principle and ethical requirement for all mental health practice. There are many reasons for this, including the fact that the United States continues to grow more diverse. In addition, several decades ago, it was reported that most minority clients dropped out of psychotherapy after only a single clinical interview (S. Sue, 1977). At the very least, these facts imply a poor fit between clinical interviewing as traditionally practiced and the needs or interests of minority clients.

Increased diversity in the United States constitutes an exciting and daunting possibility for mental health professionals: exciting for the richness that a diverse population extends to our communities and for the professional and personal growth that accompanies cross-cultural interaction; daunting because of increased responsibilities linked to learning and implementing culturally relevant approaches (Hays, 2013). The good news is that multicultural training for mental health professionals significantly improves service delivery and treatment outcomes for diverse clients (Griner & Smith, 2006; T. Smith, Rodriguez, & Bernal, 2011).

Multicultural competence should be front and center as an essential component in learning to conduct clinical interviews. You'll hear this message repeatedly in this text. We repeat this multicultural message because it's a message that's surprisingly easy to forget. Similarly, achieving multicultural incompetence is far easier than achieving multicultural competence. We hope you'll join us on this more difficult road.

Four Principles of Multicultural Competence

Culture is ubiquitous. All humans are born to families or individuals embedded within a larger community and cultural context (Matsumoto, 2007). The membership, values, beliefs, location, and patterns of behavior within this community are generally referred to as *culture.* In this way, culture can be understood as the medium in which all human development

takes place. From a mental health perspective, answers to such questions as "What constitutes a healthy personality?" or "What should a person strive for in life?" or "Is this person deviant?" are largely influenced by the clinician's and client's cultural backgrounds (Christopher, Wendt, Marecek, & Goodman, 2014).

Over the past 20 years, many professional disciplines have established multicultural principles to guide teaching, research, and practice. Specifically, all three primary nonmedical mental health disciplines (professional counseling, psychology, and social work) have articulated at least four common multicultural practice competencies:

1. Clinician cultural self-awareness
2. Multicultural knowledge
3. Culture-specific expertise
4. Culture-sensitive advocacy

We briefly define these dimensions now and return to them throughout this text.

Cultural Self-Awareness

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

Culture and self-awareness interface in several ways. Individuals from dominant cultures tend to be unaware of and often resistant to becoming aware of their invisible and unearned culturally based advantages. These "unearned assets" are often referred to as *White privilege* (McIntosh, 1998).

Developing self-awareness can be difficult, especially when it pertains to culture. One way of expressing this is to note, "We're unaware of that which we're unaware." When someone tries to help us see and understand something about ourselves that has been outside our awareness, it's easy to be defensive and resistant. Despite the challenges inherent in this process, we encourage you to be as eager for change and growth as possible, and offer three recommendations:

1. Be open to exploring your own cultural identity. It can be interesting to gain greater awareness of your ethnic roots.
2. If you're a member of the dominant culture, be open to exploring your privilege (e.g., White privilege, wealth privilege, health privilege) as well as the sometimes hidden ways that you might judge or have bias toward minority populations (e.g., transgender, disabled).

3. If you're a minority group member, be open to discovering ways to have empathy not only for members within your group but also for other minorities and for the struggles that dominant cultural group members might have as they navigate the denial and guilt sometimes associated with increasing cultural awareness.

Multicultural theorists and experts believe that increasing cultural self-awareness is a precondition for moving from an ethnocentric, culturally encapsulated perspective to a truly multicultural orientation. Understanding other perspectives will help you avoid imposing your own cultural values on clients (Christopher et al., 2014). Multicultural Highlight 1.1 includes an activity to stimulate cultural self-awareness.

MULTICULTURAL HIGHLIGHT 1.1: EXPLORING YOUR CULTURAL BEING

The first multicultural competency focuses on self-awareness. D. W. Sue, Arredondo, and McDavis (1992) expressed it this way:

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

For this activity, you should work with a partner.

1. Describe yourself as a cultural being to your partner. What's your ethnic heritage? How did you come to know your heritage? How is your heritage manifested in your life today? What parts of your heritage are you especially proud or not so proud of? Why?
2. What do you think constitutes a "mentally healthy" individual? Can you think of exceptions to your understanding of this?
3. Have you ever experienced racism or discrimination? (If not, was there ever a time when you were harassed or prevented from doing something because of some unique characteristic that you possess?) Describe this experience to your partner. What were your thoughts and feelings related to this experience?
4. Can you identify a time when your thoughts about people who are different from you affected how you treated them? What beliefs about different cultural ethnicities do you hold now that you would consider stereotyping or insensitive? (C. Berger, personal communication, August 10, 2012).
5. How would you describe the "American culture"? What parts of this culture do you embrace? What parts do you reject? How does your internalization of American culture affect your definition of a "mentally healthy individual"?

At the conclusion of this activity, reflect on and possibly make a few journal entries about any new awareness you have about your cultural identity.

Multicultural Knowledge

Cultural self-awareness is a good start, but not enough. Cultural competence includes actively educating yourself regarding diverse cultural values, behaviors, and ways of being. It's not appropriate to be passive in this professional domain. It is also not acceptable to rely on clients to educate you about specific minority issues.

To help with your accumulation of multicultural knowledge, we've included multicultural highlight boxes and coverage of specific diversity-related issues throughout this text. We've also included outside resources focusing on multicultural knowledge in the Suggested Readings and Resources section at the end of every chapter.

Reading to acquire diverse cultural knowledge is a useful but limited approach. To become multiculturally sensitive and competent, you'll also need experiential learning. We recall an interaction that occurred at a recent grief conference that illustrated this limitation. During the conference, there was a question-and-answer period with a panel of local Native Americans. At one point, a White participant posed this question: "As a White person, how can I better understand and relate to Native American people?" One of the Native American panelists quickly quipped, "Get some Indian friends!" Laughter ensued, some of which probably stemmed from discomfort. But her message was delivered—along with what she referred to as Indian humor. As the discussion progressed, she continued to advocate for experiential cultural learning:

> If you want to understand us, you'll need to spend time with us. You can read about pow-wows and Indian fry bread, but if you really want to experience Indian culture, you'll need to attend a pow-wow, actually eat the fry bread, and reach out to make Native American friends.

The more diverse interviewing, supervision, and life experiences you obtain, the more likely you'll be able to develop the broad knowledge base needed to understand clients from their own worldview and experience (D. W. Sue & Sue, 2016).

Culture-Specific Expertise

Culture-specific expertise speaks to the need for clinicians to learn skills for working effectively with different minority populations. For example, learning the attitudes and skills associated with affirmative therapy is important for clinicians working with LGBTQ clients (Heck, Flentje, & Cochran, 2013). Similarly, integrating spiritual constructs into your work with African American, Latina(o), Native American, and traditionally religious clients is often essential (R. Johnson, 2013).

Stanley Sue (1998, 2006) described two general skills for working with diverse cultures: (a) scientific mindedness and (b) dynamic sizing.

Scientific mindedness involves forming and testing hypotheses about client culture, rather than coming to premature conclusions. Although many human experiences are universal, it's risky to assume you know the underlying meaning of your clients' behavior, especially minority clients. As Case Example 1.3 illustrates, culturally sensitive clinicians avoid stereotypic generalizations.

CASE EXAMPLE 1.3: HAND SHAKING NOT ALLOWED

A young woman from Pakistan was studying physics at the graduate level in the United States. She attended a departmental party and, by her description, "had a frightening interaction with a male graduate student." She was upset and decided to go to the campus student health service for supportive counseling. A male counselor met her in the waiting room, introduced himself, and offered to shake hands. The Pakistani student shrank away. The counselor noted this, thinking to himself that she either was shy or had issues with men. As the student shared her story about the rude male student at the social gathering, the counselor considered the possibility that his hypothesis about her having "men issues" was correct, but he didn't come to that conclusion. Instead, he remained open to both possibilities and eventually concluded that her behaviors had more to do with her religion than issues with men.

Scientific mindedness requires therapists to search for alternative cultural explanations before drawing conclusions about specific client behaviors. Without using scientific mindedness and exploring less commonly known and understood explanations, the counselor wouldn't realize that for a Muslim woman, it's not proper to touch a male—even to shake hands. Her shrinking away had everything to do with her religion and nothing to do with the incident she came to talk about.

This case illustrates the importance of scientific mindedness as a clinical interviewing principle and practice. If he had not practiced scientific mindedness, the counselor in this case might have inaccurately concluded that his Pakistani client had "men issues." She was in fact behaving in a manner consistent with her religious beliefs.

Dynamic sizing is a complex multicultural concept that guides clinicians on when they should and should not make generalizations based on an individual client's belonging to a specific cultural group. For example, filial piety is a value associated with certain Asian families and cultures (Chang & O'Hara, 2013). *Filial piety* involves the honoring and caring for

one's parents and ancestors. However, it would be naïve to assume that all Asian people believe in or have their lives affected by this particular value; making such an assumption can inaccurately influence your expectations of client behavior. At the same time, you would be remiss if you were uninformed about the power of filial piety in some families and the possibility that it might play a large role in relationship and career decisions in many Asians' lives. When clinicians use dynamic sizing appropriately, they remain open to significant cultural influences, but they minimize the pitfalls of stereotyping clients.

Another facet of dynamic sizing involves therapists' knowing when to generalize their own experiences to their clients. S. Sue (2006) explained that it's possible for a minority group member who has experienced discrimination and prejudice to use this experience to more fully understand the struggles of those who have encountered similar experiences. However, having had experiences similar to a client may cause you to project your own thoughts and feelings onto that client—instead of facilitating an empathic response. Dynamic sizing requires that you know and understand and *not* know and *not* understand at the same time. We will return to dynamic sizing intermittently in this text.

Culture-Sensitive Advocacy

There's general consensus that the dominant US culture consistently disadvantages, marginalizes, and sometimes oppresses minority group members. These discrimination experiences come in different shapes and sizes. For example, the Black Lives Matter movement in the United States is a response to repeated large-scale racial profiling and discrimination. While some individuals may argue about the intentionality underlying disproportionate shootings of African American youth, the existence of this discriminatory phenomenon is a shared reality.

Racial or minority discrimination also comes in smaller packages. One term for these smaller forms of discrimination is microaggression. *Microaggressions* are defined as

> the brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial, gender, sexual orientation, and religious slights and insults to the target person or group. (D. W. Sue, 2010, p. 5)

Microaggressions are "brief and commonplace" and occur in everyday settings. It's not unusual to see them happening on the street, in the grocery

store, at the movies (on and off screen), and anywhere else where individuals with diverse backgrounds interact. Here's an example:

> Three Latino males pull their car into a grocery store parking lot. As they get out of their vehicle, a 40-something White male makes eye contact, pulls out his car key, and pushes a button, automatically locking his car. For the White male, seeing the youth reminded him that he should lock his car. For the Latino males, this brief and commonplace behavior is viewed as a derogatory assumption that they're likely to break into unlocked cars.

Given that many minority clients probably experience intermittent macro- and microaggressions, clinicians need to be prepared to help clients deal with these discrimination experiences. Culturally sensitive advocacy has become a core multicultural competency (see Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2015). *Advocacy* is a process through which clinicians become aware of social or cultural barriers that clients face, and work with clients to constructively address these barriers.

Discrimination is disempowering. When minority clients experience discrimination, they may experience anger or sadness; they also may be at a loss for how to respond constructively. These experiences may involve government or institutional policies, employment situations, or interactions in schools and neighborhoods. For example, transgender individuals report a high frequency of being threatened in public restrooms. At minimum, clinicians need to display empathy for clients' discrimination experiences. Depending on clinicians' theoretical orientation, professional discipline, and other factors, it may be appropriate for them to take on an advocacy role within the context of a clinical interview.

CASE EXAMPLE 1.4: A CHRISTIAN COUNSELOR ADVOCATES FOR A BISEXUAL MALE

An openly Christian, conservative colleague (we'll call him Paul) who works at an inpatient youth training facility asked us to consult on a case of a young male who was exploring his bisexuality. The young male was also exploring his desire to be a "furry." Furry is a label that describes people who derive sexual satisfaction through role playing with other people—all of whom simultaneously play various animal roles. We imagined that Paul might be uncomfortable working with this young man. But instead, Paul was curious, open, and deeply invested in being an effective counselor and advocate for his client. There was no proselytizing and not a shred of evidence that Paul was judging the young man in any negative way. This example illustrates

that, using core attitudes of acceptance and empowerment, professionals with very conservative value systems can work with clients. We encourage you to stretch yourselves in ways that allow you to work effectively with a broad range of clients, as Paul did.

Multicultural Humility

VIDEO 1.6

To this point, consistent with the literature on multicultural counseling and psychology, we've been using the term "multicultural competence." However, we have reservations about this because it implies that clinicians can reach a culturally competent end point. In fact, it seems that as soon as clinicians grow too confident in their abilities to relate to and work with diverse peoples, they often lose their cultural sensitivities. We agree with Vargas (2004), who expressed similar concerns:

> The focus on cultural competence also worries me. I very much try to be culturally responsive to my clients. But can I say that I am "culturally competent"? Absolutely not! I am still, despite my many and genuine efforts, "a toro (bull) in a China shop" with all the cultural implications of this altered adage intended. (p. 20)

For these and other reasons, we prefer the terms *multicultural sensitivity* and *multicultural humility* and refer to multicultural competencies with reservations (Stolle, Hutz, & Sommers-Flanagan, 2005).

Over the past decade, researchers and writers have begun making distinctions between cultural competence and cultural humility. Cultural humility is viewed as an overarching multicultural orientation or perspective that mental health providers may or may not hold. It springs from the idea that individuals from dominant cultures—or any culture—often have a natural tendency to view their cultural perspective as right and good and sometimes as superior. This tendency implies that attaining multicultural competence isn't enough for clinicians to be effective with culturally diverse clients. Clinicians need to be able to let go of their own cultural perspective and value the different perspective of their clients (Hook, Davis, Owen, Worthington, & Utsey, 2013).

Three interpersonal dimensions of multicultural humility have been identified:

1. An other-orientation instead of a self-orientation
2. Respect for others and their values and ways of being
3. An attitude that includes a lack of superiority

Cultural humility is closely aligned with multicultural competence, but is not the same thing. It's generally presented as a supplement to multicultural competence. It has its own research base and appears to independently contribute to clinician effectiveness. In a recent research study, when clients viewed therapists as having higher levels of cultural humility, they also endorsed higher ratings of the working alliance and perceived themselves as having better outcomes (Hook et al., 2013).

Why Stereotyping Is Natural, but Inadvisable

Human brains are designed to organize and make sense of the apparent chaos and disorganization in the world. One process through which this happens is categorization, which involves abstraction and generalization. Examples of abstract generalizing abound. There are categories for fruits, vegetables, furniture, geographical settings, animals and breeds of animals, musical genres, trees, clouds, and, of course, people.

Humans naturally organize other humans into ethnic or cultural groups. This process can provide useful information. No doubt, evolutionary psychologists would claim that this "hard-wired" tendency exists due to its survival value. Generally, individuals perceived as similar to ourselves are judged as safer, and those who appear different may be categorized as dangerous.

Here's a simple stereotyping example: Many people think of Italians and Italian Americans as expressive and emotional. Knowing this general information can explain your experiences when attending a big family dinner with your Italian roommate. Interestingly, depending on your personal history and current attitudes, even if you have a stereotypical Germanic stoic demeanor, you may find yourself drawn to Italian culture. Alternatively, you may feel an aversion toward the full-on traditional Italian experience and avoid it whenever possible.

However and unfortunately, generalizing your knowledge of your Italian roommate and her family across all Italians is the foundation of stereotyping. This is where S. Sue's (1998) dynamic sizing comes into play. You may conclude that everyone with an Italian heritage is emotionally volatile. This might be based exclusively on your single experience from that one night with your Italian roommate's family. Or, as is often the case, you might take that single experience and add it to your preexisting ideas about Italian Americans, and end up with a firm and general stereotype. This involves moving from a concrete, situationally specific description (i.e., my friend's family behaved in ways that were gregarious and emotionally expressive on the night of my visit) to an abstract and general description (i.e., all Italians are gregarious and emotionally expressive). This generalization can easily

be fused with positive or negative attributions (i.e., I love the expressiveness of Italians vs. I hate the emotionally volatile nature of Italians). Finally, although these descriptions and assumptions may operate in ways that seem mostly harmless, when, as a professional, you sit down to meet with an Italian American immigrant and she turns out to be quiet, shy, and emotionally stoic, your broad stereotyping assumptions can quickly break down. Even worse, you may feel compelled to make her fit your Italian American stereotype—even if she doesn't. Alternatively, if your assumptions are correct, you may marginalize or oppress your client with your beliefs when, as she works herself into an emotional explosion, you think to yourself, "She's just showing her Italian side."

To extend this example, imagine if we had used one of the following minority groups to illustrate stereotyping and dynamic sizing. As you read this list, linger on the different cultural groups and focus your awareness on your personal thoughts, feelings, and potential stereotyping in response to each group:

- Inner-city Black youth
- Inner-city White police officers
- Females whom you might describe as "Southern Belles"
- Rural Wyoming ranchers and farmers
- Gay males
- Ex-gay males
- Lesbian women
- Transgender females (male to female)
- Conservative Christians
- Liberal, contemplative Christians
- Muslims
- Mormons
- Atheists
- Jews
- Buddhists
- All First Nation peoples (aka Native Americans)
- Navajo Indian Americans
- All Latina(o) people
- Puerto Ricans
- Dominicans

- Cubans
- White South Africans
- Black South Africans
- All Asian people
- Chinese
- Japanese
- Hmong (Laotian)

Stereotyping may occur because of natural tendencies to categorize and generalize, and it may be more or less universal; nevertheless, allowing stereotypes to inform your interpersonal relationships or clinical work is inadvisable. Your goal is less about eliminating all stereotyping tendencies and more about continuing to work on self-awareness so that you can apply the multicultural skill of dynamic sizing in constructive and helpful ways with clients.

Summary

The clinical interview is the most fundamental component of mental health training in professional counseling, psychiatry, psychology, and social work. It has its roots in a procedure that Piaget termed the semi-clinical interview. Piaget was interested in combining standardized and spontaneous questions as a means of assessing children's cognitive abilities. The tension between standardized and spontaneous approaches to clinical interviewing remains alive today.

Clinical interviewing is a complex and multidimensional process. It comprises two primary functions: (a) assessment and (b) helping. All clinical interviews involve a professional relationship between client and service provider. Clinicians use information obtained in an initial clinical interview to develop case formulations and treatment plans.

Clinical interviews are usually classified as assessment procedures. However, the complete range of skills and procedures used during longer-term counseling or psychotherapy may occur during a single clinical interview, and some professionals refer to any single psychotherapy session as a clinical interview. Also, at any point in the midst of psychotherapy or counseling, clinicians may shift into a more focused assessment procedure, such as a suicide assessment.

Clients are motivated to seek professional help for a variety of reasons. Whatever the reasons and level of motivation, clinicians should recognize and respect that their clients are the best experts on themselves. One way

this is accomplished is by using a collaborative goal-setting process with clients during a clinical interview.

This book is organized to emphasize a learning model that comprises the following steps: (a) quieting yourself and listening well, (b) adopting a helpful and nonjudgmental attitude toward all clients, (c) developing rapport and positive therapy relationships, and (d) learning diagnostic and assessment skills.

Developing cultural competence is a central foundational principle for contemporary mental health practice and clinical interviewing. Four principles of multicultural competence are self-awareness, multicultural knowledge, culture-specific expertise, and culture-sensitive advocacy. Although not considered one of the multicultural competencies, multicultural humility is an attitude that is independently related to positive therapy outcomes.

Suggested Readings and Resources

The following resources provide a useful foundation for professional skill development and multicultural sensitivity.

Cormier, L. S., Nurius, P. S., & Osborn, C. J. (2017). *Interviewing and change strategies for helpers: Fundamental skills and cognitive-behavioral interventions* (8th ed.). Boston, MA: Cengage. This excellent text is similar to *Clinical Interviewing,* but has a stronger cognitive-behavioral perspective.

Fadiman, A. (1997). *The spirit catches you and you fall down: A Hmong child, her American doctors, and the collision of two cultures.* New York, NY: Farrar, Straus & Giroux. This book explores clashing cultures within the context of medical treatment. It contrasts the differences between a Hmong family's cultural beliefs about illness as compared to the contemporary medical paradigm.

Finn, S. E., Fischer, C. T., & Handler, L. (2012). *Collaborative/therapeutic assessment: A casebook and guide.* Hoboken, NJ: Wiley. This book applies the principles and practices of collaborative or therapeutic assessment to specific cases. Even if you don't read this whole book, you should go online and read Fischer's description of how she developed her interest in individualized and collaborative assessment.

Fischer, C. (1994). *Individualizing psychological assessment: A collaborative and therapeutic approach.* Hillsdale, NJ: Erlbaum. Originally published in 1985, this work by Constance Fischer paved the way for greater sensitivity and collaboration in psychological assessment.

Hays, P. A. (2013). *Connecting across cultures: The helper's toolkit.* Thousand Oaks, CA: Sage. In this practical text, Pamela Hays offers many concrete examples of how clinicians can develop a strong therapy alliance with diverse clients.

Lee, C. (Ed.). (2013). *Multicultural issues in counseling* (4th ed.). Alexandria, VA: American Counseling Association. This edited volume has chapters on