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Unstructured Interviewing

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Clinical interviewing has occupied a long and extensive history as the basic clinical skill necessary for successful psychotherapy. Interviewing is the first step in the overall therapy process (i.e., interview, assessment, treatment, termination, and follow-up). Unstructured interviews are used to cover a broad range of possible data points for integration. Essentially, the clinician using unstructured interview techniques presumes that the most pertinent issues will present themselves spontaneously if an expansive net is cast over the client's mental processes, unhindered and uninfluenced by the therapist's preconceptions, perspectives, or assumptions. Access, to the fullest extent, to the real inner life of the client is the main goal. Spontaneity of responding is the key difference between *unstructured* and *structured* interview formats.

An unstructured interview format permits clients' mental processes and functioning to be revealed through their choice of words, meanings, and interpersonal styles. Presented with broad questions and given the opportunity to verbalize in any manner, the client's thoughts, memories, and feelings will emerge in a flow or stream of information. Spontaneous responses are especially important in this process, and every effort is made to obtain them. Interpretations of clients' spontaneous responses are used as indicators of their innermost feelings, thoughts, and values. To facilitate the appropriate interpretations it is important for the therapist to assume a particular stance or attitude. It is critical that the therapist avoid assuming that he or she understands completely a client's meanings and to maintain a position of openness and curiosity. The therapist's main role is to listen attentively and interpret the client's statements as clues to his or her general level of functioning, lifestyle development, interpersonal attitudes, underlying conflicts, and unresolved traumas. Observation of the client's nonverbal and verbal behavior is extremely important (Sullivan, 1954).

All interview formats have precise elements that structure the interview and subsequent outcomes. The setting, time constraints, and skill levels of the participants affect the quality and the flow of information. However, unstructured interview techniques do require an environment, an atmosphere, and attitudes that promote information collection. Every element must support the overall goal of collecting information in a manner that encourages the client to communicate freely, without distractions or inhibitions. From the very beginning of the interview, first impressions shape the ensuing relationship.

Unstructured interviewing is not synonymous with unplanned or unintentional interviewing. All clinical interviewing is defined and structured by both the therapist and the client.

Interviewing is inherently structured by the social norms of agreed-upon roles and the ensuing mutual understandings between the participants. Therapist-client interactions are also structured by the particulars of the therapy situation, such as the setting, time constraints, skill levels of both therapist and client, and purpose of the interview. In most situations therapists are expected to lead the interaction, guided by their theoretical orientation and level of training and experience.

Purpose

Interviewing styles, questions, and interactions follow from the purpose of the interview. An attorney has a very different purpose than an employer, a medical doctor, or a psychologist. Essentially, the purpose of any interview is to gather the necessary information to carry out some larger professional goal, such as diagnosis and treatment. Systematic information gathering allows an organized analysis, which is systematically integrated into hypotheses for diagnosis and treatment.

Theoretical Orientations

The primary elements of theoretical orientations, roles, expectations, settings, time limits, purpose and goals, and therapist skill levels determine the features of unstructured interviewing. Theoretical foundations provide the logical sequence of questions to ask and the plausible observations to be made to arrive at a working hypothesis about the problems to be resolved. Different orientations use some techniques that are the same or similar but place the focus of the inquiry on different aspects of the client's responses. The interview process follows naturally from these theoretical orientations toward the development of the treatment goals.

An extensive life history usually is a substantial part of the information that is gathered in most therapy approaches. Past life events and overall life development are considered crucial diagnostic aspects of current problems in functioning. History taking of symptoms usually is accompanied by perusal of the overall life development history, including social, educational, and economic development.

Psychodynamic therapies, including psychoanalysis, have long used unstructured interview methods. Beginning with Freud, therapists adopted an unstructured model of interviewing as a procedure designed to allow the client to freely report whatever seemed relevant. In psychodynamic interviews the focus usually is on past events that were painful and traumatizing, leading to symptom development, which form the basis for current problems with appropriate functioning. The psychodynamic therapist pays particular attention to the client's relationship history, beginning with parents, siblings, and extended family members. Observations of the transference, or the client's responses to the therapist, are part of the assessment of past significant relationships. The quality of relationships, from childhood to current adult relationships, is examined for evidence of enduring relationship distress and difficulties that are rooted in the client's early life history. As the interview proceeds the therapist listens carefully to the history of origins and onset of symptoms. It is presumed that the client's traumatic experiences were rendered bearable and managed through use of defense mechanisms that keep the traumatizing events out of conscious awareness. Eventually, connections are drawn between past traumatizing experiences and the client's patterns of malfunctioning. As the proper interpretations reveal these connections between past and present, the client reaches insight, or awareness of the unconscious motives determining dysfunctional behavior (Yalof & Abraham, 2005).

This unstructured, fluid process fit very well with humanistic approaches, such as Gestalt therapies, which are predicated on treatment goals involving awareness, understanding, and insight. However, there are some key differences from psychodynamic therapies. The Gestalt therapist is more focused on assessment of present interactions between therapist and client than on past life events and historical relationships. Through use of present-tense dialogue the therapist observes and analyzes the client's present patterns of experience and awareness. It is assumed that the present subjective experience not only is more available and accessible but also is the most efficient means of effecting change. As the dialogue proceeds the therapist observes the unfolding and cresting of inner processes along a continuum of sensation, excitement, action, contact, reflection,

and withdrawal. As patterned thoughts, feelings, and behaviors emerge the therapist empathizes with the client's present experience, attempts to understand phenomenological elements, and offers feedback. The client is then asked to reflect on his or her current experience and reconsider patterns of experience by engaging in an experiment. The experiment eventually leads to increasing awareness, followed by insight, leading to alternative conceptions and experiences (Woldt & Toman, 2005).

In cognitive and behavioral therapies the interview focuses on gathering specific symptom information and the specific factors maintaining those symptomatic behaviors. Interviews are not as fluid or as flexible because the focus is aimed at discovering and examining specific events, thinking patterns, and frequent behaviors. The interview also focuses on determining discrete environmental factors that reinforce and maintain dysfunctional behaviors. The client's past and current experiences and functioning are assessed to identify factors such as particular life events, developmental events, learning history, and cognitive schemas. Diagnostic efforts center on identifying current cognitive and affective precursors and environmental antecedents to problem behaviors. The cognitive therapist pays particular attention to the client's expression of underlying assumptions that motivate behavioral responses in a variety of possible situations. The behavior therapist focuses on past and present reinforcers of dysfunctional behaviors. Particular emphasis is placed on gathering a complete description of the target behavior, such as frequency, intensity, and duration. As the interview progresses the therapist formulates hypotheses about the factors causing and maintaining the target behaviors. Cognitive behavioral therapies are action oriented. The client is responsible for promoting change by monitoring, tracking, recording, and altering cognitions and behaviors. Motivation to sustain this change effort is achieved through the establishment of a strong, cooperative working alliance between client and therapist. It is also advisable to maintain and reinforce the quality of the working alliance by regularly soliciting feedback from the client about the therapist's ability to empathize with his or her concerns and problems. Usually the interview ends with the assignment of homework consisting of reading materials and behavior change practice instructions (Beck, 1995; Padesky & Greenberger, 1995; Truax, 2002).

The Initial Interview

The First Contact

First impressions begin when the first contact is made. If you have the services of a receptionist, be certain that he or she is well trained in receiving the general public with a tone that is welcoming and an attitude that is appropriate for greeting and informing people who are probably distressed and inquisitive. Rehearse the way the receptionist will answer the phone and take down information. Next, instruct the receptionist as to how to handle people in crisis and inform potential clients about scheduling appointments. Be certain that people are being received in a manner that is friendly and nondiscriminating with regard to race, gender, ethnicity, and other personal characteristics.

If you do not have a receptionist, then the greeting on your telephone serves that purpose. Your greeting informs potential clients about your attitudes and frame of mind as a professional as well as your availability. Greeting messages should be brief and positive in tone but not inappropriately cheerful.

The Setting

The interview format will differ depending on the clinician's practice setting. Interviews that take place in clinics, hospitals, community agencies, and campus counseling centers can all be quite different from one another. Clinical settings serving the general public differ from private practice settings in many fundamental ways. In public settings the information gathered is likely to be shaped by externally regulated policies that require collection of substantial amounts of personal data in a timeline format. For instance, a client file must contain information that is used to determine the client's appropriateness for treatment in that particular clinic. Information is then passed on to others in a chain of information gathering until a decision is reached as to whether to admit the client into treatment. Throughout the chain, specific increments of

information are recorded in the file until a clinician is assigned or the client is referred elsewhere. In accordance with state regulations for public clinics, policy usually requires a certain amount of information to be recorded within a specified period of time. An established format usually is used, with a series of questions to be asked at each step in the procedure.

In a private setting the clinician is free to select content that fits his or her theoretical leanings and the current legal and ethical codes of practice. For the most part, the intake process can be determined by the psychologist's own style of information gathering. The private practitioner is free to ask questions as they develop spontaneously within the procedure and determine the timeframe based on the client's willingness to divulge at various times during the process (Armstrong, 2000).

The setting shapes the all-important first impression that a prospective client develops. It is important that this impression be a positive one. These early impressions are part of the therapy relationship. In the same way that we create vital impressions of our early relationship with people the second we enter their home, the client enters the therapy relationship forming opinions about the therapist and the therapy relationship based on his or her reactions to the professional setting.

Before you receive a client it is always advisable to examine every inch of the office setting, including the waiting room, if there is one. Your office space should be easy to find, well lit and ventilated, and as private as possible, with no noises filtering in from the outside, and it should be clean and attractive. A common courtesy is to provide a box of tissues within easy reach of wherever the client is likely to sit.

Some accoutrements are important to avoid, such as art or pictures that are too suggestive or that depict content likely to elicit certain emotions. Avoid pictures of family, children, and spouses, so as not to advertise your happy private life. Natural color tones and textures, with some splashes of more vibrant colors, provide a soothing and inviting atmosphere. Avoid furnishings that are uncomfortable to sit on for long periods. An atmosphere of comfort and neutrality is likely to help clients relax and focus on their internal processes without distractions.

Personal Appearance

How you dress is very important. Clothes should be comfortable but not too casual (save the jeans for later in your relationship). Avoid any clothing that calls attention to your political stances. As with your office space, an attitude of neutrality is both freeing and soothing to the stranger who has entered your space for the first time. Avoid clothing that is flashy, trendy, exceedingly odd or peculiar, or expensive looking. Clients respond best to a professional person who conveys a sense of comfort, is easygoing, takes pride in his or her appearance, is able to assume the role of an authority figure, and is capable of adequate self-care. When in doubt, clothes that convey a neutral message, in keeping with the culturally determined expectations for a professional role, are the most prudent option (Weinberg, 1996).

The Interview Process

Two strangers enter a room and one person, designated as the interviewing professional, instructs the other and then begins to ask questions. The other person, designated as the interviewee, responds to the questions and begins to reveal deeply personal information, including personal problems experienced in their past and current life.

For anyone who has seriously attempted to study the context of the first interview, one thing stands out: It is an unusual situation. How does a stranger entice another stranger to reveal so much on their first meeting together? The answer lies in certain aspects of the situation itself. First, the strangers share a common understanding about their respective roles. Second, the stranger assuming the role of interviewer is presumed to possess a set of skills and a body of expertise. Third, the stranger in the role of interviewee can reasonably expect that the interaction will benefit him or her in someway. Fourth, the setting and roles provide a definition of professional purposes and outcomes. Finally, any professional interaction is presumed to be about something important (Sullivan, 1954).

The interview can be broken down into stages or phases. Put simply, there is a life span

quality to the process, featuring beginning, middle, and end stages. Each phase should be seen as one distinct aspect of the process, with its own planning and preparation.

Preparation

Careful and thoughtful preparation is the key to achieving the goals of the interview. The steps in preparation include clarity about the goals in each phase. In the beginning phase, two goals are equally important: Make a good first impression and establish sufficient rapport to encourage the client's openness and willingness to reveal personal information. In the middle phase the goal is to facilitate the gathering of enough information to begin the appropriate treatment or to make the appropriate referral. In the end phase the goals are to summarize information and close the interview. This should include some method for checking with the client to make sure the information and your understanding of its meaning are accurate and correct. Next, bring the interview to a close on a note that is proper for the kind of information that has been conveyed.

Before the interview begins it is advisable to review any information already known to you about the client. Establishing rapport should be planned according to cultural norms and expectations for respectful and proper behavior. Cultural norms of introduction can vary depending on ethnicity, age, gender, and marital status. Are you familiar with the differing norms? Do you know the proper way to introduce yourself and the task at hand with people from different cultural backgrounds? Will you need an interpreter? If so, make certain the interpreter is properly trained. Never use family members, especially children, as interpreters.

How did the client sound to you over the phone? How would you rate his or her degree of distress (high, medium, low)? Did the client sound especially anxious, cautious, depressed, or angry? Did the client seem more positive than negative, or the other way around? Was the client anxious to get an appointment? Was there a tone of desperation in the caller's voice? Was he or she experiencing a crisis? Will you need to do a risk assessment for possible harm to self or others? How and why was the person referred to you? Who referred the client, and how well do you know that referral source? These questions and answers are all part of the formulation of a first impression of the client, and some groundwork is laid for what to expect when we meet.

How much time is available? Normally, 50 to 60 minutes is needed to properly conduct an initial interview, and some clinicians prefer to schedule a longer amount of time than that. In this era of managed care many clinicians feel the pinch of time constraints on their billable hours and restrict their sessions accordingly. Make certain that enough time is available to achieve the goals of making a positive impression and establishing rapport. A timeframe that is too limited will give the impression that the client is not respected or valued or that his or her problems are not taken seriously.

Therapist's Attitudes and Personal Qualities

The interpersonal attitude that the therapist assumes during the interview greatly affects the process. Certain personal qualities are known to promote the establishment of rapport and enhance the gathering of vital information. The process is aided by attitudes of respect, openness, and curiosity. Respect does not necessarily mean agreement with the client or with things the client has done. Nor does it mean that we necessarily believe the client is "a good person." Respect means that we are meeting a stranger with a willingness to open ourselves to his or her point of view and offer assistance and understanding for his or her troubles.

The inevitable influence of personal values and biases is always an important consideration. Research shows that all of us are susceptible to the influence of biased preconceptions and attitudes. Different groups, regions, and age cohorts were raised with differing biases about differing groups of people. Personal life events can also create biased attitudes (e.g., in a therapist who was molested as child or treated badly by a member of a minority group). Recent research in bias shows that most Americans no longer espouse or admit to racist attitudes. Yet it is also evident from research conducted on unconscious cognitions that most of us still harbor biased thoughts and feelings.

Allowing ourselves to become aware of any prejudices we have is ethical, responsible clinical

practice. Next, it is necessary to determine, as honestly as possible, the impact of our biases on our clinical practice. In coping our biases and prejudices an ethical clinician strives toward identification, careful monitoring, and appropriate referrals, when necessary. An ethical and responsible therapist will avoid working with clients on whom they are likely to impose a biased frame of mind.

Attitudes of openness and curiosity may be the most important interviewer attributes. Good unstructured interviewers take pleasure in meeting and getting to know new people. It is an opportunity to exercise one's abundant curiosity. Who is this person? What has this person's life entailed? What is this person's world view? What interesting experiences has this person had? Who and what matters most? Comprehending the totality of this new person is a welcome challenge. A stance of openness and curiosity allows for the flow of information to take any direction and follow any path and promotes awareness of many possible characteristics of the client's unique personhood (McWilliams, 2004).

Anxiety and Safety

Both strangers enter the interview with a set of expectations, but neither can be certain that those expectations will be met. For that reason a certain amount of anxiety is always present when the first interview begins. Indeed, anxieties for both people begin before they actually meet one another. For both parties there is always the looming basic question, "Will we like each other?"

Therapists wonder about their competencies and abilities to perform well with a new client that they have never encountered before. Will I know what to offer and how to respond, or will I feel completely stymied, inadequate, and lost? Anxiety-provoking questions such as these tend to occur no matter how long the therapist has been practicing and how skilled the therapist is. Although certain anxieties are likely to be more prominent in the novice, there is always the possibility that a new client will evoke feelings of ineptitude and self-doubt in an experienced therapist (Morrison, 1995; Wiger & Huntley, 2002).

For clients there are even more intense anxieties having to do with trust. Is the therapist a kind, patient, understanding, and competent person? Will I feel respected by the therapist, and will I feel confident that the therapist has something to offer as a clinician? Am I wasting my time and money? What will I do if, after we meet, I do not feel good about the encounter, and how will I extricate myself? Maybe more important, there is anxiety about the potential power of an authority figure on whom the client wants to depend in his or her time of need. Anyone in such a position will have some fears that his or her own state of needfulness will create vulnerabilities that may prove to be liabilities. Many clients fear that their needs and emotions will become overwhelming and too intense for them to exercise sufficient self-control. Will they be able to protect themselves should the therapist be inept, too callous, or too controlling?

It is important to keep in mind that whatever the purpose or goals of a professional meeting, two people who are strangers to each other will each experience some amount of anxiety. Because anxiety cannot and should not be eliminated, controlling the amount and the source of anxiety is indicated.

To control inevitable anxieties the clinician should be aware of certain things. Careful monitoring of one's own anxiety offers important clues into our own and the client's functioning. Were there some indications on the phone that this may prove to be an especially difficult client? Are my anxieties signs of professional or personal shortcomings, such as an unacknowledged lack of expertise or the presence of personal biases? Am I ready to take on another client at this time, or should I accept the fact that my case load is already excessive?

Careful preparation and adherence to expected cultural and professional norms are indicated for the first meeting. Anxieties can be minimized for both strangers when the therapist maintains the usual cultural expectations associated with a professional interaction. It is also advisable to pace the first session slowly. Any questions remaining after that session can always be addressed in a later session. Do not try to eliminate anxiety by doing too much information gathering into the initial session, a mistake many novices make.

The Beginning Phase

The therapy process begins with the initial interview, which is used to provide an introduction to the process and to assemble the necessary

information that will guide the process. Most practicing clinicians would agree that the initial interview is structured to produce certain interaction effects that will affect the subsequent therapy work. By no means is the initial interview the only interview; interviewing as information gathering continues in some way or other throughout treatment, but the initial interview sets the crucial expectations for what is to come. In the initial interview roles are established, and the relationship is defined.

Receiving and Greeting the Client

The manner in which you greet your clients for the first time begins the all-important first impression of you as a therapist. Both strangers are socially obligated to make the best possible impression on the other. Generally, clients should be received in whatever manner is proper and respectful for their cultural group (Mishne, 2002; Tseng & Streltzer, 2004). If the client is within the same age range or younger, using his or her first name is acceptable, but if the client is much older, then it is advisable to use his or her last name. Some clinicians prefer to initially address all of their clients by their last names (e.g., "Hello, Mr. Smith.") and allow clients to make it clear that they feel more comfortable being addressed by their first name (e.g., "Call me Hal."). Typically, Hispanic and Asian clients should be addressed with some formality, using a title (i.e., Mr., Ms., or Mrs.), followed by their last name. If the interview is conducted with a couple or family unit it is usually appropriate to address the person who called to make the appointment first, followed by the other adults, then their children. For Hispanic and Asian families it is best to address the husband first and then his wife (e.g., "Hello Mr. and Mrs. Blank.").

Much research evidence shows that minorities, especially in public clinics, are reticent to reveal information to a strange White person. Research on racial matching continues to show mixed results. Yet evidence mounts that race of interviewer does play a role in the information gathered. That is, minorities tend to offer different information depending on the race of the interviewer (Hersen & Turner, 2003).

It is customary to shake hands at the first face-to-face contact. However, it is advisable to wait for clients to offer their hands first. Touch, no matter how slight, is probably the most powerful signal of intimacy, actual or expected, in any culture. Many clients have histories of abuse, both physical and psychological. Until a solid basis for trust has developed, it is always possible that any touch, no matter the intentions, can be misinterpreted, creating unnecessary anxiety and distress. Never touch a client until the relationship is well established, and then only in ways that are completely within the norms of a professional relationship.

If you have a waiting room you may have a short distance to walk to arrive at your office. The walk to the office area can be anxiety provoking for both therapist and client because it can impose an ambiguous relational mood. Resist the temptation to fill this relational void with any chatter about clients or their problems. Hallways are not private spaces, and it is not wise to give the impression that anything the client says is not completely confidential. If you must engage in conversation, now is a good time to ask whether the client was able to find the office and a parking space without too much difficulty. Save any more meaningful conversation for after you have entered your office and shut the door.

Setting the Frame and Structure

Once they have entered the office, therapists intentionally differ in what they do next. Some therapists tell the client where to sit. This releases the client from having to make a decision, which can be awkward in a stranger's domain. Furthermore, it prevents the added awkwardness of what to do if the client chooses the therapist's favorite chair. Another reason for telling the client where to sit has to do with the therapy method. Some therapy orientations require certain seating arrangements to achieve the suitable interpersonal connection, and some therapists prefer to exercise control over the therapy process, such as sitting in a position where only they can see the clock.

Some therapists prefer to tell clients, "Sit wherever you like," and offer a variety of available seating possibilities. This leads the clients to a decision, and the therapist can then observe how they make that decision. Do they move quickly and decisively? Or do they waver and wait for cues from the therapist? Do they assume their seat nervously, or do they behave as if they have been coming to your office for some time and already feel some ownership of the space? Will

they sit some distance from the therapist, or will they seek a chair that closes the distance? Do they prefer the chair as close to the door as possible, or will they enter into the inner recesses of the room?

Once seated, the therapist should begin the work of the interview. If you have not done so already, a polite inquiry as to whether the journey to your office was easy enough should be made. A brief introduction is now in order. What do you plan to do in this session? A brief overview can provide a sense of structure and give the relationship a set of clear expectations (e.g., "In this meeting I would like to begin by going over my treatment procedures and make sure that you understand your rights and responsibilities. Then I want to spend the rest of our time getting to know you and have you tell me about yourself and the reasons why you have come here today.").

Next it is expected that the therapist will introduce the necessary terms and conditions for treatment (e.g., fees), privacy rights including Health Insurance Portability and Accountability Act (HIPAA) documents, limits of confidentiality, and consent to treatment forms. It is wise to have well-written documents that can be read and discussed easily and quickly.

If you are taking notes it will become obvious when you lift pen to paper, but if you want to record this or other sessions, now is the time to get the client's permission. Note taking, especially in this first interview, is always advisable, and clients have come to expect it. However, do not allow note taking to interfere with the natural flow of emotions and information. Your attention should not stay too fixed on writing but on the client's attempt to be heard and to bond with you.

About 5 minutes is a reasonable amount of time to spend on these preliminary procedures. The therapist should remember that clients can be given copies of documents to take home and read at their leisure, and any questions raised can be addressed in the next session.

Some amount of anticipation has been rising between the first contact and the first interview, perhaps over a few weeks or a few months. It is not advisable to prolong the opportunity to let clients talk about the problems they are experiencing. During this interim anxieties are inevitably building, and people under stress often are anxious to get to the point.

Next it is customary to ask the client why he or she has come to see you. Several openings are acceptable. "Why have you come to see me?" is the simplest. Other possible opening questions include "What did you want to see me about?" or "What brings you here today?" At this point clients will begin to tell you about their problems and present the level of distress that they are undergoing.

The Middle Phase

The use of unstructured interviewing during the initial contact is intended to maximize the amount and depth of the information gathered and to establish rapport. Rapport creates a trusting bond between therapist and client and encourages the client to reveal information that he or she might otherwise prefer to keep hidden. Essentially, it is believed that the more the client reveals, the more effective and useful the therapy can be. During this phase the therapist should remain attentive to both verbal and nonverbal information, including interpersonal styles, speech patterns, and the degree of self-awareness as well as the content of the information revealed. The therapist's inquiry skill levels determines how well information is gathered and how well rapport is established.

Asking Questions

Asking the appropriate questions is the essence of unstructured interviewing. Different frames of inquiry facilitate different responses on the part of the client. Questions that encourage a range of possible responses are best. This method allows a richness of responses that can aid in understanding and interpretation of revelations at the deepest possible levels of meaning. Typically, the kinds of questions that expedite spontaneous and deeper levels of responding include *open, focusing,* and *clarifying questions.*

Open questions begin with words that encourage the client to conduct an extensive scan of their inner processes in order to provide an answer. Open questions usually begin with "What," "How," or "When," or a statement such as "Tell me about. . . ." For instance, the therapist asks, "What do you want to talk about?" or "How do you feel about your marriage?" or "Tell me about yourself." In response to any question clients must formulate an answer by first focusing on and scanning through their internally

organized environment, calling on their own unique processing. Open questions act as a projective technique to expand the boundaries of responses. Properly executed, open questions may prompt clients to respond in ways that even they had not expected, especially if they have never thoroughly considered the subject matter before.

Focusing questions ask the client to focus on a specific topic or some topic detail. A focusing question usually is phrased in the form of an open question but works to narrow the client's scanning toward specific content (e.g., "What was your childhood like?" "Tell me about your education background," "Who else is involved?" "How do you plan to deal with that?"). Focusing can help to fill in the details or allow a particular topic to be explored in more depth.

Clarifying questions ask the client to report enough specifics about a topic to eliminate vagueness or ambiguities that might hinder understanding or lead the therapist to make inaccurate assumptions. A clarifying question or statement has the advantage of making the topic and its meaning clearer to both client and therapist. Some examples of clarifying questions include "What do you mean by . . . ?" "Describe the last time you . . . ," Are you saying . . . ?" or "Give me an example of. . . . " Clarifying the subject expands the therapist's knowledge of emotional and behavioral patterns and conveys the therapist's intention to work toward as much understanding of the client's experiences as possible.

Open, focusing, and clarifying questions and statements achieve the goal of complex information gathering by opening up the inner world of experiences, emotions, values, intentions, needs, desires, and hopes. Conversely, some questions and statements should not be used because they tend to have the opposite effect. It is best to avoid *closed, leading,* and *why questions.*

Closed questions can be answered with a simple "yes" or "no" answer, limiting the range of responding. Closed questions usually begin with words such as "Are," "Did," "Can," and "Is" (e.g., "Are you happy?" "Did you want to come today?" "Can you tell me about your depression?" "Is it okay to ask you about . . . ?").

Leading questions suggest a right or desirable answer. The client may respond by providing it rather than responding more authentically. Some examples of leading questions include "Are you prepared to work hard to get better?" "Is it okay with you to take medications?" or "How well do you think this session went?"

Why questions often have the effect of imposing a demand to explain or justify one's choices and behaviors. Clients may feel they have been put on the spot and respond defensively. In any case, they may not honestly know the answer but feel pressured to provide some reply, whether it is genuine or not. Examples of why questions are "Why don't you talk about sex?" "Why didn't you deal with that problem?" or "Why did you allow that to happen?"

Keeping the Information Flowing

Keeping the information flowing is also the goal of good interviewing. No matter how skillfully executed, a steady stream of questions can have a detrimental effect on the interview. Constant inquiry can create an ambiance more akin to an interrogation than an interview. The absence of mutual connection hinders development of rapport and trust. The flow of questions should be interrupted and integrated with statements that allow the client to pause and shift the focus onto the therapist's capacity to understand and empathize. This can be accomplished by using *empathy, paraphrasing,* and *summarizing.*

Empathic statements and comments address the client's feelings, using feeling words that capture the emotional content of the client's verbal and nonverbal messages. Empathy conveys warmth, caring, and nurturance. It is also an indicator that the client will be taken seriously and his or her problems will be attended to respectfully. Clients tend to develop trust more quickly with the skillful use of empathy. They also tend to offer more personal information if the therapist has demonstrated his or her capacity for affective comprehension and compassion.

Paraphrasing comments convey that the client's messages and meanings have been heard and understood. The therapist essentially repeats what the client has said but uses different phrasing to avoid being redundant. These comments tend to help the client feel heard and inclined to continue talking. If the client says, "Why do I do these things? I wish I could stop," the therapist might respond with, "You feel worried and frustrated and want more control over your life."

Summarizing comments are useful tools in pulling a sequence of client comments together into a meaningful whole. Again, the client feels

heard but has the added sense that his or her comments have been processed at a comprehensive level, and the larger meanings are clear. Summarizing is also useful in unifying a list of complaints or concerns. This conveys that therapist has been attentive to all of the pertinent data, not just focusing on one problem or a single aspect of a problem. Summarizing can help a client clarify and keep track of his or her feelings and problems, instead of drifting in a state of confusion. Finally, summarizing can signal that the interview is drawing to a close, and the client will be encouraged to wind down and refrain from bringing forward new material.

Rhythms and Cadences

Every interview has a verbal tempo. Usually the interview begins at a slow pace as the client begins to feel connected to his or her feelings and a bond is formed with the therapist. As problems and complaints are drawn out into the open, the tempo and signs of tension tend to increase. The client often experiences increasingly powerful emotions, with a corresponding increase or decrease in his or her rate of speech. Typically, the tempo ebbs and flows as the interview progresses through different content areas. As the content becomes more sensitive, the therapist should take care to match the client's pacing as much as possible while continuing to make inquiries. It is usually better for therapists to pace inquiries too slowly, rather than too quickly, through sensitive and emotionally loaded content areas, to avoid causing the client to feel pushed or hurried along.

It is not uncommon for the interview to be punctuated by long pauses or silences. During these moments the interviewer should respond with appropriate matching of the mood. Many times novices are distressed by silence, believing that they have an obligation to fill these anxiety-provoking verbal voids by introducing topics or continuing to ask questions. This tendency is almost always a mistake and reveals more about the therapist's level of discomfort than the client's.

Silences can be quite appropriate and informative. The experienced interviewer learns to distinguish between different characteristics of silence. Some silences occur as the client turns inward to focus on sorting through a complex thought. Other silences denote the building of strong emotions that the client is struggling to restrain or control. Clients fall silent when their thoughts or feelings are difficult to express in words or when there are simply no words to articulate a powerful and momentous experience. If the emotional content is weighty and the client becomes silent, it is best for the interviewer to do likewise and wait for the client to resume talking. Therapist silence at such times conveys a respect for the client's feelings and prevents interruption of a significant inner process that may take some time to complete.

Different ethnic groups respond best to a verbal rhythm and tone that is familiar in their cultural experience. For instance, American Indians typically prefer a slower cadence and longer pauses than do European Americans. The right pacing for an American Indian interviewee is about half the speed suitable for European American cultural groups. A rate of speech that would be comfortable for an American from the East Coast, for instance, could be felt as rude and overbearing. Asian and American Indian cultures emphasize harmony and mindfulness, so a slower, lower, and softer tone of voice is also advisable.

Interview Content

Typically, clients are first asked why they have sought therapy. This is followed by the taking of an extensive life history and some assessment inquiries. The reasons for seeking therapy, or life problem experiences, should be explored using empathy and paraphrasing to form a trusting connection. Clarifying and focusing questions and summarizing are used to make sure the information is perceived accurately.

The Life History

The information from the client's life history forms the basis for later hypotheses about diagnosis and treatment. The interviewer seeks to gather enough information to formulate a picture of the client's past experiences, life patterns, life choices, symptom patterns, and overall life development. Apart from the *what,* or content, it also pertinent for the interviewer to pay attention to *how* clients report their history for clues to their interpersonal style and ability to tell a story that is cohesive and coherent. During this phase of the interview clients' verbal and nonverbal behaviors

express their overall ability to relate and their willingness to reveal.

The interviewer probably will begin by using an open inquiry (e.g., "Tell me about your life to this point."). From there the interviewer notices how the client proceeds. Does the client begin in early childhood and proceed from there to the present? If so, what does the client choose to tell us about, to emphasize, and to omit? What past experiences seem most relevant and important to the client? What past people and events have shaped the client's life, and what events have contributed to the client's problems? What happy themes does the client mention, and what setbacks, failures, and disappointments does he or she describe?

As the history unfolds the interviewer should be attentive to forming an impression of the person and his or her personality. The interviewer's curiosity should be activated. Is the client sociable and outgoing? Or shy and reticent? Does the client tell the story with feelings, values, and attitudes prominently displayed? Or does the presentation sound flat, like a recitation from the phone book? Is eye contact appropriate? Or is the client barely able to look at you? What messages does the client send through body language and postures? Does the client appear comfortable and at ease? Or does his or her posture express tension, disdain, and defensiveness? Does the client welcome talking about himself or herself? Is the client proud, self-deprecating, self-critical, grandiose, or balanced and realistic in his or her self-appraisal? What is the client's overall disposition or attitude about life? Is the client self-assured, hopeful, calm, and generally satisfied? Or, is it apparent that the client feels sad, angry, depressed, or despairing? Does the client have an appropriate sense of humor? Or does the client seem humorless, morbid, or bitter? Or does the client assume an inappropriate cheerfulness and gaiety about seriously painful and hurtful events?

Does the client speak slowly and clearly, or does he or she speak so rapidly that it is difficult to follow and take notes? Does the client respond straightforwardly and readily answer your questions, or does he or she respond with deflections, diversions, circumspections, and tangents?

Unless clients have rehearsed, either on their own or through many visits to a therapist's office, the history inevitably will be choppy and disjointed. Few people are able to give a complete account of a lifetime without some out-of-sequence or missing material. Furthermore, it is also likely, and quite common, for clients to censor some important material until trust has been better established. The interviewer should not expect to receive the whole story in the first interview. In later interviews the pieces will begin to fit together as deeper revelations emerge.

Within 50 to 60 minutes, depending on the client's mood and skill levels, it may not be possible to elicit more than the presenting problem and a brief life history. In most cases, however, the therapist should attempt to get as much pertinent overview information, with some key details, as possible. If time is limited, important information can be touched on briefly and rounded out later, but it is best to gather as much as possible in the first interview to lay the groundwork for a treatment plan.

Key information includes the client's date of birth, education history, employment history, marital or adult relationship history, children, friendships, and family of origin information including a description of parents, siblings, extended family members, and significant life events. It is also desirable to gather some information on alcohol and drug use, medical problems, legal problems, and any previous psychotherapy.

Assessment

At some point in the latter part of the middle phase, the interviewer should reflect on what he or she has ascertained that will guide and inform a preliminary diagnosis or diagnostic impression. Much has been learned at this point by careful and attentive listening and direct observation, but some specifics may still be needed. Are there signs of disorder? If so, the interviewer will want to get a detailed picture of symptom patterns. Most clients expect to be examined, to some extent, about behaviors that appear abnormal and usually are prepared to give in-depth responses to direct, diagnostically oriented questions.

A useful technique is to envelop each symptom in narrowing circles of history, influence, and impact. If the client shows signs of depression or despair, the interviewer should ask for an integrated symptom history (e.g., "As far back as you can remember, when did your depressed moods begin?" "How often have you felt depressed in the last year?" "On a scale of 1 to 10, how would you

rate the intensity of your depressed moods?" "What events triggered your depression?" "How has your depression affected your work, your marriage, your family, your social life, or your hobbies?" or "Have you ever felt suicidal, and if so, did you have thoughts of harming yourself, did you have a plan for hurting or killing yourself, or have you ever done anything to hurt yourself when you were depressed?").

Moreover, the interviewer should take notice of speech, thought, or behavior patterns that indicate any signs of severe disorder. If there are any signs of severe disturbance, such as loose associations, incoherence, chaotic confusion, paranoid ideations, or preservations, be prepared to conduct a mental status exam. Ask about specific symptoms, including unusual somatic complaints, loss of memory, hallucinations, or delusions.

The End Phase

Bringing the interview to a close or end point should be done with some forethought. Avoid abrupt or sudden shifts in content or connection. Abruptness can be interpreted as rudeness or a desire to be rid of the client. A good way to signal the approaching end of the interview is to begin to summarize what has been discussed and what has been learned. Then save time for the client to ask questions, if any, as a gesture of mutuality. Remember, the client has just spent nearly an hour submitting to the leadership and inquiries of the interviewer and might appreciate an opportunity to balance, somewhat, the relative power positions. Allotting time for the client to ask questions demonstrates an interest in and respect for the client's independent initiative and contributions. This phase is also the proper time to discuss follow-up issues, if any, and transitions into treatment.

When summarizing what has been discussed, keep the summaries brief and segmented. For example, "You want to deal with your depression, which you have felt for some time." Pause for a second and then proceed, "You have tried therapy before, but with limited success, and this time you want to be clear about how the therapy will help you, so we should discuss this in detail at the next session." Pause again, then, "I will give it some thought for next time. Is that it? Do I have it, do you think I get what you were saying?"

Once it is established that you and the client have had a meeting of the minds, if there are follow-up issues raise them at this point (e.g., "I would like you take some tests to get a better fix on the extent of your depression and go over the results with you next time," "I want to encourage you to get a full medical exam to rule out the possibility of any medical problems that might be contributing to your depressed moods," or "I want to discuss the possibility of a psychiatric referral to have you evaluated for possible medications that might help your depression.").

Next, some transition into therapy, if that is indicated, or a referral to a suitable therapist should be completed. A good way to segue is to ask what the client would like to accomplish in therapy and determine whether the client is suitable for the type of therapy you offer or is someone you would welcome working with. An open or focused question is useful for getting this information. Some examples of useful questions are, "If we worked together in therapy and the therapy was successful, how would you and I both know that our work was successful?" Or, "What would tell you that our therapy work has succeeded?"

When the client is invited to ask questions it is advisable to be prepared for what might be asked. Generally speaking, honest and frank responses are appropriate to establish trust. Most clients can sense when the therapist is hedging or fabricating. If you are not sure what to answer or how to answer, it is best to admit that is the case. If you feel pressured to make promises, be advised that one common mistake, especially for novices, is to overpromise. "I don't know, I will think about it" is always preferable to making up answers to questions when you actually don't have a good answer.

When time is up, a simple statement will suffice to bring things to an end. "I'll see you next time," or "Our time is up for today." Many therapist find it hard to bring their sessions to a close, especially if the client has experienced intense emotions; they think it is imperative to allow the client time to calm down before stating that the time is up. Some clients seize on this empathic courtesy to extend the therapy time. Instead of reaching a calmer point, other continue to emotionally escalate. Some clients need to know that they are expected to leave at the end of the appointed time, and a gentle but firm expression that "it's time to leave" can help them learn to focus and modulate their feelings to fit within the allotted time.

At the end of the first session it is a common courtesy to escort the client back to the waiting area, elevator, or door. Many people fell some amount of disorientation after an emotionally intense experience. Helping them back to the point of origin often is helpful. A final statement such as "It was good to meet you" serves as an appropriate parting.

Case Example

The first contact with Susan H. (not her real name) is by phone voice message. She states her purpose very clearly: "This is Susan H., calling on Tuesday morning. I was referred to you by Dr. M. for some therapy. I would like an appointment. I can be reached at (phone number). Please return my call. Thank you." Her voice is clear, her speech is precise and well organized, but there is also a hint of stiffness and sadness or depression. She sounds pleasant but cautious. When she is reached via a return phone call, she says, with some slowness, "I was hoping to get an appointment to see you. I have been feeling in a rut lately, and my doctor thought therapy might help." She asks what times I have available but then suggests a timeframe when she is most available. The appointment is made, and I tell her how to find my office, including where to park, what floor, and the location of the receptionist and waiting room. Her response is affirmative.

My first impressions are forming. She seems to be a thoughtful person with good planning abilities. She also seems depressed but with her emotions well controlled. She is probably Caucasian and well educated. What does she mean by "in a rut"? How depressed is she? Is "a rut" her polite euphemism for "depressed" or "desperate"? There is no mention of symptoms that sound serious or unfamiliar to me as a clinician. I do not remember the doctor who referred her, but I do remember giving a talk to a group of physicians a few months ago. What did her doctor tell her about me? What did I say in the talk that made the doctor remember me? My own anxiety levels are low. My general sense is that she will be an interesting and comfortable client with whom to work.

Our appointment is for 5:00 p.m. the next Tuesday. At 4:45 p.m. I go to the receptionist to tell her that I am expecting a new client at 5:00 p.m. and to buzz me when she arrives. The receptionist says, "She's already here, in the waiting room." She is early. Why? Is she anxious to see me? Entering the waiting room, I see a nice-looking Caucasian woman, probably in her 30s, reading a magazine. She looks preoccupied but comfortable. She is used to this type of environment. As I approach her and introduce myself, two things become readily apparent. One, she is impeccably dressed in a manner that suggests a business or professional career life. The clothes are well chosen for her height and build (both within normal range); color tones are natural hues, with some brighter colors in her accessories. Her shoes are flat and sensible. Her hair and makeup are casual but studious looking. As she rises to greet me, she is pleasant but smiles only slightly; she gathers her things and does not offer her hand. This is a no-nonsense interpersonal approach. She intends to be amiable but get down to business.

Entering my office, I instruct her to sit where she likes. She chooses a comfortable proximity that conveys an appropriate level of intimacy and deference for the first meeting. Her movements are decisive; however, she seats herself in a somewhat heavy way, suggesting that she feels tired or burdened but resigned to the weighty decision to see a therapist. There is now a hint of anxiety and vulnerability. She is anxious to see how this will go. I take this as a good sign. A certain resistance has begun, indicating her awareness that she feels vulnerable and insecure but able to mange these anxieties. She anticipates the possibilities of opening her vulnerable self to a stranger, which suggests that on some level she is willing to do so.

I ask whether she found the office easily, but I am aware that small talk will feel frivolous to her. I sense a need in myself to form a connection as soon as possible, perhaps to alleviate her intensifying anticipations. I make a quick but considered decision to wait for a while before introducing treatment documents and confidentiality issues. I move rather quickly to business. "So why did you want to see me for therapy?"

"Don't you want me to fill out forms?" I reply that that can wait a bit. "Thank God. I was in no mood to do all that right now." She then talks about feeling too down lately to function well. She has trouble sleeping and feels tense and low in energy. I ask, "So are you depressed?" She sinks into her seat and considers the question, then says, with much hesitation, "I guess so, I suppose I am." I now have the sense that she is very emotionally

constricted, perhaps too much so. She prefers to put her emotions aside and think her way through her problems rather than letting her emotions guide her. Are her feelings threatening to her? I continue, "Tell me about what your life has felt like lately."

She begins a description of mood problems and burdens at work, and a sense of alienation becomes apparent. She works as an administrator in a law firm and is struggling to keep up with the workload and high performance expectations. She states that her marriage is supportive. She has three children: a son aged 8, and another son aged 11, and a daughter who is 13. Her voice is now stilted and monotone, her rate of speech is slowing, and she seems to be withdrawing into herself. It crosses my mind to wonder whether she is angry. Then she admits that she has had trouble getting out of bed in the morning, and some evenings she goes straight to bed after work, and her husband and children have become worried about her. She states, "Sometimes I worry that I just can't do it anymore, it all feels like I'm on the brink of collapsing." I make two mental notes. First, her tone suggests more marital dissatisfaction than she has admitted to, so I need to know more about her family life, especially the quality of her marital relationship. Second, I must get more detailed information about the extent of her depressed mood and possible suicidal ideations.

Moving into life history information, I ask her, "Tell me about your life, starting with your childhood." I am aware of being anxious to hear this information; I anticipate that her history will provide clues about the origins of her depressive symptoms and emotional style. I am also beginning to get the feeling that she has a history of social alienation and loneliness, and I wonder whether her life story will confirm these impressions.

She tells her life story in a well-organized, linear fashion. She offers a good amount of detail. As I take notes, I notice she paces herself at a speed that is expeditious but comfortable enough for me to write down her story. I wonder whether she has been in therapy before.

Susan did indeed grow up a lonely only child. She was studious, well behaved, and responsible and worked hard in school to excel. She was also passive and shy. She had some difficulty making friends. She kept to herself a lot and spent much of her time alone in her room reading. Her mother was abusive and distant. Her father was warm and sympathetic but submissive to his wife and was absent a lot working. As she tells her story I offer some clarifying questions (e.g., "What did your mother say to you?"), some focusing questions (e.g., "When did you first notice that?"), and summarizing. I feel my own sympathy for her growing. Given her business-mindedness, however, I keep my empathic statements limited to an occasional comment such as, "That must have been hard."

As can happen in any interview, I make a few mistakes. When she talks about an argument between her parents, her mother had said her father was "hopeless." I ask, "Did she mean she thought he was inadequate as a husband or a provider?" She stops and then starts and then stops again, struggling to formulate an answer. Obviously, my question is badly phrased and causes her to feel confused and frustrated. I interrupt her and state that I know it was a badly formed question and rephrase it to ask, "What did you think your mother meant?" After a pause she answers that she thought her mother had never appreciated her father and was inclined to nag and criticize him. She then proceeds in an even rhythm and flow; she seems to feel increasingly at ease and safe.

She begins to talk about her parents' marital problems, which reached a crisis point when she was 13. Her father threatened to leave, and a divorce seemed imminent. I ask, "So what happened next?" She answers, "My Dad broke down and decided to stay. They are both still living and will obviously be with each other until one of them dies. I may have been disappointed actually, that they didn't divorce. It was very hard living with my mother; it was hard on both of us [implying her and her father]. I left home to go to college at 18, and I will never go back." I wonder again about her anger, and because her own daughter is now 13, I wonder again about the state of her marriage.

Moving forward, she describes life in college and the first time she fell in love. She was far too shy and socially unskilled to make any approach or to respond well when he approached her, so the young man never knew how she felt. She met her husband at a time when she was ready to leave home forever. She describes her husband as intelligent and compassionate and a very responsible father. He enjoys the children and spends a lot of time with them. They rarely fight.

Nor do they tend to socialize with friends or other couples. Vacations are also rare because of their heavy work schedules.

I ask a focusing question: "How would you rate your sex life?" She hesitates in her thoughtful, perhaps censoring manner before answering, "Its okay, it's all right, there are no complaints." This response raises further questions in my mind. I get the impression that her marriage is definitely not as satisfying as she would like. Is there is a "sedate" relationship pattern lacking some important qualities, with tensions building underneath the surface? How much time does she spend with her children? Are there difficulties for her relating to them? Does she ever enjoy herself in any aspect of her life? What about her job? What are the causes of her distress at work? Considering the time remaining and confident that we have made an optimal connection to one another, I decide to shift into a semistructured format to obtain more details about her depression symptoms.

I begin by asking for a specific history of her symptoms: "When, as far back as you can remember, were you aware of being depressed?" She replies, "When, I guess since childhood, although I wasn't always clear about that fact. Sometimes I'm okay. But, no, before you ask, I've never thought seriously about killing myself." I am relieved, and I believe her, but I do want to know about key times and events when depression might be triggered, how she behaves when she is depressed, what has she tried in the past to relieve her depression, and so forth. It is advisable to tell her that we will both carefully monitor the severity of her depressed moods, and if she becomes suicidal we will consider a number of options to prevent a suicide. I now tell her that I want her to take the Minnesota Multiphasic Personality Inventory 2 and will be referring her to see a psychiatrist for an evaluation for medications. She agrees readily to both proposals, another clear sign that our connection is working well.

Next, questions designed to fill in the data are asked. I inquire about her date of birth, medical history, substance use, and any abuse history. Nothing remarkable is reported. Some inquires can round out the life events picture (e.g., "Who are the most important people in your life?" "What events have made you the happiest?" "What was the worst thing that has ever happened to you?"). My assessment has led to hypotheses about her symptoms and personality. She is a high-functioning person with no signs of severe disorder. She is intelligent, responsible, and diligent. She shows signs of emotional constriction and social alienation. Her sadness and anger, along with other feelings, are deeply buried and rigidly controlled. She can be self-effacing, hard working, time conscious, and preoccupied with her demeanor and performance in a way that hint at perfectionist tendencies. There is a clear thread of family social isolation. Does she lack social skills, or does she find others so lacking that she prefers her own fantasies to actual human company? Is she obsessive or compulsive? In the next sessions I will pay more attention to perfectionistic strivings, perhaps leading to self-punitive tendencies, her work history and current work environment, and her feelings about her children.

Beginning the end phase, I ask whether she has had any previous therapy. She states, "Yes, for a short while in college, but I didn't like it. She was always late and her office was never clean!" Finally, she sounds angry and resentful, but it doesn't last. "No, I didn't stay because she was a million miles away sometimes; I didn't feel like she wanted to be bothered with me. No, actually, it was probably my fault, I just didn't know how to talk about myself back then, it was too hard to say what I thought or felt, so I really wasn't getting much good out of it." I make a mental note to avoid being late and to make sure that my office is never too cluttered. As for giving her the desired amount of attention and empathy, I am convinced that that concern has been satisfied.

Next, presuming that we will work together, I tell her it is time to go over the HIPAA and consent to treatment documents. She sighs but puts on her glasses and gives the materials and my overview spiel her full attention. I give her forms to sign and material to take home with her. I now ask, "So, say we have worked together and the therapy has been successful and we both know it has been successful, how would you know it has been successful?"

After a long and thoughtful silence she states, "I wouldn't feel so bad all of the time. I guess I would like a normal life, I mean. . . ." For the first time she looks away, breaking eye contact, and her voice breaks a little; clearly she is experiencing powerful emotions that she is struggling to control. After she composes herself she continues, "I haven't had much of a life really, I mean, I think other people have gotten more out of their lives. I would know it was successful

if I wasn't afraid to live a halfway happy life, a life that I wanted." I see the results of our successful connection in her candor and her willingness to let her painful feelings reluctantly come through. Although many more questions are raised, it is time to end the interview.

I say, "Well, it is time for us to stop. I will think about what you have just said. It was good to meet you. I will see you next week." Susan looks toward the clock, surprised that the time has gone by so quickly, which I take to be another good sign that we have made a good connection. She says, "Oh, so it is." Then she rises, gathers her things, declines to be escorted back to the elevator, pauses at the door, looks back, smiles, and says, in a sincere voice, "Thank you."

I am convinced that our first interview was successful. There are many more questions to be asked. I am curious about the rest of her life, beliefs, values, and feelings that we did not yet touch upon. I look forward to seeing her again, working with her, and learning more about her.

Summary

The unstructured interview has many advantages. One main advantage is the richness of information that ensues when client and therapist have the greatest possible freedom within which to operate. When the client is free to offer any possible perspective and the clinician can seize the moment as it arises to pursue any topic of clinical interest, information flows freely and naturally. Another advantage is that unstructured processes enhance the potential for depth of bonding between client and therapist, often leading to greater openness and trust.

Freedom of expression combined with ingenuity allows a process to develop that is an additional source of information. The interview is an interpersonal situation in which both the therapist and the client are engaged in a dynamic. This dynamic is a source of information about the client's interpersonal life and his or her preparedness for a therapeutic alliance. In a process that has been well planned and executed, attention is paid to the client's style of interacting as clues to disorders, resistances, and defenses that will become part of the therapy work. The client's verbal and nonverbal behaviors are then used to formulate a diagnostic impression that leads to a treatment procedure.

Client behaviors and responses to questions offer an expansive view of their personal and interpersonal development, skills, mental organization, and motivation levels. Despite careful planning and interview structures, both social and psychological, it is never possible to predict how things will unfold as two strangers interact. Once a connection has been made and the client is actively engaged in telling his or her story, it is impossible to know where the interview will lead. Therefore, it is wise to keep an open mind and learn from the process itself.

The unstructured format has important advantages but also some disadvantages. For many years unstructured interviewing was the primary format for gathering information pertinent to therapy goals and purposes. With the ascent of behavioral orientations, interviews needed to focus on specific symptoms and outcomes. In behavioral approaches sometimes the structured interview is found to be more suitable. Today, the relative merits of unstructured and structured interviews continues to be debated.

Some studies suggest that structured interviews work better when the goal is to arrive at a *Diagnostic and Statistical Manual*–oriented diagnosis. Structured interviews also tend to improve interrater reliability in settings that are intended for determinations based on specified diagnostic criteria, such as hospital emergency rooms. Other studies show that structured interviews reduce rater bias when used to gather information cross-racially. Structured interviews also appear to be more useful and reliable in employment decision making (Dougherty, Turban, & Callender, 1994; Huffcutt & Roth, 1998; Mantwill, Kohnken, & Aschermann, 1995; Miller, 2003; Orpen, 1985; Van Iddekinge, Raymark, & Roth, 2005).

Much depends on the purpose of the interview. If the main objective of the interview is a broad goal, such as getting to know someone, then unstructured interviews still offer the best method for achieving that goal. Unstructured interviewing techniques are designed to promote the emergence of information that may be known or unknown to the client. Certain aspects may be too threatening and are suppressed from the client's conscious awareness. Sometimes the client may not have associated different aspects of the problem as parts of the same problem. As the client engages in the unstructured interview, a process of discovery is shared by both parties.

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