PART II

Assessment Tools
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Alexandria arrived at our first meeting promptly, having greeted me with a business-like introduction that was polite and managed to convey that she was ready to get to work on the assessment immediately. Surprised at her eagerness, I invited her to sit on the sofa across from my chair, and we began our first conversation. Alexandria, a Caucasian woman in her early forties, had been referred for an assessment to help explain a lack of progress in her psychotherapy. For the first year of her therapy, she had continued to struggle with a paralysis of her work productivity and been forced to take a leave of absence from her job as an administrative assistant, eventually leading to her resignation.

Introductions already made, I shared with her what I had learned already about her from her therapist and discussed a little bit of what our work together might look like. I noticed how attentively and patiently she listened to me as I spoke, and even today I remember the way her eyes revealed the rapid pace at which her mind worked. She was quick, efficient, cool—almost unperturbed by feeling or worry—almost robotic.

As she spoke during the interview, I became distracted. Something about her was nagging at me. Listening a little more distantly, I looked more closely at her. I noticed how pristinely dressed she was, how well pressed her pants were—no wrinkles. I noticed they were pleated like a pair of men’s pants. Her shirt, upon second glance, now registered to me as a plain, long-sleeved cotton shirt with a turtleneck. Odd for this heat wave we’re living through, I thought to myself. Catching myself critiquing her fashion, I suddenly became aware of how unnerved I was that there seemed nothing feminine about Alexandria—no makeup, no perfumed scent, no purse, no jewelry. A scientific quality seemed to replace any sign of gracefulness, sensuality, or passion. I had become struck by what seemed to be an androgynous quality about Alexandria and was quickly suspicious that it might relate to her problem.
But immediately, I began to feel uneasy. How do I know these things I’m noticing might have anything to do with her problem? What exactly do my reactions mean, anyway? Am I unduly pathologizing a woman for presenting in this way, simply because she appears at variance with how women usually appear? Being myself a gay, white, cis male and having worked with so many LGBTQ clients, it was unlike me to be so rigidly concerned about a client’s gender presentation, and my concern made me uncomfortable, as though I was rediscovering the remaining vestiges of my own internalized homophobia and gender biases. Yet, there was something about what I was seeing about her that I couldn’t reconcile. Something important was going on here, but how to get to the bottom of it?

Surprisingly, assessment professionals do not agree on the relative value of the clinical interview and of the assessment data garnered from it. Some authors argue that the clinical interview—too subject to examiner bias and too variable in its execution across assessments and assessors—should be given little emphasis or weight in comparison to the quantitatively rich data of assessment measures (Craig, 2009). Others strongly argue that the clinical interview and its data should be given great importance and should comprise the core foundation of any psychological assessment (Groth-Marnat, 2009; Maruish, 2008). Others still point to the difficulty of integrating interview and test data, arguing that both data are derived from clients’ own subjective self-reports and thus vulnerable to distortion or inaccuracy (Machado, Beutler, Harwood, & Pratt, 2011). Despite such disagreements, there is no question that the clinical interview is, and will remain, a critical component of any psychological assessment, and for that matter, any introductory clinical effort with clients (Karg, Wiens, & Blazei, 2013).

However, very little has been written specifically about considerations of gender and sexuality in the assessment interview. This is somewhat ironic. Gender has been termed “omnirelevant” to human interactions, dictating some of our most fundamental understandings of people and our uses of language (Klein, 2011). Of gender, Brown (1990) states, “There are few other variables that are persistently present in the lives of humans and that cross all bounds of race, class, and place” (p. 13). Yet, surprisingly little has been discussed of these issues in the literature. Most writing about clinical interviewing is done for the purpose of training students and new professionals, and thus provides only broad overviews of formats and styles of interviewing, with very little attention paid to sexual orientation and gender. Writings on the pedagogy of clinical interviewing emphasize the teaching of global knowledge, skills, and attitudes, omitting discussion of how to instruct students to address important issues such as gender, race, class, and so on (i.e., Rudolph, 2005). With so little written about such fundamental aspects of clients’ identities, one wonders at how easy it is for important issues of gender and sexuality to hide in plain sight—right in front of us—in our conversations, our interviews, our measures, and in our interpretations, without perhaps ever looking for it, or ever finding it.
The identity variables of gender and sexuality, while interrelated, are often confused and conflated. Erroneously, practitioners may make generalizations or assumptions about one portion of a client’s identity based on the other; for example, assuming that a transgender man primarily experiences sexual attraction to cisgendered women. Such assumptions and confusions are results of cultural imperatives that have long taught us, falsely, that gender is the singular determinant of sexual orientation, that our biological sex determines our sense of gender, and that all of us belong to one of two fixed and uniform genders (see Chapter 1 for a more in-depth discussion of these points). Indeed, today we are in greater recognition that gender and sexuality are separate though related aspects of one’s identity, that they both are complicated and nuanced in innumerable ways and are critical to understanding one’s personality (Goldner, 2003; Harris, 2005; Hays, 2008; Nichols, 2011; Suzuki & Ahluwalia, 2003; Suzuki, Onoue, Fukui, & Ezrapour, 2012).

In this chapter, I pursue several goals. First, I will discuss the importance of the assessor in the clinical interview, detailing how evolutions in thinking about the nature of the assessment process now encourage us to consider how the personalities of assessors, including their own genders and sexualities, are inevitably relevant and influential in how assessment data are formulated and take shape. These newer, intersubjective (Finn, 2007) models of assessment have important implications for the clinical interview, most importantly that assessors must do more than ask questions in order to conduct an effective and responsive clinical interview. Second, I will review writings on gender and sexual orientation as they pertain to the clinical interview, further illustrating the importance of the assessor’s presence and role when with their clients. In reviewing these works, I will show how they similarly demonstrate that the conventional practice of using predetermined lists of questions is insufficient in ensuring that the assessor has given enough attention to issues of gender and sexuality during the interview—that asking questions alone does not ensure that what may be hiding in plain sight will be found. Third, I hope to offer some general recommendations and suggestions of topics and content areas that assessors might address in a clinical interview. I hope these goals benefit from the inclusion of clinical examples throughout the chapter.

The Interviewer’s Role: More Participant Than Observer

Assessors are increasingly recognizing the importance and influence the assessor has on clients, their experience of assessment, the interpretation of test data, and even the data gleaned from the assessment. Much of the current recognition can be traced back to important empirical investigations of examiner influence on testing data, where experimental methods demonstrated that assessors’ behaviors and attitudes, as well as clients’ reactions to the testing process, had observable, measured effects on assessment data and the assessment process (Fischer, 1970; Fiske, 1967; Hamilton & Robertson, 1966). While many such investigations were
conducted in an attempt to eliminate or reduce the influence assessors have on the assessment process, others, notably Fischer (1994), relied on these data to bring about a new, collaborative model of assessment that valued the formation of a relationship with clients over psychometric issues. Where before the assessor’s influence was considered removable or reducible, today there is increasing recognition that the assessor’s influence is inevitable; that is, attempts to try to fully eliminate the effect the assessor has on the assessment process are likely unproductive (Finn, 2007). Assessors are better positioned by accepting the inevitability of their influence and by attempting to understand and explore it.

This development in the assessment field parallels evolutions in contemporary psychoanalytic theory and practice, particularly within the writings of the relational psychoanalytic community (Aron, 1991; Harris, 2005; Hoffman, 1983; Mitchell, 1997). Relational psychoanalysts, heavily critiquing the theoretical and technical tenets of classical and American ego psychology theories, argue that technical ideals such as the therapist’s neutrality and objectivity are impossible standards that often alienate clients and elicit the very kinds of client resistances and defensiveness that were traditionally considered pathological. Today, relational psychoanalytic therapists acknowledge the therapist as an inevitable participant in the treatment relationship and whose very person and character has a role in determining the kinds of clinical data observed in the treatment relationship. As such, relational practitioners place high value in countertransference as a route to understanding clinical process and additionally suggest that therapists often become unwitting participants in enactments of clients’ interpersonal dramas in the treatment relationship. As relational therapists eschew objectivity as impossible, they continually question their subjective impressions and thoughts and often reveal them to their clients in the spirit of collaborative understanding.

Finn (2007), borrowing from one component of relational psychoanalytic writing, intersubjectivity theory (Stolorow & Atwood, 1992), recently described the kinds of consequences of adopting similar understandings for the assessment process. He wrote: “Assessors can never escape the influence of their own subjective views on their perceptions of their clients” and “one can never fully know the extent or nature of one’s contribution to an interpersonal context, although one can be open to and curious about such factors” (p. 244). Assessors, according to Finn, are continually bound by their own subjective ways of feeling, experiencing, and interpreting the world around them, and this has inevitable, and often unclear, effects on their work with assessment clients. It is important to add here that assessors’ subjectivity includes her own biases, anxieties, conflicts, and assumptions, and while assessors may possess considerable self-knowledge and insight, there is always the possibility that they come to appreciate something new and important about themselves, their clients, and their assessments, by continuous self-reflection and inquiry.

These changes in the conception of the assessment process challenge long-standing views of assessment as a procedure that is done to a client, as well as assumptions that the person of the assessor is irrelevant or unimportant.
Gender and Sexuality in the Interview

However, even today, such “one person” views can be found endorsed or evident in writings about the assessment process generally and even the clinical interview specifically. This is especially the case in the writings of authors who place diagnosis as the primary goal and purpose of the clinical interview (i.e., Rogers, 2003; Widiger & Samuel, 2009). One illustrative example can be seen in the work of Craig (2005). Of the clinical interview, he writes:

The conversation is focused on the patient and is often unidirectional. The relationship is primarily professional, and it is intimate only to the extent that personal material is conveyed with the expectation that such material is protected ethically and legally from evidentiary discovery (i.e. confidential).

(italics added, p. 21–22)

Craig’s view of the clinical interview is in stark contrast with collaborative (Fischer, 1994), therapeutic, and intersubjective (Finn, 2007) sensibilities. Craig’s description suggests that the examiner communicates little about herself, her attitudes or biases, or her character during the interview. This is a questionable proposition. As many clinicians have repeatedly noted (Aron, 1991; Hoffman, 1983; Silverstein, 2011a; Singer, 1965), almost every action taken by the assessor reveals something about her, however large or small. The decorations (or lack thereof) of her office reveal her tastes in art, or perhaps the members of her family. The manner in which she speaks and interacts with her client might reveal her mood that day or her level of enthusiasm for meeting with her client. The questions she asks reveals what she finds interesting, important, or worth additional inquiry. The questions she doesn’t ask reveal what is uninteresting, unimportant, or not considered—and so on. I would suggest, in keeping with Finn’s (2007) adoption of intersubjectivity, that the communication between assessor and client during the interview is bidirectional, though the explicit communication may be largely unidirectional. Clients are capable of observing assessors as closely as we are of them; and as we are able to notice their passions, predilections, and prejudices, so too are they of us. Many assessment professionals appear in agreement with this proposition. Lanyon and Goodstein (1997) acknowledge that assessor cues are often present in an interview and can dictate the outcome of the interview. Baker and Mason (2010) have specifically noted how an assessor’s biases are revealed through any variety of means, including nonverbal body language.

Second, and equally important, Craig’s (2005) description of the interview suggests that the intimacy of the interview is moderated by the client’s expectation of confidentiality. Although clients are more likely to disclose intimate details of their lives when they have the expectation of confidentiality, I would suggest that the most important moderator of intimacy during the interview is the extent to which the assessor is comfortable being with the client. Part of what assessors can unwittingly reveal about themselves during an interview includes how comfortable they feel with the client, having either encouraging
or suppressing effects on clients. Bandura, Lipsher, and Miller’s (1960) often-cited study of therapist reactions to clients’ hostility demonstrated that clients reserve important reactions and emotional expressions from therapists who implicitly communicate their discomfort with those same reactions.

These arguments show why thinking that the clinical interview is not intimate or that communication in the interview is unidirectional is problematic: When an assessor conceives of herself as simply an observer, there is little incentive for her to be in constant circumspection of reactions and participation with the client, and thus risks enabling patterns of interaction that actually suppress productive and useful dialog and/or alienate or trouble her client. She may never have reason, for example, to question if she is not asking enough about certain topics because of her own discomfort; or, conversely, question if she is asking too much about other topics because she finds them exciting or alluring. She does not ask if her client’s hesitation to respond is because of something disturbing to the client in their interactions or in the assessor herself—instead, the client’s hesitation registers only as defense, anxiety, or guardedness. Without this ongoing monitoring of self, client, and the interaction between, the interviewer runs the risk of losing so much important data and perhaps damaging the overall assessment. Indeed, some have proposed including such monitoring of self as a criterion for evaluating a student clinician’s ability to conduct an effective clinical interview (Rudolph, 2005).

Recognizing the influence of the assessor during the clinical interview is especially relevant to considerations of gender and sexuality. An assessor’s personal uncertainties, discomforts, generalizations, misconceptions, familiarities, and even expertise—concerning gender and sexuality or otherwise—can emerge in any number of ways during a clinical interview and thus influence the clinical process. Hays (2008) identified a framework useful to clinicians in trying to help them better understand both their clients and themselves. She suggests that clinicians utilize her ADDRESSING framework (see Chapter 2) to conduct a self-assessment that helps identify important aspects of the clinician’s identity, including gender identity and sexual orientation. This critical beginning stage involves asking oneself questions such as “How might my sense of my gender perhaps have left me unaware of how other people experience their own gender?” or “What if my sense of my gender were different? How would I feel about that?” Inquiries such as these create space for therapists and assessors alike to think more deeply about such issues and begin to contemplate how their own complex identities likely emerge and interact with those of their clients.

The importance of attending to the process of the clinical interview is a theme found in the existing assessment literature on gender and sexuality. As I move on to present these works, the theme of a mindful, active assessor who questions his or her personal biases, prejudices, and clinical activities will emerge as a consistent recommendation. The model of passive observer who reads questions from a list is discarded as insufficient; rather, assessors must acknowledge
they are participants in the interview and that the nature of their participation makes quite a difference.

Gender and the Clinical Interview

Much of the existing writing concerning gender and psychological assessment involves addressing gender bias. The first (and only) author to explicitly discuss gender with regard to the clinical assessment interview was Brown (1986, 1990). Brown (1986) first wrote about gender and psychological assessment generally, advocating that assessors conduct “gender role analyses” with each of their clients, in an effort to “enlighten the assessing clinician regarding the impact of her or his own biases regarding the meaning of gender-role-related behaviors” and to “aid in separating out gender-role-appropriate behaviors from psychopathology” (p. 244). Much of Brown’s concern regarded the potential for assessors to inappropriately pathologize behavior that contradicted prevailing societal and cultural understandings of gender; for example, she identified the possibility that women who are comfortable with conflict and exercising interpersonal power could be unfairly or inappropriately judged as evidencing “domineering” personalities (Brown, 1986).

She suggested that clinicians conduct a detailed inquiry into how clients developed their sense of gender and gendered behaviors, covering a wide range of topics about the context in which the client developed, including the following: family roles of women and men in the client’s family of origin, class backgrounds and education of parents, class and cultural difference between parents, wantedness of children, including the client, and how gender may have been variable in the wantedness of any given child (Brown, 1986). Part of what Brown hopes to learn in exploring these topics is how the client internalized and added meaning to each of these important contextual and developmental influences, including how the client came to attach meaning to gender. She suggested that assessors should “critically question and examine the meaning of gender roles, both in the culture in general and for a specific client” (p. 248), as a way to prompt assessors to widen their understandings of gender with each client with whom they work and to loosen themselves from their own gender biases.

In a second paper, Brown (1990) specifically addressed gender and the clinical assessment interview, reiterating her concern about the potential for assessors’ disowned biases to operate outside of their conscious awareness, possibly leading them to render unfair or overly pathologizing judgments about interview data. She elaborated her earlier recommendations, depicting the gender-conscious assessor as taking proactive steps to address bias and to conduct more thorough interviews. She suggested a series of “preassessment” steps assessors could take to prepare for their interviews, including familiarizing themselves with scholarship on gender and its relationship to clinical judgments of mental health, becoming knowledgeable about experiences that occur at higher base rates in one gender than another (i.e., domestic violence, sexual assault), and understanding
the impact of those experiences on the entire gender. In addition, she rec-
ommended that assessors, before conducting an interview, examine their own
conscious and unconscious biases and expectations regarding gender, a process
that might even include consultation and supervision from colleagues who are
known for or experienced in thinking about gender issues.

During the interview, Brown (1990) advocates for assessors actively inquir-
ing into clients’ meanings of their gender, including the meanings of gender
in their families and cultures of origin. She suggests exploring the changes in
the meanings of gender to the client over the client’s lifespan and inquiring
about the presence of gendered high and low base rate phenomena for the
client’s gender. She encourages assessors to attend to the presence and meaning
of “gender role compliance or noncompliance” (p. 14) and the rewards and
consequences of doing so. By this, she means that assessors should consider and
inquire about any behavior or trait their client demonstrates or reports that
contradicts the cultural and societal expectations generally held for members of
that client’s gender.

But Brown’s (1986, 1990) recommendations go further than simply sug-
gestig topics the assessor should inquire about during the interview. It is not
enough for clinicians, in her mind, to rely on a series of questions in order to
sufficiently address gender in the interview. She does not construe gender as a
fixed element of the client’s biography. Instead, she suggests that assessors need
attend to how gender is part of the process of the interview, such as the
client’s response to the assessor’s gender and assessors’ own responses to their
clients’ genders. She goes further and suggests that assessors should notice “how
issues of perceived attractiveness of one party to the other have an impact on
the interchange and the assessor’s opinions of the client” (1990, p. 14). The
gender-conscious assessor, she writes, “develops hypotheses about the gendered
aspects of the interaction between the client and the assessor” (1990, p. 14).
In these additional recommendations, Brown is clearly articulating a model of
interviewing that demands assessors to reflect upon how their own gender and
behavior has influence on the interview process as it is taking place. Brown’s
(1986, 1990) works have had a great deal of influence on the area of gender
and assessment, being widely cited and discussed within the works of assessors
who have written on the topic (Eriksen & Kress, 2008; Smart, 2010; Suzuki &
Ahuwalia, 2003; Suzuki et al., 2012; Worell & Robinson, 2009). The following
case example illustrates how Brown’s (1990) recommendations can be utilized
not only to more thoroughly address gender in the clinical interview, but also
how attending to issues of gender during the interview can lead to important
nongendered understandings of the client.

**Gender as an Opening for Other Issues: Ann**

Ann was referred for an assessment as part of an evaluation of her mental health
disability claim. Ann, a project manager in a consulting firm, experienced severe
anxiety, sometimes to the point of panic, whenever she was required to conduct conference calls and other forms of public speaking. Her anxiety had steadily increased over her career, having its roots in an episode in college when she became nervous during a class presentation and her professor, a man, had noticed and commented on this to the entire class. Ever since that day, she would go to great lengths to avoid having to speak publicly.

Ann was the only female project manager in her firm. In the interview, she spoke about the pressures of being a mother, a caretaker for her ailing mother, and managing the demands of her job, while working among peers who had few of these responsibilities and appeared competent and confident in their work, including their ability to interact with clients and important colleagues. She described going to great lengths to hide her anxiety and depression from her male colleagues, fearing they would view her as weak or inferior. She would skillfully avoid the most intimidating demands of her job by inventing last-minute emergencies that would allow her to delegate or cancel these responsibilities. The fear of her anxiety problems being discovered by her colleagues was so intense that she had managed her work role in this manner for over 10 years, until lukewarm performance reviews and stress finally led her anxieties to reach unmanageable levels, and she was having panic attacks in her office.

As we talked about her struggles and as I listened to her repeat the theme of how concerned she was about her male colleagues' judgments of her, I realized that she had been revealing to me, a male, all about these worries. “I wonder what it’s like to tell me about these struggles you’ve been having,” I said.

“What do you mean?” she asked.

“Well, I’m a man, too, so I just found myself wondering if it’s uncomfortable for you and me to be talking about this, given your concerns about your colleagues.”

“Well,” she thought for a minute. “I do feel embarrassed talking about it with you,” she said.

“Yeah, I had wondered if you might,” I said.

“But it’s not because you’re a man,” she corrected me. “I think it’s because you’re younger than me. You’ve got your office, your busy schedule, and you know what you’re doing,” she began to tear up. “I wish I could have felt so comfortable when I was your age. . . . I’ve been a screw-up all my life!” And in that moment, Ann became incredibly emotional. I was surprised, but I also sensed that it was a relief for her to emote as openly as she was. She moved on to discuss a lifelong trend of feeling incompetent and inferior to many people, including other women in the workplace. In fact, one of her direct supervisors was a woman, and Ann felt deeply inferior in comparison to her.

What is important in this example is that Ann’s narrative seemed to hint that she had understood a good many of her struggles to include something about gender. She felt inferior and judged by her male colleagues who, by her estimation, were confident and capable, whereas she, a woman, was afraid of being discovered incompetent due to her anxiety and lack of confidence. And indeed,
I believe that gender held many meanings for her in her struggles. However, when I commented on the gendered aspects of her struggle in relation to her interactions with me, more elaborate understandings emerged. I was able to see more clearly how deeply ashamed and inferior she felt in many areas of her life and across her lifespan. Her correction that it was my age, not my gender, which had her in touch with feelings of embarrassment, revealed that her shame and humiliation about her anxieties and self-doubt had much greater, overarching meanings to her. Here, by addressing gender between us, my inquiry had opened up meanings and understandings that were also nongendered.

Other authors also focus on the potential for gender-based bias in the assessment process. Much of what has been written, however, has focused on the assessment of women. For example, in discussing assessment issues with women clients, Suzuki et al. (2012) note that psychologists are inevitably tied to their own cultural and gendered contexts and warn about the potential for assessors’ biases and stereotypes to influence how they conduct themselves with clients. They recommend the use of several structured interviews to minimize the impact of such bias; however, such interviews are not always available, may conflict with the goals of the assessment, and, as Brown’s (1986, 1990) work suggests, do not address the need for assessors to consider how interactions between client and assessor are informed by and reflect issues of gender identity. Worell and Robinson (2009) similarly urge the importance of clinicians attending to gender bias in assessment with women, arguing that clinicians should take great care in exploring and attending to their own internalized gender biases in an effort to reduce the impact of them on the assessment process overall. Smart (2010) provides a series of useful questions that clinicians can use to identify potential sources of gender and cultural biases.

**Sexual Orientation and the Clinical Interview**

The writings on gender have emphasized the importance of attending both to bias and to the interactions between client and assessor that can reveal or illuminate gender issues in the clinical interview. In contrast, authors addressing sexual orientation in the clinical interview write much more on the importance of acceptance and affirmation of lesbian, gay, bisexual, transgender, or queer clients (American Psychological Association [APA], 2011; Donatone & Rachlin, 2013; Dorland & Fischer, 2001; Heck, Flentje, & Cochran, 2013). Affirmation with LGBTQ clients comprises many components; however, most authors agree that the most central and important attitude of affirmation includes the clinician understanding that same-sex attractions, feelings, and behavior are normal variations of human sexuality (APA, 2011; Heck et al., 2013).

Many LGBTQ clients arrive to the clinical interview sensitive to the presence of homophobic or transphobic attitudes in others (Heck, Flentje, & Cochran, 2013). For example, Dorland and Fischer (2001) conducted a study in which LGBTQ participants were asked to read a vignette of a clinical interview.
Some participants were given a vignette that contained heterosexist language; in other words, the vignette contained language that revealed heterosexist assumptions and attitudes in the clinician, such as using pronouns that presumed the fictitious client’s romantic partner was of the opposite sex. Other participants were given a vignette that removed the heterosexist language. Participants who were given the nonheterosexist vignette expressed that they would have greater comfort working with the clinician described and would feel more comfortable discussing issues pertaining to their sexual orientation. Their results demonstrate the importance of conveying an accepting and affirming attitude with LGBTQ clients and how nonaffirming attitudes are easily revealed and detected.

The values of acceptance and affirmation are not simply important to promoting the comfort of LGBTQ clients, however. In a study of countertransference reactions to a female client discussing her sexual problems with her partner, Gelso, Fassinger, Gomez, and Latts (1995) found that their sample of clinicians did not report greater countertransference reactions to a lesbian client than a heterosexual client. Nonetheless, clinicians endorsing stronger homophobic attitudes displayed greater avoidance behavior in their responses to the lesbian client, such as exhibiting silence, disapproval, ignoring the client’s material, and/or changing topics of discussion. This replicated results found in a similar study by Hayes and Gelso (1993) of clinicians’ reactions to a gay male client. The findings of the studies suggest that while homophobic attitudes of the assessor may not produce greater emotional reactions to the client, they may indeed elicit from assessors a behavioral reaction of avoidance, a set of behaviors that can easily undermine the effectiveness of a clinical interview and jeopardize the alliance with LGBTQ clients.

Thus, Heck, Flentje, and Cochran (2013) describe affirmation as a “necessary component” of work with LGBTQ clients, especially in the clinical interview. In a similar manner as Brown (1986, 1990), they regard self-examination of biases and prejudices within the assessor as a necessary first component to developing LGBTQ-affirming attitudes. They suggest that assessors refrain from making assumptions about a client’s sexual orientation, even if a client describes sexual contact or relationships with members of the opposite gender. Because sexual orientation is an identity variable that can be concealed, it is important to remain curious and open about all clients’ sexual orientation and history of sexual experiences. They also note that LGBTQ clients, who are often concerned about discrimination or encountering homophobic or transphobic bias, may directly ask assessors about their own sexual orientation and/or gender identity. Assessors may or may not feel comfortable responding directly to such questions, but they should strive toward providing a response that is affirming of LGBTQ persons in either case. For example, for the assessor who prefers not to disclose, Heck et al. (2013) suggest responding, “I don’t usually share my sexual orientation with clients, but I do want you to know that I affirm and celebrate all types of diversity, and this includes gay, lesbian, bisexual, transgender, and people with similar identities” (p. 26). Similar to Brown (1986, 1990) and others,
Heck et al. (2013) offer a series of self-examination questions for practitioners to help them evaluate their own internalized biases as well as to identify areas of development for better competence in working with LGBTQ clients. Notice, again, that simply “observing” a client’s sexual orientation is not a sufficient action on the part of the assessor. Asking clients about their sexual orientation as if it were as simple as asking them what they had for lunch fails the expectation of an affirming assessor.

Practitioners and scholars are increasingly studying and writing on the topic of asexuality and asexual-identified individuals (Chasin, 2011; Foster & Scherrer, 2014; MacNeela & Murphy, 2015). Individuals who identify as asexual report having little or no sexual attraction to others. As Chasin (2011) notes, asexual-identified persons may still experience romantic attractions and thus pursue romantic relationships that may or may not include sexual activity. Foster and Scherrer (2014) note that many asexual-identified persons encounter prejudicial attitudes from mental health practitioners who ipso facto consider asexuality evidence of sexual pathology. As a result of these kinds of biases, found in both clinical settings and in society at large, many asexual-identified persons find support and guidance from web-based media incredibly valuable and may shy away from seeking services from medical and mental health professionals (Foster & Scherrer, 2014; MacNeela & Murphy, 2015). Chasin (2011) provides an excellent review of important underlying theoretical issues in the understanding and conceptualization of asexuality as a variation of normative human romantic and sexual experience. For clients who identify as asexual (and clients who may exhibit qualities of asexuality but do not identify as such), clinicians should be cautious in their inquiries to reserve clinical judgment and attend to biases that may be guiding their questions and interests in clients’ experiences. Asexual clients find affirming responses from clinicians as helpful, supportive, and indicative of clinicians’ willingness to take their sexuality seriously (Foster & Scherrer, 2014; MacNeela & Murphy, 2015).

Affirmation is also an important component of work with transgender clients. While transgender persons are often included in considerations of lesbian, gay, and bisexual clients, they are identified differently and therefore sometimes neglected or misunderstood by their inclusion with LGB persons (APA, 2008). Whereas lesbian, gay, and bisexual clients are distinguished by their sexual and romantic attractions, transgender persons are distinguished by their experience of their gender as different from or in conflict with their biological sex (see Chapter 1). Transgender is a broad label that includes persons with a wide variety of gender identifications, including persons who reject identifying their gender with a uniform, binary-based term like man or woman (Donatone & Rachlin, 2013; Heck et al., 2013). Such clients may prefer to be addressed by their name and the use of nongendered pronouns, such as “they” or “zie” (pronounced “z”) instead of he/she (Donatone & Rachlin, 2013). Because transgender clients widely differ in their identifications, it is necessary and important to inquire respectfully about their identities. Donatone and Rachlin suggest
beginning with asking the client to identify a preferred primary gender pronoun, or PGP. Because of the wide variety of gender identifications these clients hold, it is important to consider the administrative paperwork given to clients, particularly forms that include gender-based items.

A unique issue that pertains to clinical interviewing and assessment with transgender persons concerns access to medical interventions to address gender identity (Donatone & Rachlin, 2013). Many medical professionals follow the World Professional Association for Transgendered Health (WPATH) standards of care (Coleman et al., 2012), which detail the need for mental health professionals to provide assessments of transgender persons mental health and related recommendations before clients can receive hormone therapy or surgical interventions to bring their gender identities and physical sex characteristics into agreement. Interviewers conducting an assessment for this purpose should carefully read these guidelines, as a psychological assessment involving a large battery of tests may, in some cases, represent a violation of these standards1 (Coleman et al., 2012). Furthermore, it is important to understand that transgender clients frequently receive questions from people who hold transphobic attitudes about their genitalia, transition status, and intentions to receive hormone therapy or surgery (Donatone & Rachlin, 2013; Heck et al., 2013). For many transgender people, such questions can convey an invalidating attitude or belief that gender is solely determined by the state or quality of one’s genitalia or secondary sex characteristics. Additionally, not all transgender persons wish to pursue such medical interventions. While it is often important to discuss these matters with transgender clients in order to better understand their subjective experiences, clinicians should be mindful about the purpose of their questions and the biases they may reflect. Again, affirmation is an important attitude to inhabit and express during interviews with these clients (APA, 2008; Dorland & Fischer, 2001; Heck et al., 2013).

**Hidden Questions Within the Client: Paul**

Paul is a 30-year-old black woman. When we spoke on the phone to set up the first appointment, I had guessed that Paul was a woman but did not ask more about this, feeling open to many possibilities and content to learn more about the client during our first interview together. When she arrived, she was dressed in men’s clothing and with a very short, clipped haircut. In the interview, she quickly volunteered that she identified as a lesbian and that she was concerned about her struggles in finding a girlfriend. As our conversation moved through discussing her relationship history, I realized that I had quickly taken her identity as a lesbian as sufficient explanation for going by the name Paul. Once I had noticed this, all kinds of possibilities had occurred to me: Had she been named Paul by her parents? Had she adopted the name as part of her lesbian identity? Did she experience gender dysphoria, or, in other words, did she not feel comfortable with her sex?
With this brainstorm of activity, I asked Paul about her name and if it had been her birth name or a nickname of it. Born Tanya, she stopped using her birth name in college when she discovered that she was a lesbian. “I hate that name, please don’t ever call me by that name,” she said.

In an effort to both convey my respect for her request as well as my curiosity about this preference, I said, “No problem. Of course, I will not address you in that way. At the same time, I am struck at what you said about hating your birth name. Could you tell me more about that?”

At first she seemed not able to describe anything more than just distaste for the name. When she offered little more than that, I asked about her choice of the name Paul, what she liked about it, and wondered if there was anything meaningful about her choosing a name typically given to men.

This opened up a wide and rich area of discussion between us. I learned that Paul had always preferred imagining herself as a man and that she often did not correct people when they occasionally misidentified her as a man. “I don’t really do labels,” she said, “but I’ve been curious about transgender people lately and have been wondering about that.” She explained that she didn’t think she was transgender because she couldn’t imagine taking hormones or having surgery, even though she often bound her breasts and enjoyed girlfriends who complimented her on her masculinity. It became evident that an important part for Paul’s growth involved exploring questions about her gender identity and the meanings she attached to gender in her life overall. As we moved on in talking about this during the interview, we discovered that she hated the name Tanya because it had been a reminder not only of her femininity and painful memories associated with not being “feminine enough” during her childhood, but also other important traumas from this period of her life.

I think several elements were key in making our interaction successful. First, I think my comfort and familiarity with gender-variant behavior and qualities in people allowed me to be more aware of my reactions and thoughts to Paul and to be able to use them to identify areas we had not yet discussed enough in the interview. In fact, we might never have ended up discussing these matters, as I could have easily moved on to my next series of standard questions. Second, I think my expressing my respect for Paul’s choice to refrain from using her birth name was instrumental in conveying respect to Paul and my affirming attitude. Third, I think asking Paul about her feelings about the name Tanya was the most critical juncture of our interaction. The strength of her request to not be called Tanya might have been enough to elicit anxiety in another assessor, who might not have invited Paul to explain more about her dislike of her birth name, and instead avoided further discussion of the topic. After all, there are many other topics to discuss in the interview. However, had I experienced anxiety in that moment, I hope that I might have considered it a signal that there was something important happening in the moment that could be unpacked and examined further. Last, it is important in moments like these to be aware of
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one’s own potential for judgment and to attend to how well one is occupying an affirmative attitude with the client.

Paul’s case is also useful in demonstrating the complex relationship between gender identity and sexual orientation. While Paul is a woman who identifies as a lesbian and experiences sexual attraction to other women, she is also questioning her gender identity. It is possible that clients like Paul might eventually identify as transgender and may or may not pursue medical interventions. Those who do pursue medical interventions may consider or experience their sexual orientation differently as a result.

Without fail, gender and sexuality overlap and interact, often in complicated and nuanced ways that require careful consideration and thought. One incredibly unique and current contribution to the examination of issues of gender and sexuality in the clinical interview is Silverstein’s (2011b) edited volume, *The Initial Interview: A Gay Man Seeks Treatment*. This is a creative and conceptually rich work that begins with Silverstein, a gay man, presenting the transcript of an initial interview he has with another gay man who is seeking psychotherapy. Subsequent chapters of the book, contributed by a variety of authors representing differing theoretical perspectives, offer discussions of issues raised by the interview presented. While I expect that readers would find the entire volume helpful in demonstrating how issues of sexuality and gender quickly emerge in initial conversations with clients, one contribution in particular is most relevant to the topic I consider here.

Nichols (2011), after reading Silverstein’s interview, provides an in-depth consideration of how the initial interview might have proceeded differently if the client had been a heterosexual man or a woman of either lesbian or heterosexual sexual orientation. She also considers how the interview with the gay male client may have proceeded otherwise if she, a lesbian therapist, had been conducting the interview. Drawing on her own clinical experiences and research on gender and sexuality, Nichols imagines her therapist-client dyads and draws attention to the similarities and differences in the interview that she would expect among them. Her comparisons reveal interesting hypotheses that illustrate how identity variables such as gender can make an important difference in what areas are discussed and explored and how closed or open clients might be. For example, Silverstein’s client, a gay male, reveals in the interview that he suspects he may have been sexually abused by his father and that despite his suspicions, he has never before sought treatment. Nichols (2011) believes that if the client had been female, she would have already received or pursued some form of mental health treatment or support and that the interview would not have been the first time the client would be sharing her experience of abuse. Such observations cogently demonstrate that identity variables such as gender identity and sexual orientation necessarily influence clinical process.

Moreover, Nichols’ (2011) chapter further illustrates how the intersection of client and clinician identity variables is also influential in determining how the clinical narrative shapes or unfolds during the interview. For example, she
imagines when being with Silverstein’s client she would behave much more warmly and maternally, offering the client more encouragement and perhaps revealing more about herself than did Silverstein. She suggests that her feminist inclinations would have her address some topics in the interview in much greater detail, such as the client’s suspicion of childhood sexual abuse, as well as paying greater attention to the client’s reports of suicidal ideation. How such conjecture generalizes to other clinician–client dyads is less important than the theme that Nichols’ (2011) illustration illuminates: The clinical interview will look, feel, and proceed differently based on a variety of client and clinician variables that importantly include both gender identity and sexual orientation.

In summary, it is impossible to adequately consider issues of gender and sexuality in the clinical interview solely by relying on a list of predetermined questions or topic areas. The assessor must be much more active and engaged with these issues during the interview. Assessors must consider their own biases and prejudices, examining how these biases have developed or changed over time and how they may consciously or unconsciously influence their own actions during the interview. Assessors must consider what of their own attitudes and values around gender and sexuality are explicitly or implicitly revealed to their clients and how their clients react to these revelations. They must attend to their own experiences of anxiety and discomfort and use these reactions as a compass that might help them realize the importance of opening up areas of discussion that make them anxious, as this process can often lead to important understandings that are otherwise hidden in front of them in the room in which they sit.

**The Assessor’s Gender and Sexual Orientation: Matching Assessor and Client Variables**

As much of what I have reviewed already has underscored the importance of the assessor’s attitudes, beliefs, and biases being attended to during the clinical interview, one might raise the question of whether a practice of “matching” assessors and clients on these identity variables makes sense, in an effort to minimize opportunities for bias and discrimination and maximize the likelihood of clients feeling comfortable with the assessor. Indeed, some have suggested that matching assessor and client on these variables, particularly gender, might make a discussion of “sensitive” topics easier (McConaughy, 2013), a practice that some data support. For example, Catania et al. (1996) conducted a study examining the effect of interviewer gender on client disclosure of sexual behavior during an interview. The results were mixed. Offering interviewees the ability to choose the gender of their interviewer did produce interview data of better quality; however, the style of questioning interviewers employed also demonstrated an effect. That is, how interviewers phrased questions, in some cases offering multiple-choice questions to interviewees, allowed greater disclosure and more descriptive responses. Catania et al. (1996) interpret their findings to suggest that matching interviewer and respondent gender when interviewing
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about sexual topics is an effective practice, but the individual’s interviewing style is also important.

There is no question that clients often have a gender preference, and sometimes a preference of clinician sexual orientation, when seeking out mental health professionals. Assessors should respect such preferences when expressed by clients or when considering accepting a referral for assessment. In addition, when arranging to accept a referral for assessment, assessors might ask clients if they would feel comfortable working with someone of their own gender, and if comfortable, sexual orientation if the client does not mention such a preference. However, the practice of psychological assessment often occurs in situations where clients and assessors have little flexibility in matching client identity variables; for example, many assessments take place in contexts where the conditions of the assessment are arranged and determined by a third party.

Furthermore, I would argue, the practice of assessor-client matching does not alleviate the need of assessors to attend to their own internalized biases and assumptions. Matching can also lead to an ill-conceived assumption that because the assessor and client share identities on these variables that there is less opportunity for difficulty in the dyad. Assessors of all gender identities and sexual orientations have their own unique experiences, feelings, and conflicts around these identities that are not eliminated because of matching. Last, expression of such preferences can sometimes reflect important aspects of clients’ experiences of their own identities, discrimination, biases, or histories that could be worth exploring.

The following case example illustrates how the assessor’s experience of gender and sexual orientation is activated in the clinical interview, with the consequence of negatively impacting the quality of the interview and the assessment results.

The Client Reads the Assessor: Frank

I assessed Frank early in my training, having had some experience with assessment, but I was still very much a novice. Frank was a 19-year-old Mexican American man who had been admitted to an inpatient hospital unit. He had, it seemed, been experiencing auditory hallucinations and delusions. He had been homeless right before his admission, and the referring psychiatrist had wondered if Frank might be faking his symptoms to get off the street for the week. I had received the referral for the assessment from my supervisor, who knew a little about Frank and the referral situation, and together we agreed I might administer the Structured Inventory of Reported Symptoms (SIRS), Rogers, 2010), a structured interview designed to detect feigned symptoms of mental illness. When I went to meet Frank, I brought the SIRS with me.

After quick introductions, we began the SIRS, me in my button-down shirt and tie, him in his hospital-issued attire. “Do you believe tulips have their own
philosophy?” I ask. “Yes,” he replies, and I know his response is scored in the direction of malingering. A dozen or so questions into the test, Frank interrupts and says, “You know what? I’m hearing the voices again right now.”

“Are you?” I ask, interested, and I can tell he is feeling anxious. “Yeah,” he continues, “they’re telling me that you’re wanting to do something sexual to me,” and as he finishes saying this, he giggles.

Immediately, I was embarrassed. I had not, in fact, been feeling attracted to him, nor had I been thinking sexual thoughts about him. I had, however, been anxious he might sense that I was gay. Whether or not he knew for sure in that moment does not matter. What matters is how it felt in the moment: I felt humiliated. I think it was his giggling that reminded me of so many times when I had been teased, harassed, bullied by others who sensed I was gay before I could ever tell them myself. I felt exposed, embarrassed, and shortly afterward, angry. If this client was faking his symptoms, he was now taunting me (never mind that one could argue that the SIRS is a taunting of the client). I describe my reaction now as though it were crystal clear to me at the time; however, the experience of my feelings in that moment was one of being flooded and disoriented. Without hesitating to understand my reactions in the moment, I tried to ignore them, and we were quickly continuing on with the SIRS. Afterward, my supervisor and I scored and interpreted the SIRS and concluded the client had been malingering.

The next day, I reported to the psychiatrist that there was a good chance the client was malingering. The psychiatrist quickly told me that he disagreed with the findings and suggested I think more about the case. He would treat the patient for schizophrenia and put into place appropriate aftercare plans. In looking back, I think the psychiatrist had been correct: The client was not malingering. By ignoring my reaction, not attending to it enough, I foreclosed too much of my mental capacities to be able to clearly see that the patient had been psychotic, that he had, as many psychotic patients do, possessed an uncanny ability to detect my anxiety, and the consequence had been a strong, unformulated series of reactions that clouded my ability to think and relate to the patient. I did not recover from my reaction during the interview, and today, I strongly question how effectively I had administered the rest of the measure after having been so deeply affected and not having taken the time to regain my bearings. This example clearly illustrates that clients can often, with remarkable ability and accuracy, sense and detect important things about their assessors, including their internal affective states, and that clients’ detections of these states shapes and influences the clinical process.

**Specific Areas of Inquiry in the Clinical Interview**

While it is essential for assessors to consider how gender and sexual orientation emerge within the interview and how they manage the interview, assessors...
should also be mindful of important content areas to inquire about that are specific to gender and sexual orientation. The content areas I include here do not represent an exhaustive list of topics or questions assessors might include in their interviews with clients; rather, they are meant to provide assessors with general guidance and direction.

As a preliminary note, it is important first to know a little about your client’s gender identity and sexual orientation before moving into more gender-specific questions or questions related to specific sexual orientations. Assessors can inquire about a client’s gender identity with questions like, “How would you describe your gender?” and “What is your preferred gender pronoun?” (Donatone & Rachlin, 2013). Similarly, assessors can inquire about sexual orientation with questions like, “How would you describe your sexual orientation?” and “Have you ever had questions about your sexual orientation?” Questions like these open these topics and allow for greater exploration. It is important to be attentive to and respectful of the language that clients use when discussing these issues. Sometimes clients, particularly among those with gender-variant identities or minority sexual orientations, may use language that is confusing or obscure, or in some cases, may exhibit only little familiarity with generally accepted terms. For example, a male client might describe himself as a “cross-dresser,” a term that describes behavior but does not clearly articulate anything more meaningful than his interest in wearing women’s clothing. It does not convey, for example, what his felt sense of his gender is or how he generally experiences sexual and romantic attraction to others. In instances like this one, assessors should try to clarify what their clients are intending to express about themselves and, if appropriate, perhaps offer them more descriptive terms they might use.

**Interviewing Men**

When interviewing men, some authors have noted the importance of recognizing the effect of prevailing attitudes and stereotypes of masculinity that may contribute to how they present during the clinical interview (Person, 2006; Shepard & Rabinowitz, 2013). Specifically, Shepard and Rabinowitz (2013) discuss how some men may experience a kind of shame in conjunction with symptoms of mental illness, as they fear that symptoms and a need for help with them are threats to their masculinity and sense of autonomy. Person’s (2006) work offers a clear illustration of how concerns about masculinity can be powerful among men and how they can inform many kinds of anxieties, including concerns about sexual abilities and sexual endowment. These may be important feelings to keep in mind while interacting with male clients, but these feelings may also be useful to discuss in the interview. Questions like, “How do you view your role as a man?” or “What expectations do you have for yourself because you are a man?” may open up important avenues for exploring feelings and experiences related to concerns about masculinity. It is not uncommon for
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gay or bisexual men to have concerns about their masculinity either, and it is important to be aware that they may have feelings about their masculinity that relate to their sexual orientation (Person, 2006).

Several authors have commented on how gender biases may lead assessors to overlook inquiry in certain low base-rate phenomena with men (Brown, 1990; Burlew & Shurts, 2013; Suzuki & Ahluwalia, 2003). For example, although most research indicates that men are at less risk for disorders of body image like anorexia nervosa or bulimia, it is not rare for men to experience concerns about their bodies and body dissatisfaction (Burlew & Shurts, 2013). Brown (1990) noted that biases about men might lead assessors to fail to inquire about experiences of victimization, such as experiences of domestic violence or childhood sexual abuse.

Neukrug, Britton, and Crews (2013) suggested that clinicians be prepared to discuss common health-related concerns with male clients, specifically citing erectile dysfunction, sexually transmitted diseases, prostate conditions, testicular cancer, diabetes, and accidental traumas and injuries as important topics to not overlook.

Interviewing Women

Several authors have proposed important areas of inquiry in working with women. For example, Smart (2010) suggests asking clients to describe their experiences of being women. She suggests asking questions like, “What did you learn about being a woman as you grew up?” and “What kind of messages have you received about being a woman?” She also encourages assessors to ask clients how they feel about other women and their sense of how they are similar or different. She underscores the importance of asking women how they feel their gender impacts their relationships, their feelings about their bodies, and if/how they have benefitted or been limited by their gender.

Worell and Robinson (2009) offer a thorough list of topics for assessors’ consideration when working with women. The topics they suggest include (a) experiences of violence, abuse, and trauma; (b) experiences of being a caretaker of children, friends, and/or parents; (c) medical issues specific to women, including breast and ovarian cancers, and the regularity of visits/checkups to gynecologists; and (d) concerns regarding career and employment, including experiences of sexual harassment and discrimination.

Brown’s (1990) suggestion of inquiring about high base-rate experiences is also pertinent here. For example, women are more frequently the target of domestic violence and sexual assault and, as such, assessors should inquire about these experiences. Some symptoms of mental illness, such as self-injurious behaviors, are also higher base-rate behaviors for women and should be explored. Assessors might also inquire about low base-rate behaviors and experiences for women, such as if they have ever committed a violent crime or been physically abusive toward a partner.
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Interviewing Gay, Lesbian, Bisexual, and Transgender Clients

For clients who identify as gay, lesbian, bisexual, or transgender, an important series of questions concerns coming out (Donatone & Rachlin, 2013; Heck et al., 2013; McConaughy, 2013). It is important not to presume that a client who identifies as LGBTQ has come out to persons outside of the consulting room. “Are you out?” is an appropriate question that can lead to other important areas for discussion, including when clients first realized their LGBTQ identity, to whom they have come out, and what their experiences of coming out were like. These experiences are often formative for LGBTQ clients and frequently relate to the extent to which they feel comfortable with their LGBTQ identities (Heck et al., 2013). Furthermore, it is important to note that there is wide variation in when LGBTQ individuals begin to identify as such. For example, many women have been known to live and identify as heterosexual before coming out as lesbian later in life (Heck et al., 2013). For all LGBTQ clients, it is important to assess the level of support they receive from friends and family members, both within and outside of the LGBTQ community. For some LGBTQ clients, disclosing these kinds of information can be difficult; in fact, for clients who struggle with especially high levels of internalized shame and/or with histories of harassment and discrimination, assessors may find that these data emerge slowly in the assessment process—in subsequent discussions or in follow-up interviews.

Additionally, it is important to ask LGBTQ clients about experiences of discrimination, harassment, or bullying throughout their lives, as these are frequent and damaging events these clients may have faced (Heck et al., 2013; McConaughy, 2013). The consequences of such experiences are profound and place LGBTQ persons at greater risk for substance abuse, self-harm, and suicide. In addition, while gay men are not more likely than heterosexual men to engage in unprotected sex, they are at greater risk for sexually transmitted infections. Careful and sensitive questioning about these behaviors can lead to important information regarding clients’ self-esteem, shame about sex, and concern for their own physical health (Nichols, 2011). Women, in contrast, are more likely to report minority stress related to family issues (Lewis, Kholodkov, & Derlega, 2012). Suicide and self-injurious behavior is an important area for questioning, especially among clients who have reported experiences of harassment and bullying.

Heck et al. (2013) correctly note that many bisexual persons experience a particular kind of marginalization due to their sexuality, feeling they neither fit in with gay or lesbian nor heterosexual communities; instead, many bisexual persons feel their sexuality is frequently misunderstood by most people. One particular idea that is harmful to bisexual persons is an assumption that their identification as bisexual is a label of convenience, meant to avoid a more shameful and marginalizing identification as gay or lesbian (Heck et al., 2013). To avoid hurtful assumptions or judgment from members of the LGBTQ community,
bisexual persons might selectively disclose their identity and “pass” as heterosexual. This is why it is important for assessors to remain open to the possibility that all of their clients may have experiences and relationships with members of either sex and make no assumptions about clients’ sexual orientations (Heck et al., 2013). Additionally, assessors might ask clients how they feel about their bisexual identity and if they have struggled to feel understood by others.

Donatone and Rachlin (2013) provide an excellent overview of considerations for interviewing transgender clients. As terminology is complicated and nuanced with transgender clients, it is important to inquire about the client’s preferred terms, identifications, preferred name, and pronouns. Exhibiting interest in and curiosity about a transgender person’s history of gender identifications and development can open up a wide range of issues that can be important to better understanding the client. Binding of the breasts is a common practice among transgender men who wish to reduce the appearance of their breasts. For clients who bind, it is important to ask about their binding habits, including if they have had any medical problems associated with the practice (e.g., bouts of dizziness or difficulty breathing from binders that are too tight) (Donatone & Rachlin, 2013).

For transgender clients, gender transition is an important process that involves planning and implementing a lifestyle change from living as a member of one gender to another. Not all transgender clients have interest in or intend to pursue a transition. One way to open the topic for discussion is to ask, “Do you have an interest in transition?” or “Have you undergone a transition?” For clients who indicate a wish to transition, asking if they have a plan for transition can open discussion about a variety of possibilities, including hormone therapy and surgery and legal proceedings to have a new gender recognized (Donatone & Rachlin, 2013).

Conclusions: Returning to Alexandria

Considering gender and sexuality in the clinical interview is a complex aim that requires significant attention, thought, and reflection by the assessor. While some practitioners might argue for a well-regulated, structured approach to ensure that all relevant topic areas are inquired and that opportunities for assessor bias and prejudice are limited, I believe the recommendations and ideas described in the literature are in opposition to such practices. Gender and sexuality are complicated aspects of human identity and experience, but they can be easily swept over as though they are simple and uncomplicated facts. It is easy to miss what is “hidden” right in front of us. To avoid ignoring key identity facets of the client, assessors must acknowledge their own participation in the clinical interview, which includes their own anxieties, beliefs, biases, and conflicts about gender and sexuality, as well as race, ethnicity, age, and class. Assessors must consider how their own gender and sexuality influence how the interview takes shape, monitoring how issues of gender and sexuality are discussed in the interview and how it feels to address them explicitly and implicitly. While arriving to an interview with a list of prepared questions or topic areas is useful to ensure that important
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issues are not overlooked, this activity alone is not sufficient. Assessors must carefully monitor their own biases as they are discovered or lost in the interview and work toward affirming clients who encounter such biases regularly.

These remarks bring me back to Alexandria. I had realized when interviewing her that I had felt that she seemed to lack anything feminine about her, and that, for whatever reason I could not determine in the moment, her lack of femininity disturbed me. I quickly judged her gender presentation as odd and off-putting. In observing these reactions, I began to question myself, concerned that I was perhaps unfairly holding Alexandria to a standard of gender that was arbitrary.

Unclear on what to do with my reactions, I held them in mind and allowed the interview to unfold. After awhile, we began to talk about dating and relationships. Alexandria explained that she had never been on a date, nor had any interest in dating, and that she found the idea of love and marriage terribly archaic and useless. She explained that she really didn’t experience any interest in sex and was perfectly content living her life as a single woman. I asked her what she thought about her sexual orientation, and she explained that she wasn’t quite sure; she really didn’t find in herself any attractions or fantasies about members of any gender. Slowly, my initial reactions about her seemed to make sense, even though, paradoxically, I was becoming more confused and puzzled about how to understand Alexandria. Our conversation was going well, though, and I sensed we had established a comfortable rapport with one another. Eventually, I asked her, “I guess I find myself wondering a little bit about how you feel about being a woman?”

She shrugged her shoulders simply and said, “I guess it’s okay. I don’t really enjoy girly stuff or anything like that, but I’m happy to be a woman. Just don’t ask me to wear a dress.”

We laughed a little bit together, and while I asked more about her feelings about being a woman, how she felt about other women, and if she ever felt like she stood out from other people, I can’t say that I ever felt that I fully understood what to make of my reactions to Alexandria. Ultimately, the assessment led us to a diagnosis and a description of her personality that helped to explain some of her struggles. But at the end of our work together, despite my efforts, I still feel like there was something very mysterious about Alexandria. And, I am satisfied with that outcome. In the end, assessors, I think, should feel comfortable with some uncertainties, even after we’ve completed a careful and sensitive assessment of our clients.

Practical Points

• An effective clinical interview requires assessors to do more than ask questions; in addition, they must consider how their own personal feelings, fears, hopes, biases, and conflicts shape and influence their participation in the interview, and consequently the kinds of data that emerge.

• To effectively consider gender and sexuality in the clinical interview, assessors must strive to be aware of their own biases, stereotypes, discomforts, and prejudices that concern gender and sexual orientation.
• Assessors should attend to how their clients presenting concerns involve or relate to issues of gender and sexuality, and how the assessor’s gender and sexual orientation may influence how these matters are discussed in the interview.
• Effective assessors consider both high and low base-rate experiences and behaviors among members of different genders and sexual orientations and strive to inquire about both during the interview.
• Assessors should strive toward attitudes of affirmation toward members of the LGBTQ community or decline referrals of these clients. When interviewing LGBTQ clients, assessors should convey their affirmative stance explicitly.
• Assessors should consider important content areas specific to their client’s gender and sexual orientation and make efforts to ask questions of the client in these areas.

Annotated Bibliography

Comment: Brown’s specific discussion of gender and the clinical interview is a useful and accessible primer in identifying the need for attending to gender issues in the clinical interview. She offers a useful outline to help clinicians consider important aspects of the clinical interview process and how they intersect with gender.

Comment: The discussion of the initial interview with transgender clients provided by Donatone and Rachlin is an incredibly useful guide that will quickly familiarize readers with the unique needs and areas of concern among transgender clients. The authors provide affirmative and supportive questions that are sensitively worded and easily adapted for practice.

Comment: Heck, Flentje, and Cochran provide a very helpful introduction to interviewing LGBT clients and address specific areas of focus or concern for gay men, lesbians, bisexuals, and transgender clients. A continuous emphasis is placed on affirmation, which is helpful in that they convey how to express affirmation and support clients while discussing important concerns relevant to these communities.

Note
1 The WPATH standards of care heavily emphasize an informed consent–based model of access to such medical procedures. The eligibility criteria do not mandate that clients be free of mental illness or psychological distress before referral for medical interventions; as such, some might view the administration of a full battery of psychological measures with transgender clients who present with little or few indications of mental illness a practice at odds with the standards. The standards of care are also available online at http://www.wpath.org.
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