

The Role of the Clinical Interview in Constructing Psychological Diagnosis: Between Subjective Data and Objective Indicators

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Abstract—This theoretical article examines the role of the clinical interview in constructing psychological diagnosis by analyzing how subjective data—the interviewee’s account of distress, history, and inner experience—interact with objective indicators drawn from observed behavior, collateral sources, and standardized instruments. Using an analytical review approach, the article discusses interview formats and their diagnostic functions, together with the strengths and limits of self-report and of objective indicators. It then proposes an integrative model that treats diagnosis as a gradual inferential process grounded in triangulation across sources. The review concludes that the diagnostic value of the clinical interview derives from neither source alone; it depends on the degree of structure in the interview, the clinician’s ability to manage cognitive biases, and sensitivity to cultural context. Recommendations for training, practice, and research are offered.

Keywords—clinical interview, psychological diagnosis, subjective data, objective indicators, triangulation, clinical judgment

A. The Role of the Clinical Interview in Constructing Psychological Diagnosis: Between Subjective Data and Objective Indicators

I. INTRODUCTION

Psychological diagnosis is among the most sensitive processes in clinical practice. It is not limited to attaching a label to a cluster of symptoms; it underpins therapeutic, educational, legal, and social decisions that affect the course of an individual’s life. Unlike medical diagnosis, which in many cases rests on laboratory and imaging findings with direct diagnostic significance, diagnosis in the field of mental health relies heavily on information gathered through direct interaction with the interviewee—that is, on the clinical interview (Sommers-Flanagan & Sommers-Flanagan, 2017).

The clinical interview is distinguished by its dual nature. On the one hand, it is a means of gathering subjective data that the interviewee expresses in his or her own words: complaints, suffering, personal history, and the meaning attributed to experience. On the other hand, it is a setting in which objective indicators emerge that the clinician observes in the interviewee’s appearance, behavior, speech, emotional expression, and manner of interacting with the clinician. Hence arises the central problem of this article:

How is psychological diagnosis constructed from material that is subjective by nature, and how can that material be elevated to a level of objectivity that permits a reliable diagnostic decision?

This problem is of particular importance for two reasons. First, subjective data may be affected by insight, memory, the desire for social approval, and current emotional state, as well as by the capacity for verbal expression. Second, objective indicators are themselves not free from interpretation, since they pass through the clinician’s perception, theoretical background, and expectations (Garb, 1998). Objectivity is therefore not a ready-made given in the interview but the outcome of methodical effort grounded in structure, triangulation, and continual review.

This article pursues five objectives: to define the concept of the clinical interview, its formats, and its diagnostic functions; to analyze the nature and limits of subjective data; to analyze the nature and limits of objective indicators; to propose an integrative model for constructing diagnosis; and to discuss the principal epistemic, cultural, and ethical challenges associated with this process. To this end, it adopts an analytical review approach based on a survey of the relevant theoretical and empirical literature, without claiming to present new field data.

II. A BRIEF OVERVIEW OF THE DEVELOPMENT OF THE CLINICAL INTERVIEW AS A DIAGNOSTIC TOOL

The development of the clinical interview has been bound up with the development of psychiatry and clinical psychology themselves. In the classical descriptive phase, attention centered on observing and classifying symptoms, and the examiner had the final word in interpreting what he or she saw. The emergence of phenomenological approaches then shifted attention to the patient’s lived experience and to the need to understand it from within (Jaspers, 1913/1963), while humanistic approaches emphasized the relationship as a condition for disclosure and change (C. R. Rogers, 1957).

In contrast to this trajectory, concerns about consistency among clinicians led to the emergence of structured interviews and explicit diagnostic criteria, with the aim of increasing standardization and reliability (American Psychiatric Association, 2013; First et al., 2015). Thus a productive tension has taken shape in the contemporary literature between the weight of subjective experience and

the need for objective control—the tension that this article takes as the axis of its discussion.

III. CONCEPTUAL FRAMEWORK OF THE CLINICAL INTERVIEW

A. Definition and Functions of the Clinical Interview

The clinical interview is defined as a structured professional interaction between a clinician and an interviewee that aims to gather information about the psychological complaint, the personal and family history, and psychological and social functioning, in order to understand the case, formulate diagnostic hypotheses, and determine the course of intervention (Shea, 2017). It differs from ordinary conversation in being goal-directed, framed by professional and ethical rules, and asymmetrical in roles, as the clinician bears responsibility for guiding and regulating the dialogue and for protecting the interviewee.

The interview serves multiple functions beyond information gathering. It establishes the therapeutic alliance highlighted by C. R. Rogers (1957) through empathy, acceptance, and genuineness—conditions that prepare the interviewee to disclose sensitive material that might not be shared in another context. It is also a means of differential diagnosis, risk assessment, identification of personal resources, and treatment planning. This means that the quality of the professional relationship is not a supplementary element but a condition for the quality of the data themselves.

B. Types of Clinical Interviews

Clinical interviews are usually divided into three types according to their degree of standardization: the unstructured (free) interview, the semistructured interview, and the structured interview (Sommers-Flanagan & Sommers-Flanagan, 2017). Table 1 summarizes the characteristics, advantages, and limitations of each type.

TABLE I.
TYPES OF CLINICAL INTERVIEWS AND THEIR CHARACTERISTICS, ADVANTAGES, AND LIMITATIONS

Type	Characteristics	Advantages	Limitations
Unstructured (free) interview	Open-ended questions without a fixed sequence, usually led by the interviewee's line of discourse	High flexibility, depth in exploring meaning and context, and strengthening of the professional alliance	Weak consistency across clinicians, possible omission of diagnostic domains, and greater susceptibility to personal impression
Semistructured interview	Predetermined topics, with freedom in wording, probing, and ordering of questions	A balance between comprehensiveness and flexibility, and suitability for everyday practice	Quality depends on the clinician's competence, training, and experience
Structured interview	Questions, sequence, and scoring rules specified in advance (e.g., SCID-5)	High interrater consistency and systematic coverage of diagnostic criteria	Constrains spontaneity, may neglect individual and cultural differences, and requires time and training

Note. Prepared by the author based on Sommers-Flanagan and Sommers-Flanagan (2017) and First et al. (2015).

TABLE I.

SHOWS THAT THE CHOICE OF FORMAT IS NOT GOVERNED BY AN ABSOLUTE PREFERENCE BUT IS DETERMINED BY THE PURPOSE AND CONTEXT OF THE ASSESSMENT. A STRUCTURED INTERVIEW, SUCH AS THE STRUCTURED CLINICAL INTERVIEW FOR DSM-5 DISORDERS (FIRST ET AL., 2015), RAISES INTERRATER CONSISTENCY AND LIMITS THE OMISSION OF CRITERIA, AND IT IS THEREFORE SUITABLE FOR SCIENTIFIC RESEARCH AND FOR ASSESSMENTS THAT REQUIRE STANDARDIZATION. BY CONTRAST, THE FREE OR SEMISTRUCTURED INTERVIEW ALLOWS GREATER ATTENTIVENESS TO INDIVIDUAL EXPERIENCE, WHICH IS WHAT THE EARLY STAGES OF CONTACT WITH THE INTERVIEWEE REQUIRE. IN ADVANCED PRACTICE THE TWO FORMATS ARE OFTEN COMBINED: THE CLINICIAN BEGINS WITH AN OPEN INTERVIEW AND THEN MOVES TO DIRECTED QUESTIONS TO VERIFY THE CRITERIA.

The literature also indicates that the method of assessment influences the diagnostic outcome itself. Zimmerman's (1994) review in the field of personality disorders showed that diagnostic results differ according to the method adopted, whether an interview or a self-report questionnaire, and that the source of information is a decisive factor. This finding supports the idea on which this article rests: the diagnostic judgment is the product of an interaction between the source of information and the way it is gathered.

C. Stages of the Diagnostic Interview

The diagnostic interview usually passes through three overlapping moments. It begins with the opening stage, in which the purpose and limits of confidentiality are explained

and a minimum of trust is established; its quality affects the interviewee's readiness to disclose (Shea, 2017). The exploration stage follows; this is the cognitive heart of the interview, in which the complaint, history, and symptoms are gathered and initial hypotheses are tested. The interview ends with the closing stage, which involves summarizing what has been understood and verifying it with the interviewee, determining next steps, and allowing an opportunity for what has not yet been said.

It would be a mistake to regard these stages as mechanical, successive steps. The clinician returns to building trust whenever sensitive material emerges, revises hypotheses during exploration, and uses the closing to correct his or her understanding. From a diagnostic standpoint, reflective summarizing allows the interviewee to correct misunderstandings and add decisive information, and it gives the interview a collaborative dimension that narrows the gap between what the interviewee said and what the clinician understood.

IV. SUBJECTIVE DATA IN THE CLINICAL INTERVIEW

A. Nature and Components

Subjective data refers to everything the interviewee reports about his or her inner experience and history: the chief complaint and its onset and course; thoughts, feelings, and bodily sensations; perceived suffering; personal and family history; and the meaning the interviewee attributes to what he or she is living through. These data occupy an

indispensable position because many psychological phenomena—such as obsessive thoughts, depressed mood, auditory hallucinations, and suicidal ideation—can be apprehended only through the report of the person who experiences them. Within phenomenological psychopathology, Jaspers (1913/1963) stressed that understanding subjective experience from within is a condition for distinguishing the pathological phenomenon from other phenomena, and that causal explanation cannot substitute for this understanding.

Subjective data also give access to the dimensions of meaning and context, since a single symptom may carry different significance depending on personal history and the cultural and social setting. This accords with the biopsychosocial model advocated by Engel (1977), in which a disorder is not understood in isolation from the psychological and social conditions surrounding the individual. The subjective account thus becomes material for understanding the case rather than merely a list of symptoms to be recorded.

B. Techniques for Improving the Quality of Subjective Data

The quality of subjective data depends on how they are elicited as much as on the interviewee's honesty. Good practice begins with open questions that leave the initiative of narration to the interviewee, then moves to clarifying questions that request specific examples from everyday life in place of generalizations, and then to closed questions that verify the presence or absence of particular symptoms (Shea, 2017). A question such as "When was the last time that happened, and what did you do then?" yields more verifiable behavioral information than a general question about feelings.

It is also useful to trace the temporal course of symptoms (onset, duration, fluctuation, and triggers) and to determine their functional impact on study, work, and relationships, because functional impact forms a bridge between subjective and objective data. It is likewise advisable to define the terms the interviewee uses rather than assuming their meaning: an expression such as "I am depressed" may mean transient sadness, exhaustion, loss of interest, or anger, and it becomes a diagnostic datum only after it has been clarified.

C. Limits of Subjective Data

Despite their importance, subjective data are subject to multiple sources of error. The report may be affected by limited insight, as in some psychotic disorders and manic states, in which the interviewee does not recognize the pathological nature of what he or she is experiencing. It may be affected by retrospective memory bias, as interviewees tend to reconstruct their past in a way consistent with their present state. It may also be affected by the desire for social approval or fear of stigma, leading the interviewee to conceal or minimize symptoms, and symptoms may sometimes be exaggerated for secondary reasons (R. Rogers, 2008).

To this must be added considerations of verbal expression. Some interviewees find it difficult to name their emotions and to distinguish bodily sensations from affective states, and others express psychological suffering in the form of somatic complaints, with patterns of such

expression varying across cultures (Kirmayer, 2001). Reading the self-report literally may therefore lead to diagnostic errors, whether through overdiagnosis or underdiagnosis.

V. OBJECTIVE INDICATORS IN THE CLINICAL INTERVIEW

A. Sources and Types

Objective indicators refer to information that can be observed or verified outside the interviewee's direct report. In practice they fall into four sources. The first is direct observation of the interviewee's behavior during the interview, which includes general appearance, motor activity, eye contact, speech rate and rhythm, thought content and organization, observable mood, and affect. The second is the mental status examination, a structured framework for recording these observations (Morrison, 2014). The third is collateral information from family, the occupational or educational environment, and medical records. The fourth is the results of standardized tests and scales.

The value of these indicators lies in allowing comparison between what the interviewee says and how he or she appears. The consistency or inconsistency between discourse and affect is a meaningful indicator—for example, when an interviewee describes intense sadness with a bright, smiling affect, or denies a sleep disturbance that the family confirms. Likewise, careful observation of disorganized thinking or slowed responding may reveal a cognitive or mood disturbance that the interviewee does not report.

B. The Mental Status Examination as a Framework for Organizing Observation

The mental status examination provides a shared language for recording clinical observations. It usually covers appearance and behavior; speech; mood and affect; thought process and content; perception; cognitive functions such as attention, orientation, and memory; and insight and judgment (Morrison, 2014). Its value lies in converting general impressions into descriptions open to discussion: instead of saying that the interviewee is "strange," one describes speech as slow and halting, or thinking as loose or circumstantial.

However, this framework is not free of challenges, because separating description from interpretation is not always easy. When it is recorded that "affect is inappropriate," the judgment presupposes an implicit norm of appropriateness, which is in part cultural and social. It is therefore advisable for the clinician to record what was actually seen (what the interviewee did and said) before recording his or her inference, so that others can review the reasoning.

C. Limits of Objective Indicators

Objectivity does not mean complete neutrality. Behavioral observation passes through the clinician's perception, which may be influenced by expectations, theoretical background, and prior knowledge of the case, rendering behavioral readings vulnerable to selective interpretation (Garb, 1998). Moreover, behavior observed in the interview situation may not represent the interviewee's habitual behavior because of situational anxiety, medication effects, or fatigue. As for external sources, family reports

may themselves be affected by the informants' attitudes and the nature of their relationship with the interviewee.

With regard to standardized instruments, their value is conditional on their validity, reliability, and suitability for the population assessed and the cultural context, and critical reviews have shown that commonly used instruments vary in the level of scientific evidence supporting their diagnostic use (Lilienfeld et al., 2000). Test results are therefore regarded as additional hypotheses to be integrated into the overall picture rather than as final verdicts that replace clinical inference.

VI. TOWARD AN INTEGRATIVE MODEL FOR CONSTRUCTING DIAGNOSIS

A. Diagnosis as an Inferential Process

Psychological diagnosis does not take shape in a single moment. It is built gradually through an inferential cycle that begins with generating initial hypotheses from the

complaint, then gathering further data to test them, and then revising, confirming, or ruling them out. This view accords with the emphasis of the *Diagnostic and Statistical Manual of Mental Disorders* that applying the criteria requires trained clinical judgment rather than mechanical matching to a symptom checklist (American Psychiatric Association, 2013). The eleventh revision of the *International Classification of Diseases* (World Health Organization, 2019) adopts a similar approach based on clinical descriptions and diagnostic guidelines.

This cycle can be represented in four stages: an initial stage of generating hypotheses; a stage of gathering in-depth subjective data; a stage of confronting these data with objective indicators and triangulation; and a stage of diagnostic formulation and review. Table 2 shows the fundamental differences between subjective data and objective indicators, together with the control procedures that make combining them possible.

TABLE II.
COMPARISON OF SUBJECTIVE DATA AND OBJECTIVE INDICATORS IN THE CLINICAL INTERVIEW

Criterion of Comparison	Subjective Data	Objective Indicators
Source	The interviewee's report of inner experience and history	Behavioral observation, mental status examination, family reports, records, and tests
Examples	Sadness, obsessive thoughts, hallucinations, suicidal ideation, and somatic complaints	Expansive or flat affect, slowed speech, disorganized thinking, and deteriorating occupational functioning
Strengths	Access to inner experience, meaning, and personal context	Comparability and verifiability, and detection of what the interviewee does not report
Sources of error	Limited insight, memory bias, social desirability, stigma, and exaggeration or concealment	Clinician interpretation, limited representativeness of interview behavior, informant bias, and limitations of instruments
Control procedures	Precise clarifying questions, requests for behavioral examples, and cultural sensitivity	Structured observation, multiple sources, and use of standardized, culturally appropriate instruments

Note. Prepared by the author based on Jaspers (1913/1963), Garb (1998), Morrison (2014), and R. Rogers (2008).

TABLE II.

SHOWS THAT THE TWO SOURCES ARE COMPLEMENTARY RATHER THAN COMPETING: WHAT ONE CANNOT ACCOMPLISH, THE OTHER CAN PARTLY MAKE UP. SUBJECTIVE DATA PROVIDE UNDERSTANDING AND MEANING AND INDICATE WHAT SHOULD BE LOOKED FOR, WHEREAS OBJECTIVE INDICATORS PROVIDE VERIFIABILITY AND LIMIT REPORTING ERRORS. THIS BENEFIT IS REALIZED ONLY IF THE CLINICIAN REGARDS EACH SOURCE AS A PARTIAL WITNESS REQUIRING INTERROGATION RATHER THAN AS FINAL TRUTH.

B. Triangulation and the Handling of Discrepancies

The principle of triangulation rests on comparing information from multiple sources in search of convergence or divergence. When subjective and objective data converge, confidence in the diagnostic hypothesis increases. When they diverge, the discrepancy should not be resolved automatically in favor of either source; rather, the discrepancy itself becomes material for analysis. Does it reflect limited insight? An attempt at concealment? Exaggeration? A cultural difference in expression? A limitation of the measuring instrument? Posing these questions transforms the contradiction from an obstacle into a source of diagnostic information.

In the context of clinical judgment, research comparing clinical prediction with mechanical prediction based on statistical rules indicates that the latter equals or outperforms the former in most studies (Grove et al., 2000; Meehl, 1954).

This does not mean eliminating the role of the interview; it means that clinical inference needs structured anchors—such as structured and semistructured interviews and standardized scales—that limit the influence of personal impression and make the decision more open to review.

C. Criteria for Appraising the Quality of the Diagnostic Interview

On the basis of the foregoing, four general criteria can be proposed for appraising the quality of an interview as a foundation for diagnosis. The first concerns comprehensiveness, that is, the extent to which the interview covers the core domains (complaint, history, functioning, risk, and diagnostic alternatives). The second concerns consistency, that is, the extent to which the clinician would reach the same conclusion if another clinician conducted the interview in the same way, a criterion supported by structured and semistructured interviews (First et al., 2015).

The third criterion is transparency, that is, clarity about the bases on which the conclusion was built and the separation of what the interviewee said, what the clinician observed, and what the clinician inferred. The fourth concerns revisability, that is, the clinician's readiness to modify the judgment when new information emerges and to record the degree of certainty attached to it. These criteria derive their importance from the fact that they do not

presuppose absolute objectivity; rather, they seek to render the subjectivity inherent in the interview a disciplined and inspectable subjectivity, which is the most that can be attained in a field in which human interaction is indispensable.

D. From Hypothesis to Diagnostic Formulation

The diagnostic interview does not end with naming the disorder. A good clinical formulation combines classification with an individual understanding of the case, identifying predisposing, precipitating, perpetuating, and protective factors in light of the biopsychosocial perspective (Engel, 1977). Such a formulation helps move beyond diagnosis as a label toward diagnosis as an explanatory map that guides intervention.

Moving from hypothesis to formulation requires verifying three matters: that the data are sufficient to support the diagnostic criteria; that alternative explanations, such as medical causes, substance effects, or stressful circumstances, have been excluded; and that functional impact and suffering have been assessed. When these conditions are not met, it is more appropriate to settle for a provisional diagnosis or for probable hypotheses accompanied by a plan to complete the assessment, rather than issuing a categorical judgment that is difficult to retract.

E. Differential Diagnosis and Reasoning by Exclusion

Differential diagnosis represents one of the most important stakes of the clinical interview, because a single symptom may belong to different disorders. Insomnia and loss of energy may be associated with a depressive disorder, an anxiety disorder, a sleep disorder, a medical condition, or a substance effect, and the differences among them are not resolved with a single question. The clinician relies on comparing the course of symptoms, their onset, and their relationship to triggers, substances, and physical illnesses, and on asking about the accompanying symptoms that distinguish one disorder from another (Morrison, 2014).

This type of reasoning requires avoiding the practice of settling for criteria sufficient to confirm a hypothesis without testing competing hypotheses. The structured interview provides something akin to a checklist that reduces the likelihood of overlooking important alternatives (First et al., 2015), but it does not replace the clinical sense that links data to one another and picks up signals about which no questions were asked. The challenge lies in combining the comprehensiveness that structure provides with the sensitivity that listening provides.

F. Illustrative Example

To bring the model closer to practice, we posit a hypothetical case that does not refer to a real interviewee: a young man in his twenties presents with fatigue and difficulty concentrating and states at the beginning of the interview that he is “not sad.” Direct observation reveals flat affect, slowed speech, and little eye contact, and the family reports that he has withdrawn from his usual activities and that his academic results have declined over several weeks. In this case the matter is not settled by taking the self-report at face value, nor by disregarding it; rather, the question arises of whether the interviewee may be expressing his suffering in the language of physical fatigue instead of the language of sadness.

Reasoning here requires generating multiple hypotheses (a mood disorder, an anxiety disorder, a substance effect or medical condition, or situational life stress), then returning to the interviewee with clarifying questions about loss of interest, sleep, appetite, and self-esteem, and comparing his answers with what the clinician observed and with the family’s reports. Triangulation may end in confirming or in ruling out the depression hypothesis, but in either case it gives the decision a stronger basis than reliance on a single source would have provided.

VII. CHALLENGES IN CONSTRUCTING DIAGNOSIS IN THE CLINICAL INTERVIEW

A. Clinicians’ Cognitive Biases

The clinician is part of the assessment instrument. Studies of diagnostic reasoning have described common cognitive errors, including anchoring on first impressions, premature closure of hypotheses, and confirmation bias, which leads to seeking supporting information while neglecting contradictory information (Croskerry, 2003). These risks are magnified when the clinician has a prior file or a previous diagnosis that guides expectations. Limiting them requires keeping several diagnostic hypotheses open, asking questions that seek to refute the favored hypothesis, and reviewing the case with colleagues.

B. Malingering, Exaggeration, and Concealment

Subjective data may be affected by external motives such as compensation, exemption, or the desire to avoid social or legal consequences, resulting in symptom amplification or denial. The specialized literature affirms that detecting this does not rest on a single indicator but on comparing the consistency of the self-report with observed behavior, records, and collateral information, with the use of dedicated instruments when appropriate (R. Rogers, 2008). At the same time, it is essential to avoid hasty accusation, because inconsistency may stem from other causes, such as genuine suffering expressed in an unfamiliar manner.

C. Cultural and Linguistic Context

The way psychological distress is expressed, understood, and addressed through help seeking is shaped within specific cultural frameworks, which means that subjective data and behavioral indicators alike must be read in light of culture (Sue & Sue, 2016). Reviews have shown that the presentation of depression and anxiety varies across cultures and that somatic complaints may in some contexts constitute a legitimate idiom of distress (Kirmayer, 2001). In Arab contexts, the effect of social stigma attached to mental disorder may be added, along with the disparity between Modern Standard Arabic and local dialects in naming emotions, which calls for the clinician’s particular attention to the connotations of words as the interviewee uses them.

D. Practice Pressures and Time Constraints

In reality, the clinical interview takes place under institutional conditions that sometimes limit the ideal conduct of procedures, such as limited time, large caseloads, scarce resources, and multiple administrative tasks. These conditions push toward abbreviation: clarifying questions are cut short, external sources are neglected, and first impressions suffice—precisely the conditions under which cognitive errors multiply (Croskerry, 2003). Thinking about

the quality of diagnosis therefore cannot be separated from thinking about the conditions of its practice.

The effect of these pressures can be mitigated by adopting brief structured protocols that ensure coverage of the minimum core domains, by scheduling a second interview when needed instead of closing the file with a hasty diagnosis, and by explicitly documenting what was not completed so that missing data are not turned into presumed negatives. These simple measures are among the most effective means of improving the quality of diagnostic decisions at little cost.

E. The Clinical Interview in Institutional and Forensic Contexts

The clinical interview does not always take place in a therapeutic context; it may be requested in evaluative contexts such as school and vocational guidance, forensic expertise, and assessment for purposes of compensation or exemption. In these contexts the distribution of the interviewee's motives differs and the likelihood of being influenced by self-interest increases, which heightens the importance of objective indicators, multiple sources, and instruments for verifying consistency (R. Rogers, 2008). The nature of the professional relationship also changes, as the interviewee must know that the clinician is not working within a therapeutic framework and that the results of the assessment will be submitted to another party.

This requires doubled clarity regarding role, confidentiality, and the limits on the use of information, and it makes precise documentation and the separation of description from interpretation two conditions for protecting the judgment from criticism. In these situations, more than in others, it becomes evident that the objectivity of diagnosis is not a property of the interview in itself but the product of a method for gathering it, analyzing it, and justifying its results.

F. Validity and Utility of Diagnosis

Scientific integrity requires acknowledging that categorical diagnosis itself is a matter of debate regarding its validity and utility (Kendell & Jablensky, 2003). A diagnosis may be practically useful in guiding treatment and professional communication even if its theoretical validity remains contested. This observation helps frame our expectations of the clinical interview: it does not produce a final "truth" about the interviewee but rather the best possible diagnostic formulation in light of the available data, open to revision whenever new information emerges.

G. Interviewing Children, Adolescents, and Older Adults

Objective indicators and external sources become more important when the interviewee is a child or adolescent, because the capacity to describe inner states accurately is still developing, and the young person may not realize that what he or she is experiencing calls for help. In these cases the clinician benefits from interviewing parents and teachers and reviewing the school record, while noting that sources of information may diverge from one another according to their position relative to the child and their expectations of him or her (Sommers-Flanagan & Sommers-Flanagan, 2017).

In older adults, psychological symptoms may overlap with physical illnesses, medication effects, and cognitive changes associated with aging, which makes reliance on self-report alone insufficient and calls for comparing it with medical examinations and the reports of close others. In both cases the same principle holds: every source is a partial witness, and its value is determined by the context in which it arises.

H. Risk Assessment and Its Effect on Judgment

The diagnostic interview always includes a dimension concerning the assessment of risk to the interviewee or to others, a dimension that cannot be deferred until the diagnosis is complete. It requires direct and clear questions about thoughts, intentions, and plans, together with attention to the related behavioral and contextual indicators (Shea, 2017). The complementarity of the two sources emerges clearly here: self-denial does not obviate attention to objective indicators, just as an objective indicator alone is not sufficient to assess the interviewee's intentions.

ETHICAL CONSIDERATIONS

The sensitive nature of subjective data obliges the clinician to clarify the purpose of the interview and the limits of confidentiality before beginning and to obtain informed consent from the interviewee, particularly when external sources such as family, employers, or schools are to be consulted. It also requires attention to the effect of diagnosis on the interviewee's self-image and social standing, to the risks of stigma, and to the need to explain the diagnostic formulation in language that is comprehensible and non-categorical.

Professional ethics further require acknowledging the limits of competence: the clinician does not issue a diagnostic judgment in cases that exceed his or her training or for which sufficient data are unavailable, and refers the interviewee to other specialists when necessary. Transparency about the degree of certainty in the diagnostic conclusion is part of scientific and professional integrity, because it protects the interviewee from the false reassurance of classification.

VIII. LIMITATIONS OF THE ARTICLE

This article is confined to a theoretical-analytical approach and is not based on field data collected by the author, which limits the generalizability of its conclusions to specific institutional contexts. Nor does it claim to encompass all of the literature related to the topic; rather, it draws on selected reference works in psychiatry and clinical psychology. Future field studies could test the hypotheses put forward in this article, for example by comparing diagnostic consistency across interviews of different formats or by examining the effect of training on the control of biases.

IX. RECOMMENDATIONS

In light of the foregoing, the following recommendations can be formulated:

- (1) Adopt at least a semistructured approach in diagnostic interviews, with the use of structured interviews in research and in assessments requiring high precision.

- (2) Train clinicians in clarification techniques, in eliciting behavioral examples, and in the mental status examination, as skills that improve the quality of both subjective and objective data.
- (3) Generalize the practice of triangulation across the interview, observation, external sources, and standardized instruments, and document points of divergence and how they were handled in the clinical file.
- (4) Integrate training in detecting cognitive biases and peer case review into continuing professional education.
- (5) Develop interview instruments and formats suited to Arab cultural and linguistic contexts, and verify their psychometric properties in field studies.
- (6) Conduct empirical research comparing interview formats and information sources in terms of consistency and diagnostic validity in Arab settings.

X. CONCLUSION

This article has sought to trace how the clinical interview contributes to constructing psychological diagnosis through the interaction between subjective data and objective indicators. It has become clear that subjective data are indispensable because they open the door to inner experience and its meaning, yet they are at the same time exposed to multiple sources of error, and that objective indicators offer verifiability but are free neither from interpretation nor from the limits of instruments.

It follows that constructing a diagnosis is a gradual inferential process, nourished by triangulation across sources and requiring critical awareness of the limits of each source, of the clinician's biases, and of the effects of culture and context. The clinical interview, when it is structured and supported by multiple sources, remains a central instrument of clinical practice, one that combines attentiveness to the interviewee with methodological rigor, which constitutes the essence of scientific and professional integrity in psychological diagnosis.

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