Interviews are the most basic and most frequently used method of psychological assessment and the most important means of data collection during a psychological evaluation (Watkins, Campbell, Nieberding, & Hallmark, 1995). They are endemic to the task performance of almost all psychologists—especially clinical and counseling psychologists. A computer search, using the key search words clinical interview, assessment interview, and initial interview, for the past 20 years yielded 1,260 citations, or 63 per year. Clearly interviewing continues to be an important process and one that continues to occupy clinicians and researchers alike.

This chapter discusses contemporary issues in assessing psychopathology and personality with interviews. We discuss types of interviews, how clients and clinicians approach an interview, and structured versus unstructured interviews. The structure of the interview is presented along with continuing concerns with official diagnostic systems. Issues that complicate the assessment process for personality disorders are discussed, including the base rate problem, the role of affective disorders, state versus trait assessment, the role of culture, reliability of psychiatric diagnosis, diagnostic overlap, and comorbidities. Current findings on the reliability of structured
Disorders—Fourth Edition diagnoses in mania (depression), and paresis. There are now hundreds of somanias (alcoholism), epilepsy, mania, melancholia, monomania (depression), and paresis. There are now hundreds of diagnoses in Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition (DSM-IV; American Psychiatric Association, 1994). Readers interested in the history of psychiatric diagnosis are referred to several excellent reviews of this elsewhere (Menninger, Mayman, & Pruyser, 1963, a 70-page history of psychiatric diagnosis from 2600 B.C. to 1963; Zilboorg, 1941) and to the several revisions of DSM.

The word interview was initially included in standard dictionaries in 1514 and designated a meeting of persons face-to-face for the purpose of formal conference on some point (Matarazzo, 1965). Initially assessment interviews were modeled on question-and-answer formats. The introduction of psychoanalysis allowed for a more open-ended, free-flowing format. During the 1940s and 1950s, researchers began to study interviews in terms of their content versus process, problem-solving versus expressive elements, degree of directedness within an interview, the amount of structure, and the activity of both the respondent and interviewer. Carl Rogers stimulated much research in the 1960s by emphasizing personal qualities of the clinician (e.g., warmth, accurate empathy, unconditional positive regard, genuineness). The 1970s introduced the idea of using structured diagnostic interviews, and advances in behavioral assessment resulted in more specificity and objectivity in interviews. Seminal behavioral assessment models include such approaches as the BASIC-ID model (behaviors, affect, sensation, imagery, cognition, interpersonal relations, and possible need for psychotherapeutic drugs). In the 1980s, the DSM revision provided improved reliability of diagnostic entities, and the 1990s afforded increasing appreciation of the role of culture, race, and ethnicity in the development of psychopathology. Managed health care also emphasized cost-setting measures and essentially required psychologists to rely on assessment interviews to the near exclusion of other assessment methods (e.g., psychodiagnostic testing; Groth-Marnatt, 1999).

Although assessment interviews have much in common with more social interactions such as group dynamics, dyadic considerations, and rules of etiquette and communication, they are fundamentally different. In assessment interviews, communication is generally both privileged (i.e., material discussed in the context of a professional relationship is not discoverable in legal evidentiary proceedings unless otherwise permitted in writing by the client) and confidential (material discussed in the context of a professional relationship cannot be disclosed and is protected from discovery by both professional ethics and laws). The demeanor of the clinician tends to be more professional, and the nature of the inquiry is often unidirectional and organized for the task at hand. There are limits on the nature of the interaction imposed by both law and ethics. The clinician’s statements serve a larger purpose than mere mutual dialogue (Craig, 1989).

PURPOSE OF ASSESSMENT INTERVIEWS

Assessment interviews can be thought of as having four major functions: administration, treatment, research, and prevention (Wiens & Matarazzo, 1983). Sometimes, psychologists’ interviews are for purposes of fulfilling certain agency requirements, such as determining eligibility for services. The treatment function of an interview might involve assigning differential diagnoses. For example, I was once asked to determine whether the patient had a delusional disorder or a borderline personality disorder. If the patient had a delusional disorder, the physician was going to treat the patient with medication, whereas if the patient had a borderline condition, the treatment would have been psychotherapy and no medication would be given. Assessment interviews are also conducted for research purposes. A salient example is the use of interviews for psychiatric epidemiological research or the use of structured psychiatric interviews to assess reliability and validity of clinical interviews. Finally, the prevention function follows the treatment and research function. If we have ways to reliably classify disorders, then we can include homogeneous groups of patients into research protocols. Findings from these studies then could serve a prevention function.

TYPES OF INTERVIEWS

We need to make a distinction between therapeutic versus assessment interviews. The former includes generic activities within a session designed to advance some treatment goal. The latter includes an array of activities in order to gain
information that leads to the development of treatment goals and intervention plans or other decisions, such as personnel selection. An example of a therapeutic interview is Miller’s (1991) motivational interviewing. Although this approach was developed for the purpose of changing addictive behavior, the principles are generic enough so that the technique could be applied to a number of assessment situations requiring behavior change.

This approach considers motivation a dynamic concept rather than inherently a personality trait. The behavior of the clinician is a salient determinant as to whether change will occur. Miller recommends that clinicians give feedback, emphasize that clients take responsibility for change, give clients advice and a menu of treatment choices and strategies, be empathic, and promote self-efficacy. The acronym FRAMES is used here as a mnemonic device. The technique also requires that the clinician point out discrepancies in behavior, avoid arguments, roll with resistance, use reflective listening, emphasize personal choice, reframe, and continually support self-efficacy. Thus, motivational interviewing can be used as an assessment tool and as an intervention tool.

Several types of interviews have been delineated. They differ in purpose, focus, and duration. Listed in the following sections are several types of interviews that have been discussed in the literature. They are not necessarily mutually exclusive, and several of the formats listed in the following sections can be utilized within a single interview. For example, a clinician can begin with an orientation interview, transition into a screening interview, continue with an interview for etiology, and then conclude with an ending interview. On the other hand, there are settings and circumstances in which each of these types of interviews is conducted separately or perhaps to the exclusion of the others. There is no agreed-upon list of interview types and the list presented in this chapter is somewhat arbitrary, but it provides the reader with a reasonable array of the various kinds of interviews available for clinical use.

Case History Interviews

Sometimes additional or more elaborate and detailed sequencing of case history material is required in order to make final decisions. In this case a special interview is completed in which the focus is only on ascertaining the nature of the person’s problems in historical sequence, with a possible focus on critical periods of development or events, antecedents and precipitants of behavior, and other matters of clinical interest. Case history interviews can be conducted with the respondent directly, the respondent’s family, friends, or others.

Diagnostic Interviews

Here, the clinician attempts to categorize the behavior of the client into some formal diagnostic system. For psychopathology, there are two official diagnostic classification systems presently in widespread use. The first is the official classification system of the World Health Organization—International Classification of Disease—Tenth Edition (World Health Organization, 1992). The second is the DSM (American Psychiatric Association, 1980, 1987, 1994). For reimbursement purposes, insurance companies recognize both, but the DSM is more popular in the United States and is the more commonly used diagnostic system in psychiatric research, teaching, and clinical practice. The DSM is also becoming more popular internationally than ICD-10 (Maser, Kaelber, & Weise, 1991). Although there have been calls for considering other classification systems (Dyce, 1994), DSM is the predominant diagnostic system in use today. For assessing personality, the issue is a bit more complicated. Most clinicians still use the personality disorder diagnostic categories contained in these two official diagnostic systems, but others prefer to assess people according to more theoretically derived personality classifications, such as Milon’s (1991, 2000) bioevolutionary model, Cattell’s (1989) factors, interpersonal models (Benjamin, 1996), the five-factor model (Costa & Widiger, 1997), or more biologically based systems (Cloninger, 2000).

Follow-Up Interviews

These are specific-focused interviews, which usually have a single purpose. Perhaps it is to review highlights of assessment results or to evaluate quality of services and patient satisfaction received from an HMO. Researchers may conduct a debriefing interview when the research involves deception.

Forensic Interviews

Psychologists may be called upon to contribute their expertise in legal matters that may be complicated by factors related to mental health. These factors include evaluations for dangerousness, competency to stand trial, various insanity pleas, behaviors that may be induced by substance abuse, or custody evaluations, to name a few. These interviews are typically far more investigative than many other types of interviews, often are of longer duration, and may occur over multiple sessions. Often the person being interviewed is not the client at all, but rather the court or perhaps private attorneys who retain these services on behalf of their clients. Forensic evaluations do not carry with them the same protection of privacy and confidentiality of material obtained in the evaluation as do most other mental health interviews.
Assessing Personality and Psychopathology With Interviews

**Intake Interviews**

These interviews are designed to obtain preliminary information about a prospective client and most typically occur within agencies; they may include a determination as to a person’s eligibility in terms of the agency’s mission. Intake interviews may also be used to acquire information to be presented at a case conference, to help clarify the kind of services available at the agency, to communicate agency rules and policies, or to consider whether the case needs to be referred elsewhere.

**Interviewing for Etiology**

This type of interview is designed to determine such matters as etiology and motivational attributions. The interviewer seeks to understand from a theoretical perspective why the person is behaving in a certain way. This kind of interview can be conducted from many theoretical frameworks, such as psychodynamic behavioral, cognitive-behavioral, family systems, and existential-humanistic perspectives. Also, within each of these defined frameworks are subcategories that also differ from each other. For example, an interview from an analytic perspective can proceed along the line of classical Freudian theory, object relations theory, or self psychology. An interview from a behavioral perspective can be conducted using Pavlovian (classical conditioning), Skinnerian (instrumental conditioning), or more cognitive-behavioral perspectives. The main point is that interviews for etiology are theory derived and theory driven.

**Mental Status Exams**

A special type of interview is the mental status exam, which is conducted to determine the kind and degree of mental impairment associated with a given clinical disorder. Mental status exams traditionally explore content areas such as reasoning, concentration, judgment, memory, speech, hearing, orientation, and sensorium. They are particularly relevant when evaluating for major psychiatric disorders, neurological involvement, or substance-induced disorders. These exams can be formal, wherein each content area is specifically addressed, or informal, wherein information is ascertained about these content areas while talking to the person about other issues. Table 21.1 presents content areas often addressed in a mental status exam.

**Orientation Interviews**

These interviews are designed to orient a person to some protocol. They may be used by clinical researchers, who are required to tell each prospective participant the basic procedures of the experiment, any risks associated with it, and the right to withdraw from the study at any point in time. The goal here is to obtain informed consent for the study. A clinician might use this type of interview to inform a new client about treatment options, program policies, rules, and expectations. A psychologist in private practice may use this procedure to orient the client to such matters as confidentiality, cancellation procedures, billing practices, insurance claims, and professional credentials. An industrial psychologist may begin executive assessments with this type of interview in order to prepare the interviewee for what lies ahead. Orientation interviews are particularly useful to help answer any questions the recipient may have and to help develop a client-interviewer contract for services, which may be either a formal document or an informal understanding between both parties.

**Pre- and Posttesting Interviews**

Modern methods of psychological assessment require interviews that initially explore with the client particular problem
areas prior to more formal psychological assessment, and then a posttesting interview, wherein the psychologist reviews or highlights major findings or recommendations derived from the assessment, which may include psychological testing. These findings are also valuable in that hypotheses derived from the assessment can be later explored with the client in the posttesting interview.

**Screening Interviews**

These interviews are usually brief and designed to elicit information on a specific topic. They may include such areas as determining whether a client is eligible for services, whether the patient is acutely suicidal, whether the patient meets the criteria for a particular diagnosis, or whether the patient needs to be hospitalized as a danger to self or others. Screening interviews are very common in psychology and may in fact be the most frequent kind of clinical interview.

**Specialized Interviews**

Sometimes the clinician needs to conduct an interview for a special purpose, such as determining the ability to stand trial, determining legal insanity, assessing the need for psychiatric hospitalization, or making a specific diagnosis of a particular disorder. Many specialized clinical interviews have been published for these purposes.

<table>
<thead>
<tr>
<th>Table 21.2 Content Areas of Assessment Interviews</th>
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<tbody>
<tr>
<td>History of Problem</td>
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**Termination Interview**

Very often, clinicians ending services to a client conclude with an interview designed to review treatment goals, progress, and future plans. Clinicians working in inpatient settings often have an ending interview to reinforce the need for continued outpatient follow-up services. Addiction specialists usually have a last session to review planned aftercare and to highlight patient risk factors for relapse. Industrial psychologists meet with a person to review highlights of assessment findings.

Table 21.2 presents topics frequently addressed in assessment interviews.

**THE CLIENT’S APPROACH TO THE INTERVIEW**

Interviews are influenced by a number of factors. First, is the client’s visit voluntary or involuntary? Presumably a voluntary client has noticed that there is a problem, has made failed attempts to resolve it—perhaps through discussions with friends or clergy or through self-help methods—and then has sought professional assistance. The client may come with the expectation that the distress (often a particular symptom or cluster of symptoms) will be ameliorated through professional help. This fact tends to increase the truthfulness of client self-reports and promotes a therapeutic working alliance and a more goal-oriented approach within counseling.

When a third party has referred the client, the situation is quite different. There are many cases in which the client is receiving services at the insistence of someone else. Clients arrested for driving under the influence may be sent for an evaluation to a psychologist by a judge. A teenager showing oppositional and conduct-disordered behavior may be taken to a psychologist by his or her parents. A person who is addicted to drugs may seek inpatient treatment for detoxification but actually may be...
hiding out from the police. A psychiatric patient may allege delusions, hallucinations, and threats of suicide so that he or she is determined to be in need of inpatient care, whereas the true motivation may be to receive basic food and shelter during the severe cold weather. It is incumbent on the clinician, if possible, to ascertain the person's real motivation for assessment and treatment.

Third, client expectations can affect the quality of the assessment results. All clients come to the interview with expectations about the nature of the process, how the psychologist may approach the task, and what results the process will have. It is a good idea for psychologists, who will be in a subsequent professional relationship with the client, to clarify any misperceptions or misunderstandings about the interviewing process. In order to explore possible misconceptions, ask the person, “What do you think we are going to do here?” or “What do you expect to happen as a result of our meeting?”

Fourth, the client also has perceptions of the psychologist, which can affect the course and outcome of the interviewing process; analysts have referred to this as object relations. Here, the interviewer embodies all that is contained in a particular role, and all of the client’s prior experiences and beliefs of people in this role are then projected onto the psychologist. The patient may view the relationship as parent-child, teacher-student, judged-accused, or lover-love object. These projections are transferences and tend to develop quickly in an ongoing relationship. Sometimes they are outside the awareness of the client. At other times they are at the surface and can contaminate the relationship with unreasonable expectations. In fact, a large body of research in social psychology has shown that humans tend to evaluate someone on the basis of their first impression, and all subsequent encounters with that person are evaluated in the light of those first impressions.

THE PSYCHOLOGIST’S APPROACH TO THE INTERVIEW

Psychologists approach an interview with certain preexisting values. The first of these values is philosophical or theoretical orientation. As clinical psychologists, we do not come to an interview with a blank slate; rather, we bring with us attitudes that may influence the areas of inquiry, the methods and techniques used in that inquiry, the words we use to subsequently describe the person, and the goals we set for clients. For example, a psychologist with an existential-humanistic theoretical orientation will conduct a very different interview from that of a psychologist who has a family systems orientation. Treatment goals developed from an assessment interview with a behaviorist will look quite different from treatment goals from an analyst.

Just as the client has certain expectations and beliefs about the nature of the interview, the psychologist also comes to the interview with certain preexisting beliefs and values that may affect the course of the interview. First, some psychologists value a directed approach, whereas others value a nondirected approach. Some value humor, whereas others refrain from its use. One psychologist may value discussions about a client’s manifest behavior, whereas another may value a focus on a person’s inner mental life. Second, psychologists value certain kinds of material more than they do others, and they selectively respond to client material that is considered more important (e.g., more highly valued). Third, psychologists may have a set of assumptions about behavior change and may view the person in the light of those assumptions. There are certainly other areas that could be explicated, but the essential point here is that we all come to the interview with preconceived notions and then act according to these preexisting beliefs and assumptions.

Psychologists eventually try to understand the client and problems in the light of their theoretical orientation. Most arrive at a diagnosis or some formulation of the problem, but the nature of this description differs. Some may think of the client in terms of oedipal and preoedipal functioning. Others may think of the person in terms of a homeostatic emotional system designed to maintain a dominant-submissive dyadic relationship against a triangulated third party. Others may couch the problem as lack of assertiveness because of a history of punishments during attempts at assertiveness. Still others may see the person as primarily dependent with borderline features. All of these characterizations are a diagnosis of a sort, but by the end of the interview, the psychologist is likely to have a hypothesis upon which an intervention approach will be fashioned.

DIAGNOSTIC INTERVIEWING

Good interviewing consists of putting the client at ease, eliciting information, maintaining control, maintaining rapport, and bringing closure. Putting the client at ease consists of attending to privacy and confidentiality issues, reducing anxiety, avoiding interruptions, showing respect by using the client’s preferred name, and arranging seating configurations that promote observation and interaction. Eliciting information is accomplished by asking open-ended questions, avoiding unnecessary interruptions, intervening at critical junctions of client elaborations, and clarifying any inconsistencies.
Controlling the interview does not mean assuming a completely directive interviewing stance; rather, it means that the psychologist has a purpose in mind for the interview itself and engages in behaviors that accomplish this purpose. The psychologist does not dominate the interview but rather guides it along a desired path. Skillfully disrupting client ramblings that are counterproductive, discouraging unnecessary material, and making smooth transitions from one stage of the interview to another can accomplish this goal. Rapport is maintained throughout by being nonjudgmental, displaying empathy, using language appropriate to the client, addressing salient client issues, and communicating a sense that the client’s problems are understood and can be helped. Finally, the psychologist brings closure to the interview by informing the person about the next steps in the process.

STRUCTURE OF THE CLINICAL INTERVIEW

The interpersonal psychiatrist, Harry Stack Sullivan (1954), suggested a format for the clinical interview, conceiving it as a phase-sequenced process consisting of (a) the formal inception, (b) reconnaissance, (c) detailed inquiry, and (d) termination. This model remains viable even today (Craig, 1989).

In the formal inception (e.g., introduction) phase, the clinician learns what brought the client to the interview and explains to the patient what will transpire within the interview. Sometimes all that is necessary in this introductory phase is to tell the client we’re going to put our heads together and see if we can find ways to help you. Next, tell the client what information you already know. If little or no information is available, it is acceptable to communicate that as well.

The reconnaissance (e.g., exploration) is the phase in which the clinician learns some basic information about the interviewee. The client will present what has come to be called the presenting complaint. Aside from demographics, the clinician also assesses for clinical syndromes and personality disorders during this part of the process. Sullivan (1954) believed this phase should not take longer than 20 min.

By assessing the syndrome, the clinicians convey that they understand the problem. Consider a patient who is new in town, is looking for a primary care provider to manage Type 2 diabetes and has narrowed down the search to two physicians. Doctor A takes a history, records the patient’s present symptoms, reviews the most recent glucose levels, and gives the patient a prescription. Dr. B does the same thing but also inquires about the person’s kidney function, examines the heart, eyes, and feet, and asks whether there is any numbness in the feet. In other words, Doctor B is telling the patient by his or her actions that he or she knows about diabetes and its complications and assesses for them. Other things being equal, the patient will probably select Doctor B as the provider, feeling that he or she is more competent. Doctor A may be just as competent in managing diabetes but failed to communicate that to the patient through a systematic review of the disease. This same process is recommended in mental health interviews. Show the client that you understand the problem or syndrome by assessing its major symptoms, associated disorders, and comorbidities.

The third phase is called the detailed inquiry (e.g., hypothesis testing). Here the initial impression gained during the first two phases is further assessed, and the clinician interviews for an understanding of why the client is in the present situation and why the patient exhibits particular behaviors and coping styles. I term this phase “interviewing for etiology.” Again, the clinician can frame the etiology within a preferred theoretical framework, citing such concepts as negative reinforcements, unbalanced family systems, or oral fixation. The crucial point is to develop a working hypothesis that will account for the behavior. At the end of this phase, the clinician should have a working hypothesis as to the source of the problem.

The final phase Sullivan called termination, but I prefer to call it planning and intervention. Here the clinician makes a summary statement (e.g., feedback) as to what has been learned in the session; this is not a mere repetition of what the interviewee has said but rather a clinical assessment from the interviewer’s perspective. It can be framed in psychodynamic, behavioral, existential-humanistic, or family systems perspectives, but in any case, it tells the client that you understand the problem. It lays the groundwork for how the problem will be addressed. An important point in this phase is to communicate that you can help the client. You understand the problem and can address it so that you can give the client hope and an expectation of improvement. At this phase, basic procedural issues are also discussed. These issues include things such as frequency of visits, issues of confidentiality, fees, or emergency calls. I believe that if the clinician follows this format and satisfactorily addresses the items to be assessed in it, the probability that the client will return for therapeutic work is maximized.

INTERVIEWING TECHNIQUES

Regardless of one’s theoretical position (for the most part), clinicians rely on a finite set of interviewing techniques that cut across interviewing systems.
Questioning

This interviewing technique is certainly the most often utilized. Clients rarely spontaneously reveal the kind of information necessary, and the interviewer must, perforce, ask questions to get more precise information. Questions may be either closed-ended or open-ended. In closed-ended questions, the interviewee is asked a specific question that has to be answered in a yes-no format. There is little opportunity for elaboration. An example of the closed-ended question is Have you lost any weight within the past 30 days? In contrast, an open-ended question allows for a full range of response and for client elaboration. An example would be How does your spouse feel when you keep losing your job? Both open-ended and closed-ended questions are necessary, but clinicians should try to avoid too many close-ended questions because they inhibit free-flowing communication.

Clarification

This technique is often necessary because the nature of a person’s responses may remain obscure; this is usually done by using one of the other interviewing techniques (e.g., questioning, paraphrasing, restating) and is often appreciated by clients because it gives them a continued opportunity to tell their story.

Confrontation

This is a technique whereby the clinician points out the discrepancy between what is stated and what is observed. It has frequently been employed with substance abusers, who continue to deny or minimize their drinking and drug abuse. It is also used with persons with character disorder diagnoses to break down their defenses. When done in a nonhostile and factual manner, it can be helpful, but too often it is done in a destructive manner that increases client resistance. Neophyte interviewers often have a problem with this technique because they may not be prepared to deal with the client’s response if this technique is mishandled. This technique probably should be minimized and rarely used because more recent evidence has called into question its utility (Miller, 1991).

Exploration

Some areas may require a review that is more in-depth than what is initially presented by the client. In this technique the clinician structures a more thorough inquiry into a given area. Most clients expect to be questioned about certain issues and may wonder why this was not done. Clinicians also should not be reluctant to explore areas that may be considered sensitive.

Humor

There is increasing recognition that humor does play a role in clinical interviews. It should not be overdone and should always be done to benefit the client. It can reduce anxiety, facilitate therapeutic movement, and enhance the flow of the session.

Interpretation

This technique has a long history in clinical psychology and emanates from the Freudian tradition, which considers much of human motivation outside of conscious awareness. It is probably the most difficult technique to use successfully because it requires a good knowledge of the client, personality, motivation, and dynamics. Interviewers in training should not employ this technique without first processing this technique with their supervisor. It is important to recognize that many clients will acquiesce to the authority of the clinician and agree with the interpretation when in fact it may be erroneous.

Reflection

Here the clinician skillfully and accurately restates what the client has just said to show that the feelings and statements have been understood.

Reframing

This technique is sometimes called cognitive restructuring. Attitudes, opinions, beliefs, or feelings are rephrased so that they correspond more to reality. Reframing can provide a client with a new perspective and may undercut negative self-statements that are often irrational and maladaptive. Reframing also suggests new ways of thinking and behaving.

Restatement

This technique is sometimes called paraphrasing. It differs from reflection primarily in purpose. Restatement is most often used to promote understanding and clarification, whereas reflection is used primarily as a therapeutic tool.

Silence

Sometimes no response is the best response. Silence can provide the client with an opportunity to process and understand
what has just been said. It should be done to promote introspection or to allow clients to recompose themselves after an emotional episode. It needs to be done in such a way that the client understands that the clinician is using silence for a reason.

The basic techniques of interviewing and examples illustrating these techniques are presented in Table 21.3.

INTERVIEWING MODELS

The Medical Model

Many psychologists have argued that interviewing from the medical model is inappropriate. The medical model assumes that symptoms are developed due to external pathogens; heritable vulnerabilities that are biologically determined; or structural, anatomical, or physiological dysfunctions and abnormalities. These problems can only be corrected or ameliorated through surgery, medicine, or rehabilitation techniques. One can think of the medical model as having two broad functions. The first is to guide classification, diagnosis, and ultimately, treatment and prevention. The second major function is to control both socially and legally the health practices of society. Some psychologists would prefer that we adopt a biopsychosocial model, which admits the role of biological processes in the development of disorders but which also includes the role of psychological and social factors in their etiology, course, and treatment.

Behavioral Assessment

Many psychologists prefer a behavioral to a medical model of interviewing. Behavioral psychologists do not espouse the idea that health-related problems are rooted in biology. Rather, they believe that contingencies of reinforcement occurring in the context of certain environments are primarily responsible for problematic behaviors. They thus decry medical terminology and nosology in favor of such concepts as response patterns, positive and negative reinforcements, and antecedents and consequences. A behaviorally based interview might analyze the problem by taking a reinforcement history, looking for patterns of rewards and punishments following critical behaviors, and carefully defining and quantifying each targeted behavior for intervention. The chapter by O’Brien, McGrath, and Haynes in this volume discusses behavioral interviewing at greater length.

Interview Biases

Interviews are not without problems, and many sources of interviewer biases have been researched. These biases include factors such as positive and negative halo; reliance on first impressions; client attractiveness; theoretical biases (e.g., insisting that one theory can explain all forms of behavior); emphasizing trait, state, or situational determinants of behavior to the exclusion of the others; and conceptualizing behavior as a static rather than a dynamic process.

One problem with an assessment interview is the extent to which bias exists throughout the diagnostic process. One bias

### Table 21.3  Basic Interviewing Techniques

<table>
<thead>
<tr>
<th>Technique</th>
<th>Patient Statement</th>
<th>Interview Response</th>
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<tbody>
<tr>
<td><strong>Clarification</strong></td>
<td>Sometimes my husband doesn’t come home for days.</td>
<td>What do you think he’s doing when this happens?</td>
</tr>
<tr>
<td><strong>Confrontation</strong></td>
<td>I no longer abuse my wife.</td>
<td>You hit her yesterday!</td>
</tr>
<tr>
<td><strong>Exploration</strong></td>
<td>In service I saw a guy get killed.</td>
<td>What were the conditions?</td>
</tr>
<tr>
<td><strong>Humor</strong></td>
<td>Sometimes, doc, I act so crazy I think I got a split personality.</td>
<td>In that case, that will be $50.00 each.</td>
</tr>
<tr>
<td><strong>Interpretation</strong></td>
<td>I took my father’s Valium and flushed them down the toilet.</td>
<td>If he was able to stand up to your mother, then you would not have to behave aggressively towards her.</td>
</tr>
<tr>
<td><strong>Reflection</strong></td>
<td>I’m not getting anywhere.</td>
<td>Your lack of progress frustrates you.</td>
</tr>
<tr>
<td><strong>Reframing</strong></td>
<td>My boyfriend left me for someone else.</td>
<td>Although it is upsetting now, it gives you the chance to meet someone else.</td>
</tr>
<tr>
<td><strong>Restatement</strong></td>
<td>I hear voices and get confused.</td>
<td>These strange things are disturbing you.</td>
</tr>
<tr>
<td><strong>Self-disclosure</strong></td>
<td>I just can’t learn like the others. I get so upset with myself.</td>
<td>I am dyslexic too. It need not hold you up. You just have special needs.</td>
</tr>
<tr>
<td><strong>Silence</strong></td>
<td>Someday I’m going to tell her exactly how I feel.</td>
<td>(no response)</td>
</tr>
<tr>
<td><strong>Questioning</strong></td>
<td>As a youth I was in detention home.</td>
<td>What did you do to get in there?</td>
</tr>
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</table>
that has been particularly addressed is gender bias. There are other sources of bias as well, including biased constructs, biased criteria for making diagnoses, biased sampling populations to study the issue, biased application of the diagnostic criteria, and biased assessment instruments and gender biases in the methods used to assess diagnostic entities (see also Lindsay, Sankis, & Widiger, 2000). Hartung and Widiger (1998) have provided the most recent summary of prevalence rates of various diagnoses by gender, but these rates are not immune to systematic distortions, as mentioned previously. Biased representation within clinical settings, empirical studies, and biased diagnostic criteria sets can also skew the reported findings. However, these data presented by Hartung and Widiger (1998) are reasonable estimates of prevalence rates of psychiatric disorders by gender based on current research.

Brown (1990) proposed a model for integrating gender issues into the clinical interview. It includes preassessment activities, such as familiarizing oneself in the scholarship and research on gender and its relationship to clinical judgments; it also includes suggestions to attend to one’s activities within the assessment process itself. These activities include inquiries that will help the clinician determine the meaning of gender membership for the client and the client’s social and cultural environment, determine gender-role compliance or variation, notice how the client attends to the evaluator’s gender, and guard against inappropriate gender stereotyping.

ASSESSING PSYCHOPATHOLOGY WITH CLINICAL INTERVIEWS

Structured Versus Unstructured Interviews

Interviews to assess for psychopathology vary considerably in how they are conducted. A basic dimension of interviews is their degree of structure. Structured interviews follow rigid rules. The clinician asks specific questions that follow an exact sequence and that include well-defined rules for recording and judging responses. This practice minimizes interview biases and unreliable judgments, hence providing more objective information. Although structured interviews generally have better psychometric properties than do unstructured ones, structured interviews may overlook idiosyncrasies that add to the richness of personality, artificially restraining the topics covered within the interview. They also may not create much rapport between client and clinician. Semistructured interviews are more flexible and provide guidelines rather than rules. There are neither prepared questions nor introductory probes. These types of interviews may elicit more information than would emerge from a structured interview because the clinician is allowed more judgment in determining what specific questions to ask. The interviewer also may ascertain more detailed information about specific topics. In completely unstructured interviews, the clinician assesses and explores conditions believed to be present within the interviewee. These hypotheses are generated from the person’s elaborations during the interview. In clinical practice, diagnoses are more often established using unstructured interviews, whereas in a research context diagnoses are more often established by using a structured or semistructured interview.

The introduction of criteria sets in DSM-III (American Psychiatric Association, 1980) ushered in renewed interest in the reliability of psychiatric diagnoses. Clinicians devoted a substantial amount of effort to improving diagnostic categories and to establishing psychiatric diagnoses. To respond to this challenge, clinical psychologists relied on their history of measuring individual differences in personality via structured inventories. Psychiatrists relied on their rich history of observation and interviews to establish a diagnosis, and they developed a spate of structured psychiatric interviews for an array of problems and disorders. This move was an attempt to reduce subjective clinical judgments. Table 21.4 presents a selected review of available structured psychiatric interviews for a variety of conditions. I provide a brief summary of the most frequently used structured diagnostic interviews. Although each of the structured instruments was designed for somewhat different purposes and was to be used with its companion diagnostic system, all have been revised and can now be used with DSM-IV.

The structured psychiatric interviews that have received the most attention are the Schedule of Affective Disorders and Schizophrenia (SADS; Endicott & Spitzer, 1978), the Diagnostic Interview Schedule (DIS; Robins, Helzer, Croughan, & Ratcliff, 1981), and the Structured Clinical Interview for DSM Disorders (SCID; Spitzer, Williams, Gibbon, & First, 1992). The SADS is a standardized, semistructured diagnostic interview that was initially developed to make a differential diagnoses among 25 diagnostic categories in the Research Diagnostic Criteria, a precursor to DSM-III. The clinician uses a set of introductory probes and further questions to determine whether the responses meet the diagnostic criteria. The SADS has two main sections. In the first section, the interviewer ascertains a general overview of the client’s condition by using detailed questions about current symptoms and their severity. Level of impairment is determined through the use of standard descriptions and is not left to clinical judgment. The second section covers the patient’s history of mental disorders; questions are clustered within each diagnosis. It assesses psychopathology and functioning in the current episode, assessing mood, symptoms and impairment.
Current functioning is defined as level of function 1 week prior to the interview. The final results yield both current and lifetime diagnoses, and the interview requires 1–2 hours to administer. There are three versions of the SADS, including a lifetime version (SADS-L), a change version (SADS-C) that can be used to evaluate treatment effectiveness, and a children’s version (K-SADS-P).

The DIS is a completely structured diagnostic interview designed to be used by lay interviewers. It was developed by National Institute of Mental Health to assess current and lifetime diagnoses in large-scale epidemiological surveys of psychopathology and psychiatric disorders, although it also has been used in clinical research studies. To administer the DIS, the interviewer reads the questions exactly as they are provided in the interview booklet. In general, there is no probing, although a separate probe flowchart can be used for organic diagnoses with psychiatric symptoms. Separate sections are provided for 32 specific diagnoses containing about 263 items. Current symptoms are assessed for four time periods: the past 2 weeks, the past month, the past 6 months, and the past year. Administration time is about 45–90 minutes. Much of the research with the DIS has compared DIS to psychiatric-clinician diagnosis established by traditional means. There are child and adolescent versions of the DIS, and both are available in a computerized DIS (C-DIS) program.

The SCID is a semistructured diagnostic interview designed to be used by clinical interviewers and was intended to have an administration time shorter than that of the SADS. It takes 60–90 minutes to administer and assesses problems within the past month (current) and lifetime. The interview begins with a patient’s description of his or her problems. After each section, the interviewer scores the disorder for severity (mild, moderate, severe) within the past month, according to symptoms and functional impairment. The interview follows the hierarchical structure that appears in DSM. There are several versions of the SCID. One is designed for use with inpatients (SCID-P), one with outpatients (SCID-OP), and one with nonpatients (SCID-N). Subsequently, the SCID-II was developed to diagnose personality disorders. The SCID has been translated into several foreign languages. It is currently in use in Japan, Puerto Rico, and China and has become the most researched structured psychiatric interview.

Should you use a structured psychiatric interview? They can be useful to teach diagnostic interviewing for clinicians in training. They may be more valuable than unstructured interviews in certain forensic applications. They can provide an automatic second opinion, and some may save valuable time for the professional because they can be administered by mental health paraprofessionals. However, for routine clinical practice, structured clinical interviews are cumbersome and time-consuming and seem more appropriate when methodological rigor is required for research diagnoses.

Psychometric properties, so often discussed in the context of assessing psychological tests, may also be applied to clinical interviews that assess psychopathology (Blashfield & Livesley, 1991). The purpose of these interview schedules
was to improve the reliability of psychiatric diagnosis. Even so, serious problems in assessment reliability continue to exist; even when using structured interviews and response sets, both in the interviewer and patient can affect the outcome of the evaluation (Alterman et al., 1996).

One outcome of the development of structured clinical interviewing has been the inquiry of comorbidities of Axis I disorders associated with an Axis II disorders (and vice versa). For example, disorders that have been studied include eating disorders (Braun, Sunday, & Halmi, 1994; Brewerton et al., 1995), psychotic disorders (Cassano, Pini, Saettoni, Rucci, & Del’Osso, 1998), and substance abuse (Abbott, Weller, & Walker, 1994; Oldham et al., 1992). These findings are presented later in this chapter. It is incumbent on the interviewer to assess those disorders that may be associated with an Axis I or Axis II diagnosis.

Many factors interact and complicate the process of using interviews to assess psychopathology. These factors include (but are not limited to) definitional ambiguities, criterion unreliability, overlapping symptoms, contextual moderators, multidimensional attributes, population heterogeneity, and deficits in the instruments and processes (e.g. interviews) that we as clinicians use to assess psychopathology (Millon, 1991). Additionally, the diagnostic system we use (DSM-IV) is imperfect. Complaints about this system include conceptual obscurity, confusion, a questionable broadening of the range and scope of categories classified as mental disorder, use of a categorical rather than dimensional model, poor applicability to disorders in children, and issues the medicalization of psychiatric diagnosis (American Psychiatric Association, 1980).

**ASSESSING PERSONALITY WITH CLINICAL INTERVIEWS**

**Personality Assessment Versus Assessing Personality Disorders**

It is one thing to assess personality and quite another to assess personality characteristics. The latter is substantially easier because there are diagnostic criteria codified in official diagnostic classification systems (e.g., DSM, ICD-10), and to make the diagnosis one merely has to determine whether the client meets the criteria. Furthermore, there are both structured clinical interviews and psychometric tests available to supplement the clinical interview (Widiger & Frances, 1985b, 1987). Because there is no agreed-upon classification system for personality, the clinician typically looks for certain traits that are related to the referral or treatment issue.

**Problems in Assessing Personality and Personality Disorders With Clinical Interviews**

Many assessment difficulties complicate the diagnosis of personality disorders. Many issues have occupied the field of personality assessment (Zimmerman, 1994) and need to be considered by an individual clinician when interviewing for personality characteristics and personality disorders. First, the lines of demarcation between normal and pathological traits are porous and not well differentiated (Goldsmith, Jacobsberg, & Bell, 1989; Strack & Lorr, 1997). The normality-pathology continuum can be viewed from different theoretical positions, making it difficult for the clinician to determine whether the behavior observed in the interview is normative or aberrant. Second, official diagnostic classification systems have adopted a categorical system for personality disorders (Widiger, 1992). One criticism of this approach is that it artificially dichotomizes diagnostic decisions into present-absent categories when they are inherently continuous variables. From this perspective, personality disorders have no discrete demarcations that would provide a qualitative distinction between normal and abnormal levels (Widiger, 2000). In contrast, a dimensional approach assumes that traits and behaviors are continuously distributed in the population and that a particular individual may have various degrees of each trait or behavior being assessed. Dimensional systems are seen as more flexible, specific, and reliable and are able to provide more comprehensive information, whereas categorical systems lose too much information and can result in classification dilemmas when a client meets the criteria for multiple disorders (Widiger & Kelso, 1983). However, dimensional systems are too complex for practical purposes and may provide too much information. Determining the optimal point of demarcation between normal and abnormal would be difficult from a dimensional perspective.

Third, many have lamented that the DSM personality disorder section lacks a theoretical approach to the understanding and classification of personality disorders. Fourth, fixed decision rules—as contained in official diagnostic systems—decrease diagnostic efficiency when the cutoff points for diagnosis are not adjusted for local base rates (Widiger & Kelso, 1983). Fifth, affective disorders can influence the expression of traits and confound diagnostic impressions. For example, many patients with clinical depression appear to also have a dependent personality. However, when their depression abates, they no longer appear to be dependent. Patients with bipolar manic disorder may appear histrionic during the acute phase of the manic-depression but not when the affective disorder has stabilized. Affective disorders complicate the diagnosis of personality disorders. Sixth, is the
TABLE 21.5  Personality Disorders with Higher Prevalence Rates for Selected Axis I Syndromes

<table>
<thead>
<tr>
<th>Clinical Syndrome</th>
<th>Personality Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety disorders: General</td>
<td>Borderline</td>
</tr>
<tr>
<td>Panic disorders</td>
<td>Avoidant, dependent, obsessive-compulsive</td>
</tr>
<tr>
<td>Social phobia</td>
<td>Avoidant</td>
</tr>
<tr>
<td>Agoraphobia</td>
<td>Avoidant</td>
</tr>
<tr>
<td>Somatoform</td>
<td>Avoidant, paranoid</td>
</tr>
<tr>
<td>Depression: Dysthymia (episodic)</td>
<td>Avoidant, borderline, histrionic</td>
</tr>
<tr>
<td>Major depression</td>
<td>Borderline</td>
</tr>
<tr>
<td>Bipolar</td>
<td>Histrionic, obsessive-compulsive,</td>
</tr>
<tr>
<td>Eating disorders: Anorexia</td>
<td>Avoidant</td>
</tr>
<tr>
<td>Bulimia</td>
<td>Dependent, histrionic, borderline</td>
</tr>
<tr>
<td>Substance abuse (alcohol and drugs)</td>
<td>Antisocial, narcissistic</td>
</tr>
</tbody>
</table>

behavioral manifestation or expression seen in diagnostic interviews due to endemic personality traits, or is the manifestation situationally induced? Specific life circumstances can change behavior and confuse the diagnosis of personality disorders. Seventh, patients often meet the diagnostic criteria for more than one personality disorder, and the optimal number of diagnostic criteria needed for an individual diagnosis remains unclear.

One trend in the assessment literature has been to study the role of prevalence of personality disorders in Axis I syndromes. There is now recognition that personality disorders can influence the expression, course, and duration of Axis I disorders, as well as be a focus of treatment in their own right. Table 21.5 presents the personality disorders most often diagnosed for selected Axis I disorders. Clinicians who assess for specific Axis I disorders should evaluate for the presence of personality disorders commonly associated with those syndromes (Livesley, 2001; Millon & Davis, 1996).

One continuing concern is that although the reliability of personality disorder diagnoses has improved, their discriminant validity continues to be a problem. This means that there will continue to be high levels of comorbid personality disorder diagnosis within an individual patient (Blais & Norman, 1997).

Role of Culture

We are only beginning to appreciate the role of culture and how it affects behavior. DSM-IV has recognized many cultural manifestations that are viewed as common within the designated culture. However, while DSM-IV includes Axis I considerations in the Appendix, it has been slow to take into account the role of cultural considerations and applying them to the diagnostic criteria for Axis II disorders.

RELIABILITY OF CLINICAL INTERVIEWS AND PSYCHIATRIC DIAGNOSES

Most clinicians make a personality disorder diagnosis by listening to the person describe interpersonal interactions and by observing behavior in the interview itself (Westen, 1997). However, even with the introduction of criteria sets, personality disorder diagnoses generally obtain lower levels of reliability compared to Axis I disorders (Widiger & Frances, 1985a); this is because the clinician has to address the issues of boundary overlap, the possible influences of state, role, and situational factors on behavioral expression, the client’s inability or unwillingness to report symptoms, and the difficulty of determining whether a trait is pervasive and maladaptive within the confines of a brief psychiatric interview (Gorton & Akhtar, 1990).

Prior to DSM-III, the mean interrater reliability (kappa) for the diagnosis of personality disorders was 0.32. DSM-III introduced criteria sets for the establishment of a diagnosis. DSM-III also included field trials of the reliability of the proposed diagnoses using over 450 clinicians involving over 800 patients, including adults, adolescents, and children. For personality disorders in adults, results indicated that the overall kappa coefficient of agreement on diagnosis was .66 after separate interviews. For Axis II personality disorders, the kappas were .61 for joint assessments and .54 for using a test-retest format (Spitzer, Williams, & Skodal, 1980). High kappas (.70 and above) reflect generally good agreement. With the introduction of criteria sets, the mean kappa for DSM-III personality disorders was 0.61 when the decision was any personality disorder but only a median 0.23 for individual disorders (Perry, 1992). Even so, Wiens and Matarazzo (1983) concluded that “... DSM-III is a remarkably reliable system for classifying disorders in Axis I and Axis II” (p. 320).

However, method variance contributes significantly to the observed results. Reliability estimates change depending on whether the reliability is based on unstructured interviews, semistructured interviews, or joint-interview raters compared to single-interview raters (Zimmerman, 1994), as well as long versus short test-retest intervals. Perry (1992) reported that the diagnostic agreement between a clinical interview and a self-report measure of personality disorders was not significantly comparable across methods. In fact, certain domains that are part of the clinical diagnostic picture of a personality disorder may not be reliably assessed by either structured clinical interviews or self-report measures because these domains pertain to implicit processes that may be outside the awareness of the client.

There has not been a comparable presentation on the reliability and validity of psychiatric interviewing and
diagnosis since Matarazzo's work on these topics some time ago (Matarazzo, 1965, 1978; Wiens & Matarazzo, 1983); the focus of clinical interviewing research has changed from generic interviews, which were the focus of Matarazzo, to structured and focused interviews. It is not scientifically accurate to discuss the reliability of psychiatric diagnosis or to discuss the reliability of clinical interview because the reliability will change based on (a) diagnosis, (b) instrument used to assess reliability, and (c) the method used to determine reliability. Psychiatric research now addresses the reliability and validity (usually concurrent diagnoses) among these various structured and semistructured techniques.

There are three strategies to evaluate the reliability of structured psychiatric interviews. In the first strategy (test-retest methodology), two or more clinicians interview the same patient on two separate occasions and independently establish a diagnosis. In the second method, two raters interview the same patient simultaneously and the raters make independent judgments as to diagnosis. Often researchers using this method provide the raters with an audio or videotape of the interview. In the third method, two or more structured psychiatric interviews, self-report tests, or both are given to the same patient. In all methods, the extent of agreement between interviewers as to the presence or absence of a particular disorder is determined by using the kappa statistic. By consensus, kappa values greater than .70 are considered to reflect good agreement, values .50 to .70 reflect fair to good agreement, and values less than .50 reflect poor agreement. Values less than 0.00 reflect less than chance agreement between raters.

The Structured Clinical Interview for DSM diagnoses (SCID; First, Spitzer, Gibbon, & Williams, 1995a; Spitzer & Williams, 1984; Spitzer, Williams, Gibbon, & First, 1992) has been the diagnostic instrument most often used in psychiatric research, and researchers have considerable reliability data on this instrument. Our discussion on reliability of psychiatric diagnoses concentrates on research using this instrument.

The SCID and SCID-II were designed for use with experienced diagnosticians. It has different modules, including all Axis I and Axis II groups of disorders. SCID-I assesses 33 of the more commonly diagnosed DSM-III-R disorders. The structured format requires the interviewer to read the questions exactly as they are printed (in the first of three columns) and to determine the presence or absence of criteria, which appear in the second column. The third column contains three levels of certainty—yes, no, or indeterminate—as to whether the patient met the criteria. The structured clinical interview allows the clinician to probe and restate questions, challenge the response, and ask for clarification in order to determine whether a particular symptom is present. The use of operational criteria for a diagnosis has improved the selection of research participants, thereby improving participant homogeneity and reducing interviewer bias. But potential sources of bias, such as cultural bias, are present, which can influence the expression of psychiatric symptoms and psychopathology as well as the interpersonal nature of the diagnostic process between patient and interviewer (Lesser, 1997). However, these issues are extant in all structured clinical interviews as well. Prevalence rates of disorders may also vary based on which version of DSM (e.g., DSM-II-R, DSM-IV) is used as the criterion (Poling et al., 1999).

Segal, Hersen, and Van Hasselt (1994) have published the most recent literature review on the reliability of the SCID-I (Axis I) and SCID-II (Axis II) disorders. Their review found kappa values for the SCID-I ranging from −.03 to 1.00. It is interesting to note that both of these values were for the somatoform diagnosis in separate studies. The median kappa values for 33 different diagnoses reported in the literature was .78. Median kappa values for SCID-II reliability studies for Axis II disorders ranged from .43 (histrionic personality disorder) to 1.00 (dependent, self-defeating, and narcissistic personality disorders), with a median of .74.

Several additional reliability studies on SCID diagnosis have appeared since that review. Using test-retest methodology, 12-month reliability data for SCID-II diagnosis in 31 cocaine patients was .46 (Weiss, Najavits, Muenz, & Hufford, 1995). Kappa values ranged from .24 (obsessive-compulsive disorder) to .74 (histrionic personality disorder) with an overall kappa at .53 among 284 patients at multiple sites (First, Spitzer, Gibbon, & Williams, 1995b). Using a Dutch sample of 43 outpatients, six raters evaluated the same patient within 1–4 weeks of the initial interview. Kappa for one or more personality disorders was .53, suggesting only fair agreement (Dreessen & Arntz, 1998).

Research has found little agreement between SCID-II and the Minnesota Multiphasic Personality Inventory (MMPI) and Millon Clinical Multiaxial Inventory (MCMI-II) diagnoses (Butler, Gaulier, & Haller, 1991; Marlowe, Husband, Bonieskie, & Kirby, 1997). Although there were no apparent gender biases in assessing personality diagnoses between SCID-II and the Personality Diagnostic Questionnaire-Revised (Golomb, Fava, Abraham, & Rosenbaum, 1995; Hyler & Rieder, 1987), there is often low agreement between personality disorder diagnoses between these two assessment methods, with many false positives (Fossati et al., 1998). This same pattern of results appears between the SCID and the Personality Disorder Examination (Loranger, Susman, Oldham, & Russakoff, 1987)—low diagnostic agreement and many false positives (Lenzenweger, Loranger, Korfin, & Neff, 1997;
Modestin, Enri, & Oberson, 1998; O’Boyle & Self, 1990). Using two separate structured psychiatric interviews reveals different patterns of comorbidity of personality disorders (Oldham et al., 1992). Because the false negative rates between these instruments tends to be low, one possibility is to have a clinician question only those diagnostic elements endorsed in the self-report instrument (Jacobsberg, Perry, & Frances, 1995), but this has not been done to date.

In summary, the present available data suggest that although structured psychiatric interviews are reliable, they show low to modest agreement with each other in terms of individual diagnoses; this is true not only for the SCID but also for other major structured clinical interviews.

INCREMENTAL VALIDITY

Using a computer search that included the terms incremental validity and clinical interviews as well as interviews, we could find no references pertaining to research that addressed the question of whether adding an interview adds any other information than was attainable through other means (e.g., psychological tests, collateral information). Incremental validity studies are readily available for such entities as the addition of a particular test to a test battery (Weiner, 1999), the prediction of a specific behavior such as violence, (Douglas, Ogcuff, Nicholls, & Grant, 1999), or various constructs such as anxiety sensitivity (McWilliams & Asmund, 1999) or depression (Davis & Hays, 1997), but the criteria in these studies were all established using other self-report inventories rather than a clinical interview.

I did find studies that documented the fact that structured clinical interviews yield higher rates of various disorders than do unstructured interviews. For example, body dysmorphic disorder, which is relatively rare, was three times more likely to be diagnosed using a structured clinical interview (SCID) than with a routine clinical interview (Zimmerman & Mattia, 1998). Comparing comorbidities among 500 adult psychiatric patients assessed at intake with routine clinical interview and 500 patients assessed with the SCID, results showed that one third of the patients assessed with the structured diagnostic interview had three or more Axis I diagnoses, compared to only 10% of patients assessed with an unstructured clinical interview. In fact, 15 disorders were more frequently diagnosed with the SCID than with routine clinical assessment; they occurred across mood, anxiety, eating, somatoform, and impulse-control disorders (Zimmerman & Mattia, 1999a). Similarly, posttraumatic stress disorder (PTSD) is often overlooked in clinical practice when PTSD symptoms are not the presenting complaint. However, PTSD was more frequently diagnosed using a structured clinical interview such as the SCID (Zimmerman & Mattia, 1999b). Also, these researchers found that without the benefit of the detailed information provided by structured interviews, clinicians rarely diagnose borderline personality disorder during routine intake evaluations (Zimmerman & Mattia, 1999c).

These studies attest to the fact that structured clinical interviews diagnose more clinical disorders than do routine clinical interviews. The need for incremental validity studies with clinical interviews is readily apparent. We especially need studies that compare clinical interviews to other assessment methods. Several studies have reported rates of diagnostic agreement between clinician-derived or structured clinical interviews compared to self-report measures, such as the MCMI, but they are reliability studies and not studies of incremental validity.

COMPUTER-ASSISTED DIAGNOSIS AND COMPUTER INTERVIEWS

In recent years the use of computers to interview patients has been attempted, mostly in research contexts. Its potential advantages include increased reliability of the information and an increased ability to obtain specific data about a patient. Critics complain that computer interviews are too impersonal and miss subtle aspects of a patient’s problem. Perhaps the most promising use of computer interviewing is in highly focused evaluations of a particular problem, such as depression, substance abuse, or sexual disorders.

We can safely predict that computers and technological advances will eventually permeate future diagnostic studies. Indeed, researchers have already established that it is feasible to do diagnostic work via the computer (Keenan, 1994; Kobak et al., 1997; Neal, Fox, Carroll, Holden, & Barnes, 1997). Some research has shown that automated screening can record basic client information—particularly as it pertains to demographics and symptoms—even before clients see a clinician for the initial assessment and that clients view it as helpful to their treatment (Sloan, Eldridge, & Evenson, 1992).

Computerization of standardized clinician-administered structured diagnostic interviews has also been shown to have validity comparable to that obtained in face-to-face contexts (Levitan, Blouin, Navarro, & Hill, 1991; Lewis, 1994) and can also be reliably done via the telephone using structured formats (Ruskin et al., 1998). One study reported that outpatients in an acute psychiatric setting, who had been diagnosed
by computer, generally liked answering questions on the computer (94%), understood the questions without difficulty (83%), and even felt more comfortable with the computerized interview than with a physician (60%). However, psychiatrists agreed with only 50% of the computer-generated diagnoses, and only 22% of psychiatrists believed that the computer generated any useful new diagnoses (Rosenman, Levings, & Korten, 1997).

Computer-based systems usually provide a list of probable diagnoses and do not include personality descriptions, in contrast to computer-derived psychological test interpretations (Butcher, Perry, & Atlis, 2000). Logic-tree systems are designed to establish the presence of traits or symptoms that are specified in the diagnostic criteria and thereby lead to a particular diagnosis. Examples of computerized systematized diagnostic interviews include the DTREE for DSM-III-R diagnoses (First, 1994), and the computerized version of the International Diagnostic Interview (CIDI-Auto; Peters & Andrews, 1995). However, research in this area has more commonly evaluated the computerized version of the Diagnostic Interview Schedule. This research has found that kappa coefficients for a variety of DSM-III diagnoses ranged from .49 to .68, suggesting fairly comparable agreement between clinician determined and computer-based psychiatric diagnoses (Butcher et al., 2000).

Research in the area has shown that computer-assisted diagnostic interviews yielded more disorder diagnoses than did routine clinical assessment procedures (Alhberg, Tuck, & Allgulander, 1996). Compared to computer-administered clinical interviews, clinician-administered interviews resulted in less self-disclosure—particularly of socially undesirable information (Locke & Gilbert, 1995). In fact, respondents seem more willing to reveal personal information to a computer than to a human being (Hofer, 1985) and tend to prefer a computer-administered interview to a clinician-conducted interview (Sweeny, McGrath, Leigh, & Costa, 2001). This is probably because they felt more judged when interviewed in person than when identical questions were administered from a computer. However, some evidence exists suggesting that computer diagnostic assessment, although it is reliable, shows poor concordance with SCID diagnoses, except for the diagnoses of antisocial and substance abuse (Ross, Swinson, Doumani, & Larkin, 1995; Ross, Swinson, Larkin, & Doumani, 1994).

Advances in technology are likely to find applications in the diagnostic process as well (Banyan & Stein, 1990). The future will certainly see more utilization of these types of sophisticated technologies. Technology, however, will not obviate the essential difficulties in the diagnostic process as described throughout this chapter—computer-assisted diagnostic formats are programmed to contain the same problems and deficiencies inherent in a face-to-face diagnostic interview.

### MISUSE OF THE INTERVIEW

Many clinicians have such faith in the clinical interview (and in their own skills) that interviews can be misused. One such current venue is that occasioned by managed care constraints that often preclude the use of other methods (e.g., psychological tests, collateral interviews) that would either add incremental validity in clinical practice or possibly confirm hypotheses gleaned from the interview itself. Psychologists need to guard against such practices and to advocate for the best possible psychological practice for a given problem.

### WHAT NEEDS TO BE DONE?

Most problems in any classification system of personality disorders are endemically and systematically related to the issue of construct validity. One continuing problem in assessment is that it has been extremely difficult to find independent operationalizations of personality traits and personality disorder constructs that are consistent across assessment devices. Convergent validity between self-report measures and interview-based assessments range from poor to modest. Median correlations between structured psychiatric interviews range from .30 to .50; median correlations between self-report measures range from .39 to .68; and median correlations between questionnaires and structured interviews range from .08 to .42. Consistently moderate correlations between questionnaires have been reported for the diagnoses of borderline, dependent, passive-aggressive, and schizotypal personality disorders. Better convergent validity between questionnaires and clinical interviews has been found with diagnoses of borderline and avoidant personality disorders. For clinical interviews, consistently good convergence has been found for only avoidant personality disorder (Clark, Livesley, & Morey, 1997).

Although method variance and general measurement error may account for some of the findings, *the real problem is a lack of clear and explicit definitions of the diagnostic constructs and behavioral anchors* that explicate examples of specific items that define the disorder and aid the diagnostician (and researcher) to diagnose the disorder. For example, with a criteria set of eight items, of which five are need to make a diagnosis of borderline personality disorder, there are 95 different possible sets of symptoms that would qualify for this diagnosis (Widiger, Frances, Spitzer, & Williams, 1988).
Are there really 95 different types of borderline personality disorders? Obviously not! The criteria merely reflect our confusion on the diagnosis itself. This situation is clearly absurd and serves to illustrate the problems that accrue when the construct and defining criteria are obfuscating. Similarly, the problem of a patient’s meeting two or more of the personality disorder diagnoses will continue to exist, due largely to definitional problems. A clinician can reduce this bias somewhat by carefully assessing all criterion symptoms and traits, but the problem in the criteria themselves remains.

Associated with the need for more conceptual clarity is the need to reduce terminological confusion inherent in the criteria set. For example, when does spontaneity become impulsivity? There is also a need for improved accuracy in clinician diagnosis. Evidence exists that trained interviewers are able to maintain high levels of interrater reliability, diagnostic accuracy, and interviewing skills, such that quality assurance procedures should be systematically presented in both research and clinical settings (Ventura, Liberman, Green, Shaner, & Mintz, 1998). For example, 18 clinical vignettes were sent to 15 therapists, along with DSM personality disorder criteria sets. Fourteen of the vignettes were based on DSM criteria and 14 were made up and suggested diagnoses of no personality disorder. Results showed and 82% rate of agreement in diagnosis. This type of procedure can be cost-effective to establish and to assess continuing competency in diagnosing personality disorders (Gude, Dammen, & Frilis, 1997).

Some have called for the explicit recognition of dimensional structures in official classification systems because such structures recognize the continuous nature of personality functioning (Widiger, 2000). Millon (2000) called for adoption of a coherent classification-guiding theory. However, it is unlikely that theorists would ever agree as to the parsimonious system to be adopted. Others suggested the use of prototype criteria sets to define pure cases (Oldham & Skodol, 2000; Westen & Shedler, 2000), but such prototypes might only rarely be observed in clinical practice, and hence such a system would live little practical utility, although Millon (2000) has persuasively argued otherwise. He has also called for the inclusion of personality disorder subtypes hierarchically subsumed under the major prototypes. Still others call for the inclusion of level of functioning (e.g., mild, moderate, severe), within the personality diagnostic system. Hunter (1998) suggested that personality disorder criteria be rewritten from the patient’s perspective. This would have the effect of removing negative language and provide a simplified and more straightforward and objective means of assessment. Cloninger (2000) suggested that personality disorders be diagnosed in terms of four core features: (a) low affective stability, (b) low self-directedness, (c) low cooperativeness, and (d) low self-transcendence. Perhaps a blend of both the categorical and dimensional systems is preferable. The clinician could diagnose a personality disorder in a categorical system, reference personality (disorder) traits that are specific to the individual, and include a specifier that depicts level of functioning.

The aforementioned suggestions apply more to assessing personality disorders with interview. Karg and Wiens (1998) have recommended the following activities to improve clinical interviewing in general:

- **Prepare for the initial interview.** Get as much information beforehand as possible; be well-informed about the patient’s problem area. This preparation will allow you to ask more meaningful questions. There may be important information learned from records or from other sources that warrant more detailed inquiry within the assessment interview. If this information is not available to you at the time of the interview, the opportunity for further inquiry may be lost.
- **Determine the purpose of the interview.** Have a clear understanding of what you want to accomplish. Have an interview structure in mind and follow it.
- **Clarify the purpose and parameters of the interview to the client.** If the client has a good understanding of what is trying to be accomplished, his or her willingness to provide you with meaningful information should increase.
- **Conceptualize the interview as a collaborative process.** Explain how the information will be used to help the client with his or her situation.
- **Truly hear what the interviewee has to say.** This may be accomplished by using active listening and by clarifying the major points of understanding with the interviewee during the interview.
- **Use structured interviews.** These interviews promote a systematic review of content areas and are more reliable.
- **Encourage the client to describe complaints in concrete behavioral terms.** This will help the psychologist to understand the client better and will provide examples of the potential problematic behavior in relevant context.
- **Complement the interview with other assessment methods, particularly psychological testing.** This may provide both convergent and incremental validity.
- **Identify the antecedents and consequences of problem behaviors.** This will provide more targeted interventions.
- **Differentiate between skill and motivation.** Some patients may have the desire to accomplish goals that are beyond their capacities, and vice versa.
• Obtain base rates of behaviors. This will provide a benchmark for later assessment of progress.
• Avoid expectations and biases. Self-monitor your own feelings, attitudes, beliefs, and countertransference to determine whether you are remaining objective.
• Use a disconfirmation strategy. Look for information that might disprove your hypothesis.
• Counter the fundamental attribution error. This occurs when the clinician attributes the cause of a problem to one set of factors, when it may be due to other sets of factors.
• Combine testing with interviewing mechanistically. This is because combining data from interview with data from other sources will be more accurate and valid than data from one source alone.
• Delay reaching decisions while the interview is being conducted. Don’t rush to judgments or to conclusions.
• Consider the alternatives. Offering a menu of choices and possibilities should engender greater client acceptance of goals and interventions.
• Provide a proper termination. Suggest a course of action, a plan of intervention, recommended behavioral changes, and so on, that the person can take with them from the interview. It is pointless for the psychologist to conduct thorough assessments and evaluations without providing some feedback to the client.

The future will no doubt actively address, research, refine, and even eliminate some of these problems discussed in this chapter. We can look forward to improvements in diagnostic criteria, improved clarity in criteria sets, increased training so that clinicians can self-monitor and reduce any potential biases in diagnostic decision-making, and take the role of culture more into account in the evaluation of clients. I hope that these advances will lead to improvements in therapeutic interventions designed to ameliorate pathological conditions.

REFERENCES


