The Value of the Interview for the Evaluation of Psychopathology

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The study of psychopathology — its phenomenology, etiology, course, and response to treatment — requires techniques for evaluating those aspects of human behavior that are judged to be relevant to the construct of psychopathology. For hundreds of years, the primary methods of obtaining relevant data about psychiatric patients were naturalistic observation and the interview. For the purposes of this paper, "interview" refers to a situation in which a trained person gathers a body of information about a subject by asking him questions, and making observations and evaluations of his responses. It differs from naturalistic observation or ordinary conversation in that the interviewer exerts some control over the interaction for the purpose of obtaining the desired information.

The interview as a procedure for obtaining information came under attack with the advent of the scientific method and the realization of the need for reliable measurement techniques. First of all, the reliability of data collected during the interview was often shown to be disappointingly low due to variability between interviewers in regard to the topics covered and the manner in which questions were phrased. In addition, an interviewer often varies his interviewing procedure on subsequent occasions. Secondly, this variability was shown to result to a large degree from the interaction between the interviewing style of the interviewer and patient characteristics. For example, interviewers whose style is to challenge patients aggressively are more likely to elicit data suggesting patient hostility.
These and other limitations of evaluations based on the interview procedure, led many researchers to reject or disparage it as a data gathering technique and to turn to other methods which seemed to offer more methodological rigor, such as self-report questionnaires, or strictly observational procedures in naturalistic or experimental settings. The authors feel that investigators who have rejected the interview have often been forced to ignore completely, or inadequately evaluate, several important dimensions of psychopathology. This paper discusses some of those areas of psychopathology which we think can be reliably and validly evaluated using an interview.

At this point, it is necessary to clarify the boundaries of what is, in the authors’ opinion, a useful way of conceptualizing “psychopathology.”* First of all, psychopathology is concerned with behavior and/or functioning of individuals. To us, this includes not only that which can be directly observed, but also private experiences, such as thoughts, feelings and perception. One quality, and perhaps the only quality, that all psychopathological behavior or functioning shares is that it is judged to be undesirable in some fashion. It may be undesirable to the individual who is exhibiting or experiencing it; for example, a painful mood. It may be undesirable to other people with whom the individual interacts; for example, belligerence. And finally, it may be undesirable to society in general; for example, compulsive setting of fires. Merely deviant, that is, statistically unusual behavior, which is not considered undesirable by someone is not included as psychopathology; for example, genius is not psychopathology, but its converse, mental retardation, is.

Although all psychopathology is considered undesirable by someone, undesirable behavior which is consistent with and apparently reinforced by subgroup norms often is not

*Strictly speaking, psychopathology is the study of whatever it is that we are talking about rather than the thing itself. However, our use of the term in the latter sense is not unusual.
considered psychopathology. Examples are some varieties of criminal behavior and some of the expected behaviors of soldiers in combat. We would argue, with others, that these forms of behavior can also be considered in the domain of psychopathology and therefore be worthy of study.

Undesirable behavior or disordered functioning, when due to organic defects or processes, are sometimes, but not always, considered psychopathological. For example, grand mal seizures are generally not considered psychopathology, unless associated with some disturbance of personality or "ego" functioning.

Some behavior, which is undesirable from the perspective of the person experiencing it, may not be considered psychopathology if it is considered appropriate to the situation in which it occurs, e.g., a grief reaction to the death of a loved one, or an anxiety reaction during combat.

With the above qualifications in mind, we use the term psychopathology to include subjective distress, impaired thought processes, impaired relations with other people, abnormal motor behavior, inappropriate behavior or affect, impaired ability to carry out goal directed activities and impaired ability to adequately test reality.

We will now discuss the value of the interview as a data gathering procedure for each of these broad areas.

By subjective distress we mean unpleasant thoughts about oneself or painful inner states, such as feelings of guilt, depression, or anxiety. The reason that simple observation is often not an adequate procedure for evaluating these conditions is that many individuals experience these painful inner states without visible alteration in their appearance or motor behavior. Conversely, facial expression and bodily posture are often poor guides to the identification of specific inner experiences.
On the other hand, there is considerable evidence that it is possible to construct self-report questionnaires which permit cooperative subjects to accurately report the presence and intensity of different inner states. However, for many subjects, self-report procedures are not useful because the subjects are too disturbed to complete the task, cannot read or understand the intent of the questions, or are motivated in some way to falsify their responses. Although these same problems can interfere with the ability of an interviewer to obtain information about these inner states, the interviewer can often lessen their effect through his interaction with the subject. For example, he may calm the disturbed patient sufficiently so that he can answer questions. He can clarify the meaning of questions and responses. He can often detect the intent to falsify or the tendency to under or over report and can make efforts to get the subject to give accurate information. Another procedure for evaluating subjective distress is to make a content analysis of a segment of a subject’s verbal productions in response to a standard neutral stimulus, such as “Talk for five minutes.” This has proven to be a useful procedure but it would seem to have the limitation of not permitting clarification of the subject’s responses and of being dependent upon the subject’s spontaneous report of material relevant to an assessment of subjective distress.

Impairment in a subject’s thought processes can be demonstrated in many different ways. The subject’s speech may be so disorganized as to render it unintelligible to others. Milder impairment may be revealed by the juxtaposition of statements, each of which is intelligible, but which lack a logical connection or inherent relationship. In milder impairment, there may only be a tendency to give excessive and unnecessary details or to proceed indirectly to a goal idea with many parenthetical and irrelevant additions. There are also instances where impaired thought processes are not revealed
by an analysis of the formal properties of a subject’s speech (as in previous examples), but by
analyzing the logic by which a subject reaches conclusions. At times the impairment in thought
processes is only evident to the subject himself; e.g., an inability to concentrate or a feeling that
his thoughts are racing. Self-report measures are severely limited in their ability to evaluate this dimension
of psychopathology. While they can acknowledge difficulties in concentration, or other subjectively
experienced difficulty with their thinking on a self-report measure, many subjects are not aware of the
difficulty that others have in understanding their speech or their thinking. Procedures which depend
upon naturalistic observation of spontaneously elicited speech are apt to miss or underestimate the
presence of impaired thought processes because such procedures do not permit questioning the subject
to determine the underlying logic of his statements. In addition, impaired thought processes may not
be revealed unless a subject is directed to discuss certain selected topics or put under some stress.

The dimension, impaired relations with people, has several components. It includes
the subjective element of negative attitudes towards people, as well as manifest behavior which
interferes with satisfactory relationships with others. Self-report measures can tap some aspects of
negative attitudes towards people, but many subjects are reluctant to acknowledge to themselves
or others that they have such attitudes as suspiciousness, resentment, or prejudice. Frequently those
attitudes can be observed directly in the interaction of an interview or detected when a subject
describes how he behaves in various situations. Self-report measures can also be used to obtain
information about manifest behavior but frequently subjects are unaware of behavior that they
exhibit which impairs their relationships with other people. Often it is necessary to obtain detailed information through probing to clarify whether the difficulty in an interpersonal relationship is because of the subject’s psychopathology or the behavior of the other person. Naturalistic observation would seem to offer an ideal method for evaluating manifest disturbance in interpersonal relations. However, even in a highly structured setting such as a psychiatric ward, the samples of behavior that are available for observation are a small part of the universe of the subject’s total interaction with others. The advantage of the interview, of course, is that the subject can be questioned about the entire gamut of possible interactions that may have occurred with other people.

Information on abnormal motor behavior such as psychomotor excitement or retardation, or posturing, can best be obtained by observation. This can occur during an interview, but the time period may represent a poor sampling of the subject’s ongoing behavior. Self-report measures of this dimension are unreliable and often reflect the subject’s feelings of “restlessness” or being “slowed down,” rather than actual motor behavior.

By inappropriate behavior we mean behavior that is odd, eccentric or not in keeping with the situation. Inappropriate affect refers to affect which is not appropriate for the situation or is incongruous with the content of the subject’s speech. It is very difficult to obtain measures of these by self-report alone, since generally the subject is not aware of the inappropriateness of his behavior or affect.

Naturalistic observation would seem to be the best source of information for inappropriate behavior. To determine inappropriate affect, however, it is often necessary to encourage the subject to talk about specific situations or topics which would be expected to have strong emotional
meaning for him.

In the evaluation of impaired ability to carry out goal directed activities, both the interviewer and self-report measures must rely on what the subject is able and willing to report about his difficulties. However, the interviewer can probe to clarify circumstances and try to overcome attempts to conceal impairment. Observational techniques can reveal difficulties of which the subject may be unaware. However, it is difficult to observe subjects at work, or while engaged in leisure time activities.

Of all the dimensions of psychopathology, impairment in reality testing is the one whose evaluation is most difficult without use of the interview. Such manifestations of impaired reality testing as hallucinations or delusions, require a judgment on the part of a trained person that what the subject perceives or believes is at variance with reality. Attempts to tap this dimension by such self-report items as “Do you see things that other people do not see?” or “Do you have ideas that people do not understand?” have only limited success. Some subjects answer the first question affirmatively although they do not have visual hallucinations because they misinterpret the meaning of the question and think it refers to their attentiveness or sensitivity to detail. The interview permits probing for a full description of the perceptual experience as well as information regarding the setting in which it occurs so that the interviewer can judge whether the experience was a true perception, an illusion, or a hallucination. Similarly, a subject may answer affirmatively to the second question and only be referring to political or religious beliefs to which he ascribes. By skillful interviewing, it is often possible to determine the nature of a subject’s personal beliefs, how he arrived at them, and the likelihood that they are at variance with reality. The use of observation
alone to measure reality testing has limited validity because the subject's behavior may reveal very little about his beliefs or his perceptions.

The above discussion should indicate the unique role of the interview as a means of obtaining data relevant to psychopathology: the interview is the only procedure which permits access to data relevant to all of the dimensions of psychopathology discussed earlier. Given its great potential as a source of data, can it be improved to answer some of the criticisms of it that were mentioned in the beginning of this paper?

During the past few years, attempts have been made by these authors (Spitzer, Fleiss, Burdock, & Hardesty, 1964; Spitzer, Endicott, & Fleiss, 1967; Spitzer, Endicott, Fleiss, & Cohen, 1970) and others (Wing, Birley, Cooper, Graham, & Isaacs, 1967) to improve the research value of the data collected during a psychiatric interview by standardizing the interview procedure, so that variability associated with differences in interviewing techniques and coverage is reduced. Interview schedules are developed in order to combine the advantages of flexibility and rapport that are inherent in clinical interviews with the advantages of completeness of coverage and comparability of method of eliciting information. The interview schedules consist of a series of statements and questions that the interviewer uses to obtain the information from the subject.

The schedules are organized in such a manner that when skillfully administered they have the feel of a clinical interview. They can be used either to elicit information on small units of behavior (e.g., insomnia) or for rather broad dimensions (e.g., depressive syndrome).

Many of the questions in interview schedules can be open ended so as to stimulate the subject to discuss an area (e.g., "How do you feel about yourself?") and to avoid creating a set in
which the subject merely says "Yes" or "No" to a list of symptoms provided by the interviewer.

Some areas can be more specifically explored with direct close-ended questions, (e.g., "Do you need a drink to get through the day or to feel well?"). Supplementary questions and alternate phraseology can be provided to clarify or probe areas when the interviewer wishes more information. The interviewer can be urged to use general probes for more information or for clarification (e.g., "Describe what actually happens," or, "What do you mean?").

The initial reaction of many clinicians to the use of an interview schedule is generally negative. A more positive attitude almost invariably results either from watching an experienced interviewer use an interview schedule, or from the clinician himself becoming experienced in its use.

Two opposing tendencies can interfere with the effective use of an interview schedule. The first is to adhere so rigidly to the schedule that transitions from topic to topic are awkward, previous information is ignored, and no modifications in the questions are made for the specific circumstances of the subject. The second is to use the interview schedule as if it were only an outline of suggested coverage from which the interviewer creates his own specific questions, thus reducing comparability with the results of other interviewers.

Interview schedules increase the reliability of data that is elicited during an evaluation interview. However, interview-elicited data cannot be scored directly, but generally is dependent upon the clinician's recording of his evaluation of the material elicited. Furthermore, some of the criticisms of the interview as a procedure for assessing psychopathology have been directed at the use of clinical judgments rather than the means of obtaining the information.
Procedures for standardizing clinical judgments antedate procedures for standardizing the interview by several decades. A great variety of rating scales and inventories describing and defining psychopathological behavior have been available to research investigators (Lorr, Klett, McNair, & Lasky, 1966; Overall, & Gorham, 1962; Wittenborn, 1955). These rating scales have generally been used in a setting where the data upon which the judgments are based is obtained by an unstructured clinical interview. Well-constructed rating scales in which careful attention is given to defining terms, giving examples, and providing instructional material, have been used with high inter-rater agreement provided that the raters have access to the same interview data.

Procedures which combine an interview schedule with an inventory of carefully defined relevant items or rating scales descriptive of psychopathology, reduces sources of error variance present in both the procedure for eliciting the data as well as that for recording the clinical judgments based on the material.

The authors and their colleagues have developed four procedures of this type. They are, the Mental Status Schedule, the Psychiatric Status Schedule, the Psychiatric Evaluation Form, and the Current and Past Psychopathology Scales. Figures 1 shows a portion of the Mental Status Schedule, which was the first such instrument developed.

In terms of interrater agreement, these procedures have been found to be highly reliable, with coefficients generally higher than those based on unstructured clinical interviews (Spitzer, Endicott, Fleiss, & Cohen, 1970; Spitzer, Fleiss, EnDICOTT, & Cohen, 1967). In addition, their use in a variety of research studies has yielded considerable information supporting the usefulness of evaluations based on a structured clinical interview for a number of research purposes.

Groups known to differ in amount of psychopathology, such as normals, outpatients, and inpatients, are differentiated at a high level. Similarly different diagnostic groups and subtypes are clearly differentiated (Figure 2). These procedures have been of value in evaluating response to treatment (Gottschalk, et al, 1970) and have proved useful in determining the relative efficacy of different treatment modalities (Hertz, et al, 1971).
In addition to the above uses, computer programs have been written which take as input the data collected with these procedures, and using a decision tree model, yield a psychiatric diagnosis (Spitzer & Endicott, 1968, 1969). The computer derived diagnoses have substantial agreement with diagnoses provided by a heterogeneous group of well trained clinicians and in one study almost perfect agreement was found between the computer diagnosis of schizophrenia and that made by two clinicians screening a group of maternity patients for the presence of absence of schizophrenia (Schachter, 1970).

The purpose of this paper has been to show the potential value of the interview and the hazards of failing to use it as an evaluation procedure. This is not to minimize the value of non-interview procedures, which are superior as measures of some specific aspects of psychopathology. However, in any broad assessment of psychopathology, the interview will continue to be indispensable for a long time to come.


Overall, J. E., & Gorham, D. The brief psychiatric rating scale. Psychological Reports, 1962, 10, 799-812


Spitzer, Robert L. & Endicott, Jean DIAGNO: A computer program for psychiatric diagnosis utilizing the differential diagnostic procedure. Archives of General Psychiatry. 1968, 18, 746-756.


Interviewer should identify himself, offer to shake hands and explain the purpose of the interview.

(Please tell me your full name.) (How old are you?) (Are you married?) (Any children?) (What [is, was] your work or occupation?)

How long has it been since you came to the [hospital, clinic]?
Now I would like to hear about your problems or difficulties and how they led to your coming to the [hospital, clinic].

If patient fails to specify event or behavior which precipitated admission:
(But what actually happened that made it necessary for you to go to the [hospital, clinic]?)
(How did you happen to come to this [hospital, clinic]?)

What problems or difficulties do you have now?

THE PROBLEM

What kinds of moods have you been in recently?

MOOD

What kinds of things do you worry about?

WORRIES

If admits worries:
(How much do you worry?)

What kind of fears do you have?

FEARS

If patient indicates a fear:
(Does this fear of . . . . . . prevent you from doing something you want to do?)

ANXIETY

How often do you feel anxious or tense?
(How much of the time do you feel this way?)

What about feeling restless?

RESTLESSNESS

How often do you feel depressed or blue?
(How much of the time do you feel this way?)

Crying

When was the last time you felt like crying?

SELF-APPRaisal

How do you feel about yourself?
Do you like yourself?
(When you compare yourself with other people, how do you come out?)

RESPONSE TO CRITICISM

How do you feel when people criticize you?

1 Refuses to shake hands.

2 Perspires profusely or his hand is either wet or clammy when shaken.

ORIGINAL COMPLAINT*

3* Gives a description of his behavior which is inadequate or insufficient to account for admission (e.g., just says he got “nervous” or “depressed”).

MOOD

4 Says he has felt elated or “high.”

5 Says he feels nothing, has no feelings or feels dead.

WORRIES

6 Says he has no worries or that nothing bothers him.

7 Mentions he worries a lot or that he can’t stop worrying.

FEARS

8 Admits to three or more different fears or says that he keeps feeling afraid of different things.

9 Mentions a fear of being abandoned or left alone alone.

10 Indicates he is fearful of losing his mind or losing control of his emotions.

11 Indicates a morbid fear that something terrible will happen to him.

12 Indicates he has an irrational fear of a particular object or situation (e.g., crowds, heights) [phobia].

13 Says he gets attacks of sudden fear or panic.

14 Indicates his fear prevents him from participating in some activity.

ANXIETY

15 Admits that he is bothered by feelings of anxiety.

16 Admits he feels anxious practically all the time.

RESTLESSNESS

17 Says he has felt restless or unable to stay still.

DEPRESSION

18 Admits he is bothered by feelings of sadness or depression.

19 Admits he feels depressed practically all the time.

Crying

20 Admits he feels like crying.

SELF-APPRaisal

21 Mentions he loves himself or that he thinks he is perfect.

22 Accuses himself of being unworthy, sinful or evil.

23 Indicates he is bothered by feelings of inadequacy, he says he doesn’t like himself.

24 Indicates he is bothered by feelings of guilt.

RESPONSE TO CRITICISM

25 Indicates he feels hurt or overwhelmed when criticized.

*This section should only be used with patients who have been in a psychiatric ward or clinic; it may be omitted in repeated testing. 05/8.
Figure 2: Mean Psychiatric Status Schedule Scale Scores of Four Schizophrenic Subtypes

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I. Subjective Distress
II. Behavioral Disturbance
III. Impulse Control Disturb.
IV. Reality Testing Disturb.

Summary Role

Depression — Anxiety
Daily Routine — Leisure Time
Social Isolation
Suicide — Self Mutilation
Somatic Concern
Speech Disorganization
Inappropriate
Agitation — Excitement
Interview Belligerence — Negativ.
Disorientation — Memory
Retardation — Lack of Emotion
Antisocial Impulses or Acts
Drug Abuse
Reported Overt Anger
Grandiosity
Suspicion — Persecution — Halluc.
Alcohol Abuse
Denial of Illness

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Standard Scores: 35, 40, 45, 50, 55, 60, 65

Paranoid (N=110)
Acute Undifferentiated (N=28)
Chronic Undifferentiated (N=146)
Schizoaffective (N=20)