The Value of the Standardized Interview for the Evaluation of Psychopathology

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The interview as a procedure for obtaining information about psychopathology 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 many sources of variability between interviews. Interviews differ in regard to topics covered and the manner in which questions are phrased. In addition, an interviewer often changes his interviewing procedure on subsequent occasions. Moreover, variability has been shown to result from the interaction between the interviewing style of the interviewer and patient characteristics. For example, interviewers who challenge patients aggressively are more likely to elicit data suggesting patient hostility. In addition to the nonstandardization of clinical interviews, other criticisms of the interview have been directed at the use of clinical judgments and the usual manner in which they are recorded. 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 exclusively 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 as an assessment procedure have often been forced to evaluate inadequately or to ignore several important dimensions of psychopathology. These include impairment in thought processes, impaired relations with people, painful inner states and unpleasant thoughts, impaired reality testing, abnormal motor behavior, and inappropriate affect and behavior. We have found that interviewers of different levels of clinical experience can be trained to make and record accurate judgments about the psychopathology of individuals whom they interview. The level of judgment may range from simple observations such as “he cried during the interview” to more complex judgments such as “he has a paranoid delusion.”

During the past few years, attempts have been made by the authors, as well as others, (Burdock & Hardesty, 1969; Gurland, Yorkston, Stone, Frank, & Fleiss, in press; Wing, Birley, Cooper, Graham, & Isaacs, 1967) to improve the research value of the psychiatric interview by standardizing both interview techniques and the procedures for recording judgments of psychopathology, so that the variability associated with differences in interviewing methods, coverage, and recording procedures is reduced.

Interview schedules and guides have been 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 schedules and guides consist of a series of statements and questions that the interviewer uses to obtain the information from the subject. Figure 1 shows a portion of the interview schedule and items of the Psychiatric Status Schedule. This instrument uses a relatively highly-structured interview schedule with an accompanying inventory of specific items which are dependent upon the responses given during the interview. Figure 2 shows a portion of the Psychia-

INTERVIEW SCHEDULE

How long does it take you to get dressed?
(Why does it take that long?)

MOOD
What kind of moods have you been in recently?

WORRIES
What kind of things do you worry about?

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

FEARS
What kind of fears do you have?

(Are there things or situations you are afraid of?)

(Anything else?)

People sometimes have fears they know don’t make sense — like crowds or certain activities. What kind of fears do you have like this?

If says he does not like or worries about an object or situation ask: (But are you afraid of _______?)

If indicates any fear: (Does this fear of ______ prevent you from doing something you want to do?)

ANXIETY
How often do you feel anxious or tense?
If unclear: (Nervous)
(How much of the time do you feel this way?)

RESTLESSNESS
What about feeling restless?
If unclear: (Can’t stay still.)

DEPRESSION
How often do you feel sad, 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?
If unclear: (When you compare yourself with other people, how do you come out?)

(Do you feel that you are a particularly important person or that you have certain special powers or abilities?)

INVENTORY

13 Indicates he spends an excessive amount of time dressing or grooming himself because of rituals, indecision, perfectionism, dawdling or lethargy.

MOOD

14 Says he has felt elated or “high” (do not include mere good spirits).

WORRIES

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

FEARS

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

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

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

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

20 Says he gets attacks of sudden fear or panic.

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

ANXIETY

22 Admits that he is often anxious.

23 Admits he feels anxious most of the time.

RESTLESSNESS

24 Mentions he is often restless or is unable to stay still.

DEPRESSION

25 Admits he is often sad or depressed.

26 Admits he feels depressed most of the time.

CRYING

27 Admits he has felt like crying.

SELF-APPRAISAL

28 Accuses himself of being unworthy, sinful or evil.

29 Indicates he is bothered by feelings of inadequacy or that he doesn’t like himself.

30 Indicates he is bothered by feelings of having done something terrible [guilt].

31 In appraising himself he indicates an inflated view of his value or worth [grandiosity].
Figure 2
One of the Psychiatric Evaluation Form

ORIGINAL COMPLAINT
If a psychiatric patient: Now I would like to hear about your problems or difficulties and how they led to your coming to the hospital, clinic.

GENERAL CONDITION
Tell me how you have been feeling recently.
(Anything else been bothering you?)

SOMATIC CONCERNS
How is your physical condition?
Does any part of your body give you trouble?
Do you worry much about your health?
If necessary, inquire for doctor’s opinion about symptoms or illnesses.

APPETITE-SLEEP-FATIGUE
Disturbances in these areas are often associated with Depression, Anxiety, or Somatic Concerns.

What about your appetite for food?

Do you have any trouble sleeping or getting to sleep?
(Why is that?)

How easily do you get tired?

ANXIETY AND DEPRESSION
This section covers both Anxiety and Depression. The interviewer must determine to what extent the symptoms are associated with either one or the other or both dimensions.

What kinds of moods have you been in recently?

What kinds of things do you worry about?
(How much do you worry?)

What kinds of fears do you have? (Any situations...activities...)

How often do you feel anxious or tense?
(When you are this way, do you react physically...like sweating, dizziness, cramps?)

What about feeling restless?

How often do you feel sad, depressed, or blue?

When was the last time you felt like crying?

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

Is it hard for you to concentrate on things?

Do you enjoy things now as much as usual?

SOMATIC CONCERNS
Excessive concern with bodily functions; preoccupation with one or more real or imagined physical complaints or disabilities; bizarre or unrealistic feelings or beliefs about his body or parts of body. Do not include mere dissatisfaction with appearance.

ANXIETY
Remarks indicate feelings of apprehension, worry, anxiety, nervousness, tension, fearfulness, or panic. When clearly associated with any of these feelings, consider insomnia, restlessness, physical symptoms (e.g., palpitations, sweating, dizziness, cramps), or difficulty concentrating, etc.

DEPRESSION
Remarks indicate feelings of sadness, depression, worthlessness, failure, hopelessness, remorse, guilt, or loss. When clearly associated with any of these feelings, consider crying, insomnia, poor appetite, fatigue, loss of interest or enjoyment, difficulty concentrating, or brooding, etc.
Figure 3 - Mean Psychiatric Status Schedule Scale Scores of Three Groups of Subjects

I. Subjective Distress
   - Inpatients (N=470)
   - Community Sample (N=130)
   - Outpatients (N=55)
   - Raw Score of 0

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
Wage Earner Role (95, 93, 24)*
Housekeeper Role (143, 75, 28)
Student or Trainee Role (70, 10, 4)
Mate Role (108, 82, 24)
Parent Role (91, 58, 25)

*Number scored on role scale, in order, by Inpatients, Community Sample, Outpatients.
Figure 4 - Mean Psychiatric Status Schedule Scale Scores of Four Schizophrenic Subtypes

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

Paranoid (N=110)
Acute Undifferentiated (N=28)
Chronic Undifferentiated (N=146)
Schizo-affective (N=20)
Figure 5
Mean Psychiatric Evaluation Form Scale Scores for Study Groups on Admission and at Four-Week Follow-up

- Susceptibility
- Grandiosity
- Denial of Illness
- Alcohol Abuse
- Belonging
- Grief
- Depression
- Anxiety
- Agitation
- Disorganization
- Suicide
- Self Mutilation
- Inappropriate Appearance
- Hallucinations
- Disorientation
- Paranoid

* Difference between Day and Inpatients significant at the .10 level.
Symposium: The Value of Standardized Interview

The evaluation form interview guide and the accompanying rating scales of broad dimensions of psychopathology. Such an interview guide gives the interviewer more freedom to ask the questions that are needed to make an adequate judgment of the broad dimension under study without having to go into the detail needed for specific items.

Interview schedules and guides should be organized in such a manner that when skillfully administered they have the flavor of a clinical interview. They can be used either to elicit information on small units of behavior (e.g., insomnia) or 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 the direct closed-ended questions, (e.g., “Do you need a drink to get through the day or to feel well?”).

Procedures which combine an interview schedule with an inventory of carefully defined relevant items or rating scales descriptive of psychopathology reduce sources of error variance present in the techniques for eliciting data as well as those for recording clinical judgments. In recording clinical judgments of psychopathology, careful attention should be given to defining terms, giving examples, and providing instructional material. Carefully defined rating scales and scales constructed by summing a series of items have been found to have high inter-rater agreement provided that the raters have access to the same interview data.

The authors and their colleagues have developed four procedures which combine an interview schedule or guide with a set of judgments which are recorded during or immediately after the interview. These include: the Mental Status Schedule (Spitzer et al., 1967), the Psychiatric Status Schedule (Spitzer, Endicott, Fleiss, & Cohen, 1970), the Psychiatric Evaluation Form (Endicott & Spitzer, in press [b]), and the Current Past Psychopathology Scales (Endicott & Spitzer, in press [a]).

In regard to inter-rater agreement, these procedures have been found to be highly reliable, with coefficients generally higher than those based on unstructured clinical interviews. 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. Examples of these uses are shown in several of the figures.

Figure 3 demonstrates the differentiation between groups of nonpatients, outpatients and inpatients who reside in the Washington Heights Section of New York City and who were evaluated by interviewers using the Psychiatric Status Schedule.

Similarly, different diagnostic groups and even subtypes within broad diagnostic categories are clearly differentiated. Figure 4 demonstrates diagnostic contrasts within a group of newly admitted schizophrenic inpatients. As can be seen, some of the dimensions which show the best discrimination are those that would be very difficult to measure by techniques that did not use clinical judgment or an interview to obtain the information (e.g., suspicion-persecution-hallucinations and memory-disorientation).

These procedures have also been found to be of value in evaluating response to treatment and have proven useful in determining the relative efficacy of different treatment modalities. For example, Figure 5 demonstrates the differential affects of two treatment modalities as measured by the Psychiatric Evaluation Form scales, (Hertz, Endicott, Spitzer, & Meznikoff, 1971).

In addition to the scoring systems, computer programs have been written to yield a Standard American Psychiatric Association psychiatric diagnosis. These programs take as input the data collected by either the Psychiatric Status Schedule (Hertz, Endicott, Spitzer, & Meznikoff, 1971), or the Current and Past Psychopathology Scales (Spitzer & Endicott,
1968; Spitzer & Endicott, 1969), and are based on a decision tree, rather than a statistical model. The computer-derived diagnoses have substantial agreement with diagnoses provided by a heterogeneous group of well trained clinicians. 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 or absence of schizophrenia. The computer-derived diagnoses have also been of value in the selection of subjects for experimental studies. In one experiment, subjects classified by the computer diagnosis into one of two diagnostic groups, schizophrenic or not ill, were more significantly differentiated on reaction time than were subjects with a hospital diagnosis of schizophrenia as compared with a group of volunteers who were presumably not ill.

Although there have been parallel advances in other procedures for evaluating psychopathology, we feel that in any broad assessment of psychopathology the interviewer will continue to be indispensable for a long time to come.

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