Is it possible to have a more objective diagnosis?

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The role of Structured Interviews in Psychological Assessment

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The question of a valid diagnosis is often central to the battle between plaintiff and defense lawyers. Is it possible to have greater objectivity about the diagnosis of common disorders such as PTSD, Major Depressive Disorder, and Panic Disorder? More common ground rather than 'no man's land' might help in the process of fair negotiation and settlement.

The clinical interview is the means a mental health professional uses to collect information about a client for the purpose of assessing his or her psychological condition and current level of functioning (Saigh, 1992). In a narrow sense it facilitates diagnosis according to a selected classification system such as the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) or the International Classification of Disorders (ICD-10) and, more broadly, leads to an understanding of the problem, its likely course, causes, treatment options and outcomes. It is the foundation on which a report from a psychiatrist or a clinical psychologist is built.

Unstructured Interviews

As the name suggests, unstructured interviews do not follow a particular format. Rather, the direction of the interview is shaped largely by the clinician's questions, which may be influenced by the context and purpose of the interview and individual characteristics of both the clinician and the client. The unstructured interview may therefore depend on the clinician's personal values, theoretical perspective, level of expertise in eliciting information, drawing inferences and interpreting responses. It is also dependent upon what information the client chooses to divulge.

Unstructured interviews can suffer from a bias towards a diagnosis formulated early in the interview, inappropriate weighting of information or attention to visual rather than verbal cues (Perloff, Craft & Perloff, 1986). It is not hard to see that there may be a considerable variety of information gained in such interviews. There may be differences in the assessment of one individual by two different clinicians or in assessments by the same clinician of different individuals with (objectively) the same presenting problem (Spiker & Ehler, 1984; Saigh, 1992; Silverman, 1994).

The differences in reports from mental health professionals can confuse and frustrate those involved in the legal process. It is sometimes hard to believe that it is the same individual being assessed! Another problem is that of idiosyncratic diagnoses, such as 'masked depression', that do not conform to any agreed diagnostic labels. All this contributes to the divergence of expert opinion in injury cases. Perhaps there is a better way...

Structured Interviews

The structured interview developed, in part, from a desire to formalise the clinical interview using a standardised protocol. This approach has the advantage of a wider breadth of coverage, eliciting more specific responses and placing them in a diagnostic context to assist in the interpretation of results.

The following statement by Richardson et al (1965, cited in Silverman, 1994, p.294) well encapsulates both the purpose and format of the structured interview:

> "Because the standardised interview is designed to collect the same information from each respondent, the answers of all respondents must be comparable and classifiable—that is, they must deal with precisely the same subject matter—and differences or similarities between the responses must reflect actual differences or similarities between respondents and not differences due to questions they were asked or to the meanings they attributed to the questions."

The structured interview is conducted (more or less) in accordance with predetermined questions using relatively standard wording.

According to Spitzer, Endicott & Robins (1978), differences in criteria were the main source of early diagnostic variability. As the development of formal classification (nosological systems) progressed, it became apparent that the initial fact-finding process would be more efficient and lead to more reliable outcomes if a diagnosis systematically addressed the relevant criteria. Both inclusion and exclusion criteria should be taken into account. In this way structured interviews have been revised to keep abreast of criteria in DSM-IV and ICD-10 (First, Spitzer, Gibbon & Williams, 1994).

Four theoretical assumptions relating to the validity of diagnostic classification have underpinned the development of structured interviews. To summarize what has been previously espoused by Spiker and Ehler (1984), the use of structured interviews assumes, first, that mental "disorders" exist—that is, that certain behaviours, psychological conditions or states can be termed dysfunctional, because they lead to discomfort, impairment or differ substantially from the norm. Second, it assumes that classification is expansive rather than reductionist, providing access to additional information regarding presentation, causes, course, alternatives for treatment, and prognosis. Third, it rests

on the assumption that each disorder is discrete and readily distinguishable from others and, finally, that they can be organized into a hierarchy, moving from broad categories to more specific disorders.

A number of issues must be carefully considered when developing a structured interview (Saigh, 1992). These include: clarity of items; avoidance of technical language, compound questions and double negative phrasing; consistency regarding proportional weighting of items; the length of interview; standardised instructions for administration, scoring and interpretation; empirical validation and revision; and the existence of peer review.

Clearly it is important to increase the reliability (the likelihood of achieving the same result) and validity (actually measuring what is intended to be measured) of diagnostic assessment and classification. While it helps to facilitate communication between clinicians (Spiker & Ehler, 1984), a structured interview can also provide some common ground, where experts actually agree, in the legal process.

The SCID Interview

In the last year the psychologists in our forensic practice have shifted to using *The Structured Clinical Interview for DSM-IV (SCID-I)* (APA, 1997) in all of our plaintiff and defense reports. I think that it has helped the assessments to become more complete and added credibility to diagnoses.

The SCID-I is the result of a research project that began in 1983 through the initiative of the National Institute of Mental Health (USA). It was anticipated that DSMIII criteria would become standard in the field. The present instrument was designed to facilitate diagnoses from DSMIV (Axis I). It is organized in six relatively self-contained modules: Mood Episodes, Psychotic Symptoms, Psychotic Disorders, Mood Disorders, Substance Use Disorders, Anxiety and Other Disorders (including PTSD).

It adopts a "decision-tree" approach, whereby the client's responses determine subsequent questions. It systematically screens a range of potential symptoms ensuring that the interview is comprehensive. It contains detailed instructions for discontinuing a line of questioning and provides prompts for eliciting further details as required. Further, it specifies standard ratings of both the frequency and the severity of symptoms. By following instructions, patterns of symptoms can then be converted to diagnoses. Nonetheless, unlike more rigid structured interviews, the SCID-I is intended to be used as an adjunct to, rather than a substitute for, clinical judgment. Further questioning as considered necessary by the clinician is therefore encouraged and reframing of questions in terms appropriate to the client is permitted. Ultimately a mental health professional must make a clinical judgement about when a diagnostic criterion is met.

One of the earliest written frameworks for the clinical interview was Meyer's "Outline of Examinations" (1951, cited in Spiker and Ehler, 1984). Meyer's framework, which included Family History, Personal History, Present Illness, Physical Examination and Mental Status, remains relevant today. So, too, is his wariness about neglecting other clinically relevant information. He advocated making a "concise statement of the symptom complex, or the reaction type, exactly as it occurs in the patient regardless of whether it accords with the customary types."

However, as useful as it is, it has been suggested that the SCID-I has some potential problems. It omits guidelines for the diagnosis of Pain Disorder which is central to many injury cases. The rigid format may interfere with rapport with the client. Answers may be short and provide minimal information, making it difficult to follow up potential leads. A structured interview is primarily aimed at determining whether a disorder is present, but such a focus can neglect to address specific family or individual dynamics in order to design an effective intervention or better understand behaviour problems. In addition a structured interview can date very quickly, especially when the diagnostic classification systems change. (Sattler, 1998, pp. 24-25) However, some of these problems can be overcome by a competent clinician who follows the SCID-I with relevant questions.

The potential strengths of a structured interview outweigh any weaknesses. The standardised questions address the specific criteria of diagnoses in DSM-IV. We have found that the results of the SCID-I fit in with the data from psychological tests to provide a more comprehensive and objective assessment. The combined approach leads to less disputable diagnoses. It can help to identify common ground for the negotiation of a fair settlement. ■

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