The Unstructured Clinical Interview

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In mental health, family, and community counseling settings, master's-level counselors engage in unstructured clinical interviewing to develop diagnoses based on the Diagnostic and Statistical Manual of Mental Disorders (4th ed., text rev.; DSM-IV-TR, American Psychiatric Association, 2000). Although counselors receive education about diagnosis and the DSM classification system, the majority of them are not specifically trained in clinical interviewing. This article provides information about using the unstructured clinical interview to make a DSM-IV-TR diagnosis for adult clients with Axis I and Axis II disorders.

The initial interview is the most fundamental area of counselor training; it is the beginning of every counseling relationship and the cornerstone of assessment. In mental health and community counseling settings, the initial interview, using an unstructured, open-ended approach, remains the primary assessment tool for diagnosing mental disorders based on the Diagnostic and Statistical Manual of Mental Disorders (4th ed., text rev.; DSM-IV-TR, American Psychiatric Association [APA], 2000; Craig, 2003; Miller, 2003; Sommers-Flanagan & Sommers-Flanagan, 2003). When used for purposes of diagnosis, the initial interview is known as the clinical interview or diagnostic interview.

Traditionally only a psychiatrist's task, the responsibility of diagnosing now falls to almost all master's-level counselors (marriage and family, mental health, and community; Bogels, 1994; Mead, Hohenshil, & Singh, 1997). Diagnostic training in counselor education program curricula has existed for the last 15 to 20 years, and the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2009) mandates that community and mental health counselors receive training on the use of the DSM-IV-TR (APA, 2000). Despite the emphasis in CACREP requirements for diagnostic training, the majority of counselors are trained in traditional interviewing techniques, not in clinical interviewing (Morrison, 1995; Turner, Hersen, & Heiser, 2003). Traditional interviewing techniques focus on gathering background history about the client, but they do not emphasize the identification of diagnostic signs and symptoms that aid in determining a diagnosis. The importance of clinical interviewing cannot be overemphasized because a client's DSM-IV-TR diagnosis is the primary basis for treatment planning. Being an effective clinical interviewer requires a broad knowledge of psychopathology and the current diagnostic system as means to properly evaluate the information obtained during the initial interview.

Information about clinical interviewing is scarce in the counseling literature or in counseling assessment textbooks. The literature that does exist on clinical interviewing is published mostly in psychiatry journals and textbooks, and much of that literature espouses the use of structured and semistructured interviews for accurate diagnosis (Basco, 2003). Despite the current emphasis on the use of structured and semistructured interviews, the unstructured clinical interview remains the most commonly used clinical assessment among psychiatrists and psychologists, as well as counselors (Craig, 2003; Miller, 2003; Sommers-Flanagan & Sommers-Flanagan, 2003).

The ability to interview for diagnosis is an important skill for counselors to develop. Counselors should know what information they need to obtain during the clinical interview and how that information is relevant to making a DSM-IV-TR (APA, 2000) diagnosis. This article provides (a) information about clinical interviewing for the purpose of making a DSM-IV-TR diagnosis, (b) the format of the unstructured clinical interview, and (c) examples of diagnostic clues and questions. This article focuses on interviewing adult clients with DSM-IV-TR Axis I and Axis II disorders. The term clinical interview is used throughout this article to describe interviewing for the purpose of developing a DSM-IV-TR diagnosis.

Clinical Interviewing

Clinical interviews may be unstructured, semistructured, or structured. Each approach has benefits and drawbacks, but the primary purpose of all three types is to obtain accurate information relevant in making a DSM-IV-TR (APA, 2000) diagnosis. Unstructured interviews consist of questions posed by the counselor with the client responses and counselor observations recorded by the counselor. This type of interview is considered unstructured because there is no standardization of questioning or recording of client responses; it is the counselor who is "entirely responsible for deciding what questions to ask and how the resulting information is used in arriving at a diagnosis" (Summerfeldt & Antony, 2002, p. 3). The accuracy of diagnoses based on unstructured interviews depends on the counselor's ability to recognize DSM-IV-TR diagnostic symptoms. Structured interviews are a type of diagnostic interview procedure that consists of a standardized list of questions; a standardized sequence of questioning, including follow-up questions; and the system-
atic rating of client responses (Bagby, Wild, & Turner, 2003). Semistructured interviews are less uniform than structured interviews and allow some flexibility for clinicians in terms of follow-up questions (Craig, 2003). Numerous studies attest to the improved accuracy in diagnoses when semistructured or structured interviews are used instead of the more traditional unstructured clinical interviews (Basco, 2003).

A comprehensive initial clinical interview is the first step in determining the initial DSM-IV-TR diagnosis and treatment plan. Despite its apparent weaknesses in accuracy of diagnosis, the unstructured clinical interview remains the most commonly used clinical assessment among psychiatrists, psychologists, and counselors (Craig, 2003; Miller, 2003; Sommers-Flanagan & Sommers-Flanagan, 2003), perhaps because of its flexibility in establishing rapport with the client (Turner et al., 2003). Some clinicians view the unstructured clinical interview as just one form of the assessment process, which involves the collection and integration of multiple forms of data from multiple sources (Bagby et al., 2003). Whether counselors use unstructured clinical interviews alone or use other assessment instruments to supplement the unstructured interview, they must be able to recognize diagnostic clues and engage in diagnostic questioning throughout the clinical interview to make a DSM-IV-TR diagnosis.

Diagnostic Clues and Questions

The ability to interview for diagnosis “without the counselor sounding as if he or she is reading off a checklist of symptoms and without getting sidetracked by less relevant information” (Carlat, 2005, p. 2) is an important skill for counselors to develop. The process of interviewing for diagnosis involves the counselor’s ability to listen for diagnostic clues: signs and symptoms of DSM-IV-TR (APA, 2000) disorders expressed by or observed in the client during the unstructured clinical interview. These clues can be viewed as red flags that the client may have a DSM-IV-TR disorder.

Counselors follow up diagnostic clues with diagnostic questions to help specify a diagnosis. By using diagnostic questioning, counselors focus on the client’s signs, symptoms, and behaviors, basing specific diagnostic questions on the diagnostic criteria of a particular disorder (Othmer & Othmer, 2002, p. 2). Ideas for diagnostic questions can be derived directly from diagnostic criteria provided for specific disorders in the DSM-IV-TR (APA, 2000), from published structured and semistructured interviews, or from textbooks on diagnostic interviewing.

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Although unstructured clinical interviews do not have a standardized format or standardized questions, it may be useful for counselors to follow a general outline consisting of several general content domains (APA, 2006; Carlat, 2005; Morrison, 1995; Othmer & Othmer, 2002). Counselors may use the outline to guide the interview process and organize interview questions on the basis of the diagnostic clues provided by the client. When counselors recognize diagnostic clues, they formulate specific diagnostic questions to obtain the information needed to determine a diagnosis.

The following section describes a general interview outline that counselors can follow when engaging in unstructured clinical interviews with adult clients. In addition, examples of diagnostic clues are provided for each section of the outline. In this article, I do not attempt to provide all the possible diagnostic clues that could be presented during an interview; however, I provide examples of diagnostic clues throughout the discussion with the goal of helping counselors understand the link between the background information received during the interview and the identification of diagnostic signs and symptoms that aid in making a diagnosis. Although not discussed fully in this article, it is understood that the therapeutic alliance is vital in forming the groundwork for the assessment process and effective counseling interventions.

Outline for an Unstructured Clinical Interview Format

A. Identifying Information

Identifying information includes the client’s name, sex, age, race/ethnicity, relationship status, and referral source.

Diagnostic clues—Besides providing basic information about the client, identifying information can provide clues to a potential diagnosis. For example, a client’s sex can be associated with vulnerability to certain mental illnesses—men have higher rates of substance abuse and antisocial disorders, whereas women are more vulnerable to depression, anxiety disorders, and somatic complaints (Klose & Jacobi, 2004). Referral source can also provide diagnostic clues. If a client was referred by a psychiatric hospital or other clinical setting, the client may have a previous DSM-IV-TR (APA, 2000) diagnosis that remains applicable to the current reason for counseling.

B. Presenting Problem/Chief Complaint

The presenting problem/chief complaint is a statement about the client’s problems or concerns that brought him or her to counseling. Presenting problems can be about the client’s psychological functioning (e.g., depression or anxiety), occupational functioning, or social functioning (e.g., problems in a current relationship).

Diagnostic clues—Counselors need to listen for psychological symptoms, patterns of maladjusted behavior, stressors, and interpersonal conflicts in order to pick up clues to diagnosis. For example, if the client expresses that he or she has problems sleeping, the counselor may wish to ask specific questions about depression. Or, if the client reports a recent divorce, diagnostic questions about adjustment disorder may need to be explored.
Diagnostic clues—Obtaining a history of the presenting problem is vital in establishing a diagnosis. For example, symptoms for major depressive disorder and dysthymic disorder share similar symptoms, with differences in onset, duration, and severity. The depressed mood in major depressive disorder is more severe and must be present for at least 2 weeks, whereas dysthymic disorder has milder symptoms and a duration of at least 2 years. In addition, a client’s identification of a stressor preceding the onset of symptoms (within 3 months) may indicate a diagnosis of adjustment disorder.

D. Family History

Family history focuses on information about the client’s family background, particularly about any history of psychiatric problems among family members. The following are common areas of questioning regarding family history (APA, 2006):

- Client’s first-degree relatives (parents, siblings, and children) and their mental health history
- Information about the client’s parents and siblings—age, education, and occupation
- Composition of the family during the client’s childhood and adolescence
- Medical history of family members
- Quality of the client’s relationships with family members, both past and present
- Any history of child abuse, substance abuse in the family, domestic violence, or other traumatic experiences
- Any family history of suicide or violent behavior

Diagnostic clues—Gathering information about the client’s family is important because many mental disorders are often associated with or exacerbated by the client’s current or past interactions with family members. Gathering information about family history can also help to uncover any previous experiences, such as child abuse, that may be associated with a mental disorder (e.g., posttraumatic stress disorder [PTSD]). In addition, mental disorders seem to have a genetic component; thus, the mental health history of older, first-degree relatives may predict the client’s future in terms of potential mental health problems (Othmer & Othmer, 2002). Disorders for which there is evidence of familial transmission include bipolar disorder, schizophrenia, depression, panic disorder, alcoholism, and anxiety disorders.

E. Relationship History

Relationship history consists of information about the client’s current living situation, current and previous marital and nonmarital relationships, number of children, and the nature of his or her social life and friendships. Questions may include the following:

- How many close friends do you have (aside from your spouse/partner)? Describe problems, if any, that you think you have in developing and keeping friendships.
- Are you in an intimate relationship or married? If yes, for how long?
- Tell me about your previous relationship. How long did it last? What happened?
- Describe problems, if any, that you think you have in developing and keeping intimate relationships.
- Has there ever been any violence in your current intimate relationship?
- Have you ever experienced violence in your past intimate relationships?

Diagnostic clues—Relationship history is important in determining whether the client has shown the ability to initiate and sustain intimate relationships. A pattern of short-term or the lack of long-term relationships may indicate a pattern of maladjustment indicative of people with personality disorders (Carlat, 2005; Othmer & Othmer, 2002). Questions often arise concerning the client who has few, if any, friends. Understanding why the client has few friendships is essential in determining whether the lack of friends is a sign of a mental disorder. For example, a client whose fear of possible humiliation causes him to avoid interacting with others may have a social phobia; in contrast, an individual who neither desires nor enjoys close relationships and has a pattern of living a solitary life may be diagnosed with schizoid personality disorder. Change in relationship status can also be associated with mental disorders; for example, divorce or separation appears to be a risk factor for mood disorders, anxiety disorders, and substance-related disorders in single mothers (Cairney, Pevalin, Wade, Veldhuizen, & Arboleda-Florez, 2006). Any history of violence in a relationship may be indicative of antisocial behavior, substance-related disorders, narcissist personality disorder, or anxiety problems in the perpetrator (Stuart, Moore, Kahler, & Ramsey, 2003) and of depression,
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anxiety disorders (e.g., PTSD), suicidality, and substance-related disorders in the victim (Golding, 1999).

F. Developmental History
The purpose of developmental history is to identify risk factors, cultural issues, and system variables (e.g., family, community) associated with the later development of mental disorders. Early developmental milestones (such as the age at which the client learned to walk, learned to speak, was toilet trained) are usually not worth asking about (Morrison, 1995). Questions should instead be focused on known child and adolescent risk factors associated with the development of mental disorders in adulthood. Areas to assess include the following:

- Behavior problems in childhood
- School performance (including failed grades)
- Childhood diagnosis of attention-deficit/hyperactivity disorder (ADHD)
- Childhood depression
- Child abuse
- Traumas and/or losses during childhood

Diagnostic clues—Most adult psychopathology is preceded by childhood mental disorders or other psychosocial risk factors (Rutter, Kim-Cohen, & Maughan, 2006). For example, child abuse and other childhood traumas have long been associated with later problems, including PTSD and antisocial behavior (Widom, 1989, 1998); conduct problems in childhood predict substance abuse, antisocial personality, and psychotic disorders in early adulthood (Sourander et al., 2005); adolescent-onset depression denotes a strong, specific, and direct risk for recurrence in adulthood (Rutter et al., 2006); and childhood ADHD is a precursor of later antisocial disorder (Mannuzza, Klein, Abikoff, & Moulton, 2004).

G. Educational History
Educational history consists of information about the client’s educational level and professional, technical, and/or vocational training. If not addressed in the developmental history section, education history can also include academic performance, failed grades, and social interaction with peers. Questions may include the following:

- Did you graduate from high school? If not, what was the highest grade level achieved?
- Did you go to college or receive technical/vocational training? If yes, describe the area of study.

Diagnostic clues—Problems in academic achievement have been linked with substance abuse problems, antisocial behavior, and other mental disorders in adulthood (McConaughy, 2000). In addition, because the onset of mental disorders often occurs early (i.e., 50% of all lifetime cases begin by age 14, and 75% of all cases by age 24), poor academic performance or interrupted education can be a sign of the early onset of mental illness (e.g., anxiety disorders, impulse-control disorders, and mood disorders; Kessler et al., 2005).

H. Work History
Work history consists of specific information about current employment status, length of tenure on past jobs, job losses, leaves of absence, and occupational injuries. The following are sample questions:

- Where is your current employment? What is your position? How long have you worked there?
- Where did you last work? What was your position? How long did you work there? Why did you leave? (Note. Ask these questions to document jobs held over a period of several years. Ask about any periods of time when the client did not work.)
- Were you ever in the military service? If yes, for how long? Did you experience combat? What was your discharge (e.g., honorable, general, dishonorable)?

Diagnostic clues—Work history can provide many clues that might indicate potential DSM-IV-TR (APA, 2000) disorders. Individuals with disabling mental disorders are less likely to be working and more likely to be unemployed, out of the labor force, or underemployed than are those without such disorders (Cook, 2006). Severe, disabling mental disorders such as schizophrenia are commonly known to be associated with work disability. However, research indicates that mood disorders, anxiety disorders, and substance abuse disorders—not the severely disabling types—are also associated with work-related problems such as reduced work activity, increased absenteeism, and lost productivity time (Kessler & Frank, 1997; Stewart, Ricci, Chee, Hahn, & Morganstein, 2003).

I. Medical History
The client’s medical history consists of information about previous and current medical problems (major illnesses and injuries), medications, hospitalizations, and disabilities. Questions may include the following:

- What is your current, overall health?
- Have you ever had a serious medical illness or injury?
- Have you ever been hospitalized for a medical problem?
- Are you taking any medications related to a medical problem?

Diagnostic clues—A number of medical illnesses and medications have resulting psychiatric symptoms or may aggravate existing psychiatric problems. Clients with increased risk for medical problems associated with their psychological difficulties include indigent persons (because of limited access...
to medical care); persons with well-established histories of medical illnesses or injuries; individuals with severe, disabling mental disorders (e.g., schizophrenia); and older adults (Pollak, Levy, & Breitholtz, 1999). Common medical problems associated with psychiatric symptoms include (among others) thyroid disorders, head trauma, neurological disorders, circulatory disorders, hepatitis, seizure disorder, lupus, electrolyte disturbances and B-vitamin deficiencies. Clues that a medical problem could be related to a client’s symptoms include the following (Pollak et al., 1999):

- Psychiatric symptoms begin following the onset of the general medical condition or while taking medications
- Psychiatric symptoms vary in severity with the severity of the general medical condition
- Psychiatric symptoms disappear when the general medical condition resolves
- Psychiatric symptoms onset after age 40
- Family history of heritable medical problems
- Signs during the interview of an altered state of consciousness, fluctuations in alertness and attention, disorientation, confusion, short-term memory loss, hallucinations, and changes in motor functioning (e.g., speech problems, unsteady gait, tremor, or problems with coordination)

J. Substance Use

Regardless of the client’s presenting problem, screening for alcohol and drug use is advisable (Hodgins & Diskin, 2003). Often, individuals who seek counseling have existing substance use problems, but they do not cite the substance use as a presenting problem to the counselor. It is important to rule out alcohol or drug use as the underlying cause or contributor to a client’s difficulties. When questioning for alcohol or drug use, it is helpful to begin with general questions about behaviors consistent with problematic substance use such as the following (Antick & Goodale, 2003):

- Do you drink coffee? Caffeinated? If yes, how many cups per day?
- Do you smoke (e.g., cigarettes)? If yes, how much do you smoke? For how long have you smoked? Have you tried to quit?
- Have you smoked in the past? If yes, when did you quit?

After asking about caffeine and smoking, move on to questions about alcohol and drug use such as the following:

- Do you enjoy a drink now and then? If yes, what kinds (e.g., beer, wine, distilled spirits)?
- In the last week, how many days did you drink alcohol (every day, 4–5 times, 1–2 times)?
- How much do you drink in one day (a case of beer, 12-pack, 6-pack, 1 to 2 beers)? How many drinks can you hold?
- Do you sometimes drink or use drugs more than you planned?
- Have you used any drugs in the past year? If yes, what kinds? (Be sure to ask about prescription drugs.)
- Have you ever had an arrest for driving under the influence or had other legal problems associated with drinking or using drugs?

Diagnosis clues—When questioning about specific substance use, it is important to know what is considered appropriate drinking limits. A standard drink is defined as one 12-ounce bottle of beer, one 5-ounce glass of wine, or 1.5 ounces of distilled spirits. According to epidemiologic research, men who drink 5 or more standard drinks in a day (or 15 or more drinks per week) and women who drink 4 or more drinks in a day (or 8 or more drinks per week) are at increased risk for alcohol-related problems (Dawson, Grant, & Li, 2005). Often, red flags for substance use problems can be determined by asking about problems at work, home, and school; problems with family or friends; or trouble with the law because of substance use. For example, substance abusers often have unstable work histories with a pattern of brief periods of work interspersed with periods of not working. Other indicators of substance use problems include housing instability, financial problems, violent behavior, mood swings, hygiene and health problems, and a family history of substance abuse.

Counselors may use the CAGE questionnaire (Ewing, 1984) to assess alcohol abuse problems during the unstructured clinical interview. The CAGE questionnaire is a very brief, relatively nonconfrontational questionnaire for detection of alcoholism. Alcohol dependence is likely if the client gives two or more positive answers to the following questions (Ewing, 1984, p. 1907):

- Have you ever felt you should Cut down on your drinking?
- Have people Annoyed you by criticizing your drinking?
- Have you ever felt bad or Guilty about your drinking?
- Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (Eye opener)?

K. Legal history

Legal history entails a description of past or current involvement with the legal system. This may include warrants, arrests, detentions, convictions, probation, or parole as an adult as well as involvement with the juvenile justice system. Specific questions may include the following (APA, 2006, p. 17):

- Have you ever felt you should Cut down on your drinking?
- Have people Annoyed you by criticizing your drinking?
- Have you ever felt bad or Guilty about your drinking?
- Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (Eye opener)?
• Do you have any past or current involvement with the legal system (e.g., warrants, arrests, detentions, convictions, probation, parole)?
• Do you have any past or current involvement with the court system (e.g., family court, workers compensation dispute, civil litigation, court-ordered psychiatric treatment)?

Diagnostic clues—A history of legal problems may be associated with aggressive behavior, antisocial personality disorder, substance-abuse-related disorders, or a manic episode of bipolar disorder (Morrison, 1995). Other past or current interactions with the court system (e.g., family court, civil litigation) may serve as significant stressors for the client and may indicate adjustment or anxiety disorders.

L. Previous Counseling
The history of previous counseling includes a chronological summary of the previous counseling sought by the client. Questions about previous counseling include the following:

• Have you ever been to counseling before (as an adult or a child)? If yes, why? How long did treatment last? Was it helpful?
• Have you ever been hospitalized for a psychiatric problem? If yes, why?
• Have you ever been on medications for psychiatric problems (e.g., antidepressants)?

Diagnostic clues—Information about the client’s previous counseling can provide clues about current diagnoses. Many disorders commonly recur, and the reason for the client’s previous counseling could apply to the client’s current problem. For example, at least 60% of individuals with a single episode of major depressive disorder can be expected to have a second episode (APA, 2000). Previous psychiatric hospitalization usually indicates that the client has experienced severe psychiatric symptoms such as suicidal behavior, homicidal or aggressive behavior, or psychosis (delusions or hallucinations). Thus, if the client reports being previously hospitalized for delusions, the counselor may wish to direct specific diagnostic questions about schizophrenia (or other psychotic disorders) or bipolar disorder. The client’s current or previous use of psychotropic medications may indicate disorders such as mood, anxiety, or psychotic disorder, depending on the medication prescribed.

M. Mental Status Examination (MSE)
The MSE is a screening evaluation of all the important areas of the client’s emotional and cognitive functioning. It is based on observations of the client’s nonverbal and verbal behavior, including the client’s description of his or her subjective experiences (Othmer & Othmer, 2002; Turner et al., 2003). The MSE consists of the following general domains: appearance and behavior, speech and language, thought process and content, mood and affect, and cognitive functioning (e.g., orientation, concentration, memory, and intellectual functioning; Sommers-Flanagan & Sommers-Flanagan, 2003). Although the MSE is commonly identified as a separate part of the interview process, most elements of the MSE are evaluated simultaneously throughout the unstructured clinical interview.

Although mental status information is useful in the diagnostic process, the MSE is not a primary diagnostic procedure and not appropriate for all clients (Sommers-Flanagan & Sommers-Flanagan, 2003). A good basic guideline is that an MSE becomes more necessary as suspected level of psychopathology increases. If the client appears to be well-adjusted and the counselor is not working in a medical setting, a full MSE is typically unnecessary. For more specific information about the MSE, the reader is referred to Polanski and Hinkle (2000).

Conclusion
As the role of counselors in mental health, family, and community counseling settings becomes more clinical, so does the need for more training on accurate diagnosing during the assessment process. The unstructured clinical interview is the primary assessment strategy used among counselors for determining a client’s DSM-IV-TR (APA, 2000) diagnosis. Because most master’s-level counselors (marriage and family, mental health, and community) must engage in clinical interviewing, they need to be aware of effective interviewing guidelines to aid in developing accurate DSM-IV-TR diagnoses.

Counselors should know what information they need to obtain during the unstructured clinical interview and how that information is relevant to making a DSM-IV-TR (APA, 2000) diagnosis. Counselors ask questions associated with several general content domains to receive comprehensive information to make a diagnosis. Throughout the interview, counselors look for diagnostic clues of DSM-IV-TR disorders and follow up those clues with diagnostic questions to help specify a diagnosis.

References


