An accurate diagnosis is an important precondition for effective psychotherapeutic treatment. The use of structured interviews provides the gold standard for reliable diagnosis. Suppiger et al. (2009) showed that structured interviews have a high acceptance among patients. On a scale from 0 (not at all satisfied) to 100 (totally satisfied) patients rated overall satisfaction with a structured interview at $M=86.55$. Nevertheless, therapists rarely seem to use structured interviews in clinical practice. The aim of this study was to assess how frequently therapists use structured interviews in daily practice. Secondly, we hypothesized that therapists underestimate patient acceptance of structured interviews. As a third goal, we explored further reasons why therapists choose not to use structured interviews. We conducted an online survey of 1,927 psychiatrists and psychotherapists in Switzerland and asked them how frequently they used structured interviews and how they estimated patient satisfaction with these interviews. Furthermore, we asked therapists why they chose to use or not use structured interviews. Therapists reported using structured interviews on average with about 15% of their patients. Furthermore, therapists estimated significantly lower patient acceptance than patients themselves indicated ($M_{\text{therapist}}=49.41$, $M_{\text{patient}}=86.55$). Our data suggest lack of familiarity with these instruments as well as an overestimation of the utility of open clinical interviews as further reasons for not using structured interviews.

**Keywords:** structured interview; acceptance; diagnosis
proven to be reliable and valid tools (Rogers, 2001; Suppiger et al., 2008). While classification manuals become increasingly complex, structured interviews help to clarify and facilitate the diagnostic process. In systematically assessing a wide range of diagnoses, structured interviews can help to detect comorbid conditions (Basco et al., 2000; Zimmerman & Mattia, 1999). Experts thus agree that use of structured interviews is the gold standard in research and clinical practice (Ehler, 2007; Joiner et al., 2005; Schneider & Döpfner, 2004; Silverman & Ollendick, 2005).

In research, use of structured interviews is well established. However, it is unclear whether this is the case in routine clinical practice. Researchers are concerned that structured interviews are very rarely used and instead open-ended clinical interviews are preferred in clinical practice (In-Albon et al., 2008; Pinninti, Madison, Musser, & Rissmiller, 2003; Shear et al., 2000; Suppiger et al., 2008, 2009). To our knowledge no empirical data are available on this issue.

If in fact structured interviews are used as rarely as suggested in clinical practice, it would be important to find out why therapists choose not to use them. Yet, there are no data concerning this question either. One potential reason for not wanting to use structured interviews could be that therapists assume patients dislike the interviews, they feel “questioned out,” and they perceive the relationship with the interviewer to be negative. To test this assumption and to explore whether patients in fact dislike structured interviews, Suppiger et al. (2009) conducted a study to assess the satisfaction of 183 patients who took part in a structured interview (DIPS; Schneider & Margraf, 2006). After the interview, patients filled out a questionnaire asking for their evaluation of the interview. This questionnaire contained 11 items assessing patients’ satisfaction with the interview and their emotional responses toward it. Patients’ responses were very positive. On a scale measuring their global satisfaction with the interview, 0 (not at all satisfied) to 100 (totally satisfied), patients’ ratings were on average $M=86.55$. Moreover, $96.7\%$ of the patients rated the relationship to the interviewer as positive and less than $15\%$ reported that they felt questioned out after the interview. More than $78\%$ stated that the procedure was helpful. These results go in line with other studies that report patients’ positive evaluation of structured interviews (Jonasson, Jonasson, Ekselius, & von Knorring, 1997; Marshall et al., 2001; Newman, Walker, & Gefland, 1999; Pinninti et al., 2003).

These results demonstrate that patients have a positive attitude toward structured interviews. However, it is not the patient but the therapist who decides whether a structured interview is administered. Therefore, for the use of structured interviews in clinical practice, it is not crucial what patients in fact feel, rather what therapists think they might feel. Hence, underestimated patient acceptance could have a major impact on the use or nonuse of structured interviews.

In our study, we wanted to assess how often practicing therapists use structured interviews in their daily clinical practice. Furthermore, we wanted to test whether therapists underestimate patient satisfaction with structured interviews. Besides this, therapists might also have additional reasons that prevent them from using structured interviews. As an additional question we therefore wanted to explore further reasons for not using structured interviews.

To assess these questions we sent an online survey to psychotherapists and psychiatrists in Switzerland asking them how often they used structured interviews. Furthermore, we enclosed the acceptance questionnaire of Suppiger et al. (2009) and asked the therapists to estimate patients’ evaluation of structured interviews. We also asked therapists to indicate their reasons for using or not using structured interviews. We expected that in most of the cases the therapists would not use structured interviews in their daily clinical practice and they would underestimate patient acceptance.

**Method**

**Sample**

For our sample, we used the official mailing lists of the three main professional organizations of psychotherapists (Föderation Schweizer Psychologen FSP [Confederation of Swiss Psychologists] and Schweizer Psychotherapeutinnen und Psychotherapeuten Verband SPV [Swiss Association of Psychotherapists]) and psychiatrists (Schweizerische Gesellschaft für Psychiatrie und Psychotherapie SGPP [Swiss Society for Psychiatry and Psychotherapy]) in Switzerland. All three organizations provide member lists on the Internet, predominantly used for patients seeking a therapist. Therefore, it is likely these lists are ecologically valid and representative of the psychotherapists and psychiatrists in Switzerland working in an outpatient setting. We used all $N=1,038$ available addresses of psychotherapists and $N=889$ addresses of psychiatrists.

One aim of this study was to compare therapists’ answers with the answers of the patient sample of the Suppiger et al. (2009) study. Therefore we used the patient sample of the Suppiger et al. study as a comparison group. There were $N=183$ participants.
in the Suppiger et al. study, about one-half of whom (51.6%) were recruited from an inpatient unit, 28.6% from an outpatient unit, and 19.8% from a research study. Approximately two-thirds of the patients (65.6%) were female. Their mean age was 38.56 years. About half of the sample (53%) were married or living with a partner. On average, patients received 2.33 (SD = 1.84, range 0–9) diagnoses. The mean Global Assessment of Functioning (GAF) scale score was 65.03 (SD = 14.79, range 35–97). Further details concerning this comparison group can be found in Suppiger et al. (2009).

**Procedure**

All therapists received an e-mail request to take part in the online survey. As an incentive, therapists who had completed the survey could take part in a lottery to win a voucher worth approximately US $200. After ensuring confidentiality, we provided a link to the survey questionnaire. Three weeks later we sent a reminder e-mail to all therapists thanking those who had already completed the survey and encouraging the others to participate.

**Survey Questionnaire**

The questionnaire contained several questions allocated in four subsections. The questions were developed by the authors. The items of Suppiger et al. (2009) were adapted and also incorporated.

**Section 1: Use of structured interviews, knowledge about structured interviews.** This section contained the question “With approximately what percent of your patients do you use structured interviews for diagnosis?” (question 1.1) Therapists could answer on a scale from 0 to 100%.

**Section 2: Estimation of patient acceptance.** This section was comprised of the 11 items of the patient acceptance questionnaire of Suppiger et al. (2009; questions 2.1–2.11). A global assessment scale ranging from 0 (not at all satisfied) to 100 (totally satisfied) measured the overall satisfaction of being interviewed with a structured interview. In addition to this key item, the questionnaire consisted of another 10 items measuring mental effort and emotional reaction of patients toward completing a structured interview. Five items were positively worded and five negatively worded. Answers were given on a 4-point Likert scale ranging from 0 (disagree) to 1 (slightly agree), 2 (almost completely agree), and 3 (completely agree). For detailed information concerning the development of the questionnaire and its psychometric properties, see Suppiger et al. (2009).

In our survey, we presented the items of the questionnaire and asked the therapists to estimate how their patients would evaluate a structured interview. To make it easier for the therapists, we changed the formulation of the questions from the first- to the third-person perspective and added the phrase “after a structured interview.” For example, the item “I feel questioned out” (patient version) was changed to “After a structured interview patients feel questioned out” (therapist version). Besides these changes, we kept the wording the same in both versions to ensure identical content. The response format was the same in both the patient and the therapist versions. The items in both the patient and the therapist versions are included in the Appendix.

**Section 3: Reasons for or against the use of structured interviews.** This section contained the question “Which arguments for or against the use of structured interviews do you agree with?” (question 3.1). We presented a list of possible reasons for and against the use of structured interviews. Therapists could mark all alternatives with which they agreed. In addition to the given alternatives, therapists could list their personal reasons for or against the use of structured interviews in a blank field.

Furthermore, we asked several other questions concerning familiarity with structured interviews and evaluation of them. These questions were 3.2 “How familiar are you with structured interviews?” (scale from 0 [not at all] to 4 [very]), 3.3 “How helpful do you perceive DSM-IV and/or ICD-10 diagnoses to be for your everyday practice?” and 3.4 “How helpful do you perceive structured interviews to be for your everyday practice?” (scale from 0 [not at all] to 4 [very] for both questions). The last two questions were included in order to assess therapists’ attitude toward DSM-IV or ICD-10 diagnoses, in comparison with their attitude toward structured interviews in general.

**Section 4: Sociodemographic data.** In this section we asked therapists for their sex, age, and their theoretical orientation. We also asked them for their degree (medicine vs. psychology), years of work experience, amount of therapy hours (full vs. part time), and their scope of work (inpatient vs. outpatient).

**Response Rate**

The response rate was in total 25.7% (n = 495) with 14.1% (n = 272) of the therapists responding to our first e-mail and an additional 11.6% (n = 223) responding following our reminder. It is possible that among the contacted 1,927 therapists a certain percentage did not receive our e-mail, possibly because their address was not currently in use. Therefore, the response rate might be somewhat higher than 25.7%. As some therapists did not fill
out the complete survey, the resulting $n$ for some analyses is smaller than 495. The average age of the therapists was 52 years ($SD=8.54$) and 53% were female. They had an average of 19 years of work experience ($SD=8.97$). Of the participating therapists, 89% stated that they work in an outpatient setting and 11% stated that they work in an inpatient setting. As their main therapeutic orientation, 19% indicated cognitive behavior therapy, 22% psychoanalysis, 11% depth psychotherapy, 18% systemic, 12% Rogerian, and 5% gestalt therapy (therapists could choose only one alternative). Slightly more psychologists than psychiatrists responded to the survey ($28.1$ vs. $23.0\%$, respectively), $\chi^2(1, N=495)=5.23, p<.05$. Psychologists and psychiatrists did not differ significantly in their demographic characteristics such as age and years of work experience, except that there were more female psychologists than female psychiatrists ($62$ vs. $40\%$, respectively), $\chi^2(1, N=379)=16.96, p<.001$.

Statistical Analysis
To compare therapists’ estimations with patients’ answers, we performed $t$ tests for independent samples. In this analysis we included therapists’ estimations obtained in this study ($N=495$) and compared them to patients’ answers in the acceptance questionnaire ($N=183$) from the Suppiger et al. (2009) study. To analyze which factors predicted use of structured interviews, we performed a hierarchical analysis of regression. Categories were developed for open questions. Therapists’ answers were categorized by two independent raters.

Results
USE OF STRUCTURED INTERVIEWS
The hypothesis that therapists seldom use structured interviews was supported by our data. On average, therapists stated that they use structured interviews with $14.8\%$ of their patients. More than half of the therapists ($51.6\%$) stated that they never used structured interviews with any of their patients (see Fig. 1). Psychologists and psychiatrists, respectively, did not differ significantly in their use of structured interviews, $M_{\text{psychologists}}=15.4, M_{\text{psychiatrists}}=14.1, t(368)=0.52, ns$.

Estimation of Patients’ Acceptance
Our hypothesis that therapists underestimate patient acceptance was also confirmed by the data. With regard to the global satisfaction scale, as well as the other 10 items, therapists clearly underestimated patient satisfaction (see Fig. 2). Looking at the global satisfaction rating, therapists estimated the global patient satisfaction on average of $M=49.41, SD=24.3$. In contrast, patient ratings reported by Suppiger et al. (2009) were on average $M=86.55, SD=13.2$. This difference was significant, $t(521)=23.20, p<.001$ (two-tailed); $d=1.90$.

With regard to the 10 other items, the highest therapist rating, scale 0 (disagree) to 3 (completely agree), was observed for the item “In a structured interview patients do not report everything that is bothering them” ($M=1.85$), which was one of the negatively formulated items. In contrast, patients themselves showed a very low agreement with this item (“I did not report everything that was bothering me”; $M=0.56$) in the Suppiger et al. (2009) study. This difference was significant, $t(544)=−16.08, p<.001$ (two-tailed); $d=−1.48$. Also, in the other four negatively worded items (“too many questions,” “feel ‘questioned out,’” “exhausting,” and “more confused,” see Fig. 2) therapists’ estimations were significantly higher than patients’ ratings reported by Suppiger et al. (2009), $M_{\text{therapist}}=1.24$ versus $M_{\text{patient}}=0.70, t(550)=−6.92, p<.001$ (two-tailed), $d=−0.62$; $M_{\text{therapist}}=1.23$ versus $M_{\text{patient}}=0.46, t(554)=−10.59, p<.001$ (two-tailed), $d=−0.98$; $M_{\text{therapist}}=1.11$ versus $M_{\text{patient}}=0.61, t(552)=−7.07, p<.001$ (two-tailed), $d=−0.64$; and $M_{\text{therapist}}=0.53$ versus $M_{\text{patient}}=0.28, t(552)=−4.30, p<.001$ (two-tailed), $d=−0.39$.

With regard to four of the positively formulated items (“enough detail for appropriate understanding,” “positive relationship to the interviewer,” “feel taken seriously,” and “procedure perceived as helpful”) therapists’ estimations were between $M=1.01$ and $M=1.66$ (see Fig. 2). This indicates moderate agreement. However, patient ratings reported by Suppiger et al. (2009) for these items were between $M=2.12$ and $M=2.72$ and therefore considerably higher. This difference was significant for all four items (all $p<.001$, two-tailed). The fifth positively formulated item, “better understanding of problems after interview,” was the only item where therapists’ estimations did not differ.

FIGURE 1 Use of structured interviews among therapists.

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significantly from patients’ ratings, $M_{\text{patient}} = 0.94$ versus $M_{\text{therapist}} = 1.01$, $t(540) = -0.95, ns$. In all items, psychologists and psychiatrists did not differ significantly in their answers.

These results show that therapists underestimated patient acceptance. The difference was particularly noteworthy for items concerning patients’ emotional response toward a structured interview.

**Therapists’ Arguments Against Using Structured Interviews**

The third goal of our study was to explore further reasons for therapists not to use structured interviews in their clinical practice. Fig. 3 shows the percentage of therapists’ agreement with the different statements for or against the use of structured interviews. Interestingly, therapists mostly agreed with two statements arguing for the use of structured interviews: “They help not to overlook something” (63%; $N = 253$ of 399) and “They are a reliable source of information” (43%; $N = 170$ of 399). This indicates that therapists are aware of the strengths of structured interviews and seem to value them.

However, since therapists reported that they use structured interviews only with an average of 14.8% of their patients, the reasons against using structured interviews might be of more practical relevance for the therapists than the reasons for using structured interviews. Of the list of reasons for not using structured interviews, therapists showed the highest agreement with the alternative “my clinical judgment is more useful to me” (37%; $N = 148$ of 399). The second- and third-highest agreement was shown, respectively, with the alternatives “They take too long” (34%; $N = 135$ of 399) and “They disturb the relationship to the patient” (32%; $N = 126$ of 399). The percentage of agreement with the other alternatives can be seen in Fig. 3.

Therapists could give further reasons as a free response. The $N = 111$ answers were summarized in several categories. The most frequent categories, in descending order, were “The patient feels uncomfortable/it disturbs the relationship of patient and therapist”; “Structured interviews are too mechanistic and inflexible”; “I am not familiar with these instruments”; “Structured interviews interfere with general conditions like costs and time”; “Other concepts, other information is relevant” (e.g., transference–countertransference); “Structured interviews are hard to learn on one’s own, too complicated”; and “Detailed criticism of aspects of structured interviews” (e.g., skip out of order, unclear, formulation of questions not optimal).

**Helpfulness of Structured Interviews, Familiarity With Structured Interviews**

The answers to the additional questions in this section of the survey (3.3, 3.4) shed some further
light on the question why structured interviews may be used so seldomly. Concerning question 3.3, “How helpful do you perceive DSM-IV and/or ICD-10 diagnoses to be for your everyday practice?”; scale 0 (not at all) to 3 (very much) therapists’ answer was on average $M=1.69$ (cf. Fig. 4). However, concerning question 3.4 “How helpful do you perceive structured interviews to be for your everyday practice?”; scale 0 (not at all) to 3 (very much) therapists’ answer was on average $M=0.99$ and therefore significantly lower; $t(393)=13.72, p<.001$. This indicates that therapists tend to appreciate DSM-IV or ICD-10 diagnoses, but do not consider structured interviews to be necessary in order to derive these diagnoses.

Concerning question 3.2 “How familiar are you with structured interviews?” 35% of the therapists stated “not at all/hardly,” 42% “a little,” 17% “quite well,” and only 6% chose the alternative “very well.” These results show that according to therapists’ own report, there is a remarkable lack of knowledge of structured interviews.

To assess whether therapists’ reasons against structured interviews were associated with their use of structured interviews, we conducted a hierarchical analysis of regression. We tried to predict therapists’ use of structured interviews (question 1.1 “With approximately what percent of your patients do you use structured interviews for diagnosis?”) with their reasons for not using them. In the first block we included the different reasons against the use of structured interviews (i.e., “They take too long,” “They disturb the relationship to the patient,” etc.) as predictors. In the second block we included question 3.2 “How familiar are you with structured interviews?” and the global acceptance rating. We did this in order to obtain a more powerful predictor assessing specifically whether the underestimation of patient acceptance and the knowledge of structured interviews predict their use. In the third block, we included personal and sociodemographic variables such as sex, age, or theoretical orientation to assess whether these variables related to the use of structured interviews. The dependent variable (use of structured interviews) was log transformed to meet assumptions of regression analysis.

The overall model explained 45.8% of the variance. Blocks 1 and 2 reached statistical significance whereas Block 3 did not ($R^2=.28$ for Step 1, $\Delta R^2=.15, p<.001$ for Step 2; $\Delta R^2=.02$ for Step 3, $ns$). Among the reasons against the use of structured interviews, the statements “My clinical judgment is more useful to me,” “They disturb the relationship to the patient,” and “I am not familiar with these types of interviews” were significant predictors for the use of structured interviews. Therapists’ knowledge of structured interviews as well as their global patient
estimation (Block 2) were also significant predictors. The inclusion of these predictors raised the explained variance from 28.4 to 43.7%, $\Delta R^2 = .14$, $p < .001$. Looking at the results of the third block, a cognitive–behavioral–therapeutic orientation was significantly associated with a higher use of structured interviews. All other variables such as sex and age were not significant predictors. All in all, the inclusion of these variables in Block 3 did not significantly improve the model, $\Delta R^2 = .02$, $ns$.

**Discussion**

Our study reveals that structured interviews are rarely used in clinical practice. This finding, even though it has been assumed repeatedly (In-Albon et al., 2008; Pinninti et al., 2003; Shear et al., 2000; Suppiger et al., 2008), has not been empirically shown heretofore. Such findings might have relevance for the quality of diagnoses and, as a result, the quality of treatment in routine clinical practice.

Our study shows that therapists underestimate patient acceptance. A look at the effect sizes shows that this underestimation was pronounced. For a thorough interpretation of this result, it is important to consider whether the patients assessed by Suppiger et al. (2009) were comparable to the patients seen by the therapists participating in this study. We recruited therapists through official mailing lists for patients. This list mostly contained therapists working in outpatient settings. As noted, 89% of the participating therapists stated that they work in an outpatient setting and 11% in an inpatient setting. The 183 patients assessed by Suppiger et al. included patients from outpatient (28.6%), inpatient (51.6%), and research (19.8%) settings. The results referred to were average values across all patients. However, the three groups only minimally differed in their acceptance ratings (see Suppiger et al., 2009, Table 1). There was a significant difference in the overall satisfaction score between the research group and the two clinical groups, but not between the inpatient group and the outpatient group. The average acceptance ratings of the outpatients were very similar to the acceptance ratings across all patients. A closer look reveals that the outpatient group of Suppiger et al. showed a higher acceptance than average in 9 of the 11 items. Therefore, a comparison of the therapists’ ratings with only the outpatient group of Suppiger et al. (2009) results in a very similar outcome or even in a higher difference between patient acceptance and therapists’ estimation.

The reported underestimation of patient acceptance shown by the therapists is significantly related to a less frequent use of structured interviews. These results show that the rare use of structured interviews is at least partly based on a mistaken assumption about the patients’ feelings. In a strict sense, our results do not demonstrate that the underestimation of patient acceptance is causal for the rare use of structured interviews. It might be that therapists who do not use structured interviews retrospectively try to explain their behavior with the assumption that patients would dislike the interviews. However, our further results show that many therapists themselves, as one reason for not using structured interviews, name the assumption that the interview would harm the relationship to the patient or be unpleasant for the patient. This suggests that the rare use of structured interviews might in fact be a consequence of the underestimation of patient acceptance.

Besides the underestimation of patient acceptance, our results suggest further reasons for the rare use of structured interviews. One important factor might be therapists’ lack of familiarity with structured interviews. Our results concerning the question “How familiar are you with structured interviews?” show that therapists’ knowledge of structured interviews is

### Table 1

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<tr>
<th>Summary of Hierarchical Regression Analysis for Variables Predicting Therapists’ Use of Structured Interviews (N=311)</th>
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<tr>
<td>Knowledge about structured interviews</td>
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<td>Estimation of global patient satisfaction</td>
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<td>Argument “I am not familiar with these types of interviews”</td>
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<tr>
<td>Cognitive behavior therapy (yes vs. no)</td>
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<td>Argument “my clinical judgment is more useful to me”</td>
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<tr>
<td>Argument “the information is not relevant for therapy”</td>
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<td>Argument “they are unpleasant for patients”</td>
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<td>Systemic (yes vs. no)</td>
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<td>Depth psychotherapy (yes vs. no)</td>
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<td>Argument “they disturb the relationship to the patient”</td>
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<tr>
<td>Argument “other reasons against”</td>
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<tr>
<td>Age of therapist</td>
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<td>Psychologist (vs. psychiatrist)</td>
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<td>Gestalt (yes vs. no)</td>
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<td>Argument “they are too detailed”</td>
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<td>Argument “they take too long”</td>
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<td>Sex of therapist</td>
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<td>Psychoanalysis (yes vs. no)</td>
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<td>Rogerian (yes vs. no)</td>
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<td>Years of working experience</td>
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Note. r = zero-order correlation; * $p < .05$; ** $p < .01$.  


very limited. The answer “I am not familiar with these types of interviews,” among the arguments against structured interviews (question 3.1) points in that direction, even if it was chosen by only 17% of the therapists. However, the agreement of 17% might be an underestimation accounted for by social desirability. Interestingly, even if only 17% of the therapists marked this alternative, it was significantly related to the use of structured interviews. Furthermore, among the open answers, a remarkable number of therapists stated not being familiar with these instruments as a reason for not using structured interviews. All in all, these results suggest that the lack of familiarity with structured interviews might be the second important explanation for their rare use. Again, this result does not allow us to draw causal conclusions, as a less frequent use of structured interviews also might lead to less familiarity with these instruments. However, about one-third of therapists stated that they were almost totally unfamiliar with structured interviews. Furthermore, more than 17% of the therapists explicitly named their unfamiliarity as a reason for not using structured interviews. Therefore, it is likely that their unfamiliarity is at least partly a cause for the therapists not to use these instruments. Further research is needed to assess the causal relation of therapists’ use of structured interviews and their familiarity with them. One possible way to assess this question would be to assess therapists’ use of structured interviews before and after a training course for structured interviews.

Furthermore, our results on the questions concerning the helpfulness of DSM-IV diagnoses versus the helpfulness of structured interviews show that therapists, although they appreciate DSM-IV diagnoses, seem not to consider a structured interview necessary for making DSM-IV diagnoses. This suggests that, as a third reason, therapists might overestimate the reliability and validity of an open clinical judgment. This assumption is supported by the fact that therapists most frequently agreed with the argument “My clinical judgment is more useful to me.” Again, the agreement with this statement was significantly related to a less frequent use of structured interviews. However, several studies have shown that open clinical judgment leads to less reliable diagnoses and lower detection of comorbidity (e.g., Zimmerman & Mattia, 1999). Therefore, an overestimation of open clinical judgment may have relevant consequences for the quality of diagnoses and treatment in clinical practice.

A fourth reason for therapists not to use structured interviews appears to be the length of time that is required for the interview. Interestingly, however, patients do not seem to perceive the length of the interview negatively, as the patients’ high acceptance ratings derive from a study where the mean administration time of a structured interview was 104.87 minutes (SD = 47.27; Suppiger et al., 2009).

Our results also show that therapists with a cognitive–behavioral orientation were more likely to use structured interviews than therapists with a different therapeutic orientation. This could be explained by the fact that the cognitive–behavioral approach fosters a more empirical, data-driven approach to diagnosis, which might increase the use of instruments like structured interviews. This finding goes in line with the results of Bruchmüller and Meyer (2009), who showed that therapists with a cognitive–behavioral approach were more likely to make diagnoses in accordance with DSM-IV criteria than therapists with a psychodynamic approach.

One limitation of our study might be that our results are based on therapists’ self-reports and therefore might be affected by social desirability. However, as therapists’ participation in the survey was anonymous, this seems less likely. Furthermore, as therapists frequently acknowledged not to know much about structured interviews and not to use them, our data does not appear to be greatly biased by social desirability.

Furthermore, the question arises whether our results concerning the use of structured interviews could be generalized to countries other than Switzerland. However, researchers in the United States (Pinninti et al., 2003; Shear et al., 2000) are also concerned that structured interviews are very rarely used in clinical routine care. This suggests that use of structured interviews outside of Switzerland might be comparably low. However, to fully answer this question, international studies are needed.

Our results suggest several options to enhance the use of structured interviews in daily clinical routine. First of all, it is essential to inform therapists about patients’ positive attitude toward a structured interview. It is important for therapists to know that patients would be receptive to structured interviews and that patient concerns are often overestimated. Furthermore, it is also significant to explain the disadvantages of open clinical judgments in deriving reliable DSM-IV or ICD-10 diagnoses. However, one of the most important consequences might be to train future clinical psychologists on structured interviews and their application. The consideration of these issues will hopefully lead to a more frequent use of structured interviews and thus help to ensure optimal diagnosis and treatment for a wide range of patients in routine clinical practice.
### Appendix

**Acceptance-Questionnaire: Patient and Therapist Version**

<table>
<thead>
<tr>
<th>Item No.</th>
<th>Patient Version (questions from Suppiger et al., 2009)</th>
<th>Therapist Version</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 global acceptance rating</td>
<td>Bitte machen Sie ein Kreuz auf der untenstehenden Skala, um zu beurteilen, wie zufrieden Sie insgesamt mit dem eben stattgefundenen Interview sind. Please indicate on the scale below how satisfied you are with this structured interview.</td>
<td>Bitte machen Sie ein Kreuz auf der untenstehenden Skala, um einzuschätzen, wie zufrieden Ihre Patienten Ihrer Meinung nach generell mit strukturierten Interviews zur Diagnostik sind bzw. wären. Please indicate on the scale below your estimation of how satisfied you think your patients are, or would be, in general with structured interviews for diagnosis.</td>
</tr>
<tr>
<td>2.2 “more confused”</td>
<td>Ich fühle mich verwirrter als vor dem Interview. I feel more confused than before the interview.</td>
<td>Nach einem strukturierten Interview fühlen sich Patienten verwirrter als zuvor. After a structured interview, patients feel more confused than before.</td>
</tr>
<tr>
<td>2.3 “feel ‘questioned out’”</td>
<td>Ich fühle mich ausgefragt. I feel “questioned out.”</td>
<td>Nach einem strukturierten Interview fühlen sich Patienten ausgefragt. After a structured interview, patients feel “questioned out.”</td>
</tr>
<tr>
<td>2.4 “too many questions”</td>
<td>Es waren mir zu viele Fragen. There were too many questions.</td>
<td>Patienten finden, dass ein strukturiertes Interview zu viele Fragen beinhaltet. Patients think that structured interviews have too many questions.</td>
</tr>
<tr>
<td>2.5 “exhausting”</td>
<td>Das Interview war zu anstrengend. The interview was exhausting.</td>
<td>Patienten finden ein strukturiertes Interview zu anstrengend. Patients find structured interviews exhausting.</td>
</tr>
<tr>
<td>2.6 “feel taken seriously”</td>
<td>Ich habe das Gefühl, der Interviewer nimmt meine Probleme ernst. I think the interviewer took my problems seriously.</td>
<td>Bei einem strukturierten Interview haben Patienten das Gefühl, dass der Interviewer ihre Probleme ernst nimmt. In a structured interview patients feel that the interviewer takes their problems seriously.</td>
</tr>
<tr>
<td>2.7 “positive relationship to the interviewer”</td>
<td>Die Beziehung zum Interviewer habe ich als angenehm empfunden. The relation to the interviewer was positive.</td>
<td>Die Beziehung zum Interviewer empfinden Patienten bei einem strukturierten Interview als angenehm. The relationship to the interviewer is perceived as positive by the patient in a structured interview.</td>
</tr>
<tr>
<td>2.8 “not report everything that is bothering”</td>
<td>Heute habe ich nicht alles vorgebracht, was mich wirklich bewegte. I didn’t report everything that was bothering me.</td>
<td>Patienten bringen in einem strukturierten Interview nicht alles vor, was sie bewegt. Patients do not report everything that is bothering them in a structured interview.</td>
</tr>
<tr>
<td>2.9 “better understanding of problems after interview”</td>
<td>Ich habe das Gefühl, dass ich mich selber und meine Probleme nach dem Interview besser verstehe. Due to the interview I have a better understanding of myself and my problems.</td>
<td>Patienten haben das Gefühl, dass sie sich selber und ihre Probleme nach einem strukturierten Interview besser verstehen. Patients have the feeling that they understand themselves and their problems better, after a structured interview.</td>
</tr>
<tr>
<td>2.10 “enough detail for appropriate understanding”</td>
<td>Ich denke, der Interviewer hat genau nachgefragt, um meine Situation zu verstehen. I think the interviewer asked for enough detail to get an appropriate understanding of my situation.</td>
<td>Patienten denken, dass der Interviewer bei einem strukturierten Interview genau nachfragt, um ihre Situation zu verstehen. After a structured interview, patients think that the interviewer asked for enough detail to get an appropriate understanding of their situation.</td>
</tr>
<tr>
<td>2.11 “procedure perceived as helpful”</td>
<td>Das Vorgehen des Interviewers habe ich als hilfreich erlebt. The procedure used by the interviewer was helpful.</td>
<td>Patienten erleben das Vorgehen des Interviewers bei einem strukturierten Interview als hilfreich. Patients perceive the procedure used by the interviewer as helpful in a structured interview.</td>
</tr>
</tbody>
</table>

*Note. Question 2.1 could be answered on a scale from 0 (not at all satisfied) to 100 (totally satisfied). All other questions could be answered on a scale from 0 (disagree) to 3 (completely agree).*
References


Ehler, U. (2007). Eine Psychotherapie ist immer nur so gut wie ihre Diagnostik. (A psychotherapy is only as good as its diagnosis.). *Verhaltenstherapie*, 17, 81–82.


Received: August 5, 2010
Accepted: February 11, 2011
Available online 6 May 2011