This remarkable book fills a substantial gap in psychiatric research and practice, which, though often unrecognized, has fueled the current state of crisis in psychiatry and brought along not only scientific stagnation but also inadequate treatment of the patients, whose care is the raison d’être of the discipline. What I am alluding to here is the very bedrock of psychiatry, namely psychopathology (i.e. symptoms and signs) and how to assess it properly in the diagnostic interview. In the absence of extra-clinical markers, mental disorders are defined on the basis of sets of diagnostic criteria that contain specific symptoms and signs (along with duration, functional, and exclusion criteria). Allocating diagnoses to patients is not a goal in itself but a first, necessary step to provide adequate treatment for the patients and to further the understanding of mental disorders through research. In other words, everything hinges on getting the diagnosis right, which of course is tantamount to saying that we must get the psychopathology right. Unfortunately, therein lies the problem: far too often, we don’t get the psychopathology and diagnosis right. If psychiatry is to recover from its current crisis, a restoration of psychopathological knowledge, of differential-diagnostic know-how, and of the art of psychiatric interviewing is urgently needed. This book delivers on all these parameters.

The book is written by two highly experienced clinicians and researchers, who have extensive knowledge of psychopathology, differential-diagnosis, and psychiatric interviewing. The book is divided into two parts. The first part explores the essentials of the diagnostic interview, and the second part deals with the question of how to navigate between the different diagnostic spectra, including organic pathology, schizophrenia spectrum disorders, affective disorders, anxiety disorders, and personality disorders. Given the complexity of the topics covered in this book, I will in this review focus narrowly on, what I consider, two of its most significant contributions to the field, namely the authors’ discussion of the nature of the psychiatric interview and of the necessity of grasping the psychopathological Gestalt in any differential-diagnostic assessment. To fully appreciate these contributions, I will also try to elucidate the current way of diagnosing, which this book problematizes and offers solutions to rectify.
Psychopathological information is obtained in the diagnostic interview by talking to patients about their experiences (symptoms) and by observing their behavior (signs). Inevitably, this puts high demands on the clinician conducting the interview. Her clinical experience and psychopathological knowledge will affect what she hears and observes, how she interprets this information, and, more basically, what kind of psychopathological information she is able to elicit during the interview. Furthermore, as the authors emphasize, “the quality of the rapport established with the patient is probably the most decisive factor determining the quality of the data collected during the interview” (Jansson & Nordgaard 2016, 28). The obvious conclusion is that it takes years of training and supervision by experts to become a skilled clinician and interviewer. However, in the wake of the “operational” revolution in psychiatry, which took place with the introduction of polythetic diagnostic criteria in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (APA 1980), a “short-cut” to the diagnostic interview was introduced, viz. the fully structured interview. By asking all patients the same series of preformulated questions, presented in a fixed order and tailored as closely as possible to the diagnostic criteria, the intention was to minimize ‘information’, ‘criteria’, and ‘interpretation’ variance and thereby improve diagnostic reliability (Spitzer 1983, 401; Jansson & Nordgaard 2016, 30f.). Notably, Robert Spitzer, chair of the American Psychiatric Associations’ Task Force on Nomenclature and Statistics in the construction of the DSM-III, argued that non-clinicians could conduct a highly structured diagnostic interview and make reliable diagnosis, and he posed his now famous, polemic question, “are clinicians still necessary?” (Spitzer 1983). Spitzer, also being an architect of the Structured Clinical Interview for DSM-III (SCID), strongly believed that the structured interview was part of the solution to the problems of diagnostic reliability reported in the 1970s (e.g., Cooper et al. 1972), yet he suspected that clinicians would indeed still be “necessary” or, as he also put it, “at least highly desirable […] to make the most valid psychiatric diagnoses” (Spitzer 1983, 400f.; my italics). Specifically, Spitzer hypothesized that since clinicians, unlike non-clinical interviewers, know the intent of the diagnostic criteria, they would not merely accept a simple ‘yes’ or ‘no’ answer to a question and thereby be likely to minimize false-positives.

For several decades, the structured interview has been the “gold standard” in psychiatric research and increasingly also in clinical work,¹ often administered by non-clinical interviewers. Thus, when Jansson and Nordgaard critically

---
¹ Examples of structured diagnostic interviews are the SCID: Structured Clinical Interview for DSM-IV (First et al. 2002) and the MINI: Mini International Neuropsychiatric Interview (Sheehan et al. 1998).