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THE ROLE OF CLINICAL EXPERIENCE IN MENTAL HEALTH ASSESSMENT

There are data showing clinical experience as disadvantageous for the quality of mental health assessment. On the other hand, according to American Psychological Association standards of evidence-based practice in psychology, clinical experience is one of the fundamental factors in professional psychological practice. The paper presents this controversy in the context of relevant psychological knowledge and empirical data. The conclusions are as follows: (1) the valuable input that clinical experience may bring to mental health assessment is intuitive thinking; (2) habitual cognitive errors and mindlessness, which are the possible side effects of long-lasting diagnostic practice, can be reduced by means of careful self-monitoring of the assessment process. A practical self-monitoring procedure is suggested.

Keywords: mental health assessment, clinical experience.

Meeting the demands of evidence-based practice in psychology requires solving numerous problems emerging at the interface of academic and occupational approaches to the tasks performed by psychologists. The main current of debates on this issue concerns psychological interventions, especially psychotherapy as direct intervention in the clients' mental state and life quality, but an issue no less important, though less often discussed is the ways of reaching empirically justified standards of reliability and professionalism in psychological assessment. Among the numerous specific issues that require examination in this context, the question of the role of clinical experience in the psychological assessment of

mental health has been asked for many years. In the literature, clinical experience is mentioned as an unfavorable factor, co-occurring with low assessment quality (see e.g., Stemplewska-Żakowicz, 2009). Still, in professional settings it is very highly valued. So-called clinical expertise is one of three elements in the definition of evidence-based practice in psychology (APA, 2006). Possessing clinical experience is formally required to qualify for training courses whose completion makes a psychologist eligible for a document certifying his or her practical competence in the area of mental health – such as a psychotherapist’s certificate or the title of clinical psychology specialist (see e.g.: <http://www.psychoterapia-polska.org/kto-moze-ubiegac-sie-o-certyfikat-psychoterapeuty-pfp>; <http://www.pttpb.pl/pl/pttpb-info/regulaminy/18-regulaminy/51-regulamin>). The Polish National Health Fund refunds the assessment work of psychologists in health care institutions, provided that they are psychologists with clinical experience measured by the length of service in a medical institution or by clinical specialty certification, the acquisition of which, as already mentioned, requires having proper experience (see the Order of the Minister of Health of August 30, 2009, *Dziennik Ustaw [Journals of Laws]* No. 140).

The incompatibility of different positions on the value of clinical experience could be resolved by assuming that it is formally helpful in professional career but at the same time a burden on the quality of professional work. In this article, however, we intend to demonstrate that the problem is more complex and that its solution requires that diagnosticians show sensitivity to this issue, adopt a special kind of attitude to their own work, and make systematic efforts that would allow them to make the best possible use of the accumulated professional experience as well as avoid the pitfalls that experience involves.

CLINICAL EXPERIENCE AS A TRAP

As early as the 1970s, the value of professional experience in mental health assessment began to be doubted and perceived as leading to a rigid, shallow, and narrowed down understanding of a person rather than – as experienced clinicians would like to believe – heightening sensitivity to the signals of various states and processes inaccessible in direct examination and extending the interpretative possibilities to relationships clinically observed but (still?) not described or explained by science. Research on these issues did in fact reveal not merely a lack of significant improvement in assessment competence with the acquisition of experience but its downright deterioration. Because this problem has been ex-

haustively presented in the Polish literature (Stemplewska-Żakowicz, 2009), we will limit the present discussion to presenting the major argument against the usefulness of clinical experience in assessment – namely, the claim that assessment is a cognitive activity and cognitive processes are subject to distortion in diagnosticians as well as in other people. Consequently, every “independent” observation or assessment made by a diagnostician which is not directly based on a strong scientific theory or on the results of standard assessment examination is unjustified, imprecise, and unreliable, and if it is repeated over the years of practice and thus established it becomes a permanent cognitive burden.

Summing up the numerous data, collected over many years, on the occurrence of typical perception and reasoning deficits in assessment clinicians, Garb (2010) lists nearly all deficits that are found in people: the first impression effect and the halo effect; involuntary assessment and inference; the use of heuristics of emotions, earlier behavior, information availability, and representativeness for a particular gender, social class, or ethnic or national group; a tendency to confirm hypotheses and to perceive illusory correlations; as well as excessive use of cause-and-effect thinking and contextual information. Another assessment distortion that is signaled more and more frequently is the preference for negative information in perceiving, reasoning, and remembering (Keyes, 2009). This principle organizing information processing is natural due to the importance of unfavorable situations (Baumeister et al., 2001), which, in clinical conditions, is additionally reinforced by the negative context of contact with the patient/client. The client initiates this contact because of the suffering and life’s difficulties that he or she regards as things of the utmost importance, demanding the clinician’s attention and understanding – and so the preference for negative information affects the course of cognitive processes in the diagnostician even more strongly (Snyder et al., 2001).

Apart from the universal phenomena that have been mentioned, specific factors that may occur in the diagnostician should also be mentioned among the factors causing cognitive distortions; these include both personal dispositions and temporary states that affect the course of information processing. The particularly detrimental dispositions include the rigidity and narrow character of the conceptual representation of the world, resulting in a reduced sensitivity to information incompatible with that representation or even in twisting or rejecting such information. Regardless of whether the depletion of representations stems from socialization and reflects the diagnostician’s personal outlook or whether it stems from training in a particular clinical approach and reflects his or her theoretical orientation, it is a source of persistent bias in assessment (Maddux, 2002;

see also Brzeziński, 2010; Brzeziński & Kowalik, 2000). The temporary factors distorting assessment at the cognitive level include fatigue, positive or negative mood, or a particular attitude caused, for instance, by some event in private or professional life or by a private event directly preceding the meeting with the patient/client. Such conditions occur occasionally, usually with little intensity, which – paradoxically – aggravates the problem by making it more difficult to notice them and take into account their possible impact on the course of assessment at a given moment.

It must be stressed that all cognitive limitations occur unconsciously and, as such, they are not immediately corrected or even reflected on. With the results showing that the amount of cognitive distortions in assessment does not decrease as years of practice elapse, it is legitimate to suppose that in this case the learning based on the effects of performing tasks, natural in the case of other professional activities, does not take place (Garb, 2010). This can be accounted for by the relatively weak feedback in mental health assessment, especially in the clinical area. This is mainly caused by the lack of clear accuracy criteria for mental health assessment and the frequent separation between assessment and treatment. Assessment usually precedes intervention and constitutes a separate part of the patient/client handling procedure. It is sometimes even conducted by a person different than the therapist, which means that immediately after performing his or her work the diagnostician loses touch with the patient and has no access to information about the validity of the conclusions drawn. In these circumstances, with little feedback information available, not only is there no effective learning taking place, but, with time, what happens is the automation of repeated errors stemming from the above-mentioned distortions in the perception and resolution of decision problems. Admittedly, correct cognitive activities undergo automation too; however, this constitutes a threat to the accuracy of assessment as well, since they become unconscious and uncontrolled. When speaking of the pitfalls inherent in professional routine, it is precisely the automation of professional cognitive activities that we mainly have in mind.

From the point of view discussed here, clinical experience is, above all, reiteration of common (and largely erroneous) patterns of thought and action. Reliance on such reiteration, and even merely allowing it to play a role in mental health assessment, lowers the value of assessment as well as exposes the patient to the dangers stemming from the incomprehension of his or her problems and from the resulting erroneous decisions concerning the patient.

THE BENEFITS OF CLINICAL EXPERIENCE

In spite of the circumstances that seriously argue against clinical experience, there are some objections to questioning its usefulness. Not only is it difficult to accept that, of all occupations, clinical psychology should be the one in which professional experience constitutes a harmful burden; we are also in possession of empirical data that, directly and indirectly, shed favorable light on the value of experience in assessment.

The discussion of these data should begin with relating clinical experience to what is called clinical assessment. This expression refers to mental health assessment procedure that has no clear forms or grounds (Westen & Weinberger, 2005; see also Stemplewska-Żakowicz, 2009). This manner of assessment is challenged from the viewpoint of the scientist–practitioner model, established in psychological assessment and referred to as the statistical approach, according to which every element of assessment should have clear justification in specific empirically verified knowledge and should meet the standards of scientific research (Cautin, 2011). Data concerning assessment accuracy indicate, generally speaking, that clinical assessment as defined above does indeed prove to be less effective than the statistical approach. Meta-analysis of data from 67 studies showed that the use of statistical methods in assessment generally leads to a 13% increase in assessment accuracy (Ægisdóttir et al., 2006). However, drawing conclusions from that research involves certain difficulties, since this tendency has limitations: not all statistical procedures have an advantage over clinical ones, and only in a small number of assessment areas has such an advantage really been found. It turned out, for example, that statistical procedures guarantee higher assessment accuracy only with regard to those clinical problems that are well known to the diagnostician, and that a truly marked and definite advantage in forecasting on the basis of statistical methods concerns only violent and self-destructive behaviors. The authors conclude their meta-analysis by declaring clinical assessment to be entirely acceptable, the only reservation being that diagnosticians should not rely on it exclusively and that combining it with the statistical approach appears to be the optimal solution (cf. Paluchowski, 2010).

In order to better understand the nature of clinical assessment as a cognitive process and to correctly judge its value for the assessment and explanation of mental health, it is worth considering its relations with intuitive thinking. Intuition is defined as reasoning about a specific problem that takes place unconsciously, based on an extensive network of associations and with affect playing a role, too (Dane & Pratt, 2007). Intuition emerges in the face of new problems

(professional, interpersonal, or moral) in areas in which the individual has collected information and practiced using it in his or her life, which means that the basis for the capability of intuitive thinking is the possession of solid relevant knowledge and the repeated use of that knowledge (Gore & Sadler-Smith, 2011). Because research results indicate that judgments and decisions that people reach intuitively appear in particularly complicated situations and are valid in the sense that they meet the requirements in a given field or in the sense of general adaptability, this way of processing information is regarded as particularly advantageous. Based on research on unconscious psychological automatisms we know not only that these automatisms concern advanced cognitive activities but also that in the face of particularly complex problems, whose solution requires taking into account a considerable amount of information, reasoning taking place unconsciously – so-called deliberation without attention – leads to more accurate decisions than conscious reasoning (Dijksterhuis, 2006). Thus, the assumption that clinical assessment may have the character of intuitive thinking not only explains why it is sometimes accurate but also sheds light on clinical experience, since the repeatability of certain information processing procedures is the basis of accumulating extensive knowledge and developing unconscious automatisms in its use. It must be stressed, however, that quick assessment without using specific procedures may also result from superficial intellectual involvement, described in psychology as the mindlessness phenomenon (Langer, 2009). A confirmation of the fact that clinical assessment may have a character either intuitive or “mindless” is the lack of strong arguments that it is better or worse than the statistical method. As research results show, differences are neither large nor consistent here. This dual nature of clinical thinking is also confirmed by results showing that the advantage of statistical methods over clinical ones concerns very well known problems (Ægisdóttir et al., 2006), namely such situations in which a quick diagnosis made “out of the blue” more probably stems from mindlessness than from intuitive thinking.

The data that directly concern clinical experience argue in its favor, too. The research results given by APA (2006) show a marked professional advantage of clinicians with many years of experience over novices. As it turns out, the former are better at recognizing the characteristic patterns of human functioning; they are more effective in rejecting information that is irrelevant to the patient and to the treatment, have broader and better organized psychological knowledge, have knowledge organized in accordance with functional criteria (as opposed to descriptive ones), have more fluid and automatic access to knowledge pertinent to the current clinical task, are better at adapting to new situations, more often mon-

itor their own way of thinking and acting, detect their own mistakes more effectively, learn more, actualize more concepts, and make better use of the time assigned to case conceptualization. These data explain why, according to APA, expertise – one of the three main criteria of evidence-based psychological practice – is defined, for instance, in terms of clinical experience. They make it legitimate to suppose that, despite limitations and cognitive distortions, together with clinical experience there also appear desirable professional skills and habits – including those that are directly useful for assessment purposes as well as those that improve general professionalism and thus also indirectly enhance assessment.

The most convincing defense of the value of clinical experience for mental health assessment follows from the analysis of the results of research devoted specifically to this issue. Spengler and collaborators (2009) criticized the earlier reviews of research in this field, unfavorable to clinical experience, for their selective and survey (qualitative) character and carried out their own statistical meta-analysis of the available research results. They adopted a few assumptions which, apart from the application of statistical procedures, were meant to improve the precision and reliability of conclusions. They decided that the uniform criterion for evaluating professionalism in clinical assessment will be general assessment accuracy as well as accuracy evaluated separately for each of the key elements of assessment: identification, prediction, and recommendation. They took into account two forms of clinical experience: experience traditionally understood, namely such that results from many years of practice, and so-called educational experience, which results from intensive clinical training received mainly as part of doctoral studies. The latter form of experience was taken into account because the authors decided that the degree of familiarity with assessment tasks and the degree of being accustomed to clinical reality is incomparably greater in people who pursue supplementary education at clinical doctoral programs than in individuals who begin assessment practice directly after graduation, assessment issues occupying a relatively little part of graduate studies and being discussed mostly at the theoretical level. For this reason, according to the authors of the meta-analysis, the traditional classification of novice practitioners after doctoral studies and after graduate studies into the same category of “novices” is ungrounded.¹ At the same time, however, educational experience and

¹ Consistent with this position is the research carried out by A. O’Donovan’s team, which demonstrated a significant difference in the effectiveness of teaching assessment competencies between postgraduate internship and internship combined with academic education (postgraduate academic education), the difference being in favor of the latter. If the undertaking of practical

length of service were considered as separate due to different kinds of contact with practice.

The meta-analysis covered 75 studies involving 4,607 clinicians. It showed a positive relationship between both kinds of clinical experience and the accuracy of clinical assessment in all the three areas considered. Although the relationship proved not to be particularly strong (mean $d = 0.12$), it is visible that experience improves assessment skills, especially in the areas of identifying mental disorders ($d = 0.15$) and predicting behaviors ($d = 0.24$). It also turned out – despite fears of the adverse effects of professional routine – that considerable experience was the most advantageous, since the strongest effects were found in comparisons between individuals with no experience and very experienced ones. This advantage manifests itself above all when mental state assessment criteria are ambiguous, which suggests the already discussed contribution of intuitive thinking in the case of experienced diagnosticians. At the same time, the authors point out two additional circumstances that, in their opinion, increase the reliability of results and their significance in favor of clinical experience. Firstly, samples in the studies available for meta-analysis were small, which negatively affects the possibility of obtaining strong effects, and therefore the small effects that were found gain in importance in the light of this explanation. Secondly, the positive relationship between experience and assessment accuracy proved to be resistant to the contextual factors included in the analysis. It must be added, though, that the general reliability of results is reduced by the deficiencies of the empirical material on which meta-analysis was performed.

Tentatively summing up the recommendations that follow from the meta-analysis discussed, we may assume that diagnosticians should not rely too strongly on their experience, but they should not ignore what experience suggests, either – least of all in situations unclear when it comes to the identification of disorders and the prediction of behaviors. Another important conclusion is that intensive clinical education training has a value similar to clinical practice from the point of view of improving accurate assessment skills, which suggests the

interventions by a novice diagnostician is not accompanied by training in academic knowledge offered at the postgraduate level but merely by supervision that consists in discussing the activity reported by the learner, after a year of such professional activity there occurs a deterioration in the sphere of assessment skills (O'Donovan, Bain, & Dyck, 2005). This may be an argument not only in favor of the necessity of lifelong education but – we believe – also in favor of understanding clinical experience in two ways: as a potentially advantageous intuitive process based on effortless processing of knowledge at the automatic level or as mindlessness in action, disadvantageous to practice.

legitimacy of taking up such training, or perhaps – more generally – to the legitimacy of making various efforts to ensure the professionalism of interventions.

MAXIMIZING THE BENEFITS OF CLINICAL EXPERIENCE

The reflections on clinical experience so far encourage us to appreciate its benefits for assessment, but at the same time to precisely establish the conditions that determine whether benefits do indeed occur without the diagnostician falling into the trap of cognitive errors and routine “mindlessness.” An important clue to how to look for those conditions may be the already cited findings of APA (2006), which clearly show that the competencies that grow as psychologists acquire professional experience include ones that ensure the control of errors made as well as the monitoring of their own reasoning and activity. It therefore seems that, with regard to assessment, the key condition of deriving benefits from clinical experience may be the introduction of procedures enabling psychologists to detect and correct cognitive distortions and distinguish “mindlessness” from intuitive thinking.

Among the means of controlling the assessment process, those mentioned in the first place are the procedures of searching for feedback information on assessment accuracy – that is, actively making it possible for oneself to learn from one’s own assessment mistakes and successes. Still, one must not rely on this exclusively, since there is no empirical support as yet for the expectation that feedback information constitutes a factor that makes for better assessment. In the meta-analysis carried out by Splengler and colleagues (2009) no such relationship was found, but – as the authors stress – this factor was considered only in two studies, which means the issue can hardly be regarded as settled. At the same time, however, theoretical doubts appear as to whether or not the acquisition of feedback information can make experience an advantage, since cognitive distortions such as the confirmatory tendency affect the receipt of feedback information (Garb, 2010). Yet another doubt stems from the fact that feedback information usually concerns the final product of assessment and hence it neither helps to identify the specific mistakes made “along the way,” which makes those mistakes difficult to eliminate in the future, nor helps to rectify the mistakes made. It is also necessary to allow for the already mentioned limited access to feedback information concerning assessment accuracy, resulting both from systemic pa-

tient/client care solutions and from natural obstacles to keeping track of its long-term and delayed indicators.

It is, then, worth looking at the second factor involved in controlling one's own assessment, namely self-reflection. It is the most easily accessible and natural way of monitoring one's own diagnostic activities, and one that also allows to avoid some of the weaknesses inherent in relying on feedback. Effective self-reflection seems to require introducing certain special rules and even certain special elements into assessment procedures because, in order to yield benefits, self-reflection must be applied to the entire assessment procedure so as to ensure its systematic character, that is, the consistency of the implemented strategy and particular decisions with the adopted model of assessment. The systematic character is expressed in indicators such as the number and diversity of measures used, the number of hypotheses formulated, as well as the heterogeneity and reliability of the premises from which they were generated (the aim being to reduce reliance on theories, especially those with questionable scientific status), consistency in the verification of hypotheses (including the formulation and verification of counterhypotheses), and the thematic diversity of conclusions (Garb, 1998; Bell & Mellor, 2009; Keyes, 2009). Promoting self-reflection in assessment is not incompatible with emphasis on obtaining feedback information, but, unlike the latter, it is aimed above all at the elimination of errors caused by "mindlessness" and cognitive limitations as they arise and at improving the accuracy of the currently performed assessment by actively striving to maintain the completeness and justifiability of the assessment procedure itself rather than only at the verification of its product. It is thus a means of improving one's assessment-related activities and competencies rather than merely of evaluating them.

Given the continuous character of the procedure and the diversity of elements that are to be taken into account in assessment self-reflection, the monitoring of one's own work in this respect is difficult indeed. It therefore requires proper preparation and support. The recommended support for self-reflection is diagnostic supervision (Cooper-Thomas & Traves, 2008), no less needed though much less frequent than supervision in psychotherapy. Another kind of support, a more accessible one, can be detailed registration of the course of assessment in every single case. For example, Wright and Lopez (2009) propose recording data from assessment examination using a template obtained by combining two two-term categories: (patient/client vs. his/her environment) and the significance of the facts determined (favorable vs. unfavorable). Following the content of the four areas that combinations of these categories yield, the diagnostician may monitor the effects of data collection and, on that basis, select questions and as-

assessment tools in such a way as to obtain information necessary to formulate a diagnosis balanced in terms of the identification and understanding of difficulties as well as resources both in the patient/client and in his/her environment. Using a template facilitates conscious control of the systematic character of one's own assessment work in the area defined by the categories determined in accordance with the principle of even distribution of attention, time, and space in the final report between the four distinguished areas of data. This particularly prevents frequent mistakes that consist in habitually omitting or devoting disproportionately little space in assessment to positive aspects of the patient's/client's life and external factors that define his or her situation.

The template discussed covers only selected areas of assessment, but using this way of thinking about supporting self-reflection it is possible to develop and use more elaborate forms referring to many elements of the procedure in accordance with the adopted model of assessment, including the proportions between qualitative and statistical methods, which most diagnosticians "unwittingly" combine regardless of their beliefs concerning the applicability of the former (Strieker, 2000) and, in consequence, without conscious control. An example of an elaborate template comprehensively supporting the self-monitoring of assessment may be the Assessment Form presented in Figure 1, covering all the essential steps of this process.

The structure of the Assessment Form is governed by three principles of conducting psychological clinical assessment, which are usually discussed separately in the literature; it seems, however, that only their joint application guarantees the reliability and modernity of the assessment process. The first principle is functionality, which states that assessment should be conducted with a particular aim in view (cf. Pasikowski & Sęk, 2010). The second principle concerns the scientific character of assessment, namely, its being planned and conducted on the basis of reliable up-to-date psychological knowledge (cf. Brzeziński, 2010; Brzeziński & Toeplitz-Winiewska, 2010). The third principle – the completeness of assessment – refers to the scope of content and the ways of collecting data, which should be exhaustive due to the goal that has been set and the possibilities offered by science and by the diagnostician's professional experience (Shadel, 2010). The Assessment Form has been divided into three segments, corresponding to the successive stages of the assessment procedure – preparation (the pre-assessment stage), examination (assessment proper), and the processing of information obtained, including the communication of assessment results.

Preparation			Study			Data processing						
Task	Area	Problem conceptualization		Phenomenon	Tool	Measurement Result	Conclusions				Summary	
		Assumptions	Questions Hypotheses				Patient	Environment		Case description	Case Presentation (communication)	
1	2	3	4	5	6	7	Resources	Deficits	Resources			Deficits
Assessment of Functioning												
Explanation of Functioning												
Prediction of Functioning												
Recommendation												
Other												

Figure 1. Assessment Form

The aim of the first segment of the Form is to monitor the way in which assessment objective is set: as a result of the choice of assessment task (or tasks) and areas of functioning that the task will concern, specific questions are asked and specific hypotheses are put forward for verification. Thus, the proposed version features an extension of the traditional approach, in which assessment focuses on modifiable variables (Paluchowski, 2006, 2007), by the possibility of including variables that we do not plan to influence directly but which are known to be interrelated with other variables whose modification is considered, for instance, on the basis of knowledge derived from research on the indicators of the effectiveness of psychological interventions (Castonguay & Beutler, 2006; Norcross, 2002). It must be stressed that, in the Form, the knowledge used in translating assessment tasks into questions and hypotheses is registered (the “Assumptions” column). Consequently, the use of this segment of the Form imposes conscious reflection on the source of the knowledge used for planning assessment. Given that knowledge may derive from the adopted clinical model or from basic psychology, or that it may be pragmatically compiled from various sources (Paluchowski, 2006), or it may come from experience, thorough self-monitoring will allow to evaluate the situation and, if necessary, to correct it – especially if the inspection of the record in this segment of the Form reveals that knowledge derived from experience dominates in the process of formulating questions and hypotheses over scientific knowledge or that it is absent from it altogether.

The second segment of the Form is aimed at controlling the selection of assessment instruments appropriate for the objective, that is, at controlling the manner in which hypotheses are translated into indicators (the “Phenomenon” column). Their proper selection is crucial to the success of the examination (cf. Suchańska, 2007; Stemplewska-Żakowicz, 2005) since empirical data show that this maximizes the chance of asking questions and using other tools of high assessment value (Brammer, 2002). The specification of tools applied in turn allows to check whether their set goes beyond those traditionally associated with clinical assessment (such as MMPI, Rorschach’s, TAT, or Rotter’s tests). Most of them cannot be linked with the concepts and mechanisms that psychology currently refers to in describing and explaining human functioning, so they should be supplemented with such tools that specifically refer to the indicators measured (Shadel, 2010). The analysis of record in this segment also gives a possibility to control the proportions between standard and nonstandard techniques applied.

The aim of the last segment is to control the integration of the obtained data. It is necessary to stress the difficulty inherent in this part of the assessment process, particularly when its scientific basis is knowledge from different

branches of psychology (e.g., developmental psychology, personality psychology, and the psychology of emotions) or from mutually unrelated theoretical models and results scattered across specific branches (Shadel, 2010). Given the lack of generally accepted rules concerning how to bring together data collected in the assessment process that is elaborate in terms of theoretical background and measurement (Wright & Lopez, 2009), focusing the synthesis and interpretation of results on the assessment task set at the beginning of the assessment may effectively guide work at this stage. This is all the more beneficial as information thus organized are directly translatable into communication directed at the recipient of assessment, who is interested in its outcome precisely because of the aim.

The use of a template such as the Assessment Form presented in Figure 1 may bring several benefits. Firstly, its very construction requires preliminary reflection on the preferred assessment model as well as on each of its steps and stages (see e.g., *Guidelines for the Assessment Process* – Fernandez-Ballesteros, et al., 2001; the model proposed by Paluchowski 2006, 2007; and the one by Szustrowa, 1991). Secondly, working with the Form introduces order into theoretical thinking and practical activities, since it guides the diagnostician through successive decisions, thus preventing omissions and “shortcuts.” Thirdly, the record of successive choices as well as their grounds and results allows to reduce memory distortions that interfere, for instance, with the self-correction of the procedure. Fourthly, the content of the Form gives a complete picture of the earlier assessment process, which makes it possible to reflect on and control not only particular decisions but also its entire course, including the proportions and interrelations between “clinical” and statistical elements in examination and reasoning; and, as research shows – at least in the case of nosological assessment – the most effective assessment strategy appears to be the combination of analysis based on experience (identifying the client’s ailments on the basis of the similarity of their image to cases already known from earlier practice) with analysis based on knowledge and “hard” measurements (Kulatunga-Moruzi, Brooks, & Norman, 2011; cf. Eva, Hatala, Leblanc, & Brooks, 2007). Fifthly, such a register ensures precise communication concerning the objectives and execution of particular assessment activities when assessment supervision is applied. Sixthly – the assessments following such a consistent and consciously monitored procedure may constitute a basis for capitalizing on the experiences resulting from good practice. These assessments are relatively less prone to cognitive bias and to the “mindlessness” phenomenon; they can also be compared, which facilitates relating them to one another. Finally, it is worth stressing that for different assessment tasks, performed in a variety of practical contexts, more specific tem-

plates may be useful – due not only to the material content but also to the inclusion of other elements. One of the most obvious changes is the extension of the Assessment Form to include another segment, aimed to assess the results of interventions (see the GAP model – Guidelines for the Assessment Process – Fernandez-Ballesteros et al., 2001). The Assessment Form presented here is therefore a proposed basic version of the tool supporting self-reflection in the assessment process, from which various other versions can be developed.

THE IMPORTANCE OF CLINICAL EXPERIENCE – CONCLUSION

The picture that emerges out of the solutions presented in the article is one of clinical experience as a factor whose influence is considerably modified by motivational and cognitive determinants. The answer to the question of the role of experience may therefore come down to a description of the conditions that should occur for it to contribute to the best possible assessment of mental health. It seems that the essential thing is the monitored structuring of planning and assessment as well as data processing, including the communication of assessment results. The beneficial introduction of experience-based knowledge into the solution of a specific assessment problem will occur when the diagnostician is motivated to thoroughly register and analyze his or her own interventions and the information collected in the course of assessment. This will allow to buffer the negative influence of limitations in cognitive processing and the “mindlessness” tendency, which every diagnostician struggles with at some point in professional practice.

Summing up the reflections on the status of clinical experience, one cannot overestimate the need for research in this area. This is not simply a matter of more research but a matter of their better quality. What needs improvement is the definitions of clinical experience and the effectiveness of assessment. The experience indicators used at present, namely the length of service or education, should be refined in a way modeled, for instance, on research concerning the role of experience in psychotherapy, where, for example, the minimum length of service entitling one to be regarded as having experience is considered to be between 10 and 15 years. It may also be a good idea to consider supplementing the quantitative indicators of experience with criteria pertaining to its quality (Spengler et al., 2009). Assessment accuracy evaluation should be made objective and should refer to more specific and concrete assessment activities. The

most advanced work in this field can currently be found in American psychology. In 2005, a task force was established (*Assessment of Competency Benchmarks Work Group*; Fouad et al., 2005) that defined 15 key competencies (including assessment competencies) based on the American model of the psychologist's competencies, namely the so-called Cube Model (Rudolf et al., 2005, cf. Paluchowski, 2012), and described the manifestations of each at the level of observable behaviors at three stages of development, creating the so-called Benchmark List. Drawing on that list, there also appeared the Competency Assessment Toolkit (Kaslow et al., 2009), being a set of 14 tools for assessing the level of students' competence. In Europe there is a lack of similar tools helpful in monitoring the dynamics of changes in the level of competence that accompany the accumulation of practical experience. Everywhere in the world there is a lack of research with sufficient ecological validity, carried out in clinical conditions, in which situational and personal factors influencing the stage-related and final levels of assessment task performance would be controlled (cf. Roe, 2002). There is a need for longitudinal research, hardly done at all in this field nowadays. There is also a need for research aimed at detecting the characteristic mechanisms of influence of clinical experience on assessment quality, for example the role of intuitive thinking and "mindlessness." Finally, the simple observation that some clinicians are better at assessment than others (Holt, 1990) suggests that it is worth taking into account individual differences as predictors and mediators of the constructive use of experience (Skovholt et al., 1999). By systematizing the knowledge on the nature of experience and its impact on diagnosticians' work, we could contribute not only to better assessment but also to a more effective education of psychologists in this respect.

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