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THE FACES OF PROFESSIONAL EXPERIENCE IN CLINICAL ASSESSMENT. A COMMENT ON TRZEBIŃSKA AND FILIPIAK (2015)

The comment addresses issues concerning the importance of professional experience for various kinds of assessment carried out in the field of clinical psychology. The influence of clinical experience is understood broadly and considered in connection with assessment procedure leading to differential and structural-functional diagnosis, with special attention to the context of the diagnostocian's personality. The limitations that stem from monitoring focused exclusively on cognitive processes are also discussed.

Keywords: clinical assessment, assessment procedure, professional experience, clinical supervision.

Clinical assessment (interpretation and diagnosis) is a complex process and, according to Trull and Prinstein (2013), its effects are influenced by things such as: (1) data concerning the patient obtained using various methods (tests, case history, behavior observation); (2) clinician's reactions to such data and to the patient; (3) clinician's characteristics, such as cognitive structures, preferred theoretical approach, and others; (4) situational variables, e.g., connected with the workplace or a "fashion" for diagnosing certain mental disorders. As emphasized by Butterworth (2006; cf also Berg, 2008), at different stages of this

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process the clinician activates two different groups of skills and information: explicit, consciously accessible, derived from explicit knowledge – and implicit, often equated with intuition. Looking for procedures and algorhithms in assessment, evidence-based practice in psychology attaches much greater importance to explicit than to implicit knowledge, often treating the two as separate systems or pointing out the negative influence of intuition on reason. It is not very frequent for papers to show the two sides of intuition in the assessment process (which the authors of the article to some extent do); it is still less frequent for them to address issues concerning clinicians' and therapists' ability to distinguish (and the procedures of distinguishing) an intuition that is an effect of countertransference from an intuition that is a special "creative act," neither bearing reference to explicit knowledge. In consequence, clinicians are required to have practical expertise encompassing specific competencies from different areas, namely knowledge, general clinical skills, specific technical skills, interpersonal skills, and professional evaluation skills, the requirements concerning personal development being often overlooked (cf. Overholser, 2010). A clinician's professional experience, in the best sense of the term, is defined as the ability, exhibited in the process of assessment, to activate explicit knowledge and skills as well as the ability to distinguish intuition reflecting the activation of countertransference from adequate implicit knowledge. The inconsistency of research results concerning the importance of intuition to assessment accuracy indirectly confirms this thesis or lends credence to it.

We assume that each of the three types of clinical assessment – differential, structural-functional, and epigenetic[1] – calls for a different kind of practical expertise, which is a very complex kind of competence acquired over years of work and education, requiring constant deepening and broadening of knowledge, the improvement of a variety of skills, and personal development on the diagnostician's part. Professional experience, understood as the number of years of service in institutions dealing with mental health, is one of the aspects of expertise, whose influence on the appropriateness of assessment procedure depends on many other variables, including the diagnostician's self-confidence (Overholser, 2010). Not only particular types of assessment but also, according to Groth-Marnat (2003), each of the successive phases of assessment – collecting and organizing data as well as interpretation and clinical inference, largely consisting in data integration, which makes it possible to build up in-depth knowledge

[1] Due to the complexity of epigenetic assessment and the necessity it involves of using current knowledge about the causes of mental disorders, we do not discuss this area here; see more in Cierpiałkowska, 2007.

about the patient – requires different competencies on the clinician's part. The role of professional experience in the phase of data collection may differ, for example, depending on the type of methods used – in structured methods experience is slightly less important, though data are not unambiguous in this case, either (Beatty, 1995; Westen & Weinberger, 2004).

Because there is no single kind of clinical assessment, a clinician does not activate the same explicit and implicit knowledge in the process of inference, the same way of processing information about the patient, or even the same kind of cognitive and emotional abilities to monitor his or her own activity. Out of the three types of clinical assessment, only differential assessment is discussed in the article; the authors omitted to analyze the other two, whose essence is to explain what underlies health or disorder. Differential assessment consists in recognizing symptoms (i.e., a person's clinically meaningful behaviors and experiences), relating them to the description (matrix) of clinical conditions distinguished in medical classifications (ICD and DSM), and making a judgment on whether the person is healthy or suffers from a mental disorder. A diagnostician collects data from the phenomenological level using self-report, observation, and test methods. As Meehl's classic research and its various continuations show, clinical assessment, understood as intuitive, informal aggregation and interpretation of data is worse than assessment of test results consisting in statistical analysis, e.g., actuarial (cf. Westen & Weinberger, 2005; Garb, 2010; Paluchowski, 2007).

The issue of the significance of clinical experience becomes even more complicated if we consider the common co-occurrence of mental disorders, especially those from Axis I and Axis II of DSM, and the resulting necessity of making a dual diagnosis. In order to make it, a clinician has to identify two different categories of disorders on the basis of information about the first-rank significance of some symptoms to the identification of one disorder while not overlooking the significance of second-rank symptoms, which are often first-rank ones for the second disorder. Studies show that experts with at least 12 years of experience, as opposed to novice clinicians, do not ignore less probable alternative categories but exhibit a predominance of multicategory inference in their familiar field (Hayes & Chen, 2008), which will be conducive to accurate diagnosis in less unambiguous cases.

The aim of structural-functional assessment is to explain the references and/or meanings that these symptoms have in the structure of personality, understood in a specific way in each of the paradigms in psychology This kind of assessment is not limited to describing elements or aspects of personality and, above all, the dynamic relationships between these elements, with special atten-

tion to those mechanisms that sustain symptoms and/or adaptive behaviors. A clinical diagnostician focuses also on identifying the external stimuli significant for a person that activate these pathogenic and/or salutogenic mechanisms (Sęk & Cierpiałkowska, 2005). Formulating such a diagnosis is a divergent problem with many possible solutions, in which producing consistent explanations in the language of a given theory plays the decisive role. In this kind of assessment, the use of psychological tests is treated as collecting data and their results are a source of hypotheses rather than the final effect of the procedure solving assessment problems (Groth-Marnat, 2003). What plays an immense role in structural-functional assessment is the combination of symptoms (reportable and observable) with theoretical constructs that make it possible to build consistent explanations based on a particular theoretical approach. A clinician needs not only cognitive competencies (knowledge, self-monitoring) but also personality-related (emotional) ones to link external manifestations (words, gestures, behavior) correctly with mentalistic terms and psychological ones deriving from theory in order to make a decision to apply an appropriate therapeutic intervention. Intuition may prove to be highly deceptive when it becomes necessary to recognize strong desires, negative emotions, and incomprehensible behaviors in a patient and to translate them into the language of pathomechanisms associated with the selected psychological theory. However, also excessive use of explicit knowledge – for example, following thoroughly described procedures – may lead a clinician astray, since excessive reliance on the algorithmization of assessment may perform defensive functions, thanks to which the diagnostician does not need to notice those aspects of the patient's psychological functioning that are personally difficult and for the diagnostician and carry a potential for conflict.

Even though practices consisting in purposeful application of professional knowledge to solving assessment problems are desirable, it is worth looking at the role of the clinician's possibilities of transforming explicit knowledge under the influence of feedback information in the process of acquiring professional experience. This is because experience is not defined merely by the time that has elapsed since the completion of a particular stage of education but, above all, by exposure to a variety of clinical cases, by repeated exposure to them, by involvement in professional supervisions, and by personality dispositions to process feedback information. In qualitative research on the significance of this information in psychologists' professional development, clinical experience, understood, among other things, as multiple performance of a particular diagnostic activity, has been observed to be directly related to self-confidence. Clinicians with average self-confidence more often took feedback information into account,

even that information which was a potential threat to their self-esteem, than clinicians with high self-confidence, who frequently did not take such information into consideration (Eva et al., 2012). Although the need to work on personal problems is more strongly stressed in the case of therapists, it also refers to clinical diagnosticians, whose countertransference processes are related to assessment accuracy. The tradition of clinical supervisions as well as Balint and Brammer Groups (Brammer & MacDonald, 2003) is the appropriate context for reflection in this area, and the reflection should be extended by contemporary research.

The monitoring of the assessment process in which a clinician is involved cannot be overestimated. However, it has at least two aspects: cognitive (the awareness of the limitations of one's own mind stemming from the nature of its functioning, cognitive economy, etc.) and personality-related – resulting from personal experiences related as well as unrelated to the situation of assessment. The influence of using the self-monitoring assessment procedure based on an Assessment Form on the accuracy of assessment has rather important limitations, which stem from: (1) the complexity of the assessment procedure – it does not only lead to differential diagnosis; (2) the necessity of monitoring not only cognitive processes but also the diagnostician's personality characteristics and their effects on assessment.

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